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Just one of the unique opportunities available as an Occupational Therapist at Massachusetts General Hospital (MGH) is the opportunity to interact with patients who have a wide variety of diagnoses, cultures, backgrounds, and social situations. The exposure and experience that comes with treating so many different people, afflictions, and barriers to discharge is an invaluable aspect of professional and clinical development. I feel exceptionally grateful for this experience as I build my own practice. Every day I have the privilege of experiencing new learning opportunities and areas of personal and professional growth.

One recent patient who challenged me on all of these levels is Tom. He is a 64 year old man with a history of alcoholism and head injury who lives with his daughter. He was admitted to MGH in January 2015 with a new head injury sustained by a fall when he relapsed on alcohol. At baseline, Tom has weakness and neuropathy in his right lower extremity related to complications of diabetes. He wears an ankle-foot orthosis (AFO), has decreased hearing, and requires glasses. As a multi-disciplinary team, we did not know if he had any long-term impairments or effects related to his prior head injury in the area of cognitive functioning. The impairments noted upon admission in my initial evaluation were aphasia, both receptive and expressive with expressive language appearing to be the more afflicted, left body and environment neglect/inattention, decreased motor control and planning, and decreased strength of his left side, as well as generalized decreased insight and safety. Tom was limited in his ability to complete self-feeding, bed mobility, functional transfers, bathing, dressing, and functional mobility.

Given Tom's presentation, I would expect that he remain at MGH for a period of 3-7 days for medical work-up and then transition to inpatient rehab given his significant limitations in self-care and functional mobility. Because of his limited language and cognition, I was not able to gather the information related to his home environment, roles, routines, and daily patterns. This information provides a sense of a person's baseline, what he or she hopes to return to, as well as the status of the social support network. Because he would likely remain in the hospital for several days, there would be time to gather this information.

Evidence based practice in central nervous system injury dictates that early and intensive therapy yields the best recovery. Therefore, I set a frequency of 4x/week for Tom, which is considered a high frequency in the occupational therapy department at MGH on the trauma rotation given that it is a high-referring service with a significant number of patients with complex therapy and discharge needs. As a team, we learned that prior to admission, Tom lived an extremely independent life and had been sober until the relapse that led to his injury and hospitalization. He would take the T to the VA in West Roxbury where he attended men's groups for alcoholism support. Although his daughter lived in his house, they lived very separate lives and he did not require her assistance for safe functioning. As

an OT, this information was essential for me to get a sense of what Tom's goals would likely be if he could tell me himself. I've found that building treatment goals around what is important to patients themselves leads to the best outcomes because they are that much more invested in therapy, rather than treatment sessions comprised of rote tasks. I structured my treatment sessions with Tom with a focus of pulling back verbal and physical assistance as much as possible to guide him back to his prior level of functioning.

Although Tom was still requiring minimal assistance to sit at the edge of the bed, I initiated grooming tasks, including tooth brushing, face washing, and hair combing in order to facilitate participation in 'normal' tasks because research in patients with neurological injury shows engaging in functional tasks increases their overall performance. I knew from experience, that as patients' performance of individual tasks improved, they then are able to build them into more complete routines, such as a full morning routine of getting ready for the day. Initially, due to Tom's motor planning impairments, he would complete the steps of these basic tasks out of order or skip a step altogether. So although we would complete the task at the end of the session, the quality of the task was often quite poor. Tom would show signs of frustration, compounded by his language impairment which limited his ability to express his frustration. Tom required moderate assistance and visual cuing from me throughout the task.

Upon returning to work on a Monday, I noted Tom had moved to the floor and was now walking short distances; given his progress, I knew it was time to start working on self-care in a more realistic context. Tom bumped into every object on his left from the bedside to the bathroom including the tray table, chair, and door frame indicating his left neglect was still a significant impairment he would need to overcome for improved functioning. Standing at the sink, with my hands securely holding onto Tom's hips, I asked Tom to brush his teeth. The moment he turned his attention from standing to tooth brushing and started to reach for the items on the edge of the sink, his left leg buckled. Tom regained his balance at the same time as I assisted him on his left side. Tom turned and looked at me and said, "Whoa, I almost just fell." I considered this statement to be a turning point because it started to show insight and self-awareness emerging and that although he was still below his baseline, Tom's functioning was becoming increasingly safe through this new awareness of his limitations, even at if it was at a basic level.

As Tom and I continued to work together, I knew that the team was waiting for his discharge to inpatient rehabilitation; however as is common with young, trauma patients, insurance can be a barrier. In my experience, after the medical work-up is complete, if a patient is able to be up and walking, the medical team will often push for a discharge to home rather than wait for any insurance barriers to be ironed out. Given that Tom had now been at MGH for longer than 7 days, I was concerned that his mobility and ability to engage in simple, rote conversation would overshadow his cognitive and perceptual impairments that were still significantly impacting his safe functioning. Unfortunately, I have learned that cognitive and perceptual impairments are often masked when a person is in bed and tend to come out most significantly when a person is attempting to function in a realistic context that involves high stimulation, multi-tasking, and distraction that simulates a home environment. Consequently, patients sometimes appear more high-functioning than they

actually are because they are able to engage in conversation, know the date, and where they are. Therefore, I continued working with Tom at a high frequency, sometimes 5x/week because I wanted to provide Tom as much therapy as possible in the event that he was not able to get into rehab and had to go directly home.

Tom was now approximately 3 weeks into his hospital stay and one of the physicians approached me indicating he thought Tom could go home in the next day or two. I stated that I felt Tom was too unsafe to go home; that although Tom was much steadier on his feet, his left neglect, both of his body and environment, continued to be a constant challenge. He continued to have difficulty with tasks involving higher-stimulation, multi-tasking, or more items to remember. I referred the doctor to the speech and language pathology and physical therapy notes for detailed documentation on how significant his language impairments continued to be as well as how his balance was impacted due to inattention or limited ability to multi-task to corroborate my assessments. The doctor agreed to give Tom additional time at MGH until he received insurance approval for inpatient rehabilitation.

Over the next week, as the trajectory and pace of Tom's progress continued to improve, I began to see home as a potential discharge option. To validate my hypothesis regarding a change in discharge disposition, I requested an order from the team, so I could take Tom off the floor. I thought about the community-level skills that he would need to complete in order to resume his routines at home and chose activities that would incorporate money management, multi-tasking, locating his room, and remembering the steps of the task. Observing his performance would inform my decision if a home discharge would be feasible, and if so, how much assistance he might need. Tom was able to locate Coffee Central, buy coffee, make change, find other locations in the hospital he had been given to locate, and navigate all the way back to his room. This indicated to me that he could go home with intermittent supervision from his daughter. I approached the other multi-disciplinary team members to discuss Tom's performance. As a team we agreed that we felt comfortable approaching the physicians about a home plan. I started an email with the other therapists of the specific tasks or areas with which Tom would still need assistance or supervision, so the case manager could relay the information to Tom's daughter.

After significant coordinating with homecare and Tom's daughter, the case manager and team set a date for him to leave. From an occupational therapy perspective, I recommended Tom's daughter supervise him with money management, medication management, ensuring medical follow-up with his various appointments, verbal cues to initiate his morning showering, and all community-level mobility. I wanted to ensure success for Tom in his transition home and all the changes he would encounter. Although he would be returning to an extremely familiar environment, Tom was very different than when he last left it and would need assistance and support despite all of the progress he made.

Cases like Tom's have forced me to grow most as a therapist. Not only did it require that I have a strong working knowledge of Tom's injury and impairments, but that I convey that to the medical team in order to advocate for Tom's safety and chance at rehabilitation. Due to systems barriers, he received his rehab at MGH, which forced me to constantly monitor

and track his progress in order to determine when he was safe to be considered for a home discharge. Also, given that he was not at his baseline, Tom's case required significant collaboration and planning with the team and his family to ensure that his discharge was a safe and supported one. However, this does not come without some risk-taking both along his treatment course and right through his discharge. Ultimately, having a patient's goals align with the team goals and being able to achieve them is one of the most rewarding parts of working as an occupational therapist at MGH. As difficult as many of these patient cases are, I have learned that advocating for the patient and promoting team consensus has propelled my clinical and professional growth forward at MGH.

SAMPLE QUESTIONS:

Patient/Family Relationship

1. Tell us about your relationship with Tom's daughter and how it evolved. How did you prepare her for Tom coming home and how did she receive it?

Clinical Knowledge

1. You mentioned that you made Tom's plan of care 5x per day which is a high frequency rate for the trauma floors. How did you consider how many times a week to see a patient? What factors did you consider?

Teamwork/Collaboration

1. How did you build a team around Tom to help make decisions regarding his discharge and rehabilitation program?

Movement

1. How do you adjust your cues and guidance with a patient to get the desired clinical results? For example with Tom? How do you decide when to pull back or push forward?