

Part V

Skilled Nursing Facility

Chapter 16

Paula: Parkinson's Disease

Paula is a 76-year-old Caucasian female with a diagnosis of Parkinson's disease and secondary diagnoses of cataracts and hypertension. Paula is retired from her job as a professor of history at an area college. Prior to her admission to the skilled nursing facility, Paula was living at home with her husband, Dave, and had been receiving home care services for bathing, dressing, laundry, and light housekeeping 7 days a week. Paula and Dave both receive Meals on Wheels 5 days a week. The home-care agency had to cut back on the services they were providing due to changes in Medicare reimbursement, and this left a hole in Paula's ability to remain at home with her aging husband, who is unable to care for her and the home. She was admitted to the skilled nursing facility in the same town she and her husband have lived in for 45 years.

Although retired as a history professor, Paula kept up with colleagues at the college where she taught, maintained an office at the college (although she rarely went in), and had contact with former students and colleagues through the Internet. She spent much of her time at the computer in her home office. She continued to review manuscripts for a publishing company as well as a professional journal.

Paula and Dave have one daughter, but she lives far away and cannot be a part of their daily support services. She is in touch with her parents every few days by phone and visits every other month. Their daughter works and has two small children of her own.

Paula is a strong-willed and independent person who does not like being in the skilled nursing facility, but is resigned to it. She did explore assisted-living facilities, but she and her husband could not afford this option. She misses her husband, the contact via Internet with her colleagues, and her own home and the independence it afforded her.

Paula was admitted onto the skilled nursing unit for long-term care. All residents upon admission are screened by occupational and physical therapy. Minimum Data Sets (MDS) are completed with each team member completing the appropriate section and a team meeting is set within 7 days to discuss the treatment plan and goals.

Paula was screened by occupational therapy and a subsequent occupational therapy evaluation was requested to gather more data on her functional skills in bathing, dressing, feeding, cognition, and psychosocial status.

Occupational Therapy Evaluation

Paula demonstrates intact cognition, sensation, perception, and hearing, but has decreased visual acuity due to cataracts.

Her UE AROM is WFL bilaterally, muscle strength is 4/5 in the shoulder muscles on both sides, and 4+/5 in the remainder of her UEs, with her right side being her dominant side. She demonstrates very poor trunk control, however, and cannot sit unsupported for greater than 5 minutes before she begins to slide down and lean to the left in the chair. She demonstrates the ability to sit unsupported for about 30 seconds before slouching and lateral trunk flexion to the left begins. Her head is laterally flexed to the left as well. She has decreased neck ROM both passive and active, with only about 1/3 of full head rotation present. She has decreased gross- and fine-motor coordination in both UEs. Her handwriting is illegible, and her movements are slow. There are intention tremors in both her UEs of a mild type, but the tremor increases with effortful activity and makes it difficult for her to use her right arm during functional activities. She has moderate tone in her LEs, with the left leg having increased tremor and spasticity with effortful movement and at rest. This leg flexes at the knee and

hip during any activity in sitting leading to poor sitting balance. The right leg has mildly increased tremor, but does not interfere with function. Paula's trunk is rigid and moves as if a log with no dissociation between her upper and lower trunk.

She ambulates with a rolling walker, but does not like to use it, and ambulates by holding onto the furniture to get to the bed or chair. At home, she experienced frequent falls and had taken to wearing kneepads to protect herself from the inevitable falls. When moved from stand to sit, she gets near the chair or bed and just flops down any old way, sometimes coming close to missing altogether. Bed mobility is independent but effortful. She is able to roll side to side using the bedrails; she uses the controls of the hospital bed to raise the head of the bed to assist in sitting up.

She has difficulty bathing at the sink. She sits on the toilet to sponge bathe her upper body, but due to her poor sitting balance, she slides off the toilet onto the floor. She is unable to bend over and wash her lower torso, and dresses her upper body slowly, requiring moderate assistance with her lower body. She has difficulty with buttons, but can eventually get them all done. She is dependent for her shoes and stockings. She is able to feed herself, but her hands shake when lifting glasses, mugs, and her silverware. It takes her a very long time to eat and to cut up her food. Her swallowing is intact, but drooling does occur during activities that require a lot of effort.

She is short-tempered with the staff, although this is not her usual personality. She states she doesn't want to participate in the activity program and says the groups are "boring" and for the "mentally challenged." She doesn't understand what occupational therapy is and states she "already has an occupation." She misses her husband, who is still living in their home, and the contact with her academic colleagues and students.

Paula wants more than anything to be able to bring her computer in and have Internet access so she can stay "mentally with it." She shares a room with another resident who loves to watch TV most of the day. Her roommate leaves the TV on even when she isn't there and doesn't want anyone to turn it off. Paula's goals also include independence in daily bathing and dressing and to eat in the dining room.

QUESTIONS

Goals/Treatment Plan

1. Paula doesn't have a clear understanding of the role of occupational therapy. How would you explain your role to her so that she would be invested in her occupational therapy program?
2. Write a problem list for Paula.
3. Write long- and short-term goals for Paula.
4. List the treatment activities that you will use with Paula.
5. What part of the treatment plan is appropriate for a COTA to do?
6. What other team members would you consult and collaborate with?

Safety/Precautions

7. What are some of the safety concerns for Paula? How would you prioritize these?
8. Besides Paula's Parkinson's disease, which other diagnoses could pose safety issues for her and why?
9. How will you go about working with Paula on these issues?
10. What equipment might you recommend?

NOTES

Self-Care/Work/Leisure

11. What would you identify as Paula's major problem in the work/leisure area?
12. What would you do to address this problem?
13. In what way might you enlist the support of Paula's husband around her work/leisure activities?
14. What would you identify as the major obstacle(s) for Paula in being independent in bathing, dressing, and feeding?
15. How would you address this/these in treatment?
16. How would you address Paula's difficulty at mealtime?
17. How would you educate other staff about your mealtime recommendations?

Equipment/Adaptations

18. What type of adaptive equipment would you use with Paula to assist with bathing, dressing, and feeding?
19. How would you teach Paula to use the adaptive equipment recommended?
20. What type of seating equipment would you use to position Paula properly? Remember, customized wheelchairs are not usually paid for when in an SNF.

Neuromusculoskeletal

21. What are Paula's deficits in her UEs?
22. How would these deficits affect her functionally throughout her day?
23. What type of treatment activities would you use to address Paula's musculoskeletal status?
24. Parkinson's disease is characterized by rigidity and tremors. How would you address these as they are seen in Paula?
25. Would an exercise program be beneficial for Paula? Please explain your answer.

Psychosocial

26. What are the psychosocial issues that need addressing with Paula?
27. How would you address these issues in your treatment sessions?
28. What other individuals might you enlist to help in this area? What types of groups might be meaningful to Paula?

Patient/Family Education

29. Given that Parkinson's disease is a progressive neurological disease, how would you teach Paula about the functional import of the disease?
30. Explain to Paula the importance of using the rolling walker during functional activities.

NOTES

Situations

31. At the team meeting, Paula is identified by the dietician as a high risk for aspiration and wants to start her on a ground diet. You feel that Paula needs dysphagia treatment before changing her diet. How do you address this issue in the team meeting?
32. The CNAs see Paula as a very difficult resident. She requires a lot of their time at meals and for ADLs because she is so slow. They want to do everything for her so they can get on to their next resident, but Paula gets angry at them because she wants to remain as independent as possible and do as much for herself as she is able. How do you address this issue with the CNAs who care for Paula daily?

Discharge Planning

33. Paula has refused to participate in treatment for the past week, stating she just doesn't feel like doing anything. What are some of the possible reasons for this, and what would you do?
34. How would you ensure that gains made during your OT treatments are maintained once Paula is discharged from therapy?

NOTES

Chapter 17

Quinn: Dementia

Quinn is a 77-year-old Caucasian man with a diagnosis of dementia. Quinn has a past medical history of congestive heart failure, hypertension, depression, and gout. Quinn has been a resident at the nursing home for the last 2 years. He resides on the long-term care wing of the facility. It is the family's plan that Quinn remain at the nursing home indefinitely.

Quinn's wife, Dorothea, visits on Wednesdays and Fridays. She takes him outside onto the patio and reads him letters from their grandchildren. When she has no family news, she reads him the newspaper or the church bulletin. Dorothea wants Quinn to remain as mentally capable as possible. It is obvious that there is a strong bond between them. Dorothea holds Quinn's hand for her entire visit. She attends all of his care plan meetings and frequently speaks as an advocate on his behalf.

Quinn participates minimally in the facility's activities. If someone wheels him into the day room, he'll listen to the radio or watch the entertainers. Quinn speaks only if spoken to or if he needs something. He uses simple sentences and often answers incorrectly when asked simple questions. Quinn recognizes Dorothea, but sometimes confuses his daughters and grandchildren. He cannot recall the names of staff members, but does smile when he sees someone he recognizes.

The nurse, who realized Quinn is now requiring more assistance from the nursing assistants at meals, has referred him to occupational therapy. Quinn had been eating in the main dining room for lunch and dinner, but now has to eat in the day room on the unit because he requires assistance with his meals. Such one-on-one assistance is not available in the main dining room.

Upon speaking to the nurse and his primary nursing assistant, it becomes clear that Quinn has been requiring more help with his meals over the last 3 to 4 weeks. He had required only setup with his meals in the past. Reportedly, he now needs to be fed. Quinn has been dependent for his ADLs since he arrived at the facility and is non-ambulatory. The facility staff feels that Quinn is more cognitively impaired than he appears.

Because Quinn is not newly admitted to the facility, it is the policy of the occupational therapy department to use a specialized feeding evaluation for long-term residents. A feeding evaluation is performed with Quinn.

Occupational Therapy Evaluation

Quinn is sitting in a wheelchair that his family purchased for him (Figure 17-1). His leg rests are elevated to prevent LE edema. The wheelchair that Quinn sits in has a reclining back, and he is leaning back at approximately a 35° angle. His pelvis is tilted posteriorly, his head is jutting forward, and his cervical spine is in a kyphotic posture.

Quinn has AROM WNL for his UEs through slightly less flexion of the shoulders secondary to the kyphosis. His strength is G-/F+ and his gross-motor control is WFL. His fine-motor coordination is impaired but could not be formally assessed due to his cognitive status. His sensation appears intact for both UEs but could not be formally assessed either. He is right-hand dominant.

Cognitively, Quinn displays short- and long-term memory deficits and a decrease in executive functions. He is able to follow some verbal commands accompanied by visual cues, such as "shake my hand." He is unable to learn new information, but performs automatic responses without prompting. He has an attention span of approximately 5 minutes. He is oriented to self only. Quinn is on a regular diet.

Quinn requires setup for his meal. He is unable to identify and locate the various utensils used during his meal. However, he is able to demonstrate holding a spoon and a fork correctly once it is properly placed in his

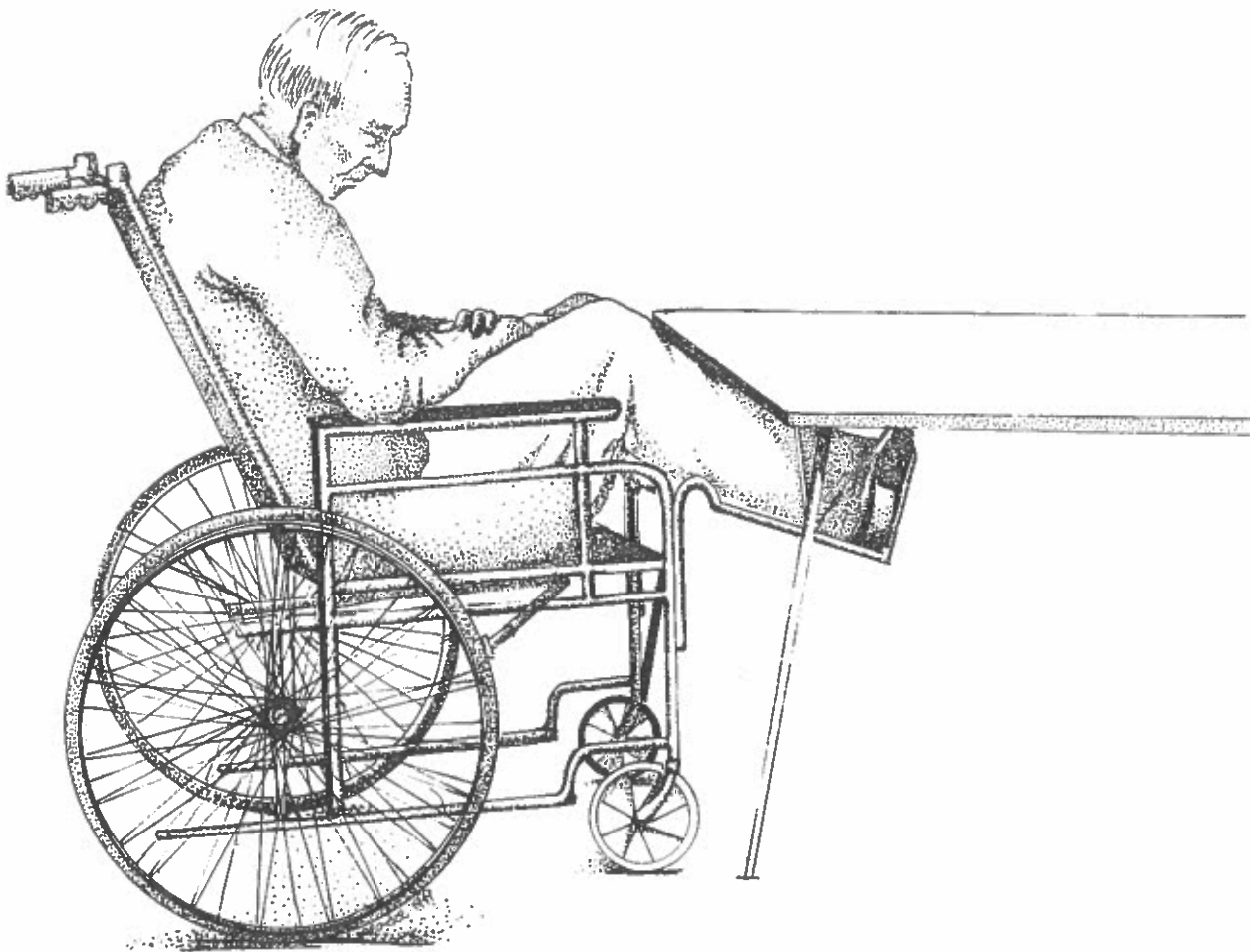


Figure 17-1.

hand. Quinn has much difficulty scooping the food onto the spoon. He is unable to successfully pierce food with a fork six out of 10 tries. Quinn also has difficulty not dropping the food once he has successfully gotten it onto his utensil. While bringing it to his mouth, many pieces fall into his lap. Quinn then puts the fork or spoon down and picks the pieces up with his fingers. He gets the pieces of food into his mouth every time.

Quinn is able to eat a piece of buttered bread independently once it is placed in his hand. Quinn is also able to hold a cup independently, again, only after it is placed in his hand. He is only able to drink half of his liquid because he cannot extend his neck from the flexed position to tip the remainder of the liquid out of the glass. He is able to continue drinking once given a straw. However, he neglects to use the straw the next time the cup is placed in his hand. He does not finish his drink without assistance. Quinn uses his napkin spontaneously once placed in his hand.

Quinn is unable to state his goals for occupational therapy. He does not appear to understand the purpose of occupational therapy. The purpose and projected outcome of occupational therapy is explained to his wife. She repeats her own goal of having her husband be able to eat in the dining room at meals. She agrees for OT services to begin.

QUESTIONS

Goals/Treatment Plan

1. Write out a problem list for Quinn.
2. What strengths do you see that Quinn has to help him achieve his goals?

NOTES

3. What short-term goals would you set for Quinn to help reach the long-term goal of eating in the main dining room?
4. What obstacles do you see for Quinn in reaching his goals?
5. Write out a specific treatment plan for Quinn including frequency and duration.

Safety/Precautions

6. You adjust Quinn's wheelchair so he sits upright at a 90° angle. He slowly begins to slip out of his chair. Explain what you do in this situation.
7. Make a list of all the possible complications Quinn might have because of his position in the wheelchair.

Self-Care/Work/Leisure

8. Describe a single OT treatment session with Quinn, focusing on increasing independence at meals.
9. What techniques might you use to facilitate the skills needed to improve his self-feeding abilities?

Equipment/Adaptations

10. What type of environmental adaptations need to be made for Quinn to allow him to feed himself more independently?
11. What type of adaptive equipment might Quinn need to enable him to be independent in self-feeding? How does food texture influence self-feeding? Do you think Quinn needs a change in textures?
12. Explain how you would involve the dietary and nursing staff in this process.
- 12a. Using Figure 17-1, describe what is correct and incorrect with Quinn's wheelchair positioning.

Neuromusculoskeletal

13. What can be done to treat Quinn's decrease in fine-motor coordination?

Cognition/Perception

14. What can be done to treat Quinn's cognitive deficits? What compensatory strategies will you use for the cognitive deficits you cannot treat?

Psychosocial

15. What psychological impact do you think being fed may have on Quinn?
16. What impact do you think it may have on his wife? What type of support do you think might benefit Dorothea as Quinn's condition progresses? What other disciplines might you refer Dorothea to?

Patient/Family Education

17. Write out how you would explain Quinn's abilities to his wife.

Situations

18. You have made changes in Quinn's mealtime routine and want other staff to follow through with your interventions. Name all the staff who are involved and what type of teaching you must do to ensure the program carryover that you want.

NOTES

19. Quinn becomes agitated when you try to rearrange his plate to facilitate independence. He refuses to eat after you have intervened. What do you do?
20. Dorothea wants to see how her husband is doing in therapy. She asks what can she do to help promote independence. What do you tell her?
21. Dorothea decides to visit Quinn during the day at lunch. She wants him to sit on the patio with her. There is no table out there. What adaptations would you need to make to enable Quinn to eat his lunch on the patio with Dorothea?
22. You arrive at the facility early and go in to see how Quinn is doing with his breakfast. You see his nursing assistant feeding him oatmeal. What do you do?
23. This same scenario occurs several days in a row. Why might be some of the reasons as to why the nursing assistants keep feeding him day after day?
24. How would you deal with staff enabling Quinn's dependence at meals?

Discharge Planning

25. When you decide to discharge Quinn from OT services, what do you need to have in place to ensure he would be able to maintain his current level of independence?
26. How could you monitor Quinn to see that he did not decline again to being fed at meals?

NOTES



Chapter 18

Rob: Blindness, Insulin-Dependent Diabetes Mellitus

Rob is an 83-year-old Caucasian man with a diagnosis of glaucoma, non-insulin dependent diabetes mellitus, gout, and hypertension. He is blind due to the glaucoma. He has been living in a skilled nursing facility for 1 month and has been having a difficult time adjusting to the new environment.

Prior to his admission to the skilled nursing facility, he had been living alone in his own house with services of a home health aide (HHA), homemaker, Meals on Wheels, and weekly nursing visits to monitor his insulin levels and blood pressure. He has been widowed for 6 years. A neighbor was also helping him with meals on the weekends and errands, as well with companionship. However, she was hospitalized herself and is no longer able to assist Rob, given that her assistance was one of the reasons Rob had been able to stay at home so long. Rob has a son, but they are not close and he is not available to help; therefore, placement was sought in a nearby skilled nursing facility.

Rob is a retired factory foreman. He has been retired for 18 years and has lived on Social Security and a small pension plan. Rob lost his vision gradually due to glaucoma. He knows his way around his home and had been able to remain there because of the services and the familiar environment. Rob is fiercely independent and is not happy about having to go into a skilled nursing facility. He uses talking books and listens to the TV. He enjoys going out for walks with his HHA in the nice weather.

In the skilled nursing facility, Rob has been having a difficult time adjusting to the loss of independence and to the institutional routines. A referral was made to OT by Rob's physician to assess his ability to be more independent in ADLs, mobility around the facility, and to work on leisure skills. He is being seen only by occupational therapy.

Occupational Therapy Evaluation

Rob has no observable deficits in his cognition or hearing. Sensation is impaired in his hands for hot/cold, sharp/dull, and light touch. He is blind due to the glaucoma, but can detect shadows and differences in light levels (bright light versus low light). He can recognize familiar people by their footsteps and voices.

Rob's AROM is WFL for his age with strength at the 4/5 bilaterally. He suffers from frequent onsets of gout in his left great toe which are extremely painful and leave him unable to get around without a wheelchair. He is left-handed and has no significant deficits in gross-motor coordination, but due to the sensory deficits in his hands, he has difficulty manipulating small objects, including buttons, pant zippers, and shoelaces. Except when he is experiencing an episode of gout, he does not have any pain.

Rob is able to move from supine to sit, sit to supine, and from sit to stand independently. He ambulates without any assistive device, but bumps into objects in his room and the environment outside his room. He is unable to find his own room if he is in the hallway. He spends a lot of time standing in the doorway to his room and talks to people who come by, but he is very reluctant to leave the room itself. Rob shares his room with one other gentleman who has Alzheimer's disease.

Rob requires setup for washing at the sink in the bathroom and for dressing because he has trouble finding his supplies and clothing. The staff never put things back in the same place. He has difficulty with the buttons on his shirts and with the zipper on his pants, and needs someone to tie his shoelaces for him.

Rob eats in the main dining room of the facility at a table with three other residents, where he enjoys the socialization. Rob can feed himself if someone cuts up the food and opens the containers and milk cartons. However, he doesn't know what the meal is until he starts to eat it and is not sure when he has eaten all the food on his plate. He knocks his glass over often and has difficulty locating his coffee cup on the table. He finds meals to be a frustrating experience and gets embarrassed by his clumsiness. The other people at his table try to help him as much as they can.

He alternates between feeling frustrated and depressed. He misses his independence and feels that he would be better in his own home, where he knows where everything is, but his son has put the house on the market and does not want him to go back home. When questioned about his interests, he says that "being blind took care of that." He used to fish, was in a bowling league with his wife, and enjoyed classical music. Now all he does is listen to the TV and occasionally the talking books.

Rob is open to OT and has stated that his goals are to be able to "do more for myself." When questioned further, he stated that his dignity is most important to him and he wanted to be able to bathe and dress himself, and to eat his meals without all the frustrations. He will be seen five times a week. His insurance is Medicare Part A.

QUESTIONS

Goals/Treatment Plan

1. What special considerations should you have when working with someone who is blind?
2. What are Rob's strengths and deficits?
3. Write long- and short-term goals for Rob.
4. If you were the OTR, what portions of the treatment plan would you have the COTA complete, and how would you monitor Rob's progress in these areas?
5. If you were the COTA, how would you collaborate with the OTR on this case?
6. How do you think Rob's psychological status will impact his motivation during therapy? How can you help to motivate him?

Safety/Precautions

7. Do you think that Rob is safe in his current environment? If not, what would you change and how? If yes, why do you think he is safe?

Self-Care/Work/Leisure

8. Please write your treatment activities for 1 week's worth of treatment to work on Rob's bathing and dressing deficits.
9. Mealtime is a very stressful time for Rob. What recommendations would you make to increase his independence and reduce his anxiety at meals?
10. How would you go about implementing your recommendations and getting the cooperation of the dining room staff (mostly CNAs and diet technicians)?
11. When Rob is not engaged in therapy, he spends his time standing in the doorway to his room chatting with staff, residents, and family members or in his room listening to TV. He has indicated that he wishes he could do something else with his time as he gets bored. He states that he isn't interested in doing any "crafts stuff with the ladies." Given what you know about his past leisure interests, what ideas could you suggest to Rob?

NOTES

12. How would you implement the ideas you have from Question 11?
13. What types of activity groups do you think Rob might enjoy?

Equipment/Adaptations

14. What type of adaptations would you make in Rob's room so that he could find the different clothing items in his closet and dresser (T-shirts, underwear, socks, shirts, slacks, belt, shoes)?
15. What type of adaptations would you make in the dining room to assist Rob during meals?
16. In general, what are some common environmental adaptations for people with visual impairments?

Neuromusculoskeletal

17. How would you address Rob's sensory deficits, especially as they relate to his difficulty with buttons and zippers?
18. Please describe three treatment activities that will address the sensory deficits. At least two need to be functional and purposeful activities.

Psychosocial

19. Rob gets easily frustrated and is having difficulty adjusting to his new environment. What psychosocial issues may be influencing his feelings?
20. What are Rob's strengths in this area, and how can these be incorporated into daily treatment? How can the team address these strengths together?

Patient/Family Education

21. Design a patient education program for the staff on how to work with a blind resident.
- 21a. What services can you find in your area for the blind? Explain how Rob might benefit from them.

Situations

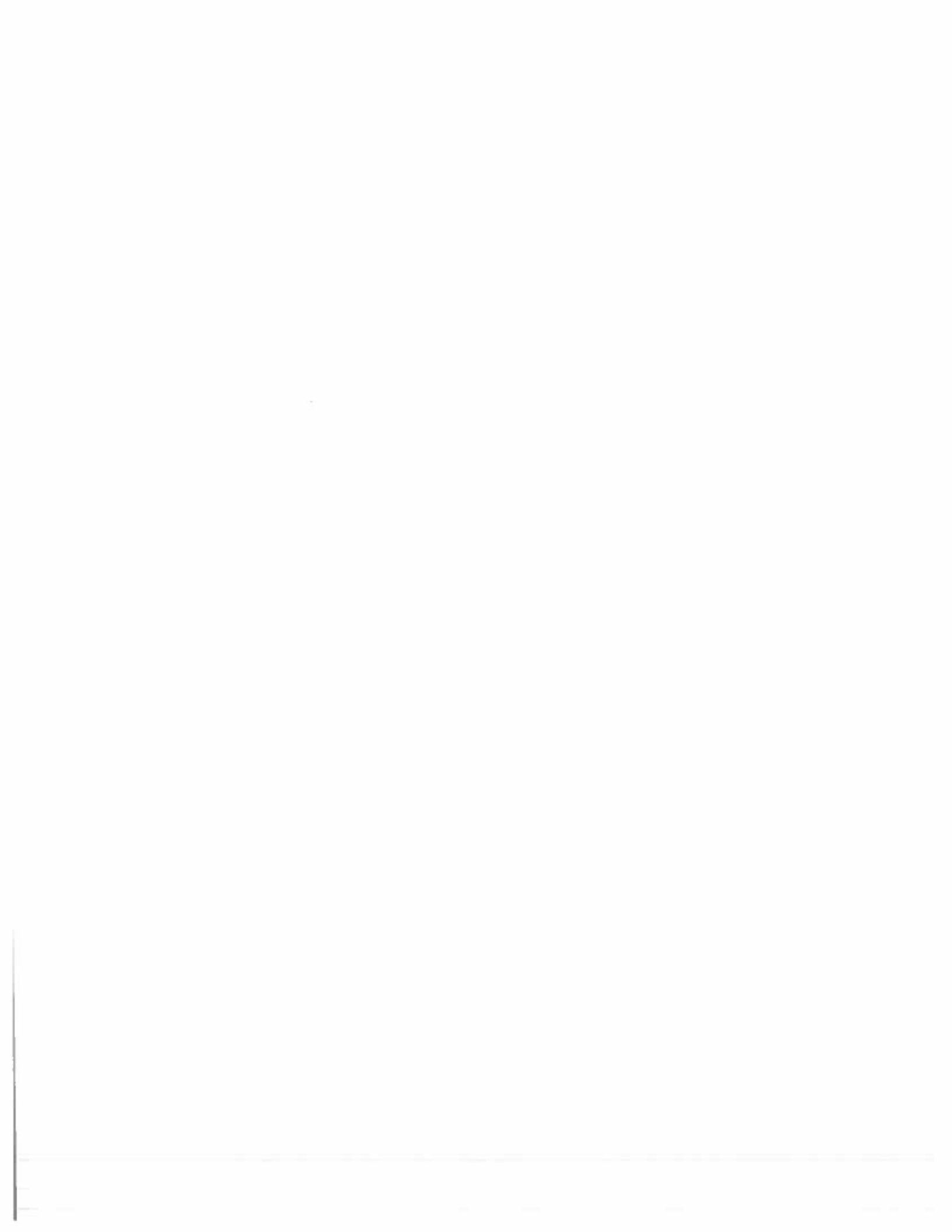
22. You have given the dining room staff (both day and evening) an in-service on setting up Rob's place setting and orienting him to his meal. However, you go into the dining room to check on this and see that no one followed your in-service guidelines. You check with Rob and find out that staff is inconsistent about doing this, but that when they do what they are supposed to do, he has a much better dining experience. How do you handle this situation?
23. Similar to the situation in the dining room, you have posted signs on Rob's dresser and closet saying what clothes go where so he can find them and dress himself. You have also in-serviced the housekeeping and nursing staff. However, when checking his room, you see that his clothes are not put away as requested. How do you handle this situation?
24. Could you combine the situations in Questions 22 and 23 and address them together? What would you say, and how would you go about doing this?

NOTES

Discharge Planning

25. You are ready to discharge Rob from skilled OT, but are afraid of things slipping without regular monitoring to ensure that the techniques you have put in place are continued. Who do you think would be the best person to monitor his programs for mealtime and room organization? How would you set up this monitoring program?

NOTES



Chapter 19

Sean: Left Above Knee Amputation, Stage II Sacral Decubitus Ulcer

Sean is a 67-year-old Caucasian old man with a diagnosis of left above knee amputation secondary to diabetes mellitus. He also has a diagnosis of a Stage II sacral decubitus ulcer. Sean has a past medical history of alcohol abuse, depression, and status post right great toe amputation. Sean had the left leg amputated below the knee ten years ago. The amputation to above the knee was performed 11 weeks ago. The decubitus ulcer on his sacrum had healed from a Stage III to a Stage II while Sean was in the hospital.

Sean was transferred to the nursing home from the veteran's hospital. Sean had been living alone in the community. His daughter had come to visit from out of state and found him without food in the house, unclean, and with a sore on his buttocks and left stump. Sean thought the sore on the left leg had started when he accidentally banged his leg against the wheelchair during a transfer. His daughter thought the sore on his sacrum had probably come from poor hygiene, nutrition, and positioning. Sean had been staying in his wheelchair all day, sometimes even sleeping in it at night.

Sean has had multiple hospitalizations in the past, usually due to not caring for himself properly. Sean routinely refuses to see his doctor and will only go if his daughter drives him. "I can't understand all that garbage they tell me. That's why I need Mary to come with me. She can talk to them," he says. Sean's only daughter, Mary, is a nurse. Unfortunately, she also lives almost 2 hours away. She moved when her husband was transferred about 3 years ago. She has invited her father to come live with them, but he refuses to leave his home.

Sean has been widowed for 15 years. His wife died quickly of cancer, and he still grieves for her. Mary reports that her mother did everything for her father and upon her mother's death, her father was truly lost. Sean owns a grand home in the oldest part of the city. He says that the house has 18 rooms if you include the loft in the attic. He and his wife had planned on having a very large family but "God had other plans for us." They had only one child, Mary, to whom Sean is very close. Sean worked as a carpenter until he lost his leg 10 years ago.

Prior to his hospitalization, Sean had been able to perform his ADLs independently, but admitted he "cleans up" sporadically. Sean says he bathes and changes his clothes twice a week. He does not use the shower. He transferred independently, is nonambulatory, and moved around the house with his wheelchair. Sean is continent of bowel and bladder and uses a drop arm commode over the toilet at home. He also keeps a urinal hanging on his wheel chair to use, but will often spill the urinal while voiding or while moving around in the chair. His daughter reports throwing his wheelchair cushion away after she got him into the hospital because it was too soiled to be used again.

Sean receives Meals on Wheels from the Department of Elder Services once a day. He does not cook and relies on the microwave to heat meals, usually frozen dinners. Sean does not drive and hires a neighborhood woman to grocery shop for him. Mary says he had not called the woman for her services for almost a month before he went into the hospital. "I just don't feel that hungry anymore," he told Mary when she scolded him for not having enough food in the house.

Sean does not do housekeeping or laundry. He has a housekeeper from Elder Services in once every 2 weeks. She has offered to come more frequently, as the house needs it, but Sean refuses. Mary says the house was in the "worst shape ever" when she visited her father this last time. Sean has also let his finances go, despite his ability to manage his own money. Mary found many late notices from the gas and electric companies.

Sean is admitted to the nursing home until Mary is able to build an addition onto her home where her father can live. He has only agreed to this recently. He has insisted on going back to his own house but Mary forbids it. He agrees to move in with her only if he can have his own quarters so he will not burden her and her family.

He also will not let her use her own money to build the addition, and insists the money from the sale of his house go to cover the costs of the renovations. He wants Mary to have the rest of the money from the sale of his home as payment for his care. Mary wants him to move in right away but Sean is adamant about waiting. "I pick my battles with my father," Mary says. "He is very stubborn and if I expect to win all of them, I'm wrong!" Therefore, the plan remains for Sean to stay at the nursing home until an in-law apartment is ready for him.

While this seems like a reasonable discharge plan, the entire process is slowed by the lack of an interested buyer for Sean's house. It is large, but needs many repairs. Sean hopes it will not take too long, as he wants to "get out of institutional living!" At best, Sean and his family estimate this will be several months. Sean is to receive nursing, PT, OT, nutrition, and social services while at the facility.

Occupational Therapy Evaluation

Upon evaluation, Sean is cooperative and friendly. He seems to like to talk despite his no-nonsense attitude. He has no cognitive, perceptual, or hearing deficits. He wears bifocals for reading and distance. He has decreased sensation in the right LE and in bilateral fingertips. The amputation is still sensitive to touch, and Sean reports that sometimes even feeling his pants brush against the stump makes him quiver.

Sean has normal range and coordination in his UE. He is slightly weak in his bilateral UEs, scoring only a F+/G- overall in manual muscle testing. He says he feels like he is weaker than he was before his surgery. Sean complains of pain in his left stump only during occasional movement or touch. He reports muscle spasms in the limb and says they seem to occur at will. He describes the pain from the spasms as shooting up into the hip area. He says the ulcer pain in his sacrum is unbearable at times, and he takes pain medication for relief. Because of the location of the sore, he can only tolerate being out of bed a few hours at a time. The stump is mostly healed, and nursing is caring for the wound area. There is slight redness but no swelling.

Sean is able to roll side to side in bed and pull himself up from supine to sit with minimum assistance. He performs his transfers with contact guard to minimum assistance depending on his level of fatigue. He washes himself in bed independently except for his back, buttocks, and left stump. Although it takes him awhile, he is able to dress himself independently. Sean is not very thorough during the bathing activity. Sean can manage to cleanse the stump but has been asked by the nursing staff to allow them to do it. He states he has little interest or experience in any kitchen or homemaking tasks and refuses to partake in that portion of the evaluation. Sean spends his free time watching TV or reading.

Sean is open to having therapy but isn't sure how occupational therapy can benefit him. He states his goals are to go live with Mary and feel stronger again.

QUESTIONS

Goals/Treatment Plan

1. Write out a problem list for Sean.
2. What long-term goals would you and Sean set for his occupational therapy treatment?
3. What short-term goals would you and Sean set for his occupational therapy treatment?
4. What strengths do you feel Sean can capitalize on to help him meet his goals?
5. What obstacles do you foresee for Sean in his efforts to meet his goals?
6. Write out a specific treatment plan for Sean including frequency and duration.

Safety/Precautions

7. What precautions should be taken to prevent further skin breakdown for Sean? Write out a list and note which staff members would implement each step.

NOTES

Self-Care/Work/Leisure

8. How long do you anticipate it will be before Sean is performing his bathing independently? Why?
9. How would you address Sean's refusal to participate in the kitchen and home management portion of the evaluation?
10. How would you address Sean's lack of concern with home management and meal preparation in the past?
11. How would you assess Sean's leisure needs?
12. How, if at all, would you incorporate these needs into his treatment plan?

Equipment/Adaptations

13. What type of adaptive equipment might benefit Sean in reaching his goals?
14. Sean's daughter asks you what type of adaptations should Sean have in his apartment so she can tell the architect. What recommendations do you make?
15. Would you recommend an overhead trapeze for Sean? Why or why not?

Neuromusculoskeletal

16. Describe how you would address Sean's complaint of weakness in his UEs.
17. Give a description of a treatment session with Sean to address this issue.
18. How would you determine when Sean's strength has sufficiently improved?
19. What would you use as your benchmark point?

Psychosocial

20. What psychosocial issues do you think were affecting Sean before his hospitalization?
21. What psychosocial issues do you think are affecting Sean since his arrival at the nursing home?
22. How would you address Sean's previous lack of concern for his own care?
23. How do you think Sean's deteriorated condition has impacted Mary?
24. What impact do you think her feelings have on Sean?
25. In a skilled nursing facility, what discipline specializes in dealing with psychosocial issues?
26. Who could be used as a consultant in this case?

Patient/Family Education

27. What are topic areas in which you feel Sean needs to be educated?
28. How should the information be presented to Sean in order for him to be receptive to it?

NOTES

Situations

29. You overhear other team members laughing about how dirty the hospital said Sean was when he was admitted to the nursing home. What is your initial reaction? How do you respond and why?
30. You stop in to see Sean at lunchtime to say hello. You see he has not eaten any of his lunch. His answer is that he's not hungry. How do you respond?
31. You are assisting Sean with a transfer to the wheelchair. He complains of pain on his buttocks during the transfer. What do you do?
32. You are working on toilet transfers in the OT clinic with Sean, and he asks you to actually help him use the toilet in the bathroom. You do, and then you leave the bathroom for his privacy. After he moves his bowels, he asks to be transferred back to the chair. He tells you he already wiped himself, but since the toilet paper is out of his reach behind the sink, you doubt this is true. How do you handle this?
33. You meet Sean in his room to bring him to occupational therapy. You notice he has an odor like urine. You casually look at him to see if it looks as though his pants are wet. They don't seem to be, but you can't tell for sure. What do you do?
34. You ask Sean if he urinated in his pants and he becomes angry with you, telling you to mind your own business. How do you respond to his reaction?
35. You go to Sean's room to bring him to the therapy clinic and he has on the same clothes that he's been wearing for the last 2 days. They are stained and he has a slight odor. What might you do in this instance?
36. Sean continues to refuse to participate in any meal preparation activities, despite the fact that he'll be responsible for his own lunch preparation while Mary is at work. Since you cannot force him, what do you do?

Discharge Planning

37. Sean is discharged from OT before it is time for him to leave the facility to live with Mary. How would you ensure that Sean maintains the gains he made in OT?
38. When it comes time for Sean to leave the nursing home, what do you think should be in place to ensure a safe transition to his new home?
39. Would you recommend home OT for Sean? Why or why not?

NOTES

Chapter 20

Teresa: End-Stage Alzheimer's Disease

Teresa is a 79-year-old Caucasian female who has been living in the skilled nursing facility for 8 years. She has a diagnosis of Alzheimer's disease, hypothyroidism, and osteoporosis. She is married, but her husband doesn't come to visit anymore, partly because of his age and partly because she doesn't recognize him and he doesn't like to see her in her current condition. He is supportive and will supply whatever the facility asks for in terms of clothing and inexpensive items (i.e., a stuffed animal). They have one daughter who lives far away, but comes to visit her parents at least four times a year and calls frequently. Currently, Teresa is in the end stages of the disease. She is nonverbal, dependent for all ADLs, is fed by a g-tube, has a foley catheter, and is non-ambulatory. She is transferred out of bed to a reclining chair daily. She used to love gardening and dogs and was very religious. She and her husband were a devoted couple. During her daughter's recent visit she was shocked at the deterioration in her mother's condition and requested that something be done to address some of the issues. Teresa was referred by her physician to occupational therapy for positioning needs and to address contractures and sensory stimulation.

Occupational Therapy Evaluation

Teresa is seen by occupational therapy while she is in bed and while she is in her recliner to address positioning needs. She opens her eyes and can make eye contact sporadically, but does not respond to any commands or questions. She moans if painful stimuli are felt. Testing for sensation and hearing were not completed. Her AROM is limited as she has contractures at the elbows, wrists, and fingers. Her shoulders may be passively ranged to 90° before she moans with pain. There is also resistance at the end of the range. Her elbows are contracted at 90° of flexion. Her wrists have contractures at 45° of flexion and her hands are fisted. The contractures can all be passively stretched an additional 10°–15°, but no more. The contractures in her UE make it difficult for staff to bathe Teresa. Her hands have a foul odor because they have not been properly cleansed. Teresa also has LE contractures, hips 100° flexion, knees contracted at 45°, and plantar flexion contracture at 35°. Her knees can be passively ranged to –10° extension. She has increased tone in the hip adductors, which make it difficult to separate her legs for cleansing and catheter care. Teresa's positioning in the recliner is difficult. She is propped up by pillows on all sides and still slips down in the recliner. She has to be reclined all the way, but this puts her neck into hyperextension. She also leans more to the left side. Currently, it takes two nursing assistants to wash and dress Teresa due to the tightness of her limbs. She is transferred by a Hoyer lift. The goal for OT is to properly position Teresa both in and out of bed, address the PROM and contractures so that daily care can be more easily given, and provide sensory stimulation.

QUESTIONS

Goals/Treatment Plan

1. What would your long- and short-term goals be for Teresa?
2. Write out a problem list for Teresa.
3. What frame of reference would you use for each of your goals?
4. What aspects of the treatment can be done by a COTA? By a rehab aide? By an OT aide?

Safety/Precautions

5. What precautions do you have to take when doing PROM with Teresa? Why?
6. What is a Hoyer lift, and how do you use one?

Self-Care/Work/Leisure

7. How might you incorporate some of Teresa's past leisure interests into your treatment sessions?
8. Because Teresa is dependent in her self-care, what is the role of OT in this area?
9. Because Teresa is unable to ambulate, what are the problems that are associated with prolonged immobility? How would you address some of these in OT treatment?
10. How is skin breakdown prevented in a patient in Teresa's dependent condition?
11. How do you address the foul smell of Teresa's hands? What do you think causes this smell?

Equipment/Adaptations

12. What types of adaptations might you suggest to properly position Teresa while she is in bed?
13. What is the optimal seating positioning for Teresa when she is out of bed?
14. What do you see as the major obstacles to properly positioning Teresa when she is out of bed? Would you suggest any different types of seating systems? Remember, insurance rarely allows for specialized wheelchairs for nursing-home residents.
15. Look at a catalogue and see if there is any positioning equipment that might help to position Teresa properly when she is out of bed. What is the cost of this equipment? Who do you think would pay for it? Do you think the amount of money you are asking for is reasonable for the benefits it may have?

Neuromusculoskeletal

16. Teresa has many contractures. How would you address each one of her contractures in a comprehensive program?
17. If you chose to use splints, what type of splint would you make initially and why? What material would you make this splint out of?
18. What would be the wearing schedule for the splints?

NOTES

19. Look at a catalogue of splints. What kind could you purchase instead of make? What would be the advantage of purchasing a splinting device over making one? Why did you choose the splint(s) that you did?
20. Describe optimal bed positions for Teresa in supine and side-lying.
21. What are the major obstacles to positioning Teresa properly when she is in bed?
22. What would the benefits of PROM be for Teresa?
23. How often would you recommend that Teresa receive PROM each day? Who will be responsible for doing this?
24. Describe a sensory stimulation program for Teresa. Who would carry out this program and how often should it be done?

Patient/Family Education

25. What would be important to educate staff about in relation to Teresa's occupational therapy plan of care?
26. How would you go about this education process?

Situations

27. You go in to check on Teresa's splints and find that they are on totally wrong. You have put a sign on the wall by her bed telling the staff how to apply the splints, but they are not done correctly. You check with the nursing assistant assigned to Teresa and discover that English is not her primary language. What do you do?
28. During PROM with Teresa, you feel a slight "click" during shoulder ROM. You notice that Teresa starts to moan as if she is in pain during this ranging activity, and she never did before. What do you think might have happened and why? What do you do?
29. One day, you notice that Teresa does not have one of the positioning devices on her chair. What do you do?

Discharge Planning

30. You are about to discharge Teresa from skilled OT services. Does Medicare allow you to monitor her on a regular basis? If so, how often will you put in your discharge plan that you want to do this? If not, how will you ensure that all your splints and positioning devices are used and used correctly?

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