# SNAPSHOTS AND TRAMLINES

## A preliminary report of a research journey into one Occupational Therapy department's use of assessment

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**Do you continue to feel a responsibility for patients once they have been discharged from an episode of your care? For one occupational therapist, some feedback she received, which showed a patient had not coped as well as expected after discharge, led her to question her current practices. Could a different approach to the traditional occupational therapy assessment process during an inpatient stay result in more timely and accurate assessment, safer discharges and lower readmission rates? This questioning has resulted in a research study into occupational therapy assessment techniques. The researcher is Bel Youngson, Deputy Head Occupational Therapist at Westmorland General Hospital (WGH), who works on a Care of the Elderly Acute Medical ward. Here, she describes her journey through this process, offering some challenging and thought provoking insights.**

Occupational therapy (OT), like any of the other myriad professions practised across the University Hospitals of Morecambe Bay (UHMB) Health Trust, is *'a complex intervention'*.[1] In the hospital setting occupational therapists have a vital role to play in diagnosing and quantifying functional problems, making decisions about further rehabilitation and providing information to inform multidisciplinary discharge plans. They do this through structured observations of patients undertaking personal activities of daily living (PADL) such as dressing, toileting and bathing, and instrumental activities of daily living (IADL) such as household management and meal preparation.[2] Through interview with patients and their relatives therapists also examine the potential need for ongoing support on discharge for both the patient and carer. They *'ensure facilities at home are appropriate for the needs of the patient'*[3] through the use of home visits (with or without the patient) and engage patients in further rehabilitation (where appropriate) to enable participation in occupation, which is considered to be central to health.[4] This may include training patients in new techniques or routines, providing compensatory equipment, adapting the patient's environment, or teaching new strategies such as energy conservation to enable patients to manage the activities that have meaning to them.[2]

*'There can be no standardised interventions in occupational therapy because each client has a unique life history, social context and occupational needs.'*[1] However, assessments are often one-off snapshots of how the patient manages and may, in reality, only reflect how the patient did at that particular time on that particular day. With the push for shorter lengths of stay and a speedier discharge process, assessments are necessarily time limited, they may not accurately predict how a patient manages on discharge and the complexity of intervention can be reduced. There is much debate in the occupational therapy literature[2,5,6,7,8,9] about the elements of good assessment, such as professional credibility, validity, clinical utility, standardised versus non-standardised assessments, and it is in this context that research into the assessment process began in the OT department at WGH.

This report describes the research journey that is currently being undertaken into the custom and practice of assessing patients on the acute medical wards, a comparison with an alternative assessment – the Semi Structured Anchored Approach to Functional Assessment (SAAFA), as devised by Helen Wilby[10] – and the implications for future OT practice especially in view of the proposed changes to patient care in the Trust.[11]

My own journey towards trying to refocus what OT means in the hospital setting began with a sad story. Quite by chance I heard about the outcome of a patient's discharge that I had been involved with on one of the elderly acute wards which was not as predicted and which, with hindsight, may have been preventable. The patient had been admitted following a fall from her bed. She lived with her son in a house and was referred to OT to assess bed transfers. Our usual custom and practice is to interview the patient for details of home situation, level of functioning, occupational performance, social supports and then to assess current functional performance on the ward. Using a further series of one-off assessments by the multidisciplinary team – bed transfers, personal care assessment, stair assessment, mobility assessment – this patient 'ticked all the boxes' and was duly discharged. I heard some months later that the patient had gone home to sit in an armchair in her living room. She had never ventured upstairs, had never slept in her bed again but had spent all the time in her armchair and developed, as a result, widespread pressure sores. So could we have predicted and prevented this?

It caused me to re-examine our assessment processes to see what we had missed. Quite by chance an article on the SAAFA was published at the same time.[10] This assessment approach was *'designed to include a person-centred and time efficient occupational therapy functional screening assessment that would meet the needs of patients and be appropriate for use in an acute physical inpatient setting.'*[10] I contacted the author and the journey to develop a more thorough assessment process began.

The clincher for me was that the SAAFA had been developed in response to concerns that therapists had identified *'about inconsistencies in assessment findings and hence reliability of assessments.'*[10] The therapists developing the SAAFA reviewed practice, searched the literature to understand how evidence-based information and theory could be applied, developed their knowledge of the role of cognitive functioning in functional performance, and developed their reasoning skills and knowledge about various assessment methods (and how they could be combined).

Their framework included:[10]

- collection of background information from medical and nursing notes on current and previous medical and functioning history
- face-to-face interactive assessment with the patient at the bedside
- collection of information from relevant third parties (eg nearest relative or carer) about the patient's level of functioning currently and prior to admission
- synthesis of assessment findings using clinical reasoning and reflection to develop an occupational therapy diagnosis
- consideration of patient's functional situation in relation to the discharge environment to determine whether changes to the patient's level of function are needed and to what extent they can be achieved
- discussion of provisional findings and recommendations with patient and relevant third parties throughout the assessment process
- completion of written (typed) report to include the perspectives of the patient and relevant third parties with recommendations for the patient's future management

At first sight many of these areas appeared to overlap with current practice but it was the content and focus which showed a marked difference. Whereas our current assessment focuses mainly on a description of (some of) the performance components – the basic skills that are necessary to successfully engage in activity[12] – the SAAFA placed a large emphasis on cognitive functioning, particularly attention and executive functioning. The therapists also collected data from a variety of sources and perspectives and continued to collect data until saturation had been achieved, thereby adding to rigour and trustworthiness. Their reflection and reasoning was explicit in the report and informed recommendations were made.[10]

Advice on how we might move forward was sought from both St Martin's College (where Helen Wilby is a senior lecturer) and from the Trust's Research and Development (R&D) department who suggested that before we looked into the possibilities of adopting the SAAFA and all the learning that would entail we should first ensure that it was actually the assessment that we wanted. This could be achieved by doing a direct comparison of our custom and practice with the SAAFA. A research proposal was submitted, with the help of the various members of the OT department, R&D and St Martin's College, with Helen Wilby as chief investigator and myself as research therapist. The proposal was to compare the similarities and differences in process, content and outcome between the two assessment processes. This was to be undertaken by assessing the next four patients on the acute wards, who would normally be seen by the occupational therapists, with both the usual WGH process and by the SAAFA. Two therapists were chosen of a similar grade and level of experience, one to represent the WGH process and one who was experienced in the use of SAAFA from the site on which it was developed. Although four patients may seem a small sample, it was felt that this would give sufficient data to make an informed comparison, and was based on the time resources and amount of data generated through qualitative inquiry.[13,14] Approval was granted by the Cumbria and Lancashire A Ethics Committee and permission given by the R&D departments at UHMB and Lancashire Teaching Hospitals NHS Trust. The project was supported by the head occupational therapist at WGH and by the directorate manager. The Trust R&D dept also awarded a research grant which enabled us to offset some of the costs of the research and to employ some cover to enable me to spend some time away from the wards to analyse the research findings.

Four patients were duly assessed through the two assessment processes and the therapists concerned were interviewed as to their perspectives (this information is unfortunately not yet available due to transcription difficulties) and asked to complete questionnaires giving supplementary quantitative information about the numbers, types and timings of assessments.

The assessment and questionnaire data was analysed using thematic analyses[13,14] while a concurrent literature review was undertaken to look at the elements of best practice in

| | WGH | SAAFA |
|---|---|---|
| Information gathering | From medical/nursing notes and other staff prior to seeing patient | From medical/nursing notes and other staff prior to seeing patient – then clinically reasoned to decide on approach to take with patient |
| Initial interview | By bedside with patient, sometimes with relative | By bedside with patient and always with relative or significant other (by telephone or face to face) |
| Further assessments | Performance components through practical non-standardised tests; may include visit to patient's home (with or without patient) | Standardised and non-standardised tests by bedside according to needs of patient and reasoning of therapist |
| Documentation | Use of forms, handwritten notes, typed report in the case of home visits. Documentation is emergent | One typed report |
| Timescales | Total assessment times vary from 20 minutes to 3 hours over a number of days with time added for documentation | Contact with patient and relative is 45-60 minutes, usually in the same day. Complete assessment from start to completion of typed report is between 2-3 hours |

*Table 1 Processes*

| | WGH | SAAFA |
|---|---|---|
| Cognitive assessments | None | A number of standardised eg Mini mental state examination; fist-palm-edge; animal naming and non-standardised, eg pouring cordial |
| Environmental or home visits | In some cases | Not part of SAAFA but may form a recommendation |
| PADL and IADL | Usually in the form of a wash/dress assessment | Elements of personal care, eg doing up buttons, putting on slippers |
| Compensatory equipment | In some cases | Not part of SAAFA but may form a recommendation |
| Information gathering and documentation in general | Descriptive | Analytical |
| Pre-admission history | Limited | Detailed to include functional overview, home environment and support networks |
| Current functional capacity | Focused on performance components (mostly motor or neuromusculoskeletal) and activities of daily living | Includes cognitive functioning/affective presentation, postural attitude/selective movement, activities of daily living – includes performance areas, performance contexts and performance components |
| Consideration for future management/discharge planning | Limited and not always explicitly documented | Detailed |
| Recommendations | Only documented on home visit reports | Documented on every report |

*Table 2 Content*

assessment along with the College of Occupational Therapists' Professional Standards for Occupational Therapy Practice.[15]

Preliminary results of the analysis show some interesting and significant differences in approach. I write these with some reservation because the WGH assessment process seems to come out poorly in comparison. To this end it made the research worth doing because we needed the evidence to show that the SAAFA approach had merit, not just in theory but in practice. It does not imply that what we are doing is wrong, only that we can make it a lot better and, I believe, develop an OT service that is crucial and central to many of the developments that are currently ongoing in the Acute Services Review.[11]

The therapists who developed the SAAFA aimed to:[10]

- develop an in-depth understanding of patients' functional situations
- complete assessments that respond closely and are empathic to individual functional presentations
- use assessment findings as a basis for making recommendations for patients' future hospital and/or community management – this included making predictions, considering patients' need to make changes to functional capacity, exploring ability to participate in and benefit from rehabilitation
- present 'clinically convincing' assessment findings and recommendations

| | WGH | SAAFA |
|---|---|---|
| Focus | On present<br>Linear<br>Confined | Past, present and future<br>Integrative<br>Additional breadth and depth |
| Documentation | Emergent documentation describing observations of patient mostly in present | Typed report analysing observations in past, present and future |
| Recommendations | Some recommendations but no explicitly documented predictions | Recommendations for future management in every case with predictions of patient's likely outcome for future |
| Rehabilitation | No explicit reasoning of suitability for ongoing rehabilitation | Considered decision about suitability for further rehabilitation |
| Activity | Ongoing activity until point of discharge | Involvement with patient stops with report – may include referral for ongoing OT |

*Table 3 Outcome*

- consider the needs generated by and influence of the assessment context

This is borne out in the results. The main similarities and differences in process, content and outcome are summarised in tables 1, 2 and 3.

## CONCLUSION

In summary, one of the main differences between the SAAFA and the WGH assessment process is that the SAAFA adds value to this process – it looks at the past, present and future. The SAAFA is an 'equation' rather than a description; it puts together the facts and comes up with an informed prediction based on an analysis of all aspects of the patient's condition. We will never know whether the SAAFA would have made a difference to the patient who developed the pressure sores but it is possible that a more thorough examination of her executive functioning and a more detailed knowledge of her affective presentation and history *might* have alerted the multidisciplinary team to possible concerns over her future management and the need for ongoing support on discharge.

The challenge for the OT department now is how to move forward. There are obvious training implications and decisions need to be made about whether the SAAFA meets the needs of the service or whether another robust assessment framework is required. Further research is also needed to see whether the informed predictions of the SAAFA are accurate through follow up of the patients. My own feeling is that we can develop our existing assessment processes currently by being more robust in our information gathering. We can be more specific about determining what aspect of the patient needs to be assessed rather than going straight into functional snapshot assessments. We can be much more analytical rather than descriptive with our documentation, leading to better goal setting and recommendations. We can also develop our knowledge of executive functioning to make better predictions of patients' functioning on discharge and improve outcomes. With the changes planned in the Acute Services Review,[11] particularly with regard to a rehabilitation unit at WGH, therapists will be able to inform more realistically the decision as to whether or not patients will benefit from rehabilitation and what form it will take, thereby making the most of limited resources, potentially reducing lengths of stay and reducing readmissions. We play a major role in this process already but it could be a more efficient, more thorough and more beneficial role.

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