

SAHK

Citation: Leung, C. S. M. and Su, I. Y. W. (2000). *A Holistic Model of Training for Elderly Patients with Neurological Impairments – a Case Report*. Paper presented at the 2nd Pan Pacific Conference on Rehabilitation, Hong Kong.

Introduction: Old age is characterised by multiple declines and losses. With ageing, there is a heightened inter-dependence between physical, psychological and social-environmental factors that influence the overall wellbeing of the person (Lee, 1996). A holistic approach that emphasises strategies to integrate physical, cognitive and psychosocial abilities for promoting self-sufficiency in daily life has been developed by the authors. The holistic model of training is delivered by a transdisciplinary team consisting of different staff disciplines adopting a common philosophy in the management of their clients. The strong team approach is particularly important with the existing limited professional input in the residential homes for the elderly. The six principles of the holistic approach are: (1) motivation is fundamental to learning; (2) functional tasks are composed of movement sequence that can be broken down into basic motor patterns; (3) acquisition of a movement can be enhanced by mental rehearsal before executing the movement; (4) external visual, auditory and verbal cues can be given for augmenting the mental rehearsal and for regulating an action; (5) skills retention and transfer are enhanced by variability of practice in real-life situation; and (6) physical and social environments should be structured to maximise the use of their remaining abilities. Training activities in the holistic model are categorised into group training in form of motor task series (MTS) and individual daily routine training in the self-care domain (DRT-SC). **Method and Results:** The practice of the holistic model of training is illustrated in two case studies. Case A is a female patient (aged 81) with left hemiplegia and Case B was a male patient (aged 79) with Parkinson's Disease. Both subjects are residents of a care and attention home. Case A walked with a quadripod under close supervision. Only minimal active movement and very weak grasp were observed in her left upper limb. She is totally dependent on others in most personal self-care tasks. Case B had developed flexion contracture over both knees. He ambulated with a walking frame under close supervision. Great tremor was observed when performing functional tasks. Selected basic motor patterns were repetitively practised in MTS during which facilitation skills like mental rehearsal and external cues were employed. With the provision of adaptive furniture and aids, guided practice of the assigned basic motor patterns in various real-life situations was given to both cases via DRT-SC. For Case A, retention and transfer of the selected basic motor patterns in drinking and feeding and in dressing and undressing lower garments were practised during DRT. For case B, washing face as well as feeding and drinking were focused. In both cases, functional abilities were documented with a self-developed assessment battery for evaluating the proficiency in using the basic motor patterns. The subjective wellbeing of both cases was evaluated by the 'World Health Organisation - Quality of Life' questionnaire after a 6-month interval upon implementation of the holistic model of training. Initially, the transformed score of 'physical' domain of QOL was lower than the corresponding norm. Improvement in subjective wellbeing was observed in the 'physical' domain in case B after the 6-month period. Among the five activities of daily living, the normalised total scores in drinking for cases A and B and that of feeding for case B were increased by 5 – 10%.