T-LEVELS | Institute for Apprenticeships & Technical Education

T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

Supporting the Therapy Teams

Assignment 1 - Case study stimulus materials

Assignment brief insert

v1.1 Additional sample material
21 November 2023
603/7066/X

NCFE CACHE

T Level Technical Qualification in Health
Occupational specialism assessment (OSA)

Supporting the Therapy Teams

Assignment brief insert

Assignment 1

Case study stimulus materials

Contents

Item A: generic falls risk assessment

First name:	Jenny	**Surname:**	Ferguson
NHS number:	123 456 7890	**Date of birth:**	19/02/1940
Medical history:	Alzheimer's disease (diagnosis 7 years ago), osteoporosis, recurrent urinary tract infections – needs prompting to drink.		

History of falls		**If no, do not continue**
Have you fallen in the last year?	Yes No	How many? 2
Have you fallen 2 or more times in the last year?	Yes No	
Recent increase in falls?	Yes No	

Give details of most recent falls (include any injuries)	Fall on way to the toilet overnight – cut and bruises to left arm. Struggling to use walking aid due to injured arm, small shuffling steps and lowered vision noted consistent with Alzheimer's. Fall getting out of bed – bruised buttock, long lie as patient not wearing falls detector. Care home has asked about bed exit sensors – refer to telecare? Falls detector review/bed exit sensors and OT for equipment review. Note – patient often wears other resident's shoes and has long trailing handle on handbag which she carries everywhere.
Loss of consciousness	If yes to any, complete baseline observations and refer to GP.
Have you blacked out or fainted?	Yes No
Have you had any unexplained falls?	Yes No
Do you have dizziness or postural hypotension?	Yes No

Osteoporosis risk	
Have you broken any bones after a minor fall or bump?	Yes No Broken left wrist last year, wore wrong glasses/tripped.
Do you have a diagnosis of osteoporosis?	Yes No If no refer to GP for screen.
Medication	If yes to any, refer to GP for review
Are you taking more than 4 medications per day?	Yes No
Do any of your medications make you dizzy/drowsy?	Yes No
Do you have any difficulty managing your medication?	Yes No Care staff support and medi pack.
Alcohol	If yes, consider alcohol use screen.
Do you drink alcohol on a regular basis?	Yes No

Item B: generic all about me document

Name: Jenny Ferguson.
What I like to be called: Jenny.
Where I live: Gardens Court Care Home.
Who know me best: My carers Debbie and Sue and my nephew Jim.
I would like you to know I like to always have my handbag and toy cat with me.

Background

I was born in South Africa, where my dad was stationed with the Navy and lived there with my parents and younger sister Liz until we moved to Cornwall when I was 14 years old. I was close to Liz and was heartbroken when she died 2 years ago. My nephew Jim is my only surviving relative and I look forward to his visits every Sunday. I used to have a pet cat called Fluffy and now I am never without my cuddly toy cat who reminds me of him.

Interests/Hobbies/Work

I am a retired secretary and use to be the treasurer for the local Woman's Institute. Now I usually watch TV; I love Emmerdale and detective stories. I do not read anymore because I struggle to see the words and I do not like to sit still long enough to listen to audiobooks. I love to share stories about growing up in South Africa and Cornwall.

My habits and routines

I like to get up at 6 o'clock in the morning and go to the toilet. When I am awake, I like to get up. I like to get showered and dressed then go for breakfast. I like to sit on my own for breakfast. After breakfast, I like to water the plants and then sit in the lounge. Sometimes I like to go back to my room. I like to join the ladies' table for lunch and usually sit next to Mary or Edna. I like to spend tea time in the conservatory and after teatime I like to watch TV until bedtime. I get my hair done every Monday and Thursday by the care home hairdresser and always wear my pink lipstick. I sometimes forget when it's night or daytime and go looking for my carers overnight.

Things I like to do for myself – I can choose my clothes for the day if you give me 2 choices. I can wash my own face, brush my own teeth and hair if you lay out what I need.

Things I might want help with – I need help with personal hygiene when I've been to the toilet, showering or getting dressed. I prefer female carers and have my own favourite toiletries which are kept in my bathroom. I wear continence pads for any accidents as often leave it too late and I don't always make it on time. My carers usually keep my room tidy and free from clutter or things to fall over, but sometimes I leave bowls of water on the floor for Fluffy.

Things that may worry or upset me – I usually become agitated or distressed when I have a urine infection or become constipated and am susceptible to hyperactive delirium with hallucinations. I like to spend time alone and don't like strangers particularly men or the dark. If I am in pain, I will be quiet and want to stay in my room. I don't usually think about falling until night-time then I am frightened about falling out of bed and need lots of reassurance. If I am feeling worried about falling, I will often avoid getting up and sit in my chair in my bedroom.

What makes me feel better if I am anxious or upset – Familiar people, the TV and having my handbag and fluffy toy cat with me.

Cultural/Spiritual needs – I am not religious but I do love to sing hymns and like to celebrate Christmas and Easter at church.

My communication

My hearing and eyesight – I have two pairs of glasses – one for reading and one for distance. I usually always carry my handbag with my glasses in but sometimes get muddled which about which pair to wear. I sometimes struggle to hear if there is a lot of background noise and turn the TV up loud.

How we can communicate – Verbally, I struggle to read and write now so please take your time and speak slowly and clearly.

My mobility

I can walk with 1 walking stick which I usually carry in my left hand, and supervision. I usually forget my stick and leave this lying on the floor. I am a little slow and unsteady when I am tired or have an infection and can rush when I am worried or upset. I have a wheelchair for trips outside or appointments. I have a special chair in my bedroom that helps me to stand up but sometimes I forget to press the buttons, so my carers help me. I also have a seat on my toilet and a rail next to my bed on the right to help me. I also have a button that I wear around my wrist in case I need help but sometimes I take this off and the carers help me to remember to put it on.

My personal habits

Personal care – I only like to shower; I don't like the bath as I'm afraid of water. I like to have my main wash in the morning and to freshen up before bed. I don't like to feel rushed and like to look well-dressed and glamorous. I like heeled shoes but must wear sensible Velcro fastening shoes and slippers which I don't like. Sometimes I borrow shoes from Edna which don't fit very well.

Sleep – I like to have a hot chocolate at 8pm every night, then go to get ready for bed at 9pm. I like to wash my face, brush my teeth and hair before I go to bed. I am usually asleep by 9.30pm. Sometimes I forget that I have brushed my teeth and do this again before bed. I need my small lamp left on to help me sleep. I also fall if the light is not on as my vision is poor overnight.

How I take my medication – I need help to remember to take all my medication. Sometimes I don't like to take them and hide them so you may need to watch me take them.

My eating and drinking – I don't like hot drinks except for my hot chocolate every night. I like water or juice but not blackcurrant. I have a small appetite now and usually eat my meals cut into smaller pieces to eat with my fingers. I can use a spoon and like jelly, yoghurts, custard and ice cream but struggle with a knife and fork now. I can eat a normal diet and drink normal fluids but don't like too many textures in my mouth at once. I have special milkshake drinks from the GP which I need to drink every day. I like this best with a scoop of ice cream mixed in.

Other – My nephew Jim is appointed as my lasting power of attorney for health and finances.

Summary of my functional ability and care needs									
Task	**Able**	**Unable**	**With assistance**	**Equipment/ Comments**	**Task**	**Able**	**Unable**	**With assistance**	**Equipment/ Comments**
Mobility indoors	X		Supervision	X1 Stick Impulsive at times.	Wash self	X		Assistance of 1.	Prompts and support.
Mobility outdoors		X	Assistance of 1.	Wheelchair, unsteady on uneven surfaces.	Bath/Shower transfers	X		Assistance of 1.	Wet room Shower Chair
Bed transfers	X		Supervision	Bed lever. Patient often gets up overnight.	Toilet transfers	X		Assistance with personal hygiene.	Raised toilet seat with rails.
Chairs transfers	X		Supervision	Raise recliner.	Dressing/ Undressing	X		Assistance of 1.	Prompts and support.
Orientation to time and place		X	Regular prompting.	Patient struggles with day/night orientation.	Meals		X	Full support.	Dietary intake chart & supplements.
Communication	X		Extra time needed.	Patient likes to talk but often muddles words and ideas.	Eating/ Drinking	X		Assistance of 1.	Prompts and support, close supervision as patient hides food.
Medication		X	Full support.	Supervision as patient hides tablets.					

Date completed:10/02/2023 **Completed by** Debbie Parr (Senior Carer)
Based on the This is me | Alzheimer's Society (alzheimers.org.uk)

Item C: multifactorial assessment checklist

Risk checklist	Summary of needs	Considerations	Recommendations
Balance and walking Do you use any mobility aids? Do you have problems with your walking or balance? Unsteady on their feet, shuffles or takes uneven steps? Impulsive or over-reaching? Unsafe use of aids/adaptations? Able to get back up off floor?		Provide appropriate equipment/check condition? Home or group exercise programme to improve strength and balance?	
Footwear/Foot care Does difficulty with foot care affect your mobility? Do you wear appropriate footwear?		Advise on suitable footwear? Check foot condition? Advise on foot care? Refer to podiatry?	
Transfers and function Do you have difficulty completing any of the following ADLs? Support provided? • accessing outdoors • standing from a chair		Advice and education regarding safe techniques? Equipment/adaptations? Refer to occupational therapy? Refer to social services?	

Risk checklist	Summary of needs	Considerations	Recommendations
• getting in/out of bed • toilet use and transfers • showering/bathing			
Environment Is the home environment contributing to the risk of fall including: • tripping hazards • inadequate lighting • obstructive walkways • equipment in situ? • is it fit for purpose?		Advice regarding safety in the home? Equipment/adaptations? Refer to occupational therapy?	
Vision Do you get regular eyesight tests? Do you wear glasses? Do you have any concerns about vision?		Signpost to optician? Discuss environmental hazards? Refer to Sensory Loss team?	

Risk checklist	Summary of needs	Considerations	Recommendations
Hearing Do you wear a hearing aid (left/right/both) Difficulty hearing conversational speech (with hearing aid if worn)?		Check any hearing aid is worn correctly and working? Signpost for hearing assessment?	
Continence Do you often struggle making it to the toilet on time? Do you go to the toilet more than normal? Do you go to the toilet more than once overnight? Do you wear continence aids?		Provide advice and education? Encourage regular fluid intake? Refer to continence service? Provide aids/equipment	
Nutrition and hydration Do you have a good appetite? Have you had unintentional weight loss? Do you have poor food/fluid intake? Do you struggle to swallow?		Advice on diet and hydration? Record dietary/fluid intake? Refer to dietitian? Refer to SALT?	

Risk checklist	Summary of needs	Considerations	Recommendations
Cognitive status Do you have a diagnosis of dementia? Consent? Do you have short-term memory which affects your ADLs? Do you have difficulty following instructions? Observed or reported agitation, confusion, and/or disorientation?		Is patient known to or actively involved with memory clinic or older persons mental health services? Refer to GP if concerned about new dementia?	
Psychological Are you afraid of falling? How often do you worry about it? Have you changed your lifestyle due to falls? Can you get help if you fall?		Advice and education? Rehabilitation to increase confidence? Refer for telecare?	

Recommendations for further assessment from wider multi-disciplinary team

Professional	Criteria	Referral (YES or NO)	Why/Why not
GP	Unmanaged/previously unidentified blackouts/dizziness. Difficulty managing medications/ no recent medication review. Osteoporosis risk identified?		
District Nurse	Pressure care review needed.		
Physiotherapy	Unsteady gait/unsafe with mobility aid. Requires exercise to improve balance, transfers, and walking.		
Occupational therapy	Environmental hazards remain requiring specialist review.		
Telecare	Patient unable to get up without help and requires method of calling for assistance		
Podiatry	Difficulty with foot care/pain.		
Continence service	Continence issues requiring further management.		
Dietitian	Nutrition issues.		
Speech and language therapy	Struggling with swallowing. Struggling with communication.		
Social services	Requires review of care needs/level of care. Requires referral to Sensory Loss team.		

Item D: generic goal-setting template

Patient: Jane Brown **NHS Number**: 147 258 3690 **Date of Birth:** 03/01/1954

Medical Diagnosis: Left side ischaemic stroke – right sided weakness in hand and arm, some swallowing difficulties **Date**: 24/02/2023

Professional assessment of needs screen	Yes/No	Comments
Can patient sit in an upright position/chair for eating and/or drinking?	Yes	Jane likes her meals at the breakfast bar or table in the kitchen.
Is patient able to maintain good oral health/hygiene?	Yes	Jane can manage independently with her electric toothbrush.
Can patient swallow and clear fluids?	No	Jane has reduced sensory input when swallowing.
Is patient at risk of aspiration? (Inhaling food/liquids into lungs)	Yes	Thickened fluids recommended.
Is patient on an alternated diet for example pureed/soft diet?	Yes	Softened diet recommended.
Is patient at risk of malnutrition? Has patient any oral nutritional supplements?	Yes	Oral supplement drinks with thickener recommended.
Can patient reach and grasp glass/cup and patient drink from it?	Yes	
Can patient bring their hand to their mouth?	Yes	Can get tired after about 5 minutes of repetitive actions.
Can patient hold a knife and fork/spoon?	Yes	Can achieve grip but slips out of hand easily.
Can patient maintain adequate grasp on?	No	Can only manage a few seconds.
Does patient struggle with feeling tired when eating?	Yes	Jane has limited activity tolerance at present approx. 10 mins.
Does patient worry about eating in public?	Yes	Jane feels embarrassed about how she looks now.
Does patient avoid eating in social situations?	Yes	Jane was very social but does not want people to see her now.
Does patient have a fear of choking?	Yes	Jane is very worried about choking when she starts to cough.

Patient goal statement(s):
1. Jane wants to eat out at her friend's café. 2. Jane wants to be able to feed herself. 3. Jane wants to be able to drink without feeling scared that she is going to choke. 4. Jane wants to enjoy a family meal with her husband Mike, daughter Lorraine and son-in-law Joe for her 50th wedding anniversary in 4 months' time.

Patient problem statement(s):		**Next steps:**
Jane is struggling to swallow normal liquids and starts to cough Jane is struggling to swallow normal liquids and starts to cough.	Jane is to trial thickened fluids.	Education regarding use of thickener.
Jane is struggling to hold cutlery with her right and get this from her plate to her mouth eating with friends and family.	Jane wants to be able to eat her meal by herself.	Upper limb exercises? Physio/OT Trial modified cutlery? OT for advice.
Jane feels embarrassed when she eats in front of people and has started to avoid mealtimes and/or eating with friends and family.	Jane is happy to practice at home but nervous about eating out. Her best friend owns a café close by and she would like to go for a catch up soon.	Education regarding food choices whilst in public to help with anxiety. Discuss a graded exposure to eating with friends and family identify safe spaces/opportunities.
Jane states that she is not taking pleasure in eating and drinking as is missing her favourite foods and is starting to feel low in mood.	Jane states that she is not taking pleasure in eating and drinking as is missing her favourite foods and is starting to feel low in mood.	Education regarding foods available on her current available softened food diet. Explore recipes, shopping options and stroke support groups to increase confidence and help Jane adapt to her new way of life.
Jane has reduced activity tolerance.	Jane's upper limbs tire after approximately. 10 minutes of repetitive use.	Goals should consider how long is realistic and whether or not to complete one long session or several shorter sessions. Education regarding planning, pacing and prioritising tasks.

Item E: short-term goals recommendation template

Patient: Jane Brown **NHS Number:** 147 258 3690 **Date of Birth:** 03/01/1954

Medical diagnosis: Left side ischaemic stroke – right-sided weakness in hand and arm, some swallowing difficulties **Date:** 24/02/2023

Patient goal(s)	Activities to meet this goal	Patient outcome	Potential barriers	How can you reduce this?	Other professionals who can help and why

Item F: generic occupational therapy report

Date of discharge from hospital: 25/01/2023 **Date of report:** 25/01/2023

Patient: Tom Jones **NHS number**: 147 863 3690 **Date of birth:** 06/08/1949

Medical diagnosis: New diagnosis of chronic obstructive pulmonary disease.

Past medical history: Recent admission for dehydration, hypertension, anxiety and depression.

Height: 5ft 8in **Weight:** 11st 2lbs **Frailty score**: 6 (moderately frail)

Client's perception of situation: Patient is aware of the new diagnosis and is understandably worried about his future ability to maintain an independent life in his own home.

Consent: Verbal informed consent to occupational intervention gained.

Social situation: Lives with wife Brenda in owner-occupied house with stairs. Patient's son Jeff lives in a nearby village with his wife Joan.

Functional ability	Before admission	On discharge	Patient goals
Mobility	Previous mobile with no aids – patient reports using furniture at home to lean on at times.	Discharged home with wheeled walking frame for indoor use. Referral sent to wheelchair services for attendant propelled wheelchair for outdoor use.	Patient wants to be able to walk with a stick by the end of the 6-week input.
Stair negotiation	Previously independent with stair negotiation x2 bannister rails in situ – straight flight, however, patient's wife reported that he often stopped for rests prior to admission.	Discharged home to downstairs living scheme as inadequate activity tolerance observed. Single bed to be located in dining room.	Patient wants to be able to access upstairs as soon as possible.
Access/Outdoors	1 x 4" step with 2" threshold at front door – main access. Rear access not used and therefore not assessed. Independent with no aids.	Discharged home to stay inside – fire safety check referral completed. Reablement to support.	Patient does not want to be 'trapped' inside for long. Patient wants to be able to independently get in and out of his house.

Functional ability	Before admission	On discharge	Patient goals
Bed transfers	Main bedroom upstairs – shares bed with wife Brenda. Use to get up through the night due to feeling breathless.	Discharge to single bed downstairs – metal bed frame. Patient struggling with bed transfers and unable to lie flat due to breathlessness – mattress elevator with a grab handle provided.	Patient wants to return to his bed upstairs.

Item G: generic support plan recommendations template

Patient: Tom Jones **NHS number**: 147 863 3690 **Date of birth**: 06/08/1949

Medical diagnosis: New diagnosis of chronic obstructive pulmonary disease **Date**:

Problem list (What are the main issues?)	
Goal setting (What are the patient's goals)	
Action plan and treatment (What interventions/support is needed to reach goals)	
What factors will support plan?	
What factors will limit plan?	
Additional therapy team member required? Include role and reason for input)	

Item H: generic follow-up call checklist template

Patient: Tom Jones **NHS number**: 147 863 3690 **Date of birth**: 06/08/1949

Medical diagnosis: New diagnosis of chronic obstructive pulmonary disease **Date**: 17/03/2023

GAS = Goal Attainment Score – +2 more than expected +1 somewhat more than expected 0 as expected -1 less than expected -2 much less than expected

Activity	Before input	After input	Ongoing needs	GAS
Mobility	I left hospital with a walking frame because I had to stop so much to catch my breath and needed something to lean on.	I can walk with 1 stick now when I'm pottering around the house but still have a walking frame for upstairs as I'm usually tired then.	I have an exercise programme to complete to self-manage my fitness.	+2
Stair negotiation	I was discharged home to sleep in a bed downstairs because the stairs were too much for my breathing and my legs felt weak.	I can now go up and down the stairs once a day and have started sleeping upstairs again. I still have a bed downstairs just in case.	I think longer term I might need to think about how I manage if I get worse.	+2
Access/Outdoors	I have 1 x step at the front door so was discharged home to stay inside.	I can now safely get in and out of the house and have a grabrail to help with my balance. I have a wheelchair for appointments and long distances outside as well now.		+2

Activity		Before input	After input	Ongoing needs	GAS
Transfers	**Bed**	The hospital gave me a mattress elevator with a handle so I can get in and out of bed easier. Also, it means I don't have to lie flat which makes me panic.	I'm managing fine with the hospital equipment.	I could do with another one of them mattress things on my bed upstairs. Who do I need to speak to?	0
	Chair	I was slow but managing fine to get on and off the sofa.	I'm about the same as before no concerns.		0
	Toilet	The hospital gave me one of the commodes and some urine bottles for downstairs since our toilet is upstairs.	I have still been using the commode downstairs but feel awful that Brenda (my wife) has to empty it so I have been trying to use the toilet when I'm upstairs but it's a bit low.	Who do I need to speak to look at options?	-1
Bathing		I have a bath with over-bath shower. Shower board and grabrail provided on discharge.	The board and rail are 'canny' however have learnt to take shorter shower as the hot water and steam sometimes catches my breath.		+1
Self-care		I needed a lot of help when I first came home as I felt weak and tired easily. I was also very anxious about my breathing.	The team have been great and I feel so much more confident and independent which has given me some privacy and dignity back.		+2
Medication		Independent no concerns identified.	Independent – medication pack introduced for convenience.	Advice given re medication management.	0
Meals		I'm not a cook my wife Brenda says I'd burn water so I leave that to her.	My wife is still happy to support me with my meals.		0

Activity	Before input	After input	Ongoing needs	GAS
Shopping and housework	Again my wife takes care of that side of things.	The wife again.		0
Occupation/Recreation	Retired construction worker. Gardening/allotment every day.	I have not yet been back to my allotment.	I would like to explore this in the future.	-1
Finances	I usually sort all the bills out but the son's been helping keep Brenda (my wife) right.	My son set me up with online banking so I am fine – no concerns there.	Advice given re carers allowance.	0
Mental/Psychological/ Emotional	I was very scared about the future and felt like giving up.	I feel like I have more to offer than I thought and the input has taught me new ways to do things to save my energy and keep me independent.		+2
Breathlessness (Medical Research Council Score)	MRC Score 4 – stops for breath after walking about 100 m or after a few minutes on the level.	MRC Score 3 – walks slower than age group on the level because of breathlessness or has to stop for breath when walking at own pace.		+1
Fatigue management	I just felt tired all the time and wasn't sure I'd be able to do anything for myself again.	I feel like the routines, advice and strategies the team has shown me have given me a reason to try and I now have energy to do more than sleep on the sofa.		+2
Other	I was asked if I wanted to stop smoking when I left the hospital but I said no.	I have learnt more about my diagnosis and how I can look after myself and want to give it a go.	Who do I contact to get some advice or support?	N/A

Patient satisfaction survey

How satisfied are you with the reablement service you received?	Not satisfied 1 2 3 4 5 6 7 **8** 9 10 Very satisfied
How were you managing before reablement input?	Not managing 1 2 **3** 4 5 6 7 8 9 10 Fully independent
How are you managing after reablement input?	Not managing 1 2 3 4 5 **6** 7 8 9 10 Fully independent

Any feedback/suggestions for change?

I am still learning to live with my new diagnosis of COPD and still get anxious about how I will get back to 'normal'. I struggled for a while before I came into hospital and now I know why. The team mentioned I will be referred to Pulmonary Rehab to learn how to manage my condition and I feel ready to go it alone.

Document information

Owner: Head of Assessment Design

Change History Record

Version	Description of change	Approval	Date of issue
v1.0	Additional sample material		01 September 2023
v1.1	Sample added as a watermark	November 2023	21 November 2023