OCCUPATIONAL THERAPY

BEST PRACTICE GUIDELINES

FOR

ACUTE MEDICAL SERVICES

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Lothian Best Practice Guidelines – this document belongs to NHS Lothian
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EXECUTIVE SUMMARY

These guidelines are meant as a tool to assist in the promotion and standardisation of good practice and equity of treatment for Occupational Therapists working in Acute Medicine.

For the purpose of these guidelines the term “Acute Medicine” is defined as a period of stay in hospital up to 48 hours.

These guidelines can also be useful if adopted in a clinical setting where the period of stay is up to 5 days.

Initially these guidelines have been formulated for use within Lothian and Borders, they may be adopted by other Trusts adhering to local procedures at the responsibility of individual therapists.

CONTENTS

INTRODUCTION TO ACUTE MEDICAL GUIDELINES

The Best Practice Guidelines for Acute Medical Services were formulated as a result of a request from Lothian Clinical Development Group (LCDG – a Lothian wide occupational therapy network), in order to promote good practice and equity of treatment across all trusts.

Following the request, occupational therapists from Lothian University NHS Division (LUHD) met to review current working practices within Acute Medicine. In order to get a broader perspective, the group was extended to include occupational therapists working in A&E in the Scottish Borders and West Lothian.

The College of Occupational Therapists' standards were reviewed, along with all local standards, policies and procedures, for guidance (1). Collectively it was agreed that these were too general and not specific to the fields of A&E and Acute Medicine, as confirmed by a recent study (2). Further research at the Accident and Emergency Specialist Section of Occupational Therapy study day concluded that there were no other evidence-based guidelines in current use in this area. Best practice guidelines, which had coincidentally been formulated by a local orthopaedic occupational therapy focus group (3), were used initially to generate discussion and begin compilation. Once the guidelines were formulated they were audited nationwide (41% return), the final guidelines are based on the results obtained.

Due to the complex and dynamic nature of the Acute Medicine field, the guidelines are based around a flow chart outlining the occupational therapy process from referral to discharge, including sections on assessment, clinical judgement, intervention and discharge. A table illustrates the specialist skills necessary for occupational therapy in Acute Medicine and appendices outline components of various assessments. It is hoped as therapists progress through the flow chart they can utilise further guidelines related to specific assessments; these are included in appendices indicated by different colours on the flow chart.

The guidelines are meant as a tool to assist the promotion and standardisation of good practice and equity of treatment for occupational therapists working in Acute Medicine. They have been formulated for use within Lothian and Borders.

THERAPY REQUIREMENTS

THE OCCUPATIONAL THERAPIST

- All Occupational Therapists will be Health Professions Council registered.
- All Occupational Therapists will refer to the College of Occupational Therapists Standards, policies and procedures. These will be used in conjunction with local standards (1).
- All Occupational Therapists will be aware of the health and community care legislation (4) and how it impacts on delivery of service.
- All Occupational Therapists will maintain accurate timely records in accordance with the College of Occupational Therapists' standards and localised guidelines.
- All Occupational Therapists will be responsible for identifying their own training needs through the process of appraisal and supervision (5).
- All Occupational Therapists will be aware of the need to update knowledge as part of the continuous professional development (5).

OCCUPATIONAL THERAPY ASSISTANTS

- Occupational Therapy Assistants will carry out delegated duties under the direction of a registered Occupational Therapist.
- The Therapy Service will ensure that Occupational Therapy Assistants participate in education/training appropriate to the needs of the client group (6).
- Occupational Therapy Assistants have personal responsibility for actively developing and maintaining their competence. Training and education needs must be discussed/identified during supervision sessions and through annual personal development plans.

GUIDELINES FOR OCCUPATIONAL THERAPY INTERVENTION

AIMS OF OCCUPATIONAL THERAPY IN ACUTE MEDICINE

- To prioritise and assess those patients for safe discharge direct from A&E or Acute Medicine either:
  - Same day
  - 24 - 48 hours
  - 72 hours - 5 days

- To identify those patients requiring further Occupational Therapy intervention as inpatients on mainstream wards (7).

- To play an active role in the multidisciplinary (MD) discharge process for those returning home directly from A&E and Acute Medicine (7)

REFERRAL

Referrals will be actioned by a registered Occupational Therapist and in accordance with local procedures;

(a) College of Occupational therapists "Code of Ethics and Professional Conduct for Occupational Therapists" (1).
(b) College of Occupational Therapists statement on Referral (125A -September 1994) (8).
(c) Local Operational Policy.
(d) Local standards of clinical practice.
(e) In some Trusts a screening policy will be in operation.

CARE GROUP

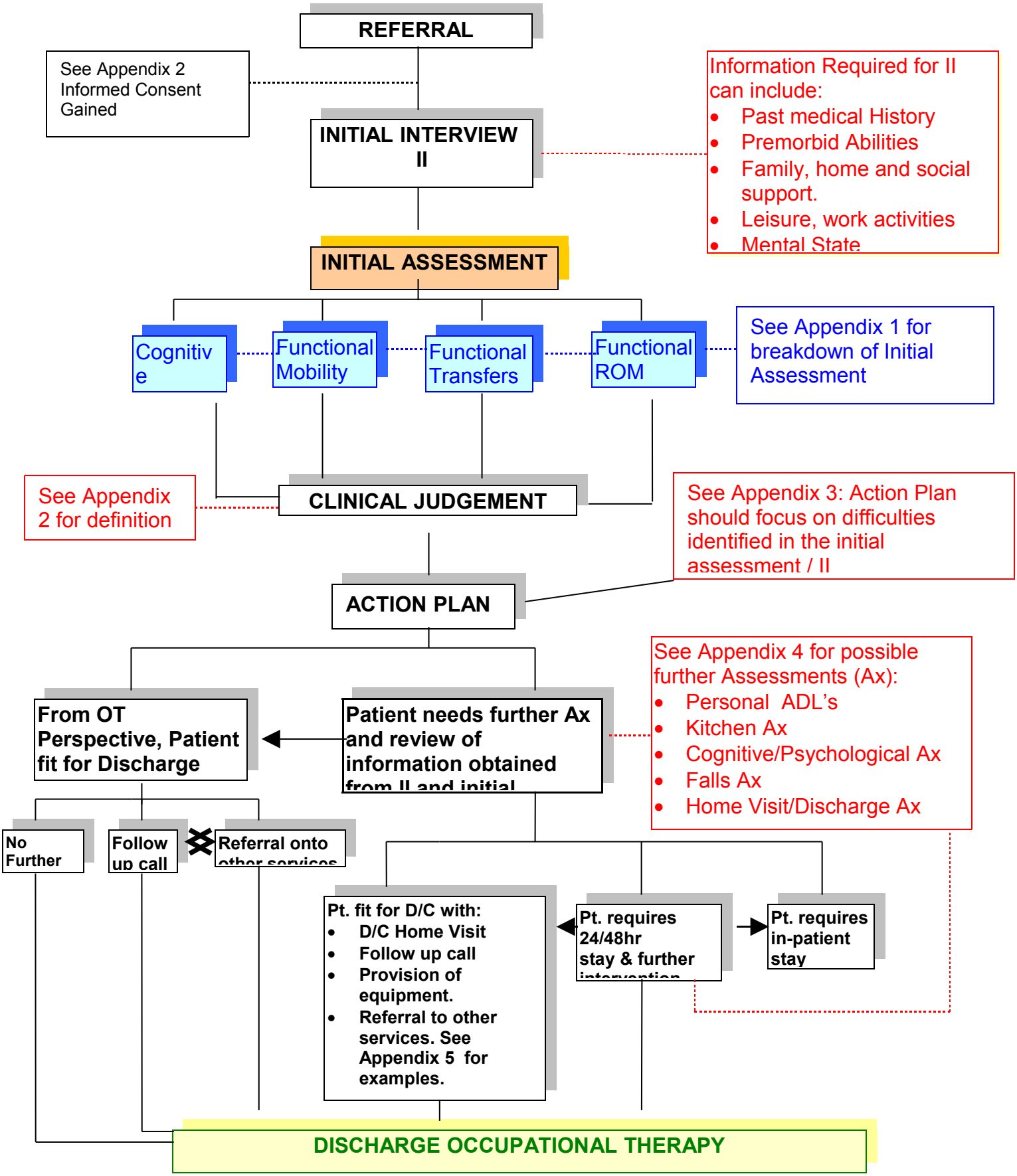
The guidelines are utilised for patients aged over 16 years with predominantly physical / functional disabilities.

These patients may also present with Mental Health Issues / Learning Disabilities. It is at this point that the therapist may liaise with colleagues in specialist fields.

OCCUPATIONAL THERAPY PROCESS

All patients accepted for Occupational Therapy intervention should have an initial screening/interview from a registered Occupational Therapist. Informed consent should be obtained from the patient and / or carers. Ideally intervention should commence within 24 hours, however it is recognised that some areas adopt the standard of 2 working days (8). For further details on the OT process please refer to flow chart overleaf.

ACUTE MEDICINE OT PROCESS



SKILLS OF OCCUPATIONAL THERAPISTS IN ACUTE MEDICINE

GENERIC SKILLS	OT SPECIFIC SKILLS	Acquired OT Skills for A&E / Acute Medicine
• Social status verification/data collection, liaising with internal/external agencies and family/carers. • Interpersonal Skills and effective communication with multidisciplinary team. • Problem solving / reasoning skills • Treatment planning. • Discharge planning. • Risk assessment. E.g. falls	• Activity Analysis • Assessment of activities of daily living. • Use of activity as a therapeutic tool. • Carrying out home assessments. • Knowledge of assistive equipment and adaptations.	• An awareness of acute medical conditions and the local protocols/contraindications associated • Effective and efficient clinical reasoning skills. • Triage referrals to assist prioritisation. • Rapid risk assessment and immediate response to risk factors. • Rapid assessment and discharge planning. • Discharge home assessments. • Knowledge of local resources

CONCLUSION

Since the guidelines have been formulated Occupational Therapists across Lothian and Borders have utilised them as a point of reference. They have been used both clinically and for educational purposes to promote good standards of practice and to provide an overview of the OT process to other professions and students alike. The contributors have since presented these guidelines and audit results at national conferences for Health Care Professionals with very positive results. The main aim of these guidelines is to promote good practice and equity of treatment in the clinical field of Acute Medicine.

GLOSSARY

Appraisal	A process by which an individual's education, training and development needs are identified as part of regular, formal performance review.
Assessment	Process by which data is gathered, hypotheses formulated and decisions made for further action; a sub-section of the problem orientated medical record.
Clinical Reasoning	Thinking that directs and guides clinical decision-making; reflective thinking.
Continuous Professional Development	The systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner's working life.
Healthcare Professionals	A generic term to describe qualified staff who are involved in patient care. Can include nursing staff, social workers, occupational therapists, physiotherapists, speech and language therapists and dieticians.
Informed Consent	Requirement that the person must be given adequate information about the benefits and risks of planned treatments or research before he or she agrees to the procedures.
Initial Interview	Interview in which the therapist gathers information about the client and / or environment.
Multi-Disciplinary	Several disciplines involved with patient care.
Multi-Disciplinary Team	Health care workers who are members of different disciplines, each one providing specific services to the patient / client.
OTA (Occupational Therapy Assistant)	An individual assigned by an occupational therapy practitioner to perform delegated, selected skilled tasks in specific situations under the direction and close supervision of an Occupational Therapist.
Pre-morbid	Patient's level of function prior to current medical status.
Registered Occupational Therapist	Individual who is credentialised as a registered Occupational Therapist with Health Professions Council.
Supervision	An umbrella term including the process that ensures safe practice, development of skills, encouraging personal and professional growth and support of the individual

REFERENCE LIST

1. College of Occupational Therapy (2001) Code of Ethics and Professional Conduct for Occupational Therapists, London: COT

2. Carlill, G et al (2002) Preventing unnecessary hospital admissions: An OT and SW Service in A&E, BJOT 65 (10) p440-445

3. Occupational Therapy Guidelines for Lower Limb Orthopaedic Trauma. Littlejohn et al 2002. Unpublished LUHT

4. The National Health Service and Community Care Act (Scotland) 1990

5. Sealy C, (1999) Clinical Governance: An Information Guide for Occupational Therapists, BJOT; 62(6), p263-267

6. The Clinical Reasoning of an Occupational Therapy Assistant, 2001, AJOT; Sept – Oct (5): p577-581

7. Sutton, S (1998) An Acute Medical Admissions Unit: Is there a Place for an Occupational Therapist? BJOT 61(1)

8. Professional Standards for Occupational Therapy Practice, 2003 London: COT

9. Higgs, J & Titchen, "A Practice Knowledge and Expertise in the Health Professions" (2001) Butterworth Heinemann

10. Robertson L J (1996) Clinical Reasoning, Pantz: Novice / Expert Differences, BJOT Vol 59, No5

11. Mini-Mental State Exam: Folstein et al (1975)

12. Clifton Assessment Procedures for the Elderly: Pattie A, Gilleard C, (1981)

13. Middlesex Elderly Assessment of Mental State. Thames Valley Test Company (1989)

14. Brief Assessment Schedule Depression Cards. Ads head et al, BMJ 1992: p305

15. Home Visiting with Hospital In-Patients – SPP 170 – July 2000

Appendix 1

INITIAL ASSESSMENT COMPONENTS

COGNITIVE ABILITIES

AREAS COVERED:

- Attention
- Orientation (time, place and person)
- Problem Solving
- Memory
- Mood

FUNCTIONAL MOBILITY

An assessment of basic mobility. Patient should be able to mobilise 6 metres (with/without normal mobility aid) from chair, negotiate obstacles, turn and mobilise back to chair.

FUNCTIONAL TRANSFERS

An assessment of basic transfers such as chair, bed and toilet should be carried out.

FUNCTIONAL RANGE OF MOVEMENT (ROM)

The movements required to perform simple functional tasks and the ability to do this is considered e.g. dressing – putting on a jacket or shoes.

Appendix 2

CLINICAL JUDGEMENT

CONSENT

DEFINITIONS

Clinical Judgement (and clinical reasoning) is based on the therapists'

- Interactive types of knowledge

    - Propositional knowledge – knowing that / academic knowledge base
    - Professional craft knowledge – knowing how / knowing through practice and learned awareness
    - Personal knowledge - individual reality and experience i.e. unique fame of reference and knowledge (9)

- Information gained from a full occupational therapy assessment and the multidisciplinary team

Clinical reasoning is a critical skill and central to the occupational therapists' professional autonomy. It is a complex process in a multidimensional context. It "is the thinking that underlies the action taken in clinical situations and is based on facts, principles and experiences" (10)

Clinical reasoning in occupational therapy will involve any of the following;

- Procedural/scientific reasoning
- Interactive reasoning
- Narrative reasoning
- Conditional / predictive reasoning
- Ethical reasoning
- Pragmatic reasoning (9)

It is not a static process, it is continually evolving as one's knowledge and experience develops.

CONSENT

"It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care for a patient. This principle reflects the right of the patients to determine what happens to their own bodies, and is a fundamental part of good practice. A health professional who does not respect this principle may be liable both to legal action by the patient and action by their professional body. Employing bodies may also be liable for the actions of their staff". (8)

Appendix 3

INFLUENCES ON ACTION PLAN

An Occupational Therapist's decision is unlikely to be taken in isolation of any other profession or agency.

Prior to formulation of the Action Plan the therapist liaises with carers, members of the Multi-Disciplinary Team and others (examples included in appendix 5).

Appendix 4

POSSIBLE FURTHER ASSESSMENTS

1. AN ASSESSMENT OF PERSONAL ACTIVITIES OF DAILY LIVING (ADL'S)

- The Occupational Therapist will assess an individual's ability to carry out their premorbid level of personal care, which includes aspects of washing/dressing and personal hygiene. The following assessment components will be considered:
    - Functional ROM
    - Functional Transfers
    - Exercise Tolerance
    - Balance (static & dynamic)
    - Cognition/Psychological function (e.g. planning, problem solving, memory, volition and motivation)
    - Perception/Sensory Abilities (e.g. orientation of garments, sensation)

2. KITCHEN ASSESSMENT

- After establishing what tasks a patient is required to carry out in their kitchen (i.e. hot drink only, all meals, heating food up) an assessment of patients' abilities to do so will be carried out by a registered Occupational Therapist.

- The Occupational Therapist will assess an individual's ability to carry out their premorbid level of kitchen skills. The following assessment components will be considered:
    - Functional ROM
    - Functional Mobility
    - Functional Transfers
    - Exercise Tolerance
    - Balance (static & dynamic)
    - Cognition/Psychological function (e.g. planning, problem solving, memory, volition and motivation)
    - Perception/Sensory Abilities
    - Safety Awareness
    - Risk Assessment

- Equipment provision

3. COGNITIVE/PSCHOLOGICAL ASSESSMENT

These can include the following standardised assessments:

- **MMSE –** Mini Mental State Exam (11)
- **CAPE** – Clifton Assessment Procedure for the Elderly (12)
- **MEAMS** – Middlesex Elderly Assessment Measure (13)
- **BASDEC** – Brief Assessment Schedule Depression Cards (14)

4. FALLS ASSESSMENT

Follow local policies and guidelines.

5. HOME ASSESSMENT/DISCHARGE VISIT

- Unlike other clinical areas, in Acute Medicine and A&E discharge home assessments are often carried out as part of normal practice.

- When undertaking a home assessment/discharge visit, the Occupational therapist should adhere to the College of Occupational Therapists' statement on "Home Visiting with Hospital Inpatients – SPP170 July 2000". (15)

- A Home assessment/discharge visit may be carried out if the following issues are identified:
  - **Significant change in function/cognitive state**
  - **Require provision of equipment**
  - **Environmental/social concerns**
  - **Sensory impairment precludes accurate hospital based assessment**

- The purpose of the home assessment/discharge visit will be explained to the patient, carer/s and family. All involved will be made aware of the date/time of the assessment.

- All relevant persons involved, including the patient will be informed of the outcome of the visit and a copy of the home assessment report will be sent to all relevant persons.

- Should a discharge visit prove unsuccessful the patient will return to the hospital according to local procedures.

Appendix 5

HOSPITAL AND COMMUNITY INTERFACE

EXAMPLES OF SERVICES UTILISED