OT Handbook

FOR ACUTE CARE SETTINGS

Clinical Process In Brief

- Consults and Standing orders
- Chart Review
- Preparing to visit a client
- Functional Evaluation
- Discharge options
- Client interaction

Consults and Standing orders

- We know we have a new patient to see because we receive one of the following:
  - A new consult:
    - A request from a doctor for OT services needed for a specific client who may be unsafe to discharge
  - New consults can typically be found in a folder in the nursing station
- Standing order:
  - The standing order dictates that all clients who have had one of the following conditions must be seen by OT:
    - Stroke
    - Back surgery of more than one level
    - Neurosurgery

Chart Review

- Once we have a new consult or standing order client, we review the client's chart for the following information:
  - Age
  - Gender
  - Date and location of arrival (example: pt presented to ER on 2017-02-03)
  - Symptoms which brought them to the hospital
  - Tests performed since admission (CT scans, MRIs, etc)
  - Diagnosis, or potential diagnosis
  - Prior conditions which may have contributed to their current conditions

Chart Review

- Charts are organized in nursing stations and labeled with the following:
  - client's last name
  - room number
- Each chart holds a client card with each client's full name and ID number printed in raised lettering
  - this card can be used to stamp official forms to be filed in the chart.
- Charts need to stay within the area of the nursing station since all the professionals on the team consult them regularly, so be sure not to take them away into a separate room.

Chart Review: ChartMaxx

- Although a lot of information can be found in charts, they contain only recent documents
- Additional info can be found by logging into ChartMaxx, which contains documentation of the pt's prior history at the JGH
  - It's important to review both the chart and ChartMaxx, because sometimes ChartMaxx will not have the most recent documents, or vice versa
  - ChartMaxx also does not contain progress notes, which contain valuable information about the pt's current level of autonomy and most recent medical developments

Common Medical Conditions/Abbreviations:

- HTN - hypertension
- HLD - hyperlipidemia
- DM type I or II - diabetes type I or II
- CHF - Chronic Heart Failure
- GERD – gastroesophageal reflux disease
- BPH - benign prostatic hyperplasia
- DLP - dyslipoproteinemia
- MCI – mild cognitive impairment
- UTI – urinary tract infection
- COPD - chronic obstructive pulmonary disease
- AD – Alzheimer's Disease
- CVA – Cerebrovascular accident
- TIA – transient ischemic attack

Medical Orders/Abbreviations

- Before assessing a pt, it is ***essential*** to check the medical orders section of the chart to ensure there are no contraindications to activity or weightbearing status
- Common abbreviations include:
  - AAT – activity as tolerated
  - WBAT – weightbearing as tolerated
  - TTWB – toe-touch weightbearing
  - DAT – diet as tolerated
- If there are positional restrictions (ex: head of bed ≤45˚) or bedrest requirements, they will be indicated in this section
- The wearing schedule of any medical devices or braces (ex: Miami-J cervical collar) will also be in this section

Preparing to Visit a Client

- Following chart review, you can plan your functional evaluation.
- The purpose of the evaluation is to determine the pt's level of occupational performance and determine an appropriate discharge plan
- To determine this, you need to ascertain:
  - Pt's baseline function
  - Deficits evoked by their condition
  - Life circumstances (ex: do they work? Drive? Social support? What is the home environment like?)
  - Discrepancy between baseline and present function
  - Remedial or compensatory strategies to maximize autonomy

Preparing to Visit a Client

- In preparing to visit a client ask yourself the following:
  - What deficits do I expect to see considering their diagnosis?
    - Ex: if a client has had back surgery, bending down for lower body dressing may be challenging.
  - Should I prepare for challenging aspects of assessment?
    - Ex: mention of aphasia in the chart may mean a client will have trouble communicating or understanding speech
    - Ex: mention of dementia may mean the client could have difficulty understanding the purpose of the assessment, what condition they have, or their baseline functioning
  - Is the client's family present? What is the family dynamic?
    - Ex: Mention of a conflict in the family dynamic may mean assessment will be more successful if the client's family steps out of the room

Functional Evaluation

- In carrying out your evaluation you will need to complete the following sections in your consult form:
  - Environment:
    - Patient's living situation, stairs, adapted equipment, etc
      - Obtained through interview
  - Psychosocial: details about the patient's life
    - Married? What work do they do? Do they have family in the area?
      - Obtained through interview
  - Baseline functioning ADLs/IADLs
    - Obtained through interview
  - Present functioning ADLs (sometimes IADLs)
    - Obtained through evaluation, observation, or task simulation
    - Often IADLs are not assessed in an acute care setting
  - Physical components:
    - ROM, strength, balance, neuro, pain, etc
      - Obtained through physical screening and interview
  - Cognitive functioning
    - Alert? Oriented? Accurate historian? Insight into their condition? Etc
      - Obtained through questions and observation
  - Analysis
  - Recommendations

Functional Evaluation: more about baseline

- Baseline interview: this section of the assessment helps determine how the pt was functioning before the onset of their condition
  - This can help us determine the degree of change that has occurred in their level of functioning and autonomy.
- A baseline information can be obtained from:
  - Patient:
    - When the pt is an accurate historian
  - Interview with a family member
    - This can be helpful if the pt has a condition which severely affects their cognitive functioning or ability to communicate
      - Contact numbers are often available in chart
  - Interview with a caretaker
- It is important to note in your documentation who provided baseline information, and to obtain the information from the client whenever possible

Functional Evaluation: More about baseline

- Open-ended questioning:
  - This style of interview favors development of therapeutic rapport
  - There will be cases in which pts are unable or unwilling to provide the info you need when asked very pointed questions
  - In such cases open ended questions can lead to stories which provide a great deal of information
- Examples of open-ended questions include:
  - “Who does the cooking at home?”
  - “Is there anything you have stopped doing since your symptoms began?”
  - “Where do you shop for groceries?”
  - “What do you do for fun?”

Functional Evaluation: Present Functioning

- Assessment of present functioning is carried out in the following ways:
  - Observation of the client completing specific tasks in hospital:
    - Ex: grooming (often assessed through observation of the AM routine) or dressing (a client can be asked to don their clothing and shoes if available, or a hospital gown and slippers if unavailable)
  - Mobilization for observation of transfers and ambulation
    - Ex: client is asked to sit up in bed, stand and take a few steps, or take a walk in the hall if capable with the appropriate level of assistance and precaution
  - Task simulation:
    - Ex: client is given a washcloth and asked to wipe their face as if they were washing

Functional Evaluation: Present Functioning

- In some cases information can be obtained subjectively if the client cannot complete a task at the time of evaluation and re-evaluation is not possible (ex: client has already groomed and assessment is not possible). Subjective sources include:
  - Chart review: progress notes contain valuable information on ADLs
  - Interview: in clients who are functioning at a high level, interview can sometimes suffice
    - Ex: OT sees an empty lunch tray and client reports having eaten independently
  - Discussion with other professionals
    - Ex: a pt's nurse reports that the s/he is toileting independently
  - If an ADL was not assessed, the field for that ADL can be filled "NE," with an explanation of why
    - Ex: "Strength: NE due to complaint of severe pain upon movement"
- It is always best to assess the client directly

Functional Evaluation: Things to watch out for

- IV/PICC line
  - Can catch on clothing and be pulled out accidentally when client is asked to don or doff clothing
- Nasogastric tube/Dobhoff
  - Clients in altered cognitive states often attempt to pull out
- PEG
  - Clients in altered cognitive states often attempt to pull out
- Feeding pump
  - Pump should be stopped prior to mobilization and restarted at the end of evaluation, respecting indications for positioning (ex: angle of head of bed)
- Foley catheter
  - A client with a Foley will need to have it attached to an appropriate place on the bed to mobilize in sitting. It can also be attached to a walker (or carried) during ambulation
- Pneumatic stockings
  - No ambulation permitted until discontinuation
- Diapers:
  - Diapers OFTEN fall off when clients are asked to stand up, which can be embarrassing for clients – make sure they are tight before mobilizing and hold in place as needed

Functional Evaluation: Preparing the environment

- Adjust Angle of head of bed appropriately
  - Ex: raise head of bed for someone with difficulty sitting up independently
  - 45 degrees for feeding
- Clear the floor of miscelanious objects that pose fall risk
- Make sure an appropriate mobility aid is present in room
  - Ex: walker, cane
- Don appropriate footwear prior to ambulation

Discharge Options

- Home
  - Need to have basic mobility, problem solving/judgment/safety awareness. Difficulties with adls/iadls can be compensated by community or private resources, family, etc.
- LPA (Lit post-aigus)
  - Convalescence (patient's who need more recovery time for their medical condition to stabilize)
  - Sub-acute therapies if rehab goals are identified (can be achieved without intensity of RFI)
  - Functional discrepancy must exist in order to be a candidate), sufficient endurance
- SARCA - Out-patient Rehab:
  - Pt must have the ability or support to travel from home to the rehab facility, and have the capacity or support needed to perform ADLs/IADLs safely at home.
- RFI (Réadaptation fonctionnelle intensive) - In-patient Rehab:
  - Ortho, neuro
  - Pt must be capable of completing at least 45 min sessions
  - For pt's who can't function safely in their home, are motivated and willing and have the potential to prove.
- Geriatric Rehab
  - For patients who have a geriatric profile
  - Reduced pace and frequency of sessions
- Relocation
  - Foster home
  - Semi-autonomous residence
  - Intermediate Resource (RI)
  - Long-term care faciliate (CHSLD)
- Palliative care
  - <3 month prognosis: Transfer to 4Main
  - >3 month prognosis: Home with palliative care services or transfer to palliative care facility

CLSC Support

- CLSC services can be requested for pts who will require additional support at home. Services include:
  - Meal prep (simple preparations: sandwich, heat up meal)
  - Bathing
  - Dressing
  - House cleaning
  - Medication administration
  - Home safety evaluation for installation of adapted equipment

Discharging Patients Who Drive

- Neurosurgery pts must cease driving until follow up appointment with their neurologist
- Pts who have had a stroke must complete a MoCA to assess their cognitive functioning, and may also complete the trail making A and B tests
  - MoCA (Montreal cognitive assessment): a cognitive screening test that helps identify mild cognitive impairment.
  - Trail Making A and B: designed to assess executive function
- If a pt scores low upon assessment the safest option may be to flag their license
- Pts must be informed that it is mandatory for *them* to report their stroke to the SAAQ

Additional Considerations

- Is your interview/assessment style working for your pt?
  - Ex: do they require an empathetic listener or a person who provides them structure? Someone who will joke with them or someone who is strict?
- It is best to be at the client's level during assessment, not talking down to them from above
  - You can kneel at the bedside/chair side, or pull up a chair to increase their comfort
- Difficult behavior
  - Keep in mind that clients who display difficult behavior or frustration are going through what may be one of the most difficult experiences of their life. Behavior is often a way of coping.

Considerations Continued

- Pts often ask if they will be discharged soon:
  - OT's cannot decide whether a pt will be discharged, so questions should be directed to their doctor
- When you cannot understand your client, or vice versa:
  - Visit with another professional (another OT, a physio, etc) to see if communication with them is easier
  - If they have a first language different than French/English: request an interpreter
- Tangential clients:
  - Some clients have a tendency to elaborate or tell lengthy stories and can be sometimes be redirected:
    - By drawing their attention to a task
      - Ex: "Lets see how you perform your morning routine like we discussed yesterday!"
    - By asking a closed-ended question
      - Ex: "Are you the driver for your family?"

At the end of the day…

- Our goal is to determine the safest discharge plan for the patient! :)