Keywords: Urinary tract infection; Antibiotics; Spinal cord injuries; Brain injuries; Clinical audit

Introduction.— Patients with neurological bladder dysfunction develop urinary tract infections (UTI) which can be very concerning considering their frequencies, severity and resistances to antibiotics (ATB) [1]. A professional practice assessment (PPA) began in 2009 through a clinical audit [2], followed by the diffusion of guidelines. A second audit has been carried out to assess the impact of guidelines (2011).

Patients and methods.— A two-month prospective study was conducted in the 7 neurological rehabilitation clinical units. Data collection included information about patient, infection and ATB. The evaluation criteria were: initial empiric treatment), ATB duration. The compliance rate of these criteria was analyzed and compared with results of the previous audit (by comparison of proportions’ test when patients’ number allowed it).

Results.— Thirty-eight patients were included in the study (47 ± 15 years). Fifty-two percent of patients had neurogenic bladder. Patients were treated for bacterial colonization before an invasive procedure (52%), for prostatitis (42%) or for a simple urinary tract infection (26%). The initial treatments were empiric in 26% of cases. The initial choice of ATB was not suitable for 21% of prescriptions (vs. 45% in 2009, P < 0.05). Ninety-two percent of patients received the right antibiotic dose (vs. 94%, ns). Empirc treatments were reevaluated at 72 h in 60% of cases (vs. 92% in 2009). Finally, treatment durations were not respected in 26% of cases (vs. 52%, P < 0.05).

Discussion.— There is a positive evolution in professional practice, including treatment durations and choice of ATB more adapted compared to the 2009 audit. However, the reassessment of empirical treatment is insufficient, even though it is a major criterion for quality monitoring in the HAS’ recommendations. The implementation of simple indicators with monthly monitoring is the next step; as it will help to perpetuate our work.

References

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A prevalence of second-look diagnoses in the post-acute rehabilitation setting: A new challenge?

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Keywords: Second-look diagnoses; Rehabilitation

Purpose.— Post-acute care rehabilitation is in full development. Indeed, the evolution of health systems aims towards an important reduction of hospital stay and towards an earlier referral of patients with severe conditions. This study aimed to measure the prevalence of diagnoses made only during the post-acute rehabilitation phase (the so-called “second look” diagnoses).

Methods.— Patients hospitalized in a post-acute care rehabilitation unit. Retrospective study over one year using the patients’ electronic medical charts. The second-look diagnoses made during the rehabilitation and also complementary investigations and therapeutic changes were recorded.

Results.— During the study, 103 patients (p) received care in our unit following multiple trauma, prosthesis implantation (hip/knee/shoulder), lower limb amputation or burn injury. Thirty-seven new diagnoses was recorded in 21 p (20.4%), 18 males, 3 females, mean age 38 years. Twelve musculoskeletal injuries were retained. In 25 cases a neurological condition was diagnosed. For 8 patients, more than one second-look diagnosis was established. Symptoms were the main argument for the revision of the initial diagnoses in 86% of the cases, and X-ray revision for 14% others. Twenty-nine additional investigations were required. For all patients, orthopaedic and/or pharmacological treatments, as well as an adaptation of the rehabilitation protocol were necessary.

Discussion.— To our knowledge, there is no a data in the literature about “second-look” diagnoses in the post-acute care rehabilitation setting. The 20% prevalence observed in our study is high. The prevalence of the neurological conditions was that of musculoskeletal disorders. The vast majority of diagnoses (95%) were made in multiple trauma patients. The evolution of the health systems, characterized by a reduction of hospital stay duration, might contribute to extend this problem. It could also represent a new challenge for rehabilitation wards in terms of organization and relation with acute care units.

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Group workshops as part of guided self-rehabilitation contracts in spastic paresis; Our 2009–2012 experience

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Keywords: Spastic paresis; Contract; Guided self-rehabilitation; Workshop; Group

Introduction.— Guided Self-rehabilitation Contracts (GSC) in paretic patients (after stroke, head or spinal cord injury, nervous system tumour, multiple contamimation. Return to a normal situation after discharge of the last patient (26/09/11) with this cost: 543 rectal swab; 388 unavailable days for inpatients; 382 days of additional nursing staff; 11 meeting of the crisis centre; increase of the length of stay related to difficulties with discharge of these patients; lack of 15 admissions compared with previous years; high psychological impact.

Conclusion.— Fighting against such epidemic in a PRM department is difficult and needs strictness leading to psychologically painful isolation, lack of change in rehabilitation and a high financial cost. We have to be prepared for such increasing problem.