

Activity coaching to improve walking is liked by rehabilitation patients but physiotherapists have concerns: a qualitative study

Caroline Stretton¹, Suzie Mudge², Nicola M Kayes², Denise Taylor³ and Kathryn M McPherson²

¹School of Rehabilitation & Occupation Studies, ²Person Centred Research Centre, School of Rehabilitation & Occupation Studies, ³Health and Rehabilitation Research Institute, Faculty of Health & Environmental Sciences
AUT University, New Zealand

Question: Does activity coaching add value to physiotherapy from the perspective of physiotherapists and patients in neurological rehabilitation? Is the use of activity coaching to promote walking and physical activity considered feasible by these physiotherapists and patients? **Design:** Qualitative study using interviews. **Participants:** Five pairs of physiotherapists and their patients with neurological conditions. **Intervention:** A research physiotherapist trained in health coaching delivered an activity coaching intervention. This was provided in addition to standard physiotherapy. The treating physiotherapists observed the activity coaching session undertaken by their patients. **Results:** Observing the coaching interview was valuable for the treating physiotherapists in that it provided a way to refocus, step back, gain insight, and facilitate more active involvement for their patients in the rehabilitation process. Similarly patients valued the opportunity to focus on what was important and put into action their rehabilitation goals. Contrasting perceptions were evident, which limits the practical usefulness of this intervention due to the concerns voiced by some of the physiotherapists. **Conclusion:** The activity coaching was perceived as providing a valuable addition to standard practice and was acceptable to patients but the mixed responses of physiotherapists limit the feasibility of this approach. Use of strategies and specific training for physiotherapists may be needed before approaches like activity coaching can be adopted successfully. [Stretton C, Mudge S, Kayes NM, Taylor D, McPherson KM (2013) Activity coaching to improve walking is liked by rehabilitation patients but physiotherapists have concerns: a qualitative study. *Journal of Physiotherapy* 59: 199–206]

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Introduction

Targeted exercise training has been shown to lead to improvements in walking for people with stroke when measured in a standardised way in a physiotherapy clinic (English and Hillier 2010). The benefits of physiotherapy interventions in neurological rehabilitation are based on the implicit assumption that improvements in physical capacity carry over automatically into changes in usual walking habits and that these improvements increase the ability to participate in meaningful activities – an important aim of physiotherapy practice (WCPT 2011). In fact there is limited carryover of these physical improvements into usual walking habits (Mudge et al 2009, States 2009). This is disappointing because for many people with neurological conditions increased physical activity is a key goal due to its significant psychological, physical and functional benefits (Lord et al 2004, Gordon 2004).

One possible explanation for this lack of carryover of benefit into usual walking is the absence of additional support to help change people's activity habits or behaviour. A behaviour is generally considered to be an activity that is able to be observed (Atkinson et al 1996, p. 12). Usual walking behaviours include being able to walk far enough and fast enough in the real world to participate in meaningful activities. A systematic review of studies in healthy people clearly confirmed that health behaviours (such as walking habits) can be improved by techniques that focus on active involvement of the person in changing their own behaviour

(Michie et al 2009). These behaviour change techniques may include goal setting, specific planning, or self-monitoring activities. Many of the techniques have a strong theoretical basis and have been described and studied extensively in health psychology (Michie et al 2011). Physiotherapists have successfully used these evidence-informed techniques as part of health coaching to improve physical activity for patients with cardiac disease (Reid et al 2011) and low back pain (Iles et al 2011). However, there have been few similar

What is already known on this topic: Health coaching involves techniques (such as goal setting and self monitoring) to facilitate active involvement of the patient in behaviour change. Health coaching has been used to improve physical activity in several patient groups but it has not been widely investigated in people undergoing neurological rehabilitation.

What this study adds: Physiotherapists and their patients in neurological rehabilitation both found that coaching helped the focus of rehabilitation to stay on the patient's expressed needs. Patients wished to be more actively involved in rehabilitation and considered activity coaching acceptable. Physiotherapists had concerns about the feasibility of activity coaching in this setting, which may limit the efficacy of activity coaching, although some specific training for physiotherapists may help.

attempts to improve physical activity using behaviour change techniques for people with neurological conditions such as multiple sclerosis (Kayes 2011), and minor stroke or TIA (Gillham and Endacott 2010); this is despite their potential to support active engagement in the rehabilitation process, which has strong links with improved health outcomes such as health status (Harwood et al 2011) and mood (Smith et al 2008).

Health coaching is where 'an interactive role is taken by a peer or professional to support a person to be an active participant in the management of their illness or injury' (Lindner et al 2003, p. 177) and incorporates evidence-informed behaviour change techniques with a collaborative interaction style. Patient-centred care is a central tenet of best practice in rehabilitation (McPherson and Siegert 2007). A health coaching approach may be useful in neurological rehabilitation because the collaborative approach, which focuses on the patient's perspective and emphasises shared decision-making, is an important characteristic of patient-centred care. One version of health coaching is where the health professional uses a 10-point framework underpinned by principles drawn from existing behaviour change theories to support change in health-related behaviour (Health Change Australia 2012). Activity coaching uses this framework but focuses primarily on supporting change in activity habits.

The research questions for this study were:

1. Does activity coaching add value to physiotherapy from the perspective of both physiotherapists and patients in neurological rehabilitation?
2. Is the use of activity coaching to promote walking and physical activity considered feasible by these physiotherapists and patients?

Method

Design

This study used descriptive qualitative methodology. This is an appropriate approach when first-hand knowledge of patients' or professionals' experiences with a particular topic is needed (Neergaard et al 2009). Semi-structured interviews with physiotherapists and their patients were used to gain insight into their perspectives of acceptability and feasibility.

Participants

Participants were physiotherapist-patient pairs recruited from two neurological rehabilitation outpatient clinics in a large metropolitan area in New Zealand. Physiotherapists were eligible if they were a registered physiotherapist and currently working in neurological rehabilitation. Patients were included if they had a non-progressive neurological condition, were currently receiving physiotherapy, and had a goal to improve walking. Purposeful sampling was used to achieve variability in patients in a range of key characteristics including age, diagnoses, gender, and ethnicity (Sandelowski 2000). If the physiotherapist wished to participate and had a patient who met the criteria, the patient was approached to see if they would be interested in participating. A researcher screened both the physiotherapist and their current patient for eligibility by telephone.

Intervention

The activity coaching intervention was delivered as an addition to routine physiotherapy care by a dedicated research physiotherapist (CS or SM), who had completed a two-day course in health coaching (Health Change Australia 2012). Using the principles of health coaching, a modified version of coaching was developed that focused primarily on improving physical activity, particularly walking behaviour. The coaching session was observed by the treating physiotherapist. Each session lasted one hour and there were two follow-up telephone calls. Details and content of the activity coaching intervention is provided in Box 1.

Data collection

Specific techniques used for behaviour change in the activity coaching sessions were recorded by the research physiotherapist using the taxonomy developed by Michie and colleagues (Michie et al 2011). Semi-structured interviews of the physiotherapists were completed by a researcher (NK) experienced in qualitative descriptive methodology. Questions for these interviews are presented in Box 2. These questions sought to explore the physiotherapists' perspectives of what worked well and provided additional value, what didn't work well and potential challenges to delivering the approach from their own perspective, and their perceptions of the patients' perspectives. Patient interviews were conducted by a physiotherapist academic or research assistant experienced in qualitative interviews, who was not involved in providing the activity coaching intervention to the patient. For these interviews, questions explored what worked well, any added value of the program to their health and wellbeing, and anything they didn't like or did not work well. Interviews lasted between 20 and 40 min, were audio recorded, and a denaturalised transcription was used (Oliver et al 2005).

Data analysis

During the data preparation phase, each transcript was read through several times by two researchers (CS, SM) to first get an idea of the whole of each interview and notes were taken of impressions and thoughts (Sandelowski 1995). A data reduction framework based on the interview guide was used to prepare data for analysis (Sandelowski 1995).

Data were analysed using conventional content analysis not only to identify themes of importance within and across the two participant groups, but also to look for any differences between experiences (Hsieh and Shannon 2005). Clusters of codes and categories were grouped to form core themes. A third researcher (NK) independently reviewed the codes as a form of member checking to ensure consistency of interpretation with identified themes and to ensure theme names adequately captured the data coded to that theme. This process was repeated twice using discussion to refine and reach consensus. Both researchers (CS, SM) kept a journal of critical reflections and discussed findings with other team members. They also undertook a process of critical reflection of the literature, which provided researcher triangulation and confirmation of broader generalisability of key issues identified (Mudge et al 2013, Neergaard et al 2009).

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