Edited by
ANN TURNER

The practice of Occupational Therapy

AN INTRODUCTION TO THE TREATMENT OF PHYSICAL DYSFUNCTION

Foreword by
KATHERINE INGAMELLS

Churchill Livingstone

THE PRACTICE OF OCCUPATIONAL THERAPY

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THE PRACTICE OF OCCUPATIONAL THERAPY

Foreword

Occupational therapy is the treatment of the whole person by his active participation in purposeful living. As an increasingly recognised member of the treatment team the occupational therapist is the one therapist who uses solely purposeful activity and the activity chosen by the therapist is with the aim of regaining maximal independence. These activities are, therefore, closely related to the person being treated, to his particular needs and the life to which he wishes to return. Activities can range from icing a cake to scrubbing the floor; from laying cement to mowing the lawn; from carpentry to cards.

Occupational therapy, however, is the youngest and smallest of the rehabilitation professions. Although the Egyptian priests were using the principles of occupational therapy in 2000 BC, the first Association of Occupational Therapy was not founded until 1917 and the first courses of training until 1927. State registration occurred in 1961. There are now 16 schools of occupational therapy in Great Britain with approximately 500 students qualifying each year, and a total professional membership of 6215 (April 1978). Despite all this growth and increasing respectability little is known about the practice of occupational therapy, little research is done and few texts are written.

This book is the work of occupational therapists who have had the enthusiasm to start and, even more creditable, the perseverance to continue and complete a detailed text on the physical side of our work. It aims to cover the general practice of occupational therapy within the experience of the authors and attempts to give enough medical background to remind the therapist of the conditions being treated. It is no 'bible', more a document for discussion. It increases the number of our specific texts by 25 per cent.

I hope this book contributes to the teaching of students, to the practice of occupational therapy and to the enthusiasm of others to write its psychiatric sister.

Exeter, 1981 Katherine Ingamells

Preface

It is, I suppose, rather strange to say that a book has grown up as a result of lack of time but this is certainly so in this case. Having taught occupational therapy for medical and surgical conditions (commonly abbreviated to 'Applied Physical') for two years at St Loye's it became obvious that lack of time prevented the students from receiving both a theoretical background and practical experience in the basic skills required by an occupational therapist. Equally, in cases of sickness or other absence, or where practical experience in a particular field had been lacking during hospital practice, students found there was little information available to serve as reference for these skills.

In addition, several qualified therapists had commented that if they had been unable to attend refresher courses or visit departments in order to discuss ideas and techniques, or if they were referred a patient who had a condition which they had not treated since college days, an outline of principles from which to work was not always available.

It is with these two groups in mind that this book has been written. It does not attempt to be a medical textbook but gives an outline of conditions to 'set the scene' for treatment. Clearly, in these days of ever widening knowledge and expertise, no one person can have experience or confidence in all aspects of a subject as diverse as occupational therapy. For this reason I am especially indebted to those who have contributed expert knowledge by writing chapters on their speciality; a special mention must go to Mrs Anne Capon for her section on the Rehabilitation Lathe; Miss Dorothy Conder for her section on Upper Limb Amputees and Dr Claire Whitehead for her introduction to the chapter on Hemiplegia.

My special thanks also go to Miss Lynn Cheshire, Miss Jill Freston, Miss Ruth Green, Dr C.E. Halliday, Mr D.L. Harris, Mrs Vivien Hollis, Mr C. Jefferiss, Miss M. Keily, Dr J.K. Lloyd, Miss G. Lubbock, Miss Alicia Mendez, the staff of the occupational therapy departments at Ashford Hospital, Middlesex; Mount Vernon Hospital, London; The National Hospital, London; and the Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry, Salop. I also extend my thanks to Mrs Rosemary West, Dr W. Wright and Miss Tricia Yetton for their time spent in checking and correcting many of the chapters. I am indebted to Mr Sidney J. Lock for the use of extracts from his *Larvic Rehabilitation Lathe Manual.*

Lastly, but by no means least, I must thank Mrs Rosemary Dent for her excellent typing of the script; Mrs Ruth Morgan for her secretarial work; Mrs Avril l'Anson for the tremendous effort put into the numerous and most effective illustrations; Miss Lynn Eveleigh for hours spent holding awkward poses; the staff of Exeter ALAC, Nomeq, Akron and Carters for their kind assistance with providing photographs; and Mrs Vivien Hollis for helping me get the idea off the ground in the first place. The staff and students at St Loye's deserve special mention for their support and encouragement, in

particular Katherine Ingamells and Sybil Hopson who have borne the brunt of my temper, exasperation, gloom and obsession!

And at the end of all, I must give my love and thanks to my husband for all the effort he has put into producing photographs and for the support and encouragement he has given me during the preparation of this book.

Exeter, 1981 A.T.

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SECTION ONE

Techniques and treatment media in occupational therapy

First, do no harm

HIPPOCRATES 460 – 365 BC

1

The principles of assessment

Record keeping is often seen as an encroachment on the time spent with patients, for therapists are essentially practical people and therefore often consider writing reports as unnecessary, especially when the patient's treatment programme and progress are well known to them.

The aspiring therapist may well ask why assessment is necessary when the patient's problem can be seen and his* diagnosis is known. Also, what difference does record keeping make to treatment and why is it necessary to write facts down in such detail?

The aim of this chapter is to show the basic principles of referral of patients for treatment, interviewing, assessing, recording and reporting, and why these are so important to a comprehensive treatment programme.

REFERRAL

When working in a hospital or for the social services department the therapist may first hear about the person to be treated from one of the following sources:

1. *Clinics.* In hospital the first information about a patient may often come from an outpatient clinic. The therapist may attend such a clinic in order to receive information about new patients and also to report on the progress of those already being treated in the department. In many hospitals occupational therapists regularly visit

*Throughout 'she' has been used to refer to the therapist and 'he' to the patient/client

clinics such as those run by orthopaedic surgeons, rheumatologists and physical medicine consultants not only for this reason but also to update and extend their knowledge in a particular field.

2. *Ward rounds.* Where the therapist has responsibility for the occupational therapy given to patients on a particular ward, it is usual for her to attend the ward round. This is most frequently conducted by the consultant, his team of doctors, the ward sister/charge nurse and other paramedical personnel concerned with the ward. During such a round it is not only possible to find out relevant information about new patients but also to ask questions and give reports on those already being treated.

3. *Case conferences.* Many hospitals are now using this form of meeting for the exchange of information instead of the traditional ward round. In this case only the consultant, his team of doctors and the senior nurse will visit each patient for examination and discussion of their medical treatment. Later a conference is held which can involve not only all medical and paramedical staff who have contact with the patients, but also others such as the community nurse or the patient's relatives, who may be asked to attend all or part of the discussion. In this way there is no need for a huge 'army' of white-coated personnel to descend at the patient's bedside, and it is easier to discuss progress reports and queries freely in private.

4. *Patient's notes.* Each patient's medical history is recorded in a personal folder which, while the patient is in hospital, is kept on the ward and, on discharge, is filed in the hospital's records department. If the therapist is not present at the time of referral for occupational therapy, a request may be written in the patient's notes.

5. *Referral forms.* Most occupational therapy departments design their own referral forms and these are kept on the wards, in departments or in clinics, so that they can be used when it is considered necessary to refer a patient for treatment. In the community the patient's general practitioner may contact the therapist directly.

6. *Other medical personnel.* In some cases other personnel may refer the patient to the occupational therapist prior to his next appointment with the doctor. This may happen where the patient is seen by a physiotherapist, nurse or social worker who feels that he would now benefit from occupational therapy. However, it should be emphasised that in such cases it is essential to obtain the doctor's consent before treatment is commenced, for it is the doctor who is responsible for the patient's overall treatment. In some areas, especially on wards where the majority of patients receive treatment from the occupational therapist, it is not uncommon to find that a 'blanket' referral is given. In this case the occupational therapist has permission to begin treatment with any of the patients when she feels it is necessary without having to notify the doctor in each individual case.

7. *The general public.* In the community especially, the therapist may frequently receive requests to see clients from members of the public. Such a request may come from the client himself or from others such as a neighbour, relative, priest or friend.

THE INITIAL INTERVIEW

Having received a referral for the treatment of a patient the therapist should obtain as much basic information about him as possible around which to conduct the initial interview. This may well have been supplied at the time of referral, otherwise it may need to be obtained from the patient's notes. At the minimum, it should consist of:

1. *the patient's name.* Both the surname and forenames are necessary, and the marital status.

2. *address/ward* and any other identification such as the record number. This is essential if the therapist is to make contact with the patient and will also enable her to obtain any additional information that may be necessary.

3. *date of birth.* Not only will this help to identify the patient but, combined with the diagnosis, may give some indication of the likely history and prognosis of the condition.

4. *diagnosis.* Both the primary and any secondary diagnoses or precautions should be known. For example, is a stroke patient incontinent or an amputee also diabetic?

5. *patient's doctor.* In the hospital the consultant in charge of the patient's treatment should be known, whilst in the community the general practitioner's name and address are essential.

6. *date.* All referrals should be dated so that an accurate record of progress can be kept.

7. *signature.* This is important as the referee may not be the patient's doctor.

Other useful, although not essential, information to obtain at this stage includes:

(a) *the patient's occupation.* This will give a guide to the general level of function required in order for the patient to return to work. It may give a guide to the patient's level of intelligence, although this is not always so; it will, however, give no indication as to his motivation to get better!

(b) *treatment required.* Some therapists will be asked to treat a particular area, joint or problem of the patient. This, may, however not be so in all cases and the therapist is therefore expected to plan the patient's treatment from her own assessment.

The initial interview usually takes place in the occupational therapy department, on the ward or in the client's home. The therapist must remember that especially the elderly, the young or the very disabled, will feel more relaxed and secure if they are approached on their 'own ground', that is by the bedside, in the day room or in other familiar surroundings, rather than in a strange department. With such patients it is often advisable to see them only briefly prior to the first interview just to introduce oneself and arrange the next meeting. In this way the patient is not taken unawares by a complete stranger bombarding him with a barrage of rather personal questions and it is also possible to arrange a time when both the therapist and the patient are free.

The initial interview should be conducted in as private a place as possible so that both the patient and the therapist feel free to ask and answer questions. The therapist must remember that this first contact with the patient is important, for first impressions last and too formal or casual an approach can hinder the relationship being formed. The therapist should be neat, tidy, well prepared and unhurried. She should be able to address the patient by name, have any information about him to hand, any necessary equipment for assessment ready and be aware of the appointment time. This first interview may be an emotional experience for the patient, especially if he has been seriously ill, as this may be the first occasion on which he has been asked to face the facts about the results of his illness. The therapist must be prepared to cope with emotional outbursts such as crying or aggression, which may result from the frustration of having to accept, and beginning to overcome, any residual disability.

The purpose of the initial interview is threefold. Both the therapist and the patient will be required to:

1. give information
2. receive information
3. establish rapport

Giving information

It is always wise for the therapist to introduce herself at the beginning of an interview in case the patient has forgotten or misheard her name. This is especially important when visiting the client's home for the first time, as he may be expecting several 'new' visitors because of his illness. It is also advisable to explain why she is there, and how she hopes to help the patient, especially as occupational therapy is a long, and frequently misunderstood, label! The therapist may also find it appropriate to explain to the patient how he was referred, as he may wonder from where the therapist's information was obtained.

The therapist's introduction may, therefore, be along the following lines: 'Hello, Mr Jones, my name is Miss Thompson and I'm the occupational therapist. Dr Johnson has asked me to see you, as I hear you fell and hurt your leg last week. I hope that now you're getting about a bit we can make things a little easier for you to manage.'

In this way the therapist not only introduces herself and briefly explains her role, but also informs the patient of how his problem was made known to her.

During the first interview, the therapist should also confirm or arrange times for treatment sessions and their frequency and duration. She should remember that these have to be fitted not only in to her own routine, but also round the ward routine, other treatment schedules, the patient's work or school hours (if applicable) and available transport. An appointment card should be completed for him and any necessary transport arrangements

made or confirmed. If the patient is still in hospital the ward staff should be informed of the times he is required for treatment.

Receiving information

The therapist will need details from the patient in addition to a confirmation of his name, date of birth and address. It is necessary to discover during this initial interview how much the patient understands about his condition and what his attitude to it is. The therapist should never assume that the patient is aware of his diagnosis — especially as the doctor may not yet have revealed it to him — so that shocked statements such as 'Well, the doctor didn't tell me I had multiple sclerosis.' or 'Do you mean that Billy is a spastic?' don't occur.

The therapist should offer the patient the opportunity to reveal his knowledge and attitude towards his condition by asking, for example 'How long have you had difficulty with walking?' This may disclose an open 'Well, the doctor told me last month that I had multiple sclerosis but I'd had my suspicions for a year or so,' or a wary 'Oh, it's been awkward for a month or two but it's getting better.'

The therapist should also enquire about the patient's home and work circumstances, where these are relevant to treatment, and should assess the extent of the injury or condition. Where the problem is limited to one particular area, as in a crush injury to the hand or a fracture at the ankle, a full physical assessment can be carried out at this stage, but if the patient has more extensive problems (as in the case of someone suffering from rheumatoid arthritis or a stroke) only a general assessment will be made initially and a more detailed one should follow. It is necessary to check what other treatments the patient is receiving so that sessions do not clash, or the patient does not arrive too tired to benefit from treatment. The date of the next clinic appointment should be noted so that reports can be prepared in time.

Establishing rapport

This is a vital, though often forgotten aspect of the initial interview, as it is during this first meeting that an understanding is built up between the therapist and the patient. A good relationship will lead to mutual trust and respect so that both parties can feel at ease and secure during treatment sessions. (These may seem ideal sentiments but they form the basis of a successful partnership.)

Whether the interview is conducted in a department or on the patient's own 'territory', it is the therapist who arranges and directs the proceedings and it is therefore her responsibility to ensure that the interview is as successful as possible.

Positioning is important. The patient should feel comfortable and secure without feeling hemmed in. The therapist and patient should sit at the same level so that either can take the initiative to make or break eye contact. The patient should not feel dominated by a therapist who stands over him or lurks behind a large, untidy desk with books and telephones creating a barrier to the free exchange of information (Fig. 1.1). The therapist should not sit so close to the patient that he feels uncomfortable and any direct contact which is needed during lifting or measuring should be made confidently and positively. Again, it is important for the therapist to explain her role and how she hopes to help the patient. She should show empathy, that is understanding without over-involvement. This can be shown by the non-verbal techniques mentioned above and also, for example, by the early suggestion of one minor treatment technique, such as how to tie a shoelace with one hand. The explanation of a relevant remedial activity will demonstrate to the patient an understanding of the condition and reassure him as to the techniques to be used during treatment sessions.

Empathy comes through observation, knowledge, experience and a desire to help, and any good therapist will find more understanding through time and, where possible, through the personal experience (perhaps best gained early on during training) of 'becoming handicapped' for a while and having to cope herself with the problems encountered. The therapist should use language and terminology which the patient understands, although this does not mean treating the patient like a child. Her voice should be clear and natural, never patronising or demanding. Gesture, either conscious or unconscious, can assist or detract from the establishment of a relationship. Obviously the therapist should display the normal

Fig. 1.1 '. . . lurks behind a large, untidy desk . . .'

social graces and not blow cigarette smoke over her patient or scratch her feet! Unconscious gestures such as constantly checking the time, avoiding eye contact or stifling a yawn can indicate to the patient that his problem is a bore and his presence undesirable. Conversation should be based on topics relevant to the situation. Although some informal exchange about the weather, pets or the ability of the local rugby team may help to relax the atmosphere, an interview which rambles off the point for too long can be both tiring and puzzling to the patient.

ASSESSMENT

Taking and recording information in a way that is clear, relevant and unobtrusive is an art gained through experience, observation and practice. To be too conscientious and write down every word that is spoken will make the patient feel uncomfortable and less likely to give information, while being too casual may make him wonder why all his personal information is so important in any case.

The reasons for assessing and recording can be summarised as:

1. forming a basis on which to plan treatment
2. showing progress, or lack of progress, to the therapist, the patient and the doctor
3. showing the exact extent and effect of the injury and/or disability
4. showing the expected level of recovery in a unilateral condition by using the unaffected side as a guideline.

Whatever is being assessed it is important for the therapist to bear the following in mind:

What is she assessing?

Will the activity being used tell her what she wants to know? For instance, does a week spent working in the heavy workshop really assess the capability of a milkman to return to work; or does a session in