

rehabilitation centres in Lebanon. Describe how this team is based on international data.

**Patients and methods.**— Descriptive study with prospective collection. Survey on the state of play of Physical Medicine and Rehabilitation (PMR) established two institutions in Lebanon MPR: The RRTC Beit-Chabab and hospital Mgr Cortbaoui. A grid reference to the quality charter MPR rehabilitation facility and the criteria for accreditation RRTC is developed. It includes all team members present and their job profile and policy of the institution.

**Results.**— **Doctors:** presence once a week, no well-defined contract, the job profile is not clear. The meetings of the Board are often without doctors. There is no complementarity between doctors. Everyone has their own patients. No work within well-defined or inter-services. No weekly meeting study records. The evaluation of the patient is done with physical therapists during the visit but traceability is incomplete. The medical record is incomplete, does not contain all the elements. **Physiotherapists** working in the absence of rehabilitation physician who evaluates and modifies the program every week. There is more solidarity and complementarity intra-team work. Sometimes insufficient, given the limited time to an hour a day patient. Little cooperation with the occupational therapist and speech therapist, which are only three half-days per week on request. The orthotics are from outside experts on demand. No role of the social worker.

**Conclusions.**— This study shows that the qualified personnel of the multi-disciplinary team work well in their respective fields. But the lack of physical medicine doctors presence is an obstacle for multidisciplinary work. In addition each specialty team tends to work in isolation for reasons which will be set if the hospital policy is made according to quality charter.

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### Rehabilitation teams in University Hospital Centers working extra muros: Current situation



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**Keywords:** Rehabilitation; Extra muros; Organisation

**Background.**— There is no analysis of the existing interventions extra muros of rehabilitation teams of CHU in literature, while the official texts provide the opportunity for some personal of SSR to move at patient's home.

**Introduction.**— The purpose of Physical Medicine and réadaptation is to limit disability, which is defined by the mismatch between the capabilities of the person and his environment. To assess this disability involves a visit to the living areas.

**Material and method.**— A questionnaire was distributed by mail to all faculty Rehabilitation Hospital in metropolitan concerning the existence, personnel, organization and financing of rehabilitation teams involved extramural patients' homes.

**Results.**— Thirty-three services contacted, 27 responses, 10 teams intervennent outside the hospital, nine at patient's home.

Missions, human resources, organization of these teams are very heterogeneous, ranging from therapist's visit to authentic homecare.

**Conclusion.**— Teams assessing handicap situations outside CHU are few, with very different operating conditions. Harmonization appears necessary.

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### Survey bedsores and nosocomial infections in two rehabilitation centers in Lebanon and profile of inpatient



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**Keywords:** Rehabilitation centers; Urinary tract infection; Bedsores

**Introduction.**— The purpose of this study was to investigate the frequency of bedsores and nosocomial infections in rehabilitation centers.

**Patients and methods.**— A descriptive study with prospective collection. Survey on the prevalence of pressure ulcers and nosocomial infection in two rehabilitation centers: Beit-Chabab & Cortbaoui. All patients hospitalized were included. Study enclosed demographic (age, gender), diagnosis, length of stay (< or > 3 months). Presence or absence of bedsores or nosocomial infection. Statistical Study: Data analysis is performed using the SPSSv.10 (Chicago, Illinois). Univariate and descriptive studies. ( $P < 0.05$  is considered significant).

**Results.**— Patients descriptive study identified 80 patients. Mean age  $59 \pm 20$  with male: 67/80. Beit-Chabab hospital (74.7% of patients) against 25.3% in Cortbaoui hospital. Length of stay more than 3 months (72%). Diagnosis: hemiplegia (30.4%), quadriplegia, Parkinson, MS, IRC, fracture, amputation, paraplegia, cancer and other diagnoses. Frequency of 25.3% bedsores. Location sacral 45%. bedsores during hospitalization 11.5% against 14.1% before hospitalization. Urine tract infection in arrival 0%. During hospitalization 23%. Cultures were grown in majority E. Coli isolated or associated. Appearance in 20.7% of cases of ESBL strains. Significant relationship in univariate study among the predictors and the occurrence of pressure ulcers are the presence of bedsores before hospitalization ( $P = 0.001$ ) and other diagnoses ( $P = 0.05$ ). Predictors of the occurrence of urinary tract infections during hospitalization: the female with a history of urinary tract infections treated ( $P = 0.01$ ), the cancer and other diagnosis ( $P = 0.05$ ) and accident with fractures ( $P = 0.09$ ).

**Conclusion.**— Decubitus complications are frequent. Bedsores prevention is better applied than nosocomial infections. It is urgent to establish a multidisciplinary committee for bedsores prevention and involve PMR doctors in CLIN and create clear policies.

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### Evaluation at five years of post-acute unit (UPR) at the Saint-Hélier Pole, Rennes



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**Keywords:** Unit post-acute; Epidemiology

**Introduction.**— Post-intensive care rehabilitation services aren't currently normalized by any text. The 2012 brain injuries and spinal cord injuries action program plans a study of this type of structure.

**Method.**— Four UPR beds were created in 2008 at the Pôle Saint-Hélier in Rennes. In 2010, four extra beds were opened. We suggest a five years existence assessment of this unit, from January 2008 to December 2012. Epidemiological data (age, sex), medical (pathology type, occurrence of a tracheotomy, enteral feeding) and administrative (average duration of hospital stay, hospital service of origin and leaving mode) were collected.

**Results.**— Eighty-one patients were admitted in UPR in five years. The UPR admission delay is four weeks. The median age of the patients is 50.72 years. Pathologies are primarily cerebral lesions (stroke, brain injury, anoxia...), then spinal cord injuries or rehabilitation after multi-visceral failure. Seventy-five patients had a tracheotomy at the time of their admission. Sixty-nine had a gastrostomy. The average duration of stay in UPR is 11.8 weeks. At five years, 62 of the 81 patients had left the hospital, including 43 who could go back to home.

**Conclusion.**— The activity of a UPR, between acute care services and rehabilitation, meets a need for public health. This type of unit allows patients to access early rehabilitation care in a medically monitored environment. The issue of downstream chain remains the main obstacle to a steady output flow and to the decrease of stay duration in upstream services.

**Further reading**

Programme d'actions 2012 en faveur des traumatisés crâniens et des blessés médullaires ([www.sante.gouv.fr](http://www.sante.gouv.fr)).

Physical and rehabilitation medicine (PRM) care pathways: adults with severe traumatic brain injury. Pradat-Diehl P & al. Ann Phys Rehabil Med. 2012 Nov;55(8):546-56.

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