Occupational Profile of Client H.

The following is information derived from interviews and assessments conducted with Client H. during May 2011 and a review of the records held on her by at the skilled nursing facility. (This document has been adjusted to protect the confidentiality of the client.)

History

Background Information.

Client H. is 73 (date of birth: Date, 1937). She lives at a skilled nursing facility in Massachusetts. She has been a resident since August 2010, coming to the facility upon discharge from Sisters of Providence Health System Mercy Medical Center (SPHS-MMC).

Prior Medical History.

Upon discharge from SPHS-MMC, the list of Client H's medical issues included:

- Delirium associated with a urinary tract infection (UTI)
- Chronic obstructive pulmonary disease (COPD) with CO_2 retention with lacunar stroke, encephalopathy of unclear etiology
- Lacunar infarct with left internal carotid artery, 50-69% stenosis
- Tobacco abuse
- History of abdominal aortic aneurysm and chronic left groin methicillin-resistant staphylococcus aureus (MRSA) infection, chronically on minocycline
- Chronic renal insufficiency
- Depression
- Hypertension
- Coronary artery disease status post-stent
- History of strangulated hernia and recent repair

Client H. regularly takes 14 medications, including Prednisone, Advair, Spiriva via inhaler, Ceftin, Nicotine, Prozac, and Lipitor.

Client H's **trigger legend** includes periods of altered perception to surroundings; mental function varies over the course of the day; showing cognitive decline; variable mood; short-term memory problems; impaired decision making; and problems understanding others.

Main concerns are:

1. Short-term memory problem
2. Impaired decision making
3. Problems understanding others

Client H. was found **not independent** in: transfers, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, toileting, personal hygiene, and bathing.

According to her chart, Client H. has shown persistent anger with self and others; unpleasant mood in the morning, and mood persistence. (These symptoms were not apparent during two recent long interview and assessment sessions with Client H.)

Prior to SPHS-MMC admission, Client had fallen several times. Her medical records attributed these to the psychotropic medications she was taking. There is no record of any recent falls, but Client H. uses a wheelchair at the center and said her legs are weak.

Client H. is on a sodium-restricted diet and has diffuse osteopenia.

Social History.

Client grew up in Massachusetts. She had two older sisters, both deceased, one of whom she was close with and one of whom, with a 12-year age difference, she did not know very well. She has been married twice. Her first marriage resulted in two sons, and ended in divorce when the children were young. She remarried and had another son. Her sons are currently ages 49, 47, and either 42 or 43. The older two live in Georgia and on Cape Cod. Her younger son, Joe, lives nearby and is a director-level employee at a local college. He is married, and his wife teaches at a local elementary school. Client H. has 6 grandchildren, but only regularly sees the two who live nearby, a girl of 15 and a boy of 19.

Client and her second husband moved to western Massachusetts when her husband retired. Joe felt they needed to live closer if he was going to help them as they aged. Some years ago, Client H's husband began falling frequently and he was moved to an assisted living facility where he died two years ago. Client H. said she thought her husband's death was closer to three years ago, but reported Joe said it was two years. It was clear in the discussion that Client H. continues to miss her husband.

Client H. reported that she thought she had been doing okay living on her own, but has come to recognize that Joe was correct in saying she could no longer live on her own. She admitted when alone she had stopped eating properly and also found it difficult to walk around, as her legs no long seem to support her. She reported Joe said she had also stopped taking her medication, and that he is her healthcare proxy. She uses a wheelchair while at Governor's Center, but said she uses a walker when she visits her son's house.

Client H. said if she had to be in a long-term, residential medical facility then Governor's Center was pretty good. She said she had not enjoyed living in the senior center as many of the people living there were *old* and "acted like they were going to die tomorrow."

Client H. said she was not a friendly person, by which she meant she would rather do things by herself. She went on to say it was not that she could not be social, but it depended on the circumstance and the people. She made the effort to attend and participate in the music and movement group led by Bay Path College students.

Educational History.

Client H. left school in the 12th grade without completing requirements for a high school diploma.

Work History.

Client H. held many jobs, including working in an eyeglass factory, being a secretary, a waitress, and a switchboard operator, the last which she described as fun. The switchboard was in an insurance company and she liked receiving calls from all over the world.

Daily Routine

Typical Weekday.

Client H. likes reading and doing jigsaw puzzles. Most days she will do jigsaw puzzles for hours in the *puzzle room*.

Typical Weekend.

Client H. said on Sundays she usually spends the day at her son's house. In those instances she takes a walker, but said she usually does not need one in his house.

Life Roles

Competence and Satisfaction with Roles.

Client H's main roles are mother, grandmother, and skilled nursing facility resident resident. It appears Client H. has gone through a significant life adjustment in losing her husband, two years ago, and she has been adjusting to her changed sense of independence by coming to the skilled nursing facility nine months ago. She appears satisfied in her roles as mother and grandmother, and seems to have regular contact with her third son and his family. She has also come to realize that living in a long-term care facility is probably what she needs at this time in her life, and she reported feeling comfortable.

Client Goals

Client H's only stated goal, or concern, is her memory. She is concerned that she cannot remember things.

Strengths and Problem Areas

Strengths.

Demonstrates self-motivation.
Has found two activities, jigsaw puzzles and books, which keep her entertained.
Is in the process of adjusting to life in a long-term facility.

Problem Areas.

Short-term memory.
Moodiness.
Social interactions, with staff, other residents.
Ability to stand and walk.

Assessments

Client H. was found to have a score of 5.0 on the Allen Cognitive Level Screen (ACLS), which means she should have 22% cognitive assistance, primarily to monitor safety and effectiveness of her problem-solving abilities. Also, at this level, Client H. requires standby cognitive assistance to anticipate environmental hazards and prevent social conflict. The 5.0 level also suggests 6% physical assistance is needed with fine motor activities.

Client H. scored a 22 on the Montreal Cognitive Assessment (MoCA), of which 26 or above is considered normal. In the verbal fluency section, the assessor was struck by the intricacy of the words Client H. chose. After the assessment was concluded, the assessor admitted she had thought of simple words like *fox* and *fat*, and Client H. replied she had not even thought of simple words like that. One of Client H.'s words was *freeway*.

Conclusion

Client H. has more than once reported having memory problems and mentioned that she might be getting some therapy to help. She seems to be looking forward to this therapy, practicing and testing her memory. While Client H. does not seek a lot of social interaction, she does like people and will interact if interested.