CHAPTER 1
ACUTE CARE SETTING (HOSPITAL SETTING)

CHAPTER OUTLINE

- DISCHARGE PLANNING
- DISCHARGE SITES
- ICU
- LAB VALUES
- PRECAUTIONS
- MEDICATION MANAGEMENT

ACUTE CARE SETTING

As you prepare for the exam, understanding the acute care setting is crucial for success. Although many of you may not have direct experience in this fast-paced environment, mastering the concepts and terminology presented in this chapter will equip you with the knowledge needed to confidently answer exam questions. This chapter provides a comprehensive review of acute care occupational therapy principles, focusing on key concepts, discharge planning, and evidence-based practices. By the end of this chapter, you'll be well-prepared to tackle acute care-related questions on the exam and take a significant step towards passing the exam.

As an OT in the acute care or hospital setting, you will encounter clients who require short-term, intensive treatment for a sudden illness or serious medical problem that can't be handled at home or by their regular doctor. This might include a new disease, a sudden worsening of a long-term condition, or a mental health crisis that requires immediate attention. The goal is to stabilize the patient, and hospital stays are usually short—just a few days to a week. After that, patients are often moved to another setting for follow-up care if needed.

OTs are key players in helping patients recover and return to their daily lives. Our job is to quickly determine the patient's challenges, whether its memory issues, trouble moving around or performing ADLs, or concerns about being safe at home. But we don't just stop at identifying the problems. We help patients work through these issues and start planning for their discharge from the hospital.

Discharge planning is a primary responsibility of OTs in acute care settings, focusing on Activities of Daily Living (ADLs), cognition, and activity tolerance to ensure optimal patient outcomes. adverse effects.

Effective planning involves evaluating:

•Autonomy Promotion (encouraging independence)

• Risk Avoidance (preventing adverse effects)

• Prior level of function (PLOF) and current level of function (CLOF) within 24-48 hours, allowing us to reevaluate and craft discharge plans accordingly.

- Recommendations will come from all stakeholders (patient, family, health care providers).

By addressing these factors, OTs facilitate smooth transitions, reduce readmission rates, and promote optimal patient outcomes in the time-sensitive acute care environment.

Acute Care Challenges

Occupational therapists face unique challenges in acute care, including:

- Medically unstable patients
- Environmental constraints (infection control, equipment, protocols)
- Interdisciplinary collaboration and communication
- Time limitations and chaotic environments

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Don't overcomplicate it box

Understanding Inpatient Settings: Acute vs. Rehabilitation
The term "inpatient" simply means the client stays overnight in a facility.
Two common inpatient settings:

1. ***Acute Care Inpatient Setting (Hospital): Clients receive intensive medical care for severe, new conditions (e.g., heart attack, stroke, trauma). Medical stability is the primary focus.***
2. ***Inpatient Rehabilitation Setting: Clients are medically stable, require less acute medical care, and can tolerate more therapy (3+***

hours/day). Focus shifts from acute medical care to rehabilitation and recovery.

Note: Acute Inpatient Rehabilitation Setting (Acute Rehabilitation) is a subset of inpatient rehabilitation. Clients may still require some level of acute medical care, but it's less intense than in an acute care hospital.

Think of it like a continuum:

Acute Care (Hospital) → Acute Inpatient Rehabilitation → Outpatient/Home Care

Clients transition from intense medical care to rehabilitation, and eventually, to outpatient or home-based care as their condition improves.

Now, you'll be able to distinguish between these settings with confidence!

DISPOSITION (DISCHARGE) SITES	
Hospice	• Client "probably" has 6 months or fewer to live. • This setting is for the terminally ill. • Goals are comfort measures, minimal or NO rehabilitation, and family education to meet patient needs.
Skilled Nursing Facility (SNF)	• There are little to no goals for rehabilitation. • Subacute/short-term rehabilitation programs can be housed in SNFs. • The client will D/C back to a SNF if they were hospitalized from a SNF. • The goals are patient safety and assistance with ADLs.
Long-Term Acute Care (LTAC)	• This setting is for hospital-level clients who require an extended stay. • They have **medical complexity but are not critically unstable**. • They are typically too sick for the hospital floor, ventilator-dependent, have complex wounds, or are on more than two antibiotics. • The goal is to maximize function using an interdisciplinary approach. • Patients may be discharged home, hospice, SNF, inpatient, subacute, or outpatient.
Home Health	• Most natural context for intervention. • This setting requires a multidisciplinary approach. • Treatment is not as intensive, possibly homebound, and provides client-centered care since they live in their own environment. • The goals are to maximize patient/caregiver carryover of therapeutic intervention and support family.
Subacute/Short-term Skilled Nursing	• This setting is for clients requiring less than 3 hours of therapy daily. • Provides rehabilitation without acute medical care. • The focus is on restoring functional abilities at a slower rate of change. • Allows for slower progress.
Acute Rehab Unit	• This setting is for medically stable clients, and the discharge plan is for home, family's home, or assisted living facility (ALF). • The client must tolerate 3+ hours of skilled therapy daily and be willing and motivated to participate. • The goal is for functional improvement within a reasonable time frame.
Day Treatment	• This setting is for clients who can be managed at home. • Provides physical, cognitive, and behavioral intervention. • Cohesive interdisciplinary team. • The goals are for increased awareness, community reintegration, return to work/school, IADLs, and basic ADLs.

Assisted Living Unit or Residence or Facility	• Apartment or a cottage. • Meals and medication management can be provided on a daily basis. • 24-hour support is available. • OT services enhance ADLs and IADLs necessary to remain housed at the ALU/ALF.
Outpatient Care	• This setting is for the medically stable, who live at home and require 1-3 therapies. • The goal is to educate the patient or family for the final discharge home.
Table 1.1	

Evaluation For Discharge from Acute Care

In acute care settings, OTs typically provide simultaneous evaluation, intervention, and discharge planning within a single day, as patients' lengths of stay can be unpredictable, and discharge can occur suddenly. Discharge planning is considered in every session to ensure timely identification of needs, immediate intervention to address barriers, and seamless transitions to post-acute care settings.

The occupational therapy evaluation and discharge planning begins the moment you enter the patient's room.

Chart Review

The primary source of information is the chart review of the patient's medical record, which includes:

- Physician orders
- Patient precautions
- Vital signs
- Medications
- Laboratory and imaging reports
- Progress notes from interdisciplinary team.

Assessments

Assessments in acute care occupational therapy involve a combination of standardized tools, observation, and interview. Due to time constraints, therapists often utilize select subtests or a limited number of assessments to quantify clinical observations and track progress. When standardized assessments aren't feasible, facilities should establish consistent evaluation procedures.

Occupational Profile & Interview

To develop an Occupational Profile, occupational therapists gather information on patients' living environments, home support, needs, and wants. Effective interviewing involves understanding what patients need to do, want to do, and are expected to do. Semi-structured assessments like the Canadian Occupational Performance Measure (COPM) or visual analog scales facilitate client-centered evaluations, capturing patients' perspectives on their functional levels and satisfaction.

Occupational Performance

Occupational evaluation begins by assessing patients' wants, needs, and values. Functional performance assessments, such as transferring or using the restroom, take precedence over evaluating patient factors like range of motion, sensory abilities, or strength. Experienced occupational therapists employ deductive reasoning and clinical reasoning to understand patients' functional capabilities. For instance, a patient requiring maximum assistance with bed-to-wheelchair transfers likely cannot transfer to the toilet independently. These reasoning skills help occupational therapists navigate acute care's time limitations.

Preparing For Discharge

When you're getting a patient ready to be discharged from the hospital, you will first need to figure out how they were functioning before they came in (PLOF) and compare it to how they're doing now (CLOF). You're looking for any significant differences that might make it hard for them to go home safely. Sometimes, the fix is simple—like giving them adaptive equipment to make things easier at home. Other times, they may need more occupational therapy. If you're unsure how safe they'll be at home or if they'll be able to manage everything, it's a good idea to have family members involved and/or recommend home health therapy to check on them in their home environment.

You also need to check how well they can handle everyday tasks, like getting dressed or cooking a meal, and their cognitive function. By looking closely at how they do certain activities, you can spot any problems that might make it hard for them to be independent. Since you don't have much time with them in the hospital, use functional tasks to see how focused they are or how well they remember things. For example, give them two tasks but only provide materials for one and see if they remember the second one. If you find cognitive problems that might make things unsafe for them, you may need to recommend they go to a facility where they can get more care unless they have family who can support them.

Throughout this process, ensure you work with the patient and their family. If the patient can't make decisions independently, talk to the family, but still involve the patient where you can—it's essential to respect their autonomy. Patients can participate in their care by choosing the facility location and selecting personal items to bring from home.

Your main goal is to figure out if they can go home safely or need to be in a place where they can get more help. For older patients, especially those living alone, consider recommending services like day programs, Meals on Wheels, or home health care to help them stay safe. Always remember the community resources available, like low vision training or adult day care, to ensure patients have the support they need after leaving the hospital.

Key risk factors for 30-day readmission include:

- Living alone
- Unmet ADL/IADL needs
- Limited skills for carryover
- Limited education.

INTENSIVE CARE UNIT (ICU)

Navigating the complex world of Intensive Care Unit (ICU) occupational therapy requires precision, expertise, and confidence. Critically ill patients, life-sustaining equipment, and delicate medical balances demand a deep understanding of therapeutic strategies, vital signs, hospital equipment, lab values, and medical interventions. This section is designed to help you answer the toughest ICU-related questions with confidence, clarity, and expertise.

Vital Sign Monitoring

As occupational therapists, monitoring vital signs before, during, and after therapy sessions isn't just a routine task—it's a critical safeguard for your client's well-being. It allows you to gauge their physiological responses to therapeutic activities, identify potential complications early on, and adjust your interventions accordingly. This is particularly crucial when working with clients in the intensive care unit, where even slight fluctuations in vital signs can signal a change in their condition. Remember, a proactive approach to monitoring vital signs demonstrates your clinical understanding and commitment to patient safety. Now, take some time to familiarize yourself with the tables below of commonly monitored vital signs and their normal ranges.

HEART RATE (HR)	
Bradycardia	<40 bpm
Normal	60-100 bpm

Higher Than Normal	90 - 110
Tachycardia	>140 bpm
Cardiac Distress	• HR increases by >20 bpm

Table 1.2

Red* Contact medical team
Yellow* Modify activity/rest break
Green* Continue with treatment

BLOOD PRESSURE (BP)			
	Systolic (mmHg)		**Diastolic (mmHg)**
Too Low	**<60**	**and**	**<40**
Hypotension	<80	and	<60
Borderline Low	90	and	60
Low Normal	110	and	75
Normal	<120	and	<80
Prehypertension	120 – 139	and	80 – 89
Hypertension Stage I	140 – 159	or	90
Hypertension Stage II	160 – 179	or	>90
Hypertension Stage III	**>180**		>100
Orthostatic	**Drops by 20 mmHg**		**Drops by 10 mmHg**
Orthostatic			

Table 1.3

SpO2	
Normal	95%-100%
Abnormal	<95%
Sub-Optimal	<90%

Table 1.4

RESPIRATORY RATE (RR)	
Normal	<12
Normal	12-20 bpm
Abnormal	>20 bpm
Medical Emergency	>35 bpm

Table 1.5

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Don't overcomplicate it box

COMMONLY USED ICU EQUIPMENT	
VENTILATOR 	It is a machine that provides respiratory support for patients who cannot breathe independently. • Do not panic if a disconnection occurs; alarms will alert nursing. • Reconnect the tubing and continue with treatment following facilities protocol. • Or call nursing to help.
Aterial line	**avoid flexion of joint, if becomes dislodged, apply pressure to area immediately**
Nasogastric tube	**Becomes dislodged, tube feeds should be held immediately to avoid aspiration**

Hospital Bed	• An air mattress is for skin integrity maintenance and healing.
	• **Trendelenburg** is when the foot of the bed is higher than the head.
	  ○ Used for hypotension or shock to increase blood flow to the brain and organs.
	  ○ Can also be used to help boost patients up in bed.
	  ○ Risk of aspiration or regurgitation.
	• The **Chair Position** places the head of the bed as high as possible, with the legs in a dependent position, to prepare for sitting EOB.
	• **Physician orders are required to have all four bed rails up because this is considered a restraint.**

Bedside Commode	• Portable toilet

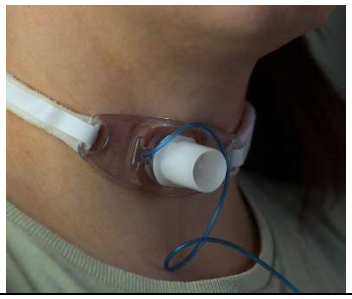
	• Can be placed directly over toilet. • Can be placed next to patients bed.
Restraints	• Patients with confusion may need restraints • Can prevent patients from climbing out of bed or falling, or pulling out medical equipment. • Make sure physician orders for restraints are in place before applying them.
Mechncal Lifts	• Help move patients who are dependent or profound disability
TRACHEOSTOMY 	It is used for acute respiratory failure. • Therapy will be scheduled after trach collar or spontaneous breathing trials. Collaborate with the respiratory therapist and nurse to schedule a good time for therapy.
Postsurgical Drains	Collects excess fluid Notify nurse immediately if the tube becomes dislodged.
TEMPORARY PACEMAKER 	It is used for clients after heart surgery. • If wires are accidentally removed, contact the nursing staff immediately. • Clients can engage in ADLs and mobility. • Keep the pacemaker box clean and dry.
PICC Lines	Long-term medication needs Avoid taking BP over PICC line. Caution with using crutches. Follow facility procedures.
EXTERNAL VENTRICULAR DRAIN (EVD)	It relieves intracranial pressure, hydrocephalus, or cerebral spinal fluid. • It must be clamped before the patient sits up.

Table 1.6

LABORATORY VALUES

OTs must consider the total clinical picture. The values listed in this section are general guidelines and should be used as a reference in helping decide when treating a patient is appropriate or needs to be deferred.

Glucose

Glucose is the body's primary energy source, especially for the brain and muscles, and maintaining balanced levels is essential for overall well-being. As an OT, it's crucial to recognize diabetes-related emergencies. Hypoglycemia (insulin reaction) occurs when there's excess insulin, inadequate food/sugar, or excessive physical activity, causing confusion, dizziness, and weakness. If the client is conscious, provide sugar (candy, juice) and rest; if unconscious or severely symptomatic, seek immediate medical attention. Hyperglycemia (ketoacidosis) is a medical emergency requiring immediate action. Symptoms include fruity breath, dehydration, and blurred vision, often caused by inadequate insulin or poor diet. Do not give sugar; instead, alert medical personnel for prompt intervention.

Glucose		
Critical	<40 mg/dl	Defer OT
Abnormal	<70 mg/dl	Defer OT, provide orange juice. Candy.
Abnormal	<100 mg/dl	Unsafe to exercise
Normal	70 – 110 mg/dl	BADLs and resistive exercises
Abnormal	>240 mg/dl	Light exercises, supported mobility
Critical	>300	Defer OT

Table 1.4

Hemoglobin (Hgb)

Hemoglobin (Hgb) is a critical component of red blood cells and is responsible for carrying oxygen throughout the body. When hemoglobin levels are low, the heart must work harder to pump enough oxygen to the body, which can cause symptoms like lightheadedness or dizziness, especially during upright activity. When hemoglobin is low, more rest breaks may be needed and activities should be modified. Low hemoglobin is often seen in conditions like anemia, which can be caused by chronic diseases such as COPD or CHF, dehydration, or certain medications. On the other hand, elevated hemoglobin levels, while less common, can also be problematic, leading to thickened blood and increased strain on the heart. High hemoglobin can be caused by dehydration,

living at high altitudes, or some bone marrow disorders.

Hemoglobin		
Critical	>21	Increased Blood Vicosity
Normal	13 - 18	No Restrictions
Abnormal	>10	ADLs, Mobility, Resistive Exercise
Abnormal	8 - 10	BADLs, Weights 1-2 lbs, Closely Monitor
Abnormal	<8	Light BADL
Critical	<7	Heart Failure, Death
Table 1.4		

Hematocrit (Hct)

Hematocrit measures the percentage of red blood cells in relation to the total blood volume, which gives us essential information about a client's overall health, particularly when diagnosing conditions like anemia or dehydration. Low hematocrit levels can indicate nutritional deficiencies (particularly iron), chronic diseases, or anemia, where the body doesn't have enough red blood cells to carry oxygen efficiently, leading to symptoms like weakness, fatigue, tachycardia, and dyspnea. These clients may need more rest breaks during therapy, and their activity levels should be closely monitored. Conversely, high hematocrit levels, which can be caused by dehydration, burns, congenital heart defects, or even extreme physical exercise, increase the risk of blood clotting and heart palpitations. This abnormal increase can lead to severe complications like strokes or heart attacks.

Hematocrit		
Critical	>65%	Blood clotting
Normal	>35%	ADLs, mobility, exercises
Abnormal	25% - 35%	BADLs, light exercise
Abnormal	<25%	BADLs
Critical	<20%	Cardiac Failure
Table 1.4		

International Normalized Ratio (INR)

INR is a crucial measure for patients taking anticoagulation medications, like Warfarin, as it tells us how effectively their blood is clotting. Clients are considered safe for movement and therapy when their INR is within the therapeutic range (2.0 – 3.0), meaning their blood is thinning appropriately to prevent clots without causing excessive bleeding. When INR levels are too low (<0.9), the client is at increased risk of dangerous blood clotting, which could lead to conditions like stroke, heart attacks, or deep vein thrombosis. Conversely, when INR levels are too high (>5.0), the risk of bleeding becomes significant, and clients may need to be placed on bed rest to prevent severe complications like internal bleeding. Common causes for high INR levels include overuse of blood thinners or liver disease. In contrast, low levels might be due to inadequate anticoagulant dosage, certain health conditions, or interactions with certain foods or supplements that enhance blood clotting.

International Normalized Ratio (INR)		
Normal	0.9 – 1.1	ADLs, mobility, exercises
Normal	2.0 – 3.0	BADLs, light exercise
Abnormal	3.5 – 4.0	BADLs and resistive exercises
Abnormal	4.0 – 5.0	Light exercises, supported mobility
Critical	>5	Defer OT, educate on fall and bleeding risk
Table 1.4		

Platelets

Platelets are the blood cells responsible for clotting, crucial in stopping bleeding when injuries occur. Low platelet levels (thrombocytopenia) increase the risk of bruising, excessive bleeding, and even spontaneous internal bleeding, making physical activities or interventions risky. On the flip side, high platelet levels (thrombocytosis) can lead to abnormal blood clotting, raising the risk of stroke, heart attack, or deep vein thrombosis. Common causes of low platelet counts include certain medications, leukemia, autoimmune disorders, chemotherapy, and viral infections. In contrast, chronic inflammation, cancers, infections, bone marrow disorders, or iron deficiency can cause high counts. As OTs, it's essential to be aware of these conditions and their impact on therapy plans—modifying activities for clients with low platelets to prevent injury or closely monitoring those with high platelets for signs of fatigue or shortness of breath.

Platelets		
Critical	<10,000	Defer OT unless cleared by MD
Abnormal	<10,000 – 20,000	AROM, light exercises, CGA mobility
Abnormal	<20,000-50,000	AROM, moderate exercise, mobility, ADLs
Normal	50,000	Resistive exercises
Normal	50,000-150,000	Progressive resistive exercises
Normal	>150,000	No restrictions
Table 1.4		

White Blood Cells (WBCs)

WBCs are crucial to the body's immune system as these cells fight infections and foreign invaders. When white blood cell levels are low (leukopenia), a client's immune system is weakened, leaving them more susceptible to infections, requiring increased vigilance for signs of illness and potentially necessitating modifications to therapy to avoid overexertion or exposure to pathogens. On the other hand, high white blood cell levels (leukocytosis) often indicate the body is actively responding to an infection, inflammation, or stress, potentially impacting energy levels and requiring adjustments to activity demands. Some common causes of low WBCs include certain cancers, chemotherapy, autoimmune diseases, or viral infections. High WBCs are commonly seen with infections, inflammation, or more severe conditions like leukemia.

White Blood Cells		
Critical	<500	Fatal
Critical	<1,000	Defer OT unless cleared by MD, avoid exercise, wear PPE
Abnormal	<4,000	Strict precautions, confirm if mobility is allowed
Abnormal	<5,000 w/ fever	Defer OT
Normal	5,000-11,000	Light exercises, progress as tolerated
Abnormal	>11,000 w/ fever	Caution with exercises
Critical	>30,000	
Table 1.4		

Standard Precautions

Protecting patients and healthcare personnel from infectious diseases is a top priority. Standard Precautions are essential practices that prevent the transmission of infectious agents in all healthcare settings, regardless of suspected or confirmed infection. These guidelines outline simple yet crucial steps to ensure a safe environment, including hand hygiene, protective clothing, and safe injection practices. By familiarizing yourself with these guidelines, you'll be well-prepared to address infection control scenarios on the exam and in real-world practice.

Standard Precautions for Infection Control:

Hand Hygiene

- Wash hands before direct contact with patients, body fluids, and medical equipment.

Personal Protection Equipment

- Wear PPE treatment involves being in contact with bodily fluids.
- Remove PPE and perform hand hygiene before leaving patient's room.
- Donn PPE in the following order:
    - Gown > Mask > Gloves
- Doff PPE in the following order:
    - Gloves > Gown > Mask

Equipment and Environment

- Clean and disinfect equipment after patient use and before being used with another patient.
- Single-patient use equipment should be used when equipment cannot be easily cleaned.

Barriers and PPE

- Wear gloves with mucous membrane or nonintact skin contact
- Wear protective clothing (gown, mask, goggles) with anticipated splashing

Transmission-Based Precautions

When Standard Precautions are insufficient, Transmission-Based Precautions provide an additional layer of protection to prevent the spread of infectious agents. These precautions are implemented for clients with known infectious diseases that require specialized control measures, such as contact, droplet, or airborne precautions. In these cases, clients may be isolated to minimize transmission risk, and specific infection control techniques must be followed by all healthcare personnel entering the client's room. Understanding Transmission-Based Precautions is crucial for occupational therapists to provide safe and effective care, and to confidently answer related questions on the exam. See table1.1.

Medical Emergencies

In the heat of a medical emergency, every second counts and decisive action is crucial. As an occupational therapist, your calm and confident response can be the difference between life-changing outcomes and devastating consequences. But how do you stay focused and make the right call under pressure? The answer lies in preparation, not guesswork. This section equips you with the essential knowledge and step-by-step guidelines to respond effectively in emergency situations, ensuring you're ready to tackle high-stakes scenarios on the certification exam and in real-world practice. See table 1.1.

TRANSMISSION-BASED PRECAUTIONS		Common Conditions
Contact Precautions (Think direct contact with the patient, environment, or bodily fluids)	• Gowns and gloves • Disposable and single-use equipment	• Methicillin-resistant staphylococcus aureus (**MRSA**), • Vancomycin-resistant staphylococcus aureus (**VRSA**) • Vancomycin-resistant enterococcus (VRE) • Clostridium difficile (**C-Diff**)
Droplet Precautions (Think respiratory or mucous secretions)	• Use standard precautions • **Properly fitting mask** • Sessions take place in patients room. • Use equipment that can be easily cleaned and disinfected.	• Pseudomonas • Tuberculosis (TB) • Influenza virus • Bordetella pertussis • Pneumonia (**PNA**)
Airborne Precautions (Think infectious agents traveling over long distances suspended in the air)	• Clients will be in an airborne infection isolation room (AIIR) or monitored negative-pressure room. • Gowns, gloves, and a properly fitted mask.	• Rubeola virus (measles) • Varicella virus (chicken-pox) • Tuberculosis
Table 1.9		

Medical Emergency	OT Response
Burns	• Treat with basic first-aid procedures. • Rinse or soak the burned area in cold water. • Cover with a clean, sterile or moist dressing or bandage • Do not apply any cream, ointment, or butter. • Get immediate care if skin is charred, missing, or blistered. • If patient is medically unstable, postpone therapy until they can tolerate treatment.
Bleeding	• Wash hands, put on gloves, treat the wound. • Put a clean towel, sterile dressing, or gloved hand over the wound and apply direct pressure. • Elevate the wound above the level of the client's heart. • Do not apply a tourniquet unless trained.
Loss of Balance	• Trying to keep the patient upright can be unsafe If a client falls forward:

	• Guide them to reach for the floor slowly by bending their elbows to cushion the fall. If the client falls backward • Have patient lean against your body or sit on your thigh. • Using good body mechanics, lower the client into a sitting position on the floor using the gait belt.
Chocking (Conscious)	• Ask the client, “Are you choking?” If they can speak or cough let them attempt to expel the object. • If they cannot speak, cough, or breathe, look in mouth and remove any visible object. • Position yourself behind the client and clasp your hands over their abdomen, between the umbilicus and diaphragm. • Use the closed fist of one hand, covered by your other hand, to give 3 - 4 abrupt thrusts against the person's abdomen by compressing the abdomen in and up forcefully (Heimlich maneuver) until the obstruction becomes dislodged or the person becomes unconscious. • Do not do a finger sweep to remove the object. • Seek medical assistance.
Chocking (Unconscious)	• Place the patient in supine and call for help. • Open the patient’s mouth and remove the foreign object using a finger sweep. • Open the airway (tilt the head back and lift the chin forward). • Ventilate using the mouth-to-mouth technique. • If unsuccessful, perform Heimlich maneuver, repeat the finger sweep, and attempt to ventilate. • Continue steps until the object is removed or medical assistance arrives
Seizures Signs: rigid then begin to convulse with all-over jerking motion.	• Put client in a safe location away from anything that might cause injury. • Do not restrict the convulsions. • Loosen clothing around the person's neck. • Do not put anything into the person's mouth. • Once convulsions stop, roll the person onto side to prevent the person from aspirating. • Then have the client rest. • Get medical help.
Autonomic Dysreflexia	• Do not leave the patient alone. • Place the patient in an upright position and remove anything restrictive to reduce blood

	pressure (abdominal binders, elastic stockings). • Drain bladder bag or check leg bag tubing for obstruction. • Monitor blood pressure and other symptoms.
Shock Signs: pale, moist, cool skin; shallow, irregular breathing; dilated pupils; a weak or rapid pulse; dizziness or nausea	• Get medical assistance ASAP. • Figure out the cause and correct it if possible. • Monitor blood pressure, breathing, and pulse rate. • Place in supine, with the head slightly lower than the legs. • If head or chest injury, or respiration issue, keep the head and chest slightly elevated. • Apply a cool compress to the client's forehead and cover with a light blanket. • Prevent exertion and keep the client quiet until emergency medical help arrives.
Hyperglycemia (Fruity Breath)	• Ketoacidosis and dehydration can lead to a diabetic coma and eventual death if not treated. • A nurse or physician should notified ASAP.
Insulin Shock	• If the client is conscious, give sugar such as candy or orange juice. • If unconscious, glucose may need to be provided intravenously. • Allow rest and stop all physical activity.
Table 1.9	

As you prepare for the certification exam, this chapter has provided a comprehensive review of acute care concepts essential for occupational therapists. You've learned critical skills for responding to medical emergencies, implementing infection control measures, and collaborating with interdisciplinary teams. Mastering these principles will help you confidently tackle exam questions and demonstrate your competence in acute care settings. Now, you're one step closer to achieving success on the certification exam and launching your career as a competent and compassionate OT.

Reference: **Smith-Gabai, H. & Holm, S. E. (Ed.). *Occupational therapy in acute care*. (2nd ed.). Bethesda, MD: AOTA PRESS.**

Pendleton, H.M. & Schultz-Krohn, W. (2018). *Pedretti's occupational therapy: practice skills for physical dysfunction* (8th ed.). St. Louis, Missouri: Elsevier.

Learning Objectives: OT Settings, Vital Signs, Standard Precautions, Transmission-Based Precautions, Medical Emergencies, Lab Values, Hospital Equipment, Discharge Planning, ICU,