Bed Care prevention and supportive equipment for care homes

Stephanie Clarke

Occupational Therapist

HCPA & Hertfordshire County Council

- How many people do you see who are cared for in bed???
- What percentage of residents in your home are cared for in bed?

WHAT IS BED CARE: WHY TERMINOLOGY IS IMPORTANT

BED CARE

- Person's care needs all center around them being in bed
- Likely are managed in bed long term
- No official definition of 'Bed Care'

Often no formal decision made but something that happens over time

BED REST

- **Person's care needs can fluctuate between bed care or have opportunity to be managed out of bed (temporarily)**
- **Bed rest is usually temporarily and part of a treatment plan due to illness.**
- "restriction of a patient's activities, either partially or comp letely"(Medical Dictionary)

WHAT ARE THE RISKS OF BED CARE?

RISKS OF STAYING IN BED?

- Isolation: being alone in a room:
- Pressure Sores
- Impact on choices: where/how they live
- Lack of socializing
- Limited access to their home environment
- Loneliness
- Muscle weakness/wastage
- Distorted body shape: Contractures/spasticity
- Depression/Low mood
- Overall well-being
- All the above means that more complex care is required

WHY IS THIS IMPORTANT?

RESTRAINT

The Mental Capacity Act's definition of restraint means:

If you want to do something to, or for, a person who lacks capacity to consent or refuse this intervention, you are restraining them if you:

- **Use, or threaten to use, force to make the person do something they are resisting,**

OR

- **Restrict their freedom of movement, whether they resist this or not.**

<u>Keeping someone in their bed can be considered restriction and therefore Depriving them of their liberty</u>

If a person who 'lacks capacity to consent to the arrangements necessary to give them essential care or treatment' – they can't consent to their care plan and is deprived of their liberty if they are;

- Under complete and effective care and control of staff; *and*
- Not free to leave.

(UK Supreme Court 2023)

LAWFUL PRACTICE

<u>How do we ensure we are compliant?</u>

There are extra conditions to meet for restraint to be lawful.

Staff are only protected by the law if, as well as showing in their records evidence of someone's lack of capacity, and that it's in their best interests, they also show that the restraint is both:

- Necessary to prevent harm to this person
- A proportionate response to how likely this harm is, and how serious it would be.

e.g Mr X is only able to be managed in bed as he does not have a chair suited to his needs and is at risk of falling or slipping from a standard armchair. He has been assessed and a chair has been recommended. He is being supported with bed rest whilst awaiting provision of chair.

REASONS FOR BED CARE AND HOW TO EXPLORE THE BARRIERS CAUSING THEM

REASONS FOR BED CARE-BARRIERS

MEDICAL CONCERNS

-Pressure sores
-Pain
-Feeling weak tired
-Posture and Positioning (breathing)
-Contractures Palliative
-Poor communication from professionals

MOVING & HANDLING CONCERNS

-Difficulty with transferring out of bed
-Inappropriate transfer equipment.
-Contractures

CHOICE/BEHAVIOUR

-May want to stay in bed
-May not understand what's being asked
-Fear
-Familiar
-Reduced Motivation
-Loss of independence

SEATING

-Unable to sit in a standard chair/slipping
-Discomfort

DECISION MADE FOR PERMANANT BED CARE

-Person is so severely contracted they are unable to sit out

BARRIERS

CHOICE/BEHAVIOUR

-May want to stay in bed

-May not understand what's being asked

-Fear

-Familiar staying in bed

-Reduced Motivation

-Loss of independence

- A PERSON MAY STATE THEY DO NOT WANT TO GET OUT OF BED, DO THEY UNDERSTAND? OPINION OF NOK
- CONSIDER WHAT HAS CAUSED THIS CHANGE
- GENTLE ENCOURAGEMENT
- IS IT IS RELATED TO OTHER CONDITIONS/PAIN? IS THERE A RECORD OF A HISTORY OF ANY ISSUES
- DO THEIR CHOICES FLUCTUATE? IS THIS EFFECTED BY OTHER FACTORS?
- HAS MOOD BEEN REVIEWED RECENTLY?
- FOCUS ON WHAT THEY CAN DO : DON'T DO THINGS FOR THEM IF THEY CAN DO IT!
- HAS **MEANINGFUL ACTIVITY** BEEN USED TO ENCOURAGE? **LIVING WELL THROUGH ACTIVITY**

ILL HEALTH/PALLIATIVE CARE

- RESPECT WISHES OF THE PERSON
- IF FAMILY ARE AVAILABLE AND THEY ARE NOT SURE GET THEM INVOLVED IN THE DECISION PROCESS.
- SEEK PROFESSIONAL SUPPORT PARTICUALRY WHERE THERE IS PAIN OR EXTREME FRAILITY INVOLVED
- PLAN A TRIAL IF THE PERSON HAD NO ISSUES AND HAS BEEN ABLE TO BE TRANSFERRED WITH NO PROBLEMS WITHIN THE LAST MONTH.

HOW TO ENSURE SUPPORTIVE BED CARE

- Discussion with the person/NOK
- MDT Discussion: Informing GP during rounds, care staff and engagement leads
- Documentation making clear the date this was decided and on the front page of care plan.
- Weighing plan: how are they going to be weighed.
- Posture & equipment considerations: Referral to Community PT/OT- Wendyletts. Posture equipment.
- Focus on GOALS



CONTRACTURE AWARENESS AND PREVENTION

CONTRACTURES

Contractures in nursing home residents have been under-reported (Müller et al, 2013) but a systematic review by Offenbächer et al (2014) estimated the prevalence of contractures in nursing homes to be 55%.

Wagner et al (2008) found that, of 273 frail, older nursing home residents, 61% had contractures.

CONTRACTURES: HOW DO THEY DEVELOP

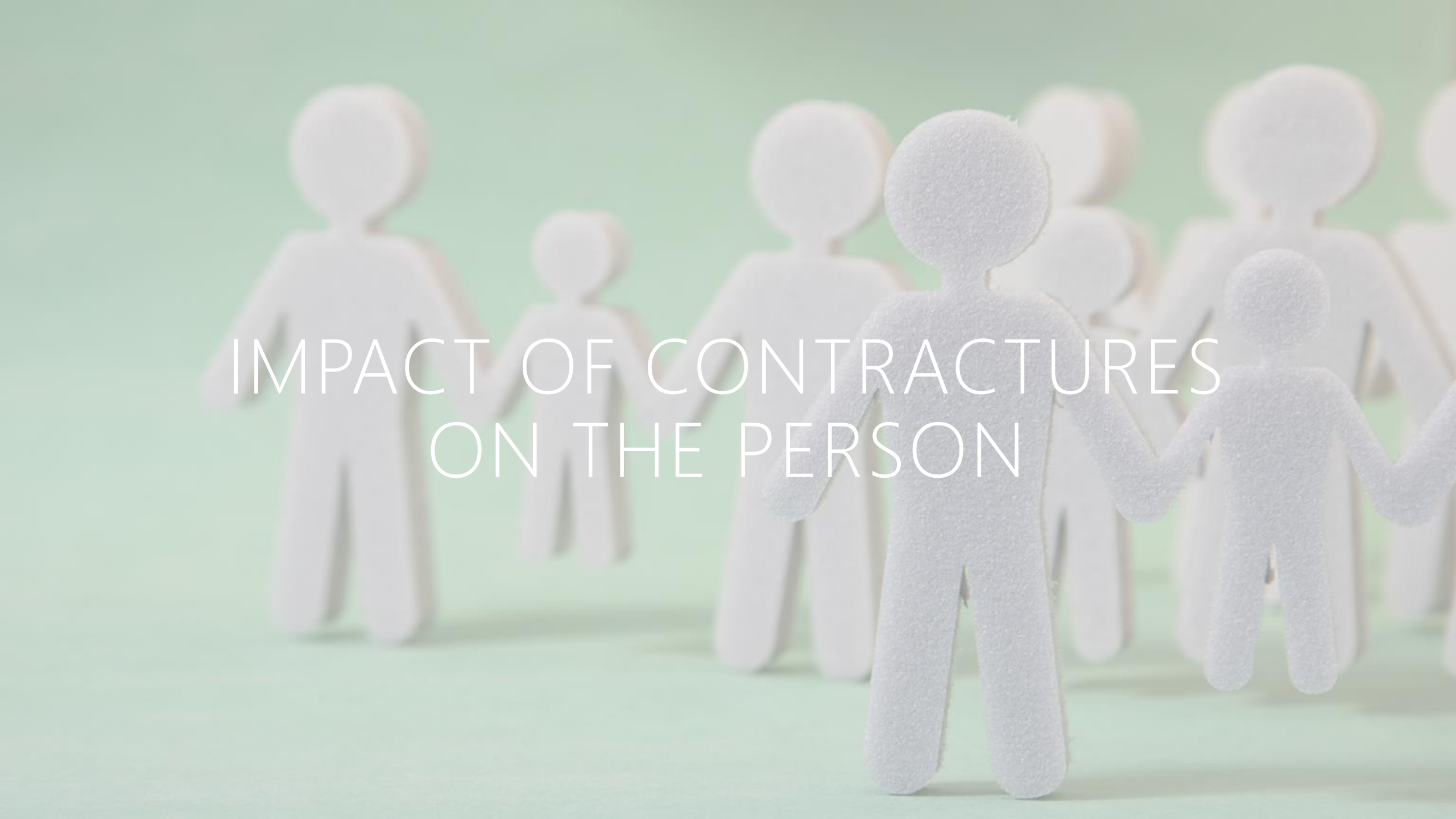
- When a person is not moving regularly
- Often when they are unable to move without assistance; the result of a stroke, injury, dementia- assuming a position may be more comfortable (arthritis/burns)
- Staying in a chair or bed for long periods of time
- Poor positioning in bed or chair
- Insufficient exercise for those with paralysis

Dorset, Bournemouth &
Poole Safeguarding-NHS

WHO IS AT RISK?

Table 1. **Contracture risk assessment**

Risk level	Risk factors	Tick
Significant presentation – urgent action	● Already presenting with contractures	❑
	● Confined to bed	❑
	● Spasticity/high tone in some muscles	❑
High risk	● Neurological deficit, eg stroke/head injury	❑
	● Progressive neurological condition, eg multiple sclerosis/ progressive supranuclear palsy/Parkinson's	❑
	● Lifelong neurological condition, eg cerebral palsy/ muscular dystrophy	❑
	● Dementia	❑
	● Trauma/burns	❑
Moderate risk	● Musculoskeletal problems, eg arthritis/fracture	❑
	● Cognitive impairment – moderate to high	❑
	● Concordance issues (detail reason in notes section)	❑
	● Joint pain/stiffness on movement	❑
	● Resistant to staff giving care/repositioning	❑
	● Assistance with mobility/hoisted	❑
Low risk	None of the above identified	



IMPACT OF CONTRACTURES ON THE PERSON

IMPACT OF CONTRACTURES ON THE PERSON

- Increased pain Impaired motor function
- Reduced mobility, range of movement
- Swallowing/Nutrition
- Comfort
- Reduced range of movement
- Loss of function for Activities of Daily Living (ADL's)
- Social participation/ isolation
- Quality of Life is affected
- Pressure sores
- Hygiene and Infections

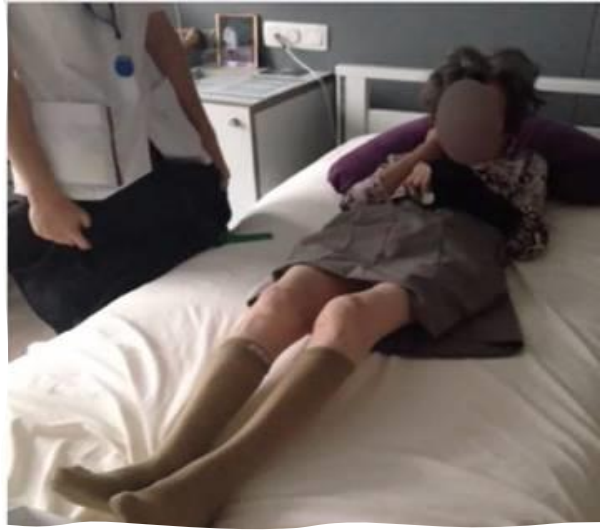
IMPACT AS A PROVIDER

- Loss of reputation
- Risk of litigation
- Contractual Sanctions
- Difficulty Transferring
- Staff morale
- Difficulty moving and handling (rolling, fitting slings, clothing & personal care).
- Individuals have more intensive care needs

CAN WE UNDO CONTRACTURES ?

- Studies have been completed in care homes & with SIGNIFICANT input involving expensive equipment, specialist therapists & around the clock care from trained carers to undo the damage from contractures as well as medication (botox).

- This is dependent on the person, pain relief, compliance, availability of staff and resources.



WHAT **CAN** WE DO?

EARLY RECOGNITION

Early recognition to prevent contractures is considered the best solution for contracture management (Jamshed and Schneider, 2010).

Early intervention safeguards individuals and could reduce the health and social care costs associated with contractures.

At present, there is no recommended risk assessment tool, and nurses and care assistants have limited access to education and training; this makes it more difficult for them to develop the knowledge and skills needed to identify residents who would benefit from early intervention to limit the progression of contractures (Sackley et al, 2009).

CAN YOU ADD RISK OF DEVELOPING CONTRACTURE CONSIDERATIONS INTO YOUR CARE PLAN

Can we get a risk assessment in place once a person is cared for in bed or in chair for long periods of time and add this to the moving and handling/mobility section?

EQUIPMENT CONSIDERATIONS

The key is using symmetry and balance and a supportive surface. With considerations of comfort and pressure relief.

EQUIPMENT & SUPPORT FOR HOMES

PREVENTION AND EARLY RECOGNITION IS KEY.

Training! Train your staff to attend Bed Care Prevention Training!

Ensure people have appropriate seating & postural support and are sitting out or moving regularly.

Make referrals for support when necessary! Physio's and OT's will provide advice but not equipment. Also inform clinical leads, GP, for advice. Can botox be considered if it is having an impact on their health/function.

Inform the engagement leads: are they able to keep a close eye to motivate the person? Liase with family to ensure there is appropriate life history for everyone to motivate and encourage that is meaningful to them. Exercise Groups?

Try and maintain flexibility with some active movement: hand over hand assisted feeding, brushing teeth, this can be shared with family if you have concerns with their level of movement so they too can join in.

Keep a close eye on muscle tone and any tightening and inform clinical leads Can this be incorporated into their care plan?

WHAT IS YOUR ROLE?

- Current legislation and guidance do not always provide clear-cut answers to certain questions concerning the provision of equipment in care homes. RCOT 2023

- Homes have the job of understanding their role in provision of equipment and enforcing discussions with their local authorities so that these standards can be preserved.

- Do you know your role in equipment provision?

Overarching principles

The Royal College of Occupational Therapists would urge all partners to hold to the following principles and standards when planning and providing equipment to care home residents:

1. Residents of care homes have the same access to a needs assessment, with the provision of equipment and other services, as any other resident in their local area (DHSC 2018, section 6.13; DH 2013, section 47b and UK country equivalent guidance).

2. The focus of the **planning and provision of equipment to care homes starts with the residents and their needs**, **with their chosen goals or outcomes** (DHSC 2018, section 1.1). Equipment is a tool to enhance wellbeing, enabling a person to actively and safely participate in occupations (everyday activities).

3. No single organisation can step back from their responsibility to be part of a comprehensive service to care home residents.

4. The **totality of equipment provision services in an area are primarily shaped by the needs of residents, not by funding structures**. Provider partners plan and work together to prevent delays in equipment provision.

Equipment Assessments

The following principles apply to assessment of equipment and should guide practice:

1

■ Using the same criteria as people living in their own home, residents admitted to hospital should be considered for an OT assessment. Following assessment, temporary loans of equipment should be offered, in line with local agreements between health and local authorities, to enable discharge and to prevent the exacerbation of health issues

2

■ Equipment provision should be based upon the assessed needs of the resident/s. These are met with the most appropriate equipment. There is no 'standard' resident or 'one size fits all' response.

3

■ Very particular or specialised needs, out with the care home's stated purpose, should be assessed and met with specific apposite equipment from the most appropriate provider. Equipment provided to 6 Care homes and equipment Assessment for equipment meet a particular resident's needs should only be used with that resident.

4

■ The individual who is assessing the need for, recommending, providing, or using the equipment, must be demonstrably trained and experienced to do so. Expert advice and assistance should be shared across provider partners when necessary.

5

■ Assessors and providers should consider the most cost-effective way of meeting the individual's needs, as well as the health, safety and welfare of both the resident and any formal or informal carers.

6

■ Alongside an assessment of need, a full assessment of risk should be made. This defines how the right equipment will be used appropriately to enable the safe movement and care of a resident, whilst protecting both the resident and the care staff from injury

EXPECTATIONS OF RESIDENTIAL HOME

The standard equipment which a care home may be expected to have would equate to that which is widely available to end users in their own homes.
Standard equipment may be of the type that will:

- ■ be used by more than one person;
- ■ be frequently/regularly used by the end user
- ■ support care given by informal or funded carers
- ■ support general personal or nursing care
- ■ assist activities of daily living and enable independence
- ■ be issued without the requirement for an advanced assessment;
- ■ be for short-term or long-term needs
- ■ support a safe environment for users.

Although care homes are expected to have a range of equipment to meet variations in height, weight, size and support needs, this list would suggest that items of equipment specifically tailored to meet one resident's needs and not suitable for use by other care home residents would be supplied by the community equipment service and not the care home

GET SUPPORT

- Local authorities must undertake an assessment for any adult with an appearance of need for care and support … Wherever an individual expresses a 5 Royal College of Occupational Therapists Assessment for equipment need (previous slide), or any challenges and difficulties they face because of their condition(s), the local authority should ensure that it has established the impact of that on the individual's day-to-day life.

- For example where an adult expresses a need regarding their physical condition and mobility, the local authority must establish the impact of this on the adult's desired outcomes … During the assessment, local authorities must consider all of the adult's care and support needs, regardless of any support being provided by a carer. (Adapted from DHSC 2018, section 6.13–6.15) Can this be discussed in their annual review?

- Be prepared to provide details as to why your own moving and handling lead is unable to assess to ensure appropriate time is allocated to professionals.

TYPES OF SEATING

Standard Armchair

Recliner/riser recliner chair

Integra tilting chair/Bucket chair

Specialist Tilt in Space Chair

FINANCIAL RESPONSIBILITIES- PROVIDING SEATING

- Work with local authorities and families
- Document how it is being managed and who is involved and what the specific issues are with standard seating.
- Can you attend seating training to advise? HCPA
- Have you tried anti slip mat/ recliner chairs
- Discuss with family
- Be open to considering second hand chairs
- Contact Hertfordshire Equipment Services for any support with Servicing or maintenance.
- Get OT support if needed

Tilt in Space Shower chair

- Encourages regular sitting out even for short periods of time
- Thorough personal care
- Familiarity in siting out
- Increases movement and encourages flexibility of joints.
- Try with a gentle stream and ensure the temperature is to their liking! Do family know whether they likes hot showers|?

THANK YOU FOR LISTENING!
QUESTIONS??

Courses to book on to:

- **Bed Care Prevention**
- **Equipment in Care Home**
- **Activities and Engagement Workshops**

References

- Care Quality Commission (2018) Regulation 13: safeguarding service users from abuse and improper treatment. Newcastle: CQC. Available at: https://www.cqc.org.uk/guidance-providers/regulationsenforcement/regulation-13-safeguarding-service-usersabuse-improper Care Quality Commission (2015)
- Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended). Newcastle: CQC.
- College of Occupational Therapists (2016) Care Act 2014: guidance for occupational therapists – prevention. London: COT. Daley O, Casey J, Martin S, Tierney M, McVey O (2016) The effectiveness of specialist seating provision for nursing home residents. Limavady:
- Seating Matters; Belfast: University of Ulster. Available at: https://seatingmatters.com/wp-content/ uploads/2016/01/Seating-Matters-Clinical-ResearchOverview.pdf Department of Health (2013)
- NHS-funded nursing care: practice guide. London: DH. Available at: https://assets.publishing.service.gov.uk/government/ uploads/system/uploads/attachment_data/file/211256/ NHS-funded_Nursing_Care_Best_Practice_Guidance.pdf