



12-1-1977

### Planning for the bedside Occupational Therapy

道昌 徐

瑩瑩 林

紫微 曾

Follow this and additional works at: <https://rps.researchcommons.org/journal>



Part of the [Rehabilitation and Therapy Commons](#)

#### Recommended Citation

徐, 道昌; 林, 瑩瑩; and 曾, 紫微 (1977) "Planning for the bedside Occupational Therapy," *Rehabilitation Practice and Science*: Vol. 5: Iss. 1, Article 3.

DOI: <https://doi.org/10.6315/3005-3846.1535>

Available at: <https://rps.researchcommons.org/journal/vol5/iss1/3>

This Report is brought to you for free and open access by Rehabilitation Practice and Science. It has been accepted for inclusion in Rehabilitation Practice and Science by an authorized editor of Rehabilitation Practice and Science. For more information, please contact [twpmrscore@gmail.com](mailto:twpmrscore@gmail.com).

## 病房職能治療計劃作為\*

### PLANNING FOR THE BEDSIDE OCCUPATIONAL THERAPY

榮民總醫院復健醫學部 徐道昌 林瑩瑩 曾紫微

#### I. Introduction:

Rehabilitation medicine differs necessarily from the practice of other types of medicine in one special way. It requires the abilities and skills of a complete rehabilitation team, working in an integrated and coordinated effort to assist the patient in reaching the maximum of his physical, emotional, social, and vocational potentials. Among the team approaches, occupational therapy plays an important role in amelioration of patient's disabilities and promotion of patient's abilities to regain independent living.

While many factors may prevent the patient from early and better occupational therapy treatment, bedside occupational therapy will help to provide a more effective and complete occupational therapy service.

Patients with transference problems or in general weakness are conventionally treated as bed-ridden patients, and postural hypotension, contracture, or pressure sore may take place. In this case, bedside occupational therapy program is helpful not only in early treatment to facilitate motor recovery and prevent complication, but in patient's better adjustment to hospitalization and his illness.

Patients with poor sitting balance or poor working endurance may profit more by repetition of short period of occupational therapy treatment. Usually this could only be done by sending patients to the occupational therapy clinic several times a day, putting both the ward staff and patients to inconvenience. Bedside occupational therapy will be useful in solving this problem.

---

\*本文原擬於本學會第四次學術報告中提出，但因大會時間限制未果，故特商請原報告人同意由「復健醫學會雜誌」第五期全文刊出。

## 22. Journal of Rehabilitation Medicine

A.D.L. training is one of our major programs to help get an independent living. This may be significant only when training brings about daily practice. Thus, having the A.D.L. training program carry out in the ward environment would be much more effective and practical than having it in the occupational therapy clinic.

Patients may be referred to occupational therapist for splinting or making A.D.L. aids and adaptations. This is also more convenient to have the therapist see the patient in the ward than having the patient come to the occupational therapy clinic.

In short, bedside occupational therapy program adds the conventional occupational therapy practice to provide a better and complete occupational therapy service for the patients to get a more effective and significant rehabilitation.

### II. Functions of the bedside occupational therapy:

- a. Therapeutic: through exercises, splinting and graded activities
  1. To increase working tolerance.
  2. To prevent and/or correct deformity.
  3. To increase self-care independence.
  4. To facilitate motor recovery.
  5. To increase muscle strength.
  6. To increase range of motion.
  7. To develop coordination and motor skills.
- b. Supportive:
  1. To help the patient to adjust to hospitalization and to his illness.
  2. To aid in alleviating worry and distress.
  3. To maintain and to stimulate normal interests and social contacts.
  4. To give an outlet for irritation and resentment.
  5. To divert the mind from concentrating on the physical functioning of the body.

### III. Indications for bedside occupational therapy:

- a. Patients whose condition does not permit him to come to occupational therapy clinic:

This includes the patients who

  1. Have transference problems.  
such as patients with medical apparatus, or pressure sore.
  2. have postural hypotension.
  3. are in general weakness.

4. are in the early stage after operation.
- b. Patients whose occupational therapy programs are more suitable to be carried out in the ward environment.
 

This includes the patients who

  1. need only short period of occupational therapy.
 

such as patients with poor working endurance.
  2. are with poor sitting balance/tolerance.
  3. need A.D.L. training to get independent living in the ward.
  4. need A.D.L. adaptations and aids for independent living.
  5. need (1) static splints to prevent and/or correct deformities.
 

such as burn patients.

(2) dynamic splints to increase functions.
 

such as patients with peripheral nerve injuries.

#### IV. Bedside O.T. programs

The physician's referral serves as the guide for the treatment program. This should include the diagnosis, the brief medical history, the objectives to be achieved, and precautions, the prognosis, and knowledges of the length of time recovery may take.

Receiving the referral, the bedside occupational therapist first visits the patient to evaluate his physical and emotional status. After acquainting herself with patient's abilities and disabilities, the occupational therapist adjust program planning and patient treatment accordingly.

Since O.T. is activity-oriented, we use various activities to treat the patients. Activities used to provide treatment may include woodworking, braid weaving, block printing, cord knotting, canning, etc.. Because that no patient manifest the same problems, the occupational therapist must adapt whatever activities available for the patients to meet their needs. Thus, the bedside O.T. program is meaningfully patient-oriented.

#### V. Equipments, modalities, and supplies required for bedside occupational therapy:

##### a. Equipments:

##### 1. Read-N-Study table

This is a working table for patients to proceed O.T. activities right in place on his bed. The working surface of the table can be adjusted to an angle of 30', 60', and 180' related to the ground. The table is movable that every patient

## 24. Journal of Rehabilitation Medicine

can use it on their own bed. For convenience sake, the number of Read-N-Study tables should be equal to the number of bedside occupational therapists.

### 2. Movable frame, pulleys and suspension slings.

A movable frame is used for siling and pulley attachment. The combination of movable frame and pulleys or suspension slings makes it possible for patients who can't move his arms against gravity to work against gravity as early as possible. Because of the individuality of patients' disabilities, pulleys for at least 4, suspension slings for at least 2, and one movable frame are needed for each bedside occupational therapist.

### 3. Weight carrier and weights

To provide patients graded resistive activities, weight carrier and different weight of weights are needed. Weight carrier for at least 2 and a set of weights of 0.25 Kg, 0.5Kg, 1Kg, and 2Kg are needed for each bedside occupational therapist.

## b. Modalities:

### 1. The ball-bearing platform:

This is a device that permits a paralyzed extremity to rest on and move over a plat surface with minimal muscular activity. Since some of the patients who need bedside O.T. treatment are in the flaccid stage or in general weakness, so the ball-bearing platform would be a very useful therapeutic device.

### 2. Measuring devices:

Here are the measuring devices that every bedside occupational therapy department should have:

#### (1) Stop watch:

This is a indispensable device for coordination training to improve speed.

#### (2) Timer:

Timer is useful for tolerance training. It is also helpful when the therapist have 2 more patients at the same time.

#### (3) Pocket steel tape:

It is needed for measuring the stump for an amputated patient and is also valuable for setting up the equipments at right place.

#### (4) Hines Digit-O-Meter:

It can evaluate both the opposition and composite flexion of the fingers and provide a more descriptive evaluation of the total hand function.

#### (5) Pinch guage:

It measures the patients ability to pinch accurately. It is

useful in evaluating the progress of the pinch motion and can also be used for training and evaluating the pinching ability of the U.E. prosthesis users.

(6) Dynamometer:

An indispensable instrument for measuring grasping power of the hand.

(7) Spring scale:

This is used for measuring amount of traction, and is very useful in figuring out the maximal weight that an U.E. prosthesis can afford.

3. Wrist extension exerciser:

4. Gym kit and exercise board:

This is a hand exercise board for strengthening finger extensors and flexors, and facilitating fingers individually.

5. Card holders, and adapted checker:

These provide bedside patients with hand function training.

c. Supplies:

Since the bedside O.T. is a program held by the O.T. department, so the bedside occupational therapist can get most the supplies needed for treatment from that. Only the splinting materials needs subscription.

TABLE 1. Seven "positive" personal qualities

POSITIVE QUALITIES	Averages for various groups of subjects								
	Grand Total N 510	Sex		Disabled		Professional work			
		Male N 153	Female N 353	Yes N 65	No N 436	Nurs. N 184	Rehab staff N 29	RMA ROC N 29	Non- Prof. N 232
intelligence	.564	.556	.567	.581	.562	.579	.586	.483	.553
creativity	.584	.562	.593	.588	.584	.630	.560	.491	.581
religiosity	.718	.670	.739	.608	.703	.754	.707	.767	.767
seriousness	.661	.627	.673	.627	.665	.692	.638	.664	.669
optimism	.277	.307	.266	.350	.267	.261	.371	.190	.239
self-confidence	.393	.425	.378	.485	.380	.386	.362	.267	.392
emotional control	.353	.412	.326	.435	.341	.300	.405	.190	.350

TABLE 2. Six "negative" qualities

depression	.766	.752	.771	.731	.772	.784	.698	.733	.776
inferiority	.753	.737	.759	.777	.750	.784	.716	.672	.723
discouragement	.680	.641	.698	.636	.688	.685	.672	.707	.696
aloofness	.740	.694	.759	.708	.744	.757	.629	.681	.689
stubbornness	.706	.672	.722	.638	.718	.757	.629	.681	.716
sensitivity	.800	.750	.824	.723	.815	.829	.759	.853	.841

TABLE 3. Six various other personal qualities

interest in life	.336	.346	.332	.358	.344	.333	.362	.324	.343
pleasure seeking	.510	.549	.494	.527	.510	.501	.569	.379	.531
easily satisfied	.494	.523	.480	.460	.499	.436	.552	.483	.546
like sympathy	.625	.616	.627	.619	.624	.626	.612	.698	.637
expect help	.660	.680	.654	.596	.670	.651	.698	.741	.679
easily understood	.372	.423	.351	.396	.370	.356	.397	.362	.371

TABLE 4. The disabled and the non-disabled compared about sufferance of pain

	AVERAGE WEIGHTED INDEX FOR SUBJECTS' ANSWERS								
	Grand Total N 510	Sex		Disabled		Professionally involved			
		Male N 153	Female N 353	Yes N 65	No N 436	Nurses N 184	Rehab. Staff N 29	R. M. A. ROC N 29	Not Prof. N 232
sensitivity to pain	.700	.675	.710	.723	.697	.689	.716	.693	.730
tolerance of pain	.697	.691	.698	.677	.703	.705	.672	.569	.723
acceptance of pain	.617	.646	.616	.578	.635	.633	.595	.517	.622

TABLE 5. The disabled and non-disabled compared about interpersonal relationships

kindness	.583	.580	.601	.596	.592	.584	.647	.500	.613
generosity	.541	.531	.546	.569	.538	.542	.612	.466	.523
fairness	.534	.521	.538	.554	.531	.530	.552	.509	.546
friendliness	.532	.575	.511	.596	.521	.488	.534	.517	.518
good-naturedness	.479	.511	.465	.535	.471	.461	.500	.474	.454
trust in others	.416	.513	.373	.515	.401	.348	.474	.440	.412
enjoyment of crowds	.342	.405	.317	.438	.329	.296	.371	.328	.292

TABLE 6. The disabled and non-disabled compared about action oriented qualities

ambition	.608	.588	.618	.715	.596	.649	.517	.602	.605
enthusiasm	.567	.564	.568	.604	.563	.576	.629	.483	.558
flexibility	.456	.474	.448	.473	.455	.455	.517	.388	.460
initiative	.396	.408	.392	.431	.393	.439	.440	.302	.374
risk taking	.367	.330	.382	.419	.359	.250	.310	.250	.354
energetic	.358	.363	.358	.431	.350	.341	.362	.259	.360
active	.300	.307	.297	.323	.298	.308	.336	.270	.301

TABLE 7. The disabled and the non-disabled compared about suitability for work

sense of responsibility	.579	.556	.589	.623	.576	.594	.578	.517	.574
reliability	.578	.580	.575	.604	.576	.543	.612	.543	.598
cooperativeness	.504	.556	.480	.569	.496	.457	.509	.457	.491
perseverance	.636	.644	.633	.627	.640	.622	.603	.517	.687
work ability	.386	.369	.392	.419	.382	.336	.405	.336	.391
work endurance	.371	.371	.373	.473	.354	.386	.397	.233	.341
work efficiency	.372	.353	.380	.465	.360	.353	.422	.302	.355

TABLE 8. The disabled and the non-disabled compared about getting along in the world.

have problems	.754	.714	.773	.708	.764	.776	.757	.707	.762
meet success	.428	.394	.445	.415	.432	.474	.397	.302	.430
opportunities for work	.235	.219	.242	.258	.232	.240	.284	.129	.239
social life	.213	.221	.210	.227	.210	.215	.259	.121	.233