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Examining Patient-Centered Care through the Eyes of an Occupational Therapist

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EXAMINING PATIENT-CENTERED CARE THROUGH THE EYES OF AN
OCCUPATIONAL THERAPIST

A Capstone Experience/Thesis Project

Presented in Partial Fulfillment of the Requirements for

the Degree Bachelor of Science in Biology with

Honors College Graduate Distinction at Western Kentucky University

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2015

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ABSTRACT

The concept of person-centered care is a major factor in the ongoing shift between a type of care that focuses on biological concepts ignoring psychological and emotional needs of a person, to a new type of care that considers the whole person, striving to meet not only their physical needs, but their spiritual and emotional needs, striving to involve the patient in every aspect of care. In this study, an adapted person-centered checklist was created as a possible future tool to encourage occupational therapists to implement person-centered care techniques in daily practice. Supporting research includes a literature review on person-centered care and occupational therapy, thirty-six combined hours of shadowing experience in both an outpatient care setting and in a skilled nursing facility, and individual interviews with each occupational therapist. Checklist points were evaluated based on individual interviews with each occupational therapist, along with self-reported example reports from each occupational therapist. Findings suggest relevancy of the checklist in both settings, but supports greater relevance within a skilled nursing facility.

Keywords: person-centered, occupational, therapy, outpatient

Dedicated to
Ruth Bingham Eckler

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Thanks to Dr. Dana Bradley and Patrice Blanchard for your wisdom and guidance, to Dr. Bernard Strenecky for always believing in me, and to my mother for demonstrating person-centered care every day for three years.

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CHAPTER 1

Occupational Therapy and Person-Centered Care

It's easy to spot care that is and isn't person centered, but it's harder to describe it with words. It's even harder to implement and promote it in health care on a daily basis. The culture of care for elders today has changed exponentially in the span of just a few decades. There has been an ongoing shift from a traditional, task-oriented form of care that relies solely on medical history and ongoing medical tests to a 'person-centered' approach that emphasizes the individual needs and desires of the person not only on a biological level, but on an emotional and spiritual level. Kitwood defines personhood as, "a standing or status that is bestowed on one human being in the context of relationship and social being, implying relationship, recognition, and trust" (Kitwood, 1997). He theorized five basic psychological needs to be observed when striving for more person centered care that all overlap at what he describes as the most important – love:

- Attachment: a basic need that links the elder to other human beings such as family or friends.
- Identity: the person's sense of autonomy and personal achievement.
- Inclusion: the feeling of belonging and being an integral part of a community.
- Occupation: promotes a sense of purpose within the individual by keeping active/occupied.

- Comfort: the person's overall well-being.

Although Tom Kitwood's work is some of the most significant when it comes to person-centered care, an ideal emerged even earlier, in the late 1800s and early 1900s, termed 'relationship-centered care'. This ideal, pioneered by Carol Tresolini and the Pew Fetzter Task force, stresses the importance of relationships in any health care experience. This task force sought to change the culture of care that leaned overly on the biological side of care and ignored the sociological and psychological part of patient care. This task force describes patient care further saying, "it is an essentially human activity, undertaken and given meaning by people in relationships with one another and their communities, both public and professional" (Tresolini and Pew Fetzter Task Force, 1994).

Interest in person-centered care has only grown since its initial introduction, giving way more specified approaches and ideals. In 2006, Professor Brendan McCormack built on this idea of person-centered care developing his own *Person-centered Nursing Framework* which has a general to specific approach starting with ideal prerequisites of caregivers, and moving to the quality of the environment of care, before focusing on the care process and expected outcomes. It begins with having an able caregiver, listing prerequisites of being competent, having developed interpersonal skills, having commitment to the job at hand, having clarity of beliefs and values, and possessing confidence. The next element is the environment of care itself. In this section, McCormack stresses not only the importance of a quality physical environment but the importance of having supportive organizational systems in place and maintain effective staff relationships that promote shared decision making. A qualified caregiver and an environment that is conducive to person-centered care makes promotion of specific care

processes more successful. These five care processes are A) Working with the caregiver's beliefs and values B) Engagement C) Possessing a sympathetic presence D) Providing holistic care and E) Shared Decision making. In this framework, McCormack describes essential elements needed before person-centered interactions can even be achieved (McCormack, 2011).

The Department of Health and Human Services in Victoria provides practical information about what person-centered care should like in a hospital environment. Specialists rarely treat only one disease or disorder within the older population. Elders, especially those in long-term care settings, usually have multiple care needs. Care teams can no longer expect to focus on one injury, but many. Person-centered care encourages caregivers to treat the person rather than the disease, which encourages them to consider all aspects on the person. Frailty is another reason that person-centered care is important in geriatric care. Victoria's Health Department cites that 25-50% all older people experience frailty (State of Victoria, 2015). For these older people, stressors that may seem insignificant to younger adults can significantly impact an elder's daily living and overall health.

Almost 25% of older people, age 65 and older, have some type of dementia (Wood, 2013). These elders face new challenges as they age and their dementia progresses. Ruth Drew, the director of family and information services at the Alzheimer's Association in Chicago explains how person centered care can significantly improve difficult behaviors in people with dementia. She says, "We start from the premise that everything they do has a meaning, then that helps us figure out the meaning and respond to what they are trying to say" (Wood, 2013). People with dementia often exhibit bizarre

behaviors that may not make sense if one isn't actively trying to view the world through their eyes. Ruth Drew gives an example of how this type of person-centered care improves difficult behaviors in people with dementia. A female patient was constantly taking off her pants for no apparent reason. Once her nurse considered the possible reasoning for this, she thought to take a urine sample. The patient was suffering from a urinary tract infection but was unable to properly communicate her pain to those around her. She also adds that knowing each patient individually and having a warm and caring attitude can dissolve many conflicts (Wood, 2013). This type of thinking isn't just effective for people with dementia. Many elders, whether they have dementia or not, can struggle with communication. A person-centered approach encourages the caregiver to view the person as a fellow human being, not just a list of symptoms. Getting to know each patient and forming a real relationship will improve the quality of health care and help caregivers to interpret patient behavior based on their personal relationship with the patient (Wood, 2013). Dr. William Miller of the University of New Mexico explains person-centered care through his motivational interviewing technique. He pioneered this technique while working with clients suffering from alcohol addiction, but the concepts still apply. He explains it as a more person-centered approach to therapy emphasizing understanding and empathy over confrontation. Although this model was designed for a clinical therapist's setting, his ideas are extremely applicable to person-centered care in general. He says, "Traditional therapy says 'I have what you need to get better, I'll give it to you', but motivational interviewing says, 'You have what you need to get better, let's find it together'" (Miller, 2014). His approach suggests a partnership between the patient and caregiver that empowers the person and strengthens their motivation to change. This

approach is desperately needed when working with elders, where in many settings, caregiving often mirrors baby-sitting. Dr. Miller says, “No one knows the client better than the client himself.” In the same way, no one knows the elder better than the elder himself (Miller, 2014).

Occupational therapy is holistic by nature. Physical therapists improve patients’ overall mobility and body strength, but occupational therapists work on putting that movement into motion by completing practical, functional activities of daily living. The occupational therapist evaluates a person’s existing skill set and works in concert with the patient to achieve goals that make it possible for the person to participate in society in the way that they desire. These aspects of occupational therapy make this profession a natural fit to test person-centered care techniques and goals. The overriding goal of any occupational therapist is to promote independence. The goals that occupational therapists work towards vary between practices and vary even more from patient to patient. OTs can work in school systems, private residences, skilled nursing facilities, outpatient rehabilitation centers, hospitals, and many more settings. The ‘daily living’ goals that occupational therapists work to accomplish vary from setting to setting simply because they depend on the patient’s existing skill set and history. An adolescent with Down syndrome will likely have different goals than an elderly person in long-term care. A man with a major brain injury will have different abilities than a woman recovering from a carpal tunnel release.

I chose to examine occupational therapists who work with elders. The elderly population is more likely to have comorbid issues, vision problems, problems with balance and stability, and cognitive impairments than the any other age bracket. This

means that therapists working with this population aren't just focused on one goal or injury, they must constantly account for multiple disorders or injuries in their treatment plan. The overall focus of occupational therapists working with the elderly is to promote independence and preserve quality of life. An occupational therapist assesses the elder's skill set and potential risks in the initial patient assessment. Since elderly patients are more likely to have cognitive problems than younger age segments, geriatric occupational therapists must find more creative ways to assess patients than merely asking questions.

Collin Adams, a Texan occupational therapist consultant has created a screening mechanism used to measure ability of elderly patients, called the 'Timed Up and Go' or TUG method. For this screening, the patient sits upright in a chair with both back and arm rests. The patient gets up, walks at an even pace for three meters, turns around, walks back, and sits again in the chair. If the patient takes longer than 14 seconds to complete this, the OT should be aware of possible risk of falling. The longer it takes the patient, the higher their risk is for instability and falls. This is a more telling assessment method than merely asking the patient how well they get around their house. A patient may just answer with 'fine' or 'not well'. Whether or not these answers are correct, a detailed, reliable answer is what is needed for occupational therapists to identify risks and form solutions. A patient may respond that they are getting around fine, may generally believe it, but sometimes what has become a normal way of moving for an elderly patient, may be hazardous. The TUG method is an example of one of the many methods that can be used to get a reliable, detailed, and quick sense of the patient's overall stability and walking ability (Adams, 2013).

CHAPTER 2

Person-Centered Checklist Development

The main goal of this thesis was to create a checklist that could be used by occupational therapists to promote person-centered care. To accomplish this goal I chose to A) Examine person-centered care in a long-term care setting, B) Examine person-centered care in an outpatient setting, and C) Learn what person-centered care looks like in the context of occupational therapy through observation and interview methods. I spent this past summer and fall semester researching person-centered care. I also completed 36 hours total of shadowing occupational therapists, 18 hours in a skilled nursing facility and 18 hours in an outpatient care facility. Through shadowing, I learned firsthand about the role of an occupational therapist and the challenges they faced working with elders specifically. My intent was to learn the history of person-centered care and expose myself to occupational therapy firsthand and from these experiences, form a person-centered checklist that would ideally be useful for occupational therapists working with elders.

The checklist I made to evaluate person-centered care comes from several different sources. I researched health care in Australia and found that the health care system in Victoria had much practical information regarding person-centered care in hospitals. Although much of their information was geared towards older people in a hospital setting, their step-by-step guide on providing the best care for this population was extremely relevant and easily adaptable to person-centered care and occupational

therapy. Points one, two, three, four, and five were inspired by Victoria State Government's *Best Care Fact sheet*. This fact sheet was originally meant for the care of older people in a hospital setting, but was easily tailored to be used by occupational therapists. The seventh point, *Effective Teamwork*, was influenced by McCormack's emphasis on organizational support in his *Person-Centered Nursing Framework*. The sixth and eight points were inspired by observations and conversations during the shadowing period. I set down with each occupational therapist and discussed the 18 hours of shadowing I had completed with each. I asked them to evaluate my checklist, give feedback, and contribute a personal example of how each point is observed in their particular setting.

Person-Centered Care Checklist

1. Emphasize and Improve Communication – assure communication between caregivers and patients is clear and continued throughout treatment.
2. Comprehensive Assessment - Conduct a comprehensive assessment prior to treatment creating a partnership between the older adult and the occupational therapist.
3. Identify and Manage any Cognitive Impairments – consider how cognitive impairments will affect the older person in terms of occupational therapy treatment.
4. Identify and Respond to Comorbidity – approach the patient holistically when a person has multiple conditions or injuries, treating the person rather than symptoms alone.
5. Anticipating and Preventing Dangerous Events – Anticipate possible chance of falls, self-injury or other harmful events and minimize the risk.

6. Discuss treatments goals – the patient will have a say in what functional level they wish to achieve and give feedback on progress.

7. Effective Teamwork – work with fellow treatment teams to make sure patient OT goals are met both in and outside of allotted treatment time.

8. Advocate for the Patient – advocate for the patient’s involvement and well-being at all times.

CHAPTER 3

Personal Example Reports

Personal Example Report

Toby Scott, OTR

ProRehab Outpatient Clinic

1. Emphasize and Improve Communication – assures communication between caregivers and patients is clear and continued throughout treatment.

“I call the patient by name and refer to the person by their name, never the injury.”

2. Comprehensive Assessment - Conduct a comprehensive assessment prior to treatment creating a partnership between the older adult and the occupational therapist.

“We go through a comprehensive evaluation prior to treatment, we talk about the injury, what the patient is not able to do anymore, and what the patient wants to be able to do again.”

3. Identify and Manage any Cognitive Impairments – consider how cognitive impairments will affect the older person in terms of occupational therapy.

“It’s not extremely common that we have patients with cognitive impairments but it does happen. In this case, we would request the family be present for initial comprehensive assessment. Although they are not required to, they often accompany the patient for treatments as well.”

4. Identify and Respond to Multimorbidity – approach the patient holistically when a person has multiple conditions or injuries, treating the person rather than symptoms alone.

“For what I do, this means being flexible with appointment times and creating home care plan treatments if needed. Sometimes patients have health problems that take precedence over what I am treating them for.”

5. Anticipating and Preventing Dangerous Events – Anticipate possible chance of falls, self-injury or other harmful events and minimize the risk.

“Address based on assessment, may not be a factor however, as many patients are post op, it can be addressed in relation to short term risks.”

6. Discuss treatments goals – the patient will have a say in what functional level they wish to achieve and give feedback on progress.

“All patients are involved in the treatment planning portion, specifically related to their goals/hobbies/previous activities; HEP specified related to patient home life, goals, progression, etc.”

7. Teamwork – work with fellow treatment teams to make sure patient OT goals are met both in and outside of allotted treatment time.

“I collaborate with Dr. Morrison, WKONA’s hand surgeon in the hand clinic, and sometimes with our physical therapists to address goals as needed.”

8. Advocate for the Patient – advocate for the patient’s involvement and well-being at all times.

“We try to be advocates for general health and wellness, advocating testing for other conditions as needed (thyroid, diabetes, etc...)”

Personal Example Report

Shannon Blanford – OTR

Village Manor

1. Emphasize and Improve Communication – assure communication between caregivers and patients is clear and continued throughout treatment.

“I try to adapt to the patient. If they have trouble hearing I try to speak loudly and clearly. For communication between caregivers, care giver information and update sheets are present in patient’s file for communication across shifts. It helps all being on the same page.”

2. Comprehensive Assessment - Conduct a comprehensive assessment prior to treatment creating a partnership between the older adult and the occupational therapist.

“Occupational profile (background and history) is taken upon assessment between the Occupational Therapist and Physical Therapist.”

3. Identify and Manage any Cognitive Impairments – consider how cognitive impairments will affect the older person in terms of occupational therapy.

“Cognition is assessed during OT evaluation with both OT and Speech consulting. We reevaluate if we notice a change in cognition status.”

4. Identify and Respond to Multimorbidity – approach the patient holistically when a person has multiple conditions or injuries, treating the person rather than the symptoms alone.

“Multimorbidity is addressed upon OT evaluation and identified with ICD – 10.”

5. Anticipating and Preventing Dangerous Events – Anticipate possible chance of falls, self-injury or other harmful events and minimize the risk.

“Caregiver communication is addressed to update nursing staff through verbal and written instructions. Bed alarms are used to address patient safety if needed.

We work with patients on specific techniques of transition to prevent falling.”

6. Discuss treatments goals – the patient will have a say in what functional level they wish to achieve and give feedback on progress.

“Patients are involved at initial assessment to voice their goals; they are again involved at weekly updates and for updated plan of care.”

7. Teamwork – work with fellow treatment teams to make sure patient OT goals are met both in and outside of allotted treatment time.

“Care plan meetings are addressed 2 weeks after admission and 2 weeks before discharge with patient, family, nursing team, therapy team, administration, and social services to address patient’s needs; meetings are held additionally as

requested by patient or patient family.”

8. Advocate for the Patient – advocate for the patient’s involvement and well-being at all times.

“Therapists are frequent patient advocates to establish effective carry over by nursing staff that will promote increased integrity and quality of life.”

CHAPTER 4

Outpatient Clinic Personal Interview

ProRehab Experience – Outpatient Setting

Toby Scott, OTR

Toby Scott is an occupational therapist at ProRehab Outpatient Clinic in Bowling Green, Kentucky. ProRehab is a clinic located steps away from Western Kentucky Orthopedics and Neurological Associates, a company that they work with closely. I shadowed Toby 18 hours over the course of 3 weeks. Toby specializes in the upper extremity and divides her time between the upstairs clinic, where she sees general upper extremity injuries and the downstairs hand clinic, where she works in concert with Dr. Keith Morrison, the hand surgeon at WKONA. Toby works with people from all ages on an outpatient basis. Most of her patients are referrals from Keith Morrison of WKONA or another WKONA surgeon. However, ProRehab does take outside referrals. Along with contributing personal examples of how each checklist point is used, I interviewed each occupational therapist on the construction of the checklist itself and its relevance to their own practice:

1) Improve communication

This point on the checklist proved extremely relevant in Toby's daily practice. She says, "One of the main ways we promote person centered care here is through our communication with each patient. One of the big things we were taught in school is how important it is to refer to the patient using their name." Toby explained the bad habit many therapists fall into of referring to patients by their injuries or conditions, saying things like, 'the extensor injury is coming in today,' or 'get some ice for the dupuytren's syndrome.' She went on to say, "It doesn't seem like a big deal, but it can be easy to start viewing patients as medical charts and statistics. Calling a person by their name, reminds you that they're a person with an injury. They are more than just the injury itself."

2. Comprehensive Assessment

Toby explained that on the first appointment with any patient, she spends the majority of the allotted time assessing the injury, patient needs, and patient goals. Since Toby specializes in the upper extremity, she initially examines at grip strength, range of motion, and sensitivity. She then asks questions about the effect of the injury or disability on activities of daily living, which include things like bathing, dressing, eating, toileting, and transferring. Her goal with this initial assessment is to see what the patient is already capable of and to discover what goals the patient hopes to eventually achieve. Many patients have seen an orthopedic doctor (usually one at WKONA) or some other type of specialist before their first appointment, so Toby frequently has notes or an existing medical evaluation that adds to the assessment.

3. Identify and Manage Existing cognitive Impairments

This point did not prove to be as relevant at ProRehab than it was at Village Manor. The nature of an outpatient clinic suggests a certain measure of existing independence with each patient, the ability to transport themselves to appointments and the ability to schedule appointments. Toby estimated that she sees only 2-3 patients with cognitive impairments every day. Although Toby rarely sees patients with cognitive impairments, when she does see them, they are almost always accompanied by a care-giver or family member. With these patients, Toby relies on family members and caregivers to manage cognitive impairments and assist with treatment and communication.

4. Identify and Respond to Multimorbidity

In regard to multimorbidity, Toby admitted that with most patients she works with, multimorbidity is not a common factor that she has to deal with, either because the patient only has one injury/illness or because the comorbid factor doesn't interfere with her therapy goals. She gave an example of a previous patient she treated for an extensor injury that was suffering from kidney problems. "For us, it's just a matter of prioritizing the right things and being flexible. It doesn't matter if she can't use her ring finger if she dies of kidney failure first. So with her, I had to be flexible about last minute cancellations and rescheduling around her dialysis. I created a lot of home care plans for her so she could still exercise and improve her hand function when she wasn't able to come in the clinic. You have to prioritize what matters most to the patient."

5. Preventing Dangerous events

This element varied the most between practices. The intensity and importance of preventing dangerous events in the outpatient practice was much less because the possible risks were less serious. An outpatient clinic means that the patient must be able to transport themselves there. This means that the majority of the patients served there are relatively independent, most likely living independently or with family and their injuries are usually lower risk. She says, “A lot of preventing dangerous events in this settings means not pushing the patient too far. It means listening when the patient is in pain during exercise. There’s sometimes a fine line between achieving goals and potential injury.”

6. Treatment Goals

This point was relevant at ProRehab. On the first appointment, the time is mostly spent evaluating. Most of this time is dedicated to learning about the nature of the injury, any pain present, patient limitations, and patient goals. The goal of the first appointment should be forming a partnership with the patient and creating mutual understanding and trust.

7. Effective Teamwork

Teamwork wasn’t as crucial an aspect in the outpatient setting as it was in the skilled nursing facility. The majority of the time, Toby’s interactions were solely between the patient and herself. However, teamwork is important when Toby works in the downstairs hand clinic. This space is attached to the WKONA offices, where hand surgeon Dr. Keith

Morrison often meets with Toby and patients. This space is helpful because it takes out the middle man when it comes to transferring information. Instead of the patient trying to remember notes and questions to relay to Toby in their next appointment, Dr. Morrison, Toby, and the patient are able to discuss treatments and evaluate patient progress together. On occasion, she also works with the other occupational therapists and hand therapists as well as physical therapists. Toby explained that teamwork is valued most between her patients, patient families, and herself. It is up to the patient to inform the occupational therapist about the functional level they wish to achieve. The occupational therapist provides the information and therapy needed for proper rehabilitation, but it is up to the patient to attend appointments and to work on occupational therapy goals outside of the clinic. Toby rarely works with family members of patients, citing family members of adolescent patients and patients with cognitive impairments as being the most common.

8) Advocating for the Patient

Advocating for the patient in outpatient care looks different from advocating in a long-term care setting. Since the patients Toby usually sees are independent living, non-cognitively impaired patients, most of the time they are able to advocate for themselves when it comes to patient treatment and patient rights. However, Toby explains that advocating for the patient means advocating for their overall health and well-being, which often means advocating for other conditions if she sees signs for concern.

CHAPTER 5

Skilled Nursing Facility Personal Interview

Village Manor Experience

Shannon Blanford, OTR

Shannon Blanford is a practicing occupational therapist currently working at Village Manor. Village Manor is a Christian Healthcare Community that consists of long-term care, skilled nursing, independent living, assisted living, and short-term rehabilitation. The majority of Shannon's patients, while I was shadowing, were classified as either skilled nursing or long-term care. I shadowed Shannon for 18 hours over the course of three weeks. Through the personal example report that Shannon completed and through a personal interview on the construction and usefulness of the checklist, I found that person-centered care looked very different in a long-term care setting than it did in an outpatient care clinic.

1. Improve Communication:

Communication in the setting at Village Manor is vital not only between the patient and care giver, but through the care giver and support teams. In outpatient care, Toby would give the person goals and exercises to complete and it was up to the patient to complete them. In a long-term care setting, patients often need more support, whether it's remembering to do daily exercises or carrying out therapy goals. Communication with support staff both during and between shifts is key to occupational therapy's success

within this setting. Shannon explained that since she only sees patients thirty minutes, three times a week, at most, it is up to the support staff to make sure these goals are carried out from day to day.

2. Comprehensive Assessment

Shannon explained that the patient's occupational profile which includes the patient's background and medical history, is evaluated with both the occupational therapist and physical therapist on duty. Physical therapists focus on strengthening and range of motion and occupational therapists focus on utilizing these things to accomplish meaning tasks of daily living. However, Shannon explains that for the long-term care setting, physical therapy and occupational therapy can often look similar. She says, "Our goals often overlap. Many patients' functional goals are simply to improve mobility or focus on chair or wheelchair positioning to improve comfort."

3. Identify and Manage Cognitive Impairments

Not surprisingly, cognitive impairments were more common in the long-term care setting than the outpatient care setting. As opposed to outpatient care, Shannon treats patients with cognitive impairments on a daily basis. Shannon works in concert with the Village Manor speech therapist to improve and manage cognitive impairments using skilled observation and the Allen Cognitive Levels Assessment. She explains that it's useful to have experience working with people with dementia and have knowledge of useful treatment strategies. She explained that the biggest thing that stands out when working with people with dementia is communication. "These people often respond more slowly

and sometimes in incomplete thoughts. You have to give them time to communicate what they are trying to say and be able to decipher it.”

4. Identifying and Responding to Multimorbidity

Shannon addresses multimorbidity upon patient evaluation by using the International Statistical Classification of Diseases and Related Health Problems. Multimorbidity is more common in long-term care due to overall age of patients. Fragility is more common in elders and therefore these patients are more likely to be injured. Age also suggests likelihood of cognitive impairments. Treating patients with comorbid issues can often mean that treatment is more challenging since the therapist must devise a treatment plan effective not only for primary injuries or disorder but multiple. Shannon explains that being an occupational therapist in a long-term care setting means that you must look for and expect comorbid issues in every patient.

5. Preventing Dangerous Events

Shannon explains that many methods were used to prevent dangerous events in a long-term care setting such as bed alarms, one-on-one supervision, and stability exercises. The most common thing Shannon focuses on when it comes to this subject is fall prevention. Falls are extremely common within this age group and can be debilitating to the patient. A fall can mean a huge setback in recovery and even sometimes the start to a major decline in health. Maintaining stability in walking and in transitions between the bed, bathroom, and within the room is key to preventing dangerous events.

6. Treatment Goals

Patients are involved at initial assessment and encouraged to voice their desires. In addition to this, Shannon involves patients at weekly update and evaluation. Weekly, the occupational therapist and patient discuss progress and decide on future treatment plans. Shannon explains the importance of making sure the patient is involved at all times. Often times, medical specialists forget that the person that knows the patient the best is the patient himself. If the patient has cognitive impairments, Shannon involves the patient's family to give input.

7. Effective Teamwork

Providing effective teamwork in outpatient care means working with, at most, two to three other health care professionals and the patient to successfully accomplish therapy goals. However, in long term care, Shannon explained that teamwork can make or break a patient's experience and outcome. As an occupational therapist working with fellow physical therapists and occupational therapy assistants, Shannon must rely not only on her therapy team, but she relies heavily on the nursing and nursing tech staff to carry out goals outside of treatment. She gave the example of feeding and meal time. Village manor has a charting system that labels each patient on feeding status. The nurse techs are expected to carry these out at daily meals. If the chart says assist feed then someone must prompt feeding throughout the meal. Shannon reflects, "Sadly, nursing techs are somewhat removed from the idea of person centered care simply due to workload. The work environment minimally staff for every shift which creates emphasis on basic needs instead of focusing on each individual for maximum service throughout the day."

8. Advocating for Patients

This point was inspired from a conversation I had while shadowing Shannon Blanford. She said, “A big part of our role is advocating for the patient. The shortage on nursing techs means they are always busy and often cannot spend time with the patient and focus on the patient’s individual needs. It’s our job to speak up for patients when they can’t speak up for themselves and make sure that patient goals are carried out and that they are well cared for.” I saw Shannon put this into practice the same day. An elderly lady who refused to eat in the dining room was brought her meals in her room. Instead of assisting the elder with the meal, the nursing staff would leave it on a table in front of her and it would often sit there until the next meal simply because no one made a point to observe the patient’s mental and physical condition and assist with feeding. When Shannon confronted the nursing staff about this, they said that the elder insisted she could feed herself. The elder had dementia and when she insisted she could feed herself, she thought that she could. Shannon said, “With this patient, I don’t always ask her how she would prefer to eat, I usually say something like, ‘This looks really good! Let’s try it’ and then start guide-feeding her myself. She always eats when I do this, but if I were to ask her if she wanted me to feed her, she would say ‘no’ simply because in her mind, that’s what’s expected of her.”

CHAPTER 6

Research Improvements

Observing two different settings sometimes felt like comparing apples to oranges, in that patient makeup, patient treatment, and patient status tended to dramatically differ. In hindsight, comparing two, more similar settings, such as a standard long-term setting and a memory care long-term setting, might have yielded better insights into person-centered care and occupational therapy. Research methods could be improved. To gather data, I used shorthand dictation during interviews and email. For future studies, content could be improved by recording interviews. Shadowing experience could be also be improved upon. The eighteen hours of shadowing occurred over the course of three weeks. Spending entire days shadowing instead of just a few hours at a time would have given me greater insight into the teamwork and would have given a better look at the big picture, instead of glimpses of a limited amount of treatments. If this project were to be completed, shadowing more than one occupational therapist in each practice could add to the overall learning experience. Each occupational therapist holds their own views and opinions of person-centered care, therefore each shadowing experience is different and clouded with bias from the therapists' personal views and experiences.

CHAPTER 7

Conclusion

This adapted person-centered checklist has proven to be relevant to both occupational therapists working in outpatient care clinics as well as those working in long term care settings, despite the fundamental differences reported in patient composition, disorder, injury, and treatment between settings. The beauty of person-centered care is that it's relevant in any therapy setting, simply because it's a way of providing care that allows the caregiver to connect to the patient on a human level and support patients physically, emotionally, and spiritually. Person-centered care is that much more vital to occupational therapy because of the nature of the practice. Ann P. Grady illustrates the driving belief behind the practice of occupational therapy saying, "All persons have the right to choose where they wish to live, work, learn, and play, and with whom they wish to spend time. On a deeper level, we believe that belong together because of their differences" (Grady, A., 1995). Occupational therapists assist people in reaching their functional goals, whatever they may be, that make it possible to participate in society more fully. To meet these goals, an occupational therapist considers many aspects of a person's life to find possible adjustments and solutions. Connecting to a patient on a deeper level doesn't just make for a more personable therapist, it's essential for success within the practice. An occupational therapist must put themselves in their patients' shoes daily, constantly considering what things challenge them, what things matter to them, and

what solutions best serve them. Since this mindset doesn't always come naturally, these basic checkpoints can be utilized to make sure these things are considered consistently and expertly. When occupational therapists adhere to these checklists principles, they assure that patients from all walks of life, despite disabilities, injuries, and cognitive impairments, can be an active member of society.

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