



Minimally Conscious State

Essential Components of a Rehabilitation Program

Case Study Presentations

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Objectives

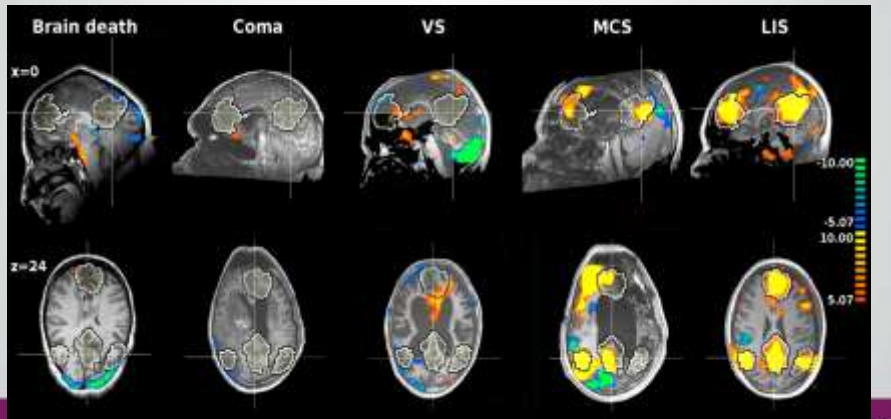
- Define 3 challenges of developing a Disorders of Consciousness Program
- Discuss 3 benefits of objectifying progress with patients who have Disorders of Consciousness
- List 3 barriers to safe/effective discharge home for individuals with disorders of consciousness
- Discuss 3 ways to improve discharge planning for individuals with disorders of consciousness in the inpatient rehabilitation setting

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Altered states of conscious are far from black and white...



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How do we provide information to patients?

- Information about a specific condition
- Evidence organized around specific decisions
- Accessible – charts, graphs
- Balanced
- Encourage patients to interpret evidence in context of their own goals and concerns
- Include patient stories

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Coma

- Definition: A state of extreme unarousable unresponsiveness, in which an individual exhibits no voluntary movement or behavior to either internal or external stimuli
- Continuous absence of eye opening
- No sleep/wake cycles
- Reflexive behavioral responses
- Loss of function in cortical/reticular systems

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Vegetative State

- Definition: Disorder of consciousness in which patients with severe brain injury that are in a state of partial arousal rather than true awareness
- Absence of behaviors that typically accompany conscious awareness of environment

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VS: Clinical Presentation

- No evidence of command following
- No intelligible verbal response or attempts to communicate
- Intermittent wakefulness with inconsistent sleep-wake cycles
- Preservation of autonomic functions to permit survival with adequate medical care
- Localizing or automatic motor responses
 - Same response to sound, sight or touch

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Minimally Conscious State

- Definition: A condition of severely altered consciousness in which minimal but definite behavioral evidence of self or environment awareness is demonstrated
- Presence of specific behavioral manifestations of conscious awareness

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MCS: Clinical Presentation

- Inconsistent:
 - Arousal on and off during the day
 - Comprehension of simple commands
 - Manipulation of objects
 - Gestural or verbal yes-no responses
 - Intelligible verbalizations
 - Stereotyped movements not attributed to reflexive activity

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Challenge to Diagnosis

- 37-43% of patients who suffered a TBI were misdiagnosed as being in a vegetative state
- Accuracy is key!
 - Daily management
 - Pain Control
 - Goals
 - Prognosis

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Childs NL, Mercer WN, Childs HW. 1993. Accuracy of diagnosis of persistent vegetative state. Neurology 42(9):1465-67



Notable Barriers in Acute

- “I don’t have any therapy goals”
- “What do I have to document?”
- “My patient isn’t awake... how can I provide realistic treatment?”
- “It is hard to justify treatment without any measurable progress...”

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TBI



DOC

- Notable barriers on 6E
 - FIM Scores do not capture progress early
 - FIM Total=18
 - Treatment strategies differ
 - Non Traditional Goals
 - Prolonged length of stay
 - Medically complex
 - Family support/ training
- Ongoing changes to program...

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DOC Program: Early Goals

- Track progress → Coma Recovery Scale
- Prevent Medical complications
- Proper positioning
- Early mobility
- Cognition and communication
- Family/caregiver support and education

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Emerging observations

- Righting reactions of the head in various positions
- Sitting Balance and balance reactions
- Tolerance to activity (EO vs EC)
- Vitals response to movement
- Opportunities for EARLY MOBILITY!

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Family Education

- It's never too early...
 - “hope for the best, plan for the worst”
 - Home setup/modifications
 - Splint schedules
 - Stretching Program
 - CRS Emergent behaviors to observe
- Keep it simple and repeat!

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DOC Program Future

- Broaden the continuum of care throughout entire length of stay
- Bridge gap between acute and IPR to improve outcomes
- Implement Coma Recovery Scale as a standard outcome use on all DOC patients

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DOC Program = Integrated Team Approach

- Team Assessment
- Team Goals
- Team Care Rounds
- Team Treatment
- Team Plan of Care Conference
- Team Family Conference

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DOC Team

Patient

Family / Caregivers

Care Manager

Neuro psychologist

Nursing Team

Occupational Therapist

Physical Therapist

Physician Team

Speech Language Pathologist

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DOC Team Assessment

Integrated Interdisciplinary Team Assessment

Assessment Tool = Coma Recovery Scale
(Revised JFK Coma Scale 2004)

Coma Recovery Scale

The purpose of the scale is to assist with

- differential diagnosis
- prognostic assessment
- treatment planning

for patients with Disorders of Consciousness

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Team Assessment

Coma Recovery Scale

- Scoring items organized into 6 subscales comprised of hierarchically arranged items associated with brainstem, subcortical, and cortical processes
 - Auditory Function Scale
 - 5 levels
 - Visual Function Scale
 - 6 levels
 - Motor Function Scale
 - 7 levels
 - Oromotor/ Verbal Function Scale
 - 4 levels
 - Communication scale
 - 3 levels
 - Arousal Scale
 - 4 levels
- Score absence or presence of responses and behaviors at each level
- Scores can range from 0 to 23

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DOC Team Assessment

Integrated Interdisciplinary Team Assessment

Weekly Prior to Plan Of care Conference

- Friday Email to team identifying time frame and patients to be assessed
- Monday Afternoon Team Assessment occurs
- Allows for most up to date status for Plan of care Conferences Tuesday
- Occurs weekly until emerged from Minimally Conscious status or Discharge

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Team Assessment

Benefits

- Individualized
- Comprehensive
- Timely
- Efficient
- Provides data to the Team
 - Clarifies status
 - Allows for comprehensive Team directed Plan of care
 - Data is timely prior to Plan of care Conference
 - 15-30 minute weekly assessment facilitates efficient treatment plan

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CRS Team Assessment Results

Data / Results

- Data = 10 months
- Sample == 20 patients
 - 15 Traumatic Brain Injury
 - 4 ACOM aneurysm
 - 1 Anoxic Brain Injury

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CRS Team Assessment Results

Discharge Disposition

- 15 Traumatic Brain Injury
 - 10 D/c Home
 - 4 D/c Acute
 - 1 D/c SNF
- 4 ACOM aneurysm
 - 2 D/c acute
 - 1 SD/C SNF
- 1 Anoxic Brain Injury = D/C Home

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TBI CRS Team Assessment Results

	Days Post	CRS 1	CRS 2	CRS 3	CRS 4	CRS 5	LOS	D/c Disposition
1	71	10	12	18	20		49	Home +
4	129	6	7				15	Home -
5	232	9	9	10			30	Home-
7	59	14	8	10	8		36	Home+
8	21	6	6	22	23		59	Home +
11	189	4	10	7			27	Home +
12	24	3	11				49	Home +
13	43	13	19				43	Home +
14	21	7	6	15			56	Home +
15	35	8					47	Home +

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TBI CRS Team Assessment Results

	Days Post	CRS 1	CRS 2	CRS 3	CRS 4	CRS 5	LOS	D/c Disposition
2	39	6	6				30	SNF -
3	48	5	5	8	6		34	SNF -
6	21	8	7	8	9		33	Acute / Crani
9	31	7	10	13	15		20	Acute / Crani
10	44	7	9	11	13	17	36	SNF -

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ABI CRS Team Assessment Results

	Days Post	CRS 1	CRS 2	CRS 3	CRS 4	CRS 5	LOS	D/c Disposition
1	67	4	6	6	6		28	Home -

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ACOM CRS Team Assessment Results

	Days Post	CRS 1	CRS 2	CRS 3	CRS 4	CRS 5	LOS	D/c Disposition
1	41	16					22	Acute
2	24	0	3				11	*
3	27	14	17	18			23	Acute
4	26	8	9	14			24	SNF

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DOC Program

Charting

Coma Recovery Scale

Vital Signs

- Pre / During / Post Activity

- Position

Level of Arousal

= % of Eyes Open (EO) / session

Response to stimuli

- Immediate

- Delayed

- Absent

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DOC Program

- DOC Program Meetings
- DOC specific Coverage Notes
- DOC Specific Patient Family Education
- DOC Acute Care staff Education
- DOC Data Collection

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CASE STUDY: PROGRAM IMPLEMENTATION

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History and Physical

- 27 year old male status post motor vehicle crash on 12/16/14
- HCT (+) SDH, SAH, IVH, DAI with brain stem involvement
- R clavicle fracture, L ankle fracture including 2nd/3rd metatarsal (non-weight bearing right upper extremity/ left lower extremity)
- Complicated hospital course by:
 - R blown pupil
 - Hemothorax
 - Trach placed 12/22/14

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History and Physical

- Lives in a 1 story house
- Employed as a pipeliner for a gas drilling company
- Enjoyed his dog, blue grass music, youth group leader, and Cleveland Browns fan
- Prior level of function: independent

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Initial Evaluation 1.7.15

- Physical Therapy
 - Dependent for all functional mobility
 - Orthopedic Complications: NWB R LE
 - PROM UE/LE WFL
 - No Spasticity
 - Spontaneous Visual field scanning
 - Arousal: Eyes open <25% of the time

Initial Coma Recovery Score: 5

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Initial Evaluation 1.7.15

- Occupational Therapy
 - Dependent for activities of daily living and transfers
 - No command following
 - Visual threat in Left eye and 50% in the Right eye
 - No purposeful tracking
 - However 2nd session spontaneous movement noted on the left upper extremity and occasional tracking to father's voice on the left.

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Initial Evaluation 1.7.15

- Speech Therapy
 - #8 cuffed Shiley trach, tolerating cuff deflation
 - Not tolerating PMV trials
 - NPO
 - Spontaneous saliva swallows, swallows w/oral care
 - Mouth guard for bruxism
 - Nonverbal
 - No gestures or command following
 - Occasional facial expression in response to discussion of others (ie. Furrowed brow)

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Week 1 Presentation

- Physical Therapy
 - Sitting Balance – Total Assist
 - No balance reactions noted
 - Poor head/trunk control
 - Arousal: Eyes open 75% of session
 - Visual Scanning to Name and family: 50% of time
 - Inconsistent 1 step commands

Coma Recovery Scale: 6

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Week 1 Presentation

- Occupational Therapy
 - Left upper extremity withdrawal response noted during morning activity of daily living routine
 - Spontaneous movement noted on left digits
 - Passive range of motion to bilateral upper extremities
 - Command following for upper extremity exercise

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Week 1 Presentation

- Speech Therapy
 - #6 cuffless Shiley trach
 - Tolerating PMV throughout the day
 - NPO, mouth guard removed
 - Nonverbal
 - Inconsistent y/n response via eye gaze or blinking
 - Inconsistent command following for simple body-centered commands
 - Inconsistent object ID in field of 2 via eye gaze

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Week 2 Presentation

- Physical Therapy
 - Maximum Assist for functional transfers
 - Improved initiation
 - Restless and Resistive behavior
 - Object Manipulation
 - Following 1 step commands 100%

Coma Recovery Scale: 10

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Week 2 Presentation

- Occupational Therapy
 - Visual scanning/tracking exercises
 - Cervical spine stretching
 - Photo identification tasks
 - Command following for activities of daily living tasks

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Week 2 Presentation

- Speech Therapy
 - #6 cuffless Shiley trach
 - Tolerating capping trials
 - NPO
 - Beginning PO trials
 - Nonverbal
 - y/n via multimodal communication inconsistent
 - Spontaneous involuntary vocalization, not voluntary

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Early Short Term Therapy Goals In Recovery

- Improved Arousal and Initiation with activities
- Develop mode of communication for basic wants and needs
- Improved command following for simple tasks
- Family Training

Long Term Goals: Modl/supervision

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Progress (week 3-5)

- Physical Therapy
 - Supervision for Sitting balance
 - WBAT R LE
 - Moderate Assistance for ambulation, transfers, stairs
 - BWS overground ambulation trianing
 - Non supported gait training
 - Verbal Agitation/frustration
 - Decreased insight, impulsive, easily distracted

Coma Recovery Scale Score : 22

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Progress (week 3-5)

- Occupational Therapy
 - Requiring Maximum assistance for grooming tasks progressing to Moderate assist for dressing tasks.
 - Maximum assistance for sliding board transfers progressing to stand pivot transfers with maximum assist
 - Yes/no response using a white board
 - Becoming resistive to tasks progressing toward pleasant/ cooperative
 - Therabar therapeutic exercise
 - Functional mobility around the unit with minimal assistance

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Progress (week 3-5)

- Speech Therapy
 - Decannulated
 - Diet Initiation
 - MBS unsuccessful as he rejected barium boluses
 - Diet progressed from D1/thins to D2/thins
 - Selecting preferred PO via pointing
 - First voluntary vocalization/verbalization week 3
 - Week 4 – mod-severe spastic dysarthria (~50% intell.)
 - Week 5 cognitive testing
 - Moderate on CLQT
 - Severe in Attention, Executive Functions
 - Mod in Visuospatial Skills, clock drawing
 - Mild in Visuospatial Skills and Memory (still confabulatory)

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Getting Ready for D/C Home (week 6)

- Physical Therapy
 - Minimal Assistance/Supervision for all functional mobility
 - Higher Level Balance Activities
 - Community Outing

Coma Recovery Scale Score : 23

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Getting Ready for D/C Home (week 6)

- Occupational Therapy
 - Completing a scavenger hunt around the unit
 - Self care routine at supervision to minimal assistance level
 - Minimal assistance for functional transfers
 - Supervision to minimal assist for moderate cognition tasks.

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Getting Ready for D/C Home (week 6)

- Speech Therapy
 - Regular diet/thin liquids
 - Mild dysarthria but 80-100% intelligible to unfamiliar listener
 - Improving prosody and rate
 - Using humor, not always appropriate
 - Moderate cognitive deficits
 - Ex functions, problem solving/reasoning most significant
 - Confabulation still a limitation

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DISCHARGE PLANNING: 2 CASE STUDIES

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Healthcare Costs of Severe Brain Injury

- The CDC estimated in 2010 that direct and indirect costs of care for severe brain injury were \$76.5 billion
 - Initial medical care
 - Loss of productivity
 - **Long term care needs**

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Benefits of Home

- #1 goal of our patients and their family
- Familiar environment
 - Less stress on brain

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Case Study #1

- 17 year old male, car surfing-ejected to highway
 - GCS 3 in the field
- Found to have diffuse SAH, SDH, hemorrhagic parenchymal contusions, multiple facial and skull fractures, bilateral pulmonary contusions, L carotid aneurysm
- Required bilateral frontal craniectomy

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Case Study #1

- Hospital Course complicated by: paroxysmal sympathetic hyperactivity, tracheostomy, PEG placement, hypernatremia
 - 2 interruptions of IRF stay
- Previously independent, senior in highschool, enjoys football, baseball, splits time with divorced parents

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Case Study #1

- Initial Eval (September):
 - No eyes open, command follow, positive withdrawal to noxious stimulation
 - Spasticity noted all extremities
 - L ankle -35* DF, R ankle -25* DF

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Case Study #1

- Full coma recovery scale not documented until December: 6/23
 - One week later 7/23
- Early family engagement with care and treatment sessions
 - Assisting with hygiene, dressing, transfers, stretching, edema management, standing frame activities

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Case Study #1

- Plan from the beginning to take individual home regardless of level of care required
- Discharged home with tilt in space wheelchair, standing frame, shower chair, hospital bed, trach supplies, tube feeding supplies

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Case Study #1

- Follow up phone call
 - Confused about medication administration
 - Little sleep for caregivers and patient
- Increased contractures
- Poor use of standing frame
- Miscommunication regarding management of heterotropic ossificans

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Case Study #2

- 23 year old male pedestrian vs vehicle
 - GCS 5 in the field with posturing noted
- Noted with diffuse axonal injury, multiple IPH, L frontal SDH, R parietal SDH, bilateral temporal bone fracture, L tibial plateau fracture with possible ACL tear
 - Placed in knee immobilizer 20-30* flexion, WBAT

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Case Study #2

- Living in 2 story home with parents
- Independent
- Working at grocery store
- Enjoys video games and hanging out with friends

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Case Study #2

- Initial Eval: Total assist for transfers, sitting EOB
- No command follow
- No tone noted all extremities, full ROM
- R gaze preference
- Auditory startle and localization noted
- Visual startle and tracking noted

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Case Study #2

Week	JFK Score
1	8/23
3	8/23
5	9/23
6	14/23
8	10/23

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Case Study #2

- Family Meeting Week 7
 - Team approach
 - Medical overview
 - Therapy interventions and goals
 - Checklist of family training to be completed
 - List of equipment likely needed at home
 - Discussion of need for home visit

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Case Study #2

- Home visit 2 days prior to discharge
 - PT/OT
 - ❖ Main goal to assess safety of use of stair glides for entry into home
 - Assessed bathroom mobility
 - Assisted with room set up

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Factors Effecting Caregiver Retention

- Anxiety
- Coping
- Relevance
- Consistency

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Goals for education prior to discharge home

- Spasticity management/monitoring
 - Splints, stretching
- Monitoring for emergence
 - Need for increased level of care
- Mobility training
 - Transfers, bed mobility
- Finding a community and/or having an option for respite care

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Goals for education prior to discharge home

- Skin care
- Use of equipment
- Medication administration
- GI Tube maintenance
- Trach care

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Future Program Changes

- Home visits on a case by case basis
- Telephone/telemedicine follow ups
 - Problem solving
 - Monitoring for emergence

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