POCKET GUIDES

OCCUPATIONAL THERAPY PLACEMENTS

Terri Grant

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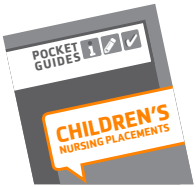

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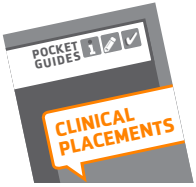

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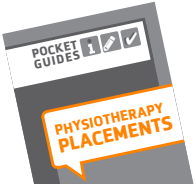

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Terri Grant

University of Worcester

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Abbreviations

Below you will find abbreviations used in this book. There is also space for you to create a list of further (approved) abbreviations that you encounter during placement.

Familiarise yourself with locally approved abbreviations in your first few days of placement.

A&E	Accident and emergency
BLS	Basic Life Support
BNF	British National Formulary
CPD	Continuing professional development
CPR	Cardiopulmonary resuscitation
FoR	Frame of reference
FSTF	Free-standing toilet frame
HCPC	Health and Care Professions Council
MDT	Multidisciplinary team
MHFA	Mental Health First Aid
NEWS	National Early Warning Score
NICE	National Institute for Health and Care Excellence
PIVO	Private and voluntary sector
PPE	Personal protective equipment
RCOT	Royal College of Occupational Therapists
REP	Role-emerging placement
RTS	Raised toilet seat
SBAR	Situation, background, assessment, recommendation
SMART	Specific, measurable, achievable, realistic, time bound
SOAP	Subjective, objective, analysis, plan
SSRI	Selective serotonin reuptake inhibitor
SWOT	Strengths, weaknesses, opportunities, threats
TILE	Task, individual, load, environment

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19 Using your mandatory training

19.1 Hygiene and infection control

Healthcare-associated infection is a significant problem causing potentially serious illness, long-term disability and death. The financial and emotional cost of these infections is considerable. Most of these infections are, however, preventable; as such, you have a responsibility to yourself, your patients and your colleagues to comply with national and local guidance.

Hand washing is a fundamental component of infection control – you must wash your hands before and after every patient contact, including contact with the patient environment.

Notes

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

Apply a palmful of the product in a cupped hand, covering all surfaces;

Rub hands palm to palm;

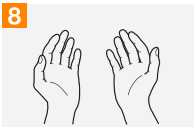
Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



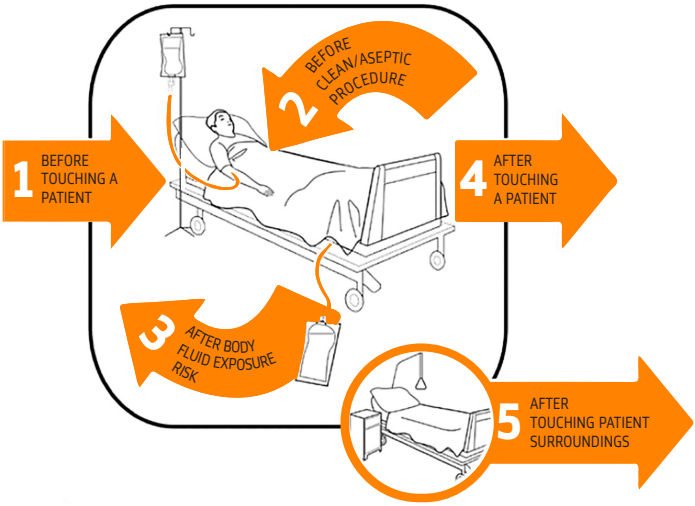
Once dry, your hands are safe.

Proper hand rub technique (World Health Organization, 2009). Reproduced with permission of the World Health Organization, www.who.int.

Directions for hand washing (World Health Organization, 2009):

- Wet hands with water
- Apply soap
- Rub hands together (palm to palm)
- Interlock fingers, alternating hands (palm to palm and top of hand to palm)
- Back of fingers to opposing palms with fingers interlocked

- Rub each thumb thoroughly
- Circular motion of fingertips in opposite palm
- Rinse hands with water
- Dry hands thoroughly with a single-use paper towel
- Use towel or elbows to turn off taps



My Five Moments for hand hygiene. Reprinted from *Journal of Hospital Infection*, 67(1), Sax, H. *et al.*, 'My five moments for hand hygiene': a user-centred design approach to understand, train, monitor and report hand hygiene, pp. 9–21 (2007), with permission from Elsevier.

19.2 Moving and handling

Placement is a time to put all the theory and principles you have learnt about moving and handling into practice. Real-life situations can be challenging – you will be working in a dynamic environment and with service users who may be in pain and have limited mobility. You will also be expected to

work alongside other staff who may expect you to take the lead, as they often regard therapists as knowledgeable in this field. You may also be asked to advise other healthcare professionals about the safest way to move or mobilise individuals. It is essential that approved techniques are used to protect both service users and yourself from injury. Your physiotherapy colleagues can support you with moving and handling assessments.

19.3 Assessing risk with TILE

When carrying out **any** manual handling task, whether this involves moving a person or a piece of equipment, you must assess the risk.

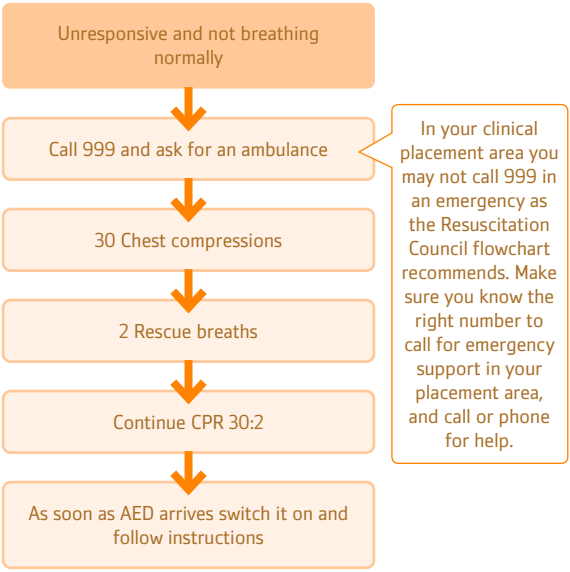
Task	What do you want to do / achieve?
Individual	What are your own individual capabilities? Consider your own health and ability – do you have any injuries or health conditions? Consider the abilities of other colleagues involved.
Load	This refers to the person or object you are moving. Additional equipment may be necessary.
Environment	Consider the space or environment that you are working in – you may have to remove potential hazards, check service users' footwear, or attend to drips, drains or other medical equipment.

Common tasks you may come across

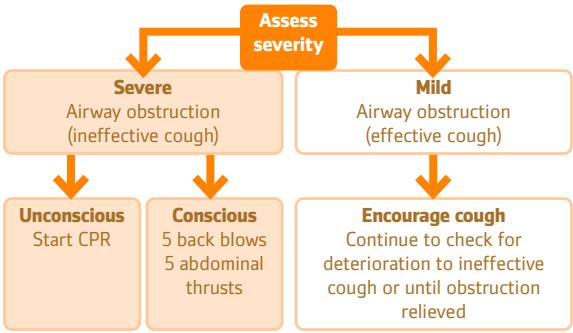
- Getting a service user out of bed, or moving them in the bed
- Assisting a service user on or off the toilet or commode
- Raising furniture such as chairs and beds
- Fitting equipment
- Using aids such as a standing aid, sliding sheet or hoist (check local policies or guidelines).

19.4 Basic Life Support (BLS)

If you come across a person who is unresponsive or choking during your clinical placement, remember to shout for help and that you are never alone. Assess the situation for your own safety first and then intervene. Never do anything that you are not confident of or that puts your own safety at risk.



Adult Basic Life Support (Resuscitation Council, 2015).
CPR 30:2 – an emergency cardiopulmonary resuscitation procedure that alternates 30 chest compressions with two rescue breaths; AED – automated external defibrillator (a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm). Reproduced with the kind permission of the Resuscitation Council (UK).



Adult choking guidelines (Resuscitation Council, 2015). Reproduced with the kind permission of the Resuscitation Council (UK).

If you need to start CPR see the Adult Basic Life Support algorithm above.

- Always keep the airway opened by tilting the head back (head tilt, chin lift).
- Do not put anything in the person's mouth.
- Wait for help before moving the person.
- If it is safe to do so, or no neck injury is apparent, place in the recovery position.
- Time and record events as they happen.

The recovery position. Reproduced from *Clinical Skills for OSCEs*, 5th ed. © Neel Burton, 2015.

Resuscitation Council (2015) Resuscitation guidelines. Available at: bit.ly/PGCP-7

19.5 ABCDE assessment

There are occasions where you might be involved with people who have become acutely unwell. Acute physiological deterioration can occur for many reasons including infection, neurological insults, acute cardiac event, electrolyte disturbance, drug reaction, etc.

Physiological 'track and trigger' systems such as NEWS2 (see inside back cover) help healthcare professionals to identify a person who is deteriorating. Patient observations are used to create an aggregate score that then allows the team to make decisions regarding monitoring and management. Six simple physiological parameters form the basis of the screening system:

1. Respiration rate
2. Oxygen saturation
3. Systolic blood pressure
4. Pulse rate
5. Level of consciousness or new confusion
6. Temperature

It is imperative that you seek help if you are the first person to identify an acutely ill patient. It is helpful to remember the ABCDE acronym to guide your assessment. Normal values can be found on the inside front cover of this book.

Notes

Airway	Check for airway patency – is the patient talking? Can you feel air flow? Are there abnormal breathing sounds or skin colour? If you have concerns about the patient's airway patency, shout for help and aim to secure the airway by using the head tilt, chin lift manoeuvre. Seek help for further airway support.
Breathing	Check respiratory rates, respiratory pattern and oxygen saturations (SpO_2). Respiratory rate changes are very sensitive indicators of physiological deterioration. Measure respiratory rate accurately – observe and count the patient's breaths over a full minute.
Circulation	Check blood pressure, heart rate and temperature. Palpate the radial pulse – is it regular and strong or irregular and weak? Do the extremities look blue or mottled? Do they feel cold to the touch?
Disability	Is the patient alert and oriented? Use the acronym ACVPU (Alert; Confused; responds to Voice; responds to Pain, Unresponsive). Are pupils an equal size and do they react to light?
Exposure	Head to toe check – are there rashes, signs of local infection, swelling, abdominal distension, wounds, drains? Remember to preserve dignity and comfort at all times.

Be sure to record your findings in the medical notes and have these countersigned by your educator. Ensure that you communicate your findings and concerns to an appropriate member of the team.

19.6 Mental Health First Aid

MHFA England (https://mhfaengland.org) supports people to learn how to recognise the symptoms of mental health issues, offer initial help and guide a person towards support. The principles are geared around developing skills in listening to

and supporting people at times of crisis and aim to build a supportive culture around mental health. Undertaking MHFA training if offered to you as part of your placement is highly recommended.

When faced with a service user who is experiencing deteriorating mental health, the key is not to panic. Listen, reassure them and seek support from your practice educator. It is also important that you seek support for yourself.

De-escalation

De-escalation is often described as one of the most useful tools when dealing with service users with poor mental health. It is used to avoid conflict, anger and frustrations that a service user may be experiencing at any time during their care.

There are three main stages to de-escalation :

- **Delimit** – this is the first stage and it involves making the situation safe for yourself and others. This may require activating alarms to enable backup from other members of staff and clearing the area of other service users to ensure their safety, or moving the service user involved to a quiet area. This will enable them to have the chance to calm down and reduce the risk of others being harmed.
- **Clarify** – this second stage is used to find out what the person is angry or upset about. To help you find this out, it is important to ask open questions. Offer to help them if you can. Make sure you speak clearly so there is no confusion and check your understanding with them, so the situation does not get worse.
- **Resolve** – this is the last stage. Try to come to an arrangement with the service user that satisfies the issues that they feel they have faced. Be calm in your demeanour. If there is something that you cannot do, clearly explain the reasons for this. Discuss different courses of action

that could be taken. Take your time, and make sure that the person understands that you are listening to what they are saying.

19.7 Falls

Falls are a common and serious health issue in the UK, with those aged 65 years or older being at greatest risk of falling. Falls are defined as events which result in the individual unintentionally coming to rest on the ground (or lower level), but which do not have a precipitating intrinsic event such as a stroke or pulmonary embolus. The consequences of falling include physical harm (including fractures), pain, loss of confidence, loss of independence and death. Of those who fall, 50% will fall again within 12 months.

There are many risk factors that contribute to falls – these may include: previous falls; impairments in balance / mobility / flexibility; impaired vision; effects of polypharmacy; environmental factors; confusion / agitation; certain conditions (for example Parkinson's disease, post-surgery, dementia, etc.); and frailty.

As a student occupational therapist, your role is likely to include working with the MDT to identify risk, implement prevention strategies, conduct environmental assessments and offer appropriate rehabilitation. If your placement involves working with older adults, you should ensure that you have completed revision on multifactorial risk assessment.

In hospital falls are the most frequently reported safety incident, but research suggests that certain precautions may reduce these by 20–30%. If you are walking with a service user you should consider the following:

- Baseline mobility – how does the service user usually walk? (consider walking aids; do you need the assistance of another person?)

- Vision and hearing (make sure the service user is wearing spectacles and hearing aids if appropriate)
- Orientation or confusion – does the person know where you are going and why?
- Toileting and continence needs
- Environment (consider footwear, clutter-free space).

What should I do if the service user falls whilst in my care?

- If a service user begins to fall whilst you are nearby, do not attempt to catch them. If it is safe for you to do so and you have been trained, you can lower them to the floor in order to protect their head.
- Stay with the service user and call for help.
- Check their vital signs (ABCDE assessment) and assess for injuries.
- Once help has arrived, assess how to safely move the service user from the floor. If they are unable to get onto their knees and stand independently, moving and handling equipment may be required.
- Inform the service user's medical team of the incident.
- Complete an incident report as soon as possible after the event – ask your educator to help you with this to ensure that you document all the relevant information.

Notes

19.8 Sepsis

Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis is caused by an infection, for example respiratory, intra-abdominal, renal, skin, joint or blood-borne. Sepsis may be complicated by septic shock when profound circulatory, cellular and metabolic abnormalities occur. Sepsis and septic shock are major global causes of morbidity and mortality.

A global initiative, the Surviving Sepsis Campaign, has established the aim of reducing mortality by 25% in 5 years, and improving awareness, diagnosis and treatment of sepsis. The Surviving Sepsis Campaign has highlighted the importance of speed in identifying and treating patients with sepsis in order to improve outcomes.

How do I identify a patient with sepsis?

Identifying a patient with sepsis can be difficult for students and trained clinicians alike – the symptoms of sepsis are very similar to many other conditions. Measuring and monitoring the patient's vital signs gives important clues – you should always report any abnormalities to a trained member of staff. Use of the National Early Warning Score (NEWS2 – see inside back cover) may help identification.

NICE recommends that all healthcare professionals think 'could this be sepsis?' if a person presents with signs or symptoms that indicate possible infection. The UK Sepsis Trust suggests a screening tool that may help your clinical reasoning. If all conditions are met, the patient should be screened for sepsis.

Could this be sepsis?	
Patient looks sick	✓
Patient, carer or relative very worried	✓
NEWS2 (or similar track and trigger system) triggering	✓
Risk factors present (over 75 years old, recent surgery / trauma / invasive procedure, immunosuppressed, indwelling device, or skin integrity breached)	✓

A Red Flag system identifies patients at most risk of deterioration. One or more of the following requires immediate action:

- Objective change in behaviour or mental state
- Unable to stand / collapsed
- Extremely breathless, barely able to speak
- Skin that is very pale, mottled or blue
- Rash that does not fade when firmly pressed
- Not passed urine in last 18 hours
- Recent chemotherapy.

Notes

Daniels, R. and Nutbeam, T. (eds) (2017) *The Sepsis Manual*, 4th edition. UK Sepsis Trust. Available online at: bit.ly/SM-4e

NICE (2016) *Sepsis: recognition, diagnosis and early management*. Available at: www.nice.org.uk/guidance/ng51