Acute Care Back to the Basics: Gerontology
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Today’s course is Acute Care, Back to the Basics: Gerontology. Our presenter today is Marie Andrews. Marie has been practicing occupational therapy since 2001, and is passionate about working with older adults. She achieved board certification in gerontology from the American Occupational Therapy Association in 2015. She has worked in various settings, including inpatient acute care for 17 years, as well as acute rehab, outpatient, and skilled nursing. Marie currently works for a large, 700 plus bed acute care hospital, primarily serving an acute care for the elderly unit, or ACE unit. Most recently, she also helped to develop a multidisciplinary outpatient fall prevention clinic for seniors. Welcome, Marie, so happy to have you.

Hi, there, thank you so much for joining today. Today, we’re gonna be doing, Acute Care, Back to the Basics in Gerontology. So, three learning outcomes that I want you to know by the end of the presentation is four of the primary functions for an acute care OT working with older adults. Participants will be able to distinguish the difference between delirium and dementia, and participants will be able to list commonly recommended discharge environments for older adults post-hospitalization. Acute care OT is an exciting and evolving field. We’re gonna be covering OT evaluation, possible interventions for the hospitalized geriatric patient, discharge destinations, ACE units, and some future directions for OT in acute care.

In a study that, using Medicare claims and cost report data, the authors of this study determined that OT was the only spending category that helped reduce 30 day readmission rates for heart failure, pneumonia, and myocardial infarctions. Preventable hospital readmissions are recognized as an important indicator of hospital quality, and increased hospital expenditures. Many older adults leave the hospital with new self-care impairments after adjusting for demographic, health, and functioning characteristics. Unmet ADL need was associated, in this study, with a higher risk of hospital readmission. The implication here is to evaluate and plan before discharging home. The OT role, we really are focusing quite a lot on assessing a patient’s functional
level, and how does this holistically impact their discharge needs? As well, we wanna optimize engagement in the daily routine, while the patient is hospitalized. We’re gonna collaborate and consider our clients, the patient, the family, and the entire medical team. OTs can work on units of the hospital anywhere from critical care to med search, to orthopedics, to the emergency room, and more.

Next, let’s go ahead and get into some of the components of the OT evaluation. After receiving an order, we’re gonna complete a chart radio. We’re interested in the medical history, what was the admitting information considering relevant labs, as well as some baseline social at home information. Before going in to evaluate the patient, it’s a great idea to check in with the nurse. Who knows if this patient has had a new event, or change in status, and we wanna make sure that, if there are new issues not reflected in the chart, that we are aware of them.

As well, on this slide here, I wanna emphasize, we do have a related question at the end of the presentation. It talks a bit about adaptive equipment, which may be relevant, but we probably aren’t gonna do this before the evaluation. We probably would consider this once we’ve met the patient, and find out what their existing equipment is, et cetera. What is the person’s prior level of function? As well, as an OT, we would wanna consider both the physical and the social environment at home. We’re gonna evaluate and develop client centered goals, and knowing each of these pieces is gonna help us form a plan of care. Ultimately, we’re looking to develop a person’s occupational profile. The occupational profile, like we said, includes the prior level of function, the living situation, the client's assets, their strengths, barriers, values. This happens to be the way that we capture, in my setting, the way that it looks as far as an occupation profile. Some of the pieces are not complete, and that’s because the reality of working in acute care means we may or may not have family available, or have all the pieces of information at our initial eval, but we’re at least getting a start at it.
The next step in the evaluation process is to engage the patient in self-care tasks to identify their strengths and impairments. Ultimately, how does that translate into performance skills? We are simultaneously using clinical reasoning to assess activity demands and grade our task accordingly. We know that getting patients up early in their stay is important to mobilize and help them perform their daily routine to prevent the risk of decline.

The following are some basics with self-care related mobility. First, you wanna make sure your environment’s set up carefully prior to initiating. For example, you wanna move obstacles. You wanna ensure lines are manageable, and you wanna think through a backup plan, because who knows what may happen, and you may wanna have a second set of hands with you, et cetera. As well, you wanna think a bit about your body mechanics, and the positioning of both yourself and the patient. One key principal is we wanna encourage the patient to perform as much of the mobility task as possible. There’s a step-wise progression of milestones. Initially, maybe we’re working on bed mobility and sitting at the edge of the bed for ADL tasks, such as grooming. If the patient can tolerate it, as much as possible, we want to get them out of bed to the chair, and then we’re working on moving toward standing at the sink for grooming tasks, working on their functional endurance, et cetera, but really trying to meet the patient at their level, and progress the milestones. You wanna make sure to follow your hospital’s policy regarding bed and chair alarms. For example, in my setting, all of our patients who are considered a high fall risk should be on a bed or a chair alarm. As well, you might wanna consider if the patient is safe to be left up in the chair. If they have some kind of cognitive impairment going on, maybe they need to be supervised, and you always wanna check with nurse before you leave somebody up in the chair unattended.

Gait belts. So, gait belts typically should be used whenever you’re mobilizing a patient. You wanna follow whatever your hospital’s policy is. For example, we have single use
gait belts so that we don't spread infection from patient to patient, and it also allows us to have the patient take the gait belt home with the family, as needed. We wanna consider the patient's medical situation and use clinical reasoning when you're positioning the gait belt. You wanna avoid effected areas that, maybe they've had a surgery, or perhaps they have a colostomy, rib fractures, and you're gonna use your judgment to, instead of, perhaps, positioning the gait belt low and around the hips like we normally would, you might wanna have the gait belts up higher on them. As well, with the gait belts, I would just say that sometimes we're training our nursing colleagues too, and modeling, how do we safely mobilize and handle patients? So, some evaluation considerations.

This is not an exhaustive list, but, for example, we're thinking about strength, endurance, balance, performance, skills. Sometimes this is measured more formally with, for example, maybe muscle testing, or with a standardized assessment. Other times we're looking at these clinical factors in the context of the self-care activity itself. Functional cognition considers the thinking and processing skills needed to complete everyday activities. That's a unique cornerstone of OT. Many of our patients are on multiple medications, or have new medications, or a brand new medical condition to manage. So, functional cognition considers not just the details of their cognition, but how does that translate into instrumental activities and daily living, and higher level tasks? Something that is relevant to note is a lot of times, older adults may have the ability to carry out a conversation and retain some of their language skills longer than they would, perhaps, novel problem solving or memory components. So, the takeaway from that is don't be fooled by the sweet patient who can carry on a great conversation, making, perhaps, an assumption that they're more intact that they actually are. We really kinda wanna dig further and make sure that they are understanding and able to carry over what is being provided. The prevalence of cognitive impairment is associated with many conditions. This is not an exhaustive list, but we know that cognitive impairment is associated with Parkinson's, various
dementias, delirium, which we’ll talk more about, strokes, hypotension, which relates to the body’s ability to profuse the brain, which can impact cognitive performance. Diabetes, brain damage, and multiple sclerosis. Patients who have a cognitive impairment are more likely to experience a greater length of stay. When they’re discharged to their usual residence, they’re also more likely to be readmitted within 28 days, as compared to those who don’t have a cognitive impairment. The costs are higher, and this really provides an opportunity for OT to play an instrumental role.

There's also a greater chance of delirium developing, the longer that patient's hospital course. So, one of the tricky things, delirium is extremely common in older adults, but teasing out what's what can be tricky. Delirium can manifest due to pathophysiologic consequences of medical illness, and certain medications, or, even, combinations of medications. Having baseline dementia does increase the patient's chance of becoming more delirious. It's certainly possible that a patient can have both, and this can create a confusing clinical picture, making it difficult to distinguish. When you're not familiar with the patient and you're going into the room for the first time, always helpful if a caregiver, family member, et cetera, can provide a little bit of context for you, but that isn't always the case. One of the ways the we assess for delirium is using the Confusion Assessment Method. According to the CAM, the presence of delirium requires both features one and two. So, specifically, we're looking to see, has there been an acute change in mental status? As well as a fluctuating course, and some inattention? It requires the presence of either disorganized thinking, or an altered level of consciousness. There are different types of delirium. Hypoactive delirium is more common, though it can be overlooked. This is a patient who is sleeping, may have some motor slowing, somnambulance. Hyperactive delirium may look like restlessness, agitation, or aggression. Both hypo and hyperactive folks who have delirium are at a greater risk for falls. Some of the things that we can be doing for patients who either have delirium or we believe are at risk for delirium are implementing some precautions. Examples would include providing the patient with some frequent reorientation. We
don’t wanna quiz the patient necessarily, but you’re providing information. You wanna introduce yourself, and your role with each new interaction. Utilize tools in the room like, a calendar, or a clock, to help them reorient. You wanna normalize any sensory deficits. For example, if they wear glasses, making sure they have them. Hearing aids, as well, we wanna implement as much routine as possible. So, that might mean making sure the lights are on. We wanna have the windows open during the day. Trying to get them on a normal sleep schedule which can be difficult when you’re not feeling well in the hospital, but we want as much as possible to choose that. Spending more time out of bed than in the bed. Also, we wanna normalize their ADL routine, and we wanna communicate in calm and concise ways. So, try and engage the patient in conversation about well-known and meaningful topics. We wanna encourage family and friends to visit the patient. Sometimes you can ask them to bring in familiar objects and pictures from home, and these things can, again, help a person keep their bearings and be less likely to develop delirium over their hospital course.

Something else we wanna consider is a patient’s vision and possible impairments. A lot of seniors have eye conditions such as cataracts, glaucoma, macular degeneration, et cetera. Like we just said, we wanna make sure that the person has access to their sensory devices like glasses, and we just wanna reinforce routine eye care with a medical provider. Sometimes the patient hasn’t seen someone and may or may not have updated information in their chart that could be a potentially treatable condition that we wanna reinforce good habits and routines.

Another part of evaluation is considering standardized assessments, and using your clinical judgment to decide which standardized assessments you may want to incorporate. The AM-PAC "6-Clicks" inpatient daily activity considers self-care performance. The Mini-Cog looks at recall and a patient's ability to correctly draw a clock. What does this reveal to us? We wanna see, can they draw the contour? Can they accurately place the numbers? As well as, do they know where to place the clock
hands? And this is just a brief screen of cognitive performance that is feasible in an acute care setting that might reveal, again, more than the conversation would with just initially engaging the patient. The Montreal Cognitive Assessment is a 30 item screen. It looks at various cognitive constructs. It is widely known. So, there’s value in it for that reason, that a lot of our partners on the medical team may be familiar with the MoCA. So, we’re speaking the same language that they are. One of the things that, if you said the MoCA, if that were your choice, you do need to be able to interpret it clinically, so you need to be able to extrapolate and say the person didn’t perform well with recall, or the person struggled with executive performance. What does that mean in terms of their daily life? But it is a useful tool as a screen. The menu task is a performance based assessment that’s designed to screen for deficits in functional cognition, using a familiar activity of a simulated hospital menu. Another example is the Executive Function Performance Test. This looks at a variety of constructs, excuse me, performance skills, including the ability to manage medication. This is a pretty helpful tool to use, and one of the things that I think is nice about this one is that it does have strong face validity. Our teammates and families can understand why we are using a tool like this when we see a relevant activity like medication management being assessed. The Allen Cognitive Level Screen looks at novel problem solving within the cognitive disabilities model. I really appreciate this tool because it helps us screen levels of assistance needed at discharge, and is a very OT specific tool that helps distinguish our value.

Another tool you might incorporate is the Cognistat Neurobehavioral Exam. This is neuropsychological measure and it provides a cognitive performance profile. It's a widely used tool, and OTs are specially mentioned in the manual as being one of the providers that’s qualified to use and interpret the Cognistat. Another thing I think that’s nice about the Cognistat is one of the cognitive profiles that it shakes out from this tool is, “Does it look like it could be dementia syndrome?” Specifically, some of the areas that may be identified as deficits are not being oriented, difficulty with constructing a
design, or memory. A lot of times you will see, again, someone’s language skills still being intact, but they’re starting to struggle with things like abstract reasoning. As OTs, we are, of course, not diagnosing dementia, but this still could be helpful collateral information for the team. Dementia is not always listed in someone's medical history, but it’s possible that they are having some struggles in that area. The Routine Task Inventory takes into account self-care performance from both the patient and the caregiver perspective. The Barthel also looks at the patient’s ability to perform ADLs.

Next, we also wanna be considering, what is the patient’s living situation? Because, again, as OTs, we’re thinking about, where is this person going to go next when they discharge from the hospital? Do they come in from home? And, if so, what does that look like? Do they have stairs? Do they have a handrail? What is their bathroom setup? What level of support do they have? For example, if they live with a family member, does that family member work during the day, or are they available to provide assistance if that is a needed thing upon discharge? We also just wanna take into account, what is this person’s habit? What are their habits and routines? Were they highly active before they came in? Were they sedentary? Understanding what their prior level of function and what their living situation is is very relevant. One thing to note is sometimes, this information, we have to tease out a little bit. In the chart, the patient may have been admitted, for example, from the emergency room. This provider initially wasn’t able to say for sure where they were from, and it may be incorrectly identified where the person actually lives. So, I think it’s an important starting place to see what the chart reflects, but it’s also great to try to get this information through our evaluation as well.

Sometimes people have come in from assisted living. Assisted livings are interesting in that they vary in terms of the level of services provided. We can’t assume that because they came in from assisted living that they have as much help as they need. They may provide meals and housekeeping. Sometimes a resident can pay for assistance with
things like bathing, medications, and dressing. There is also some distinctions between assisted living that focus on memory care. These are a little more inclusive, and they’re also more expensive. Usually, assisted living is private pay, though sometimes individuals can qualify if they are low income, or if they have long-term care insurance. In my experience, long-term care insurance, a lot of folks don’t have that benefit. It’s great if they planned ahead and they did, and they can then access some of those services, but more often than not, in my experience, folks don’t have that, and so, assisted living may take some time to set up, and it may not be a direct transition from the hospital, even if that’s what we wanted to recommend for our discharge decision.

So, with that said, I think it’s important to have an awareness of that as you help to create the discharge plan. Perhaps we would recommend that down the road, but we know that maybe the person needs it to either go home with some support in the interim, or go to a post-acute rehab setting before they could transition to assisted living. Sometimes folks come in from long-term care. This can also be referred to as a nursing home, although that term is falling out of favor. Depending on how your hospital manages caseloads and triages, it may be pertinent to have them followed, the patient followed by an OT at their prior living situation, their long-term care setting, who knows their prior level of function, instead of an acute care setting. With that said, it doesn’t mean we always would sign off if, for example, the patient was previously able to perform transfers to the toilet or the commode, and we wanna promote that level of independence or engagement, we would continue to work on that skill in the acute care setting, but there are, often times, stacking limitations. So, again, we have to have the same crew for the triage process, and sometimes people who need a discharge plan are, perhaps, the ones that we focus more upon.

Interventions, let’s talk about some of the OT interventions that we might see in the acute care setting. Here is an OT hallmark. We wanna make sure that we are engaging the patient in their daily routine and providing skilled assistance to improve their
function and prevent decline due to the risk of immobility. A really basic one is oral care. Sometimes, this has been very neglected, and you may have some interesting surprises. Of course, this is part of nursing care as well, but it is an important thing to check up on while the patient’s in the hospital. If they have been confused, et cetera, this just may not have been attended to. Reducing the bacteria that causes complication, or, excuse me, reducing that bacteria can decrease their chance of developing infections like pneumonia, or sepsis, and this, especially if we’re in sepsis, can be deadly. Discharge planning. This discharge planning begins over their entire hospital course. So, we’re thinking about it from initial eval all the way up to discharge. Sometimes a length of stay is quite short. So, we really need to have a focus upon it very early on. There's all kinds of different situations, discharge destinations that a patient might go to.

So, let’s talk through some of those. Perhaps, we’re recommending somebody go home, maybe back to their regular living situation. It’s also possible that we’re recommending home, but they need increased support. If they don’t have family or somebody else, maybe they could use hired help. When we say that, it's helpful for the team if we can distinguish, are we talking about 24 hour support? Are we talking about daily checks? Are we talking about weekly checks, or future-oriented tasks, or transportation? Again, the cognitive disabilities model speaks to this directly in terms of what can be reasonably expected and levels of assistance required. I particularly like the Allen Cognitive Level Screen for this reason, in terms of helping to know the trajectory and what level of support is necessary. Often times, home therapy is useful in the transition. This can help to carry over the things that we provided in the hospital. Also, they have the benefit of seeing the patient in their actual environment, so we can recommend that somebody go home with home therapy. Sometimes, it's outpatient therapy or an adjunct, like, for example, pulmonary rehab or cardiac rehab. We could be the ones who rank those recommendations as well. Somebody might benefit from low vision OT or regular outpatient occupational therapy, or, even, a driving evaluation.
This is the role of an OT and acute care to help identify those things. Often times, the patient may have become deconditioned or debilitated, and need a course of post-acute rehab. We are helpful in determining what makes the most sense. Should it be subacute rehab, or is the acute rehab setting more appropriate? Acute rehab is gonna require that the patient be able to participate for up to three hours a day, and there’s also specific diagnostic criteria that are required. So often, somebody would need to have had, again, a qualifying diagnosis like a neurological event, a stroke, brain injury, or with orthopedics, often times, they need to have had a bilateral joint replacement.

We're working with our PMNR, our physician team to determine if the patient qualifies or not, but we're using our clinical judgment to say if we think that’s appropriate, or if we think subacute rehab is appropriate. Maybe they're gonna need more repetitive training over a longer period of time, and we wanna think through if that makes the most sense. If someone has a complicated medical issue, for example, a pulmonary issue or skin integrity issues, a long-term acute care hospital might be more appropriate. This is referred to often as an LTAC. Other considerations, whether we like it or not, the payor source is important. We wanna think this through as we are developing our discharge plan. Medicare inpatients can go to a nursing facility for post-acute rehab if they're appropriate, and they have remaining days. Managed Medicare plans often have different roles. For example, they can go, even if they're an observation patient, with regard to their admitting status, and what I mean by that is, are they inpatient versus observation status? We wanna know this, and, also, it's something to be aware that it may change. For example, let's say a patient was admitted as an observation patient. They would not have a qualifying stay to go under regular Medicare. So, that is important to consider. However, sometimes our folks are there long enough that they came in with a UTI that wasn't the qualifying, wasn't acute enough to meet inpatient criteria, but if it becomes worsened to the point that it requires that level of care, the patient might transition to inpatient status. Once they've
reached those three midnights, that can be part of our discharge plan that they go to post-acute rehab so long as they have some remaining days. So, understanding these pieces, we get to this by working with our care management partners. That might be a social worker. That might be a case manager who is a nurse, but either way this really illustrates why we coordinate well with the interdisciplinary team.

OTs provide all sorts of levels of patient education. For example, we are thinking about, how do we reduce the risk of falling? What are the benefits of engaging in self-care to minimize risks of immobility? We also are thinking through diagnosis specific care. So, for example, CHF or some form of dementia, and providing care strategies. We’re also thinking about home safety tips. Energy conservation. So, for example, helping a patient learn to pace their activity. Maybe they have a new oxygen requirement. Helping them work on breathing techniques that will facilitate more functional endurance.

As well, we wanna work on safely mobilizing patients during their transfers. Falls are highly prevalent amongst older adults. They can be deadly, and they can be very debilitating. Fall risk is multifactorial. We know that it can be the combination of medication side effects, impaired vision, decreased safety awareness, not wearing great footwear, as well as some of the environmental hazards. This is where, again, speaking to the safety awareness, we can really collaborate with our colleagues like, for example, our physical therapy colleagues. Perhaps they have prescribed an assistive device for mobility, like a walker. Maybe that's new to the patient. As an occupational therapist, we might be able to help think through, is this patient cognitively intact enough that they are actually going to utilize the walker effectively? Maybe they're gonna need repetitive training and cues, and how to sequence. There's a cycle that can occur when patients have a fall, or even if they haven't had a fall, but they believe, they're concerned about this risk. There are adaptive strategies, and then there are maladaptive strategies, and one of our roles can be to help the patient
understand the cycle that can occur. We wanna take precautions to keep them safe, but also keep them engaged. Restricting activity can lead to progression of decline. Inactivity might lead to weakening of the muscles, and decreased strength. This increases their risk of falling. If they have another fall, become more fearful. Having had a fall is a strong predictor of future falls.

In addition to fall reduction strategies, we can be teaching medication adherence strategies. So, our nursing colleagues might be teaching specifics on their medication, the actual medications, but we can be reinforcing good habits and routines with, for example, using a medication organizer box. We might also be reinforcing follow up care for chronic medical conditions. We can also be providing recommendations to the patient and family for ADL support, and, again, that might be, this patient might need assistance with preparing meals. Maybe they are capable of simple meal prep, but they really shouldn’t be doing cooking. They might need to be supervised.

Transportation, again, is another important one. Sometimes the patient is not going to be safe, upon discharge, to resume driving. So, we can weigh on, are some alternative transportation modes important? Home safety, again, when we’re providing our education. One of the key areas to hone in on is the bathroom. We know a lot of falls happen either on the stairs or in the bathroom, so we should ask questions of the patient about what their setup is, then provide that education. Most all the time, if I have concerns about their fall risk, I recommend they do a seated shower. Some patients are not as admittable to this as we’d like, but we at least put it out there that, "Hey, this is an area where you may be at risk of falls, and we want you to conserve your energy and decrease the chance of getting injured." If somebody has a tub shower, they can modify it with a tub transfer bench. Keeping in mind, not all...

Insurance is a consideration. DME is not necessarily covered. So, if we're making these recommendations, also, we wanna provide some different suggestions where the
patient or family can either purchase or, perhaps, be loaned, if you know of community resources in your area for different durable medical equipment. Some other general principals around home safety are encouraging the person to increase the amount of clutter, removing or taping down area rugs, thinking through pets. This is my girl, Joni, on the right. I live in an area where we have plenty of winter conditions, and, so far, our older adults who have pets, maybe they're gonna need some help thinking through, "Can I have some help with walking my dog?" Or, they have a new assistive device and we just don't think that that's safe. These are some things you might wanna be talking through with your patients.

As well, we wanna recommend adequate lighting at home. Again, many older adults have different eye conditions, and, so they may benefit from further outpatient screening. We have a low vision OT clinic where I work, which is nice to be able to refer patients to if they are gonna benefit from specific devices and collaboration with the ophthalmologist. They, as well, might benefit from home therapy where they could have somebody come in and make modifications and recommendations in their own setting, and, then, sometimes it's just helpful to have a support group. So, you might be recommending these things if someone has severe visual impairments. I think an opportunity for OTs is to increase our sharing of community resource information. For example, knowing certain high fall risk activities like yard work, snow shoveling, deep cleaning, knowing about some of those resources in your area can be helpful tools to pass along to the patient. As well, we might be recommending diagnosis specific resources in the community, and then, also, like I said, some support groups. These are a few examples of resources available near me. I'll talk through them a little bit, but every community is a little different, and I, again, would encourage you to familiarize with what's out there.

So, local government agencies often have some resources. There are different levels of transportation. The organization, A Little Help, it partners seniors with neighbors, and,
again, helps with high fall risk activities like the deep cleaning and yard work.

Rebuilding Together is a national organization that has local branches that might help the patient with, for example, installing grab bars, building a ramp, taking care of some things that are beyond reach for some seniors who are still living in the community. As well, there’s the Parkinson’s Association. This provides a lot of resources for exercise, support groups, education groups, and the Alzheimer’s Association, as well, is a great place. There’s a 24 hour hotline, and I think that is a really reassuring tool for patient’s families who need dementia care strategies, or a connection to resources. These are some examples of different community resources that I like to share with patients I work with.

What is an acute care for the elderly unit? This is a concept that has developed in some hospitals. The idea is to take care of the hospitalized older adult. Sometimes it's a physical unit. Other times it's a team within the hospital that serves geriatric patients. If the patient is being admitted for something more specialized. For example, oncology, neurology, or a surgical procedure, they may be more likely to go to those services. Some of the unique characteristics of an ACE service are that there’s a specialized team. For example, there are specifically trained nurses who are more familiar with geriatrics. You may have a geriatrician or a hospitalist who specializes in older adults. There’s also, often, a social worker, case manager, CNAs, OT, PT, pharmacist, nutrition, and speech, as needed. At my hospital, we also have a mobility tech who helps focus on getting the patient up, making sure that they are participating as much as they can, in addition to what we’ve provided within the therapy context. Another helpful resource that we have on our interdisciplinary team is a resource discharge nurse, and her role is really to summarize our discharge recommendations, which can be really confusing when somebody is going home. They may need repetition of information, and this resource nurse has the ability to review our recommendations more thoroughly, again, with the patient and family upon discharge. Sometimes these units are designed physically with seniors in mind, and that is particularly nice. One of
the important things that this service offers is interdisciplinary rounds. This is often a rich discussion of what are the barriers, and what’s the progression of the patient’s medical course, and how do we synthesize that from all the interdisciplinary perspectives, and formulate plans?

Common diagnoses that I've seen on the ACE unit are pneumonia, urinary tract infections, falls, altered mental status, sometimes orthopedic issues that are less complicated. For example, a patient fell and had a humeral fracture, but they're not going to have surgery. They might be more likely to end up on our ACE unit, as opposed to our orthopedic unit, and a lot of times, there's a catch-all failure to thrive before the person has had a more specific medical condition diagnosed. Something to keep in mind is very often, our older adults have lots of comorbidities. So, we wanna take that into consideration as well. Future Directions for OTs in Acute Care.

Healthcare is dramatically transforming, and I think OTs can really impact patients at both the clinical, and the system level in acute care. We can grab a seat at the table at different, for example, committees. Maybe we're thinking about how to reduce the chance of falls, how to reduce CAUTIs, how to help with hospital throughput, and, again, OT has a relevant voice and I encourage you to volunteer yourself for some of those opportunities when able.

As policy and payment changes continue to evolve, there is an emphasis on cost-effective services, decreasing length of stay, as well as with PDPM and PDGM. Sometimes we're looking at how to avoid costly post-acute measures. This means, perhaps, the patient is having more therapy in the inpatient setting. Again, we're looking at quality outcomes. This is an increasingly important emphasis in the acute care setting, and it's tied to how the hospital is reimbursed. So, there is a lot of motivation to make sure that there's a good patient experience and prevent hospital acquired conditions. This means, ultimately, OT in acute care is an exciting and
evolving field, and there is great opportunity, and, with that said, I’m gonna transition to taking some questions.

Okay, so there is a question that came in that is, "What is the typical length of stay "on an acute care for the elderly unit?" I would say that, and, again, it’s really variable, but anywhere from three to five days. We have also had patients who have limited resources and, for example, maybe they don’t have a payor source, and those folks have ended up in the hospital setting for crazy lengths of stay. The goal is always to minimize their chance of developing an iatrogenic condition and developing more sickness in the hospital. So, we want to move them along to next setting, but there are variables that we can’t always account for, as far as, are they getting better? Are they getting worse? Have we had an opportunity to do caregiver training? Does the patient, again, have a payor source for post-acute rehab? So, the length of stay is really variable.

Okay. So, we have a question that is from a home health OT, and it is mentioning how covered visits are becoming more and more limited, and what can we do in terms of providing education or teaching patients, and caregivers? What I would say as a student is, the earlier we are able to become involved, the better, so that we can have repetitive training overtime. Sometimes the one and done approach is not enough, and anything we can start early on in their hospital course is helpful, and that may help with that transition, their going home, knowing that they may not get as many sessions as you would like for them to.

Reading through a question here about, "What do you recommend is most important "to address in patient rehab, aside from fall risks?" I think helping ensure that the patient, if, for example, they have a new medical condition. Let’s say they have CHF, or newly diagnosed diabetes. I think helping partner with our nursing colleagues to make sure that they know, what are the management principles of taking care of those issues
when they get home, is a valuable role for the OT, and, again, we're assessing, are they retaining this? Are they carrying it over into the next session? If we don't think it's within their ability, we would wanna be working with their family and making sure that if they're going home to a support, that they may also understand what's being provided. When you're in the hospital, it's overwhelming. There are so many different factors happening, and, so, not overlooking or assuming that somebody is understanding, and really trying to partner and make sure that we understand what is being provided, and I would say, as well, again, that caregiver training. Sometimes I think we make assumptions that we received training in school with regard to how to safely mobilize a patient, but if you're a family member who is newly learning this information, you benefit from both watching the therapist perform the activity, and then see, can they return demonstrate? I like to literally have them practice taking a gait belt on and off, practice how would they safely cue a patient in a way that is not overwhelming, and is an effective strategy.

Let's see, there's a question about the low vision OT clinic that we referred to. If you have time, can you talk about this? This is an awesome tool that we have available and it's an outpatient opportunity. Our patients need to be relatively cognitively intact to refer to the low vision clinic because they're being taught using different tools, then they need to be able to carry it over, but maybe they were receiving different recommendations for how to have the right illumination in your environment, as well as different task lighting, and getting specific about that. They may also be referring or partnering with the eye care provider to say, "Do they need a magnifier?" And, having prescription tools provided to them. So, yeah, that is a bit about how the low vision OT clinic works. I often had to partner with a physician team to know, how do we put that in the discharge recommendation and get it carried over? So, I consider that part of the OT role that is not face to face with the patient, but that's still part of the job in acute care.
Let’s see, do you spend a fair amount of time educating the physicians to get quick and appropriate early referrals? And, yes, I would say it's a continuous challenge. I work in a teaching hospital, so that means that each month, we have to reestablish who is appropriate for therapy, who maybe is not appropriate for therapy, and trying to get into that kind of routine. It can be helpful, certain diagnoses have an order set that already has PT and/or OT as part of that order set, and that can help us with having the ability to know earlier on that we might need to be involved. There are also those times when maybe we don’t need to see the patient, and, so, they are at their prior level of function, even if that prior level of function meant they were, a former spinal cord injury. So, we also teach the team and the physicians, when is it not necessarily indicative for us to be at acute care OT in the situation?

Let's see. So, there is a question that came in as OT and acute care being fast paced, and, "Are we as OTs provided the best care possible "in the setting that may or may not require more care?" I think it's a great question. I think we always are, I feel like there are a lot of things that I would like to focus upon more with my patients, and then I have to balance that with the limitations of staffing. As a reality, the hospital is a business, and they allocate resources accordingly and there are not always as many OT staff members around to do the evaluations and treatments. So, I think we have to be focused in terms of, where do we expend our energy? What can we hone to see the right patient at the right time?

There was a question about whether the role of the occupational therapy assistant would change in the acute care setting. I would say, I can’t speak to this. We have had different COTAs on staff in the past, and we look to potentially have them in the future. There is some challenge in that they're not able to perform evaluations, but there certainly are partners as well, and I'm not aware of a trend in one direction or another with regard to COTAs in the acute care setting.
Okay, there is another great question that is, "Is there any advice or techniques that you use "to help convey, in order to ensure special instructions "with nursing staff to make sure follow throughs is done." So, making sure that, I think there are multiple ways that we can address this. We can provide direct instruction with nursing. With that said, it may not carry over to the next one, so we would wanna be sure it's documented in the plan of care, and the way that our documentation works, we have the electronic medical record system. At the very top of each of our notes, whether it's an evaluation, or a progress note, there is a box that it has highlighted information that says "recommendations to nursing," and it identifies, what level of assistance do they need for basic self-care? And, they speak to some specific ADLs as well. There is an indication for, what level assistance do they need for self-care transfers? We also sometimes provide group instruction in transfer training, and safe handling strategies. Our nurses received orientation, but, then, it can be helpful to provide an in service on these sorts of things, so that there is improved carry over and gives them an opportunity to practice with an occupational or physical therapist directly. Another tool to help with carry over, we have a white board that's in front of each of the patient's beds. On the white board, there is some information to help the patients stay oriented, and, again, decrease their chance of developing delirium, and then there also is some information about what level of assistance is needed for performing functional mobility and self-care tasks. We wanna be sure and keep that information updated, because, obviously, it could change for the better or become more challenging for a patient over their hospital course. That is a direct line of sight for any person working with the patient, that keeps them updated in real time, and helps ensure some carry over of the things the we are instructing.

There is a question about fall risk protocols, recommending a fall risk protocol. Again, in our setting, we wanna have the patient on a bed or a chair alarm if they are at a high fall risk. They also have different identifying facts. So, we have yellow socks where we work if the patient is a high fall risk, so that gives you a quick visual cue as one of the
team members that the patient has been identified. Nursing staff reassesses it every shift. So, every 12 hours, the patient is reassessed to determine if they are a high fall risk, and we are reorienting the patient over and over that we wanna use a call light, that we don't want them getting up on their own, that we wanna help keep them safe, and, obviously, we're balancing that with not trying to restrict their activity level, we want them to engage in their daily routine, but we wanna reassure them that we like to have a staff person with them. I think sometimes a helpful quick track is to ask the patient, "Can you show me "what you would do if you needed some help?" And, I like to see, is the patient able to utilize the call light effectively and know how to get the nursing staff's attention should need be?

Okay, thank you all so much for joining today. I hope that this leaves you interested in acute care and gerontology, specific. There's lots more opportunity to come. Thank you, again, for joining us today.

- [Fawn] Thank you so much, Marie, for a great talk today, and thanks for wrapping up our virtual conference for the week. I hope everyone has a great rest of the day. You can join us again on Continued and occupationaltherapy.com, thank you.