Assessment Reflection Project: A. D.

A. D. is a 64-year-old female (date of birth: June 27, 1947). She has been married to her husband for 41 years, and they met as undergraduates at in college. A. D. holds two masters degrees, and is employed by a technology company creating training programs. A. D. said she and her husband have discussed how they are aging compared with their parents. They are proactively working to maintain their health. A. D. reported she understands it is important to maintain balance, and so has taken up exercising with a Wii to do this. Recently, she said, her score decreased from a balance age of 42 to a balance age of 22.

Edmonton Frail Scale Reflection

A. D. scored a 2 out of a total 17 points on the Edmonton Frail Scale (EFS) assessment, indicating a not-frail condition, or robust health.

I chose this assessment because it evaluates current function. I have met A. D. approximately once on month in the past year and a half through local town affairs, and had heard briefly of some medical procedures both she and her husband have been undergoing. While these items seemed to be one-time corrections, I thought the EFS would enable me to evaluate whether there was something more serious happening.

A. D.'s clock showed the studious nature of the client, as the hour hand was slightly after the number 11 because the time of 10 minutes after the hour does not position the short hand pointing directly at the exact hour but a little after.

In reviewing the results, I was surprised by the scoring relating to whether the client has available *social support*. I did not understand why a person who replied yes to having social support would score worse than someone who had no support. A quick search of peer-reviewed articles led me to find out the EFS assessment form I had used was actually incorrect. Hilmer et al (2009) showed three answers for

social support, the answer *always available* received 0 points, *sometimes* 1 point, and *never* 2 points. Using this scale, A. D.'s score on the EFS would be 1/17.

A. D. was comfortable enough to tell me that she had lost some weight recently, but this was intentional because she was back to exercising following removal of one kidney in the summer. In February, she had thought she had a kidney stone, but a CAT scan showed a kidney abnormality and her doctors said one kidney was operating at only 10 percent due to ligature strangulation. A. D. said doctors could have removed the ligature but kidney function would remain at 10 percent. Since removing the ligature was a significantly more risky surgery than kidney removal, A. D. opted for removal. Having the surgery in the summer curtailed some of her regular exercise routine, and so now that she's back to full health, she has been able to lose the few pounds she had gained during her recuperation.

The EFS provides a short, succinct questionnaire that enables clients to think about various areas of their life and function. I think it is a good measure to assess current status and possible frailty issues.

Vision Screening Form Reflection

A. D. passed the Vision Screening Form (VSF) perfectly, with no referral needed. She was able to read the last line of the text on the right-hand side of the page fluently.

In discussion, A. D. mentioned that she had had cataract surgery in both eyes approximately two years ago, and one lens was set for a long focal length and one for short. While some people find it difficult to make this adjustment, A. D. had worn hard contacts in this pattern for many years and had the surgery done this way to obviate the need to wear reading glasses.

I wanted to use a visual assessment that would be concise but pinpoint issues for referral should they arise. I was not happy with the clarity of the printout of the VSF. I think it is extremely important to ensure clean and clear copies of printed assessments, to use precise measurements, and to provide good lighting to enable the assessment is correctly and professionally done. Thus, should I be using the VSF on a regular basis, I would obtain a sharply-focused copy, or type a new one. As in our lab, A. D. found the

wording of the smallest-font quote on the VSF cumbersome. She read it correctly, but the odd sentence structure made her stop and question whether she had in fact read it properly. An item that makes a client question their ability upon completion, at a time the client knows they are being assessed, is both confusing and potentially stressful. I think this is a major drawback to the VSF, and one that could easily be remedied.

Despite its drawbacks, the VSF did prove to be a quick, easy screen for visual problems.

A. D. has a slight lazy eye, which the screen allowed me to notice, but was not directly measured by the assessment. The lazy eye is not something that seemed to limit her vision.

Berg Balance Scale Reflection

A. D. scored a 55 out of a total 56 points on the Berg Balance Scale (BBS). Her only difficulty was standing unsupported with one foot touching the other. She tried this foot-touching position and held for 10 seconds, but then decided it was difficult and opted for the one foot ahead of the other position.

I had selected the BBS because it covers a variety of positions. While we had some exposure to the BBS in sensorimotor lab last semester, each of us did not use it in full, nor did we assess anyone besides our classmates. Despite reviewing the assessment several times before giving it, I was not as fluent with the various steps as I felt I could be. However, now that I have assessed one person with it, and again revisited it in lab, I feel that I am more fluent, and another client assessment would go quite quickly, depending on the individual client's level.

I used a stopwatch for the assessment, and this made A. D. a bit uncomfortable. We were able to talk about this, and she said she would have been more comfortable if I, perhaps, had had a wall clock with a second hand behind her that I could use for timing instead. It is something that I would consider arranging in a clinic set up, and I would consider having a more portable clock with me should I be doing assessments in the home.

The BBS provides General Guidelines for use with those who are wheelchair bound and those who need to walk with assistance. From my experience with A. D., it is clear that many clients would need more support or spotting during this assessment than A. D. did. Thus, I might consider assessing postural control and stability, more than balance. I found a similarity among the balance assessments, some were shorter and some were scored a bit differently. However, what I liked about the BBS is that it provided a scale of 1 to 4 in a number of categories, providing a good range for assessment and scoring. With A. D. seeming to move effortlessly through the BBS, it was still able to reveal a modicum of discomfiture with balance, an area A. D. already works on with her Wii, as she and her husband strive to stay as healthy as possible as they age.

Saint Louis University Mental Status Examination Reflection

A. D. scored a 30 out of a total 30 points on the Saint Louis University Mental Status Examination (SLUMS).

I chose this assessment in order to compare it to the Mini-Mental State Examination (MMSE) by Folstein, Folstein, and McHugh (1975), the Montreal Cognitive Assessment (MoCA) by Nasreddine (2003-2011), and the Allen Cognitive Level Screen (ACLS-5) by Allen et al. (2007), and because I wanted to use a cognitive assessment for this assignment. Of these four, I much prefer the MoCA, and I have included a copy for reference. I find the MoCA to be more substantive than the MMSE, and it does not cost a dollar per usage. I also think the MoCA is more extensive and flows better than the SLUMS. There is also a typographical error between the instructions and the actual assessment on the SLUMS form. The five objects that the client is supposed to remember includes a car, and not a *care* as stipulated on the clinical operations sheet.

The SLUMS question 11 about what state the character in the story lived in struck both my client, A. D., and I as culturally biased. While there is some leeway given in scoring due to level of education, knowledge of states and the United States is not uniform. The knowledge of the animals on the MoCA

could also be open to a similar accusation of cultural bias. I did not ask A. D. to complete a clock on the SLUMS, because she had already completed this for the EFS, albeit the time was 10 minutes before the hour on the SLUMS and 10 after on the EFS.

While I like the explanations provided by the ACLS-5 scoring, I would much rather use the ACLS-5 in conjunction with one of the other three cognitive assessments. Since I have already administered the ACLS-5in training and in a real-life context, I chose to administer an assessment that was new to me. The MMSE, the MoCA, and the SLUMS are quite straight-forward to administer. The SLUMS and the MoCA seem to take a few more minutes to administer than the MMSE, but the time difference is not, in my experience, significant. A. D., and my previous client on the MoCA, both expressed concern with the question about remembering a set of words. In A. D.'s case, she quickly came up with a memory trick of using the first letter of each word, trying to create a single word to remember. This was a pattern she said she uses a lot, for instance when heading to the store with a list of items to buy. Even with this trick, it is clear that the occupational therapist needs to recognize that a person taking an assessment may be tense or nervous just from the fact that they are being assessed. In between assessments, I tried to put A. D. at ease by allowing her to comment as she wished on the assessment just taken.

A. D. scored well on all the assessments. She is already doing exercises to maintain balance, which is the one area where she scored a 3 instead of a 4 on the BBS. There is no need for further referral or occupational therapy services at this time.

References

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