cannot do, and we are able to suggest modifications in the home such as ramps for wheel chairs, grip rails, extra banisters, locks for the beds perhaps and all sorts of things. This again is part of treating the whole patient. We get a good idea what the home life is like and when we have met the husband or wife and seen the situations that they have to cope with it helps us with our treatment for the few remaining weeks that the patient is in hospital.

We use group exercises for general stimulation and for competition. When a patient reaches a peak (and you quickly sense this) she must be discharged from the hospital as soon as possible, otherwise she will begin to deteriorate again. This is where the medical social workers play their part in placing the patient in the most suitable home. After discharge we have the patients up for a few short courses just to prevent deterioration.

Patients with arthritis represent the second largest group we deal with, and in many cases they have knee flexion deformities. We treat this by soaking towels in iced water, wringing them out and wrapping them round the knee. This is better for relieving arthritic pain than the old heat lamp. We then treat them by proprioceptive neuromuscular facilitation because most of them have got weak flabby muscles and if weak flabby muscles are holding a joint it is not very stable, therefore it is painful. The stronger the muscle can be made the more stable the joint will be and the less pain the patient will get. Another thing we use ice for is the arm in spastic hemiplegia; the arm is dipped three or four times into a bowl of ice water all the spasm is relaxed, not for any great length of time but for just sufficient time for you to exercise the stretched muscles. Gradually the time of relaxation gets longer and as the stretched muscles become stronger, some movement comes back in the arm.

Occupational therapy in geriatrics

Miss H. Goldstone (*head occupational therapist*)

For many years occupational therapy in geriatrics simply meant handing out a ball of dishcloth cotton and a pair of knitting needles. It is a fallacy which is still believed, that if people are moving their hands their minds are occupied; this is just not true, especially in geriatrics. When I first came to St Helen's I realized that I was not just an occupational therapist come to work in geriatrics; I was a member of a vital team, full of enthusiasm, led by Dr Irvine, and the rest of us were carried along on a wave of enthusiasm which has not waned in seven years—the most exciting seven years of my life. I still enjoy every minute of it because we never know from one day to the next what he is going to think up and what we are going to be expected to do.

Of course the whole conception of occupational therapy has changed as dramatically as all other treatments in the last few years. The aim of treatment is to encourage personal independence, to assist the patient to regain confidence, to maintain mobility whether this is in walking or in a wheelchair, and to help the patient to live as near normal a life as possible. The types of illness we mostly treat are strokes, rheumatoid arthritis and Parkinson's disease. Mrs Morrison has spoken about the attitude towards the patient and the need of a good sense of humour and I add to that a very real love for the patients. I agree with Dr Ashley that all people working in geriatrics should be hand-picked. For most of these patients who come to us in hospital it is probably the first

time they have left home, they feel deserted by the people who love them, they need to feel that we care for them because they are so afraid of what lies ahead of them, and we can only establish a good rapport with them if we really care for them. Unless we do this and get their co-operation we might just as well save our breath. Although they may look frail there is usually a will of iron that has carried them through life's trials and tribulations and they are soon on the defensive, and we just cannot get anywhere with them.

Teaching people to dress

The occupational therapist is really responsible for teaching the patient to dress. If a patient is suffering from rheumatoid arthritis and finds it difficult to move her shoulder, she is taught to use what we term a dressing stick, which is simply a rod with a rubber thimble on the end, and this enables her to push the coat off her shoulder. It is ideal for a hemiplegic patient who can use it for the same purpose to overcome her shoulder paralysis. It is a useful gadget for people who find it difficult to bend; they can hold their pants out with it, and ladies who cannot get their stockings off can push them down with this because the rubber stops them from laddering.

A special gadget is used with long tapes for putting on stockings for patients finding difficulty in bending. A funny thing happened with this some time ago. In the orthopaedic geriatric ward a lady with a fractured femur was taught to use this; after about the third day she said 'You know it has been worth fracturing my leg! For 20 years I have had a neighbour to put my stockings on because I could not bend, and now I will not need her any more'. That was quite a good advertisement for our stocking aid.

Quite often the reason we have to teach these people to dress is that, although they may have been running their own home and looking after their family right up to the time of the fall, the very fact of having an accident or coming into strange surroundings makes them confused about the ordinary elementary pattern of life and you find them putting their pants on their head or trying to put a dress over a nightdress. So it's necessary for us to give them a few days' lessons to start with. Some only need coaching once or twice, some need it for a week or two, but it is important that they feel we have all the time in the world, otherwise they get flustered and confused because they think they are taking up somebody else's share of the time.

Trying to get a woolly cardigan over a thick dress is a bit of an effort, even when you have full use of both hands and both arms, but when one of your arms is affected by a stroke it is almost impossible. We discovered that putting a silk lining in a cardigan makes life very much easier, and it becomes much simpler to pull it on. We now use a special kind of dress, ordinary to look at but it wraps round rather like an overall; it appears to have a back panel, but the back panel can pull aside and the skirt is divided. This prevents the indignity of having the clothes hoisted up behind the patient.

A similar method has been adopted for a man's jacket; the back seam has been opened and 'velcro' has been put on either seam. This is basically for the use of a heavily disabled patient in a wheelchair whose wife or friend can open the jacket and put it on from the front, then simply press down at the back which saves all the hoisting and pushing of the poor wheelchair patient, who is usually twice as heavy as anyone else.

The use of velcro on men's shirts is useful for those unable to cope with tiny buttons. Velcro stitched under buttonholes and in place of buttons, enables the patient to close the opening with slight pressure, but it is helpful to sew buttons on top of buttonholes to give a normal appearance. It is important that the patient feels socially acceptable.

Rehabilitation of the housewife

Now we come to the rehabilitation of the housewife. It must be frightening after a stroke to feel one is dependent on other people, and I think for the housewife this is

almost as bad as for the man who is the breadwinner, because everyone in the home depends on her. Even if she is a geriatric patient, she still must have the horror of knowing that the people round her have got to do things for her; so it is absolutely essential that she realizes at the earliest possible moment that the team are there to help her get back her independence.

The physiotherapists call us in almost immediately the patient is able to get out of bed, to teach her dressing and then toiletry and then the ability to feed herself. When she is well enough to come down into the department, there is a kitchen unit where we are able to get her back into the rhythm of doing the normal daily chores. One of the first things needed is to make a cup of tea and to butter a slice of bread. The problem of cutting bread is disposed of by buying a sliced loaf, but a simple gadget which is only a piece of formica with a narrow border of wood clamped on to the table, saves the frustrating exercise of chasing a piece of bread all round the board when trying to butter it. Learning to stand over a hot oven needs quite a bit of restraining and confidence when the patient isn't sure about her balance. One lady who had a severe stroke and made a dramatic recovery was so excited at the prospect of getting back into the routine of daily housework, that on her first visit to our kitchen it took nearly 20 minutes to peel a potato and I am sure she washed it with her tears most of the time. Although she had her stroke in January, by March she was home, looking after her family and she still comes up to see us when she comes to speech therapy. She is terribly thrilled and full of the joy of living.

Not all women want to be rehabilitated back to the home, and at 92 one old lady decided she would like to learn a new hobby. She came in with a fractured leg, and after a couple of days doing gentle exercises on the treadle machine, she suddenly decided that she would like to take up woodwork, and thoroughly enjoyed sawing and planing a flower trough.

Some patients come into the department absolutely terrified. They have been taken care of in the ward by kind nurses, they have been looked after in the physiotherapy department in a cubicle with curtains round, then suddenly they are brought into our department which is a hive of activity and noise and most of them are genuinely scared. Fortunately I have good staff who understand this and they are all careful to make sure that each patient is made to feel at home and to understand that the exercises they learned in the physiotherapy department are now being put to a practical use.

Male patients and the workshop

Most of our male patients are rehabilitated in the workshop and it is most important that the articles they make should also be useful; the fact that they are making them for other patients as part of their rehabilitation is a great incentive. This is where all the enthusiasm comes in. Every patient is thrilled at the prospect of his friends around him making progress as well as himself and they all try to help each other. Tools and machinery have to be especially adapted to give specific exercise to paralysed limbs.

A gadget with finger shapes gouged out of a block of wood, enables the patient with a contracted hand to have extension exercises for hand, arm and shoulder as he uses this block for sand-papering a length of wood. The length of wood is eventually turned into the base of a flower trough, or cut up into bath seats by another patient using a two-handled saw, giving this exercise, i.e., the good arm taking the paralysed arm along in passive movement, which eventually becomes active movement.

Age is no barrier. A patient aged 94 with aphasia following a stroke, and paresis of the left arm and hand, was one of our most energetic and careful workers in the woodwork department. We had a confused man of 80 admitted who had had a colostomy and could not cope with it and was almost ready to go into the local psychiatric hospital. Dr Irvine brought him in for daily treatment, and fortunately our carpenter

technician who has quite a gift for dealing with these people discovered that the old man had done some metal-work. So each day the old man concentrated a little bit longer on this, and in the end the old man was spending the whole morning in the department and thoroughly enjoying himself. Gradually, he calmed down, his agitation disappeared and his confusion grew less and less and the nurse was able to teach him to clean his own colostomy. He was an immaculate old boy and it seems that was all he needed; he was soon well again looking after his wife, whom he waited on hand and foot. He used to teach the other patients how to do metal work and was insistent that they did it properly.

The workshop has proved a common meeting ground for professional men, farm labourers and tradesmen, and all enjoy using tools, some for the first time, and getting pleasure out of the knowledge that while working for other people they are also increasing their own ability and restoring their own confidence.

Not all patients are fortunate enough to go home well enough to walk, and many who have suffered multiple strokes are going to be heavily disabled and chair-bound, so if their relatives are brave enough to have them at home and nurse them, they need all the support the hospital can give them. Probably the most practical way of giving assistance is by providing a hoist. These are loaned by the local welfare to the patient's home, so that they can transport themselves from bed to chair, from chair to commode and so on. Obviously once they can do this it's a great help to the relative. The speech therapist is an important member of the team because so many patients suffer from speech defects after strokes; unfortunately these therapists are few and far between, so it is up to the rest of the team to carry on their work and make sure the patients get plenty of practice in both speaking and writing.

For those patients requiring only diversional occupation, I find group activities are most valuable. It encourages the timid ones to feel brave and to enter into a conversation, and even if it sometimes leads to a little quarrel, at least they have shown animation rather than just sitting alone withdrawn and sad. The type of group activities we use here are—art classes, make-up and manicure sessions, music and movement, percussion band with sing-song, discussion group, quiz programme, travel talks (people from outside come and talk about their own particular jobs, often bringing slides to show); craft groups.

I have found it of great importance, both to the patients and the staff, to have a project to work for part of each year. Sometimes this is working towards an exhibition in the area, and recently our project was a sale of work and toy fair. This was one of the best things we have produced. The excitement grew week by week as articles began to take shape. It was indeed a group effort, some patients able to cut out articles, others able to machine and some only capable of stuffing toys or cushions, but each felt they were taking an important part of the whole project. One old lady really came to life with a glove puppet and began talking to it. We realized this was quite an asset for speech therapy. The result of the sale gave great satisfaction to everyone and meant that we could buy various objects for the department.

Outings also are of great therapeutic value, whether it is a trip to the country or to see a play or film. The important thing is to keep a spirit of competition going, whether this is in work or games, or even their personal appearance, and we have found an outing particularly important where the elderly are concerned. The patients arrive in their best clothes and really take a pride in themselves. Occupational therapy with the elderly people is certainly a very worthwhile job. They are so appreciative and when one patient can write "thank you for making the end of the road a happy one" then we too feel it has been worthwhile.