WELCOME TO

EMERGENCY MEDICINE

AT

THE ROYAL VICTORIA INFIRMARY

OCCUPATIONAL THERAPY DEPARTMENT

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Senior Occupational Therapist
February 2010

Review Date February 2011
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Introduction
Welcome to the Royal Victoria Infirmary (RVI) Occupational Therapy Department in Emergency Medicine. The purpose of this handbook is to allow you to gain an overview of the possible learning experiences and resources available to you on this placement. The RVI is a regional, specialist hospital providing care and specialist services to the local population and patients from other geographical regions within the northern area. The occupational therapy role within this clinical area is to promote a safe discharge of patients at the earliest appropriate time, either back to their home environment or to an alternative one where more rehabilitation and further assessment can take place before the patient returns home. Thereby, reducing the overall length of stay as a hospital inpatient and enhancing quality of patient care by initiating the achievement of optimal level of function at the beginning of their hospital stay.

Service Overview
The OT on the Emergency Assessment Unit (EAU) and ward 43 (Medical admissions) is part of a team called the Interface Team. The Interface Assessment Team was set up to address the bridge between community and Hospital care and has shared aims.

The aims are to:
- Direct patients through the most appropriate pathway of care.
- Prevent unnecessary hospital admission
- Avoid multi-presentation at A&E by providing community support.

The Interface Team also works closely with the Primary Care Response Team (PRCT), when appropriate they can assist with short term support at home.

Team Members.
The members work in inter-disciplinary way, which means that there is some flexibility between team members (e.g. OT & Physiotherapist will organise the restarting of care packages). This has led to a team which has excellent communication

The Team Members are:
- Seema Haridas – Physiotherapist – Based on Ward 43 RVI
- Helen Harvey – Social Worker (Based on Ward 43 am & with PRCT pm)
- Christine Armstrong – Occupational Therapist – Based on Ward 43 RVI.

The OT working as part of the Interface Team 4.5 days per week. Hours are 8.30 – 4.30, with the OT working one half day per week, this is usually a Friday, but this is flexible depending on staffing levels in the interface team.

The majority of the placement will be based on Emergency Assessment Unit or Ward 43 at the RVI. The occupational therapist is also available to assess patients in A&E, usually the Social worker visits A&E each day screens any patients and contacts the OT or Physiotherapist if needed.

Medical care of all the patients change daily with post-take ward rounds taking place at 5.00 pm on day of admission and then at 8.00 am next morning.
WARD PROFILES

Ward: 43 and Emergency Assessment Unit (EAU)

Ext: Main Reception  20646 / 20249
     Nurses Station  25715

Ward Manager: Angela Macnab
Ward Sisters: Gillian Smith and Alison Kennedy
Ward Clerk: Joanne and Madge

Ward Round: Takes place at 5.00 pm on day of admission and then 8.00 am the following day

Method of Referral: Referrals are made to OT on daily handover jointly with the Physiotherapist based on the ward, and also informally on ward during the day

Social Worker: Helen Harvey – Dect 21917

Physiotherapist: Seema Haridas – Dect 21529

Occupational Therapist: Christine Armstrong – Dect 29528

Method of Communication Within the Ward: Via verbal handover, medical notes and telephone.

Additional Information: Hot and cold water, tea and coffee are available within the ward kitchen area.
<table>
<thead>
<tr>
<th><strong>Useful Telephone Numbers</strong></th>
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<tbody>
<tr>
<td><strong>Newcastle Hospitals Switchboard</strong></td>
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<tr>
<td><strong>Occupational Therapy Department</strong></td>
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<tr>
<td>All ward numbers are prefixed with 28</td>
</tr>
<tr>
<td><strong>Primary Care Response Team</strong></td>
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<td><strong>Taxi</strong></td>
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<tr>
<td><strong>Rehabilitation Department</strong></td>
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<tr>
<td><strong>Andrea Hepburn, Rehabilitation Manager</strong></td>
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<td></td>
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<tr>
<td><strong>Odeth Richardson Head OT</strong></td>
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<tr>
<td><strong>RVI Dect Numbers</strong></td>
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<tr>
<td><strong>Cardiac Arrest</strong></td>
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<tr>
<td><strong>Fire</strong></td>
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<tr>
<td><strong>Security</strong></td>
</tr>
<tr>
<td><strong>Newcastle Loan Equipment</strong></td>
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<tr>
<td><strong>Spa (Single point of Access)</strong></td>
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</tbody>
</table>
Primary Conditions

There are many conditions with which people are admitted to hospital. Listed below are some examples of common conditions; however, this list is not conclusive.

- Back Injury
- Cardiac Dysfunction
- Cellulitis
- Chest Infection (CI)
- Urinary Tract Infection (UTI)
- Acute Confusion
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Pain
- Cognitive Impairment
- Collapse? Cause
- Diabetes
- Falls
- Fractures
- “Off Legs”
- Oncology
- Parkinson’s Disease
- Psychiatric Episode
- Renal Impairment
- Respiratory Disease
- TIAs
- Visual Disability

Patients are often admitted with more than one of the above problems; however, these often lead to a significant decrease in the patient’s functional ability resulting in the patient not coping at home.
Assessment

The OT works very closely with the Physiotherapist, and assessments are often joint functional assessments, as the pace is rapid a joint assessment has been designed and implemented over the past year, and documentation is also completed on a form designed for use by both the OT and Physiotherapist, and in most cases the appropriate professional completes the relevant section. This model of interdisciplinary working works well in this setting and ensures that in rapid assessment setting a thorough assessment is completed. This is filed directly in the Medical notes to ensure good communication. The OT and Physiotherapist complete rapid functional assessments their joint assessment completed covers

- Consent
- Cognition and communication
- Falls history
- Pain scale
- Motor sensory assessment
- Blood Pressure
- Functional assessment
  Lying    sitting    standing
  Transfers
  Balance
  Gait & walking aids used, Stairs
  Activities of daily living
  Social Situation & support (linking closely with the Social Worker)

Following assessment a plan is formed, assuming the patient is medically stable the patient may be discharged directly home, the Social Worker is often also involved. During the assessment consideration as to how the patient will cope in their environmental is clearly essential. This often means balancing the patient's independence, risk and safety, sometimes providing equipment to increase safety. On some occasions patients need a follow up visit the day after discharge to provide a home based assessment. On other occasions the OT may be involved in getting someone home for End of Life care, this can mean ensuring appropriate equipment is in place, liaising with the Palliative Care Team, District Nurses, Care Agencies, Social Worker, carers and relatives. Sometimes PCRT are able to provide carers for short periods either to bridge the gap between hospital discharge and a care package restarting or assisting with end of life care.

If the assessment highlights a patient is struggling to cope with functional activities such as mobility in the home, personal care or domestic tasks but are medically stable they may be recommended for Rehab, either at Walkergate Hospital, Medical Rehab at Newcastle General or in Community Rehab units. The interface Team has a key role in identifying patients who would benefit from Rehab before returning home, and liaise with appropriate medical staff to direct patients to the most appropriate rehab bed; they also have a key role in organising a transfer to a Rehab bed via established pathways.

Patients who are discharged home, particularly those who have been admitted following a fall, are often followed up at home by the OT and Physiotherapist, to ensure their safety and help prevent re admission.
Theoretical Models Guiding Practice

- Bio-medical Approach
- Compensatory Approach
- Rehabilitation Approach
- Problem Solving Approach
- Client centred Approach

It would be of benefit to you to read around the highlighted areas prior to starting with the Interface Team, but it is not expected that you know all about the area, as the learning will take place during the placement.

If you have any further questions you can Christine Armstrong on 0191 28 29528 and I will be happy to answer any questions.
### HIGH RISK REFERRALS

Referrals to occupational therapy must include a deficit within a functional area shaded below

<table>
<thead>
<tr>
<th>Level of function – recent deterioration</th>
<th>Level of function – gradual deterioration</th>
<th>Level of function – minor deterioration</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>mobility</strong> – major difficulties, supervision required to mobilise safely, at risk of falls.</td>
<td>- <strong>mobility</strong> - recent provision of frame.</td>
<td>- <strong>mobility</strong> - independent, problems identified with long distance mobility – requiring potential wheelchair assessment.</td>
</tr>
<tr>
<td>- <strong>cognitive function</strong> - prompts / supervision constantly required to maintain safety.</td>
<td>- <strong>transfer</strong> difficulties – struggling to complete.</td>
<td>- residual problem that is being addressed by local services.</td>
</tr>
<tr>
<td>- <strong>transfer</strong> - unable to transfer safely without assistance or equipment.</td>
<td>- <strong>self care</strong> - partial assistance.</td>
<td>- <strong>self caring</strong> on ward but identifies difficulties with bath or car transfer issues.</td>
</tr>
<tr>
<td>- <strong>self care</strong> - assistance needed with all aspects of personal self care.</td>
<td>- <strong>domestic tasks</strong> – previously completing main meal increased difficulty reported.</td>
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<td></td>
<td>- <strong>grip</strong> - specific problems reducing performance in ADL.</td>
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<td></td>
<td>- <strong>fatigue and stamina problems</strong> – reduced activity tolerance.</td>
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</tbody>
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**Social circumstances**

- lives in house with stairs.
- lives alone / carer working full time.
- Inadequate services in situ.

**Discharge plans**

- Patient condition palliative and no support services to follow.
- Limited life expectancy with discharge imminent.

**Patient must have deficits within the shaded area and one or more of the categories to be included within that criteria**

Service is from Monday to Friday 08:30 to 16:30. Occupational Therapist can be contacted on dect 29528

### MEDIUM RISK

### LOW RISK REFERRAL

\[ \Delta \text{This is an example of the framework used for prioritising referrals. It is aimed to identify those at high risk who require our most urgent attention, not necessarily those who would benefit most from Occupational Therapy. It is designed for use at point of referral based on information provided by the referrer at the time. Response times may be subject to variation depending on caseload and staffing levels. These response times do not relate to timescales for discharge; this will be dependent on needs and resources available to access. Completed 02/02/2010. Review Sept 11.} \]
Recommended Reading:

Crane K Sparks L (1999) An admission avoidance team: Its role in the Accident and Emergency Department Accident and Emergency Nursing (7) 91-95


Rapid intervention Specialist section of OT, Guidance notes for OT’s working in A&E.


Smith T Rees V ( 2004) An Audit of Referral to Occupational Therapy for Older Adults attending an Accident and Emergency Department BJOT (67) no 4 p 153-158

Sutton S (1998) An Acute Medical Admission Unit: is there a place for Occupational Therapy ? BJOT 61 (1) 2-6


www.cot.co.uk (RISSOT specialist section)