An Enabling Care Approach:

Changing the culture across the Care Sector in Hertfordshire - An education resource for anyone involved in the delivery of Care

STOPFALLS

HCPA StopFalls in Partnership with Enlight Physiotherapy

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An Enabling Care Approach:
Changing the Culture across the Care Sector

Aims of this booklet:

AIM 1	AIM 2	AIM 3
To provide a Tier 1, Awareness Level Introduction to Enabling Care that is designed to be followed up with Tier 2 and 3 Education*	To provide an overview of some of the key areas to consider when embedding an Enabling Care Approach	To help those involved in delivering care to understand the benefits of an Enabling Approach in care.

AIM 4	AIM 5	AIM 6
To empower those involved in delivering care to question whether they are enabling or *disabling* individuals with everyday practice	To provide an awareness tool for those involved in delivering care	To continue to positively impact the health care system, through enhanced knowledge and skills

AIM 7
To continue to improve the experience and quality of life of people in receipt of care

**Please refer to HCPA's Website for more information on the Enabling Care Tier Training*

Introduction:

Whilst Person-Centred Care of the late 1990's[1] and the Mental Capacity Act (MCA) of 2005[2], have revolutionised the face of Care over the past two decades, the drive is now to further improve the delivery of care to one that maximises an individual's potential to participate in their life, physically, mentally, emotionally and socially.

Recent guidance on the health benefits of being more: active, empowered, independent and supported [3], emphasises what has been known in Therapy settings for a long time and that is: *through an enabling approach, people can actually improve!*

For many years it has been the culture in the Health and Social Care sectors that tasks should be performed *for* people who are unwell or in need of care, as they are unable to do them themselves.

This is likely, at least in part, due to a lack of knowledge about the principle of "use or lose it" and thus, a lack of questioning (outside of the Therapy professions), about whether a person has the potential to 'improve'.

Understandably, it has therefore been a common expectation that an individual will deteriorate, or at most, remain the same, rather than improve. Some individuals have consequently become more dependent, requiring higher levels of care, as a result of doing less for themselves. After all, 'care' was not set up with the outcome of rehabilitation in mind, unless specifically prescribed.

Another factor may be that people who are paid to deliver care are generally expected, by everyone involved, to 'do for' the individuals. This mindset has begun to change over the past few years, with the introduction of the Mental Capacity Act, 2005 [2] and the Care Act, 2014 [4].

Furthermore, as the aging population changes, and there are even greater demands on the Health and Social Care systems, it is vital that we continue to reform this culture through an Enabling Approach, to prevent deterioration, to reduce the reliance upon a stretched system, and most importantly, to empower individuals and improve their quality of life.

The act of empowering others has an invaluable impact on the mental health and well-being of individuals who deliver care, and staff tend actually tend to report greater job satisfaction and feelings of self-worth [5].

The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always.

Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable? [6]

Linking an Enabling Approach to Safeguarding and The Mental Capacity Act Code of Practice

One of the major barriers to implementing an Enabling Approach to Care appears to have been a fear amongst Care Providers (and consequently their staff) that because they are responsible for keeping those they care for safe, they have to ensure that *all risks are eliminated*. This has resulted in a *risk adverse* culture which is exacerbated by the fear of culpability and safeguarding litigation.

The Mental Capacity Act [2] has helped to move this attitude forwards and, when establishing the most Proportionate Response and the least Restrictive Option, as well as considering the benefits and burdens of a decision, the following statement made by Sir Judge Munby, puts what is now known as *positive risk taking* into a much more comprehensible light.

What is Enabling Care?

The NICE guidance NG47 2017 [7] explains enablement as:

> *"Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence".*
>
> *These guidelines refer to Intermediate Care Teams and aim "to ensure that these staff have the skills to support people to optimise recovery, take control of their lives and regain as much independence as possible".*

There are several terms which seem to be used interchangeably: Reablement, Rehabilitation, Intermediate Care.

According to the Care and Support Statutory Guidance (Care Act 2014, updated June 2020):

- 'Reablement' refers to a service within Social Care, provided to people in their own home by a team of mainly care and support professionals.
- 'Intermediate care' refers to services provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists
- The term 'rehabilitation' is used to describe a particular type of service designed to help a person regain or re-learn some capabilities where these capabilities have been lost due to illness or disease. Rehabilitation services can include provisions that help people attain independence and remain or return to their home and participate in their community, for example independent living skills and mobility training for people with visual impairment.

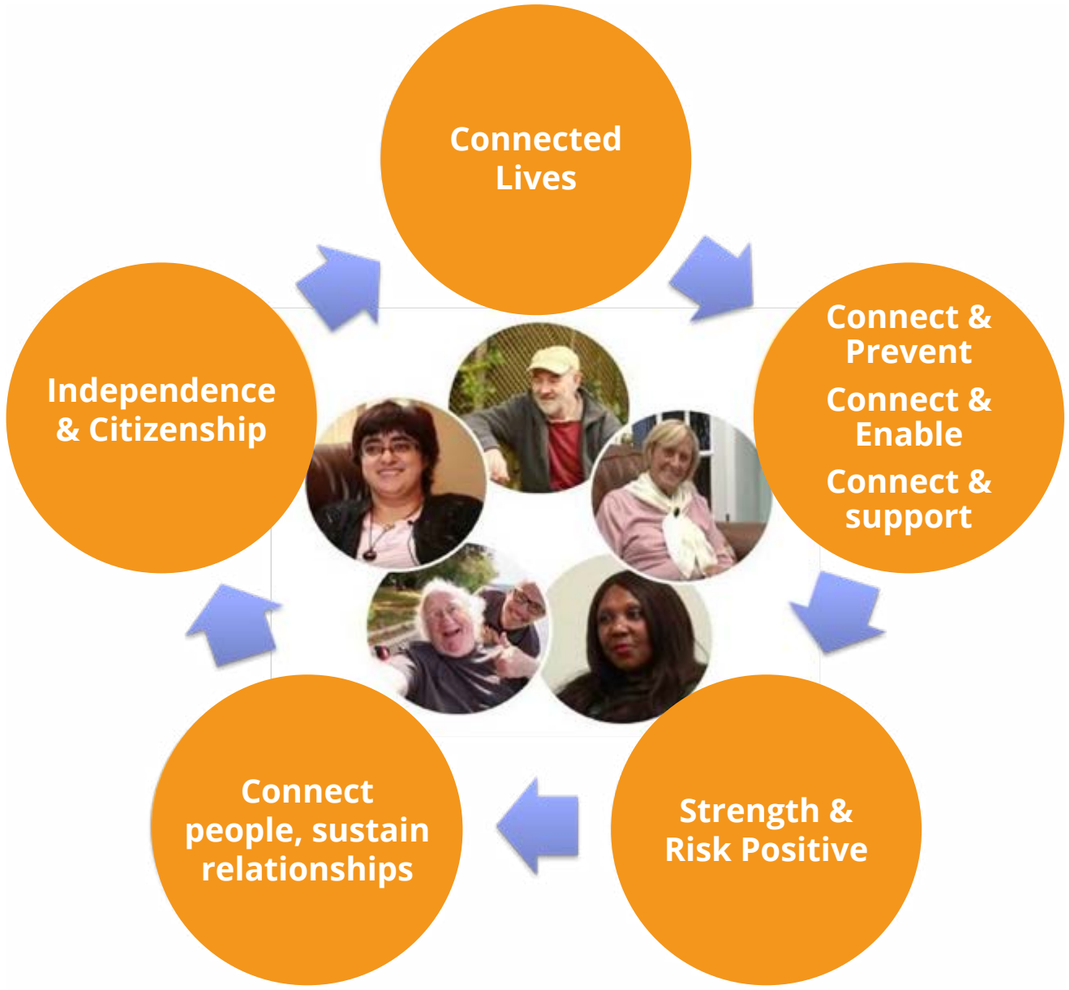
There is no other guidance on what is meant by the term Enablement and even less on how to create an Enabling Care Approach culture across all care settings.

Hertfordshire County Council's Outcomes Framework: Connected Lives

Emphasises the need for enabling care to support every individual receiving care to achieve the best for themselves, and to gain independence in the areas that they are able to and wish to. This model brings together practitioners, commissioners and care providers, using the core concepts of the Care Act (2014), to ensure that, in the move towards implementing Hertfordshire Social Services "Connected Lives" principles, community opportunities, citizenship and personalised outcomes are explored for all:

- Connect and Prevent
- Connect and Enable
- Connect and Support

Aimed at positive risk taking, connecting people and sustaining relationships, and at promoting independence and citizenship.



Principles of Enabling Care

An Enabling Approach is one which, (in order to improve wellbeing and quality of life), maximises an individual's potential to improve through:

- Choice
- Empowerment
- Independence
- Positive Risk Taking

It also emphasises a questioning mind, which enquires about a person's ability to:

- Improve
- Do more
- Do more easily
- Do better, physically, mentally, emotionally and socially

Whilst offering encouragement and taking the time to assist a person to mobilise is clearly enabling, the smallest of interventions can *also* be enabling; from reducing pain by repositioning someone who cannot move themselves independently so that their knee is not twisted, to spotting signs of a chest infection as early as possible, thereby preventing an unnecessary hospital admission.

A questioning approach considers all factors that may be contributing to how a person presents at any given point, with a view to learning from experience and knowledge. This then informs future situations, thereby promoting a preventative approach.

For example, questioning whether a person has had adequate fluid intake, when they are diagnosed with a Urinary Tract Infection (UTI), should lead to a preventative approach in the future. Similarly, if a person has a new onset of reduced exercise tolerance, it may be that their dietary intake requires a review by a Dietician in addition to the obvious referral to the GP for a medical review.

Mental Capacity

What does it mean to have choice?

Every individual has the right to make a choice on how they live and to make decisions about their care, provided they have the capacity to make decisions. A person who lacks capacity, should be supported to make each specific decision and if they are still unable to do so, a best interests decision must be made [8].

Assessing Mental Capacity: The 4-Question Test

Under the Mental Capacity Act, the following 4 questions need to be asked when assessing whether someone has the capacity to make a particular decision:

- Are they able to understand the information related to that decision?
- Are they able to retain the information (long enough to come to a decision)?
- Can they use the information to make a decision?
- Can they communicate that decision?

What does it mean to make Best Interest decisions?

Making best interest decisions ensures that people are supported to make decisions for themselves when they lack mental capacity. If people do not have the mental capacity to make decisions, then they should always be at the centre of the decision-making process[9].

What does it mean to be empowered?

Staff should always look to empower individuals with knowledge skills and experience, by working together to improve quality of life within a person's communities. Individuals should be helped to feel confident to make decisions about their own care and to manage their own health. Individuals should also be supported to improve their health, so that they have as much chance as possible of leading the life they choose [10].

Why is being independent important?

A lack of independence can negatively affect a person's mental and social well-being, as well as their physical health. The impact that being able to make choices and to live independently (with or without support) has, on a person's overall functioning, cannot be underestimated[11].

Staff/Relative Tips

NHS '5 WHYs' [12]

The NHS '5 whys' helps staff to identify the sources of an issue or a problem. It causes staff to start to question why individuals are not being enabled by repeatedly asking the question "Why?".

Write down the specific problem and then begin to ask why the problem occurs, write this answer down.

If the answer does not identify the problem then ask "Why?" again until you, or those you are working with, agree that the problem's root cause has been identified. This may take more than '5 whys' or fewer.

Motivating Communication

A fundamental element of an Enabling Care Approach is communication.

Using the right strategy/strategies, at the right time, to engage and motivate people to achieve their absolute highest potential, in whatever is right for them, is likely to make them (and us!) feel empowered. Whether communication involves verbal or non-verbal language, there are some key aspects that need to be considered and practised.

EVERYONE IS DIFFERENT, with different values, beliefs and interests

In practice:

It can be challenging to find the communication strategies that work for each individual, whether we are trying to encourage someone to participate in activity, or to give them confidence to continue with a task about which they lack confidence. It is vital that we find out what is meaningful to an individual, not just about the activities they want to pursue, but also regarding how to communicate with that particular individual in a way that is meaningful and enabling. This is known as a 'personalised conversation' [13].

We must, of course, also consider the Mental Capacity Act and, whilst we are not permitted to 'coerce' someone, giving them information about a decision, is the only way that, even a person who has capacity to make all decisions, may be able to make an *informed* decision. This is extremely important when people are unable to do things for themselves, as is often the case in a Care environment. For example, if you ask someone if they want a cup of tea and they decline because they want to wait for their daughter to arrive, and you do not communicate the information you have just heard that the daughter is not coming today, you have not enabled that person to make an informed decision about the cup of tea. See the Case Study on page 13, which further emphasises this point.

A considerable part of enabling happens before a task has started, through communication and motivation.

Communication is used to:

- Empower
- Engage
- Encourage
- Reassure
- Inform
- Give choice
- Set goals*

**Use SMART goals or Patient Specific Functional Scale (PSFS), as well as other commonly used outcome measures – refer to HCPA for more details*

Case Study

John, who has MS and a mild cognitive impairment, was due to have an appointment with the visiting Wheelchair Services Therapist. He was due to be issued with a new powerchair as his had broken three weeks ago and as a result, he had been requiring assistance to be pushed in an attendant-propelled wheelchair.

On the day of his appointment, the in-house Therapy team asked a Care Staff Member to go an get him for his appointment. The Staff Member returned stating that John was about to have his lunch and therefore had declined to come. When the Therapist questioned this decision, the Staff Member stated that it was John's choice, as he had capacity to make decisions. The Therapist stated that whilst that may be true, John had not been informed of the fact that this was the last appointment that Wheelchair Services had scheduled in for this visit to the home, and that if John didn't come to this appointment, he would need to wait until the next visit, in a month's time.

The Therapist therefore asked the Care Staff Member to see if John wanted to change his mind, based on this new information, and if so, to tell him that his lunch could be kept for him until after the appointment. John, of course, did decide to attend his appointment as his independence was very important to him.

He subsequently got his new powerchair and he also got his late lunch!

Staff/Relative Tips

Stop and reflect on your own interactions/conversations, Do you notice yourself doing any of the following?

- Making judgements about what you think a person should do/want
- Wanting to fix things and pushing too hard
- Trying to appease someone other than the individual e.g. a relative
- Listening to respond, rather than to understand

Try to incorporate the following into future interactions/conversations

- Active listening
- Investigate – be curious about their wishes need and preferences
- Gain trust and build rapport
- Set smart goals
- Before the task - Communicate to motivate
- During the task - Communicate to facilitate
  - ▶ Use verbal cues that are concise, short and sharp, timing is vital
  - ▶ Use physical cues*– light touch, timing
- After the task – Communicate to reflect and re-evaluate

***** *Please refer to HCPA's website for more information on Enabling Care Training*

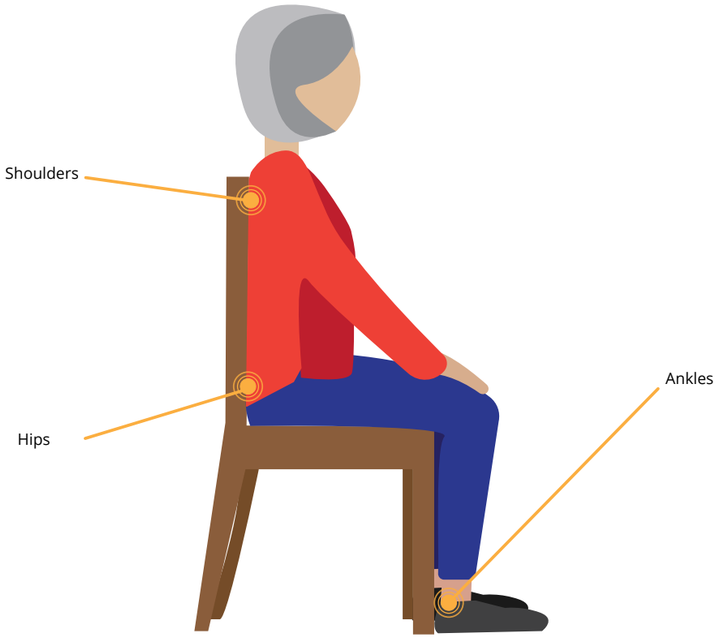
Posture and Positioning (Postural Alignment)

Background:

Posture means 'the position of a person's body, in any position for example in lying, sitting or standing'.

A person *without* impairment is generally able to adjust the postural alignment of their body and to balance with minimal twists and effort. A person *with* an impairment, or indeed someone who is elderly, may find this difficult, and may need:

- Assistance to achieve a position that is comfortable, and which allows optimal function, including being able to take a deep breath and cough [(14)]
- Assistance to reposition themselves regularly to reduce the risk of pressure sores and pain [(15)]



Most of the available evidence in the UK on Posture and Postural Management relates to the Learning Disabilities sector and is aimed at individuals with complex postural needs, who are unable to move or reposition themselves and are therefore managed by specialised Physiotherapists [(16)].

There is a lack of guidance regarding Postural Management in the adult care sector and, moreover, there is limited availability of guidance from Physiotherapists in this sector, as Physiotherapy is primarily funded by Health, and not by Social Care.

This section of the resource pack aims to raise awareness of the impacts of posture on health and function, as this is a fundamental part of an Enabling Approach to care. This resource pack draws on the currently available evidence on Falls Prevention, Frailty and Independence.

In practice:

Problems with posture, for example in sitting*, are often the result of the pelvis not being in a neutral position (i.e. level and not twisted). If the pelvis is in a poorly aligned position, this can subsequently lead to problems in the hips, knees and ankles, and also the spine, which may in turn affect the position of the shoulders and upper limbs, the neck and head.

Good (optimal) posture is important for being able to:

- Move
- Perform functional tasks
- Be independent
- Breathe
- Eat
- Be free of pain

Consequences of poor (non-optimal) posture:

- Reduced ability to move functionally, e.g. lifting arm, sit to stand
- Breathing problems
- Difficulty eating and drinking
- Pain
- Muscle shortening/contractures
- Pressure sores
- Chest infections
- Death
- Safeguarding cases

**Please note, for the purpose of this resource, the examples here focus on sitting posture. Other positions are, of course, of equal importance and depend upon a person's individual needs. For advice regarding difficulties you may be having concerning an individual's postural management, please refer to the Signposting Section in this booklet on page 36.*

The links between poor posture and breathing, chest infections and death:

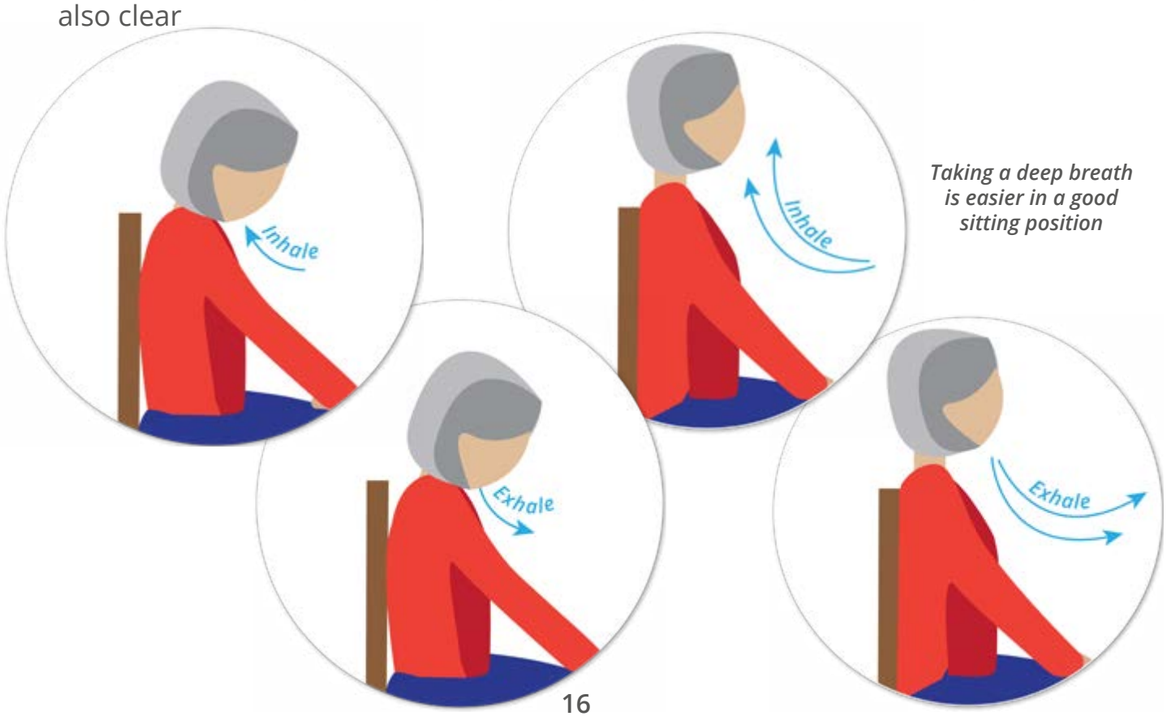
- A cough is required to 'clear' our chest (upper airways). We need to take deep breaths in order to cough. Poor posture can impact upon a person's ability to take a deep breath, and therefore if an individual is unable to take a deep breath, they may be unable to generate a cough and thus are likely to be at a greater risk of developing a chest infection
- A large study carried out by University of Bristol in 2013 found that the most common cause of premature death in a person with a learning disability was a chest infection [17] and Public Health England have recognised the direct link with posture.[16,18] As a result, NHS England commissioned the Learning Disability Mortality Review (LeDeR), 2019, [19] to improve the standard and quality of care for people with a learning disability. The principle applies to anyone who has difficulty with repositioning themselves
- The link between pain and inability to take a deep breath, is also clear

i.e. Better posture = deeper breaths = less chest infections = less risk of death

- The link between positioning and pressure sores is widely understood in the Health and Social Care sectors. *I.e. Better postural management = less pressure areas = less infection risk = less risk of death*[20]
- The link between deterioration/death and potential safeguarding cases (and costs involved in time spent on safeguarding processes) is clear

In terms of Enabling Care:

- The links between pain and quality of life, improved function and independence are also clear



Taking a deep breath is easier in a good sitting position

Staff/Relative Posture Self-Assessment

1a) Check *yourself* in a sitting position

- Is your pelvis level?
- Are your shoulders level?
- Do your arms feel of an equal weight when you lift each arm up separately?

1b) Check yourself in a 'crooked' position (you can do this by shifting so you are sitting more on one side of your bottom)

- Is one shoulder higher than the other?
- Is your trunk shorter and squashed on one side?
- Is your lower back or neck twisted?
- Do your arms feel an equal weight when you lift your arm up or does the one on the side of the lower shoulder feel heavier to lift?
- How long can you stay in this position before you are uncomfortable and want to move?

2a) Sit in an upright sitting position

- Now stand up without using your arms
- Notice whether this feels easy or difficult

2b) Now sit in a really 'crooked' position

- Now stand up without using your arms
- Notice whether this feels more difficult
- Can you actually do it without repositioning yourself?

3a) Sit in an upright sitting position again

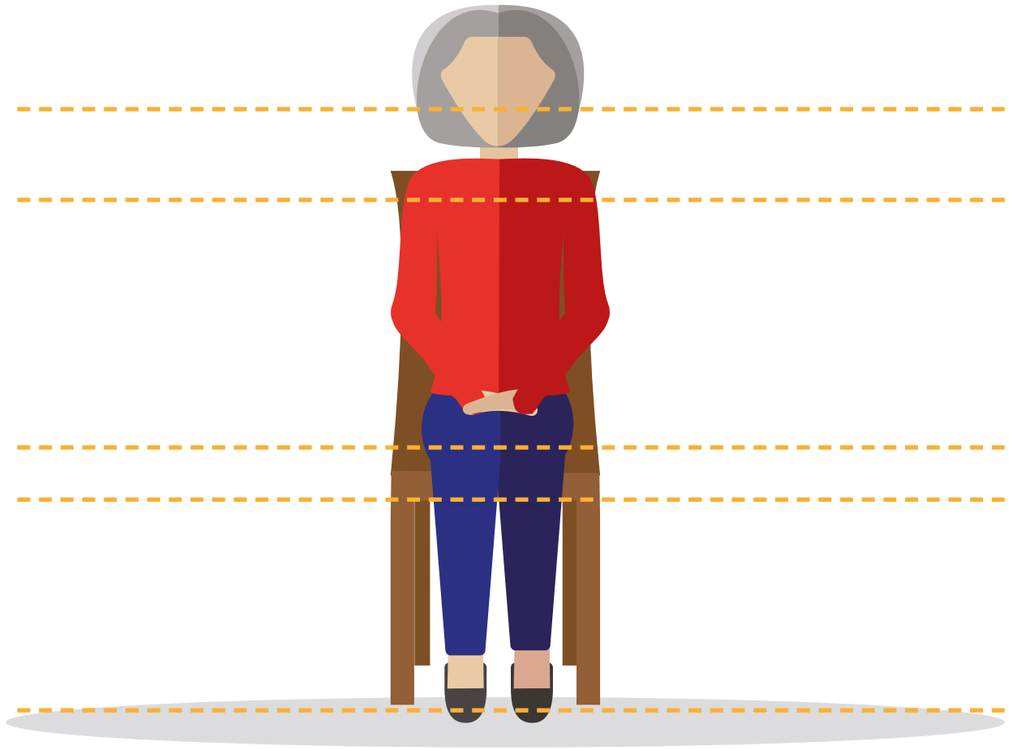
- Now blow up a balloon
- Notice whether this feels easy or difficult

3b) Now sit in a really crooked sitting position

- Now blow up a balloon.
- Notice whether this feels more difficult.
- Do you need to take extra breaths or is it harder to reach the same volume of air in the balloon?
- What are you likely to have felt when you did the above activities?
- Was that it was more difficult to do a functional activity from a crooked or non-optimal position?

Remember:

- People without impairments can move themselves frequently, usually without even thinking, if they are becoming uncomfortable
- Imagine you are in a crooked or uncomfortable position for a long period of time. You may be in pain as well as being less able to carry out functional activities
- You may also feel pain when you are eventually moved. This may cause you to resist being moved. Imagine if, on top of this, you cannot express how you feel



Staff/Relative Tips

Use **PEAK** to check the sitting posture of the person:
Is the person evenly positioned?

P - pelvis in a neutral position
E - equal weight on both buttocks
A - 90° angles at hips, knees and ankles
K - knees facing forwards

- If not, can you improve it by repositioning them? This may involve re-hoisting! OR, do you need professional advice from a Physiotherapist?
- The pelvis is the most important point to look at to check if someone is sitting well, as, when corrected, this will often also improve the alignment of the rest of the body

Ensure joints are in supported in good alignment, with appropriate equipment/pillows where necessary

Reposition OFTEN

Contractures

Contractures, particularly of the hands, wrists and ankles, are common in individuals who have a neurological (brain) injury, such as a stroke, as well as in people who have a progressive neurological condition, including dementia. These can cause complications, such as:

- Pressure sores, for example where the fingernails 'dig in' to the palm
- Reduced ankle range, which may impact upon a person's ability to stand
- Reduced range at the hips, making the delivery of personal care very difficult

It is extremely important to try to minimise the effects of contractures by appropriate positioning and splinting.

There is however, a lack of training about contractures for staff in the Care Sector. This results in a lack of understanding of the potential negative impacts of contractures, and a lack of confidence in managing residents who have, or who are at risk of, a contracture [(21)]. With training, the Contracture Risk Assessment Tool (CRAT) can be used to ascertain when refer to the GP for medical management, and when to request early intervention from appropriate Allied Health Professionals, (OTs or PTs), who can give advice on treatment and equipment (see Signposting Section on page 36).

Activities/Personal Activities of Daily Living (ADLs and PADLS)

Background:

There has been a breadth of evidence since the late 1960's that supports the concept that the brain is able to 're-wire' its neural pathways through a process known as 'neuroplasticity' [(22)].

Neuroplasticity refers to the capability of the nervous system to change. Nerve cells (neurons) have the capacity to change their structure and function, according to the response generated by activity and learning. This is the basis for memory and behavioural change arising from experience [(23,24)].

Plasticity takes place continuously, whether we are undertaking a task or doing absolutely nothing. Most importantly, plasticity can be positive (adaptive) or negative (maladaptive) [(25)].

In day to day life this basically means: if you don't use it, you lose it! The concept of neuroplasticity is particularly important in relation to ADLs and PADLs, where we have many opportunities to enable people to do more for themselves i.e. to be more independent, and thereby to achieve or maintain a sense of self-worth.

Movements involved in daily tasks promote positive changes to joint flexibility and allow muscles that are often in a shortened position to lengthen and stretch, as well as encouraging muscles to work more readily. Any activity that involves moving, plays a key part in helping to improve independence and to increase confidence [(26)]. If we encourage people to be more physically active in their ADLs and PADLs, for example if someone stands to get dressed instead of sitting to do it, they will make physical gains without feeling like they have had to participate in 'exercise'.

In practice:

It is tempting to do something *for* someone as, apart from seeming to be an act of kindness, it may appear to be quicker for you to do it, rather than to assist the individual to do it themselves. However, if the individual becomes more able, and we gradually reduce the assistance we are giving to perform a task, they may be eventually able to do it independently.

We need to encourage individuals to be involved in their care *physically* as well as simply being part of the decision making around their care and, just as Principle 5 of the MCA emphasises a least restrictive model, the same can be applied to ADLS (see 'more to less support' diagram on page 23).

Meaningful Activity

The value of 'occupation' and the worth of 'occupational' engagement needs to be understood here, if we are to make things meaningful to individuals [27]. Occupation, in its broadest sense, includes paid or unpaid work, leisure, ADLs and sleep. The evidence shows a direct correlation between occupational balance, and health and well-being, and that any imbalance in these areas can lead to a reduced sense of self-worth and purpose, which can impact upon levels of motivation, engagement and therefore activity. This means that we need to embody 'Person-Centred Care by taking a truly *whole person* approach.

In order to engage a person, we need to find out what they need or want to do, and then we can incorporate this into an activity that is useful for them. For example, if a person is required to let the catering staff know their meal choice for the day, walking to the kitchen if they are mobile, (or at least part of the way), involves that individual in an occupational activity that means something to them, whilst simultaneously to: and enables them to have the opportunity of feeling they have contributed to what needs to be done, whilst simultaneously increasing their activity levels.

Meaningful Objects

In a home care or care home environment, a person may not have access to all the objects that they once used [28]. They may therefore become unfamiliar with certain objects.

We need to ensure we explore ways in which to refamiliarise individuals with objects that would ordinarily be used in a person's everyday life, in order that they maintain the ability to use them.

Staff/Relative ADL/PADL Tips

Just think how you would feel if you were able perform a task that you thought you had lost forever! Also just think how you feel if you have helped someone to achieve their goal!

1. Consider the following tasks:

- Dressing
- Hair brushing
- Teeth brushing
- Face washing
- Making a cup of tea/coffee

Are there certain tasks you automatically do for the individual you care for?

Do you think there is anything the individual may be able to do themselves, if you help them rather than doing it for them?

2. Consider brushing an individual's hair:

See the boxes below showing the options for most support to least support. Pick a individual whose hair you currently brush. Try the orange option first and if this is successful, gradually try the dark yellow, then light yellow, then the green option.

This may take several days/weeks/months. Remember improvements take time! It may take several times of doing this, but the person may 'reconnect' with the pattern and be able to do it on their own at some point. However, you may only achieve the orange option but even this is more empowering than the red option.

'More to Less Support' Diagram

Brush the person's hair for them

Assist the person to brush their hair, by placing the hairbrush in their hand and gently positioning your hand over theirs and the brushing action with them.

Position the hair brush in the person's hand and give verbal prompts and encouragement to brush their own hair (give positive feedback where needed).

Position the hairbrush in front of the person. Use prompts if needed. Be ready to carry out another task whilst they brush their hair. Keeping an eye on them in case they need support.

Allow the person to get their own hairbrush and to brush their own hair (with prompts if needed).

Other ADL/PADL Tasks

Try other tasks too, such as face washing, teeth brushing, changing the TV channel with the remote control.

Consider also all Moving and Assisting interventions. Ensure you always encourage the person to do as much as they can themselves.

Use enabling language – Try using short clear verbal cues such as, “brush”, rather than a long sentence.

Notice how *you* feel when someone can do something more independently than before.

Notice how they feel.

Notice whether you have more time to do other things.

Consider whether any of your service users would be interested in vocational opportunities.

Physical Activity

Background:

There is increasing evidence that sedentary activity among the older population is becoming more and more problematic[29]. The latest statistics indicate that lack of physical activity is the cause of diabetes, high blood pressure, obesity, coronary heart disease, stroke and other conditions that effect the blood vessels. Physical inactivity is the fourth leading risk factor for global mortality, with the most recent figure sitting at 3.2 million deaths a year[30].

The Department of Health Physical Activity Guidelines 2019 advocate that everyone should participate in daily physical activity to gain health benefits, including the maintenance of both good physical and mental health.

Light activities bring some health benefits compared to being sedentary, with more activity bringing greater improvements in physical function, as well as social benefits. The guidelines also state that there is some evidence that links an increase in physical activity to reduced feelings of social isolation and loneliness[26].

Older adults particularly should include activities that improve strength, flexibility and balance, in order to maintain function and confidence, as well as to reduce the risk of falls[26].

There is strong evidence that physical activity plays a vital role in our lives not just for the management and prevention of disease, but for the maintenance of independent living[26], therefore physical activity is one of the fundamental elements of an Enabling Care Approach.

In Practice:

Daily Movement

With the average person sitting 12 hours per day, the Department of Health suggests that “older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at least with standing, as this has distinct health benefits for older people.” (26,29)

We should be encouraging daily movement, such as standing in those who are able, and this should be followed up by promoting light activities. Beyond the areas of daily living (ADLs), this might include walking, cooking, dancing or arts & crafts (to name a few.)

These low intensity, ‘non-exercise’ activities such as standing, and walking, play a crucial role and account for more of our daily energy expenditure than moderate-to-high intensity activities. (26)

In terms of encouraging daily movement, it helps to remember that **“some is good, more is better.”** (26)

Chair Based Exercise

These exercises can only be taught by a person who has completed the necessary training. Exercise refers to ‘planned physical activity’, which one way to meet the Government recommendation that everyone “should aim to accumulate at least 150 minutes of moderate intensity aerobic activity, building up gradually from current levels”.

Chair Based Exercise is a great way to gradually build up those activity levels, with evidence suggesting it boosts physical function, independence and mental well-being. Having planned time for physical activity, such as Chair Based Exercise contributes to a sense of control over, and responsibility, for one’s own health and well-being (31).

OTAGO

These exercises can only be taught by a person who has completed the necessary training. It is important to highlight that “a loss of muscle strength in advancing age is the primary limiting factor for functional independence”, and that it is this loss that we need to address with an Enabling Care Approach. (29)

Additionally, it needs to be understood that “good balance and mobility are essential to the successful performance of most activities of daily living” (26). Therefore, in accordance with best practice, older adults who are at risk of falls should be undertaking physical activities that address both strength and balance.

OTAGO is a specific programme of physical exercises that will challenge both balance and strength, and which has shown improvements in these areas in individuals who have participated in the programme (31).

Staff/Relative Physical Activity Tips:

Think about what simple things your service users could do to increase their physical activity levels.

Try:

- Practising ‘sit to stand’ (with your supervision if needed) at intervals throughout the day*
- Set ‘mini goals’ to walk slightly further each day
- Follow the exercises in the HCPA StopFalls Brochure

Consider undertaking HCPA training to become a Chair Based Exercise/OTAGO Instructor.

** Ensure appropriate risk assessments are carried out*

Social Activities

NICE carried out a review on independence and mental well-being in older adults. It showed that older people find it hard to take part in activities that could help maintain their independence and mental wellbeing.[32]

Staff/Relative Social Activities Tips

- Identify older people who are at the most risk of decline in their independence
- Provide opportunities for older people to get involved with
- Look at putting a plan in place to help overcome barriers. Ask yourself the question what does this person want to achieve? How are we going to achieve it? Do we know enough about this person?
- Have meaningful conversations to find out about an individual's interests as this can help you develop a relationship with them
- Source support from local services and organisations

Other resources

- Get in contact with local nursery schools and schools to encourage 'Intergenerational Activity'. Intergenerational Activity can be a great weekly event and can encourage children to spark a 'new lease of life' in older adults, therefore minimising loneliness and improving mental well-being
- Consider multi-component activities and how activities can involve a range of topics and opportunities.
- Find out what motivates the people you look after so you can plan appropriately
- Identify ways to get people involved in activities, such as friends and family

Vocational Opportunities

It stands to reason that if individuals feel they are more independent and able to contribute to society, they will feel more valued.

For this reason, vocational opportunities should be explored where appropriate.

Equipment and Mobility Aids

Background

Physiotherapists are the key Allied Health Professional (AHPs) to involve regarding the appropriateness of a mobility aid, whereas Occupational Therapists are the key AHPs to involve regarding the appropriateness of a most other pieces of equipment.

These professionals have been trained to weigh up the advantages/disadvantages of each piece of equipment and are therefore able to assess an individual's needs appropriately. Since Care Staff are in regular contact with their individuals and often know them very well, they are often the people to notice when needs change and can signpost when required (see the Signposting section on page 36).

In Practice:

Although equipment that has been issued to an individual may have been appropriate for their needs at the time it was issued, it may be that it is no longer appropriate.

For example, someone who has recently been discharged from hospital with a Rotastand for transfers, may improve and be able to sit to stand without the equipment a few days after returning home. In this case, continued use of the Rotastand may in fact be *disabling*.

Two things are important here:

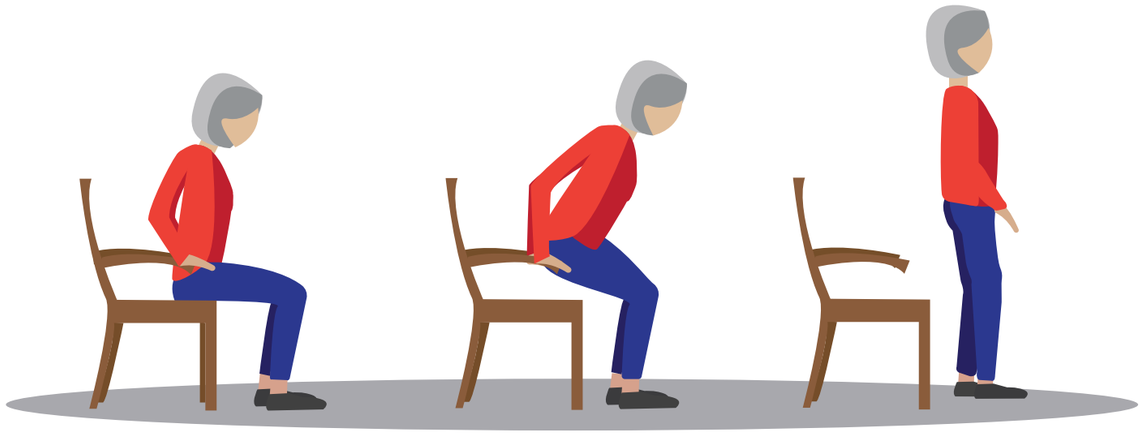
- Firstly, the individual's needs should be reviewed precisely at the point that their needs change, as delaying this could mean that their opportunity to improve is missed
- Secondly, someone (usually a member of care staff), needs to have a *questioning approach* to the possibility that the service user has the potential to improve

This means that the Care Staff may also need to try encouraging the individual to sit to stand to ascertain whether there is any potential.

This needs to be risk assessed to ensure that the benefits of being more physically active outweigh the risks of falling.

The benefits of being more active almost always outweigh the risks of not being active [26]. Therefore, providing the activity is carried out as safely as possible, with strategies in place to minimise the risk of falling, this is what is known as Positive Risk Taking.

Sit to Stand



Staff/Relative Equipment and Mobility Aids Tips

- For sit to stand practice, this may involve having two members of staff for safety, NOT to lift. For mobility practice, this could involve 3 members of staff (one close behind with the wheelchair)*
- Consider HCPA Tier 2 Module 4 on Therapeutic Handling, where you can learn practical techniques to enhance your ability to get people to get up on their feet.
- Did you know that the use of the arms to *pull up* from a chair, unless the only option, may *disable* someone as it promotes the use of arms *not* the legs. Our normal movement pattern for sit to stand is to use our arms and our legs to *push up* from the chair. Consider whether the person using a Rotunda or a Rotastand e.g. on return from hospital after being unwell, could practise sit to stand using a pushing motion *.
- Consider also, the scenario where someone who can walk to the bathroom is always transferred in a wheelchair. Is this person likely to retain their ability to mobilise or are they likely to lose it?

** Always ensure a risk assessment is carried out and that an AHP, such as a Physiotherapist or Occupational Therapist (OT) is consulted if you are in any doubt see Signposting section on page 36.*

Equipment Tips:

- Would a piece of equipment/a different piece enable someone to perform a task more easily, more independently?
- Carry out regular equipment audits: is it safe and in good working order? Was it prescribed for the individual who is using it? Does it appear safe? Does it enable or disable the individual?
- Review equipment regularly – keep an open mind and consider whether the person can improve

Mobility Aid Selection

» Comes from experience. Competence comes from knowledge, training and experience

» Weighs up safety versus independence

» Is a complex decision-making process and complex assessment

Therefore, currently, the prescription of mobility aids needs to be by a Physiotherapist, OT or qualified Moving & Handling Assessor.

Your role is:

- To spot when someone needs a mobility assessment and refer as soon as possible to an appropriate Health Professional
- To carry out regular audits on Mobility aids – are they safe and in good working order? Were they prescribed for the individual who is using them? Do they appear safe? Do they enable or disable the individual?
- Consider actions such as a referral to Wheelchair Services for a self-propelling wheelchair if an individual can use their arms and you think they are cognitively able to use one

Signs of Deterioration and Signposting

Background:

Keeping people active, healthy and independent is of course the one of the main aims of an Enabling Care Approach. However, since individuals still become unwell, one of the most important ways in which we can 'enable' people to remain well, is through early detection of acute deterioration, which may avoid unnecessary hospital admissions and indeed, potential deaths. Reducing hospital admissions has been a focus of the Care Commissioning bodies over the past few years to reduce the strain on an already overburdened NHS.[33]

In addition, the signs of more chronic problems, such as worsening postural alignment, worsening mobility or increased spasms, can delay or even prevent further deterioration, especially when accompanied by timely signposting to the appropriate Health Professional. [34]

In Practice:

- The practice of taking vital signs has not traditionally been embraced in many non-Nurse led care settings. Now, more than ever, there is a drive towards reducing inappropriate ambulance call-outs and unnecessary hospital admissions
- Over 60% of patients admitted to hospital as an emergency have a long-term health condition [33]
- Nearly a quarter were seen to be at the lowest level in managing their health [34]
- Those who were able to manage their health conditions had 38% fewer emergency admissions and 32% fewer attendances to A&E [33].

Staff/Relative Tips

Spotting signs of an acutely unwell person (acute deterioration)

- Think about physical observations – you may get a 'hunch' that someone "just doesn't seem themselves" or is a little "off colour"
- What can you see, hear, smell or feel on the service user? – these things may have contributed to your hunch. For example, you may have smelt an odour which you think could be a chest infection (CI) or a urinary tract infection (UTI). Notice these observations and report them, document them and monitor/refer the service user appropriately
- Have an understanding of vital signs - temperature, heart rate (HR)*, respiratory rate (RR), blood pressure (BP) and oxygen saturations (SPO^2). Refer to HCPA Basic Health Observations Training.

**Refer to HCPA's Tier 2 Respiratory Module*

Vital signs	Normal range	How usually measured in the Care Setting
Temperature	36.5°C to 37.3°C; (average 37°C)	■ Tympanic (ear) thermometer
Heart Rate (pulse)	60 to 100 beats per minute	■ Manually at the wrist (radial pulse) using a minute timer ■ Using a Heart Rate monitor e.g. on a Pulse Oximeter
Respiratory Rate	12-18 breaths per minute at rest	■ Manually by counting chest movement (in and out =1)
Blood Pressure	90/60 mm Hg to 120/80 mm Hg	■ Automatic blood pressure monitor ■ Manually (by a Nurse) with a sphygmomanometer
Oxygen Saturations*	94-100%	■ Pulse Oximeter (finger/toe/ear) ■ Arterial Blood Gases (ABGs) – only likely in hospital or by Community Respiratory Team

[35] Values taken from: www.england.nhs.uk, accessed 11.8.20 The Atlas of Shared Learning, Case study. Introducing bedside vital signs devices at Imperial College Healthcare NHS Trust4, March 2019. Leading Change, Adding Value Team (Nursing, midwifery and care).
** In a person who has Chronic Obstructive Pulmonary Disease (COPD), who is known to retain Carbon Dioxide (CO2), a normal range for them may be 88-92%*

Consider obtaining the WHZAN 'Blue Box'

Whzan automatically calculates the Royal College of Physicians' National Early Warning Score (NEWS2), and is in use throughout the UK supporting the analysis of illness, nutrition, hydration, frailty and other conditions. It includes health and activity pattern recognition, and independent NHS case studies demonstrate that Whzan telehealth achieves substantial savings in resources, improves patient lives and empowers Care Workers. **Contact:** www.whzan.uk/care-homes or contact HCPA for further details.

Recognising and Managing the Signs of Chronic Deterioration

- Many factors can affect the health and well-being of an individual receiving Care. They may experience physical deterioration, due to e.g. the progression or non-optimal management of disease; following acute illness or injury; or simply because of the ageing process
- They may also experience mental health or emotional deterioration, due to e.g. the progression or non-optimal management of disease; following acute emotional upset or depression; or simply because of the ageing process.
- Physical and Mental Health are inextricably linked, so can have a profound effect on each other, and consequently on the overall functioning and well-being of the individual
- Additionally, the effects of certain medications can have adverse effects on individuals, both in the short and the long term (see table on page 38 for common side effects)
- Polypharmacy (more than four different medications) is widely accepted as a factor in the risk of falls (Please refer to HCPA's StopFalls resources for further information)

Remember: You can help reduce deterioration by acting early and referring to the appropriate Health Professional

1. Be observant with regards to changes an individual
2. Don't assume that deterioration is inevitable
3. Question whether something (or someone) may help an individual to improve
4. Keep up to date with training that includes enablement skills, postural alignment, information on specific conditions, particularly neurological and respiratory conditions
5. Ensure your approach is supportive and understanding
6. Use understanding and compassion
7. Listen, encourage and guide where needed
8. Communicate clearly in the most effective way for the specific individual
9. Try to be patient and calm. Practise relaxation and mindfulness techniques for yourself!
10. Consider which extra care plans and risk assessments might need to be included for an individual with e.g. a neurological condition that causes them to have increased tone in their legs
11. Be curious and confident to ask questions about an individual's potential needs
12. Consider what other members of the in-house Multidisciplinary Team (MDT) might you need to liaise with?
13. Consider what members of the wider MDT might you need to involve?
14. Consider a person's values and beliefs regarding their health. A person's health and well-being needs are likely to be better met if their needs are identified and their goals are agreed together, and if they are given greater choice and control over the care and support they receive.[36]

Signposting to Members of the Wider MDT

Use this guide when considering who is the best Allied Health Professional (AHP) for the individual's needs. Where possible, use accepted assessment tools, such as the FRAT for risk of falls, the CRAT for risk of contractures, or other measurements such as the Waterlow Score and weight etc.

Problem	Allied health professional (AHP) to refer to*
Worsening mobility, Difficulty using mobility aid Mobility aid inappropriate or wrong size/height	■ Physiotherapist ■ Occupational Therapist
Postural problems Problems with seating or positioning in bed	■ Physiotherapist ■ Occupational Therapist ■ Wheelchair services
Increased muscle tone (causing spasms/stiffness/pressure areas developing/postural problems)	■ Physiotherapist (for positioning advice) ■ GP/Neurology Consultant (for medication review) ■ Specialist team (E.G. Parkinsons Nurse, MS Nurse) ■ Occupational Therapist/Physiotherapist (for splints) ■ Tissue Viability Nurse (for pressure areas) ■ Dietician (for nutrition review)
Not managing/coughing on food or fluids	■ Speech and Language Therapist (SALT)
Bowel or bladder dysfunction	■ Continence Nurse ■ District Nurse
Recurrent infections E.G. Chest, Urinary Tract Infections	■ Nurse ■ Speech and Language Therapist (for chest infections) ■ Physiotherapist (for chest infections) ■ Dentist (for chest infections) ■ Community Respiratory Team (for someone with COPD or someone on oxygen)
Worsening communication	■ Speech and Language Therapist (SALT)
Weight loss or weight gain	■ Dietician ■ Speech and Language Therapist (SALT)
Behavioural/cognitive changes	■ Occupational Therapist ■ Community Mental Health Team
Emotional changes	■ Community Mental Health Team ■ Talking Therapist (Counselling, Cognitive Behavioural Therapy CBT)

*Please note the list of Health Professionals here is not exhaustive and the referral pathway you need to use, as well as the team you need to access may differ for differently commissioned services. Contact HCPA if you have identified the professional help you think you need, but are unsure of the most appropriate referral pathway.

Useful Resources:

Medicines and Falls Risk

Commonly prescribed drugs that can contribute to falls. This list is to raise awareness of most commonly prescribed drugs that can contribute to falls risk. The grading of the drugs has been adapted from the Medicines and Falls in Hospital: Guidance by John Radcliffe Hospital, Oxford, March 2011 and approved by the British Geriatrics Society.

High risk Can commonly cause falls alone or in combination	**Moderate risk** Can cause falls, especially in combination	**Lower risk** Possibly causes falls, particularly in combination

Drug Name	Common Use	Effects on Falls Risk
Alfluzosin	Benign prostatic hyperplasia	Drop in blood pressure on standing
Amitriptyline	Depression	Drop in blood pressure on standing, drowsiness, slow reactions, impaired balance
Amlodipine	Hypertension, Angina	Low blood pressure, drop in blood pressure on standing
Atenolol	Hypertension, Angina, Arrhythmia	Low blood pressure, drop in blood pressure on standing, slow heart rate
Baclofen	Severe spasticity of voluntary muscle	Sleepiness and reduced muscle tone
Bendroflumethiazide	Oedema, Hypertension	Low blood pressure, drop in blood pressure on standing and sleepiness
Betahistine	Vertigo, Tinnitus	Sleepiness
Bisoprolol	Hypertension, Angina, Heart failure	Low blood pressure, drop in blood pressure on standing, slow heart rate
Bumetanide	Oedema	Low blood pressure, drop in blood pressure on standing
Candesartan	Hypertension, Heart failure	Low blood pressure
Captopril	Hypertension, Heart failure	Low blood pressure, drop in blood pressure on standing
Carbamazepine	Epilepsy	Sleepiness, slow reactions, unsteadiness and lack of movement control
Carvedilol	Hypertension, Angina, Heart failure	Low blood pressure, drop in blood pressure on standing, slow heart rate
Chlordiazepoxide	Anxiety, Acute alcohol withdrawal	Drowsiness, slow reactions, impaired balance
Chlorphenamine	Allergy, Urticaria	Drowsiness and blurred vision
Chlorpromazine	Psychosis	Drop in blood pressure on standing, sleepiness, slow reflexes, loss of balance
Chlorthalidone	Oedema, Hypertension, Heart failure	Low blood pressure, drop in blood pressure on standing and sleepiness
Cinnarazine	Nausea, Vomiting, Vertigo, Tinnitus	Sleepiness
Citalopram	Depression	Drop in blood pressure on standing, confusion
Clomipramine	Depression, Phobia	Drop in blood pressure on standing, drowsiness, slow reactions, impaired balance
Clonazepam	Epilepsy	Drowsiness, slow reactions, impaired balance
Codeine	Pain	Sleepiness, slow reactions, impaired balance, delirium
Dantrolene	Severe spasticity of voluntary muscle	Sleepiness , reduced muscle tone
Diazepam	Insomnia, Anxiety	Drowsiness, slow reactions, impaired balance
Digoxin	Heart Failure	Slow heart rate
Diltiazem	Hypertension, Angina	Low blood pressure, drop in blood pressure on standing
Donepezil	Dementia	Fainting
Dosulepin	Depression	Drop in blood pressure on standing, drowsiness, slow reactions, impaired balance
Doxazosin	Hypertension	Low blood pressure, drop in blood pressure on standing
Doxepin	Depression, Pruritus in eczema	
Duloxetine	Depression, Anxiety	Drop in blood pressure on standing, sleepiness, dizziness, confusion
Enalapril	Hypertension, Heart failure	Low blood pressure, drop in blood pressure on standing
Felodipine	Hypertension, Angina	Low blood pressure, drop in blood pressure on standing
Fluoxetine	Depression	Confusion
Fluphenazine	Psychosis	Drop in blood pressure on standing, sleepiness, slow reflexes, loss of balance
Flurazepam	Insomnia	Drowsiness, slow reactions, impaired balance
Furosemide	Oedema, Hypertension	Low blood pressure, drop in blood pressure on standing
Gabapentin	Chronic pain	Drop in blood pressure on standing, sleepiness, unsteadiness
Galantamine	Dementia	Fainting
Glyceryl trinitrate (GTN)	Angina	Drop in blood pressure on standing
Haloperidol	Psychosis	Drop in blood pressure on standing, sleepiness, slow reflexes, loss of balance
Hydroxyzine	Pruritus	Drowsiness and blurred vision
Irbesartan	Hypertension	Low blood pressure
Isosorbide mononitrate	Angina	Drop in blood pressure on standing
Lercanidipine	Hypertension	Low blood pressure, drop in blood pressure on standing
Lisinopril	Hypertension, Heart failure	Low blood pressure, drop in blood pressure on standing
Lorazepam	Insomnia, Anxiety	Drowsiness, slow reactions, impaired balance
Lortemazepam	Insomnia	Drowsiness, slow reactions, impaired balance
Losartan	Hypertension, Heart failure	Low blood pressure
Metolazone	Oedema, Hypertension	Low blood pressure, drop in blood pressure on standing and sleepiness
Metoprolol	Hypertension, Angina, Arrhythmia	Low blood pressure, drop in blood pressure on standing, slow heart rate
Mirtazapine	Depression	Drop in blood pressure on standing, drowsiness, slow reactions, impaired balance
Morphine	Pain	Sleepiness, slow reactions, impaired balance, delirium
Moxonidine	Hypertension	Low blood pressure, drop in blood pressure on standing and sleepiness
Nicorandil	Angina	Drop in blood pressure on standing
Nifedipine	Hypertension, Angina	Low blood pressure, drop in blood pressure on standing
Nitrazepam	Insomnia	Drowsiness, slow reactions, impaired balance
Nortriptyline	Depression, Neuropathic pain	Drop in blood pressure on standing, drowsiness, slow reactions, impaired balance
Olanzapine	Psychosis, Agitation	Drop in blood pressure on standing, sleepiness, slow reflexes, loss of balance
Olmesartan	Hypertension	Low blood pressure
Oxazepam	Anxiety	Drowsiness, slow reactions, impaired balance
Oxybutinin	Urinary incontinence	Drowsiness, dizziness and blurred vision
Paroxetine	Depression	Drop in blood pressure on standing, confusion
Perindopril	Hypertension, Heart failure	Low blood pressure, drop in blood pressure on standing
Phenobarbital	Epilepsy	Sleepiness, slow reactions, unsteadiness and lack of movement control
Phenytoin	Epilepsy	Unsteadiness and lack of movement control
Pramipexole	Parkinson's disease	Delirium and drop in blood pressure on standing
Prazosin	Hypertension	Drop in blood pressure on standing
Pregabalin	Epilepsy, Neuropathic pain	Sleepiness
Prochlorperazine	Nausea, Vomiting, Vertigo	Movement disorder in long term use
Promethazine	Allergy, Urticaria	Drowsiness and blurred vision
Propranolol	Hypertension, Angina, Arrhythmia	Low blood pressure, drop in blood pressure on standing, slow heart rate
Quetiapine	Psychosis, Agitation	Drop in blood pressure on standing, sleepiness, slow reflexes, loss of balance
Ramipril	Hypertension, Heart failure	Low blood pressure, drop in blood pressure on standing
Risperidone	Psychosis, Agitation	Drop in blood pressure on standing, sleepiness, slow reflexes, loss of balance
Rivastigmine	Dementia	Fainting
Ropinirole	Parkinson's disease	Delirium and drop in blood pressure on standing
Selegiline	Parkinson's disease	Drop in blood pressure on standing
Sertraline	Depression	Drop in blood pressure on standing, confusion
Solifenacin	Urinary incontinence	Drowsiness, dizziness and blurred vision
Sotalol	Arrhythmia	Low blood pressure, drop in blood pressure on standing, slow heart rate
Tamsulosin	Benign prostatic hyperplasia	Drop in blood pressure on standing
Telmesartan	Hypertension	Low blood pressure
Temazepam	Insomnia	Drowsiness, slow reactions, impaired balance
Timolol eye drops	Glaucoma	Drop in blood pressure on standing, slow heart rate
Tolterodine	Urinary incontinence	Drowsiness, dizziness and blurred vision
Trazodone	Depression, Anxiety	Drop in blood pressure on standing, drowsiness, slow reactions, impaired balance
Trimipramine	Depression	Drop in blood pressure on standing, drowsiness, slow reactions, impaired balance
Venlafaxine	Depression	Drop in blood pressure on standing, sleepiness, dizziness, confusion
Verapamil	Hypertension, Angina, Arrhythmia	Low blood pressure, drop in blood pressure on standing
Zolpidem	Insomnia	Drowsiness, slow reactions, impaired balance
Zopiclone	Insomnia	Drowsiness, slow reactions, impaired balance

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Useful Resources Continued:

Living well through activity in care homes: the toolkit (2015), The Royal College of Occupational Therapy: www.rcot.co.uk/file/940/download?token=WZIMG-fB

A-Z of activities, The Royal College of Occupational Therapy: www.rcot.co.uk/about-occupational-therapy/living-well-care-homes-2019/a-z-activities

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Notes

Notes

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