A day in the life of an occupational therapist

Nov 25, 2017 | 0

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Belinda is a senior Occupational Therapist at Caulfield Hospital, a major sub-acute rehabilitation hospital in Melbourne. Australia. Not long after graduating from James Cook University Belinda left sunny Queensland for London to travel and work. While living in London Belinda worked at the Defence Medical Rehabilitation Centre, Headley Court. It was here while working with injured service personnel her love of complex trauma grew. Belinda recently completed her Masters in Clinical Rehabilitation and outside of work she loves to travel and play sport.

Editor: Elizabeth Campbell

It's 8am on Monday morning and the day starts with a check of emails, how many new admissions need to be seen and a check of the day's timetable. First up is breakfast bar. As an organisation, we are trying to encourage increased activity outside of therapy sessions for patients during their rehabilitation admission. Breakfast bar is an opportunity for patients to get out of bed, prepare their breakfast on the ward and sit out of bed to eat it – engaging in a similar routine to what they would do at home. Don't get me wrong, some love to have breakfast in bed but for most this isn't normal! This morning is especially important for a patient I'm looking after. Barbara has been in hospital for over four months. Her fatigue has been limiting her participation and she has only been tolerating one physiotherapy session a day. Today was the second time she had come to breakfast bar. Today was a success; Barbara did all of the tasks without assistance. Although breakfast bar is simple, the joy on Barbara's face and seeing her sense of achievement after getting her own breakfast and managing to sit out of bed for two hours, reminded me how important creating a more normal routine can be.

I leave Barbara to enjoy the rest of her breakfast and join the multidisciplinary team for our daily 15-minute journey board. We learn that a patient had a fall over the weekend; physio think another patient can go home earlier than we expected; the medical team report that another patient isn't ready for discharge tomorrow, so we delay that for three days and we highlight another patient that will benefit from a family meeting, so a time is set. Daily plans are adjusted after the meeting to accommodate what has been discussed.

Next up is Betty. Betty is 96 and had a fall at home. She sustained a fractured NOF which was managed surgically with a hemiarthroplasty and she was transferred for rehabilitation 10 days post surgery. Betty is home alone and fiercely independent. The goal of today's session is to achieve independence with dressing. Betty wants to return home and dressing is part of her daily routine and isn't something she can do on her

own due to pain and reduced mobility. With a change in technique and a reduction in pain compared to last week, Betty is now independent. While we are practicing dressing, I use this opportunity to discuss Betty's home environment. It's clear that with a large step down to the toilet and a shower over bath, Betty will need a home assessment. Betty knows these areas will be challenging and hopes that I will have an easy fix. I'm not sure that there will be an easy fix; equipment is unlikely to work due to the shower over bath set-up and even if Betty can manage the step, the toilet room sounds too small to use a frame, which is what the physiotherapists are anticipating Betty will go home using. Betty and I have a realistic conversation about expectations and the challenges of her home environment. I let Betty know my concerns but also reassure her that we will explore all options to achieve her goal of returning home. I think it's so important to have conversations about realistic expectations, but not to take away a patient's hope. That hope can be what drives them to achieve their goals and for Betty we need more time to see what she can achieve. I make a time to do a joint session with Betty and her physiotherapist, so that I can plan an appropriate time to do the home assessment.

After documenting my session, I review a patient with a colleague. Doug sustained 60% TBSA burns following an accident at home. He is developing thick and tight scarring in the first web space of his right hand. This can have a significant impact on his function. His scarring is still very active and if the contracture worsens, Doug may not be able to open his hand wide enough to pick up a cup, a bottle of shampoo or be able to hold a coffee jar to open it. We make a plan to try a silicone gel sheet overnight under a small splint and a stretching and exercise program for the day that he can do on his own. Doug won't be able to access the intensity of therapy he receives as an inpatient on discharge, so it's important that he is not only independent with his day to day activities, but also his therapy programs. We try to make sure these are incorporated into things he likes, such as cooking and watching TV. During each ad break of his favourite TV show, Doug completes his exercises. We book some kitchen sessions, so that we can encourage use of the right hand in functional tasks and incorporate some exercises such as placing his hand around his coffee cup for a good stretch while he waits for the kettle to boil.

After lunch, I see one of the new patients for an initial intervention. Pat had a fall at home and sustained spinal fractures, which are to be managed conservatively in an anti-flexion brace. Pat and I have what might look like a general chat, but I make sure I collect information on Pat's pre-morbid level of occupational performance, her social supports, home environment, roles and routines, what's important to her and how she is managing her daily activities since coming into hospital. We talk about what Pat wants to achieve from her rehabilitation admission and set some short-term goals that Pat needs to achieve prior to discharge, and some long-term goals that can be achieved in the community. Pat needs to go to the toilet halfway through which gives me a great opportunity to see how Pat goes donning/doffing the brace independently, getting out of bed, mobilising, transferring on/off the toilet and performing hygiene tasks. I make a plan to meet with Pat again tomorrow morning to practice donning/doffing her brace, as she's not yet independent, and to teach Pat how to dress independently with the brace.

Next on my list is to meet with one of the new graduate occupational therapists to discuss home modification recommendations after a home assessment. She has

recommended a grab rail by the toilet and front door and a second banister rail. We discuss the grab rail by the toilet, taking into consideration the patient's characteristics: is she tall or short, does she have long arms, how does she transfer, where does she reach for support when doing a transfer, does she have any weight bearing restrictions, will a grab rail be enough or is the toilet also too low, does anyone else live in the home and need to use the grab rail – there is no point installing a rail that meets her needs but isn't suitable for her husband who would also benefit from a grab rail. Then we consider the environment: the height of the toilet, is the toilet roll holder in the way, is there enough space to install the length of rail we need and the configuration, how far away from the wall is the toilet, is the wall brick or concrete (this makes placement easy) or is it a fibro wall and we need the builder to locate the studs/noggins (which will impact on where the rail can be placed). Then we consider the grab rail: what diameter is appropriate, how long does it need to be, and what about colour and aesthetics. We often describe it as "they just need a simple grab rail by the toilet for discharge" but often it's not that simple. We do the same for the banister rail and the rail by the front door. My colleague now feels more confident to go away and do the drawings, which we'll review together before they are sent to Office of Housing to arrange installation. I spend a lot of my day coaching and teaching more junior therapists. They are often doing some of these interventions for the first time. When I have the time, like today, teaching and coaching staff is one of the things I enjoy most.

I finish the day by completing a referral to community rehab for a patient discharging and make sure tomorrow is planned – I schedule a patient to attend a lunch group as I have concerns about their cognition and managing meal preparation at home alone, another needs to practice car transfers as they have a high 4WD and I make plans to meet a patient's family to give them information on personal alarms. Tomorrow will be completely different to today but I enjoy the variety!

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