



ICU Co-Treatments

Instructions

1. View videos in small groups and go over the questions related to each video
2. Work independently to answer questions
3. Return to your group and discuss case
4. Individually write SOAPE note for case

Watch

Watch all assigned videos:

- ICU, Co-treatment, Part 1 - Preparing equipment & monitors in the ICU environment
- ICU, Co-treatment, Part 2 - LE dressing in preparation for treatment
- ICU, Co-treatment, Part 3 - Bed mobility
- ICU, Co-treatment, Part 4 - Sitting balance at the edge of bed
- ICU, Co-treatment, Part 5 - Bedside ADLs
- ICU, Co-treatment, Part 6 - 2-person transfer from bed to chair
- ICU, Co-treatment, Part 7 - Repositioning in the chair
- ICU, Co-treatment, Part 8 - Oral hygiene and suctioning
- ICU, Co-treatment, Part 9 - 2-person transfer from chair to bed
- ICU, Co-treatment, Part 10 - Returning all monitors and equipment to original positions

ICU Co-Treatments

Questions

Related Video: ICU, Co-treatment, Part 1 (Run Time: 3:57)

1. What therapies were involved in the co-treatment session today?

PT & OT

2. What did you learn and see (can include ALL of the videos) on how the two therapists communicated with one another?

PT & OT communicated and developed collegial plan for session including goals that included mobility training as well as ADL training

3. What did you see on-camera that included preparing the patient, the equipment, and the room to enhance patient safety during the co-treatment session?

Checked BP, HR, SaO2
Placed Foley cath appropriate for tx and transfer
Detached B LE sequentials
Placed all lines that remained on one IV pole
Worked on untangling lines and leads
Placed SaO2 monitor, call bell under pillow for easy access during tx
Placed suction within reach
Placed on nonskid hospital socks
Made sure patient was modest
Placed chair where you would want to start session and to transfer patient

4. What MUST have happened, but was not captured on camera to prepare for the co-treatment session?

Chart review to ascertain most current patient status
Discussion and review of plan with nurse and nurse's take on patient's current status

Related Video: ICU, Co-treatment, Part 2 (Run Time: 1:27)

1. How much assistance was required to place the shorts on the patient?

a. CARE Code 1: Dependent (helper provides all the effort; two or more helpers)

b. FIM Level 1: Total assistance (patient provides less than 25% effort or two or more helpers)

2. How well did Tom lift his hips to allow placement of shorts (how high)

Tom really tried and was able to lift against gravity to 45% of available ROM. If you were looking at assist level for this specific task you would code:

a. CARE: Code 2: substantial/maximal assistance (helper provides more than half the effort)

b. FIM: Level 2-Maximal assistance (patient expends 25% to 49% of effort)

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Related Video: ICU, Co-treatment, Part 3 (Run Time: 1:38)

1. What portion of the roll to the L did Tom do?

Reached to L rail with R UE.

2. How much assistance did he need to roll to the left?

a. CARE

Code 2 – Substantial/maximal assistance (helper provides more than half the effort)

b. FIM

Level 2: maximal assistance (patient expends 25%-49% of effort)

3. What portion of the roll to the R did Tom do?

Unable to reach with L UE and needed total assistance to incorporate L UE to reach. Once closer to bedrail on R Tom was able to use R UE to assist with motion or movement.

4. How much assistance did he need to roll to the right?

a. CARE

Code 2 – Substantial/Maximal (helper provides more than 50% of effort)

b. FIM

Level 1 – Total assistance (patient expends less than 25% of effort)

5. What portion of the transition from right side lying to sitting at the edge of the bed did Tom perform?

PT and OT encouraged pushing with R UE.

6. How much assistance did Tom need to transition from right side lying to sitting at the edge of the bed?

a. CARE

Code 1 – Dependent (Helper provides all effort; required two helpers)

b. FIM

Level 1 – Total assistance (patient expends less than 25% of effort; two helpers)

7. What did the PT and OT do to make the transition from side lying to sitting at the edge of the bed easier for Tom to perform?

Positioned head of bed in elevated position to ease transition.

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Related Video: ICU, Co-treatment, Part 4 (Run Time 4:51)

1. What did the PT and OT do to make sitting on the edge of the bed and working on ADL and balance tasks easier to perform?

Flattened bed

Scot forward use chuck to allow B LE in contact with floor

Checked lines and leads length and position

PT/OT collaborated with plan and sequence

PT set up to provide external support

2. How much assistance did Tom need to scoot forward?

a. CARE

Code 2 – Substantial/Maximal (helper provides more than 50% of effort)

b. FIM

Level 1 – Patient expends less than 25% of effort

3. What improvements in Tom's abilities from the previous treatment day did the PT comment on?

Improvement in ability to follow simple commands

Improved ability to visually scan

4. How did the PT set herself up to provide improved external support for Tom?

Sat behind patient and wrapped legs around patient and had patient lean against PT

5. What happened when the IV was beeping? How was the issue resolved?

Beeping indicated need to plug back equipment – beeping did not resolve

Correctly called nurse to f/u with equipment

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Related Video: ICU, Co-treatment, Part 5 (Run Time: 5:13)

1. What were the primary tasks that the PT and OT worked on with Tom during this vignette?

Helping re-integrate visual scanning with having patient “find” wash cloth on L

2. How did the PT alter her support for Tom and what was the impact of this alteration of support?

Patient demonstrated improved postural awareness and sitting balance ability and PT was able to slowly wean support away from patient, but monitored patient closely.

3. Did they ensure that the L UE was in weight bearing and if so how did they accomplish this?

L UE positioned in weight bearing (external rotation to assist elbow extension ability)

4. What did they ask related to Tom’s glasses and why did they do this task or activity?

Repeated visual scanning with patient “finding” glasses and assisted with placing back on

5. How did they work on Tom’s sitting balance and posture in this vignette?

Displacement right with recovery
Displacement forward with recovery
Displacement left with recovery

6. How did they visual scanning to the L?

PT manually guided turning head to L
OT provided activities to encouraged L visual scanning (lotion bottle and lip balm)

7. Was this intervention successful and if so how so?

Yes. Patient improved from initiating visual scan from first rep (wash cloth) to final rep (lip balm) and was able initiate with manual guidance by PT)

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Related Video: ICU, Co-treatment, Part 6 (Run Time: 4:45)

1. How did the PT and OT encourage participation during the transfer to the chair?

Encourage patient to hold onto R armrest and assist with scooting forward

2. In what direction did the PT direct the patient to lean and why did she make this suggestion?

Lean to R whereas leaning toward paretic side.

3. How did the PT and OT change their places they were spotting the patient and how did they ensure the patient was safe during this transition?

One therapist moved at a time while other therapist provided support to patient. PT/OT were in constant communication with each other.

4. How did the PT and OT ensure the patient knew where the chair was that he was going to transfer into?

Asked patient to scan to R and find chair or target area for transfer.

5. Why did the PT ask the patient to remove his glasses during the transfer?

Ensured ability patient was able to follow simple commands.
Glasses got in the way during tx session previous day and (almost) fell off.

6. What assist was needed for the transfer chair to bed?

a. CARE Code 2: Substantial/Maximal assist (helper provides more than half of the effort).

b. FIM Level 2: Maximal assistance (patient expends 25% to 49% of effort).

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7. Perform a Movement Analysis including joint angles during the transfer sequence

	Initial Condition Posture assessment of the initial starting position prior to the initiation of the activity	Preparation Postural set up and adjustment prior to the task. Remember this is mostly an internal process that may not be evident.	Initiation The first thing that moves as a part of the actual task	Execution Progression of the movement with description of changes in alignment, BOS with a description of movement.	Termination The final position at the end of the task.
Head and Neck	Head remains in forward bent position 60% while he is looking down, extends a little right before the transfer to about 35%	No changes in trunk or extremity position indicating that he is ready to move	Head and neck stay in the same position, flexion with neutral rotation and sidebend	Head and neck stay in relatively same position	Reclining back in chair. Head slight rotation to the right, neutral side bend. Neck is in flexion relative to trunk which is reclined backwards
Upper Trunk	Flexion apex at TL junction Appears neutral for sidebend and rotation Upper trunk appears to be centered over lower trunk		Rocking motion provided by facilitation of the PT		Upper trunk is reclined back against chair in extension, neutral rotation and neutral side bend
Lower Trunk	Lumbar spine lower segments extended , mid to upper segments flexed as approach apex of flexion at TL junction		Slight increase in forward flexion of the trunk for lift off of the bed, then trunk starts to extend	Trunk moves toward extension as the patient rises. Does not achieve full upright position, stays semi flexed	Lower trunk is reclined back against chair in extension, neutral rotation and neutral side bend
Pelvis	Pelvis posterior tilt With hip extension 110°		Delayed movement toward anterior tilt	Continued movement toward anterior tilt, does not achieve full anterior tilt position	Neutral position against chair Hips in extension 130° due to patient reclining back against chair

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<p>Upper Extremities</p>	<p>Right shoulder flexion 10° relative to flexed trunk. 20° abduction neutral rotation, 90° elbow flexion, wrist neutral with finger flexion to grab rail Left arm neutral flexion, extension and IR/ER</p>		<p>Elbow extension on the right</p>	<p>Elbow continues to move into extension until reaches Almost full extension, lacking 25° full extension</p>	<p>Right shoulder same position as initial condition resting on arm rest. Elbow flexion increases as patient waves to camera</p>
<p>Lower Extremities</p>			<p>Knee extension with delayed and decreased hip extension</p>	<p>*Note: As the movement progresses and the patient shuffles and turns with his back to the chair, COM remains posterior to the point where the patient would fall backwards if the PT were not holding onto him and he laterally leans over to the right, again is the PT were not holding him, he would fall to the right as well. PT must readjust right hand position and move him back into the chair. Knees move toward extension, hips begin to extend as patient moves towards a standing position, hips do not reach full extended position, remains in 30° of flexion bilaterally</p>	<p>Hips reclined back past 90° to 130. Neutral for abd/add and IR/ER Knees flexed to 90° bilaterally</p>

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8. Fill out the table below to predict impairments you saw during your movement analysis for bed mobility. What objectives measures would you complete to assess the impairments? What would you predict to be the outcome of the impairment testing? How would you intervene to reduce or address the impairment (within session)?

Predicted Impairment (based on movement analysis)	Objective Measure	Outcome	Within Session Intervention
Impaired cognition	Assess Orientation x 4 Assess safety, judgment, ST & LT memory.	Oriented to person and place. Not time or situation. Severe impaired short term, long term appears intact. Responds to 12 step commands with yes/no questions.	Continue to orient patient, encourage recollection of memories short and long term. Problem solving, education on safety. Start with simple vs complex questions and allow ample time for processing and response times.
Impaired balance	-Static sit balance -Dynamic sit balance -Functional Reach in Sitting	-Poor -Unable -0 left arm, 4inch right arm	NDT, Rood, PNF sitting postural control
Visual field loss	oculomotor exam	Impaired convergence Impaired tracking past midline to the left. Diplopia	Smooth pursuit Gaze stabilization Vergence "pencil pushups"
Impaired midline orientation	Oculomotor exam Visual Vertical "bucket test" Assess ability to identify when objects are midline.	Unable to align self to midline, unable to maintain midline orientation without Mod A.	Visual targets, facilitate midline with NDT or ROOD, strengthen with PNF rhythmic stab in midline
Left hemiparesis	Stream Fugl-Meyer		Constraint induced theory, forced use of L side
LE UE and LE Abnormal tone	Tone assessment Spasticity assessment	Hypotonic L UE/LE L 2 beat clonus.	Weight bearing, weight shift on to involved side. approximation, use of NDT, PNF, ROOD

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L neglect	Clock Test	Impaired clock test	Facilitate left attention to objects, family and encourage activity midline and left, weight shifting to left
-Dysphagia -Dysphasia	-Observe for saliva management, and head control. -Patient is non-verbal during session		-Refer to ST for speech and swallow eval. -encourage use of words

Related Video: ICU, Co-treatment, Part 7 (Run Time: 2:12)

1. How did the PT and OT encourage patient participation and what did the patient do to scoot back in the chair?

Patient was encouraged to reach R UE and push with B LE and bend forward

2. How did the PT and OT assist the patient in scooting back in the chair?

PT and OT used chuck to scoot patient back with PT and OT on each side

3. What did the PT and OT do to specifically position the patient in the chair?

Placed two pillows under L UE
Placed vertical pillow on L side of trunk

4. Why did they choose to do these steps and was it successful? If so what did you see?

Incorporate L UE as component of sitting base of support
Two pillows allowed hand to be elevated to address and reduce edema distal L UE/hand
Placement of vertical pillow on L side of trunk enhances support and stability in sitting position, prevent excessive leaning to L, provide support under L scapula

Related Video: ICU, Co-treatment, Part 8 (Run Time: 1:52)

1. Why was the OT on the left side of the patient?

Increase visual scanning to L; decrease L neglect; provide sensory cues L to increase awareness

2. What happened when the patient yawned and what is it called?

Associated reaction

3. Using the Fugl-Meyer assessment tool for the UE how would you score the patient with this observation?

On the Brunnstrom Scale - Stage 2: Basic limb synergy patterns begin to appear; associated reactions; Spasticity begins

4. What is the likelihood that you might begin to see spasticity in his L UE?

According to the Brunnstrom scale, this is highly likely.

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Related Video: ICU, Co-treatment, Part 9 (Run Time: 4:17)

1. What did the PT and OT do prior to transferring the patient back to bed (think of the environment and equipment)?

Reposition cath
Check lines and leads
Position IV cart optimally
Removed pillows
Positioned chair optimally for transfer

2. What did the PT and OT request the patient to do to assist with the transfer back to bed?

Requested patient hold onto chair armrest on R

3. What did the PT use to scoot the patient forward in the chair?

Used chuck to scoot patient forward in chair

4. How much assistance was required during the transfer?

a. CARE

Code 1 (helper provides all of the effort)

b. FIM

Level 1 (patient expends less than 25% of effort)

5. Why is it important to position the feet prior to transferring the patient and what would be the optimal position?

Improve balance during transfer
Increase patient's ability to assist with B LE during transfer
Would want feet pelvic width apart or 6 inches

6. The therapist cued the patient to reposition their L UE. What is this clinical evidence of with this particular patient?

L UE not component of BOS and hanging down; could be injured in transition back to bed
This would suggest neglect L and reduced sensory input
Hemi neglect L UE

7. According to what you observed when viewing the video clips what vessel or vessels are likely involved in his stroke?

Diffuse hemorrhagic stroke R MCA/R ACA (upper more significantly involved than lower extremity)

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Related Video: ICU, Co-treatment, Part 10 (Run Time: 7:39)

1. What did the PT and OT do to finalize the session?

Seen on camera:

Placed on two blankets with patient c/o feeling cold

Placed back on BP cuff

Repositioned cath

Placed on B LE squeezers

Removed socks

Placed on L LE resting night splint

Repositioned all bed rails back up

Positioned bed at lowest position

2. If the IV begins to beep and the therapists are unable to resolve addressing the alarm, what should the PT and OT do?

If beeping persists call nurse

3. Why did the patient utilize the L LE resting night splint?

Decrease risk of developing pressure sore L heel

Decrease risk of patient developing plantar flexion contraction L LE

Optimize position of L hip

4. What movement did you note in Tom's L LE? How would you describe this movement (using Fugl Meyer assessment for LE)?

Associated reaction. On the Brunnstrom Scale - Stage 2: Basic limb synergy patterns begin to appear; associated reactions; Spasticity begins

5. Describe how the therapists optimized the patient's supine position. Give examples of his bed positioning program and the equipment the therapists utilized.

L UE positioned on pillow to reduce L UE edema distal hand

6. What are the PROM precautions for a patient with a flaccid upper extremity?

Flaccid L UE would not bring shoulder abd or flexion beyond 90 degrees without mobilizing scapula and ensure appropriate glenohumeral rhythm and reduce risk of impingement injury and development of L should pain

7. Why did the therapists position the head of the bed at 30 degrees?

Reduce risk of aspiration, aspiration pneumonia

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