DLF Trusted Assessor Reference Book

Introduction

Our Trusted Assessor course provides a starting point for people who will be working with clients to assist with independence and safety through using a range of straightforward equipment solutions.

Many of the people who have completed the training have other roles and their training enables them to speed up the process of helping clients. Following the course there is an expectation that staff who undertake course will have support from experienced staff, including OTs, as they gain competence and experience in the workplace.

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Chapter 1

Background

We're all living longer

There are already well over 10 million people in the UK who are over 65 years old. There will be over 15 million by 2030 and around 19 million by 2050. By 2050, one in four people in the UK will be over 65. The number of people over 80 is growing even faster. There are currently over three million. There will be six million by 2030 and eight million by 2050.

The ageing population will have enormous impact on all aspects of society especially on caring and other public services.

Person-centred care

Already, both national and local government policy puts the client at the centre of their care. The government paper Putting People First (2010) set out the aims and values guiding adult social care. These are built around partnership, local commissioning, prevention, information, advice and clients being responsible for their own 'personal budget'. Councils must ensure that all adults eligible for council-funded social care are assessed for a personal budget as a means of directing their own care.

The key idea is personalisation - giving people who receive support or services choice and control. Councils must also develop strategies to ensure that everyone has access to good quality information, advice and, where appropriate, advocacy about where to get the care and support they need. Care Bill

Care Act 2014 "Skillsforcare.org.uk"

The Care Act consolidates good practice in statute as well as bringing in new reforms. It uses personalisation in social care as well as increasing the focus on wellbeing and prevention. It enables local authorities and partners to have a wider focus on the whole population in need of care, rather than just those with eligible needs and/or who are state-funded. For people who need care and support, and their carers, there will be: better access to information and advice, preventative services, and assessment of need an entitlement to care and support, a new model of paying for care, with a cap on the care costs for which an individual is liable , a common system across the country (national eligibility threshold).

Defining disability

As a trusted assessor, you will often be working with people who are disabled or elderly or both. There are various definitions of disability. There is a legal definition for social services. Your local social services may have their own.

Under the Equality Act 2010, older and disabled people cannot be discriminated against. Age and disability are two of the 'protected characteristics' under the Act. Other protected characteristics include sex, race and religion.

You're disabled under the Equality Act 2010 if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.

The social model of disability

Imagine you use a wheelchair. There are umpteen possible reasons for this - accident, injury, disease, disability, ageing. Whatever the reason, you're stuck outside a building and can't get in. What is it that is stopping you from getting in? It's not the accident or injury, it's the steps. Replace the steps with a ramp and you can get in. In other words, it's not really the accident or injury that is disabling but the environment. Change the environment and you enable the client.

Building a ramp removes the barrier to you entering the building. But physical barriers like a staircase are not the only barriers. There are invisible barriers too. Our attitudes to other people can be just as disabling as the environment. They can lead us to make judgements about other people's lives, the result of which could reduce their independence. Just because your Aunty has arthritis and cannot drive doesn't mean the next client you meet with arthritis cannot drive.

The next chapter looks at the most important aspect of your work as a trusted assessor: working with clients.

Chapter 2

Working with clients

Trusted Assessors can help in three ways:

- By helping the client to adapt a task - e.g. to do it one-handed or sitting down
- By suggesting adaptive equipment - e.g. cutlery with bigger handles or velcro instead of laces
- By suggesting adaptations to the physical environment - e.g. ramps or rails

What does the client want to do?

How people spend their time on a daily basis differs from client to client as people's aspirations, needs and environments vary. It is important for the assessor to understand how a client wants to spend his/her time and what their routines and habits of daily living are. We do this by talking to the client and by watching them.

Where activities are very important to a client, they can act as a motivator. When they become difficult to achieve people will give preference to those activities which are more important to them.

The sort of activities that we work with clients on include:

- stairs and steps - how many, how far, how easily, with or without equipment (eg bannister, rail, stairlift)
- transferring - getting in and out of bed, a chair, the shower or the bath, going to the toilet
- opening and closing doors
- turning on and off lights and appliances

Collecting information

Talking to the client will help you to:

- build a relationship with the client
- understand their journey so you know where they're coming from, where they want to go and how they feel about it. This is very important.
- gather information
- understand what the client wants so you can set goals for your work together.

We're all different. There may be issues which appear important to you, the assessor, but are less important to your client. Talking is the only way to find out this sort of thing.

How to encourage the client to talk

The type of questions you ask and the way you ask them will make a difference to how the client responds to you and how they feel about you.

- Closed questions which require a short answer - usually yes or no - are useful for getting the facts (eg. Did you like your job?)
- Open questions which encourage the client to talk can be useful for understanding their journey and make them feel comfortable with you (eg. Tell me what you liked about your job?) .
- Using probes for example, ‘Tell me more’, also encourages clients to talk and to provide you with answers.
- Questions should be clear and non-judgmental
- Avoid putting client on the defensive. Asking ‘why?’ at the beginning of a question can do this.
- Whilst interviewing make sure you show that you are engaged in the dialogue. This can be achieved through maintaining eye contact, friendly facial expressions and positive body language (head nodding, smiling, leaning towards the client.)
- Listening whilst interviewing and taking notes can be difficult, especially if there are distractions but practice will help.

Sample starter questions:

- What would you like to be able to do?
- What difficulties are you having doing it?
- How long has it been like this?
- How do you manage at the moment?
- Do you have any help? Have you ever had any help?
- Do you have any equipment or aids that help?

It may be relevant to ask about their medical condition or whether they’ve had any falls.

Observation

When you visit your clients for the first time you will quickly assimilate information about their property, how they meet and greet you and whether there are any obvious risks which need attention. You can get clues here about how they manage their daily living.

You may then have to decide whether to ask to actually see how the client manages the task which is causing difficulty. You will need to decide whether it is

safe for the client to do this. A clue here might be, when did they last do the task? If they can still manage but struggle then it is likely to be safe. If they have stopped being able to do it, then it would probably be unsafe to demonstrate.

How to analyse an activity

Ideally, the assessor should try to watch the client. This will not be possible for some personal care tasks or if the client can no longer do a particular task or doesn't wish to do it at a particular time for whatever reason. Either way, the assessor should talk to the client about the activity. The reason for doing this is to match a solution to the aspects of the task which are causing difficulty which will make it easier to manage.

An 'activity analysis' looks at the various aspects of an activity to see where problems arise. It includes:

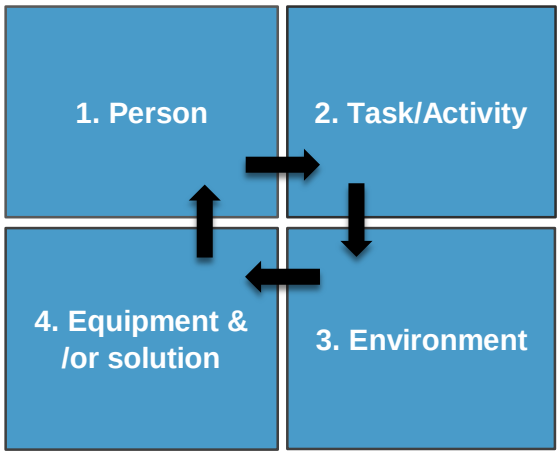
- how is an activity performed - breaking the task down into a sequence of steps
- why is it performed
- where it will be performed
- when will it be performed
- who else might be involved

Often difficulties are linked. Difficulty getting out of a chair may mean difficulty getting off a toilet or a bed.

Recording the client's needs

You should make notes but you could, with the client's permission, also record your conversation. Try to describe accurately how the client does a particular task. Are they doing it with assistance, very slowly, leaning on fixtures, in pain etc? Your notes will form part of the clinical reasoning process and help you to justify any suggestions you make to the client or other decisions that you make.

Chapter 3



Trusted Assessor Assessment Model

This summarises the information that is helpful for us when working with clients. Some questions will be more relevant to some clients than others. If with any client, any of these issues appear too complex, you should back refer to your OT.

What you need to find out about the person

- Wishes - what does the person want/wish to be able to do?
- Future condition - is their ability to do what they want to do static, likely to improve or to deteriorate?
- Limitations - what exactly are the limitations on doing what they want to do? (What are the implications of reduced balance, grip, sensation, thin skin, poor sight etc?) Will the physical weight, size or shape of the client have a bearing on options available?
- Attitude - how do they feel about the situation and the sort of solution that might be acceptable to them? Is equipment an acceptable option? Does their culture or belief system affect the options that are available or acceptable to them?
- Learning - are they able to learn how to use new equipment?
- Help available - are there relatives or other carers and how can they help if at all? For example, can they learn how to use new equipment?

What you need to find out about the task

- Importance - how important is the task to the individual?
- Preference - how would they prefer to do it? Would help be more acceptable then equipment? (For example, some people might prefer a commode/bottle to making a hazardous journey to the toilet. Others might hate this option.)
- Task analysis - what parts exactly of the task is the client unable to do? Make sure that your suggested remedy compensates for the correct part of the task.
- Linked difficulties - how is the task linked to other difficulties? Difficulties identified in one area may be linked to difficulties in another. (For example, difficulty picking things up from the floor might suggest difficulty managing low sockets.)
- Current situation - how is the task currently managed? Are they not doing it? Doing it with pain or difficulty? Is someone else helping? How long could this continue?

- Simple alternatives - is there another way of doing the task? (For example, a higher chair may be easier to get up from.)

What you need to find out about the environment

This will depend very much on the particular circumstances of the client and the task you're analysing with them but could include consideration of: the built environment; distance; stairs, steps and banisters; space; lighting; walls (for example, are they hollow/solid/moveable?); pipes; toilet outflow; number of toilets; and the needs of other family members/carers (who else uses the facilities and their size and needs?).

What you need to consider when suggesting a solution

- Effectiveness - the key question is: will the solution suggested do the job? Will it solve the difficulty?
- Acceptability – is the solution acceptable to the client and carer?
- Fit – does the size/height/width suit the person? Have you considered weight and equipment tolerances?
- Usage - does the client (or a carer) understand what the equipment does? Can the client (or a carer) use it or learn to use it?
- Maintenance – can the client or their carer look after it and inform the service of changes/difficulties?

Remit of a Trusted Assessor

There may be situations where it is appropriate to refer your client back to the Occupational therapist. The following will help you to appreciate where you might intervene and when to refer on. You can work with the client if:

- the client is still managing to do the task, but struggling
- you and your client have identified a straightforward solution(s) in a particular area
- it is low cost
- the client's medical condition and general health is 'static'

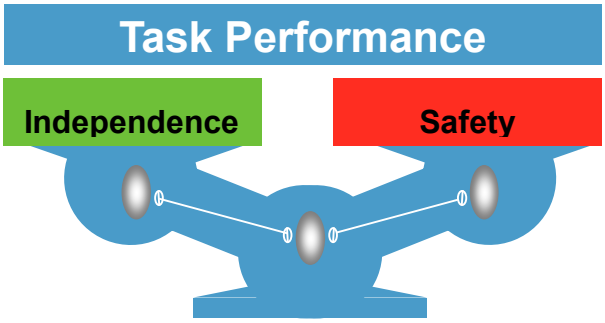
You should need to refer back to the OT if:

- the client has stopped being able to carry out a particular tasks or is losing the ability to carry out key ones such as transferring in and out of bed or on and off the toilet
- the client's condition is variable or progressive
- simple solutions are not suitable and more expenditure is needed
- the environment is difficult and needs more radical change.

Chapter 4

Assessing Risk

Is the client independent and safe?



One of the most important outcomes of any intervention is to increase independence. However, safety and independence are linked: a client can be independent but not safe.

Safety is about the relationship between the task, the person carrying it out and environment. There is always some risk involved in a task whoever is doing it. The question is: is the level of risk acceptable?

- How do you determine whether the risk is acceptable? What is acceptable to the client and what is acceptable to you or the law may be different.
- How comfortable is the client with risk?
- Clients may over or under estimate their performance and compromise their safety.

Independence is vital to us and it is important to make sure that we help a client to be as independent as possible and only advise on limiting their independence where their safety is compromised.

If the client says they can walk to the shops but when you're there they struggle to cross the room, it may be a bad day, a bad time of day or they may be unrealistic about what they are able to do. There are many possible explanations so be careful about jumping to conclusions.

Your responsibility

Public sector workers including Trusted Assessors are responsible for their actions and omissions when they can reasonably foresee that these actions or omissions might injure or cause harm. An obvious example would be failure to report that someone has fallen out of bed.

Your employer has a legal responsibility to you, your clients and the wider public. Your employer should have the appropriate insurance to cover you and them against accidents to members of the public, damage to property and related costs We're assessing risk everyday of our lives, often without realising. There's always some degree of risk. The purpose of risk assessment is to make a situation as

safe as possible for all concerned by identifying possible risks and putting preventative measures in place.
You will come across situations where clients are running risks. Risk management in social care is based on the Mental Health Act. Where someone has capacity to make their own decisions about risk, our job is to minimise them as much as possible and ensure people take reasonable and informed risk. To do this we need to assess risk openly and transparently.

The difference between a hazard and a risk

- Hazard: anything with the potential to cause harm (for example, a cable running across the floor).
- Risk: the chance that the hazard will cause harm and the potential severity of that harm. (For example, if the cable is plugged in, it will be potentially more dangerous than if not)

Common hazards

Common hazards include:

In external/internal traffic ways:

- Steps or Stairs
- Poor accessibility
- Floor surfaces
- Lighting
- Doorways

In all living areas:

- Poor accessibility
- Floor mats – small & lightweight
- Slippery furniture surfaces
- Loose/Curled edges of carpets and rugs
- Clutter including wires & cords
- Floor surfaces
- Lighting

Bathrooms:

- Slippery bath/shower
- Low toilet
- Wet flooring

Seating:

- Low chair
- Clutter around the chair

Footwear/Clothing:

- Loose fitting shoes
- High heels
- Trailing clothing

Risk can be categorized as:

- Low – where harm is possible but unlikely and likely to be only minor.
- Medium – where harm is likely to occur and the injury be more significant.
- High – where harm is very likely to occur and the injury would be major

If you identify a high-risk activity, then you MUST take action immediately to reduce the level of risk.

Priority should also be given to medium and low risks. You cannot eliminate risk factors, but you can try to reduce the risk to a more acceptable level. What action would be reasonable to reduce risk?

The nature of risk should be identified and recorded through the assessment process, including the probability of the risk occurring and the possible consequences and outcomes. The level of risk may change if circumstances change - for example, the client's medical condition changes or a carer is unavailable.

One of the common things which prompts referral for assessment is 'falls'. A fall or a near fall can have a big impact on a client in that they fear falling again and this restricts their mobility and independence.

Basic risk reduction

To reduce risk, especially of falls, you could:

- Remove small rugs
- Secure carpet edges or treads on stairs (nail or tape down)
- Reduce clutter
- Re site, tack down or remove cords & wires on the floor
- Check lighting for adequate illumination at night
- Install stair rails on both sides of the stairs
- Raise chair
- Place frequently used items at an easy level to minimize bending and climbing
- Install grab rails in the bath or shower and by the toilet Install a raised toilet seat

- Use rubber mats in bath or shower
- Remove any loose rugs in the bathroom
- Avoid high heels and poorly fitted shoes/slippers
- Avoid trailing clothes

Preventing Falls

A key part of any risk assessment is the prevention of falls.

Falls frequently lead to a fracture requiring hospital treatment; are a major cause of disability and in older people can lead to long hospital stays or even death.

A fall or a near fall, even when not serious, can have a psychological impact resulting in a fear of falling and the client choosing to do less than they would like to. This can reduce both independence and mobility.

The risk factors for a fall include not only the extrinsic environmental factors listed on above but also the intrinsic factors related to the client's medical condition, general health and mobility and attitudes.

Intrinsic factors to consider include:

- Age-related physiological changes
- Balance and gait
- Muscle weakness
- Pain (which may be related to a medical condition such as arthritis or diabetes)
- Acute illness or chronic conditions
- Postural hypotension (when a person's blood pressure suddenly falls when
- standing up or stretching leading to dizziness)
- Confusion and cognitive impairment
- Medications and alcohol
- Visual disorders
- Central nervous system disorders such as epilepsy

A single fall is not always a sign of a major problem. Anyone can fall once. (However, that doesn't mean you should not try to identify the cause.) Repeated or recurrent falls, generally defined as more than two falls in a six-month period, should be analysed for treatable causes. Remember that a single fall may have multiple causes, while repeated falls may each have a different cause, so it is critical to consider each fall separately.
Determining and treating the underlying causes of a fall can make a real difference: returning a client to a place in which they can continue to do what they want to do while reducing the risk of falls in the future.

Here are some of the questions that you might want to consider with your client after a fall. It is important that any findings should be noted and discussed with the OT.

- Does the client have poor balance?
- Do they have pain when walking or use a mobility aid?
- Do they have difficulty walking or rising from a low chair?
- Do they experience from confusion or have a visual or hearing impairment?
- Do they ever feel lightheaded or dizzy when standing or turning?
- What medication do they take? (Medications, especially in combination, can cause dizziness)
- Have they had a recent acute illness or do they have chronic conditions?
- Have they had any previous falls?
- What sort of care and support do they have, if any?
- Do they have or wear a pendant alarm?

Chapter 5

Issuing Equipment

The remainder of the guide focuses on different types of equipment and accessories. This chapter goes through the process of issuing equipment.

You will need to:

- Ensure you know the local procedures for issuing equipment and follow them Check the equipment – is it safe to use?
- Demonstrate the equipment and how it can be used in the particular task
- Ensure that whoever will be using the equipment - client or carer - can do so and wherever possible provide written instructions
- Make note of and report any advice or warnings that you give to client about the risks involved in using the equipment
- Make note of and report any problems that the user may have had with a particular piece of equipment
- The issuer - you - has responsibility to ensure that the user is aware of the procedure for reporting any problems/faults and understands who is responsible for the safe use and care of the equipment
- Before issuing equipment, especially equipment which is not new, the following should be considered:
- The design of the equipment (there may be a better, safer newer model) Its age
- When it was last serviced?
- Has it been properly maintained - for example, has routine maintenance such as charging the batteries been carried out?
- If you find any defects or problems, them note the date, model, defective part, any tests carried out and any tests required and report them to your supervisor.

Demonstration of Equipment

Here is some basic guidance for demonstrating equipment:

- Beforehand, check that you understand all the regulations relating to the equipment you are issuing. (For example, the Lifting Operations & Lifting Equipment Regulations 1998, LOLER, which were created under the Health & Safety at Work Act 1974 regulate the the use of lifting equipment at work.)
- Beforehand, check that the equipment is safe and in working order. (This also helps to remind you how the equipment works.)
- Position yourself so that the client and/or user can see exactly what you're demonstrating
- Explain the purpose of the equipment - what it does do, what it doesn't

- Break the activity down and demonstrate the task yourself - perhaps more than once, especially the more complicated bits.
- Ask the user to try the equipment and activity to show that they're happy and that you're happy with their ability to carry out the task safely. (If the person is not willing to try, you must document this. Depending on local procedures, you may need to remove the equipment or leave a safety notice on the product, perhaps saying 'Must Not Use'.)

Chapter 6

Chairs and Equipment

Even the most active of us spend a lot of time sitting.

Standing can be unstable and more tiring; lying down can be too restrictive.
In many cultures squatting or sitting cross-legged are often preferred positions for socialising, eating and drinking. However, in western cultures, the most popular position is sitting down in a chair - a position in which the body can be easily stressed or damage.

Clearly, it is important to maintain a healthy posture when sitting, especially if doing it for a long time. In practice, many people with restricted mobility often spend many hours in one chair. For some it may be necessary for them to monitor the time they spend sitting. Alternatives include perching or kneeling.

Sitting for too long can cause:

- Boredom
- Discomfort, pins and needles, pain, pressure sores and contractures
- Incontinence
- Social isolation
- Falling from over or out of the chair from reaching and stretching, bending, tripping or slipping

How do we sit down?

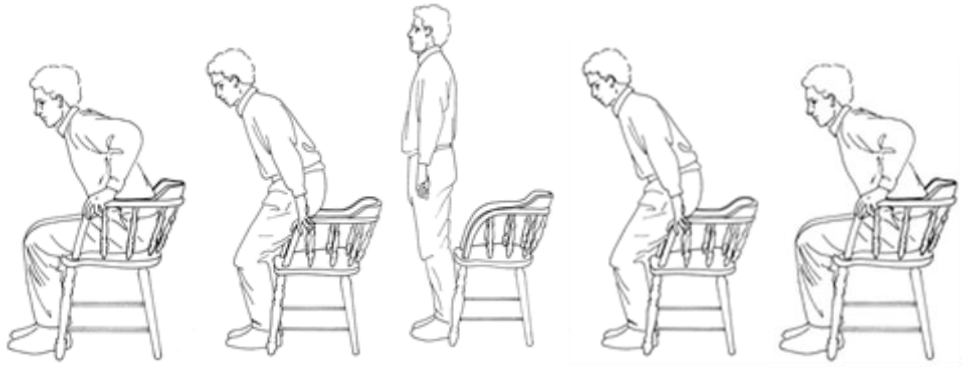
We sit instinctively but to help someone else sit more safely, it is important to break down the process of standing up and sitting down into steps.

To stand up:

- Lean forward and move bottom to edge of the chair
- Feet firmly on the ground (most stable position is slightly apart and one in front of the other)
- Lean forward (nose over toes)
- Keep head up (spine in line)
- Push up to stand (thighs, chair seat, armrests)
- Using a rocking motion prior to standing can help by generating a little momentum

To sit down:

- Make sure you can feel the chair against the back of your legs
- Slightly flex hips/knees and lean forward
- Keep backs of legs in contact with chair
- Reach for the seat of the chair and the armrests and sit down



What is a comfortable sitting position?

Different people will prefer different seating positions but in general if you want to sit comfortable for a long period you'll want:

- feet flat on the floor, bottom in the back of the seat and back supported at the base by the back rest

- hips, knees and ankles at right angles (90º). (There is no need to measure a client for this: your eyes will be good enough.)

A higher seat can make sitting and standing easier but note the principles above

What can make sitting more difficult?

In order to make sitting easier and reduce risk, we need to consider both the client and the chair.

The client may have:

- a medical condition or new hip joint therefore unable to bend more that 90º sitting
- discomfort back pain, sore bottom, contractures
- difficulty standing up
- general weakness, weak legs, one sided weakness,
- painful hands or shoulders, stiff joints
- poor balance/positioning, risk of sliding off chair
- difficulty completing task/s they wish to undertake in the chair
- mobility aids - walking stick, crutches, frame, wheelchair, over toilet chair.

If your client is unable to stand from a chair, to sit upright in the chair, or are slipping out of the chair then this situation needs referral on to the OT.

- A seat which is too low increases pressure on the bottom and makes getting up more difficult
- A seat which is too high can create pressure under the back of the knees causing pins and needles
- A seat that is too deep front to back can cause back pain
- A very sloping back can make the process of moving forward to get out of the chair more difficult
- Armrests that are set back from the chair give less assistance with raising than those which come right to the front of the chair
- Backrests that support the lumbar spine and which provide support for the head are more comfortable.
- Wings (at the top of the backrest) are down to personal preference but few provide much assistance. They can block sideways view while the head support offered by wings if sleeping in the chair does not necessarily prevent strain on the neck muscles and ligaments.

Seat Height

A low seat is difficult to get out of and there is more pressure on the pelvis bones.

A higher seat is easier for getting up, particularly if you have pain or weakness in your arms or weakness in your legs. (It's better to distribute pressure evenly along thighs through the benefits of 90º sitting).

The common sense solution of adding an extra cushion to raise the height of the seat has the effect of lowering the height of the armrests and making them less useful when repositioning or standing up. It can also make the seat base less stable.

How to measure for the correct seat height:

- Ensure the client is in their normal footwear.
- Hold the tape measure with the box at the top.
- Measure from the floor to the thigh just behind the knee.
- Next depress the cushion of the chair which is too low, and measure this.
- Subtract the measurement of the chair from the measurement of the leg.

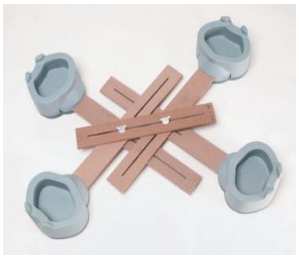
This will give the height of chair raise required. It is usually recommended to round down if the measurement comes between available chair raisers.

It may be easier to measure the client in a dining type chair, especially if their arm chair is quite low.

Chair Raisers

Chair raisers come in sets of four and are placed under, around or clamped onto the castors or legs of the chair.

Some are in sets of four individual blocks (e.g. Ladywell Sleeves) and others are connected by adjustable “arms” (e.g. Langham Multi-purpose raisers).



- The Connected raisers are more stable
- Chairs that are placed on blocks are difficult to move.
- It is important to ensure the appropriate shape or model of raiser is used for the shape of the chair leg

If you are unable to raise existing chair, refer back to OT. A high seat chair may need to be considered.

If the chair is not a usual type you may be able to arrange a joint visit with a technician, or if no solution can be found refer to the OT.

To order Chair Raisers, state the required seat height and the type of chair that needs to be raised (including any castors).

Once Chair Raisers are in place, you should visit and:

- check the raise is assisting and the person is comfortable
- check the tie piece is not protruding from the front of the chair
- remind the individual not to move the chair if the raisers are not the fixed type

Leg Rests, Footrests and Footstools

These sort of aids can be useful in a number of circumstances:

- To reduce swelling - the legs may need raising to horizontal or even higher
- For arthritis of the knee - to provide support behind knee and encourage straightening
- For a chair which is too high - a footstool to support feet

But these can be hazardous and you’ll need to assess the risk involved in using them. All leg rests require moving and positioning to use, particularly when standing up from the chair. Consider the weight of the footstool

and how easy it is to move. Consider the risks of bending and stretching and of the stool as a tripping hazard.

- Leg rest - should ideally extend from the chair edge to feet, although they are often shorter. Most people find it difficult to sit with their legs straight out. It is more comfortable if the surface slopes slightly downwards. Adjust to suit seat height, leg length and preferences.
- Footrest - this is usually lower than the leg rest and only supports the feet and ankles. It is not so suitable if you have a painful, stiff or weak knee as the knee is unsupported but it is easier to get feet on/off from.
- Footstool - supports the feet only (usually when the seat height is too high).

If getting legs on or off a stool or rest poses problems, discuss with the client the use of a leg lifter or pull strap. (Some people use the crook of walking stick). This may help if lifting the leg is difficult, but require strength and dexterity elsewhere.

Chapter 7

Beds and Equipment

Since most of us spend at least six to eight hours in bed it needs to be a secure and comfortable environment.

When getting into and out of bed becomes a problem, some clients may delay going to bed which is not good for long-term health.

How to assess a bed:

- Does anybody else use the bed?
- Exactly what difficulties is the client having?
- What type of bed of bed is it and how many legs does it have?
- Is the mattress of good quality? Is there just one?
- Does the client ever get up during the night and how often?
- Is a commode ever used and if so, how?
- Does the client dress seated on the bed?
- Are there drawers? Will equipment impede their use?

How to make a bed safer:

- Ensure there is no loose matting or clutter which may cause trips
- Ensure the client can reach slippers, walking aids etc
- Ensure they are able to reach a light.

What can make using a bed more difficult?

Again we need to look at both the client and the bed.

The client may have:

- Weakness - this may be general or in certain joints areas
- Discomfort - this may be in a specific joint or area or pressure resulting from immobility
- Dizziness - this is quite common when standing too quickly from lying and tends to increase with age. (If you have a client affected in this way, suggest they get into a sitting position first and wait a few moments before standing to prevent dizziness.)
- Difficulty breathing lying down - common for people with chest complaints

The Bed:

- The bed is too low - any difficulty in the lower limbs can cause difficulty raising from a low bed

- The bed is too high - this can make the client unstable when trying to get their feet out and onto the floor in order to move off. It can also cause difficulties if they want to dress seated on the edge of the bed
- The mattress is too soft - if the mattress is soft it gives no support when the client pushes up with their hands whne getting out of bed
- Even if the bed is a perfect height, a client who has pain or loss of function in hips and or knees may still find it difficult to get out and to standing position

Specific difficulties

It may be difficult to move from a sitting position to a lying one and vice versa because of

- general weakness of the muscles of the trunk,
- difficulty turning (if it is difficult to get from lying to sitting, then one way to get up is to turn on your side and push up this way)
- pain or stiffness in the spine, hips, hands and shoulders can make it difficult to push up or to sit at a 90° angle.

Turning may be difficult because of:

- the client not doing the maneuver correctly (turning in bed is a set of individual maneuvers that have to be done in sequence)
- weakness - particularly in the stomach muscles
- pain or stiffness in the hips or knees which can make the action of getting the leg at a right angle to the body difficult

Transfer to commode may be difficult because the commode is in wrong position and difficult to get at to use. (A man may find it easier to use a bottle than a commode.)

Bed clothes can cause difficulty if:

- they’re too heavy
- the client is unable to reach down to move them (for example, from feet)

Some people prefer to sleep sitting up in bed. Possible difficulties here include:

- insufficient strength
- the mattress being too soft (causing the client to sink down at the point when they’re trying to turn forcing them to work against gravity)

Sitting to dress

We’re all different when it comes to how and where we like to dress. Many of us sit on the edge of the bed to dress. If your client wishes to do this, it is important that they can sit well supported by their feet.

It is important to ensure that:

- Bed height is correct (t should be possible to put the feet on the floor while seated securely on the bed)
- Clothes are within easy reach
- Any equipment (such as a stool if required for putting on socks or tights, for example) is within reach. (There is a compromise between having the stool within reach and having it in the way when they get up. If it is a hazard it might be better to suggest that shoes and socks or tights are put on elsewhere.)

Equipment for Use with the Bed

A bed is different from a chair in that we do not tend to sit for long on the side of a bed. Plus there are no arms to assist so it is very important that the client can sit safely on the bed.

To identify the correct height:

- Measure (as for the chair) from the floor to the thigh just behind the knee, with the client in their normal footwear.
- Then measure the height of the depressed mattress.
- Subtract this height from the height of the client's leg.

Add three inches. This will give a slightly higher sitting height than would be desirable for an arm chair but which makes rising from the bed easier.

Bed Raising Blocks

These are generally cups into which the bed castors sit, with a raised edge around two sides of the block. The blocks are then 'tied' in pairs to prevent them moving.

Consider:

- How high you want to raise the bed?
- How many legs the bed has?
- Which type of raise is suitable for this bed?
- Whether it will affect a partner sleeping in the same bed
- Whether the raiser will stop any drawers opening
- The weight of the individual/individuals (including the weight of the bed).

To Order:

- State the type of raise
- State the amount you want the bed raised by
- State how many legs the bed has
- Which bed is to be raised

Check:
- the raise is in place and the correct raises applied
- the bed is stable

Ask the individual to show you how they are now managing to get up.

Remind the client to:
- Check the equipment is still fitting snugly from time to time
- To move the bed as little as possible
- If they do move the bed to check carefully after it is returned to its position

Bed Grab Rails

There are several types of bed grab rails, and they fit onto the bed, usually between the mattress and the bed base, at about the level of the waist/elbow to give the client a hand grip to assist them in lying to sitting or to give them a grip to steady themselves when moving from sitting to standing. They also assist with rolling from side to side. They are not guard rails (cotsides) designed to prevent an individual falling from the bed.

Consider:
- Will the rails fit the bed? Bed rails should not be fitted to profiling beds.
- Will the presence of the rail impede the individual's ability to get into bed?
- Will the fitting of the rail prevent the drawers from opening in a divan bed?

To Order:
- State the type of rail
- The bed onto which it has to be fitted
- Which side of the bed it has to be fitted (if relevant)
- The distance from the head of the bed that it has to be placed

Check that the rail is soundly fitted. If appropriate, you could ask the client to show you they are now able to get on to and off the bed.

Leg Lifter

This is a small strap, which has a loop like a dog collar one end and a hand loop the other. It is used by the individual to assist them to hold, lift and move their leg onto and across the bed.

Consider:

- Whether the individual has upper limb problems or should not be moving their limbs (following, for example, surgery)
- If they have feet problems that would preclude its use

To order:

- State name of equipment required
- If you have not shown the client how to use the leg lifter request that it is not used until demonstrated

Show the individual how the equipment works and then allow them to try several times until you are both happy that it can be used OK. Suggest a storing place that will keep it to hand

Commode

A commode for use at night should ideally be as near to the bed as is possible so that it can be used quickly and easily. This may require rearrangement of the furniture.

Chapter 8

Stair and External Rails

Stairs are a hazard that can become more dangerous as we get older. Fear of falling can stop us using the stairs. This can have a major impact on a client's life, especially when facilities such as toilets and bedrooms are upstairs. Stairs are therefore a key issue for us to consider to ensure that where appropriate continued safe use of the stairs is encouraged.

Provision of good stair rails is one of the first options to consider. Other issues to consider are good lighting and contrasting colours to aid vision.

How to assess a staircase:

- Is the client using the stairs at the moment? If not, is it appropriate to use them?
- Are they relying on another person to give major assistance?
- How often do they have to climb the stairs?
- Do they use one hand for support more than the other?
- Do they have to climb them quickly (due to urgency)?
- Who else is using the stairs?
- Are the stairs likely to be cluttered?
- What is the effect of climbing the stairs on the client's health and wellbeing?

If you have concerns about the person's ability to climb the stairs safely because, for example:

- they have stopped climbing the stairs
- they are requiring a lot of assistance from another person
- they become breathless and have to rest due to inability to breathe after only climbing 5 or 6 steps,

You should consult with an OT before considering provision of rails.

What can make using stairs more difficult?

Once again you need to consider both the client and the environment - in this case the stairs.

- Is the client unsteady on the stairs or do they have a fear of falling?
- Will whatever is making the client unsteady get worse (eg. weakness from ageing), stay the same (eg an impairment such as the loss of a leg) or improve (eg as strength is regained after surgery)?
- Is the client is in pain when ascending/ descending the stairs?

- Does the client tend to stop for rests whilst on the stairs?
- Does the client have reduced arm or hand function?
- Does the client have reduced vision? (Some glasses can cause difficulty by distorting the horizontal lines of the steps.)
- Stair climbing can be divided into moving one leg either up or down the steps and taking weight through feet, gripping the banister rail with one or both hands, and moving forward which requires exertion. Which specific aspects cause the client difficulties?

More complex diseases or medical questions about likely progressions of a condition should be discussed with your OT prior to decision about supply.

Different types of stairs

Straight stairs - these may be fairly wide steps (following the line of the outside or adjoining wall of the property with an open banister one side) or can be narrow (going up between two rooms of the property generally with walls either side).

Straight stairs with a platform turn at the top or bottom - there may be straight steps with a platform at the top or the bottom and then further steps. Generally though not exclusively with a banister the length of the stairs.

Straight stairs with a spiral turn at the top or bottom - these stairs are generally narrower that those with a platform, They may not have a banister the whole way up on the outside due to the configuration of the hallway of the floor above.

When the banister rail is missing (due to the nature of the stairs) this makes the last 4 or 5 steps of the ascent difficult as there is no rails to hold onto either side.

Steps to accommodate split floor level - generally only one to three steps within the length of a hallway or landing.

Different Types of Bannister

- Mop head with Angle Bracket
- Mop head straight Bracket
- Rounded Bannister Rail
- Square Bannister Rail
- Pig ear Bannister Rail.

The size and fixing of the existing banister should be considered, as some are much easier to grip than others. The pig ear and the square banister rail above do

not provide an easy grip, so provision of another better rail the other side may help.
The Mop head rail with angled brackets is the usual choice of rail for a second stair rail.

How to fit a stair rail

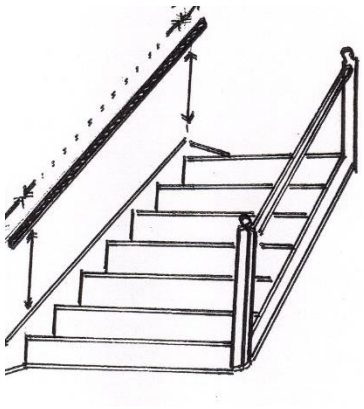
Things to consider:

- The most difficult transition - is from level walking to stair descent/ascent
- Turning on the stairs - particularly at a spiral where the available foot space is limited is more hazardous than straight descent/ascent
- The wider the stairs - the more difficult it is to hold onto rails both sides, more than 90 cms can cause a difficulty
- Which type of rail to use - generally a mop stick and angle bracket fixing
- Will the wall take a rail - check that the wall is solid by tapping; a solid wall and a deeper “ringing” tone produce a “dead” sound by a hollow wall. If the wall appears hollow can it be “batonned” (It is the responsibility of the person fixing the rail to decide if it is safe to fix, however in order to save an extra visit and for you to calculate the likely price, an obvious potential problem with fixings can usually be identified)
- Does the rail need to contrast in colour - (to make it easier to see for someone with poor vision), or blend in (to minimize the impact of disability)
- Is a second rail essential the whole way - or will provision where none existed before solve the difficulty as in diagram illustrating a staircase where banister stops at ceiling level of hallway
- Finger entrapment -Is there a danger of entrapment of the hand where a stair rail will run under a window sill
- Height of the rail - Generally a rail is fitted at the same height as the existing banister rail. Where no rail exists then 900mm (35.5inches) If the stairs are particularly steep or you are concerned that a different height is required it is worth discussing this initially with the OT

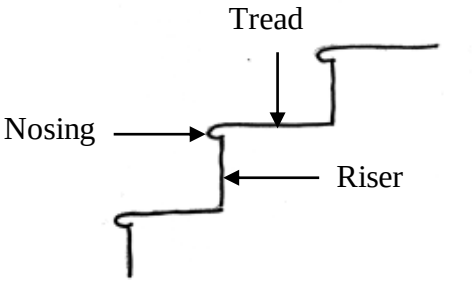
You may wish to mark the rail position with stickers, however it is usual to have a drawn template so you can select the correct type of stair and mark the rail on this. The arrow on the template denotes the direction of climb of the stairs

Measuring for a rail for straight stairs

Before measuring for stairs you will need a 5-meter retractable tape measurer



If a second rail is to be provided the length of a straight run of stairs, usually a simple rail on the opposite wall will be sufficient. It should extend 300mms (12 “) above the top step and the same at the bottom where possible. If there is a doorway or a corridor at right angles to the stairs it may not be possible to add the 300mm. As the rail would then protrude into the corridor, or across the doorway.



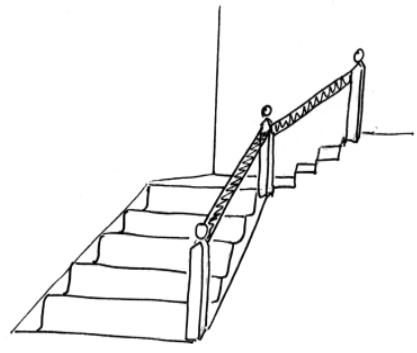
To measure the length required:

- lay the tape measure on the nose of the bottom step
- Measure up to the nose of the top step.
- Add 300mm (12“) at the top and the bottom (if possible this will be a 1-piece rail).

It will usually be the height for the new rail i.e. same as existing banister. If none exists the standard is 900 mm (35.5”). Place stickers if you wish (with permission of the occupant)

If the staircase has no bannister on one side, giving an open plan staircase, refer to OT.

Measuring for a Rail for Stairs with a Platform



Platform Staircase

- Measure the first straight length of the stairs as described earlier.

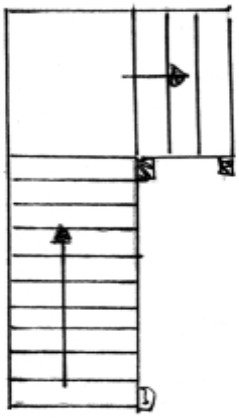
Then:

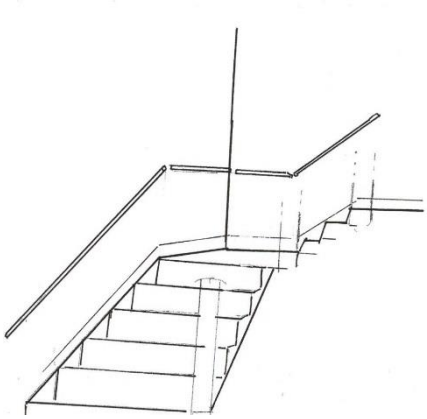
- Measure for two horizontal rails - from the top of the first run of stairs to the corner of the wall, then from that corner to the bottom of the second run.

Then:

- Measure the second run of stairs, this will be a 4-piece rail.
- Add 300mm (12”) to the rail at the very top of the stairs, and at the very bottom of the rail, if the space permits.

Plan of Platform Staircase

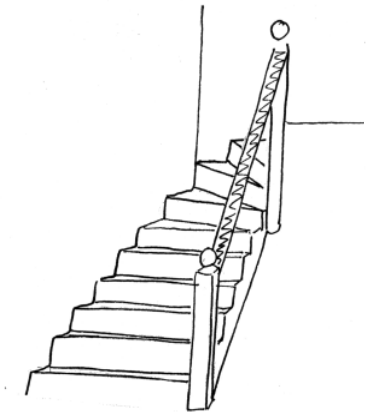




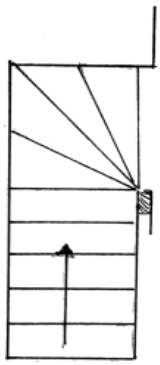
If required, place stickers

Measuring for a rail with spiral stairs

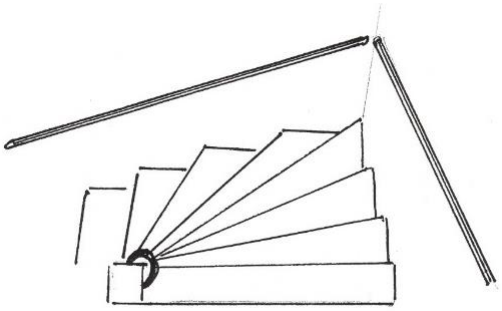
- Add 300mm (12”) to the measurement at the top and the bottom of the stairs if space permits.
- Measure the length of the straight run of stairs and continue to the wall at the head of the turn.
- Measure from this corner to the top step. This will be a 2-piece rail.



Spiral Staircase



Plan of Spiral



You are informing the fitter of the length of rail required and the type of stairs. When the fitter fits the rail on spiral stairs, s/he will alter the angle of the rail to take account of the different rate of climb of the spiral steps.

Measuring for Newel Post rails

Where the stairs start with a bend (spiral or platform), then a newel rail attached to the newel post of the stairs can give the support necessary for the transition from the stairs to the level. They are also used at the bend of the stairs. Newel posts are traditionally quite wide and therefore do not give a good hand hold. A rail attachment enables safer use of their support. They are fitted as high as is possible on the newel post.

If a person needs support on one side ascending and the other side descending then there needs to be support on either side. This can be provided with a combination of rails and newel rails.

To order stair rails:

Local procedures vary. You will need to inform the installer of:

- the type of rail required,
- the height (usually same as existing banister),
- the number of pieces,
- where it is to be fitted i.e. left/right hand side ascending
- if you think batonning may be required (due to walls not being solid)

Measuring for internal step rails

Straight steps between floor levels require a straight rail. Measure as for a straight rail (above). The individual may require a rail on both sides, either so that they can use both hands to support them whilst negotiating the step/s or because they need the support on one side for ascending and the other for descending.

The use of stairs with a walking aid

It is important to consider whether a client uses a walking aid such as a stick or walking frame when they are indoors. If they need to use two hands for support while climbing the stairs then they may not be able to carry their walking aid at the same time.

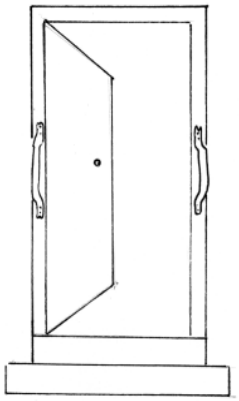
You may need to consider providing a second stick or walking aid that can be left at the top of the stairs for upstairs use if there is not already a second walking aid available in the home. Order the new stick or walking frame the same height as the existing piece of equipment. It should be stored safely away from the head of the staircase.

When to refer back to an OT

If you are concerned that a simple rail will not answer or you feel that the diagnosis of the individual is not simple then you should contact an OT.
There are other mechanisms for climbing stairs available but they require assessment from an occupational therapist. Do not refer back for a specific item e.g. a stairlift as this raises expectations and it may not be an appropriate piece of equipment.

External Grab Rails

Front door steps can be located within the framework of the building or be external to the building.

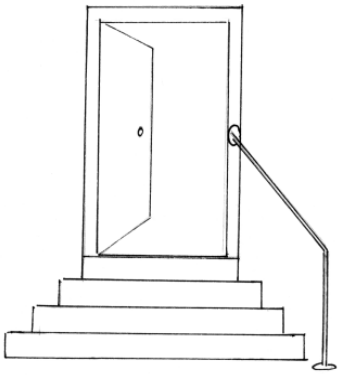


Grab rails are usually specified for doorsteps and can have round or flat ends. Where possible provide round ends as these have three fixings, but straight end rails need to be specified if attaching a grab rail to a doorframe as there is not usually sufficient space for a round end flange. Off set rails can make grab rails at the door easier to view and use from inside the property if the rails are to be located on the outside face of the building. Local procedures may dictate stainless steel or plastic coated rails.

Grab rails are usually fitted vertically and the height is approximately rising from the elbow height of the individual. You can ask the client to show you what height they want the support when they are on the doorstep. It may be necessary to provide one rail for the ascent and another for the descent. Be aware of the difficulties of placing a rail so that it interferes with access to the door opening or locking mechanism.

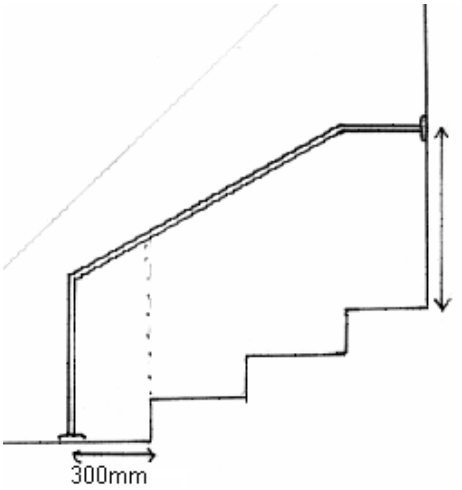
Grab rails can only be fitted where the individual can reach the grab rail from the level ground in front of the step.

To place an order, measure from the bottom of the rail position to the floor directly underneath, to give a height and give the length of rail required. If only one rail is to be provided state whether it is right or left hand side ascending.



Wall to Floor Rails

If the client is unable to reach the doorframe from the bottom step, where there are several steps, then a wall to floor rail will be required.



This is a galvanized rail set at 900mm high, following the line of the steps and extending beyond the bottom step by 300mm (12”). Measure from the door threshold to the lowest nosing then add 300mm.

Specify on the order which side the rail is to be placed. It may be necessary to order two rails if the individual can only use one hand.

Chapter 9

Equipment for Toileting

Being able to go to the toilet ourselves is key to our independence, dignity and privacy. We need to help the client in a way that maintains all three.

How to assess a toilet:

- The individuals' preference is always important but perhaps even more so here than in other areas
- What exactly are the existing facilities? How big and accessible is the room? How stable is the toilet itself?
- Where is the toilet located? Is this the only toilet in the premises?
- Precisely what difficulties is the client having?
- Who else uses the facilities?
- What are the day and night routines of the client and other users?.
- What is the environment around the toilet. Does the waste pipe exit backwards or sideways? Are adjacent walls near enough for a rail? Is the wall able to support a rail?
- Is the client pulling themselves up using the basin or toilet roll holder for example. Are they safe?

Bear in mind that it may be access that is the problem not going to the toilet. For example, a wheelchair user may be having difficulty getting through the door or turning. If you identify this as an access problem, you would need refer it back to an OT.

Safety tips for toilets

- Take your time
- Consider an alternative like a commode or bottle at night
- Ensure lighting is adequate
- Avoid loose mats (eg. a toilet pedestal mat)
- Don't hold onto fixtures; fix grab rails
- Ensure everything needed is within reach
- Check equipment given regularly for wear and tear.

What make going to the toilet more difficult?

The client may have:

- specific health issues that impact on going to the toilet.
- difficulty going or go more often or sometimes need to go urgently

- more general problems such as walking difficulties, stiffness of joints, poor eye
- sight, reduction in balance or difficulties with finer manipulation skills
- cognitive difficulties
- People with reduced manipulative skills may have difficulty managing fastening and adjusting their clothing. Careful choice of clothing including elasticated waistbands, stretchy fabrics, and Velcro fastenings may make all the difference here.

Toilet facilities are commonly sited upstairs, so stairs must be negotiated. Possible solutions include:

- Avoiding leaving getting to the toilet to the last minute
- Ensuring the route to the toilet is unobstructed
- Fitting a stair rail

There may be a specific difficulty with flushing or cleaning the toilet.

There are various toilets on the market with specialist wash dry function and flush which are available. Assessment for these is complex and should be referred back to the OT.

If the difficulty is around sitting down and standing up from the toilet, possible solutions include:

- a higher sitting position
- rails attached to an adjacent wall that can be used to push up from or to pull up
- with

Grab Rails

Rails can be used to push up from or to pull up with. They are generally fitted to the wall alongside the WC. The wall needs to be sound and free of obstruction. (Suggest that a toilet roll holder is moved if it is in the way of a grab rail.)

It is important to check the distance between the WC pan and the wall. If the user has to lean sideways to reach the rail it will not provide sufficient support and a toilet surround frame may be more appropriate.

If horizontal rails are preferred then pushing up from a seat is generally a bilateral activity and provision of toilet surround rails would be the first consideration.

If a rail is used to pull up with and steady your client, the rail is generally fitted starting from a point about 1 inch (2.5 cms) forward of the person's knee (whilst seated on the toilet), and about 2-3 inches (5-7 cms) above the elbow crease, at an angle running forwards and upwards away from the user.

Your client may like to have a vertical rail for support this gives good pulling power for an individual with strong upper limbs. The lowest point of the rail should be 6-8 inches (15-19cm) in front of the knee (while seated on the toilet) and 2-3 inches (5-7cm) above the inside of the elbow crease.

Once you have marked the rail position with stickers, you could, if appropriate, ask the client to stand and place their hand where the rail would be. You can check that the position is correct, and that the rail is sufficiently far forward to maintain a stable position once standing. This is the time that you make minor adjustments as necessary before taking measurements.

If a male client wishes to use the toilet standing, then a vertical rail placed just in front of his knuckles when his arm is held at a right angle will steady him.

Drop down rails can be used where there is no adjoining wall. These provide a horizontal bar.

They should be fitted at waist/elbow level and approximately a fist width away from the individuals' thigh.

Check the weight tolerance of any drop down rails.

When placing an order you should tap the wall to get some idea of its structure and inform the technician accordingly. As with stair rails, it is the responsibility of the technician to decide whether the wall will take a rail. An alternative floor fixed rail can be used, unless the rail is to be used in a wet room where the floor can't be drilled into

Ordering the Rail:

Plastic coated grab rails with round ends and a textured surface should be used for a bathroom area.

Inform the technician of:

- The length/type of the rail
- Which side of the toilet it has to be fitted (from the perspective of the seated user
- Position (this can be marked with stickers but should also be described with measurements) E.g. 300mm grab rail fitted to right hand side of the toilet whilst seated angled 45% away from the user starting from a point 620 mm from wall behind toilet and 520 high.
- Position on site marked with stickers.

Check visit:

- When visiting to check equipment, look at fixing and ensure it is sound and positioned as requested.
- Check for effectiveness with a dry run trial.
- Request individual reports on any future problems.

Raised Toilet Seats

Raised toilet seats fit over the toilet bowl and are kept in place by adjustable brackets. When fitted correctly they should be stable, but it should be possible to lift them off and replace them again.

They can be used in conjunction with toilet surround rails or grab rails. They come in 2 and 4 and 6 inch heights (Suppliers may vary).

Things to consider before fitting:

- Is the existing toilet pan sound?
- Is there another user who would have difficulty using this piece of equipment - would they be able to lift it off?
- The weight tolerance of the client (and others who may use it)

When ordering, state the height. This should be equal to the measurement from the floor in usual footwear to the back of the individual's thigh just behind the knee. Measure from the floor to the top of the toilet bowl. Take the height of the toilet bowl from the measurement of the person (round down rather than up).

How to fit a bracket-type raised toilet seat (RTS)

- Loosen the screws and slide the brackets back
- Place the raised toilet seat on the toilet bowl
- Locate the front bracket
- Push side brackets inwards until they locate the seat
- Tighten the side bracket screws simultaneously

Check visit:

- Feel the seat to check that the screws are located correctly
- Watch the individual using the seat to ensure that they are raised sufficiently/not too high
- Inform them to check the equipment regularly and to inform borough if there is a problem noticed
- Give written instructions on fixing (these should come with the product

Toilet Surround Rails

Toilet surround rails are free standing horizontal rails, adjustable in height, that provide arms to assist a user get up from the toilet. Heavy duty, extra wide versions are available, check your supplier for the capacity. They are free standing so can tip, consideration has to be give therefore whether they need to be floor fixed.

Things to consider before fitting:

- Is there sufficient room around the toilet for the legs of the frame?
- Is the ground level?
- Does the soil pipe go backwards or sideways (a sideways soil pipe usually makes fitting impossible)?
- Will the toilet rails give sufficient support to your client if not floor fixed?
- The height is approximately waist/elbow of your client while they are seated on the toilet
- The weight tolerance of the client (and others who may use it)

State on the order what height the rails should be supplied at and whether they are to be floor fixed or not. The height is usually just below the elbow or at the waist level of the individual seated on the toilet.

Check visit:

- Ensure that the feet are all stable and the frame is solid on the ground
- Check that the height adjustment buttons are properly located
- Watch the individual using the frame, check that they are aware that it is not floor fixed and are safe

Generally a grab rail is a less obtrusive option, but there are occasions when this is not appropriate because:

- The wall is not sound
- There is an obstruction in the way
- The person needs/wishes to use two hands
- The need is temporary

Raised Toilet Seat and Rails Frame

This piece of equipment provides a raise to the toilet seat and arms to assist sit to stand. The legs are adjustable so the height of the seat can be varied. The seat to arms height ratio will always be the same. Heavy duty, extra wide versions are available, check your supplier for the capacity. They are free standing so can tip, consideration has to be give therefore whether they need to be floor fixed.

Things to consider before fitting:

- Is there sufficient room around the toilet for the legs?
- Is the ground level?
- Does the waste pipe go backwards or sideways (a sideways soil pipe makes fitting difficult)?
- Are other people in the house using the toilet who would not be able to manage to use or remove this piece of equipment if this is the only toilet in the home?
- Will the toilet rails give sufficient support to your client if not floor fixed?
- What height should it be fitted? Equal to the measurement from the floor in usual footwear to the back of the client's thigh just behind the knee (round down rather than up)
- The weight tolerance of the client (and others who may use it)

When ordering, ensure that you state the height that the seat should be set. Request floor fixing if required.

Check visit:

- Ensure that the feet are all stable and the frame is solid on the ground
- Check that the height adjustment buttons are properly located
- Watch the individual using the frame, check that they are aware that it is not floor fixed, and safe

For clients that have difficulty balancing on the toilet, who have unusual methods of transfer onto the toilet or have difficulty getting access to the room containing the toilet then refer back to the OT.

If you are involved with the fitting or checking of equipment for the toilet your employing authority should provide you with disposable gloves and it is good practice to use these.

Chapter 10

Bathing Equipment

This chapter considers use of a bath. Use of a shower is covered in the next chapter.

Safety when bathing is a key concern for us all. There are several aspects to bathing safely including filling the bath, entering and getting out of the bath, sitting safely whilst washing and being able to empty the bath.

Many clients who have difficulty bathing will be having difficulty because they are unable to get up from the bottom of the bath. It may be becoming physically more difficult and fear of one day not being able to get up may put clients off using the bath.

Other common difficulties include:

- difficulty balancing whilst stepping into the bath
- fear of slipping once in it (or the shower)
- water spillage
- difficulty getting water temperature correct
- difficulty in washing oneself.

What makes having a bath difficult?

What is preventing the client from using the bath?

- is it general pain or stiffness or problems in specific limbs such as a pain or a lack of sensation in them.
- is the physical effort involved making them breathless?
- will whatever is making the client unsteady get worse (eg. weakness from ageing), stay the same (eg an impairment such as the loss of a leg) or improve (eg as strength is regained after surgery)?
- do they have reduction in vision causing loss of confidence and difficulty locating sides and floor of bath?
- what is their height and weight?

What is the specific difficulty?

- getting up from the floor of the bath
- balancing while standing to transfer in and out of the bath
- lifting a leg over the side of the bath while seated
- discomfort when seated on the bath floor
- manipulating the taps and plug

The bath and its environment:

- Is the maneuvering space limited? Bathrooms tend to be small and often have a narrow door (which may be an issue if your client uses a walking aid)
- What is the bath made of, metal, plastic, fibreglass?
- What is the length and width of the bath?
- Does it have a raised pattern on the base?
- Does it have handles built in?
- Is the bath moulded and shaped (this may compromise the safe fitting of bathing equipment)?
- Does the client use a bath mat, or have anti slip treads?
- It may be sensible to suggest that a client bathes when there is another person in the home and/or that they ensure they have the means of attracting help in the bath room such as a pendant alarm or telephone.

Grab Rails

Rails, used in conjunction with a non-slip mat, will help a client to get into and up from the bottom of the bath independently or with minimal assistance.

Some baths have small rails built in to them but they may not provide sufficient support, or be in the correct position to give overall support.

If extra help is required or if no rail is available, then fitting a wall fixed grab rail will provide help with:
- Standing up
- Provide a steadying support whilst sitting down and
- Provides a firm grip when transferring from one position to another

Generally horizontal and vertical rails are recommended for a bath. Although sloping rails are seen, there is controversy surrounding their use in the bath as they do increase the hazard of slipping whilst gripping them with wet or soapy hands.

Grab rails for use in the bathroom should be plastic and have flanges that cover the screws. The gripping surface should be textured. Generally longer rails are recommended. Consider arm and hand function before provision of a grab rail.

Horizontal Rails

These help if your client finds it easier to push down on a rail to assist from a sitting to a standing position, altering a sitting position i.e. pulling body forward and when lowering e.g. into the bath. The existing bath rim is often used for these purposes and can be narrow and slippery leading to loss of confidence. Provision

of a rail horizontally just above the bath rim but allowing sufficient room for the fingers to grip can restore confidence and assist with:

- Pushing up from the bottom of the bath (or a bath seat)
- Transferring into the bath using a bath board

A 24 inch/600mm rail is recommended and placed along the centre of the bath.

Vertical Rails

Vertical rails are generally placed at right angles to the horizontal rail at its tap end. A vertical rail can be used to:

- Transfer into the bath whilst standing, lifting the legs forwards.
- Standing from a bath seat or board to use/ adjust the shower head.

When planning to fix a grab rail, test the wall to see if it will support a rail.

Plastic Coated grab rails (metal rails should be avoided as they may not be earthed – risk of an electric shock & metal tends to be slippery when wet)

To order:

- State the length/type of rail
- Position (this can be marked with stickers or described with measurements or both)

Check visit:

- Look at the fixing and ensure that it is in a good position
- Check for any faults and report if any problems or defaults found
- Consider a short demonstration and a try-out to check that your client can use the equipment safely

Bath Seats

A bath seat sits inside the bath and provides a seat that is higher than the base of the bath for the individual to sit on. Bath seats can either, stand as a small stool that sits in the bottom of the bath or wedge inside the bath

The seat which wedges inside the bath is not suitable for a plastic/acrylic bath; it can damage this type of bath. It is however useful where the bottom of the bath is narrow and rounded and would not support a bath stool. It is also easier to lift out than a bath stool, which grips the floor of the bath with stickers.

A seat may assist a client who is still bathing but is finding that getting up from the bottom is difficult. They will still need a degree of flexibility in the hips and knees and strength in the arms.

- Bath seats can be used alone or in conjunction with a bath board
- Some bath seats are only available in one height, others you can adjust
- Padded bath seats provide more comfort to those who are thin or in pain
- A Rent wood (above) is not suitable for plastic/acrylic baths
- Bath seats have a limited weight tolerance check with your local supplier

Use of a Bath Seat:

- The user transfers into the bath in the normal way, but gripping the side of the bath (or grab rail) they lower themselves onto the bath seat and wash from the seat
- In order to get out of the bath, they again grip the side of the bath (or grab rail), lean forward and push down with their arms to raise themselves to a standing position. You may have to provide the grab rail to assist this process

Check visit

- A dry run demonstration may ensure that the client is safe and happy using the equipment.
- Check that the client or another person is able to move the seat from the bath if it is required for another user.

Bath Boards

A bath board wedges between the rims to provide a platform-seated area over the bath. It is useful for a client who is unable to balance or stand on one leg to step into the bath.

Using a Bath Board:

- The user turns with their back to the bath and sits on the seat with their legs outside the bath
- They then shuffle/wriggle backwards until sitting in the middle of the board.
- Next they turn and lift their legs one at a time over the side and into the bath. (A leg lifter may assist with this.)
- Then slide or wriggle to the centre of the board

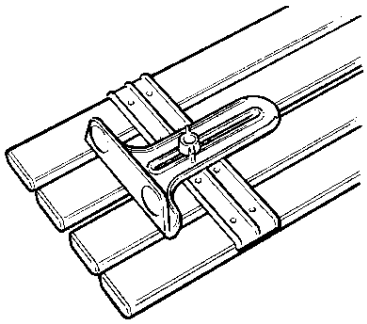
From this position there are two option: either transfer down onto a bath seat so they are lower in the bath, or remain on the board and use an over bath shower to wash. If the latter is the choice a wider bath board usually called a shower board is provided.

For those who are thin or have very delicate skin padded boards are available.

To move up from the bath seat to the bath board in order to transfer out of the bath it is important that the user places their hands on the bath board as they are lifting themselves, to prevent it from lifting up as they are attempting to sit on it. (This requires good arm and shoulder function.)

Ordering:
Take a measurement from the wall at the back of the bath to the outside edge of the rim closest to you. You need to order a board as close to this measurement as possible.

The board should not extend beyond the rims as it may tip when it takes the person's weight. The rim on the wall side of the bath needs to be approximately 1 inch, (2.5 cms) wide to support the bath board and check that any moulding within the bath will not prevent its being fixed securely. Check the weight tolerances of the boards available through your supplier.



Fitting:
All bath boards have an adjustable fixing system, usually brackets on the underside (occasionally there are 4 pillars in place of brackets, they adjust in the same way). These brackets then act as a brace against the side of the bath. All brackets adjust in width and some also in angle in order to wedge the board against the inside of the bath. They are then held in position with wing nuts.

Position the bath board on the bath rims and check for width and sufficient support on the narrow wall side rim. It should not be wider than the bath. Whilst holding the board tight against the far wall adjust and tighten the bracket on the wall side of the bath. Keeping the board tight against the wall adjust and tighten the nearside bracket. The bath seat should be secure with no sideways movement when fitted correctly. It can be lifted off for others to use the bath and replaced without refixing the brackets.

Most baths will take a bath/shower board with no problems but check:

- Length of the bath – check whether there is enough room for the person to straighten their legs, especially if both a bath board and seat are going to be used. A 170cm long bath allows for most bath equipment
- Width of the bath – check if the bath is exceptionally wide or narrow
- Material of the bath – metal baths are strong enough to withstand all types of bathing equipment as opposed to plastic or acrylic baths that must have

equipment that enables the user to transfer their weight through the base or the rims of the bath rather than the bath sides
- A corner bath - there is limited equipment available
- Built in grab rails - shaped moulding in the bath the positioning of these may hinder the use of equipment

Check visit:
- Look at the fixing and ensure that it is in a good position
- Give a demonstration of how to use the equipment, and then suggest the client try, to ensure that they are safe and happy carrying out the task
- Written instructions should accompany any product
- Be cautious if the client hasn't bathed for a while

Leg Lifters

These can be helpful for assistance with raising the lower leg up and over the bath rim.

Personal Care

There is a wide range of personal care products that people may find useful to assist with washing and drying. These include long handled sponges and toe washers, toweling straps to assist with drying and/or washing the back, wall mounted air blowers to assist with drying and tap turners if having difficulty operating taps.

When to refer to an OT

The combination of a bath board, an over-bath shower seat, grab rails and a slip resistant mat may satisfy many peoples' needs, others will need to consider a bath lift or a hoist or an alternative bath.

Referral to an OT should be considered if the standard equipment mentioned above does not provide the solution.

Showering may offer the possibility of washing independently once again.

Should you find you are in a situation where the person is in the bath during a demonstration and they are unable to get up from the bath floor or from a seat, reassure the individual, ensure they are as comfortable as is possible and dial 999 for ambulance assistance.

Chapter 11

Shower Equipment

If the client already has a shower cubicle and they have difficulty stepping in to it or standing to wash, grab rails and/or the provision of a freestanding shower stool or shower chair may assist.

Shower stool

A shower stool provides extra stability and support and is particularly useful for a person who tires easily, has weakness and balance difficulties and difficulty maintaining a standing posture to shower. Stools may be adjusted in height and can have armrests and a backrest. The seat height is important, the user should be able to sit comfortably with their feet supported on the floor.

Care should be taken, however, when using freestanding shower stools on plastic shower trays, as there is a risk of puncturing the tray.

Most showers have a slip resistant floor, but check this is the case. Shower stools vary in their weight tolerance.

Grab Rails

Horizontal and vertical rails can be fitted in the shower, providing the user with extra support and stability, whilst standing up to wash, and when negotiating a stepped entrance into shower.

If grab rails are difficult to fit in a plastic shower cubicle, a shower stool with arms may provide a better solution.

Horizontal Rails

A rail can be fitted on to the wall at the side of a shower seat in order to push up from sitting - approximately 20cm above the height of the seat.

It may also be useful to have a horizontal rail fixed on the wall opposite the shower seat in order to help pull up from the seat.

Vertical Rails

A vertical rail will help when pulling up and for support whilst stepping into the shower and for a balance support whilst standing and washing.

The position of the rails can be determined by asking the individual to show you where they wish to hold or pull.

Specify plastic coated grab rails (as for the bath see above), length of rail required and position of rail (this can be marked with stickers but should also be described with measurements)

Checking the rail:

- Look at the fixing and ensure that it is in a good position
- Check for any faults and report if any problems or defaults found
- Request a ‘dry run’ demonstration to satisfy yourself that the individual is finding the rail position helpful

When to refer back to an OT:

- If you are really concerned that an individual cannot use a bath board safely in the first instance e.g. poor sitting balance, breathlessness and they are dissatisfied with a strip wash
- When the individual, following a demonstration, is unable to safely lift their legs over the bath when using a bath board
- If in doubt about the person’s capability or if they haven’t done the activity for a long time

Chapter 12

Household Equipment

There are several basic household tasks necessary to our independence. These include cooking, eating, drinking and essential cleaning. There are number of ways you can work with the client to enable them to do these tasks more easily.

Practical help in carrying out some tasks such as cleaning the home might be available from social services, or a voluntary or private agency.

How to assess household tasks

- What are the tasks? How often are they done? How they are done? What order they are done in? What equipment is used?
- Are there any personal restrictions around, for example, mobility, balance, stamina, fine manipulation and sight?
- How specifically do these difficulties make each task difficult to manage? Is there any help available from friends/relatives/home help/carers etc?

Possible solutions:

- Task can be made simpler - we all get into habits in the way we do things but small changes from a fresh pair of eyes may make a big difference
- Change the time - are there times in the day when client is more able to tackle certain tasks?
- Change the layout - could the kitchen area where tasks centre around the sink, cooker, fridge, work surface etc be rearranged?
- Changing storage arrangements – are regularly used items accessible? Can frequently used items be kept out? Is there equipment not being used that could be thrown away or stored elsewhere?
- Could lighting and labelling be improved?

General kitchen safety

- Take your time and don’t rush to answer the door or telephone
- Don’t attempt non-essential tasks when feeling tired or unwell
- Keep space clear of obstruction. (Remove loose rugs and trailing flex)
- Don’t obstruct areas where access is needed such as wall sockets
- Fit a smoke alarm designed for kitchen use. (The local Fire brigade or Age UK may be able to help/advise on this.)
- Keep saucepan handles turned inwards
- Avoid carrying hot liquid such as a full kettle or saucepan over distance
- Ensure work surfaces adjacent to the cooker are clear for transfer of hot pans and dishes; or use a walking trolley

Perching Stool

These have an angled seat and are designed to help people who have difficulty standing by giving them support in an upright, perched position, so some weight is taken through their legs. In this position, the client is still able to reach forwards to attend to tasks by pivoting on their hips whilst still retaining good posture.

Whilst perched on the stool, the client must be able to put both feet flat on the floor.

They should have sufficient strength in their legs to prevent sliding forwards off the seat.

Armrest and backrests may not be necessary – armrests can impede sideways access. But they can provide security to a less confident client, and the armrests provide a handhold when standing up and sitting down.

There must be sufficient room in the kitchen to accommodate the stool, and thought must be given into where the stool should be stored when not used.

Some perching stools are fixed height, but the majority are adjustable, via telescopic legs.

Ordering:

- State the height of the stool measuring, from the front edge of the seat to the floor
- State whether armrests or back support are required

After issue:

- Check that the stool has been adjusted to the right height and that it is convenient to use
- Advise the client to check the stool regularly for signs of wear and tear, and advise the Provider of any problems.

Walking Trolley

These are specially designed trolleys that enable the client to take some weight through their arms if they have pain in their hips or legs; or a trolley can assist with balance. They enable safer transportation of items around the kitchen and from room-to-room.

Wooden trolleys are most commonly prescribed. These tend to have a recessed lower shelf to give legroom when stepping forwards. Some are recessed at the side to enable the trolley to also be used as a dining table.

Check that:

- The bar-style handle will give adequate walking support
- The floor surfaces and thresholds do not impede motion of the trolley
- The size of the trolley castors
- That turns into rooms can be negotiated (front castors rather than uni-directional wheels make turning easier)

You may need to advise your client to use an anti-slip mat on the trolley to keep items in place.

When ordering:

- State the style of trolley required
- The approximate height of the pushing handle. The majority of wooden trolleys are fixed height, so some compromise may need to be made. If the client uses a walking aid, measure the height of this. The handle height of the walking trolley should be no lower than this and preferably no higher than the client's waist to floor measurement, when they are wearing their usual indoor shoes

After issue:

- Check that the trolley is an appropriate height and that it is convenient to use
- Advise the client to check the trolley regularly for signs of wear and tear, and advise the Provider of any problems

Chapter 13

Commonly Seen Medical Conditions

This chapter provides a very basic introduction to some of the medical conditions that some of your clients may be living with.

However, it is important to stress once again that we are working with people and that no two people experience a medical condition or disability in the same way. We certainly shouldn't make judgments on the life of one individual with a particular condition based on what we know about the life of another individual with the same condition.

Our job is to look at the environment and how we can change that to enable our clients to live more independently. Their medical conditions only matter in so far as some knowledge may enable us to talk more usefully with our clients and so help them more effectively. Understanding a medical condition may help you be more sensitive to how client is feeling and to understand their prognosis (the likely development of their disease.

If you want more information on a condition or feel that a client needs more information, refer back to your OT.

Ageing

Of course, strictly speaking, ageing is not a disease. It's a natural process that happens to all of us. However, it is also a highly individual process that can be unpredictable.

The normal ageing process is sometimes referred to as the one-percent rule: most organ systems lose roughly one percent of their functioning each year, starting at about the age of 30.

By the time a person has reached the age of 70, skeletal density has often been reduced by about a third. The heart, liver and kidneys become weaker and less efficient with age. Skin loses flexibility, elasticity and resilience. Ageing also usually causes gradual hearing and sight loss.

People age at different rates depending on various factors including genetic makeup, lifestyle and their environment. Don't assume that the changes you see are part of the normal ageing process. They may be the result of disease which means treatment may be possible.

Diabetes

Diabetes Mellitus is a condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. It is caused by a deficiency in the production and/or action of insulin (a hormone from ther pancreas that helps the glucose to enter the cells where it is then used as a fuel by the body).

There are 2 types of diabetes. These are:

- Type I Diabetes – also known as Insulin Dependent Diabetes mellitus (IDDM). This normally begins in childhood when there is a severe lack of insulin. It develops very quickly and symptoms are normally very obvious and severe. It is treated by insulin injections and diet.
- Type II Diabetes – also known as Non-Insulin Dependent Diabetes Mellitus (NIDDM). This normally develops in people over the age of 40. Here, the body can still produce some insulin but not enough for its needs. Symptoms develop slowly and are usually less severe. It is treated by diet alone and/or tablets and occasionally insulin injections.

There are 3.2 million people diagnosed with diabetes in the UK and an estimated 630,000 people who have the condition, but don't know it. Between 2006 and 2011 the number of people diagnosed in England increased by 25 per cent and numbers are expected to reach 5 million by 2025.The symptoms of diabetes include increased thirst, increased frequency of going to the toilet, extreme tiredness, weight loss and blurred vision.

People with diabetes have a higher chance of developing certain serious problems and diseases, such as:

- Diabetic Eye Disease – retinopathy (abnormality of the retina) is the commonest cause of blindness in the UK of people aged 20- 65. Cataract is a progressive deterioration in vision, caused by opacity of the lens.
- Nephropathy – kidney damage may result in renal failure
- Neuropathy – damage to the sensory nerves that commonly presents with
- Tingling, numbness and loss of sensation in the feet and hands.
- Diabetic Ketoacidosis (DKA) – Can occur when a severe lack of insulin means that the body can not use glucose for energy and it starts to breakdown other body tissue for energy. Ketones are a byproduct of this process and they cause "acidity" in the body, hence the term Ketoacidosis. Symptoms of DKA include frequently passing urine, thirst, feeling tired and lethargic, blurry vision, abdominal pain, nausea, vomiting and breathing changes (including perhaps the smell of ketones which smell like pear drops on the breath).

- Diabetic Hypoglycaemia – this occurs when amounts of glucose in the blood become low and may occur if meals are missed. Symptoms include confusion, hunger and sweating.

There is also increased risk of heart disease, peripheral vascular disease (PVD) and cerebrovascular accident (CVA) or stroke.
Diabetes can affect:

- Mobility (Wheelchair users should ensure that feet are well supported and also to avoid knocking against objects that may cause damage to the lower limbs or feet.)
- Bathing/Showering (people with any loss of sensation due to sensory neuropathy should take safety precautions such as thermostatically controlled showers, thermometer to check temperature of bath water).
- Daily Living - much daily living equipment is available for people with diabetes who have developed sensory neuropathy or who have become visually impaired such as products that can be attached to most utensils/cutlery to make gripping more easy or for stabilising objects.

Heart disease

The Heart is essentially a muscle pump that receives its own nutrient supply through the coronary arteries. It contains four valves that direct blood flow and the heart sits in a sac known as the pericardium. An electric circuit known as the conducting system determines the action of the heart.

Heart disease can affect any of the structures and more than one at a time.

Peripheral Vascular Disease (PVD)

PVD is the medical term of the group of medical problems that causes poor circulation to the toes, feet and legs. One of the major diseases in this group is called arteriosclerosis.

Arteriosclerosis, known, as ‘hardening of the arteries’ is a condition in which there is gradual thickening, hardening and loss of elasticity in the walls of the arteries. The arteries are the blood vessels that bring the blood from the heart, down to the feet and legs.

Diabetes is a major cause of PVD. If it involves the arteries to the legs – gangrene may occur, which could lead to amputation. If it involves the arteries to the brain, the person could be at risk of a Cerebrovascular Accident (stroke).

Neuro muscular diseases

This is a broad term which covers a group of diseases which affect the functioning of muscles and their nervous control. Symptoms can include a degree of paralysis and/or spasticity leading to difficulties with movement. They are progressive and the individual has to accommodate to fluctuations in their day to day living. As a Long Term Condition there are expert patient programmes which can help to increase knowledge and confidence in management and planning. It may be within the remit of a Trusted Assessor to support with simple equipment solutions but it would more usually be appropriate to refer back to OT.
Included in this group are;

Parkinsons, Multiple Sclerosis, Huntingdon's Disease and Stroke.

Cerebrovascular Accident (CVA or Stroke)
A CVA occurs when the blood supply to the brain is disrupted. When the blood supply is disrupted, the brain is deprived of Oxygen and other nutrients, causing cell damage. CVAs occur in two ways:

- Ischaemic – when a blood clot blocks an artery. There is insufficient blood supply to the brain. This occurs in approx. 80% of cases.
- Haemorrhagic – caused by bleeding within or around the brain from a burst blood vessel. Results in too much blood to the brain. Occurs in approx. 20% of cases.

CVA is the 3rd highest cause of death and the leading cause of severe disability in the UK. There are approximately 100,000 people who have their first CVA a year.
Risk Factors associated with a CVA:

- Hypertension
- Cardiac Disease
- Peripheral vascular Disease & cerebrovascular disease
- Diabetes
- Smoking
- Other causes – stress, diet, alcohol and amount of physical activity

The effects of a CVA can be fatal, whilst others can cause permanent or temporary disability. The most common effects are paralysis (Hemiplegia) on one side of the body, which can affect the ability to communicate.

The effects of a CVA depend on which part of the brain is affected. The brain is divided into 2 halves (hemispheres). The left is the dominant hemisphere that contains speech centres. The right is concerned with visuospatial awareness and perception. Each of these hemispheres is divided into lobes. The Frontal Lobe if damaged can cause changes to the personality and cause cognitive problems; if

the Parietal Lobe was damaged, this would cause sensation problems either hyper or hypo sensitive. Damage to the Occipital would cause visual problems and if the Temporal lobe was involved this would affect taste, sound and smell.

Nerve pathways from the 2 hemispheres serve different parts of the body. These pathways are like telephone wires sending messages to and from the brain to the body. Nerve pathways from the right side of the brain crosses over to supply the opposite side, the left side of the body and vice versa.

In the early weeks often the affected 'Hemiplegic' side of the body is flaccid (little or no muscle tone). Spasticity (high muscle tone) usually follows later.
As no two people have exactly the same parts of the brain damaged in a CVA, no two people will have exactly the same combination of symptoms. Likewise the severity of a CVA, the process and speed of recovery is very individual.
Rehabilitation aims to make the maximum possible recovery from any disabilities caused by the CVA. The extent of the recovery will depend on the severity and the kinds of difficulties it has caused.

Dementia

The term 'dementia' describes a group of symptoms caused by the impact of disease on the brain, such as Alzheimer's disease and CVA (stroke).

Dementia is progressive which means the symptoms will gradually get worse. The course of dementia varies from one person to another. The decline can be rapid in some and more gradual in others.

It is commonly characterised by:

- Loss of memory – for example, forgetting the way home from the shops, or being unable to remember the names of family or friends or a particular daily activity
- Mood Changes – particularly if the disease affects the parts of the brain that control emotion. They may become angry, agitated, upset or withdrawn
- Communication problems – a decline in the ability to talk, read and write
- In the later stages of dementia, individuals will have problems carrying out everyday tasks and become more dependent on others.

Causes of Dementia

There are several diseases and conditions that cause dementia. These include:

- Alzheimer's disease – this is the most common cause of dementia. During the course of the disease the chemistry and structure of the brain changes, leading to the death of brain cells. The cause is unknown, but heredity may play a part
- Vascular Disease – associated with problems in the circulation of the blood. Can occur either suddenly following a stroke, or over time through a series of small strokes (Multi-infarct dementia). About a fifth of people who have strokes will develop problems involving their mental abilities including dementia
- Dementia with Lewy bodies – tiny spherical structures develop inside nerve cells which leads to the degeneration of brain tissue
- Pick's Disease- personality & behaviour are more affected than memory due to the dementia affecting the front part of the brain.
- Other rarer causes – Multiple Sclerosis, Motor Neurone Disease, Parkinson's Disease & Huntingdon's Disease

Dementia affects 820,000 people in the UK. It mainly affects older people, both men and women. However, there are 20,000 people or more in the UK under the age of 65 who have dementia.

Most forms of dementia cannot be cured. However, a great deal can be done to improve the quality of life of the person with dementia and assist the carer. A wide range of professionals can offer advice and support including – the GP, OT, Social Worker, Speech & Language Therapist, CPN (community psychiatric nurse), district nurse, physiotherapist, health visitors, continence advisors and home help.

Also, local support groups such as those run by the Alzheimer's society, MIND or Age Concern will be able to offer advice about services.

Arthritis

Arthritis simply means 'inflammation of the joints'. There are over 200 different kinds of arthritis and over 8 million people in the UK who suffer from the condition. The most common forms of arthritis are:

Osteoarthritis (OA)

OA is the most common form of arthritis affecting about 6.5 million people. The cartilage (which is the slippery tissue that covers the ends of the bones in a joint, which allows bones to glide over one another and also acts as a shock absorber during physical movement) becomes rough and worn away. This allows bones

under the cartilage to rub together, causing pain, swelling and loss of movement in the joint. Over time, the joint may lose its normal shape and bits of bone or cartilage can break off and float inside the joint space. This causes more pain and damage.
Usually the hands, knees, hips, feet and spine are affected. It can affect anyone of any age, though its more common in older people and women. It can develop after an injury to a joint.

OA varies a lot from person to person. For some, changes are slow and subtle, whilst others have a number of years when pain and stiffness gradually worsen. Being overweight makes OA in the knee and hips worse. Exercise and good pain control are important in the management of OA

Rheumatoid Arthritis (RA)

Approximately 1 in a 100 people get RA. There are currently around 400,000 in the UK. The cause is unknown.

RA is an inflammatory disease that causes pain, swelling, stiffness and loss of function in the joints. The inflammation occurs in the thin synovial membrane that lines the joint capsule, the tendon sheaths (tubes in which the tendons move) and the bursae (sacs of fluid that allow the muscle and tendons to move smoothly over each other).
It has special features that make it different from other kinds of arthritis. For example, RA generally occurs in symmetrical pattern. This means that if one knee or hand is involved, the other one is also affected. Also, usually there is morning stiffness with painful, hot and swollen joints.

RA affects everyone differently. It tends to go through active and inactive phases. During flare ups, joints become more painful and inflamed and a general feeling of being unwell and tired is also common. It usually starts in the wrists, hands and feet and can also spread to other parts of the body.

All of these effects lead to serious joint damage, and disability.

Much of the equipment discussed in this guide could be of use to people with arthritis: easy grip implements and attachments, reachers, grabbers, velcro, lifts and grab rails, shower chairs, long handled implements such as brushes/sponges, raised toilet seats, sticks and frames, chair and bed–risers etc.

OA and RA leads to a generalised weakness and instability which significantly increases the chances of falls and fractures.

Replacement surgery is common in people with arthritis, especially in the hip. For approximately 3 months following a total hip replacement, there are special safety hip precautions to protect the hip from dislocating including:

- Avoiding crossing legs (either in bed or seated)
- Avoiding bending the hip greater than 90 degrees (as when seated upright or bending forward to tie shoelaces)
- Avoiding turning the foot inwards
- Keeping a wedge or pillow between the knees whilst in bed to avoid crossing the legs
- Leaning back slightly when sitting to keep the hip from bending greater than 90 degrees

Appendix

Definitions of Disability

Legal Definition for Social Services

People with disabilities are defined as those ‘who are blind, deaf or dumb, or who suffer from mental disorder of any description, and other persons who are substantially and permanently handicapped by illness, injury or congenital deformity or such other disabilities as may be prescribed.’

World Health Organisation definition (WHO)

There are widely used definitions for ‘impairment’, ‘disability’ and ‘handicap’.

- Impairment: Any loss or abnormality of a psychological, physiological or anatomical structure or function.
- Disability: Any restricted or lack of ability to perform an activity in the manner or within the range considered normal for a human being.
- Handicap: A disadvantage for a given individual resulting from an impairment or disability that limits or prevents the fulfilment of a role (depending on age, sex and cultural factors) for that individual.

Equality Act 2010

A person has a disability for the purposes of the Act if he or she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

- ‘‘substantial’ is more than minor or trivial - eg it takes much longer than it usually would to complete a daily task like getting dressed
- ‘long-term’ means 12 months or more - eg a breathing condition that develops as a result of a lung infection

There are special rules about recurring or fluctuating conditions (for example, arthritis) and also about progressive conditions (a condition that gets worse over time).

People with progressive conditions can be classed as disabled depending how exactly the condition impacts on them. However, you automatically meet the disability definition under the Equality Act 2010 from the day you’re diagnosed with HIV infection, cancer or multiple sclerosis.

Some conditions aren’t covered by the disability definition. These include addiction to non–prescribed drugs or alcohol.

DLF-Data

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DLF Data is an invaluable online resource for anyone needing information on assistive technology and daily living aids. Whether you work in Social Services, NHS, voluntary sector or in private practice, DLF Data can help you find solutions to your clients' needs quickly and easily!

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Why use DLF-Data?

- You can save time - a survey of users' shows that on average they find the information they need in less than half the time of using other methods. Now that DLF Data is a web app, you can use it when out on visits
- With details of over 11,000 products from 1,000 suppliers all in one place, you can be sure to find the specialist products your clients might need
- You can compare products side-by-side or view dimensions in a table helping you find the right product for your client
- National supplier details are provided and local retailers listed with addresses, phone numbers, email and a click-through to their website/s
- You can search for products using text searches, our DLF Data classes or the ISO9999:2011 international classification of assistive products
- You can comment on products and share your experiences
- New products are constantly added, ensuring you keep up-to-date and receive the best quality information, including dimensions, features, accessories and photos
- MHRA alerts are added to products and assistive technology literature listed, helping you keep up-to-date with research and safety issues
- You can create reports listing products, national suppliers, local retailers and organisations to give to your clients. These can be printed and emailed
- You can signpost clients to products you can't provide for them to top-up or self purchase - giving them greater choice
- You can download and print PDFs of sections. The format of these may be familiar to subscribers who previously received DLF's Hamilton Directory.

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