# Primary Physical Case: Charles Garrett

Charles Garrett

**Contents**

|  |  |  |  |
| --- | --- | --- | --- |
| **Document** | **Purpose** | **Adjustments needed** | **SF/CS notes** |
| Health history | Background for all players **except students** | Suburb & postcode |  |
| Briefing: **Simulated patient** | Notes for simulated patient for in-person interview & observation |  |  |
| Briefing: **Ward doctor** | Notes for doctor to be interviewed by phone | Contact number  Appointment times |  |
| Briefing:  **Physiotherapist** | Notes for specialist to be interviewed by phone | Contact number  Appointment times |  |
| Briefing:  **Mother** | Notes for mother to be interviewed by phone | Contact number  Appointment times |  |
| Activities & Props | Description of on- and off-campus activities and props required |  |  |
| Referral form | For distribution to students | Address & date |  |

**SF/CS Notes:**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

Link to COPD clinical guidelines: <http://copdx.org.au/copd-x-plan/x-manage-exacerbations/x2-copd-acute-exacerbation-plan/x22-optimise-treatment/>

**Charles Garrett: Health history**

Case Authors: [Carol Jewell, [cajewell@acu.edu.au](mailto:cajewell@acu.edu.au); (et al]

**Client Details**

|  |  |
| --- | --- |
| **Name** | Charles Garrett |
| **Date of Birth** | 31/8/[1946] (72) |
| **Address** | [nsert address] |
| **Health Insurance** | Nil |
| **Work Injury**  **Claim Number:** | N/A |

**Medical / Surgical History**

|  |  |
| --- | --- |
| **Presenting Condition /**  **Current Presentation** | **HPC:**  Admitted 3 days ago with exacerbation of Chronic Obstructive Pulmonary Disease (COPD).  **Current Symptoms:**   * Chest tightness. * Persistent phlegmy cough. * Shortness of breath at rest worsens with physical activity. * Wheezing. * Reduced exercise tolerance. * Fatigue. * Recent weight loss. |
| **Diagnosis** | **Diagnosis:**  Chronic COPD, Emphysema. |
| **Past Medical / Surgical History** | * Longstanding history of COPD and emphysema (15 years). * Significant worsening of COPD symptoms over the last two years. * 4 readmissions in the last 3 months for acute exacerbations of COPD. * Moderate left hearing loss due to noise exposure at work. * Was a heavy smoker (30 cigarettes a day), he quit when he was 50 years because of his persistent cough. * High cholesterol and high blood pressure (being managed conservatively). * Bronchitis developed in childhood, persisted in adulthood. * Tonsillectomy (age 13). |
| **Allergies** | * Nil of note |
| **Medications** | * Salbutamol, 2.5–5 mg via nebuliser every2-4 hours. * Oral prednisolone 40 mg daily. * Receiving supplementary O2 via Nasal prongs (oxygen) at 0.5–2.0 L/minute. * Tiotropium 18mg one inhalation per day. |
| **Tobacco** | Smoked up to 30 cigarettes a day for about 30 years. Quit 20 years ago because of persistent phlegmy cough. |
| **Alcohol** | 4-6 standard drinks a week. |
| **Illicit Drug Use** | Nil |

**Family**

|  |  |
| --- | --- |
| **Living Arrangements** | * Lives with his wife Elizabeth (aged 68) who is his next of kin. * Home set up:   + Lives in a single inner city terrace house with 4 steps to the front entrance and one step at the back (rails in situ).   + Level access internally.   + Level access shower with shower stool and rails in situ.   + Commode in situ by bed.   + Kitchen trolley and perching stool in situ.   + Had an OT home visit assessment about 4 months ago.   + He feels that everything is well set up for him at home now. |
| **Relationship Status** | Married. |
| **Children** | Cecilia Freeman (45) married with two children, works as a part time secretary, lives nearby.  Neil Garrett (41) married, works in London as a project manager in construction.  Angela Garret (34) Single, works full time as teacher. |
| **Mother** | Eileen Garrett, 93yrs old, has been in a nursing home for 5 years with dementia. Elizabeth visits her regularly and Charles goes when he is up to it. |
| **Father** | Died aged 82 with heart failure (also had Emphysema). |
| **Siblings** | * One older sister Gaylene (73) retired and living in regional Victoria. * One brother Jack (68), retired and living in Frankston. * Older brother Eric died of cancer at 65 years of age. |
| **Responsibilities** | * Prior to Charles’s recent exacerbation of COPD he was organising lunch for himself on the days his wife was out (1-2 days a week). * His wife manages most of the domestic tasks and does the shopping. * His wife drives and he is dependent on her for all community mobility. |

**Psycho-Social**

|  |  |
| --- | --- |
| **Affect** | * Charles is a likeable man. He does not complain much and is willing to do the best he can to get himself better. * His worries and concerns about his health keep him up at night. * He is worried he is becoming a burden on his wife. * His anxiety further exacerbates his breathlessness. |
| **Activity** | * Charles has been housebound for the last 4 months because of his condition. * He didn’t feel confident driving so stopped using his car about a year ago. * He misses going out to see his mother (even though she doesn’t always know who he is) and visiting his friends who live locally. * He has lost contact with quite a few friends in the last year. |
| **Relationships** | * Charles is a well- liked and sociable man.   His close friends do pop in to see him from time to time.   * He misses the regular social contact he used to have with his neighbours when he was more mobile outdoors. * His wife and daughters are very supportive and the grandchildren visit regularly. * His family and friends are very important to him. |

**Employment**

|  |  |
| --- | --- |
| Occupation | Retired Fitter and Welder |
| Employer | Retired |
| Work duties | N/A |

**Orders / Plan**

**Inpatient therapy program**

A collaborative multidisciplinary approach to self-management

* **Physiotherapy:**  Respiratory physiotherapy to clear sputum, for breathing retraining, to build exercise tolerance and for assessment for suitability for domiciliary oxygen.
* **Nursing**: - respiratory assessment, including spirometry and pulse oximetry; skills training with inhalation devices; education to promote better self-management (e.g. medi­cations and response to worsening of symptoms).
* **Occupational Therapy:** Education to promote better self-management; practice domestic activities of daily living assessment; provide education on task optimisation and energy conservation; provide advice on community mobility and the set-up of home and portable oxygen.
* **Dietitian:** Nutritional advice for recent weight loss and lack of appetite.

**Charles Garrett: Simulated Patient Briefing:**

**Summary:**

Charles was transferred to the Health Enhance physical rehabilitation ward yesterday following 3 days on the acute ward for treatment of an acute exacerbation of COPD. He has had 4 previous admissions to Health Enhance Health Service in the last 3 months. He was admitted to the physical rehabilitation ward for a short term period of rehabilitation. The aim of rehabilitation is to:

* Build his activity tolerance and functional ability.
* Provide education on the best management of his condition and develop his self-management skills.
* Assess his suitability for domiciliary and portable oxygen.
* Develop a comprehensive discharge plan.

**Context/Presenting condition:**

Charles is an inpatient in the physical rehabilitation ward. He was transferred from the acute ward to the physical rehabilitation ward last night and had a very unsettled night’s sleep. He is still very short of breath and is using nasal prongs for continuous oxygen. He is using his nebulizer on average every three hours.

**HPC:**

* Significant worsening of COPD symptoms over the last two years.
* 4 readmissions in the last 3 months for acute exacerbations of COPD.

**Diagnosis:**

* Chronic COPD, Emphysema.

**Medical history:**

* Longstanding history COPD and emphysema (15 years).
* Moderate left hearing loss due to noise exposure at work.
* He was a heavy smoker (30 cigarettes a day).
* Quit smoking when he was 50 years because of his persistent cough.
* High cholesterol and high blood pressure (being managed conservatively).
* Bronchitis developed in childhood, persisted in adulthood.

Tonsillectomy (age 13).

**Current Symptoms/Function:**

* Due to breathlessness cannot talk in long sentences. Can only say a few words at time, before having to stop and take a breath.
* Becomes short of breath on exertion after mobilising 5 metres.
* Tired and has frequent sleeps during the day.
* Not sleeping well at night because of breathing difficulties and worries.
* Has lost about 10 kilos in weight over the last few months (because of loss of appetite, exhaustion, and extra effort needed for all physical activities).
* Walking up to about 3 metres on the ward with a frame and close supervision.
* Current saturations (Sa O2) are between 89-92% with supplementary oxygen via nasal prongs.

**Presentation: Appearance, Clothing and Props.**

* Sitting out in a chair, dressed in casual attire with nasal prongs on for supplementary O2 therapy.
* Tired and very short of breath so he cannot talk in long sentences.
* Has a walking frame nearby to go to the toilet because of his unsteadiness.
* Has moderate hearing loss in his left ear.

(For more information about COPD and images of what people with COPD look like/ behave like, please review the following YouTube clip: <http://www.youtube.com/watch?v=KkQ2ii_UUF0>)

**Social history:**

* Retired Welder on aged care pension.
* Lives with Elizabeth (68 year old wife) who is fit and well.
* Has 3 adult children:
  + Cecilia Freeman (45) married with two children, works as a part time secretary, lives nearby.
  + Neil Garrett (41) married, works in London as a project manager in construction.
  + Angela Garret (34) Single, works full time as teacher.
* Mother (Eileen Garrett, 93yrs old) has been in a nursing home for 5 years with dementia. Elizabeth visits her regularly. It is disappointing that it is not possible to go now.
* Father died at the age of 82 with heart failure (also had Emphysema).
* Three 3 siblings:
  + Gaylene (73) , widowed and living in regional Victoria.
  + Jack (68) married, retired and living in Frankston.
  + Eric died of cancer at 65.
* Very fond of grandchildren (Michael 11, Sophie 8) who live locally and visit regularly. They are both very keen on their sport. It is disappointing that this is not possible to go with them to their sports events.

**Activities of daily living including leisure and work:**

**Self-care:**

Previous (prior to this admission):

* Sits for most tasks.
* Able to manage all basic self-care activities with effort and some set up by wife (e.g. putting clothes out).
* Uses a commode next to the bed at night for toileting.
* Effortful chair, toilet and shower through standing stepping transfers using rails with close supervision.
* Walking short distances indoors (5 metres) with 4 point frame before getting breathless (and lightheaded).

Current:

* Dressing, toileting and showering with set up and close supervision. Needs to pace self because of shortness of breath in room air.
* Walking short distances with a 4 wheel walking frame (with seat), portable oxygen and supervision.
* Independently standing, stepping transfers with rail to steady self.
* Needs to pace self because of very limited activity tolerance.
* Has lost his appetite and has lost a lot of weight, this is contributing to his low energy levels.

**Domestic chores:**

* Unable to participate in heavy domestic tasks including domestic chores.
* Used to make own lunch when Elizabeth (wife) went out, he doesn’t have the energy to do this now.
* Now dependent on Elizabeth (wife) for all meal preparation and all domestic tasks.
* Has been housebound over the last few months because of shortness of breath.

**Home:**

* Lives in an inner city terrace house with 4 steps at the front entrance and one step at the back (rails in situ on both sides).
* Home set up:
  + Level access internally.
  + Level access shower with shower stool and rails in situ.
  + Commode in situ by bed.
  + Kitchen trolley and perching stool in situ.
  + Had an OT home visit assessment about 4 months ago.
  + Feels that everything is well set up for him at home now.

**Leisure/interests**:

* Previously enjoyed social activities. Used to go out to the RSL with friends for a quick drink or visit the local neighbours (when fitter).
* Used to be a very keen gardener and used to enjoy going out to the grand children’s sports events.
* Have lost interest in a lot of things lately, just been watching TV and doing the crossword lately.
* Look forward to family and friends visiting.

**Transport:**

* Haven’t driven over a year because it was becoming too difficult (has difficulty getting in and out of the car and feels too breathless to drive safely, don’t want to be a risk on the road).
* Rarely go out unless for appointments because of restricted mobility and motivation.
* Used to enjoy driving and was a careful driver. Don’t want to drive any more.

**Previous Employment:**

* Retired Fitter and Welder.
* Retired aged 60 because of failing health.
* On the aged care pension.
* Hearing loss in the left ear was the result of work related noise exposure.
* Enjoyed work but exposure to the fumes was bad for the lungs.

**Behaviour, affect and mannerisms:**

* An open person who is sociable and friendly.
* Gives good eye contact and enjoys conversation.
* Tired and very short of breath (so cannot talk in long sentences).
* Worried about breathlessness (readjusts the nasal prongs frequently as they are a lifeline).
* Feeling a bit down and anxious because of the significant decline in health over the last few months.
* Positive about the idea of getting domiciliary oxygen at home.

**General Ideas:**

* Very proud of the family and wants to tell everyone how much they are appreciated.
* Very regretful about smoking and wants to make sure others don’t take it up.
* Knows the team are doing everything they can and is very appreciative of their care.
* Wondering about how other people with COPD get around in the community.
* Curious to know if it is possible to get portable oxygen for going out in the community.

**Concerns:**

* Anxious and worried about general health and prognosis.
* Anxious about shortness of breath and low energy levels.
* Frustrated by how the COPD is limiting everything.
* Not wanted to go out for the last few months.
* Worried about being a burden to Elizabeth and the family.
* Worried that Elizabeth is doing too much around the house and wonders what help is available for her.
* Want to be able to go out with Elizabeth (wife) to start visiting Mum in the Nursing Home again.
* Need a manual wheelchair and portable oxygen to go out with Elizabeth (wife) now.
* Don’t feel confident driving now but do want to be able to go out and socialise with neighbours again.
* Want to get an outdoor scooter but not sure if I have enough “puff” to go out.
* Miss being able to do things with the grandchildren.

**Expectations and goals:**

* Want tips for making the things I do easier (so I don’t get so puffed out).
* Would be so good if I could just get myself a sandwich or a cup of tea on my own when Elizabeth (wife) is out.
* Want to know how I could get a manual wheelchair; one that Elizabeth would be able to push, so I can go out with her in the car.
* Want to know if it is possible to attach an oxygen cylinder to a scooter or wheelchair. Could someone help me work how to get this?
* Want to know if this (rehabilitation) will get me fitter and stronger.
* Want to know what practical help that Elizabeth (wife) could get to ease her burden (e.g. practical help for household and domestic tasks).

**Charles Garrett: (Respiratory Physician) Briefing Notes**

**1. Title**

Name: Dr [TBA]

Position: Respiratory Physician

Health Enhance Hospital

Contact: [Contact number]

Appointments:

[Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview:**

You are the Respiratory Physician that referred Charles to the Rehabilitation Ward for a short period of multidisciplinary rehabilitation and comprehensive discharge planning. You provided specialist cover to the acute inpatient, rehabilitation and outpatient services at Health Enhance Hospital. You have been in this role for the past 4 years.

You are being interviewed today by second-year Occupational Therapy students who are developing a rehabilitation plan for one of your patients Charles Garrett. Charles is 72 years old and you have been involved in his care for many years. You admitted him a week ago onto the acute ward following an acute exacerbation of Chronic Obstructive Pulmonary Disease. You arranged his transfer to the inpatient rehabilitation ward at Health Enhance Hospital yesterday.

The nature of the interview today is to gain your perspective on how Charles is progressing and to find out about any concerns you have regarding discharge home and community integration.

**3. Learning objectives:**

* Establish rapport with the doctor during the interview.
* Conduct an effective telephone interview with the doctor.

**4. Student (clinician) task (including briefing for trainee):**

* Conduct a telephone interview with the purpose of obtaining an update Charles Garrett’s medical condition and any concerns he may have.

**5. Setting:**

* You are in your office on the acute ward. You have just finished the ward round and need to complete your discharge reports before you go to your outpatient clinic. You are busy so you don’t have much time to talk.

***Specifically for the simulated doctor***

**6. Affect/behaviours:**

* Very busy so you want the students to get straight to the point.
* Empathetic and caring towards Charles.
* Relatively brief and concise in your response (because you have limited time right now).
* Want to know what the Occupational Therapy students specifically need to know right now.
* If the conversation goes on too long you will say “….what do you need from me right now?...”

**7. Opening lines/questions/prompts:**

“This is [TBA], Respiratory Physician speaking, how can I assist you?”

**8. Doctor’s ideas, concerns and expectations of the interaction:**

**Ideas:**

* Charles’s progress has plateaued in the last few days.
* There may be potential for some improved function with good interprofessional team involvement but he is at the point that he does need domiciliary oxygen at home.
* The whole multidisciplinary team need to focus on maximising his health and wellbeing and provide education on self-management strategies.
* A nutritionally highly diet and regular meals would improve Charles’s energy levels.
* It would be good if Charles could manage to make snacks and light lunches when he is at home alone.
* He may benefit from task simplification and energy conservation techniques.
* It would be good for Charles’s to be able to go out in the community.
  + Charles’s health condition is known to Vic Roads and he has a conditional licence.
  + He is cautious and wouldn’t drive if he wasn’t feeling up to it.
  + Alternatives to driving need to be considered.
  + If Charles wants to return to driving, he will need a practical off road driving assessment with portable Oxygen (this will be included in the medical report to VicRoads).

**Concerns:**

* Maintaining his medical stability, maximising his oxygen uptake and function.
  + His oxygen saturation levels are still a bit too low for him to be weaned off supplementary oxygen.
  + He will most likely need domiciliary oxygen set up at home prior to discharge.
* To be able to discharge Charles at the end of next week
* Prioritising issues that will enable him to function at home and prevent readmission.
* How his wife and family are coping.
* Charles’s inability to go out without portable oxygen as a back-up”.
* Driving: It is possible for people with Charles condition to drive although he should consider alternatives to driving.

**Expectations:**

* Ensuring safe discharge and preventing readmission:
  + “…are there any issues you can think of that would prevent a safe discharge…?”.
* Occupational Therapy will focus on improving Charles functional ability and quality of life:
  + “…can you see if it is possible for him to put together a light meal for himself…?”.
  + “…can you go over task simplification and energy conservation techniques with him…?”.
  + “ …can you see what practical mobility options there are for Charles to go out…?”.
  + “…I am expecting a good multidisciplinary team review with comprehensive discharge planning…”.
  + “…can you contact Charles’s wife to see how she is managing with it all…?”.

**9. Patient’s history of the problem**

* Charles was transferred to the Health Enhance physical rehabilitation ward yesterday because he was not fit enough to go home after 3 days on the acute ward (for treatment of an acute exacerbation of COPD).
* Rehabilitation goals:
  + Improve his nutritional status.
  + Build his activity tolerance.
  + Improve his functional ability.
  + Assess his suitability for domiciliary oxygen.
  + Develop a comprehensive self-management plan.
  + Develop a comprehensive discharge plan.
* Very concerned that he is still very short of breath and using nasal prongs for supplementary oxygen.
* He is using his nebulizer on average every three hours.
* This is the 4th readmission in the last three months for his acute exacerbation of COPD.

**10. Patient’s past medical history**

* He has under your care for the last ten years.
  + He has felt breathless and exhausted over the last few months so all activities have been effortful.
  + Prior to admission to hospital he was just able to manage basic self-care activities. However, they took a lot of effort and his wife would usually help by setting things up for him to make it easier.
  + He has lost his appetite and he has lost quite a bit of weight (about 10kilo’s) over the last few months.
  + He rarely leaves the house now (except for medical appointments).
* He has a longstanding history COPD and emphysema (15 years) and a significant worsening of symptoms over the last two years.

**11. Patient’s family history**

* His family history in combination with his smoking and his occupation has contributed to COPD.
* His mother is in a nursing home with dementia and his father died some time ago.
* His father also had emphysaema (although he died of heart failure).

**12. Patient’s social information (work, lifestyle, habits)**

* He was a Fitter and Welder and that he retired at the age of 60 because of his declining health.
* He lives with his wife (Elizabeth) in an inner city terrace house.
* His wife is fit and active although she is likely to be finding it hard to manage.
* He has a very supportive family with two of his adult children living locally.
* He stopped driving about a year ago because of his shortness of breath on exertion.

**13. Considerations in playing this role including wardrobe, makeup and challenges:**

* Professional telephone voice: firm and approachable but busy.

**Charles Garrett: (Physiotherapist) Briefing Notes**

**1. Title**

Name: [TBA]

Position: TBA

Health Enhance Hospital

Contact: [Contact number]

Appointments:

[Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview**

You are one of the Physiotherapists at Health Enhance Hospital. You have been working in this position for 3 years.

You are being interviewed today by second-year Occupational Therapy students who are developing a rehabilitation/discharge plan for one of your patients Charles Garrett. Charles is a 72 year old admitted with an acute exacerbation of Chronic Obstructive Pulmonary Disease. The focus of your role is to provide a clear outline of Charles’s current physical ability, his Physiotherapy treatment goals and your clinical opinion of his physical rehabilitation potential. You know Charles well as you have treated him over the last few admissions.

The nature of the interview today is to gain your perspective as Charles’s Physiotherapist as to how Charles has been progressing and what concerns you have about his care. The Occupational Therapy students will also discuss the Occupational Therapy plan they have developed with Charles.

**3. Learning objectives**

* Establish rapport with the Physiotherapist.
* Conduct an effective telephone interview with the Physiotherapist.

**4. Student (clinician) task (including briefing for trainee)**

* Conduct a telephone interview with the purpose of understanding Charles’s physical condition and his potential for improvement. To discuss Charles’s goals and the Occupational Therapy treatment plan.

**5. Setting:**

You are in the Physiotherapy Gym and are at your desk. You have set up your patient to do some exercises on their own. The Occupational Therapy student has called you while you are completing clinical progress notes for this patient. You are due to see your next patient soon. You have a bit of time to talk now but you do need to complete these notes and sort out tomorrow’s schedule. You also need to go up to the ward to see patients before you go home. Your time to speak is therefore quite brief.

***Specifically for the simulated Physiotherapist:***

**6. Affect/behaviours:**

* Approachable and enthusiastic.
* A good team player who values collaborative working.
* Slightly distracted (as you are keeping an eye out for your patient in the gym).
* Feeling quite hurried as you have a lot to do.
* Have very good therapeutic rapport with Charles (as you have treated him on previous admissions).

**7. Opening lines/questions/prompts:**

“This is [TBA], Physiotherapist speaking, how can I assist you?”

**8. Physiotherapist’s ideas, concerns and expectations of the interaction:**

**Ideas:**

* Charles is being seen twice a day.
* He is coughing up phlegm although his chest is clear of infection.
* He finds all activities effortful because of his shortness of breath.
  + He needs to pace himself because he has very limited activity tolerance.
  + He has completed a walking test in room air (SaO2 87%) in room air.
  + He should qualify for domiciliary and portable oxygen.
  + Having domiciliary and portable oxygen will boost his confidence and his capacity. This will help him build his exercise tolerance.
* Charles is current able to:
  + Walk short distances (5 metres) with a walking frame, portable oxygen and close supervision.
  + Transfers independently through standing, stepping transfers with a rail.
  + He has lost a lot of weight and this is contributing to his low energy levels.
  + He is managing stairs with a rail and minimal assistance.
* Charles works hard in the gym although he needs a lot of encouragement because he is anxious about pushing himself too much (because of his shortness of breath on exertion).
* He has potential to improve a bit by building up activity tolerance.

**Concerns:**

* How low his ‘oxygen sats’ are in room air.
* He will need domiciliary oxygen and portable oxygen to get back to doing things at home.
* His susceptibility to chest infections. “…his chest is clear at the moment although he has a lot of phlegm…” “…I am keeping a close eye on his chest, so he doesn’t end up with an infection…”.
* Inefficient breathing. “…I will give him advice on breathing retraining and ways he can continue to build his exercise tolerance”.
* He has potential to do better functionally although his anxiety is limiting him.
  + He is deconditioned and needs to get up and do more things to build his fitness.
  + His energy levels will pick up with improved nutrition, oxygen therapy and “conditioning”.
  + He needs some functional goals to get back into the routine of doing things.
  + He will need to get used to doing activities with portable oxygen although he won’t need this all of the time.
* He is not going out because of his fear and anxiety about losing his breath and not being able to get help.

**Expectations:**

* He should manage short distances independently at home although I will provide a frame as a back-up as his legs get weak when he is tired.
* He should be managing stairs (with a rail) at home independently by discharge.
* He will need a wheelchair to go out with his wife.
* He will need domiciliary and portable Oxygen for discharge.
* He will be referred to the Community Physiotherapist to continue to monitor his chest, build his exercise tolerance and improve functional mobility at home.
* He will be able to do a lot more in the community if he has portable oxygen.
* He will need encouragement to start going out again.

**What you want to find out:**

* How did the Occupational Therapy initial assessment go?
* What are your treatment goals?
* Can you sort out a manual wheelchair for Charles?.

**9. Patient’s history of the problem:**

* Charles condition has got progressively worse over the last year.
* Leading up to this admission:
  + He feels breathless and exhausted most of the time so all activities have been effortful.
  + He was just able to manage basic self-care activities.
  + His wife would usually help by setting things up for him to make it easier.
  + He has lost a lot of weight recently.
* Charles physiotherapy treatment aims are:
  + Assess his suitability for domiciliary and portable oxygen (and make appropriate referrals for set up at home).
  + Build his activity tolerance.
  + Improve his functional mobility.
  + Develop a comprehensive discharge plan.

**10. Patient’s past medical history:**

* He has had 4 readmissions in the last 3 months for acute exacerbations of COPD.
* He was heavy smoker until he was 50 years old.
* He is moderately deaf in his left ear due to noise exposure at work.

**11. Patient’s family history:**

* His family history, smoking and occupation have contributed to his COPD.
* His mother is in a nursing home with dementia and his father died some time ago.
* His father also had emphysaema (although he died of heart failure).
* His wife Elizabeth (68) is relatively fit and well although it must be hard for her at the moment.

**12. Patient’s social information (work, lifestyle, habits):**

* Charles’s family are supportive and they have come to his therapy sessions before.
* Charles is sad that he hasn’t been able to visit his mother with dementia in her nursing home over the last year.
* His father died at the age of 82 with heart failure (also had Emphysema).
* He often talks of his grandchildren (Michael 11, Sophie 8) and used to watch them footy and netball (respectively).
* He used to be a very sociable and jovial person who used to go out a lot.

**13. Considerations in playing this role including wardrobe, makeup and challenges:**

* Professional telephone voice: friendly but clear and decisive.

**Charles Garrett: (Wife, Elizabeth Garrett) Briefing Notes**

**1. Title**

Name: [TBA]

Position: Wife

Contact: [Contact number]

Appointments:

[Insert date] [Insert time]

[Insert date] [Insert time]

**2. Summary/Overview:**

You are Charles’s wife and you live with Charles in your inner city terrace house. You have been helping Charles out more and more over the last year. Since Charles has been in hospital you have noticed how exhausted you have become juggling everything you need to do. You are very close to Charles and you are fretting for him as you have seen his condition (chronic obstructive pulmonary disease) deteriorate significantly over the last couple of years. You are worried about the impact this is having on him, particularly in relation to how anxious and isolated he has become. You are keen for him to come home although you get very distressed when he struggles with his breathing so much.

You are being interviewed today by second-year Occupational Therapy students who are developing a rehabilitation plan for Charles.

The nature of the interview today is to gain your perspective on how you are managing at home. This includes: what you need for yourself as well as what you need to support Charles at home; what your concerns are about his discharge home; and, what your concerns are about supporting his ongoing needs at home.

**3. Learning objectives:**

* Establish rapport with Charles’s wife during the interview.
* Conduct an effective telephone interview with Charles’s wife.

**4. Student (clinician) task (including briefing for trainee):**

* Conduct a telephone interview with the purpose of finding out more about Charles’s wife’s needs and concerns.
* Identify any barriers/considerations there are for his discharge home and determine what supports or ongoing occupational therapy intervention may be required after discharge.

**5. Setting:**

You are at home and are in the middle of a big spring clean. You haven’t been able to have a good spring clean for a while because it usually aggravates Charles’s breathing. You want to get as much of this work done as you can while Charles is in hospital so everything is in order for when he comes home. You have a bit of time to talk now although you are expecting your daughter to arrive soon to help you shift some furniture. Your time to speak is therefore quite brief.

The focus of your role is to provide a summary of how you and Charles have been managing. Particularly in relation to your concerns about Charles’s wellbeing and the restrictions he has at home with his everyday activities. This includes self care, domestic, social, recreational activities as well as his community mobility.

***Specifically for the simulated wife:***

**6. Affect/behaviours:**

* Flustered and a bit distracted (because the phone call caught you off guard).
* Exhausted and worn out.
* Fretting for Charles because he is away from home and he has been so well.
* Sad (and tearful) when you think about how limited Charles’s lifestyle (and your lifestyle) has become.
* Willing to do whatever it takes to help Charles.
* Exhausted and open to getting help if it is offered.
* Hopeful that the Occupational Therapy students can help Charles.

**7. Opening lines/questions/prompts:**

* “…how is Charles doing today…?”
* “…will it get much worse for him…? (Test students’ knowledge and skills on the condition)
* “…do you think I could get some help….”
* “…could someone find out if it is possible to get ..,..?”
* “…am I doing everything that I should be doing for Charles…? (seeking reassurance)

**8. Wife’s ideas, concerns and expectations of the interaction:**

**Ideas:**

* Things are set up for Charles at home to make things easier for him (e.g. getting his clothes out ready for him to put on etc.).
* I carrying out all of the household tasks, including shopping.
* I am the only one who drives now.
* I will do whatever is needed to support Charles and get him back to doing some of the things he used to enjoy.
* I visit Charles’s mother (Eileen Garrett, 93yrs old) every fortnight. She has dementia and has been living in a local nursing home for the last 5 years.
* I used to look after the grandchildren (Michael 11, Sophie 8) after school on the days Cecilia (daughter) works but gave that up because it was getting difficult to juggle everything.
* I miss seeing my grandchildren so regularly and would like to do more with them if I had the time.
* It would be good if Charles could get away for a holiday with the family next year.
* Most of my family live in New South Wales.

**Concerns:**

* It is upsetting to see Charles struggling for breath, I feel helpless when he is gasping for air.
* His breathing is getting worse and I am concerned about how much more it will worsen.
* He has lost a lot of weight and he has lost interest in food.
* His spirits will lift if he could do a bit more for himself at home (e.g. putting a snack together).
* He has been unhappy over the last few months. It’s not like him to be out of spirits.
* I would love to be able to take him out in the car with me. This is difficult because:
  + He struggles for breath when we are out and this makes him anxious so his breathing gets worse.
  + He can’t walk very far.
  + He has lost a lot of confidence going out.
* He hasn’t been able to see his mother for a while and that really bothers him.
* He even finds it difficult to get from the car to the medical centre for his check-up.
* I do what I can but it is getting hard to manage.
* I am worn out but I won’t give up on him.

**Expectations:**

* Oxygen to be set up at home and some portable oxygen for going out.
* For Charles to be able to go out for a bit.
  + “…are you the person to talk to about getting a manual wheelchair…?”.
  + “…can you take oxygen with you in the car…?”
  + “…is it possible to attach oxygen to a scooter and/or wheelchair…?”.
  + “…how much will they cost….”, “…can I get financial help…?”
* For Charles to be able to do a bit more for himself:
  + “…put together a sandwich and cup of tea…”, “..or something like that…”
  + “ …get into a car with the portable oxygen he is using at the hospital…”
* Advice that you give Charles in writing as we have so much to think at the moment.
* Some help around the house.
* To be able to take Charles on a family holiday to celebrate before it is too late “…have you heard of any holiday accommodation that would cater for someone with Charles needs….?”

**9. Patient’s history of the problem:**

* Worried about Charles, particularly in relation to:
* His weight loss and general weakness.
* His shortness of breath at home (which is distressing).
* The effort it takes for him to do basic things for himself.
* How difficult it is for him to go out now.
* His low mood and anxiety.
* He is still very short of breath on the ward (using nasal prongs for supplementary oxygen).
* He is using his nebulizer on average every three hours.

**10. Patient’s past medical history:**

* He has had problems with his breathing for well over 15 years.
* He used to have a terrible “smokers” cough which is why he gave up smoking at 50 years of age.
* He has been deaf in his left ear for some time now and he won’t wear a hearing aid.
* I am careful with the meals I cook because of Charles’s high cholesterol and high blood pressure.
* His mother used to always say that he had terrible bronchitis when he was a boy.

**11. Patient’s family history:**

* Live with Charles in our inner city one storey terrace house.
* Been married to Charles since I was 22 years old. We have three adult children, two who live locally.
  + Cecilia (45) married with two children, works as a part time secretary, lives nearby.
  + Neil Garrett (41) married, works in London as a project manager in construction.
  + Angela Garret (34) Single, works full time as teacher).
* Retired from my job as a library assistant two years after Charles retired.
* Did voluntary work at the RSL which I enjoyed (although I gave up when Charles gave up).
* **The house is well set up**:
  + Inner city terrace house with 4 steps at the front entrance and one step at the back (rails in situ on both sides). Level access internally. Level access shower with shower stool and rails in situ. Commode in situ by bed. Kitchen trolley and perching stool in situ. Had an OT home visit assessment about 4 months ago. Feels that everything is well set up for him at home now.
* **Charles interest**:
  + Previously enjoyed social activities. Used to go out to the RSL with friends for a quick drink or visit the local neighbours (when fitter).
  + Used to be a very keen gardener and used to enjoy going out to the grand children’s sports events.
  + Have lost interest in a lot of things lately, just been watching TV and doing the crossword lately.
  + Look forward to family and friends visiting.

**Transport:**

* Haven’t driven over a year because it was becoming too difficult (has difficulty getting in and out of the car and feels too breathless to drive safely, don’t want to be a risk on the road).
* Rarely go out unless for appointments because of restricted mobility and motivation.
* Used to enjoy driving and was a careful driver. Don’t want to drive any more.

**Previous Employment:**

* Retired Fitter and Welder.
* Retired aged 60 because of failing health.
* On the aged care pension.
* Hearing loss in the left ear was the result of work related noise exposure.
* Enjoyed work but exposure to the fumes was bad for the lungs.

**12. Patient’s social information (work, lifestyle, habits):**

* Charles has been a Fitter and Welder all of his working life. He was a good provider for the family.
* He retired at the age of 60 because of his declining health. He is on the pension.
* I retired from my job as a library assistant two years after Charles retired.
* We both volunteered at the RSL which we both enjoyed (we gave up a few years back).
* Charles stopped driving about a year ago because of his shortness of breath on exertion.
  + He used to enjoy going out and socializing with people.
  + He had a lot of friends that lived locally that he used to visit.
  + He also used to go out and watch his grandchildren play sport although he can’t do this now.

**13. Considerations in playing this role including wardrobe, makeup and challenges:** (N/A)

**Charles Garrett: OT Activities & Props**

**Sub groups**

|  |  |  |
| --- | --- | --- |
|  | **Observed tasks in an OT department/university facility**  **With patient** | **Activities in a shopping centre**  **Without patient**  **(Note: students can complete multiple activities if time permits)** |
| **Group A** | * Observe functional mobility with frame (and portable 02) and transfers (bed and toilet) | * Consider barriers/considerations for scooter mobility to local RSL (or car with disabled access) |
| **Group B** | * Observe transfers from wheelchair to car with portable oxygen and/or frame to car with portable oxygen | * Consider barriers/considerations for scooter mobility at local strip of shops (capacity to go into local café etc.). |
| **Group C** | * Observe light snack preparation (heating up soup, making toast and cup of tea | * Consider barriers/considerations for scooter mobility and access from (home around local neighbourhood considering road crossings safety (etc.) |

**Group A**

|  |  |
| --- | --- |
| **On campus requirements**  Ward bedroom   * Hospital bed * Over bed table * Bedside cupboard * Adjustable height bedside chair with arms * 4 wheel walking frame (with seat) * Portable 02   Ward bathroom   * Toilet with rails * 4 wheel walking frame (with seat) * Portable 02 | **Off campus requirements**  RSL (or other relevant venue)   * Disabled parking space * Details of scooter (e.g. turning space etc.) |

**Group B**

|  |  |
| --- | --- |
| **On campus requirements**   * Car park and car * Manual wheelchair * 4 wheel walking frame (with seat) * Portable 02 | **Off campus requirements**   * Shopping strip (e.g. Errol Street North Melbourne) |

**Group C**

|  |  |
| --- | --- |
| **On campus requirements**  OT Department kitchen   * Microwave * Kettle, tea, coffee , milk, sugar * Fridge with pre made soup, butter, bread * Kitchen table, adjustable height chair with arms * 4 wheel walking frame (with seat) * Portable 02 | **Off campus requirements**   * Home address (in front of inner city terrace house e.g. Hawke Street North Melbourne). * Details of scooter (e.g. turning space etc.). |

|  |  |
| --- | --- |
| **Occupational Therapy**42_as_Interleaved_2_of_5_barcode[1] **Referral Form** | **Surname:** GARRETT  **Given Name:** CHARLES  **DOB:** 31/8/[1946  **Sex:** MALE  **Address:** [TBA]  Suburb, Postcode  **Case Number:** [TBA] |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referred from** | Grace Stephenson | | **Referred to** | | Occupational Therapy |
| **Interpreter Required:** Yes ☐ No ☒ **Language:**  English | | | | | |
| **Diagnosis:** Acute exacerbation of chronic obstructive pulmonary disease | | | | | |
| **Social Situation**  **Occupational Therapy Referral Form**  Lives in an inner city terrace house with his relatively fit and active wife (68YRS). Prior to his recent exacerbation of COPD he was organising lunch for himself on the days his wife was out (1-2 days a week). His wife manages most of the domestic tasks, she also does the shopping. His wife drives and he is dependent on her for all community mobility. | | | | | |
| **Home Assessment Completed:** Yes ☒ No ☐ Required ☐ | | | | | |
| **Equipment Provided:** Rails installed bilaterally at front and back entrance; Shower: level access, with shower seat and rails). Toilet: Rails and raised toilet seat in situ . | | | | | |
| **Current Occupational Performance** | | | | | |
| **PADLS:**   * Dressing, toileting and showering with set up and effort because of shortness of breath on exertion. * Walking short distances with a walking frame, portable oxygen and supervision. * Independently standing, stepping transfers with rail to steady self. * Needs to pace self because of very limited activity tolerance. * Has lost a lot of weight this is contributing to his low energy levels. | | | | | |
| **DADLS:**   * Used to make his own lunch when his wife went out but he doesn’t have the energy to do this now. * Now dependent on his wife for all meal preparation and all domestic tasks. * Has been housebound over the last few months because of his breathlessness. | | | | | |
| **Mobility/Transfers (Including Aid):** Walking short distances with a walking frame, portable oxygen and supervision. Dependent for community mobility. | | | | | |
| **Independent transfers** Transferring independently through standing, stepping transfers with a rail. Managing stairs with a rail and minimal assistance. | | | | | |
| **Referral Goals:**  1. Commence referral for domiciliary and portable oxygen.  2. Assess DADL and provide advice on task simplification and energy conservation. 3. Review community mobility options. | | | | | |
| **Therapist:**  Grace Stephenson | | **Date:**  **:** [TBA] | | **Consent Obtained:** Yes ☒ No ☐ | |