

G18	Standard	Dementia moving and handling (M&H)
Systems are in place to cover all reasonably foreseeable handling situations in managing people who have dementia.		
Justification		
Rationale		
<p>A person with dementia needs highly skilled handling, requiring a wide knowledge of the condition (with its various presentations) and a range of approaches/ skills incorporating clinical aspects, moving & handling as well as the management of challenging behaviour.</p> <p>The person with dementia can also have other disabilities and/ or injuries e.g. poor eye sight/ fractures.</p> <p>Explaining how a cognitively aware person who can communicate is to move/ be moved is very different to explaining to one with dementia who may be aggressive or unable to understand what s/he is being asked to do. The variables that are evident when working with a patient with any form of dementia can be challenging. It may be necessary to start from the beginning almost every time when working with this type of person.</p> <p>There are two sets of factors to balance: One concerns the person's choice and dignity in relation to their safety; the other is the need to balance staff and carer safety in relation to the person's quality of care – e.g. the issue of restraint, which should be avoided where possible but may be required in exceptional circumstances.</p> <p>Dementia persons' surroundings can affect their willingness to move about, -therefore it is important that the built environment is enabling and aids their orientation.</p>		
Authorising Evidence		
HSWA (1974); Equality Act (2010); LOLER (1998); MHSWR (2000); MHOR (2004); PUWER (1998)		
Links to other published standards & guidance		
Alzheimer's Society; CQC (2010); MHRA (2010); NICE (2006) CG42; NICE (2010); NPSA (2007 ¹); NPSA (2007 ²); NPSA (2008); NPSA (2011 ¹ & 2011 ²); Oddy, R (2011); RCN (2002 ¹ & 2002 ²); RCN (2011); Ruzala et al (2010); SCIE (2009)		
Cross reference to other standards in this document		
G1-4, 7-13, 15-17, 19-26, 28-32, 34-40		
Appendices		
16, 17, 19, 20, 26		
Verification Evidence		
- requirements for compliance to achieve and maintain this standard		
<ul style="list-style-type: none"> • Generic assessments, and person specific handling plans if necessary, are carried out and developed into 'person-centred' dementia protocols • These are implemented and staff must be trained to the level of competence required for dementia care and dementia handling • 'On the spot' (dynamic) risk assessments are essential before any MH is undertaken • Family carers receive training, equipment and support • There is evidence of a 'dementia friendly' environment, accessibility to suitable equipment and appropriate staffing levels on audit 		

G18 Protocol - Dementia moving and handling (M&H)

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This protocol concentrates on the moving and handling of people with dementia and the issues that are likely to affect the handling of these individuals.

1. Introduction and background statistics

Dementia is a term used to describe a collection of symptoms including memory loss, problems with reasoning, perception and communication skills. It also leads to a reduction in a person's abilities and skills in carrying out routine activities such as washing, dressing and cooking (RCN, 2011).

Although many people with dementia retain positive personality traits and personal attributes, as their condition progresses they can experience some or all of the following: language impairment, disorientation and changes in personality. A range of behaviours associated with dementia include: irritability, sleeplessness, self-neglect, psychiatric symptoms and out-of-character behaviour, verbal or physical aggression. Often these types of behavioural problems progress with the stages of dementia, from mild to severe (NICE, 2010).

Sometimes, people with dementia are unaware that they have any symptoms, especially symptoms that affect behaviour (NHS Choices, 2010).

Dementia can also increase the risk of falling by impairing judgment, gait, visual-spatial perception, and the ability to recognize and avoid hazards (Van Doorn et al, 2003) (see 8.5).

1.1 *Statistics of dementia* (Alzheimer's Society, 2012¹)

- There are currently 800,000 people with dementia in the UK; over 11,500 of these are from black and minority ethnic groups.
- There are over 17,000 younger people with dementia in the UK.
- One third of people over 95 have dementia.
- Two thirds of people with dementia are women.
- The proportion of people with dementia doubles for every 5 year age group.
- There will be over a million people with dementia by 2021.
- 60,000 deaths a year are directly attributable to dementia.
- Delaying the onset of dementia by 5 years would reduce deaths directly attributable to dementia by 30,000 a year.
- The financial cost of dementia to the UK is over £20 billion a year.
- Family carers of people with dementia save the UK over £6 billion a year.
- 64% of people living in care homes have a form of dementia.
- Two thirds of people with dementia live in the community while one third live in a care home.
- Only 40% of people with dementia receive a diagnosis.

Although 64% of individuals with dementia are accommodated in residential care, it is important to remember that they are also treated in acute hospitals/ mental health units and in their own homes.

Also, it should be remembered that individuals with learning disabilities can suffer from dementia in their later years, and they may remain in their existing accommodation.

1.2 *The main types of dementia (Alzheimer's Society, 2012²)*

- Alzheimers
- vascular
- dementia with Lewy bodies
- fronto-temporal

1.3 *Complex needs that challenge*

Dementia is associated with complex needs and, especially in the later stages, high levels of dependency and morbidity. Explaining about movement and how to assist to a cognitively aware person able to communicate is very different to explaining to one who may be confused due to dementia/ inability to understand what s/he is being asked to do. The variables that are evident when working with a person with any form of dementia can be challenging as the carer may need to start from the beginning each time they work with that person.

As the person's condition progresses, they can present carers/ social care/ hospital staff with complex problems including aggressive behaviour (physical or verbal), restlessness and wandering, eating problems, incontinence, delusions and hallucinations, and mobility difficulties that can lead to falls and fractures (8.5). The person with dementia has choice, but this must be viewed in terms of their safety, and that of staff safety when assisting/ handling the person (2.1).

1.3.1 *Issues about restraint/ abuse*

In the last decade the patients'/ residents'/ service users' levels of frailty and disability on admission as well as their length of stay has changed, and so has the understanding about abuse and how to balance risk and restraint in residential and nursing homes as well as in hospitals. Drugs have been given to sedate 'troublesome' individuals and bed rails used to stop the person getting out of bed. The use of electronic tagging is now being promoted if a person is a 'wanderer', but all this comes with a warning that the new ways/ chemical restraints/ technological changes should not be used inappropriately (Clarke and Bright, 2001 and 2002).

1.3.2 *Effect of restraint*

The use of restraint is undesirable/ abusive and can cause fear, frustration, unhappiness, increased agitation, loss of dignity, depression and in most cases is considered a violation of the person's human rights (Kennard, 2006).

1.4 *Aggression resulting from care staff behaviour*

Aggressive response or refusal can be provoked by the care staff's tone of voice, if not pitched appropriately, or their behaviour, if the person is not treated with dignity and respect (Oddy, 2011- eight principles of good practice, pages 77-80).

2. Management, organisation, supervision and support

2.1 Guidelines and policies

Providers of care need to ensure that current guidance about dementia care from NICE and other organisations e.g. NPSA/ HSE/ DH/ Social Care Institute for Excellence (SCIE) is adhered to in their policies. The policies should be founded on the principles of 'person-centred dementia care'. The elements include valuing people with dementia and those who care for them; treating people as individuals rather than a number (SCIE, updated 2009); looking at the world from the perspective of the person with dementia and having a positive social environment in which the person living with dementia is able to experience relative well-being (Booker, 2006).

The service must also have clear policies on managing risk and restraint. The Mental Capacity Act (2005), now included in the Equality Act (2010), has to be used as a guide when balancing keeping people with dementia safe, against affording them the right to personal choice and dignity.

Patients/ service users/ residents should only be deprived of their liberty when it is in their best interests, and only when there is "*no other less restrictive way to make sure they get the care and treatment that they need*" (the Mental Capacity Act, 2005).

The providers must also ensure that their staff are aware of the Deprivation of Liberty Safeguards (DoLS), a part of the Mental Capacity Act (2005). These safeguards require care homes/ hospitals to apply to their council/ health authority if they want to restrict a person's/ patient's normal freedoms. This is done when there is no other way to take care of that person safely (Behan, 2007; Kennard, 2006).

Risks should be reduced by detailed risk assessments and setting up safe systems of work, including the use of bed rails (only after a risk assessment), and putting in place interventions that avoid the need for restraint (Oddy, 2011).

Careful use of medication can help to reduce agitation and restraint use. But the aim should be to relieve the symptoms of agitation/ violence at a dose that is well tolerated without sedating the person to the point of drowsiness and sleep. Overmedication in dementia care has been/ is a major problem (Kennard, 2006) as highlighted in the national newspapers on the 27th of March (Borland, 2012; Adams, 2012).

People with dementia need distraction, activities that entertain and engage, and regular exercise rather than being left sitting around with nothing to do in the care facilities. Care providers need to make sure that people with dementia, such as Alzheimer's, are offered and are involved in activity that will interest them. The activities should be recorded in the individual care plans which are central to psychological and physical wellbeing (Kennard, 2006).

2.2 Responsibilities, resources and training

Management's responsibility is to provide sufficient resources; including a dementia friendly environment, equipment and a sufficient number of staff (CQC, 2010), who are trained in working with persons suffering from dementia, and how to promote a person-centred approach in order to improve the quality of care given to them. The training must emphasise the need to encourage anyone with dementia to remain as independent and active as possible (Oddy, 2011).

Dementia Quality Standards (NICE, 2010) state that commissioners have responsibility for ensuring service providers have arrangements in place for training their health and social care professionals in dementia care, and service providers are responsible for ensuring that all their staff are appropriately trained according to their roles and responsibilities. The standards also state that the staff themselves have a responsibility and must ensure that they have received training in dementia care which is consistent with their roles and responsibilities.

2.3 Access to a 'liaison' service

Advice from NICE (2010): "*People with suspected or known dementia using acute and general hospital inpatient services or emergency departments are to have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health*".

2.4 Supervision and support

Working with people who have dementia can be rewarding, but it can also be frustrating and stressful. Supervision and psychosocial support is vital for all carers/ staff working with people with dementia.

3. Staffing levels/ time to provide care for a person with dementia

3.1 Sufficient staffing levels to provide care for people with dementia

As 64% of care home residents have a form of dementia (Alzheimer's Society, 2012¹) at any one time other units/ wards are also likely to be caring for a number of people with dementia. Staffing levels should be based on generic risk assessments and dependency levels. Health and social care managers should pay careful consideration to the skill mix of staff to ensure that the environment is supportive and therapeutic (NICE, 2006).

3.2 Caring for a person with dementia (Oddy, 2011)

Caring for people with dementia can be time consuming: they may be slow to understand what is required of them and to respond to carers' requests. They may also have difficulty in finding the right words to express themselves and be unable to do two things at the same time, for example walking and talking. They may become uncooperative and resistant to carrying out daily activities if they are hurried – a clearly delivered simple request, calmly repeated, usually

avoids this. They can be particularly sensitive to the carer's tone of voice and are likely to pick up any signs of irritation or impatience.

3.3 Time to maintain mobility and reduce the risks of wandering

It is important that mobility is maintained as long as possible, and staffing levels need to take account of this, although some people with dementia are fully mobile and feel compelled to walk about for much of the day. This can be worrying for the carers as the person may wander off the premises, get lost, put themselves at risk of falls and fractures (8.5) or of being run over. If the person who is inclined to wander seems distressed/ anxious, it is important that there is a carer available to occupy the person, but still allow them to retain their independence and dignity (Oddy, 2011, page 105).

3.4 Insufficient staffing levels

If the unit/ care home has insufficient staff, the appropriate level of care required for people with dementia who tend to wander, and/ or are unable to express themselves, will not be possible/ available. Staffing levels should be sufficient to give carers the time to observe and analyse behaviour and to engage in appropriate measures (Alzheimer-Europe web-site, updated 18.1.2010).

3.5 How to meet/ reduce the incidence of wandering/ restless behaviour (Oddy, 2011)

Carers can best meet the challenge by using creativity, flexibility, patience and compassion. The person with dementia should be provided with some activity that fulfils their need to be busy and productive (2.1). It also helps if carers do not take things too personally and maintain a sense of humour!

3.5.1 Time required for a positive mood of interaction/ instructions

The attitude and body language of carers communicates their feelings and thoughts stronger than their words, so they need time to speak to the person with dementia in a pleasant and respectful manner, to use facial expression and tone of voice to reassure them, as well as physical touch to help convey their feelings of compassion.

The reason for each task should be explained to the person with dementia before any attempt is made to carry it out. Carers need to allow plenty of time for each task and to find ways of achieving it successfully. This positive mood of interaction encourages the person to reach their maximum level of ability for any activity they perform (Oddy, 2011).

Instructions worded positively, rather than negatively, are more likely to produce appropriate results. For example when walking a person with dementia who suddenly wants to sit down on an imaginary chair, the use of words 'stand up' or 'stay standing' rather than 'don't sit down' will be more effective in

achieving the required outcome. There are a number of reasons why the person with dementia may want to sit down inappropriately such as, the sight of a distant chair triggering the sitting down reaction, the distance to walk may have been too long, the person's concentration has been upset or distracted by what is going on around her/him, or s/he only heard the last word in 'don't sit down', which is the more customary way of instructing a person without dementia (Oddy, 2011).

3.6 *Summary*

Caring for a person with dementia is time consuming. Staffing levels should reflect this fact when the person with dementia is cared for in any setting.

4. Staffing competencies (after Benner, as cited by Ruzsala et al, 2010))

4.1 *Novice*

These include individuals who are new to caring for people with dementia and have little or no knowledge of how to handle and manage a person with dementia.

4.2 *Advanced beginner*

This term could be applied to carers/ handlers and students with limited knowledge of dementia and how to manage people with dementia, but with some prior experience of the safer moving and handling of people. They have been taught the principles of assessment and dementia handling, but lack experience.

4.3 *Competent*

Competent staff have received training in dementia handling and risk assessment. They can demonstrate how to assess a person with dementia and how to manage their moving and handling needs, particularly how to change the activity depending on the person's mental state/ co-operation/ aggression at the time of need. They can follow the local policy, identify individuals that have dementia and consult the person's normal carers about difficulties of handling/ managing the person's aggression.

4.4 *Proficient*

Proficient practitioners are carers/ handlers who have received additional evidence-based information and training concerning dementia/ dementia handling. They can demonstrate this by the application of appropriate assessment/ activity depending on variables, such as the environment/ the person's mental state/ co-operation/ aggression at the time of need. They are able to describe/ use suitable equipment/ techniques and can lead and supervise other staff.

4.5 *Expert*

These may include dementia link workers, key workers, champions for moving and handling with additional information, training, supervision and experience of dementia assessment/ management. These practitioners may well have had a number of years of experience in the field of caring. Experts will realise that what works today, may not work tomorrow as multiple factors that influence troubling behaviours and the natural progression of the disease process means that solutions that are effective today may need to be modified tomorrow, or may no longer work at all. The expert also recognises that the key to managing difficult behaviour is creativity and flexibility in strategies to address a given issue.

5. Environment

Dementia persons' surroundings can affect their willingness to move about (Oddy, 2011). Managers should ensure that the built environment is enabling and aids persons' orientation (NICE, 2006).

5.1 *Space*

5.1.1 *Space in private homes/ supported housing*

In private homes or supported housing, space may be limited, with narrow hallways and small rooms filled with furniture which makes moving very difficult (Oddy, 2011).

5.1. 2 *Space in hospitals/ nursing/ residential homes*

In hospitals/ nursing/ residential homes where people with dementia are cared for, the corridors need to be wide enough to allow three people (a person with two assistants) to walk side by side and allow someone to pass in a wheelchair. Lounges should ideally have enough room to allow walking aids to be left beside their users (Oddy, 2011).

5.2 *Colour schemes*

Contrasting colours are needed to ensure that armchairs can be easily picked out and do not 'disappear' into matching carpets and curtains (Oddy, 2011).

5.3 *Carpets/ flooring*

Carpets should be short-pile, plain with a waterproof finish and any hard floor coverings should have a non-slip textured finish. Sharp changes of colour, where two floor coverings meet or well defined patterns on vinyl flooring/ carpet should be avoided; either of these may be interpreted as a step by the person with dementia who may try to step over it and fall (Oddy, 2011).

Flower or leaf designs in a carpet should also be avoided as these can distract a person with dementia who is walking about – s/he may bend down to pick up the flowers/ leaves and again risks falling down (Oddy, 2011).

5.4 *Other interior features that confuse people with dementia*

Any changes in their surroundings caused by:-

- highly polished floors, changes in the texture of floor covering or strong colour contrast of flooring/ shiny threshold strips/ uneven slopes
- furniture moved into a different position
- inappropriately sited mirrors, changes in lighting/ sunlight or shadows
- sudden unexpected noises.

may confuse somebody with dementia and lead to a fall (Oddy, 2011).

5.4.1 *Lighting, sunlight or shadows*

Some people with dementia may step over, walk around or avoid distinct shadows/ patches of sunlight on the floor, as a result of which their walking will be interrupted, their balance upset and they may fall. Therefore, the position of lamps should be carefully considered and blinds/ curtains used to prevent sudden, dazzling light/ sunlight or shadows (Oddy, 2011).

5.4.2 *Reflections*

A person with dementia may mistake a reflection of her/ himself in a full-length mirror, or a window, as an intruder or a 'peeping Tom'. This can cause agitation and reluctance to be involved in the usual daily activities, making physical handling more difficult. Simply changing the angle of the person's chair or the position of the table should solve the problem (Oddy, 2011).

6. Communication and information systems regarding initial referral and entry into the system

If somebody has any symptoms of dementia in the community they should be seen by their GP as soon as possible and have a medical assessment. The person's GP will send a referral to the Community Mental Health Team (CMHT).

Dementia care needs a multidisciplinary team approach. The dementia CMHT will include a social worker, community psychiatric nurse (CPN), psychologist, occupational therapist, support worker and often a physiotherapist; all working together to meet shared goals. CPNs are key members of the CMHTs providing regular support/ visiting people with dementia in their own homes. They carry out assessments, provide treatment and advice on ways of coping, and on how to improve health and quality of life (DH, 2002).

Advice about mobility is normally given by either an occupational therapist or a physiotherapist and should be communicated to everybody providing care.

In hospital a referral can be made to the relevant practitioner.

All assessment and care planning records should be readily available to all concerned.

7. Treatment planning

7.1 *People with dementia who develop non-cognitive symptoms should be assessed as soon as possible (NICE, 2006, p 12).*

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop challenging behaviour should be offered an assessment as soon as possible to establish the likely factors that may generate, aggravate or improve such behaviour. The assessment should be comprehensive and include:

- physical health
- depression
- possible undetected pain or discomfort
- side effects of medication
- individual biography, including religious beliefs and spiritual and cultural identity
- psychosocial factors
- physical environmental factors
- behavioural and functional analysis.

This assessment should be conducted by professionals with specific skills, in conjunction with carers and care workers (NICE, 2006, p 12).

If the person with dementia is unable to understand and make informed decisions, the health and social care professionals should follow the code of practice accompanying the Mental Capacity Act, 2005 (now incorporated into the Equality Act, 2010) and remember that anything done for or on behalf of persons, without capacity to make informed decisions, must be in their best interest and must be the least restrictive alternative in terms of their rights and basic freedoms (NICE, 2006).

7.2 Care plans

Care plans should be based on the principles of person-centred care rather than on task-oriented ones. Individually tailored care plans to help carers/ staff address any challenging behaviour should be developed, recorded in the medical records and reviewed regularly. The frequency of the review should be agreed by the carers/ staff involved and documented (NICE, 2006, page 12).

8. Moving and handling tasks

Moving and handling tasks involving people with dementia are the same as for any other adult individual with the same physical conditions, but additional issues from uncooperative or aggressive behaviour may challenge the carer. Any move that is likely to cause pain and discomfort should be avoided and an alternative method found. (See G 19 – challenging behaviour.)

8.1 Use of slide sheets

Slide sheets used for bed moves should be quiet to manipulate during positioning and usage. Gliding systems that can be left in-situ may be more appropriate than sliding sheets particularly for night-time turning and repositioning. The sliding manoeuvre should be carefully explained to the person with dementia and carried out slowly. It is important to reassure them, as if they become frightened they may react noisily or start showing signs of aggression.

8.2 Using a hoist

Although the aim should be to try to keep a person with dementia weight bearing as long as possible, hoists may need to be used when this is no longer practical (Oddy, 2011, p 52). If a person with dementia is unable to co-operate during positioning of a hoist sling, the task of hoisting requires extra handlers who also have good dementia-friendly communication skills with which to reassure the person being hoisted. All staff in hospitals/ care homes and in the community should be familiar with the use and checking/ maintenance of hoists/ slings as required by LOLER, 1998.

8.3 Handling a heavier person with dementia

Many people with dementia are underweight rather than overweight, but a heavier person may need extra handlers based on a risk assessment. If the heavier person is immobile, the use of special equipment must be considered, for example a turning bed or an appropriately sized sliding/ turning device. (See also G 15 bariatrics.)

8.4 Accommodating other co-existing physical / medical conditions

People with dementia may also have other physical or medical conditions (co-morbidities) that carers need to accommodate; such as deafness/ partial sight/ needing surgery/ having a disability and/ or an injury. For example, the person with dementia may be blind and sustain a fractured hip as a result of a fall; therefore anyone treating or handling such a person must understand both dementia and any co-existing condition.

8.5 Managing a falling/ fallen person with dementia

Falls in the elderly population are common, however the annual incidence of falls in people with dementia is 40-60%, twice the rate of the normal elderly population (Shaw and Kenny, 1998). Causes can be abnormal gait/ balance, medication, cardiovascular problems and perceptual difficulties such as missing a step/ getting too close to others and being pushed away, or getting up too quickly (also see 1.3, 3.3, 5.3 and 5.4). Problems with balance, walking and falling can be an early sign of dementia (Alzheimersreadingroom, undated).

Some have difficulties in seating themselves and end up on the floor: so called 'angle parkers' unable to line up with chair; 'premature parkers' – sit down too early; 'slitherers'- slide backwards towards the chair (Perkins, 2008). Staff need to give constant reminders to these individuals about sitting down once they can feel the chair at the back of their legs and ask them to put one hand on the arm of the chair before they sit down.

Falls can cause anxiety and guilt feelings amongst the staff, relatives may complain and there could be litigation issues. Therefore, it is difficult for staff not to rush and try to go to, and catch, a falling person (if they are not in close contact with that person) and if the person has fallen staff want to get her/ him up as soon as possible, particularly if the person is restless/ noisy on the floor, but NPSA (2011¹ & 2011²) guidance should be followed. (See also G 22 and G23.)

9. Moving & handling assessment

The person with dementia has the same human rights as any other individual and needs to be given a choice in how s/he is moved – however this must not be to the detriment of safety to her/ himself or others.

The usual considerations apply to the moving and handling assessment (HSE, 2004), but this must also take account of the person's individual needs in terms of cognitive symptoms/ variable behaviour and medication; some medications may affect their mobility and behaviour (Oddy, 2011).

A risk assessment must identify what the person can do, what s/he has difficulties with and determine how s/he may respond to any movement s/he is required to perform. It should enable the carers/ handlers to carry out the movement effectively without triggering any unwanted behavioural responses.

The assessor should use whatever appropriate cues (touch, visual, sound or 'goal-based'), gestures or requests that enable the person with dementia to accomplish the activity being assessed (Oddy, 2011, p 32-37).

The number of carers to assist with each task should be identified, bearing in mind that the variables at different times of the day, or the next time, may make the situation totally different.

Generic protocols for dementia handling need to have a range of options and all staff should be aware of these.

10. Methods, techniques and approaches

The variables that are evident when working with a person with dementia can be challenging. It may be necessary to start more or less from the beginning every time the person is handled.

It is usually best to divide each task/ daily activity into its separate parts. For example, ask the person with dementia to stand up and then having completed that successfully, ask them to walk to a chair/ table and finally ask them to sit down.

10.1. Giving effective assistance to a person with dementia

Oddy (2011, p 53 – 64) suggests a range of simple 'strategies' that enable a person with dementia to carry out the basic activities of daily living. Several examples are given below.

10.1.1 Using a good starting position. The carer's starting position is important, as it can affect the outcome of the attempted movement. If the person being helped trusts the carer, s/he is going to respond more positively and move with greater confidence.

Where the carer observes the principles of good back care and is appropriately positioned for the task in hand, s/he is able to provide smooth, physical help when, or if, it is needed.

10.1.2 Overcoming gripping of chair arms

Some people with dementia who are afraid or unwilling to move can continue to hold onto the chair arms when they come to standing. Oddy (2011, p57 and 85) describes some methods to manage this issue.

10.1.3 Standing up from a chair/ bed etc

It is necessary to ensure that the person with dementia, who has difficulty in rising, has something firm to push against, such as the seat of the chair, if there are no arms; the edge of the bed; or their own thighs, amongst other possibilities (Oddy, 2011).

10.1.4 Assisting

Adjust the assistance to the required level, ensuring that it never amounts to a lift (RCN, 2002¹ and 2002²). Encourage the person to contribute as much effort as they can to every movement.

11. Handling equipment

If the person with dementia who is cared for at home has mobility problems, there are different ways of getting professional help and access to equipment: these include a referral from the person's GP or from the CMHT (Oddy, 2011).

In caring organisations, there should be a sufficient, suitable supply of handling equipment available for carers to use. It is important that all products are risk assessed for the person with dementia in their specific situation.

Hoist and slings: Hoisting equipment, like any handling equipment, should be 'user-friendly'. The person with dementia should feel secure when s/he is in the hoist and the sling should be comfortable. If a passive hoist is used, the sling should support the person's head (the authors' experience). Some hoists are more suitable than others for a person with dementia. In a hospital setting the hoist should also have a stretcher/ scoop facility to lift a fallen person from the floor in a supine position without sitting them up (NPSA, 2011¹/ 2011²). All hoist slings should be 'person specific', either disposable, or washed before allocation to another person to prevent health care associated infections.

Slide Sheets: It may be more appropriate to have a gliding system for the person with dementia to sleep on, rather than taking slide sheets in and out, but this needs to be based on a risk assessment in each individual case. (Also see 8.1).

A turning disc, if used, should be of the swivel turner type with an upright handle for the person to hold onto, in order to give the person reassurance.

A handling belt can be used to stabilise a person in standing without having to grip her/his body, but there is evidence that a handling belt should not be used by one person [Hignett et al (2003) cited by Brooks A and Orchard S in 2011]. It can also give confidence to some people with dementia when they walk if used by two people and fitted correctly – once again the use needs to be based on a risk assessment and it must not be used to lift.

HoverJack/ Lifting cushion - staff in hospitals/ residential care should have access to these to assist a fallen person with dementia up from the floor (see 8.5), particularly if the passive hoist cannot be used as a 'flat lifter'.

All carers must report any faulty/ damaged equipment, label it accordingly and not use it until it has been repaired/ replaced. Arrangements should be in place promptly to replace equipment that is out of action.

12. Other equipment and furniture

12.1 Beds

In the home situation, beds are normally fixed height divan beds. In a care home/ hospital height adjustable beds should be available. Anybody with dementia who needs assistance with bed moves should be provided with an electric profiling bed to allow the carer to adjust the height when providing care. There are also low entry height adjustable beds for those at risk of falling. All electric/ mechanical beds in a care home/ hospital should be maintained as required by PUWER (1998) and mattresses examined as indicated by the MDA/2010/002.

When the person is sitting at the edge of the bed, the height of the bed must be such that their feet are on the floor (Oddy, 2011).

Many profiling beds feature integral bedrails incorporated into the bed design. Bedrails should only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of bed (NPSA, 2007¹). Patients receiving hospital care often have impaired mobility, and may be less aware of their surroundings, particularly if they have dementia (NPSA, 2007²).

Use of bedrails, if used to helping a patient avoid doing something they do not want to do (fall out of bed) is not restraint, provided a risk assessment is carried out and bed rails are not used to stop a patient from doing something they want to do – get out of bed (NPSA,2007²).

12.2 Seating

When choosing seating for someone with dementia, it is important to consider not only the person's needs, but also those of the carers. The type of chair on which the person sits can affect their ability to get up and move around.

A very low chair or an armchair with a deep, soft seat or a chair with wide, padded chair arms should be avoided if the person with dementia has difficulties with mobility or needs assistance from sitting to standing.

A well-chosen chair encourages good posture. Day care centres/ care homes/ hospitals should be able to offer a selection of different sizes and styles of chairs: either chairs that are adjustable in height, seat length and seat width, or chairs of different heights and different seat sizes. The back of an 'easy' chair should be high enough to provide support for the person's head (Oddy, 2011).

Easy chairs should also have good pressure relieving properties. The use of reclining chairs should only be used following a risk assessment.

12.3 *Walking aids*

12.3.1 *Frames*: Many people with dementia who need the support of a walking aid, find a frame with wheels (two wheels and two feet) easier to manage than having a frame without (Oddy, 2011).

12.3.2 *Walking sticks*: Walking sticks, if required, can be effective for someone living at home, but are less useful in units where there are a number of people. There is a possibility of a stick being used by the person as a weapon. This then becomes a health and safety issue (Oddy, 2011).

A person with dementia should usually be expected to use only one stick, since using two requires considerable co-ordination. Rubber tips should be checked regularly by the carers (Oddy, 2011).

12.4 *Bathroom facilities*

Some people with dementia have difficulty managing daily activities, such as getting in or out of the bath. Adaptations to the home range from installing grab rails to specially designed shower and toilet facilities (Alzheimer's Society, factsheet 429, 2012³) or providing a bath seat/ hoist.

The following pieces of equipment will assist in the bathroom:

- grab rails to help with getting in and out of the bath
- handrails, attached to the wall near the shower, washbasin or toilet
- non-slip mats in the bath or shower
- seats to go in the bath or shower
- other aids, such as sensors that detect when bathwater is too hot, or about to overflow, are also available (Alzheimer's Society, factsheet 504, updated 2010).

The toilet seat should not be too low and hand rails must be available. A height adjustable toilet frame may be required.

The shower area should ideally be a 'wet room' where a person can be showered sitting down in a shower chair. A rush of water from an overhead shower can frighten/ disorientate a person with dementia (Alzheimer's Society, factsheet 504, updated 2010). In this situation, a hand held shower may work better.

Deep water in a bath can cause insecurity and reluctance to get into the bath, similarly if the bathroom temperature is not adequate to the person's needs. It is important that staff/ carers are sensitive, tactful, respect the person's dignity and reassure the person throughout the bathing/ showering process.

12.4 *Footwear*

People with dementia should have well-fitting shoes/ slippers. If there are mobility problems then shoes need to have a broad heel.

The Factsheet 'Finding Suitable Footwear', available from the Disabled Living Foundation provides details of slippers and a range of footwear for people with a variety of foot problems.

Further information (Oddy, 2011, pages 76-77 and 91-97).

13. Risk rating for each task

To carry out a 'suitable and sufficient' assessment, each task should be evaluated as part of the assessment process, so that the level of risk is quantified. Such assessments should be used, wherever possible, in the design of a safe system of work, and in highlighting any residual risks.

Various systems exist, but it is suggested that the NHS risk management 5x5 matrix, with 0-25 scale, is used for an overall evaluation of risk (NPSA, 2008) (see CD1, appendix 9 in folder 5). It is in common use, simple to use with 5 levels of risk, determined by a calculation of the likelihood or probability of an adverse event occurring multiplied by the severity of consequences or impact should it occur.

Likelihood/Probability (0-5) x Severity of Consequences or Impact (0-5) = 0-25

The values below are based on this system. Calculations lead to the following possible scores or ratings: -

1 – 6 = Low; **8 – 12 = Medium;** **15 – 16 = High;** **20 = Very High;** **25 = Extreme**

For people with dementia the risk rating can range from low to extreme. For more information on risk rating, please refer to Brooks, A and Orchard, S (2011).

These ratings can then be used to alert staff, to prioritise action and justify any necessary expenditure to make the situation safer, on the basis of reasonable practicability. Options can be evaluated by considering risks, costs, and actions planned or taken, to reduce the level of risk to the lowest level that is reasonably practicable, which can thus be demonstrated.

Risk analysis should be carried out on each individual and should start as early as possible during the hospital stay/ residential care.

14. Alerting the M&H team

The need to contact the M&H practitioners/ advisors will depend on the difficulties experienced with the person with dementia, the experience of staff and the equipment available.

M&H practitioners/ advisors need to be able to pass on an awareness of how to work with people suffering from different forms of dementia, to promote a person centred approach, and to emphasise a positive way of speaking (section 3.5.1), in order to improve the quality of care these persons deserve.

15. Referral to and involvement of other specialists

The usual considerations apply.

16. Transport

The usual considerations apply.

An escort should always be provided (where possible somebody with whom the person is familiar) if a person with dementia who has significant cognitive symptoms (distress or challenging behaviour) is transferred/ transported to another environment/ department.

17. Discharge and transfer planning

The usual considerations apply. The local policy should be followed. It is essential that details of handling history and recommended methods are included with the discharge summary and that this accompanies the person. (See G 32 – discharges and transfers).

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Summary/ Key Messages

➤ **The intention of the entire strategy and standards document is to contribute to the improvement of: -**

- The quality of care - 'patient experience' (dignity, privacy and choice)
 - clinical outcomes
- Patient/ person safety
- Staff health, safety and wellbeing
- Organisational performance – cost effectiveness and reputation, etc.

➤ **The standard for G18 is:**

Systems are in place to cover all reasonably foreseeable handling situations in managing people who have dementia.

➤ **Skilful M&H is key**

➤ **Special points for G18 are: -**

- **The person being handled may have variable abilities to follow instructions so on the spot risk assessments are essential before any MH is undertaken**
- **Staff require specialist training to be able to recognise how best to manage the M&H of a person with dementia safely**
- **Family carers require training, equipment and support to enable them to care safely at home**
- **Dementia friendly environments should be created**