Parkinson’s Disease
A Community Multidisciplinary Approach

DDHHS Community Care
Allied Health Service

Aims of presentation

• Increase awareness of the role of our MDT within the community setting
• Demonstrate Interdisciplinary team work using Parkinson’s as a case example
• Acknowledge barriers that comes with service provision within the community
Who are we…

- DDHHS Community Care Allied Health team
- Inter-disciplinary team approach
- Specialist therapy services
- Regional & rural home based service delivery
- Travelling service
- ‘Hub & Spoke’ model of service delivery
- Day trips within 1 hour of main hub
- Outreach service delivery incorporating satellite hubs
Geographical areas serviced

Legend:
- Up to 1hr driving time
- Up to 2hrs driving time

1. Service a large geographical area
2. Maintenance therapy within home
3. Client doesn’t have to have rehab potential
4. Prevent hospital admission
5. Thinking outside the box
6. Joint home visits
7. Trans-disciplinary approach
8. Strong link within rural communities

How we are different?
Benefits of community MDT approach

For the client & carer
• Increased access to services with an integrated approach
• Client directed therapy
• Home based service
• Decrease in fatigue, travel costs and stress
• Clients have a “go to” person
• Prompt & coordinated consultation
• Constant monitoring and screening thus increased compliance with therapy

For the Health Service
• Strong rapport with clients/significant others & other health care providers
• Keeping clients in their own home for a longer period of time
• Reduction of hospital admissions

Parkinson’s disease - A case example
Parkinson's Disease

80,000 people
In Australia are living with Parkinson's

30 people
are diagnosed with Parkinson's in Australia every day

6.3 million people
worldwide are affected by Parkinson's


Parkinson's Disease symptoms

• Motor
  – Tremor
  – Bradykinesia
  – Muscle rigidity
  – Postural instability

• Non-motor
  - Insomnia
  - Fatigue
  - Pain
  - Swallowing difficulties
  - Slowed thinking
  - Memory/cognition
  - Continence issues
  - Weight loss
Parkinson's disease Case Study - hypothetical

• Mr Barnes - 67 yrs old

• Social History:
  – Lives with wife
  – Rural property 2 hours outside Toowoomba
  – Receiving home care for domestic assistance
  – Wife has previous lower back injury

• Medical History & Medications:
  – Parkinson's disease (diagnosed 6 months ago) – commenced on Madopar,
  – Type 2 Diabetes Mellitus

• Presenting condition:
  – Client attended DDHHS podiatry appointment – diabetic footcare
  – Tremor was observed
  – Client reported difficulty with dressing
  – Podiatrist presented client at case conference
  – Internal referral made to OT

OT home safety Ax
  - Provide education & organise small aids
  - Screen for other AH
  - Mobility reduced in last 6/12
  - Liaison with PT re mobilisation
  - Noted client has difficulty in accepting Dx - declined Psych

Referral from Pod to OT re: recent PD dx & tremor

Pod = Podiatrist
OT = Occupational Therapist
PT = Physiotherapist
DT = Dietitian
SP = Speech Pathologist
Psych = Psychologist

EARLY STAGE

4/12 OT contacts:
  - OT goals met = client discharge
  - Client remains open to PT & Pod

PT initial Ax
  - Goal: maintain level of mobility
  - No Mobility aid
  - Implement HEP
  - Pilates

Review by PT 6/12 later PT
  - Maintaining mobility & HEP
  - Observed voice control & volume
  - Discus at case conference & refer to SP

SP initial Ax
  - R/V voice projection = “think loud” strategies
  - Assess swallow function = Edx on safe swallow
  - Constipation re PD meds
  - Liaison with DT to refer to DT

PT review
  - Postural Changes
  - Noted ↑ carer stress, cognitive decline
  - Liaison with Psych re: refer to psych

Client progression with Parkinson’s Disease

PT nutritional Ax
  - Review Nutritional intake
  - Education re dietary strategies to manage constipation (PD Med effectiveness)
  - Recommendations = Normal protein diet & Medication timing
MID STAGE

Client progression with Parkinson’s Disease

Psych Ax
- Acceptance of PD diagnosis
- Grief over loss of independence
- Carer Stress & relationship counselling
- Cognition = functional ability = Carer stress – Refer to OT

OT New Ax
Edx:
- Task analysis & energy conservation – showering
- Memory Strategies – diary
Observed:
↑ “off periods” & ↑ carer manual handling
- Liaise with PT

Pod ongoing R/V
Changes in gait pattern resulting in callus
- Orthopaedic pressure relieving devices recommended
- Liaison PT – gait changes

Case conference
- Client deterioration
- All AHPs involved
- Social isolation
- Refer to CHN
- Meaningful activities
- Flu GP letter

Joint PT & OT H/V
Functional Review
- Bed T/F: MH Edx
- Toilet T/F: “nose over toes” & rail
- Freezing episodes = cue strategies
- Falls = mobility Aid

Joint SP & DT visit
- SP: Commence texture modified diet & chin tuck strategies
- DT: Edx meal fortification strategies & provided supplements
- Discussion re: artificial nutrition support i.e. PEG

Joint PT & SP visit
- SP: Compliance of texture modified diet & R/V safe swallow technique
- PT: Deep breathing exercises; postural exercises & active cycle of breathing

End Stage

Client progression with Parkinson’s Disease

OT follow up (several months later)
- Delivery PDWC = ↑ mood & community access
- Ongoing incontinence issue = Refer to Continence Nurse

PT home visit
- N/H Discussion
- Modified HEP to inc. PROM exercises taking into account postural fixations etc

MDT case conference
- Discussed ongoing need of client & plans for future
- PT D/C
- OT/SP/OT/Pod: Psych ongoing

End Stage
NH placement. Care handed over from DDHHS CC AH Team

LATE-END STAGE

Client progression with Parkinson’s Disease

Psych review
- ↑ depression & Hallucinations – poor sleep hygiene
- Carer Edx re: coping skills & burn-out
- Refer to ACAT

OT visit
- Successful PDWC Trial
- Mobility:
  - Dependency oedema & ↑ Pressure ulcer risk
  - Edx: Oedema management & Pressure care Mx.
  - Equipment prescription: pressure mattress & hospital bed

PT home visit
- N/H Discussion
- Modified HEP to inc. PROM exercises taking into account postural fixations etc

MDT case conference
- Discussed ongoing need of client & plans for future
- PT D/C
- OT/SP/OT/Pod: Psych ongoing

Joint PT & SP visit
- SP: Communication difficulties
- Suggested trial of communication devices

SP review
- ↑ communication difficulties

End Stage
NH placement. Care handed over from DDHHS CC AH Team
Early Stage PD Symptoms

- Muscle stiffness/Rigidity
- Postural instability
- Mobility issues
- Mood disturbance
- Pain/Discomfort
- Reduced dexterity/Fine motor control
- Tremor
- Environmental safety hazards
  - At home
  - At work

Mid-Later Stage PD Symptoms

- On/Off phenomenon
  - Drug effectiveness
- Increasing mobility problems
  - Freezing, postural instability, stiffness
- Continence issues
- Fatigue/Energy levels
- Swallowing issues
  - Weight loss
- Communication issues
  - Written/oral
- Increasing Social isolation
  - Reduced motivation, embarrassment, low mood
- Cognitive decline
  - Memory issues
  - Multi-tasking difficulty
- Increasing Carer Stress
  - Drug effectiveness
- Fatigue/Energy levels
- Weight management
  - Physical inactivity
  - Tremor
  - DBS

- Mobility issues
- Mood disturbance
- Pain/Discomfort
- Reduced dexterity/Fine motor control
- Tremor
- Environmental safety hazards
  - At home
  - At work
Late-End Stage PD Symptoms

- Increasing Transfer difficulties
- Significant Mobility decline
- Swallowing issues - Risk of aspiration
- Reduced Nutritional Intake
- Hallucinations/ Sleep disturbance - Carer & Client
- Increasing dyskinetic movements
- Pressure areas developing
- Significant Cognitive impairment
- Respiratory problems - postural, respiratory muscle weakness

Barriers experienced within a community setting
Gold standard vs Reality

• Environmental
• Client financial strains (equipment)
• Communication from GPs and Specialists
• Timely referrals (crisis moments)
• Problem solving hats on
• Strong advocacy - Funding bodies & support organisations
• GP correspondence & service promotion
• Crisis management i.e. Telehealth
• Regular community meetings & service promotion
Summary

- DDHHS Community Care Allied Health Service can provide continuity of care for a range of client presentations
- Strong interdisciplinary approach
- Working in collaboration with other service providers to improve client outcomes

Final note:
Our door is always open – please feel free to consult us
Ph: (07) 4699 8970

Thank you for your time

- Any Questions
References


References

- Parkinson’s Australia website
- Dimensions of home article
- 2011 Deloitte Access Economics report