# Dignity in Care Network

14th July 2017

# Pyjamas Optional: Promoting Dignity to Avoid Institutionalised Care

The Mid Yorkshire Hospitals
NHS Trust

# Learning Disability VIP Scheme

*Marie Gibb Strategic Health facilitator for LD Wakefield*

Striving for excellence

# What is the VIP scheme?

- Hospitals are a scary place
- Hospital Passport was brought into hospital but it wasn’t looked at
- Because your in hospital we know best
- Patient wasn’t listened too
- Sent home without finding out if the patient has someone to care for them

# What is the VIP scheme?

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*Bringing together community and hospital services*

## VIP hospital passport

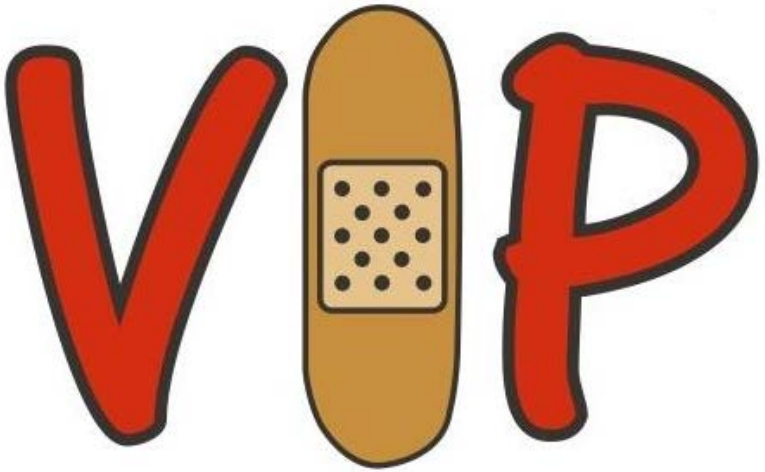
This VIP Passport gives the hospital staff important information about you.
Please take it with you if you need to go to hospital. Keep 2 copies of your passport with you. Give one to hospital staff for your notes and keep one in your health passport folder. If you need help to fill it in ask your health facilitator, a family member, your GP or nurse.

### About me

| | |
|---|---|
|  | My name: .....<br>I like to be called: ..... |
|  | My religious needs are: .....<br>My ethnic background is: ..... |
|  | Language/s I speak: .....<br>Understand: .....<br>Language/s my carer speaks: .....<br>Understands: ..... |
|  | Things I like to do and talk about: / Things I don't like to do and talk about: |

Date ..... Review date .....






**V**ulnerable **I**n **P**atient

# What is the VIP scheme?


**When a patient with a learning disability comes into hospital they will either consent to be a part of the scheme or that decision will be made in their best interest.**

# What is the VIP scheme?


**VIP symbol will be placed above the patients bed.**

# What is the VIP scheme?


**VIP symbol to be placed on the front cover of the clinical notes.**

# What is the VIP scheme?


**Ward and department based LD VIP champions identifiable by the VIP champion badge.**

# What is the VIP scheme?


**LD role specific volunteers identifiable by the yellow tabard and VIP champion badge.**

# How will it help?


**Putting the VIP symbol above the bed will alert ALL staff that the patient has a Learning Disability and may need extra support.**

# How will it help?


**The VIP sticker on the notes will alert all staff that see it that the patient may need things explaining to them differently.**

# How will it help?


**It will also refer staff to the VIP checklist full of top tips on how to support a patient who has a learning disability. (available on the intranet or in printed pocket sized format)**

# Checklist includes

**Identify the patient as having a learning disability**

# Checklist includes

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## VIP hospital passport

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### About me

My name: .....

I like to be called: .....

My religious needs are: .....

My ethnic background is: .....

Language/s I speak: .....

Understand: .....

Language/s my carer speaks: .....

Understands: .....

| Things I like to do and talk about: | Things I don't like to do and talk about: |
|---|---|
| | |

Date ..... Review date .....



**Ask if the patient has a VIP Hospital Passport.**

**Read the VIP Hospital Passport, this is about communication, how the patient expresses pain, eating and drinking, 1:1 support needs, capacity and consent.**

# Checklist includes


**Make time to get to know your patient.**

# Checklist includes

**Introduce yourself to family or support workers, carers are a valuable resource and often know the patient well.**

# Checklist includes

**If the ward require advice or input from the Acute Hospital Liaison Nurse either complete an ICE referral or contact 01924 543692, mobile 07748920280.**

# Checklist includes


**If family members or paid support workers are providing care for the patient whilst in hospital, share MYHT Carer's Guidance and agree expectations.**

**(Remember to offer them breaks)**

# Checklist includes


**Document the conversation in the patient's notes.**

# Checklist includes


**Is the patients mental capacity in question?**

**Consider Mental Capacity Act assessment, and Best Interest decision making.**

# Checklist includes


**Is it likely the patient requires 1:1 supervision?**

**Contact the ALN and request support to complete a joint 'Risk Dependency Support Tool'.**

# Checklist includes


**When planning discharge, have the patients support needs changed?**

**Liaise with care manager, family, CTLD nursing and support provider.**

# Checklist includes


**Always speak to the patient first, give time for the patient to respond.**

# Winterbourne View

# SURGICAL PATHWAY

## *for Adult Patients with Learning Disabilities Guidelines*

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***At the Out Patient consultation, if capacity is in question, the decision maker *1 must complete and document an MCA assessment *2 for the proposed procedure***

- Patient assessed as having capacity to consent to the procedure.
- Discuss: Pathway 1 and Pathway 2, with the patient and document any reasonable adjustments required in clinical notes and refer to Acute Liaison Nurse for Learning Disabilities *3
- Refer for pre-assessment visit

- Patient assessed as lacking capacity to consent for the procedure.
- Decision maker to make a Best Interest *4 decision and document the outcome on consent form 4.
- Discuss: Pathway 1, Pathway 2, Pathway 3 and Pathway 4 at the Best Interest discussion/meeting and document any reasonable adjustments required in clinical notes and refer to Acute Liaison Nurse for Learning Disabilities *3
- Refer for pre-assessment visit

### PRE ASSESSMENT

- Complete Pre assessment screening
- Discuss with senior anaesthetist for anaesthetic review and suitability of listing as a day patient
- Consider what reasonable adjustments *5 the patient requires and document any identified on the pre assessment documentation
- Inform ALN for LD of any patient requiring any reasonable adjustments.

### PATHWAY 1 (P1)

***Patient Presentation***

- Patient able to wait
- Willing to accept most interventions i.e. bloods, BP

***Consider Any Reasonable Adjustments***

- Emla cream
- Parents or carers support in anaesthetic room
- Consider early Post Op discharge

Document reasonable adjustments needed on Pre Op Assessment

### PATHWAY 2 (P2)

***Patient Presentation***

- Anxious patients who challenge existing ways of working

***Consider Any Reasonable Adjustments***

- Contact ALN for LD to discuss a need for a pathway meeting *6
- Adjustments same as P1 patients plus
- First on operating list
- Quiet or secluded areas on unit to wait
- Consider use of oral sedation *7

### PATHWAY 3 (P3)

***Patient Presentation***

- Patient difficult to get into hospital, very anxious, disruptive and non-compliant

***Consider Any Reasonable Adjustments***

- Pathway meeting needed inform ALN for LD.
- Adjustments same as P1 & P2 plus
- Home sedative required *8
- Discuss with Dr Heinz Schulenburg Clinical Anaesthetic Lead LD.

Document reasonable adjustments needed on Pre Op Assessment

### PATHWAY 4 (P4)

***Patient Presentation***

- Unable to access Pre Op Clinic, Total non-compliance. Patient exhibiting disruptive, aggressive behaviour.

***Consider Any Reasonable Adjustments***

- Pathway meeting ESSENTIAL inform ALN for LD and Dr Heinz Schulenburg.
- Adjustments same as P1, P2, P3 plus
- Anaesthetist and ALN meet patient in car in the carpark
- Administer oral sedation
- Escort patient straight to theatre
- Discharge Post Op as soon as patient is indicating a wish to leave and it is safe to do so.

Document reasonable adjustments needed on Pre Op Assessment

### GUIDELINES

***Please consider these guidelines when following the surgical pathway for adult patients with a learning disability.***

***1 The decision maker is the professional carrying out the proposed action for the patient.**

***2 The 'MCA' is the Mental Capacity Act 2005. Follow the principles of the Mental Capacity Act.**

- Presume capacity
- Support people to have capacity
- People are entitled to make unwise decisions
- Best interests
- Least restrictive options

***3 The 'ALN' Acute Hospital Liaison Nurse for Learning Disabilities.**

***4 Best Interests Decision –** This is made by the Surgeon in consultation with the patient, their family, support workers, or 'IMCA' Independent Mental Capacity Advocate.

***5 Reasonable Adjustments –** The Equality Act 2010 states changes or adjustments should be considered and made to ensure equality of access to services for people who have a disability. Examples of reasonable adjustments on a surgical pathway include first on the list, sedative given at home, straight from car park into theatre.

***6 Pathway meeting –** person centred meeting which details what, where and how the patient will access the hospital for their surgery. This includes agreement of any reasonable adjustments needed. The pathway meeting agrees the fine details of the patient journey. The people invited to a pathway meeting include the patient, family carer, paid support worker, the decision maker, the anaesthetist, theatre staff and any other person who knows the patient well and can influence the pathway.

***7 Oral sedation –** consider the use of oral / buccal midazolam

***8 Home sedative –** required to support patients to attend hospital. The use of a home sedative is often decided as a result of a Best Interest/ pathway meeting.

This guidance is not exhaustive and reasonable adjustments considered must be specific to patient need.

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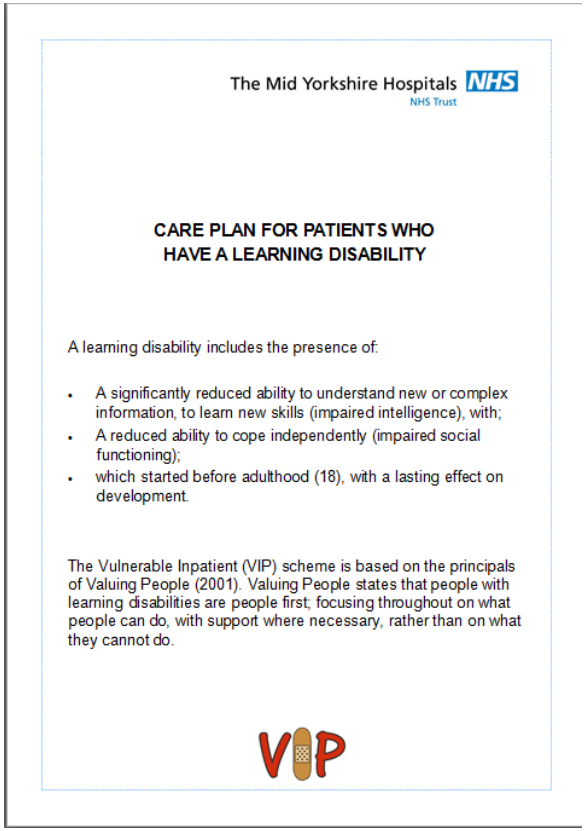
# Learning disability care plan

- To encourage the documentation of reasonable adjustments, the LD care plan was developed.



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**CARE PLAN FOR PATIENTS WHO HAVE A LEARNING DISABILITY**

A learning disability includes the presence of:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- which started before adulthood (18), with a lasting effect on development.

The Vulnerable Inpatient (VIP) scheme is based on the principals of Valuing People (2001). Valuing People states that people with learning disabilities are people first; focusing throughout on what people can do, with support where necessary, rather than on what they cannot do.

VIP

# Learning disability care plan

VIP CHECKLIST

For patients who have a Learning Disability

1. Place the VIP sticker on the front cover of the patients notes and over the patients bed, with consent, or following best interest discussion; if patient lacks capacity.
2. Read the patients VIP hospital passport, this is about communication, how the patient expresses pain, eating and drinking, enhanced care needs, capacity and consent.
3. Make time to get to know your patient. Ensure you speak to the patient first, giving time for them to respond.
4. Introduce yourself to the patient, family and support workers. Carers are a valuable resource and often know the patient well.


5. Share the trusts guidance for carers and offer breaks.
6. Ensure only appropriate medical reasons are on any DNACPR's.
7. If advice or support is required from the Acute Hospital Liaison Nurse for Learning Disabilities (ALN) either complete an ICE referral or contact 53692
8. If there is a need for enhanced care support, complete the Risk Dependency Support Tool, with the ALN.
9. Consider Deprivation of Liberty Safeguards (DoLS) if the patient lacks capacity to consent to their hospital stay.
10. Is the patients capacity to consent to treatment in question? Consider the Mental Capacity Act and best interest decision making. Use the decision making care plan.
11. When planning discharge, have the patients support needs changed? Liaise with care manager, Adult Learning Disability Health Service and support provider (plan ahead).

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## Family Carers Guidance for Hospital Staff

These guidelines are to support the role and function of family carers who provide additional support to their ADULT family members with learning disabilities (LD) when they are inpatients in The Mid Yorkshire Hospitals NHS Trust (MYHT). Carers must be recognised as partners by the hospital staff. The majority of all care for people with long-term illness or disability is provided by families in the community. They are often relied on as a matter of course to continue the medical regimes prescribed by hospital staff once the patient is discharged and returns home.

1. The duty of care for patients with LD admitted to MYHT remains with the Trust.
2. Family carers are there to support their relatives only.
3. Family carers must be recognised as experts in providing care and recognising/meeting the needs of their vulnerable relatives.
4. Family carers must be made aware of the acute hospital liaison nurse role for LD and how to contact for advice and support.
5. Family carers will be informed of all risk procedures by the MYHT ward staff (Fire procedure, COSHH, out of bounds etc.)
6. Family carers will be made aware of who is looking after their relative at each shift hand over and this staff member will be a point of contact for the family carer.
7. Family carers will inform the nurse in charge if they need to leave their relative or the ward.
8. MYHT will ensure family carers have breaks when requested. Family carers must be shown where amenities are located.
9. Family members who are supporting their relatives during the night must be offered breaks and somewhere to sleep/rest.
10. Family members and MYHT staff will ensure that there is an appropriate handover at the end of each period of duty.
11. Family members and MYHT staff will ensure that there is effective communication with regard to the ongoing or changing needs of the patient.
12. MYHT staff and family carers will work in partnership to achieve the best possible outcome for the patient to reduce inequalities and improve patient and care experience.
13. In the provision of any care supported with potential risk issues e.g. moving and handling, cross infection, family members will work alongside hospital staff on a 1:1 basis.
14. Discharge arrangements/multi agency discharge planning meetings will include, where appropriate, family members and carers.

# Learning disability care plan

VIP

## Reasonable adjustments

"The hospital must take positive steps to remove the barriers patients face because of their disability. This is to ensure patients receive the same services, as far as this is possible, as someone who is not disabled. The Equality Act 2010 calls this the duty to make reasonable adjustments." (Government Equalities Office, 2010)

Please tick reasonable adjustments implemented below:

Referral made to Liaison Nurse for Learning Disabilities. (ALN) ☐

Open visiting offered. ☐

Carer guidance shared and implemented. ☐

Enhanced care provided with input from ALN ☐

Breaks offered to those supporting patient. ☐

Sedation used to support procedures (where least restrictive). ☐

Document any other reasonable adjustments implemented on the continuation sheet overleaf:

Date..... Position..... Name..... Signed.....

First Name:
Surname:
DOB:
Unit Number:
Hospital/Ward:

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| Date & Time | Nursing Communication (Continuation Sheet) | Signature |
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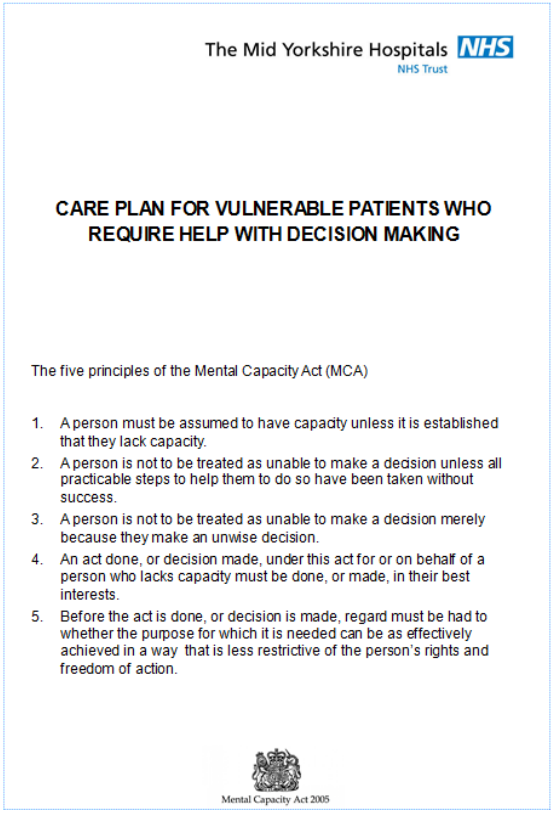
# MCA Care plan

- To encourage the documentation of MCA assessments by nurses, the decision making care plan was developed.



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**CARE PLAN FOR VULNERABLE PATIENTS WHO REQUIRE HELP WITH DECISION MAKING**

The five principles of the Mental Capacity Act (MCA)

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Mental Capacity Act 2005

# MCA Care plan

**Mental Capacity Act assessments should be completed by the health professional responsible for the procedure or proposed treatment.**

**(use one care plan per decision)**

**Assessment of capacity is time and decision specific. To carry out mental capacity assessment follow the steps below:**

Name of proposed procedure or treatment.

.....

.....

.....

.....

.....

↓

Is there a temporary/permanent impairment of mind or brain

and does this impairment impact on this decision?

↓

NO–

Patient has capacity to consent

YES– Carry out a four point capacity test

State impairment.....

.....

↓

Can they understand the significant information relevant to the decision? ☐ YES ☐ NO

Can they retain the information long enough to make a decision? ☐ YES ☐ NO

Can they weigh up the risks, benefits and options? ☐ YES ☐ NO

Can they communicate that decision by any means? ☐ YES ☐ NO

↓

Patient can do **all** of the above– Patient has capacity to consent

Patient can't do **one or more** of the above so on balance the patient lacks the capacity to consent

↓

Is the patient likely to regain capacity to consent? ☐ YES ☐ NO

If Yes state reason why decision can't wait for capacity to return.....

.....

↓

Continue to best interest documentation

Date..... Position..... Name..... Signed.....

**Best Interest decision making for patients who lack capacity**

Intended benefits of the procedure or treatment.

.....

.....

.....

Significant, unavoidable or frequent occurring risks, complications and restrictions.

.....

.....

.....

Unless the patient has an attorney or deputy for personal welfare (health), the final responsibility for determining whether a procedure is in an incapacitated patients best interests lies with the health professionals responsible for the procedure. However, the health professional must consult with those close to the patient (e.g. family, friends, carers, supporter or advocate)

**Please state who has been involved in the decision and what was their opinion:**

.....

.....

.....

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.....

I am satisfied that the patient has not refused this procedure in a valid and applicable advanced decision. As far as is reasonably possible, I have considered the person's past and present wishes and feelings (in particular if they have been written down– any beliefs and values that would be likely to influence the decision in question). As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate.

**I have considered the patients best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:**

| BENEFITS | BURDENS |
|---|---|
| | |

Conclusion:.....

.....

.....

.....

.....

Date..... Position..... Name..... Signed.....

# MCA Care plan

**Deprivation of Liberty Safeguards (DoLS) Meeting the criteria:**

These safeguards provide a legal protection for people who cannot consent to the arrangements being made for their care and treatment (i.e. their hospital stay) and who need to be deprived of their liberty in their best interests. A patient who lacks capacity for any particular decision should not be automatically considered as requiring a deprivation of liberty safeguards (DoLS), however it should be considered if the patient meets the criteria listed below in questions 1 -6. In order for a patient to be considered for a DoLS they should either be an inpatient or resident on one of our intermediate care facilities.

1. Is the person over 18?

☐ **NO** DoLS only applies to individuals aged 18 or over. **End process here.**

☐ **YES** Continue to question 2

2. Do they lack the mental capacity to consent to the arrangements being made for their care and treatment?

☐ **NO** If the patient has capacity a DoLS cannot be applied for. **End process here.**

☐ **YES** Continue to question 3

3. Is the lack of capacity likely to be temporary?

☐ **NO** Continue to question 4.

☐ **YES** Continue to treat patient under Principle 2 of the Mental Capacity Act and review in 48 to 72 hours.

4. Is the patient likely to be with us for longer than seven days?

☐ **NO** If there are firm plans to discharge within seven days then do not apply for a DoLS. If plans are not firm or discharge date is uncertain treat as YES.

☐ **YES** Continue to question 5.

5. If the person attempted to leave, or if someone were to try to remove them, would we let them go?

☐ **NO** Apply for a DoLS.

☐ **YES** DoLS not appropriate. End process here.

**Applying for the deprivation authorisation.**

If the patient meets the previous criteria and it is decided that a DoLS is required then the appropriate form should be completed by a qualified member of the ward team by undertaking the following steps. Once each step has been completed, tick the corresponding box to show it has been done.

1. Download ADASS form 1 from MCA page of intranet (Departments /M/Mental Capacity Act/DoLS forms and flowcharts) ☐
2. Decide if the patient needs an urgent or standard DoLS ☐

An authorisation would be considered to be urgent if either the patient is constantly attempting to leave the ward, is constantly vocalising that they are being imprisoned, is highly agitated, to the point of needing chemical sedation, or is demonstrating high levels of aggression.

3. Discuss the DoLS with all relevant individuals this may include family, carers or friends known to be important to the person. ☐
4. Complete the form electronically providing as much information as possible especially on page 2. To make this easier there is a template on the MCA intranet site – this can be found on the same page as the blank forms. ☐

Step 3 and 4 are interchangeable but other relevant parties MUST be informed about the DoLS application before the form is submitted as it has to be signed to that effect.

5. Attach the completed form to an email and send to DoLS@midyorks.nhs.uk. The adult safeguarding team will then check and process the form before sending onto the relevant supervisory body (local authority). ☐
6. Finally ensure the capacity assessment, and the reasons why a DoLS has been applied for, is documented and ensure the care plan reflects the information contained in the DoLS request. ☐

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# ‘Sit me out of bed!’: Reducing deconditioning in the hospital setting

**Steve Friel- Quality Improvement Lead, Mid Yorkshire NHS Trust**

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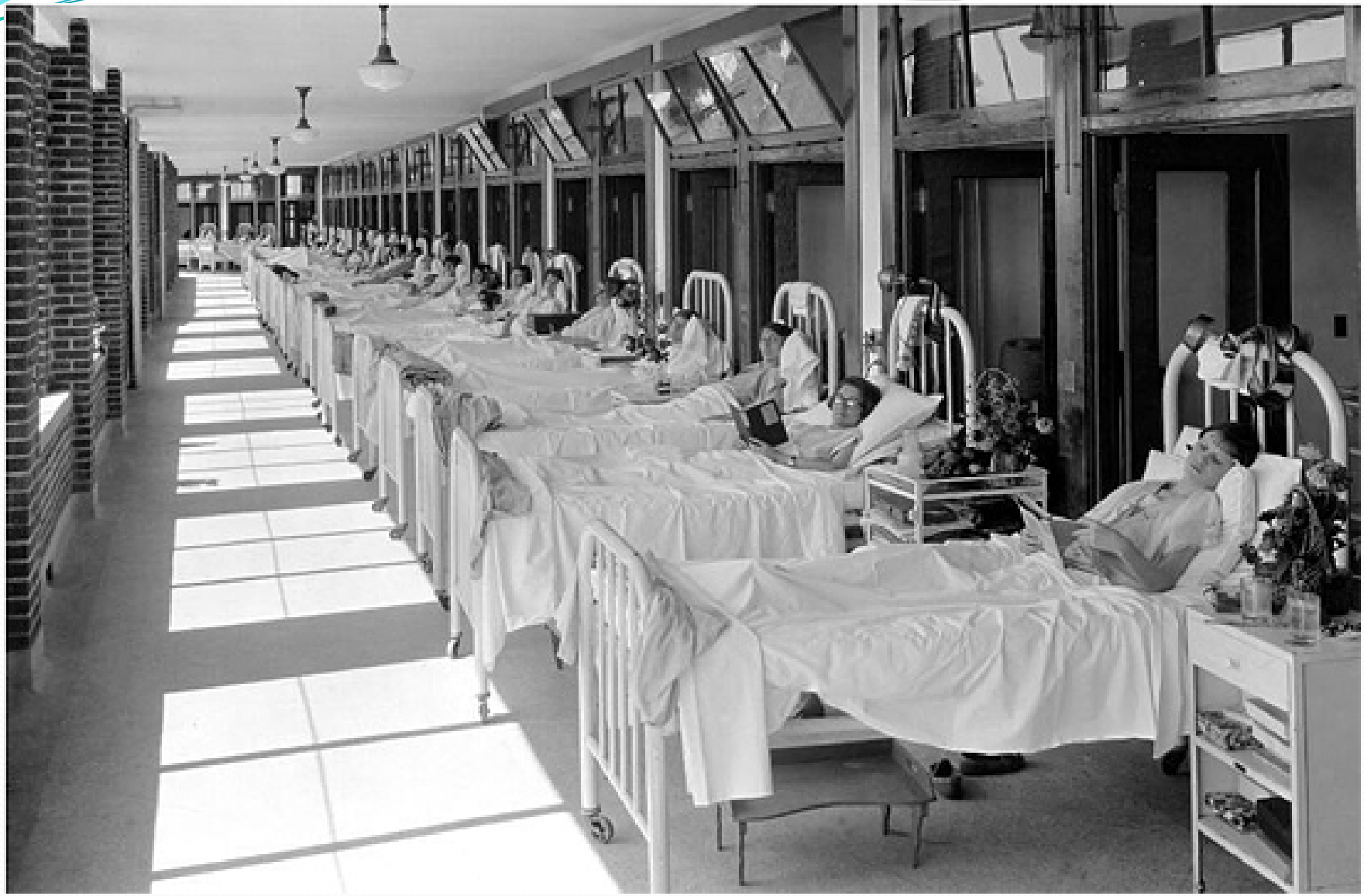
# What would your granny want?

# Background

- “Among hospitalized elderly persons, bed rest and immobilization contribute to several iatrogenic disorders, including pressure sores, deep venous thromboses, and incontinence, and commonly lead to functional decline and disability.” (Gill et al. 2004).

- This phenomenon is known as **deconditioning.**

- People over the age of 65 make up the largest bulk of long stay patients in acute hospitals, with ‘**deconditioning’** being cited as the second most common barrier to discharge in the elderly population.



# Hospital Acquired Deconditioning

**Prolonged bed rest and deconditioning:**

- Reduced mood/increased confusion
- Cardiac deconditioning
- Dehydration
- Reduced exercise tolerance- doesn't return to 'normal' for 5-10 weeks after becoming mobile
- Postural hypotension
- Reduced Lung function- TV + Residual Volume

# Hospital Acquired Deconditioning

- ‘Older adults who are discharged with poor physical function have 3 times the odds of being readmitted within 30 days than older adults with medically complex conditions and high physical function’ (Falvey et.al 2015).

- ‘MOVE IT OR LOSE IT’- mobilise + sit out of bed!
  - Increased lung capacity
  - Improved circulation
  - Increased muscle stretch + resistance not gained in bed exs
  - Improved mood/stimulation

# Evidence based practice

- High intensity resistance training
- Moderate intensity motor control and balance retraining
- Aerobic exercise
- General conditioning activities

# Early Mobilisation

- Early mobilisation has shown to not only be safe but also beneficial in increasing functional gains

- High intensity physiotherapy after #NOF  can reduce LoS (Kimmel et al 2015).

| | Usual | HIP (High Intensity Physiotherapy) |
|---|---|---|
| Acute | 7.38 | 5.98 |
| Rehab | 29.90 | 20.98 |

# National initiatives

- 48% of people over 85 die within one year of hospital admission

  Imminence of death among hospital inpatients: Prevalent cohort study

  David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*

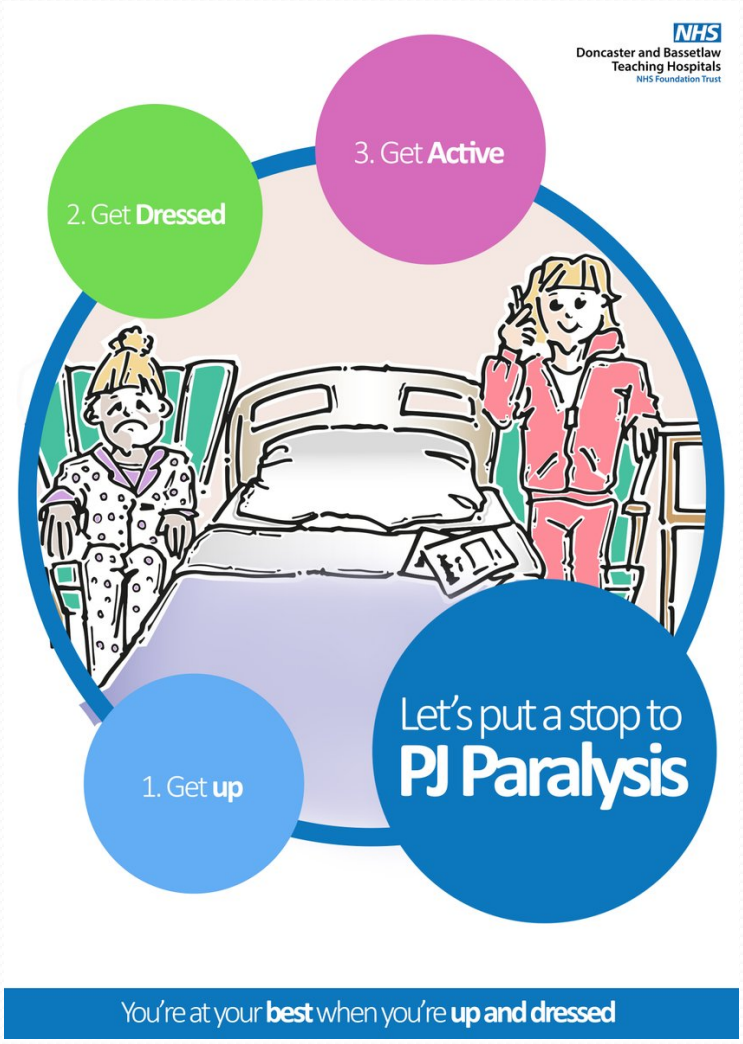
**If you had 1000 days left to live how many would you chose to spend in hospital?**

- 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80

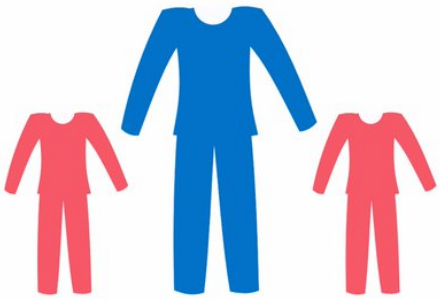
  Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

  Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

# National initiative




## What is PJ Paralysis?



### It's pretty simple

If patients stay in their pyjamas or gowns for longer than they need to, they have a higher risk of infection, loss of mobility, fitness and strength, and will ultimately stay in hospital longer. If we can help patients get back to their normal routine as quickly as possible, including getting up and out of bed, this will mean a quicker recovery.

Just **24 hours** of bed rest reduces your **muscle power** by **2.5%**, and not just in arms and legs, also your heart and lungs.

### You really should consider

Every **10 days of bed** rest in hospital is the equivalent of **10 years muscle ageing** in those over 80.


### Four questions to ask

**01** **Why** am I here?

**02** **What's** the plan?

**03** **What's** needed?

**04** **When** can I go?

You're at your **best** when you're **up and dressed** ***#PJParalysis***

# Deconditioning awareness

# Sit me out!!!!

- Multidisciplinary group of elderly care practitioners based at PGH.
- Aiming to increase awareness on elderly care wards about deconditioning as well as improving the number of patient sitting out of bed on a daily basis.

# Current status

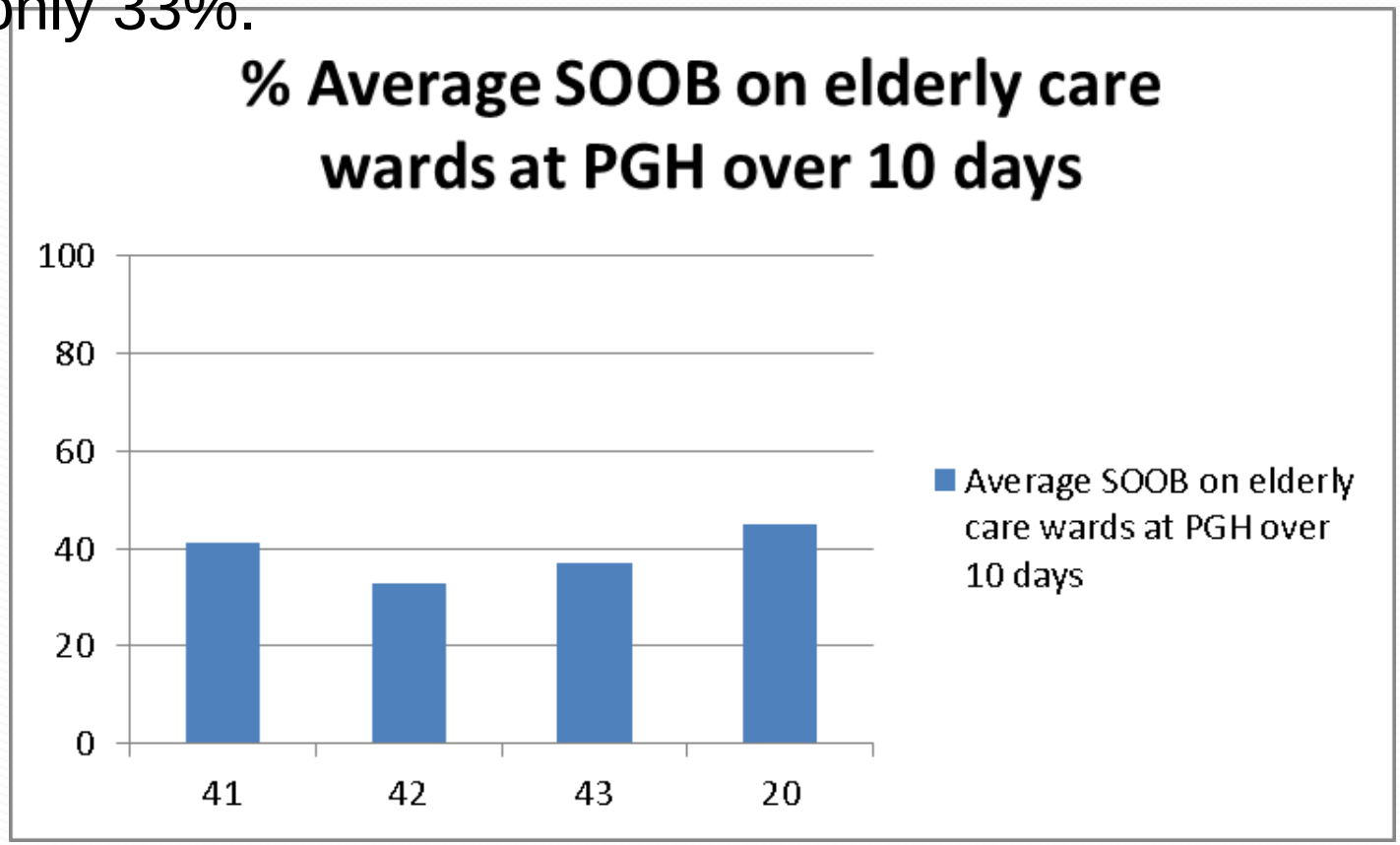
- Baseline audit results showed that across the 4 elderly care wards at Pinderfields Hospital, only 33% of patients were sitting out of bed for their lunch.

- Audit results showed that 85% of patients were still in their pyjamas, with less than 50% of patients sitting out of bed.

- **80% of patients wished to be sitting out of bed for lunch.**

# Ward comparison %SOOB

All four wards had less than 50% of patients sitting out of bed by lunchtime, with G42 having the least patients sat out at only 33%.



# Barriers to sitting out of bed:

The Top 5 reasons respondents thought patients were **NOT** sitting out of bed were :

1. No time for staff to assist patients
2. Staff lack  confidence in assisting patients
3. Patients awaiting assessments by PT
4. Increased risk of falls if patient out of bed
5. No appropriate seating available

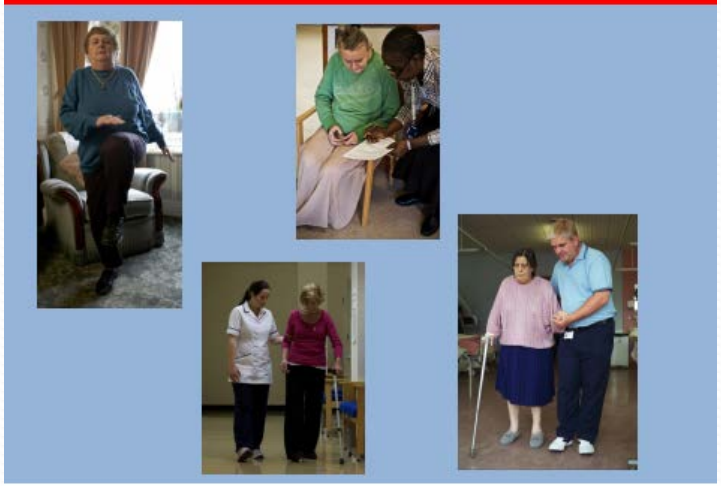
# Interventions to improve %SOOB

- Bulk order of recliner chairs and specialised seating to facilitate more dependent patients being able to be transferred out of bed

# Deconditioning awareness poster

# Deconditioning awareness patient pamphlet

## Staying Active in Hospital



Sit up...Get Dressed...Keep Moving...

Too much bed rest can cause your mobility, level of function and general well-being to quickly deteriorate. Staying up and active whilst you are in hospital is the best way to prevent this.

Follow the below advice to stay safely mobile.

You should have a full assessment to help us to know how you usually get about

Let us know if you feel light-headed on stand-ing. So we can measure your blood pressure.

If you require glasses or a hearing aid make sure they are to hand. Ask us for assistance if needed.

Do you have the right equipment to help you move about safely? If not ask us.

We encourage you to walk to the toilet. But please use the call bell if you need assistance.

Sitting out of bed helps your recovery more than lying in bed.


Eating & drinking is important for your recovery. Ask us for help if needed.


Wash and dress yourself if able and wear your own clothes where possible.

If you are restricted to bed then try to change your position as often as you can.

For further information speak with the Ward Manager or Nurse in charge

# Traffic Light System

Key to colour coding

| Mobility level | Message to staff | Patient message to others |
|---|---|---|
| Patient to be transferred with frame to/from chair/wheelchair only<br><br>Not appropriate for walking | Full assist and supervision | I need help |
| Patient requires a level of supervision with walking aid<br><br>(Distance is written on the tag) | Some assistance and/or supervision<br><br>(Level of assistance written on the tag) | I need some assistance |
| Patient is independent with aid on the unit | Independent | I 'm independent |

**Name**

_____
__

_____
__

**INDEPENDENT**

# If found

# Please return to the Therapy Team

**Additional patient info**

_____
__

_____
__

**Name**

_____
__

_____
__

**TRANSFERS ONLY**

**Assistance**

_____
__

**If found**

**Please return to the Therapy Team**

**Additional patient info**

_____

_____

_____

**Name**

_____
__

_____
__

**Assistance**

_____
__

**Distance**

_____

# If found

# Please return to the Therapy Team

**Additional patient info**

_____

_____

_____

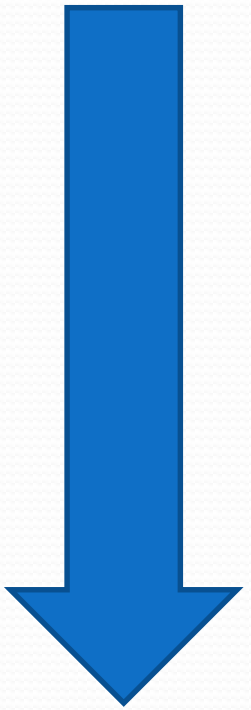
# Staff Education

- 30 minute workshop run by ward therapists
- Attended by HCAs staff nurses and medical staff
- Targeted short program aimed at deconditioning awareness together with practical component.

# Results- %SOOB

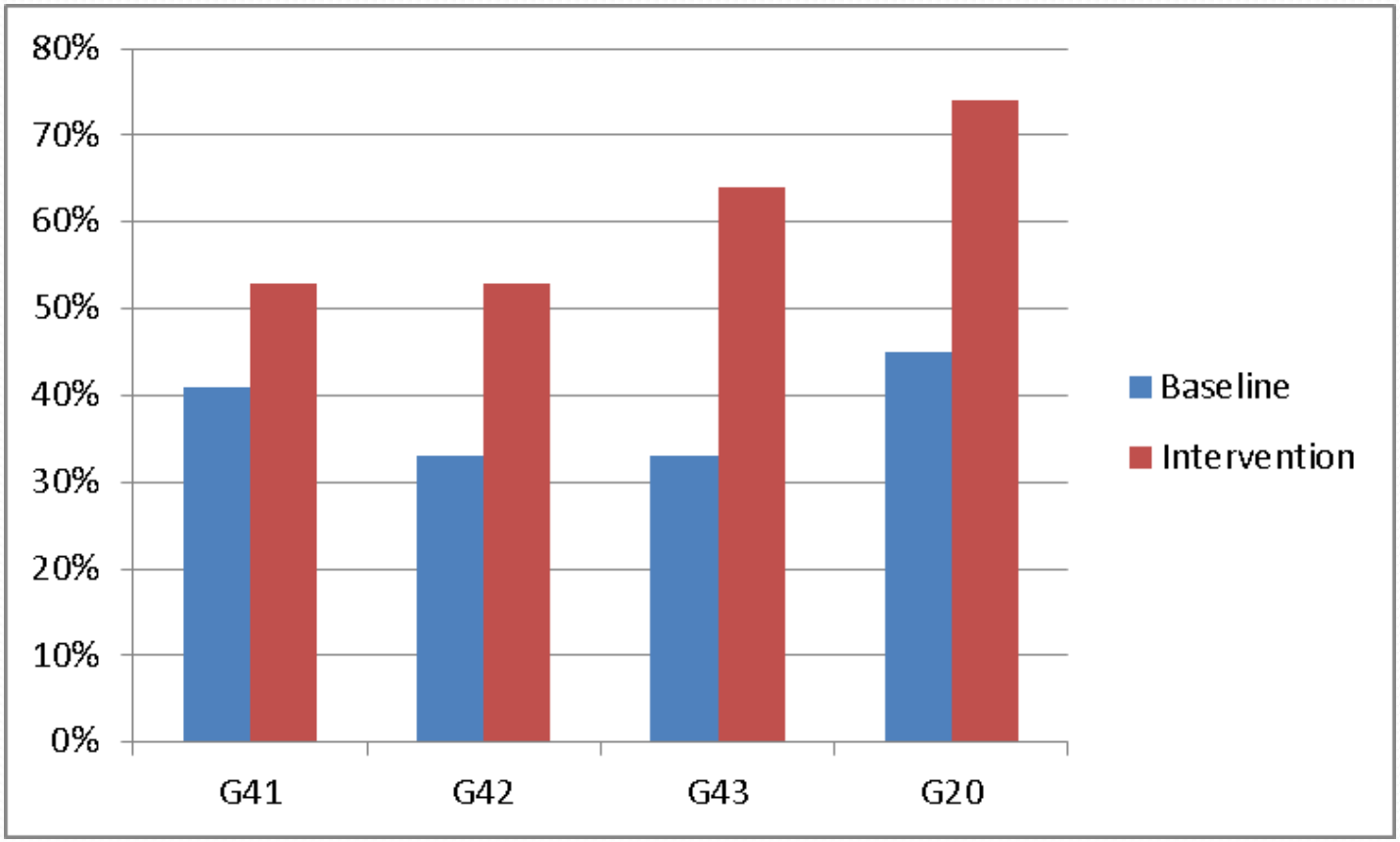
- G43- Staff training
- G20- Patient information booklet
- G42- Traffic Light System
- G41- Staff information Poster

Most effective



Least effective

# Average SOOB results by ward 2016/2017



# Secondary results

- Reduction in falls on during trial on G42 compared to other wards since Traffic Light System implemented.
- Significant reduction in total reported pressure sores on G43 after implementation of staff training.

# Future Directions

- Trustwide deconditioning awareness program.
- Develop deconditioning awareness booklet for use on elderly care wards.
- Continue to trial patient pamphlets and staff training on different wards to compare results.
- PJparalysis trial on Ward 2 with assistance of Anita Ruckledge and Ward Manager Charlotte Evans

# Take home message

- ALL Patients need to be encouraged to:
  - GET UP
  - GET DRESSED
  - GET MOVING

- It is everyone who has contact with a patient, responsibility to ensure patient is sat out of bed and active during hospital stay.

# Questions?

Locala
Community Partnerships

Caring for you, locally

# Pyjamas NOT optional

An approach to providing individualised care in Locala Intermediate Care settings

Karen Charlton- Named Professional for Safeguarding Adults

NHS

# The medical model of care

# A more holistic model of care

## Pyjama BAN for patients 'to encourage bed-blockers to go home to recuperate'

HOSPITAL patients are being told to get dressed during the day to encourage "bed-blockers" to go home to recuperate.

PUBLISHED: 10:03, Wed, Apr 12, 2017 | UPDATED: 10:18, Wed, Apr 12, 2017

SHARE TWEET 5 5

# Locala's approach

# Case study

- Mr X arrived at one of our intermediate care units after spending several weeks in hospital. He arrived from the hospital wearing pyjamas and as he had no other clothes with him, it was to be assumed that he had worn pyjamas during his entire stay.
- When he first arrived he was quite unmotivated but soon afterwards he was provided with his own clothes to wear and he began to engage with his therapy very actively and he is now well on the road to returning back to normality by returning home.