**Title and Focus of Activity:** Inter-Professional Clinical Reasoning Event

*Intervention; Inter-professional education (IPE)*

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**Course Information:** This activity is not part of a formal course in the DPT program, though attendance is expected as part of the professional behaviors expected throughout the curriculum. It occurs in Year 2, December, after Neuroanatomy and Neurophysiology, Pediatric Therapeutics and Neuromuscular Therapeutics courses, but prior to Prosthetics and Orthotics Course.

**Learning Experience Description:**

Context and Purpose: All students from the College of Health and Human Services programs of Physical Therapy, Occupational Therapy, Speech and Language Pathology, Nursing, Physician Assistant, Social Work, and Early Childhood Education meet for one afternoon in a roundtable discussion of a paper-case conference. 1-2 student representatives from each program sit at tables which are facilitated by a faculty member from one of the programs. Over the course of 3 hours, students watch a brief video of the client interacting with each of the professionals, read the documentation provided by each discipline, and collaboratively develop a plan of care for the client. The video provides a brief snapshot of the client during a PT/OT/SLP intervention, SW interview, as well as education by the RN in management of DM. In the process, students learn from each other the perspectives and contributions each team member brings to the care of our client. This case was initially developed by the committee of faculty from each program several years ago, and is refined yearly as needed by the current committee members. In addition to this case of an adult post CVA, we also have a spring session that discusses a pediatric case.

**Time for student to complete the activity:** 1. Preparation for activity outside of/before class: -- 2. Class time completion of the activity: 3 hours

**Readings/other preparatory materials:** None

**Learning Objectives:** 1. Describe the role of different disciplines in the management of a patient who suffered a cerebral vascular accident (CVA).

2. Demonstrate effective communication skills when discussing patients with other healthcare professionals.

3. Formulate a discipline specific plan of care and goals, as well as a discharge plan, for a mock patient and share their findings with students from other disciplines

4. Discuss ways disciplines can work together to improve the recovery of a patient with a CVA.

Student expectations: 1. Contribute to the learning of other group members

2. Be respectful in communication

3. Share your expertise with other group members

4. Report on your group’s plan of care (POC) and interprofessional priorities

Facilitator Expectations: 1. Assist group interactions in order to promote participation of all group members 2. Help the learners stay focused on the learning task 3. Encourage independent thinking 4. Encourage students to challenge each other 5. **Limit sharing your opinions and answers to questions**, allow students to guide the discussion

Below are the materials used for this IPE activity.

Facilitator Guide / schedule

Client documentation from each of the disciplines

Plan of care worksheet completed by each table of students

Facilitator Guide to Interprofessional Day

Try to stay on the schedule. It is disruptive when this does not happen. Your role is largely to sit back and let the students do the discussing, problem- solving, etc. Try not to intervene too quickly. A script that follows the schedule is below if you want to use it. Your facilitator packet includes the same information as in the student packet, with the addition of some “cheat sheets” from some disciplines – to help answer questions that students at your table might have that are not within your discipline.

Prior to or during Introduction

1. Have students sign in

2. Have students introduce themselves

3. Distribute student packets (one for each student at your table)

1:00 to 1:15 - Introduction: Facilitators do not need to do anything, IPE committee chair will lead

1:15 to 1:20 - Video of Standardized Patient: There will be a short video using a standardized patient.

1:20 to 1:40 - Distribution of discharge summaries

Provide the instructions, *“Read through these discharge summaries. Make notes on anything you feel is important and/or anything about which you have questions.”*

1:40 to 2:00 - Group question/answer period regarding case study specifics

Provide the instructions, *“Ask your peers for any clarification of terms or anything you want explanation.”*

2:00 to 2:15 - Discipline specific planning

Point out the discipline-specific planning sheets found at the back of their packets.

Tell the students, “*Develop goals for the patient and/or the family. If you are the only person in your discipline at the table, you will write the goals alone. If there are 2 or more of you from the same discipline, you can discuss goals and decide on them together and use only one of the planning sheets. Make sure you put the table number and your discipline on the planning sheet.”*

2:15 to 2:30 - Break

2:30 to 3:00 - Group discussion of interprofessional priorities and goals

Have students at your table identify a scribe and give the scribe the interprofessional plan of care sheet found at the back of the packet.

Tell the students, “*Let’s hear the goals each discipline would like to target and we will have the person serving as scribe summarize the information on the interprofessional plan of care sheet. Listen closely to the other disciplines because you will use this information later for developing interprofessional goals and for determining how each of you can reinforce another discipline’s goals.”*

3:00 to 3:30 - Formulate Interdisciplinary goals and complete back side of green sheet

Tell the students, *“Pick a scribe and then follow the directions at the bottom of the interprofessional plan of care sheet.”*

3:30 to 4:00 - Wrap-up

Groups will be asked to speak briefly about their content on the back of the *interprofessional plan of care* sheet. An IPE committee member will facilitate.

Tell the students, “*complete the survey of the event and make sure to circle your discipline.”*

**CASE DOCUMENTATION**

**PA Discharge Note**

Patient Name: Edna J. Brown

MR# 9843-9976523

Admit Date:

Discharge Date:

Attending Physician: Mark Jones, MD

Physician Assistant: Sally Smith, PA-C

Consulting Physician: Paul Logan, MD from Neurology

Admit Diagnosis: Acute Ischemic Stroke

Fracture – right scaphoid

Coronary Artery Disease s/p stenting

Hypertension

Heart Failure

Chronic Obstructive Pulmonary DiseaseHistory of compression fracture T10

Discharge Diagnosis:Acute Ischemic Stroke

Diabetes Mellitus Type II

Coronary Artery Disease s/p stenting

Fracture – right scaphoid

Hypertension

Heart Failure

Chronic Obstructive Pulmonary Disease

History of compression fracture T10

Hospital Course:

Patient is a 68-year old female admitted through the ED after suffering an acute ischemic stroke. Patient’s husband had found her on the floor unable to move her right side. Upon arrival, the patient was found to have significant weakness of her right side and difficulty speaking. CT demonstrated ischemic infarct in the left middle cerebral artery. Once it had been confirmed that no contraindications were present, TPA therapy was initiated as per stroke protocol. Patient was then admitted to acute care and a neurology consult obtained by Dr. Paul Logan. Her CBC and CMP in the ED revealed labs within normal range except for a glucose of 225. HgbA1C was then ordered and the result was 7.2. Therefore, the patient also received a new diagnosis of DM II. Patient was further evaluated during the next few days due to her stroke and significant PMH. Diagnostic studies were ordered. A carotid dopplers revealed 80% reduction of flow in the left internal carotid. Negative doppler of the lower extremities. Echocardiogram showed EF of 45%, MRI showed hyperintense area consistent with a thrombotic event. Consults were obtained from Physical Therapy, Occupational Therapy, Speech Pathology, and Social Work. The patient improved over the next several days and is ready to transfer to acute care to inpatient rehabilitation. Patient is stable upon discharge. Our service will continue to see patient as necessary.

**NURSING**

ACUTE CARE DISCHARGE

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| Confidential Record: Information contained will not be released except when you authorize us to do so |

**NAME:** Brown, Edna J **DATE:** XX/XX/2014

 Last, First, MI MR# 9843-9976523

**DOB:**10/11/1945 **AGE:** 68 **Married X, Divorced \_\_\_, Widowed \_\_\_ Single \_\_\_ Life Partner \_\_\_**

**Medical Insurance:** Medicare; Blue Cross/Blue Shield

**Dental Insurance:** None

**Monthly Income**: $2200 Social Security and state payments for foster care of granddaughter

**Are you currently being seen by a physician:** Yes - Dr.Who

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| **CHIEF COMPLAINT** |
| **Describe briefly your present medical problems and symptoms:** Husband states: “She fell and when I got her to wake, she couldn’t move her right arm or leg or talk right.” |
| **Pain rating (1-10):** 7 – right arm |
| **Patient’s goals for discharge:** Return home |
| **PAST MEDICAL HISTORY** |
| Surgeries/Hospitalizations (women exclude normal deliveries): Heart stents, 2003; Compression fracture T10, 2006; Kyphoplasty, 2006 |
| **List any other serious illnesses or injuries you have had:** Hypertension; Congestive Heart Failure; COPD |

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| **FAMILY HISTORY** |
| Family History | Year of Birth | Illnesses | Age at Death | Cause of Death |
| Father | 1920 | HTN |  60 | Farm accident |
| Mother | 1921 | Osteoporosis, HTN |  88 | Stroke |
| Brothers/Sisters |
| #1 F | 1939 | Breast CA |  |  |
| #2 M | 1942 | HTN |  |  |
| #3 M or F |  |  |  |  |
| Children |
| #1 M | 1959 | HTN |  |  |
| #2 F | 1961 |  |  |  |
| #3 F | 1966 |  |  |  |

**Check if you or any close blood relatives (other than those mentioned above) have or had any of the following:**

|  |  |  |
| --- | --- | --- |
| **Self Family (who)** | **Self Family (who)** | **Self Family (who)** |
| X Heart Disease | □ Unusual bleeding after surgery  | □ Depression/Nervous Breakdown |
| X Stroke (current) | or dental work | XAlcoholism Uncle |
| X High blood pressure | X Asthma Son | □ Migraine headaches |
| X High cholesterol | □ Stomach or intestinal problems | X Arthritis Brother |
| X Diabetes | □ Thyroid disease | □ Kidney disease |
| X Cancer/Tumor daughter | □ Epilepsy | □ HIV Infection |

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| **SOCIAL HISTORY** |
| **Occupation:** Retired Sales clerk |
| **What are your biggest life stressors at this time**:“Go home, can I.” “No children here.” “Granddaughter.” |
| **What do you do for recreation/relaxation/hobbies?**Travel to see grandchildren. One grandchild lives in the home. |
| **Do you live by yourself?** No, husband, Frank and 5-yr-old granddaughter |
| **Do you have stairs where you live?** 3 steps from garage |
| **Habits/Risk Factors:**Tobacco use: X Age started 16 Age Stopped 50 □ Cigarettes 1 pk/day Cigars \_\_\_ Pipe \_\_\_ □ Smokeless tobacco/snuff* How long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | Coffee/Tea/Soda X Cup per day 2 X Caffeinated □ Decaffeinated |
| Alcohol use: □ None X Seldom □ Regularly, amount/how often: □ Occasionally excessive □ Have sought help | Drug use: X None □ Seldom □ Regularly □ Occasionally excessive □ Have sought help |
| Safety: X Use seat belts in vehicles X Carbon monoxide detectors in home □ Home safety evaluation completed by OT,PT, or other: Smoke detectors | Exercise: □ Exercise regularly □ \_\_\_\_\_\_ times per week X No regular exercise |

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| **REVIEW OF SYSTEMS:** Please check any conditions you are experiencing or have experienced. |
| Constitutional: □ Unexplained weight loss X Change in appetite □ Sleeping difficulty □ Fever/sweats X Loss of energy | Genitourinary: Foley cath placed 11/30/14□ Burning or pain with urination □ Increased frequency of urination □ How often do you get up at night to urinate? \_\_\_\_\_ times□ Unable to control bladder □ Blood in urine □ Unable to start stream or weak stream □ Any venereal/sexually transmitted disease □ Kidney stones |
| Skin:□ Rashes or changes in color □ Persistent itching □ Moles that have changed □ Bruise easily X Sores Location: Rt outer malleolus R/T AFO Healing : yes Previously: \_\_\_\_\_\_\_\_\_\_\_ | Musculoskeletal: Rt-sided weaknessX Problems with strength X Problems reaching overhead X Problems picking things up from floor X Pain in bones or joints □ Muscle pain □ Joints that swell □ Phlebitis or inflamed leg veins |

|  |  |
| --- | --- |
| Eyes: □ Loss of vision □ Blurring or double vision □ Eye pain X Wears glasses | Endocrine:□ Thyroid problems  |
| Ears, Nose and Throat (ENT) □ Hearing loss □ Ringing in ears □ Ear Pain □ Frequent nosebleeds □ Sinus trouble □ Constant nasal congestion or runniness □ Persistent sore throat X Voice changes or hoarseness X Trouble swallowing | Gastrointestinal (G)  □ Nausea/vomiting □ Vomited blood or “coffee ground” material X Heartburn or indigestion □ Abdominal pain □ Constipation or diarrhea □ Bloody or black bowel movement □ Changes in bowel movements □ Pain during or after bowel movement yellow jaundice X Hemorrhoids |
| Respiratory: X Chronic cough □ Wheezing □ Blood in sputum/phlegm □ Exposure to TB □ Positive TB Test X Shortness of breath \_X Doing your usual work \_\_\_ Awakens you at night  \_\_\_ Causes you to cough \_\_\_ Accompanied by wheezing | Cardiovascular: □ Pain, tightness or heaviness in your chest \_\_\_ When exerting yourself \_\_\_ When upset or excited \_\_\_ Radiates down the arm \_\_\_ Disappears if you rest □ Rapid, slow or irregular pulse X Sleep on more than one pillow □ Rheumatic fever/heart murmur □ Calf pain when walking X Ankle swelling |
| Neurologic: □ Dizzy spells □ Recurrent headaches □ Memory loss □ Seizures or convulsions □ Blindness of one eye □ Weakness in any part of your body \_X\_\_ Location: Rt. arm and leg □ Numbness in any part of your body \_X\_\_ Location: rt. fingers | Emotional: □ Feel nervous often X Feel “down in the dumps” X Worry a lot X Loss of interests X Loss of energy or ambition □ Considered suicide  |
| Other: X Anemia | Women: X Last period 1997 X Last Pap smear 2010 X Last Mammogram 2010 □ Difficulties with periods □ Recent vaginal discharge □ Current method of birth control \_\_\_\_\_\_\_\_\_\_\_ □ Number of pregnancies 4 □ Number of miscarriages 1 □ Number of live births 3 □ Bleeding after menopause X Hot flashes □ Breast lump □ Breast pain |
| **PREVENTIVE MEDICINE** |  |
| Immunizations:I had my last vaccine in (please enter year): 2010 □ Tetanus Don’t know X Pneumonia 3/2014 □ Hepatitis A \_\_\_\_\_\_\_\_\_\_ □ Hepatitis B \_\_\_\_\_\_\_\_\_\_ X Flu 10/2014 □ Do not know | Screening Exams:I had the following screening exams in (please enter year): □ Bone density \_\_\_\_\_\_\_\_\_\_ □ Colonoscopy/color cancer screening \_\_\_\_\_\_\_\_\_\_ □ Prostate cancer screening (men only)\_\_\_\_\_\_\_\_\_\_ X Do not know |
| Dental:Date of last exam: Long time ago; don’t know □ Pain or other problems in mouth at this time X Difficulty, speaking, chewing or swallowing □ Limit types of food you eat because of problems with teeth or dentures □ Mouth pain due to sensitivity to sweets, hot or cold Temperatures, or biting or chewing □ Lumps or sores in mouth □ Bleeding gums | Risk for Falls: X Have you fallen in the last 6 months Number of times: 1 X Trouble with balance □ Dizziness: \_\_\_ Sitting \_\_\_ Standing \_\_\_ Walking X Uses a cane or walker Date trained: \_\_\_\_\_\_\_\_\_\_ Where trained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ X Trouble getting in or out of bed X Trouble getting in or out of a chair |

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| **MEDICATIONS** |  |  |  |  |
| Prescription Medications, OTC Drugs, Herbal Preparations | Dose or Strength | How often do you take this medication? | How long have you been taking this medication? | What do you take this medication for? |
| Lasix  | 40 mg | Daily | 2002 | Water pill |
| Digoxin | 125 mcg | Daily | 2003 | Heart |
| Lortab  | 5/325 | Q 4-6 hr prn | Long time | Back pain |
| K Dur | 10 meq | BID | 2002 | Don’t know |
| Avapro | 150 mg | Daily | 2002 | Blood pressure |
| Coated aspirin | 325 mg | Daily | 2009 | Heart |
| Lipitor | 40 mg | Daily | 2009 | High Cholesterol |
| Protonix | 40 mg | Daily | 2009 | Stomach |
| Glucophage | 500 mg | BID | 2005 | Diabetes |

**Medication allergies:** NKA **Other allergies:** None

**Other Findings:** Edna Brown is a 68 year old white female who was admitted 5 days ago with a left Middle Cerebral Artery infarct resulting in right sided weakness, aphasia and dysphagia. She fractured her right wrist when she fell so she has a cast on her rt. hand and forearm. Rt fingers have brisk cap refill, warm et pink without numbness or tingling. She is alert and oriented x 3. Rt arm and leg are weak. She is right handed. Her lungs are coarse. She has a non-productive cough. She has DOE. Apical pulse is regular at 74. Abdomen is soft and non-distended with active bowel sounds. Her last BM was yesterday, soft formed, brown. She has a 16 FR foley catheter that was inserted on admission. She has BLE non-pitting edema and also edema in her right fingers. She has a stage II ulcer on her rt outer malleolus, circular, approximately 1.5 cm in size thought to be related to her AFO. It is covered by Duoderm. Oral mucosa is pink, intact et dry. She is able to have thin liquids with meals but needs reminders to take breaks and swallow twice. Has been eating 50 to 75% of trays. Has been taking most pills crushed in applesauce. She is often withdrawn with little eye contact or interaction. Expresses fear that she will not be able to care for herself independently at home. Teary at times.

Was started on Zoloft 2 days ago for possible depression. Was raised Catholic, but currently is not going to any church. 2:1 transfer. Has PT, OT and Speech.

She has a history of Type 2 Diabetes . She was initially being covered by sliding scale insulin but is now back on her Glucophage. She demonstrates some emotional lability and is often teary. Her husband thinks it’s because it’s overwhelming for her with the stroke and wanting to be home.

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| **Weight: 150 lbs. Height: 66 Inches Pulse: 72 R****Blood Pressure: 150/82 Respiration rate: 16****Temperature: 98.6 F** |

**LABORATORY REPORT**

PATIENT NAME: Edna J. Brown

RECORD #: 9843-9976523 AGE: 68

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: xx/xx/2014 0500

**CBC**

|  |  |  |
| --- | --- | --- |
| **TEST ORDERED** | **RESULT** | **NORMAL RANGE** |
| WBC | 6.2 K/UL | 4.3-10.9 |
| RBC | 4.34 M/uL | 4.10-5.20 |
| HGB | 10.0 gm/dl | 13.0-17.0 |
| HCT | 28.0% | 35.0-45.0 |
| MCV | 89.9 Fl | 80.0-98.0 |
| MCH | 31.6 | 27.3-32.7 |
| MCHC | 33.5% | 31.0-36.0 |
| Platelet | 320 K/UL | 140-420 |

|  |  |  |
| --- | --- | --- |
| Serum Albumin | 1.9 gm/dl | 3.7-5.6 |
| PrealbuminGlucoseHgb A1c  | 18 mg/dl2267.2 | 16.0-35.070-1104- 5.9 |
| Serum Creatinine | 1.3 | <1.5 |
| Sodium (NA+) | 138 mEq/L | 135-145 |
| Potassium (K+) | 3.2 mEq/L | 3.5-5.0 |

|  |  |  |
| --- | --- | --- |
| INR | 0.9 | 1- 2 |
| PTT | 33 | 25 - 35 |
| Glucose (fasting) | 105 mEq/L | <110 |
| Digoxin level**FINGERSTICK BLOOD GLUCOSE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 0730 | 1130 | 1730 | 2100 |  |  |
| 114 | 256 | 325 | 301 |  |  |

 | 1.5 ng/mL | 0.8-2.5 ng/mL |

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| **TEST ORDERED xx/xx/2014** |
| **Head CT:** Impression: Large area of hyperdensity in area of left middle cerebral artery consistent with ischemic infarct. |
|  |
| **Carotid Doppler**:  |
| Impression: There is narrowing of the left internal carotid artery with an 80 % reduction in flow. Right internal carotid artery shows 30% reduction in flow. |
| **BLE Doppler:** Impression: No irregularities in flow noted in either leg. Normal bilateral lower extremity Doppler.  |
| **ECHO: xx/xx/2014**Impression: Mild stenosis (1.3 cm²) of aortic valve. Ejection fraction of 45 %.  |
| **Rt Wrist: xx/xx/2014**Impression: Simple fracture of the right scaphoid. |
| **FSA: xx/xx/2014**Impression: Laryngeal penetration with consecutive swallows of thin liquids and a minimally delayed swallow reflex. |

**MRI xx/xx/2014**

Impression: Hyperintense area, 3mm x 4 mm in Broca’s area consistent with a thrombotic stoke.

**EKG xx/xx/2014 R/O Afib**

Normal Sinus Rhythm

**Physical Therapy Discharge Summary**

Patient Name: Edna J. Brown

Record #: 9843-9976523

Start of Care Date: Three days ago

Discharge Date: Today

Number of Session: 4

Precautions

Non-weight bearing for right hand or forearm.

Subjective

Patient is a 68 year old female who experienced an ischemic stroke affecting the left middle cerebral artery five days ago. The patient’s husband reports walking into the family room and finding her on the ground. The patient could not speak and had difficulty moving her right arm and leg. Patient was taken to the emergency department where a head CT scan revealed a blockage in the left middle cerebral artery. The patient also suffered a right fractured scaphoid during the fall that was treated with casting.

Prior to admission patient tended to be inactive. She liked to visit with friends and keep up with house work. Patient was a community ambulatory and drove a car without restrictions. Her 5 year-old granddaughter lives in the home.

Throughout therapy sessions patient had difficulty speaking due to expressive aphasia. Due to homonymous hemianopsia, therapist had to stand on left side of patient or give cues to get patient to turn head to the right. Patient was able to follow commands and appeared to understand all communications. Most of history was obtained from patient’s husband. Husband reports they live in a multilevel house with three steps into the house from garage with a railing on the right side going up the steps. There are 14 steps up to the master bedroom and full bath. One room on the first floor could be converted to a bedroom as needed. The husband is unsure if a wheelchair will fit in the bathroom due to the age of the home.

Patient had a flat affect during all therapy sessions. Husband reported that the patient was not acting like herself over the last month. Her family doctor stated she might have depression. No interventions were implemented for the depression. Therapist is unsure of how much the aphasia is affecting patient’s behavior versus underlying depression.

Patient currently has a Foley catheter for bladder emptying. Patient appears to have control of bowels at this time. She had one episode of fecal incontinence, but this was because difficulty with nursing staff understanding her. After bowel program initiated, no further problems.

Objective

The four sessions of physical therapy focused on transfers, gait training, facilitation of activity on the right side of the body, and patient and family education. Listed below is patient’s performance during last session.

HR 80 bpm; RR 17, BP 120/75, and SaO2 99 at rest. Orthostatic hypotension experienced during initial examination during transfers (BP decreases to 100/60), but no further incidents.

Stage 2 pressure ulcer on right lateral malleolus from wearing an AFO. AFO was left on by mistake for over 12 hours.

*Transfers:* Bed mobility – moderate assistance

Supine to sit – maximum assistance

Sit to stand – moderate assistance

Stand pivot transfer from w/c to/from bed – moderate assistance

 *Gait:*  Ambulates 10 meters in 80 seconds (0.125 m/s), minimal assistance of one for safety and assistance from another therapist for proper placement of right lower extremity. Use of front wheeled walker with platform on the right side to protect right wrist. During stance phase on right, demonstrates a Trendelenburg pattern, decreased weight bearing, and hyperextension of knee. During swing phase on right, demonstrates decreased hip flex and foot drop. Patient is SOB after the 25 foot walk.

 *ROM:* WNL AROM on left arm and leg. Right UE AROM: Patient has approximately 60 degrees of abduction and flexion in sitting position. Patient flex elbow approximately 30 degrees. Demonstrates synergistic movement in right upper extremity during elbow ROM testing. Unable to test motion in wrist or fingers due to cast. Right LE AROM: WFL except ankle dorsiflexion which demonstrates no active motion. PROM on right upper and lower extremity WFL.

 *Strength:* Strength on left side of body ranges from 4-4+/5. Patient unable to take any resistance during muscle testing on right UE. Right shoulder abduction and flexion 2-/5. Right elbow flexion and extension 2/5. Right hip flexion 3+/5, knee extension 3+/5, knee flexion 3/5, dorsiflexion 1/5, plantar flexion 3/5.

 *Tone/Spasticity:* Modified Ashworth Scale = 2 right biceps, 1+ right plantar flexors

 *Sensation:* Proprioception absent at the right great toe, impaired at the ankle and knee. Absent at right thumb, impaired at wrist, intact at elbow and shoulder. Sharp/dull sensation intact throughout the right upper and lower extremity.

 *Pain:* With PROM on right shoulder past 110 degrees, patient appears to be in pain. Patient unable to give a number. Spouse reports that evening nursing assistant was rough on patient last night when changing her bed.

 *Balance:* Patient is able to maintain sitting static balance with SBA. She is unable to reach outside her base of support in sitting. She can stand with CGA while using walker for support. Patient requires minimal assistance to maintain standing balance if no assisted device is provided. Postural assessment scale for stroke patients score (PASS) = 16/36; Berg Balance Scale = 6/56 (see attached sheet for details)

 *Education:*Throughout sessions patient was encouraged to use right arm as much as possible. Patient also encouraged to turn head to right and scan room as much as possible.

 Assessment

Patient currently presents with deficits in right side active ROM and strength. Patient has activity limitations in transfers and gait that are affecting ability to participate in daily activities. Patient would benefit from inpatient rehabilitation to regain function.

Plan

Patient will be discharged from the acute care setting. Therapy services will be started again at inpatient rehabilitation.

**Occupational Therapy Discharge Summary**

Client Name: Edna J. Brown

Record #: 9843-9976523

Start of Care Date: 3 days ago

Discharge Date from Acute: today

Number of Session: 3 (1 eval, 2 treatment)

Precautions

Non-weight bearing through right hand and forearm. Fall precautions.

Subjective

OT Eval initiated 3 days ago. The client is a 68 year-old Catholic female who experienced an ischemic stroke affecting the left middle cerebral artery on 4 days ago. The client’s husband reports walking into the family room and finding her on the ground. The client could not speak and had difficulty moving her right arm and leg. Client was taken to the emergency department where a head CT scan revealed a blockage in the left middle cerebral artery. The client also suffered a right fractured scaphoid during the fall that was treated with casting. The client received TPA for the left MCA blockage which successfully restored bloodflow to the area.

Occupational Profile

The client is a retired sales clerk. She is married. Her adult children live out of state. Prior to admission, she tended to be inactive. She liked to visit with friends, watch “her shows”, and go out to eat. She was able to complete light housework chores independently and was independent in her activities of daily living. Prior to the stroke, she drove, shopped, and walked about in the community without assistance. She likes to play cards and go to the gambling boat. The client lives with her husband in a multi-level home with three steps into the house from the garage with a railing on the right side going up the steps. There are 14 steps up to the master bedroom and full bath. Her 5-year old granddaughter Kayla also lives in the home.

Throughout therapy sessions, the client had difficulty speaking due to expressive aphasia. Most of the history was obtained from the client’s husband. The client demonstrated a flat affect during all therapy sessions. She was tearful at times. The husband reported that the client was not acting like herself over the last month. Her family doctor stated she might have depression.

Objective

The three sessions of occupational therapy focused on assessment, transfers, sitting balance, and light ADL activities in sitting. Listed below is the client’s performance during the last session.

*Bowel/Bladder*: Client currently has a Foley catheter for bladder emptying. Client appears to have control of bowels at this time. Dependent for voiding in the toilet.

*Bed Mobility/Transitional movements:* Scooting side to side- moderate assistance x1

Rolling- moderate assistance x1

Supine to sit- moderate assistance x1

Sit to Stand- moderate assistance x1

*Functional Transfers:*  Sitting edge of bed to chair-moderate assistance. X1

Toilet transfer-mod assist x1

 Tub/Shower transfer-max assist x1

*Functional Mobility*: Minimal Assistance from bed to bathroom with FWW (approximately 20 feet),

platform on right side. Shortness of breath noted.

*Endurance/Activity Tolerance*: Poor. Client demonstrates mild SOB engaging in light grooming activities with assist. Requires set-up secondary to non-functional right hand. Requires occasional verbal cues for repeated swallows with thin liquids. On mechanical soft diet. Requires frequent verbal cues to finish meals. She frequently stops and requires redirection to the task.

*Oral hygiene*: Moderate Assistance, seated

*Grooming*: Moderate Assistance, seated

*Upper Body Dressing:* Maximal Assistance

*Lower Body Dressing*: Dependent

*Bathing*: Maximal Assistance

*Toileting*: Maximal Assistance

*IADLs*: Client is dependent for all IADL activities.

*Vision/Visual Perception*: Some visual impairment. Patient is having some difficulty with visual scanning within

the environment during ADL and grooming tasks.

 *Cognition*: Unable to focally assess at this time secondary to aphasia. During treatment sessions, client appears to understand 1 step directions 100% of the time; 2 step directions 80% of the time. She demonstrates motor delay during assisted upper body dressing and oral hygiene/grooming activities and may have a mild apraxia.

*Psychosocial*: Client is slow to engage in activities and demonstrates a flat affect during treatment sessions.

She was tearful during the last session of OT. Her husband stated that his wife used to enjoy listening to country music and cooking for the family in addition to playing cards and going to the gambling boat. She also enjoys collecting frog sculptures.

 *ROM:* WNL AROM on left arm and leg.

Right UE AROM: Approximately 60 degrees of shoulder abduction and flexion in sitting position. AROM elbow flexion approximately 30 degrees. Right wrist and fingers not tested secondary to cast.

 Right LE AROM: within functional limits except for dorsiflexion-no movement. Pt uses AFO.

 *Strength:* Strength on left side of body is within functional limits. Right shoulder abduction and flexion poor strength (2-/5). Right elbow flexion and extension poor strength (2-/5).

 *Tone:* Modified Ashworth Scale score 2 right elbow flexors.

 *Sensation:* Unable to focally assess secondary to expressive aphasia. Client turns head toward right arm in response to light tapping at the shoulder and elbow. Unable to generally assess wrist and hand secondary to cast.

 *Pain:* Client grimaces during RUE AAROM at the shoulder and elbow*.* She is unable to give a number between 0-10.

 *Balance:* Sitting static balance is fair. Dynamic sitting balance is poor. She can stand with minimal assistance while using FWW for support. Standing static and dynamic standing balance not tested at this time.

 Assessment

Client requires significant assistance to complete ADL activities and is dependent for IADL activities secondary to physical deficits, motor planning difficulties, and probable depression. Client would benefit from inpatient rehabilitation to regain function.

Plan

Client will be discharged from the acute care setting. Occupational Therapy services will be started again at inpatient rehabilitation for continued assessment of physical, cognitive, and psychosocial functioning and treatment of ADL and IADL impairments in order to maximize her level of functioning.

**Speech-Language Pathology Acute Care Discharge Summary**

Patient Name: Edna J. Brown

Record #: 9843-9976523

DOB: 10/11/1941

Start of Care Date: 3 days ago

Discharge Date: today

3 sessions (2 assessment and 1 treatment session)

Subjective

Pt. is a 68 year old female who had a left cerebrovascular accident four days ago. The MRI results revealed an infarct near Broca’s area. She was referred for an aphasia evaluation and a bedside swallow evaluation. The bedside swallow evaluation revealed possible aspiration risk, therefore a video fluoroscopic swallowing exam was also completed. Pt. was alert and compliant during the evaluation and treatment session, however she fatigued easily. Prior to admission pt. tended to be inactive. Pt. is married. Her husband reported she enjoys going out to eat each month with her friends and playing cards one time a month with the same group of friends. They have children who live out of state and a 5 year old grandchild living at home with them. A review of the nursing notes revealed instances of coughing on liquids and difficulty talking.

Objective

*Vision/Hearing*: The pt. appeared to have adequate hearing acuity. A hearing screening was not conducted. Pt. requires eyeglasses for reading. Physical therapy evaluation report indicated homonymous hemianopsia and Occupational therapy evaluation report indicated the pt. has difficulty with visual scanning within the environment during ADL and grooming tasks.

*Oral/Facial Examination***:** Pt. exhibited symmetrical facial features, and did not demonstrate signs of facial weakness. Pt. was able to prolong /ah/ for 15 seconds but was delayed in the initiation of the task. Pt was able to prolong /s/ for 15 seconds with no delay in initiation of the task. Her voluntary cough was also delayed in initiation. Pt. exhibited signs of verbal apraxia during diadochokinetic tasks (i.e. rapid productions puh tuh kuh).

*Swallowing***:** During the videofluoroscopic swallowing evaluation, the pt. coughed during and after consecutive swallows of thin liquid (ice water). There were some instances of “wet” vocal quality following consecutive swallows of thin liquid. She was able to chew, organize, and transfer a bolus without signs of premature spillage or oral stasis on a mechanical soft diet. Swallow time was minimally delayed for thin liquid (1.3 seconds average). She did have some difficulty with fatigue on a regular diet. The video fluoroscopy exam revealed laryngeal penetration with consecutive swallows of a thin liquid and a minimally delayed swallow reflex but no aspiration. Penetrated material was consistently cleared following a cough. Pt. is currently on a mechanical soft diet with thin liquids. It is recommended that she take one sip at a time and avoid consecutive swallows of thin liquids. Pt. is aware of and demonstrates an understanding of this recommendation. However, she has been observed intermittently using consecutive swallows when drinking thin liquids during meals.

*Language:* Portions of the Boston Diagnostic Aphasia Examination Short Form- Revised were administered. Pt. presents with a moderate to severe Broca’s aphasia and verbal apraxia.

**Verbal Expression**

Pt. was able to write one word responses in a notebook in instances where she could not verbalize what she wanted to express. For example, when pt. was asked for her address, she was not able to verbally respond but was able to write her street name and state. When the pt. was asked to describe a picture she was able to say ‘boy’ and ‘cookie.’ Pt. was able to repeat days of the week and count from 1-10 but verbal production was slow and effortful. Pt. was able to repeat monosyllabic words with some distortion. Pt. was unable to repeat two syllable words intelligibly. Pt. was able to verbally name 3 out of 5 objects.

**Auditory Verbal Comprehension**

Pt. was able to follow two step simple commands. For example, point to the ceiling and the floor. Pt. was unable to consistently follow three step commands. For example, put the pen on the card and put it back. Pt. was able to answer yes/no general knowledge questions (Did the South win the Civil War) but had difficulty comprehending information in a short simple paragraph that was read to her.

**Reading Comprehension**

Pt. was unable to read aloud. Pt. was able to answer yes/no and multiple choice questions following reading simple short paragraphs to herself. The pt reported needing to read the paragraph at least three times before attempting to answer questions.

**Written Expression**

Pt. was able to write her name. She was also able to write the names of objects in 7 out of 10 attempts. She was unable to write short sentences when asked to describe a picture.

Assessment

Pt. presents with a moderate to severe Broca’s aphasia and concomitant verbal apraxia. Pt. has difficulty verbally naming items and answering questions. Expressive communication is currently most efficient when using a picture board or when given a simple multiple choice question (i.e. Do you want Sprite or Pepsi?). Pt. has some delay in her swallow initiation. Her prognosis is excellent due to her cooperation with treatment, awareness of deficits, and no apparent cognitive or memory deficits.

Plan

Patient will be discharged from the acute care setting. Therapy services will be started again following patient admission to inpatient rehabilitation. Pt. and her spouse are adamant about her going home as opposed to inpatient rehabilitation.

**Social Work Discharge Summary**

Subjective:

Edna Brown is a 68 year old, woman who was recently admitted to the hospital for a stroke. The patient is a retired retail sales clerk who lives at home with her husband Frank in a two level home with three steps into the house and 14 to the bedroom and bath. The patient has 3 children who all live out of state. At the time of the stroke, her 5 year old granddaughter Kayla was living in her home. At this time, it is unclear where this child will live upon the patient’s return to the home. Prior to admission, patient states that she was mostly inactive at home, performing light housework though completely independent with her activities of daily living (ADL’s). Patient states that prior to admission she enjoyed playing cards, watching her shows, and going to the gambling boats.

Due to the stroke, and subsequent aphasia, additional information was provided by her husband. He states that, during the past month, the patient has not been acting like herself. He said the patient has been feeling "down in the dumps," she has been worrying a lot, and she has experienced a loss of energy, ambition, and interest in doing things.

Patient does not have advance directives; however, she is receptive to talking with pastoral care to complete them. Patient said she was brought up Catholic; however, she does not attend church on a regular basis and indicates no specific church affiliation at this time. She stated that she wanted to talk to a priest while in the hospital. Patient experiences significant positive support from husband and children, and strong network of neighbors and friends. However, as previously stated, the patient’s children all live out of town.

Objective**:**

The patient shows symptoms of depression including sadness, feelings of hopelessness, withdrawal, and guilt that she allowed this stroke to happen. She is tearful and anxious when talking about discharge needs and continuing therapies. In talking with the patient, she expressed apprehension that she would not be able to take care of herself when at home independently. The patient’s husband questions medical staff regarding whether they can split the pills that she will need to take because they are on a fixed income and he wasn’t sure that Medicare would pay for “all of these drugs”.

Assessment**:**

Patient will need additional help in discharge planning, as her plan is to go home and not to a skilled nursing facility. Patient will benefit from a psychiatric consultation to assess the degree of her depression and to prescribe appropriate medication and support services. Patient will need home care, community support, and emotional support due to her pre-existing tendency toward depression and the likelihood that the stroke has increased her depression experience. Patient will also benefit from meeting with pastoral care to learn about and complete advance directives.

Plan**:**

Plan is for patient to return home - her stated preference - and continue with outpatient speech, occupational, and physical therapy services. She and her husband have some reservation about allowing strangers into their home, but are willing to try in order for her to recover. In addition, she will follow up with a counselor to receive emotional support, address issues of depression, coordinate the monitoring of depression medication, and discuss changes in her life and relationships with family members that have been precipitated by this stroke. Patient may also benefit from exploring CASI services (Center for Active Seniors Services), connecting with a spiritual community and by a referral to a stroke/illness support group. Referral to CASI, to a stroke support group, and for counseling services can be made at discharge.



<http://www.aea10.k12.ia.us/divlearn/specialeducation/>

**Behavior(s) of concern.** State a clear, measureable, and observable description of the behavior(s) of concern.

Kayla plays in isolation under a table or in the corner of the classroom 3 times a day for approximately 10 minutes at a time. She whines or cries softly in small group and large group times with her peers, with increasing volume 4 times per day for 3-5 minutes at a time.

Kayla wakes crying at night 2-3 times per night for 4-5 nights per week with awake periods lasting 30 minutes.

**Strengths.** What student strengths may provide a foundation for decreasing the behavior(s) of concern and increasing replacement behaviors?

Kayla has age-appropriate verbal language skills, but has decreased in talking in class in the past month. She is able to follow multistep directions with an adult present and has independent coloring and book-reading skills that are age-appropriate. Kayla has age-appropriate self-help skills including dressing herself, hand-washing, feeding, and toileting.

**Descriptive Summary.** Document existing and newly acquired data. Include information from a variety of approaches and/or data sources: record review, interviews, observations, tests, and/or graphic displays such as scatter plots, ABC analysis, etc. The extent of data collection should reflect the complexity of the behavior(s) of concern.

In the kindergarten classroom, the teacher observes that Kayla seems to be isolated and weepy. She rarely talks or initiates verbal interactions with others during the school day. Her teacher reports that Kayla plays under furniture during center time. Upon arrival with her grandfather, Kayla cries and at dismissal she cries while being led to the bus with her classmates. Throughout the day, teachers are able to console Kayla if they rock her or hold her. Her grandfather reports that Kayla has a very small appetite at the evening meal and she has many restless nights during the week. Although Kayla has been toilet-trained since she was three, she has recently had several nighttime accidents. Her teacher reports there have been 2-3 accidents per week during naptime.

**Student skills**:

\_\_Yes **x** No Are there skill deficits related to the behavior of concern?

If yes, identify or describe:

**x\_** Yes \_\_No Does the student display appropriate skills instead of the behavior of concern? If yes, identify or describe:

Kayla usually eats most of her breakfast in the morning at school. She will sit independently in the reading center and look at a book. Kayla follows most class routine instructions. She is able to independently draw and color while sitting at the table. **Problem analysis**: (based on the **Descriptive Summary**, respond to the following questions.

1. What about the behavior is concerning? Consider the behavioral dimensions of frequency (how often), intensity (to what degree), duration (how long), and latency (time between prompt and desired behavior).

Kayla’s whining escalates to crying 3-4 times during the school day with the episodes lasting for 3-5 minutes duration. Her teachers report she can be comforted by being held. Throughout the day, particularly during small and large group activities, Kayla isolates herself by playing beneath the table or in a corner away from her peers. She remains under the table for 20-30 minutes at a time, usually until an adult verbally prompts her to come out or the daily activity changes.

1. What is the expected or desired performance? What standard was utilized to make the comparison? (e.g., standard, benchmarks, peer comparison, school norms)

Children at this age are expected to be able to express needs, wants, and feelings in socially appropriate ways. They are able to initiate and sustain positive interactions with peers, as well as develop friendships. The kindergarteners are expected to sit quietly in small and large group times and respond to teacher prompts. Singing and interacting with materials during these group times is also expected. During center times, the children are expected to sit at the tables/centers or interact with each other on activities.

1. What is the student’s current level of performance?

Kayla can follow verbal requests made by teacher and is able to look at books, draw. She plays independently but does not interact with her peers in group activities. She rarely seeks to interact with her peers and has difficulty expressing her needs, wants, and feelings in socially appropriate ways.

1. What is the discrepancy between the student’s expected and current performance?

Kayla has independent play skills but very limited peer interaction skills. She has age-appropriate verbal skills but expresses her wants and feelings by crying.

**Environmental Conditions**

 **Antecedents**

What are the events immediately before the behavior(s) of concern, or events that trigger the behavior(s) of concern?

Arrivals, departures, and group times are most the most likely settings for whining/crying to occur. When an adult approaches Kayla or the activities are open-ended and unstructured, she cries to gain adult attention. When activities dictate gathering the children together, Kayla seeks ways to avoid interacting with her peers.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Setting (Event) | Immediate Antecedent (Trigger) | Problem Behavior | Maintaining Consequences | Function |
| School | Children gather in large or small groups | Plays in isolation (under the table, alone in a corner) | Other children avoid interacting with Kayla | Avoids interacting with other children |
| School  | Arrival and dismissal | Whining that escalates in volume into crying | Teacher holds or rocks Kayla on her lap | Adult attention and care |
| Bedtime | Sleep alone and wakes crying | Wakes up several times through the night  | Attention from caregiver  | Adult attention and care |

**Consequences**

What is the observed common response(s) of the teacher to the behavior(s) of concern?

The adult (teacher or assistant teacher) will hold and rock Kayla (approximately 20 minutes) so she doesn’t disrupt the other children. When Kayla is under the table, her teacher verbally encourages her to come out for a hug and the teacher guides her to an activity at the table.

What is the observed common response(s) of peers to the behavior(s) of concern?

Some peers cover their ears when Kayla’s crying escalates, but usually the children avoid or ignore her.

**Hypothesized function (purpose) of the behavior**. Based on a convergence of data reflected in the **Descriptive Summary** and **Problem Analysis**, what is the function of the behavior(s) of concern? Is the student attempting to gain something or avoid something?

Kayla has experienced the absence of her primary caregiver and seeks adult attention during awake and sleep times of the day. She plays in isolation to avoid direct interaction with the children in her class.

**Additional Notes.** Document any additional notes or reflections here.

Kayla’s primary caregiver, her grandmother, has recently had a stroke affecting her communication and mobility. It is uncertain at this time what the home care arrangements for Kayla will be.

**Next steps.**

An FBA is an on-going process which is directly tied to the development and implementation of a Behavior Intervention Plan (BIP). Please select the appropriate box below:

**X** This FBA led to the development of a BIP

\_\_ This FBA did not lead to the development of a BIP. Any needed alternative actions will be addressed in a separate plan (504 plan or intervention plan)

**DISCIPLINE-SPECIFIC PLAN OF CARE WORK SHEET**

Discipline \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is there further discipline specific information you need?

2. Summarize your discipline specific priorities: (Each discipline must share their

goals with the other persons at the table)

3. What are your thoughts on discharge location?

4. Can you predict any equipment needs this patient/client may need at discharge?

5. How will having Edna home, even if she is unable to provide care, affect her

granddaughter?

**INTERPROFESSIONAL PLAN OF CARE** (leave at table at end of event)

Table # \_\_\_\_\_\_\_\_\_\_\_\_ Scribe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Each discipline verbally share your discipline specific goals with other disciplines at the table. Space is provided below for the scribe to summarize the information for the table.

A. Nursing Goals

B. OT Goals

C. PT Goals

D. SLP Goals

E. Social Work Goals

F. Early Childhood Ed Goals

As a group, develop/determine/agree on two long term goals and corresponding short term goals that could be reinforced by the majority of other disciplines and provide some specific examples. Write this on back page.

**Interdisciplinary Long-term Goal 1**

**Interdisciplinary Short-term goals for LTG 1**

1.

2.

**Interdisciplinary Long-term Goal 2**

**Interdisciplinary Short-term goals for LTG 2**

1.

2.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your group’s recommendation on discharge location and why?

 2. Predict any equipment/resource needs this patient/client may need for the team’s discharge recommendation.

3. How will having Edna home or not home, even if she is unable to provide care, affect her granddaughter?

**IPE END-OF-EVENT SURVEY**

|  |
| --- |
| Please rate your experience according to the following scale. We appreciate your feedback. Thank you! |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | StronglyDisagree | Disagree | Neither Agree norDisagree | Agree | StronglyAgree |
| 1. Objectives were met. |  |  |  |  |  |
| 2. Case study presented was realistic. |  |  |  |  |  |
| 3. I was provided enough information prior to the workshop to fully participate. |  |  |  |  |  |
| 4. Adequate pertinent information was provided on the day of the workshop. |  |  |  |  |  |
| 5. This workshop was too basic for my knowledge base. |  |  |  |  |  |
| 6. This workshop was too advanced for my knowledge base. |  |  |  |  |  |
| 7. The size of the group was too large for good discussion to occur. |  |  |  |  |  |
| 8. The size of the group I was in was too small for good discussion to take place. |  |  |  |  |  |
| 9. An ideal group size would be: (circle one) | 5 | 6 | 7 | 8 | 9 |
| 10. All group members participated fully in the discussion. |  |  |  |  |  |
| 11. Accommodations were comfortable. |  |  |  |  |  |
| 12. Faculty assisting were knowledgeable |  |  |  |  |  |
| 13. This was a valuable experience for me. |  |  |  |  |  |
| 14. I would like to take a 1 credit interprofessional learning class. |  |  |  |  |  |
| 15. I would like to learn more about effective interprofessional strategies for working with older persons. |  |  |  |  |  |

Comments

|  |
| --- |
| If I could change one thing about this experience it would be: |
| The most valuable part of this experience was: |
| Other cases I would like to have presented: |
| Other: |