PrePhyX

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PHYsiotherapy
e**X**ercise programme

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Introduction

Healthcare service delivery is faced with several challenges, including provision of physiotherapy services. There are increases in the ageing population, healthcare costs and patient expectations but no concomitant increase in the number of registered physiotherapists (PTs). Therapy Assistants (TAs) perform clinical tasks traditionally done by PTs and are deployed in areas where patients are medically stable to independently supervise exercises done by patients. However, in an acute neurological ward, not all patients are medically stable e.g. adverse events such as an unexpected neurological deterioration may occur. Hence TAs are only tasked to assist PTs to mobilise patients safely instead of seeing patients independently.

Aligned with the nationwide healthcare shift to go 'beyond quality to value', there is a need to explore newer models of care. Thus, our team has decided to deploy TAs to perform independent direct patient care in an acute neurological ward by exploring its feasibility and safety first.

Methodology

The team used the FOCUS-PDSA Model due to the need for rapid cycle improvement. The first step was to develop an action plan (Figure 1).

F	Find a problem	Insufficient PTs due to increased workload
O	Organise a team	PTs and TAs working in the ward
C	Clarify the problem	Mapped process of how patients receive physiotherapy
U	Understand the problem	PTs performing clinical tasks that can be delegated to TAs
S	Select an intervention	TAs to attend to all suitable patients in the ward safely

Figure 1 Developing an action plan using FOCUS.

In accordance to the action plan, PTs will review patients in the morning and perform daily rounds together with TAs. Once patients are deemed suitable and medically stable by the PTs, clinical tasks will be delegated to TAs to perform. TAs will subsequently provide feedback to the PTs if there were any difficulties with assigned clinical tasks.

With the selected intervention, the team entered the implementation phase which lasted 3 months, thus kickstarting the PDSA Cycle (Figure 2).

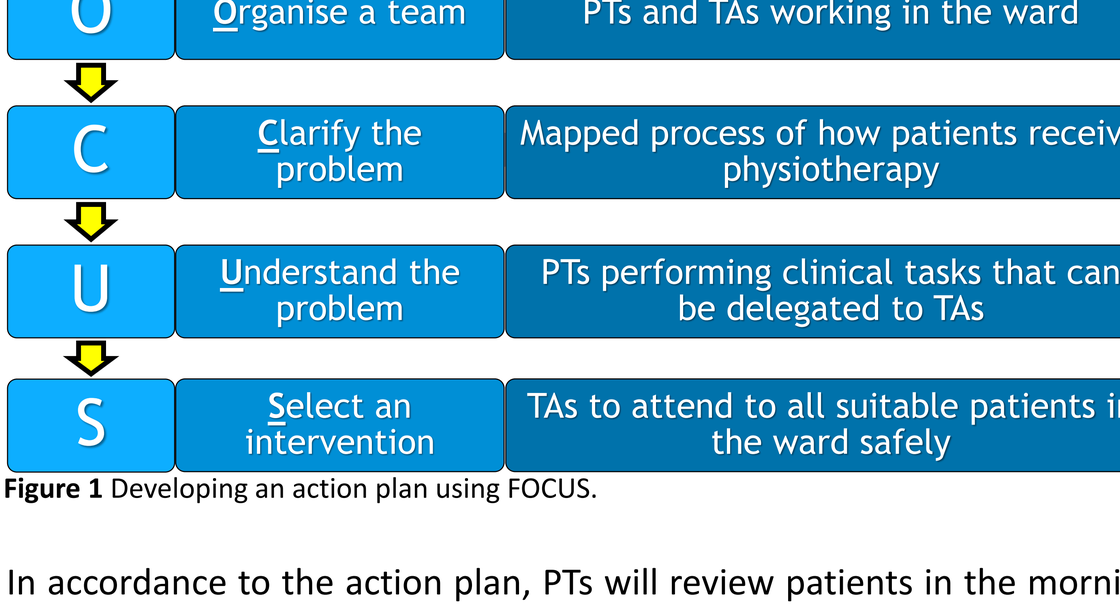

Figure 2 Implementation phase: PDSA cycle.

Results

Safety

There were **zero reported incidences** linked to this project.

Feasibility

In the 3 months preceding the implementation phase, the FTE for PTs and TAs was 3 and ≥1 respectively. During the implementation phase, the FTE for PTs and TAs was 2 and 1 respectively, a decrease in manpower for both PTs and TAs. Total patient attendances in the preceding 3 months was 1154 and was 1094 during the implementation phase. Patient attendances per FTE of PT was higher in the implementation phase (Figure 3), showing an improvement in productivity. Hence, delegating clinical tasks is **feasible**.

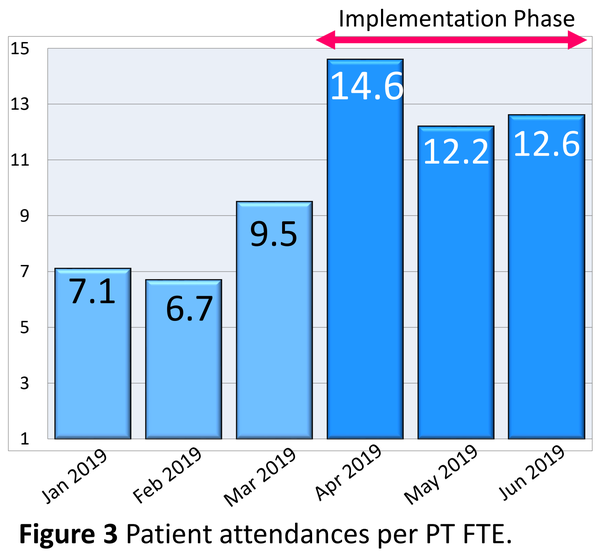

Figure 3 Patient attendances per PT FTE.

After Action Review (AAR)

The team carried out the AAR guided by the standard questions, and this is summarised in Figure 4. However, the team also decided that it was worthwhile to delve deeper into what went well, and what can be improved. As such, the facilitators and barriers (Figure 5) was explored.

What was expected to happen?	Zero incidences	Feasibility check
What actually occurred?	Zero incidences	Feasibility confirmed
What went well and why?	Improved productivity	Nil patient complaints
What can be improved and how?	Tasks not delegated at times	Difficult with a covering TA

Figure 4 Table of summarized AAR results.

Facilitators	Barriers
PTs and TAs have high level of clinical knowledge	Lack of clarity on selection of tasks to be delegated
PTs and TAs are senior and experienced	Lack of clarity for accountability
PTs and TAs have intimate knowledge of existing resources/equipment	Unwillingness of staff to delegate clinical tasks
PTs and TAs have high clinical competency level	High level of clinical knowledge needed
PTs and TAs have existing close working relationship	Amount of time taken to document sessions

Figure 5 Table: facilitators and barriers for delegation of clinical tasks to TAs.

Conclusion

Right-shaping of physiotherapists through delegating suitable clinical tasks to therapy assistants is feasible and safe in an acute neurological ward. Secondary findings include increased productivity even with decreased resources, increased satisfaction levels of PT as they are able to perform at the top of their license and increased satisfaction levels of TAs as they feel empowered.

Future Plans

Further work in relation to delegating tasks include clarifying the identified facilitators and barriers specifically in the areas of adequate training for both PTs and TAs, having clear processes to facilitate delegation and exploring both clinical efficacy and cost-effectiveness of service provision of said delegation.