Putting Occupation back into Occupational Activity
(The True Meaning of Occupational Therapy in Care Homes)

Rebecca Haythorne
Occupational Therapist, Leeds-York Partnership NHS Foundation Trust
rhaythorne@nhs.net

Over the last three years Occupational Therapists (OT) in the Leeds-York Partnership NHS Foundation Trust (LYPFT) Care Homes Team (CHT) have been providing a comprehensive service to care homes across the city. Rebecca Haythorne, rotational OT within the mental health trust reflects on her first post qualifying role and the impact that OT can have on improving the quality of life for those living in residential and nursing homes registered by the Care Quality Commission.

Occupational Therapy enables people to participate in daily life to improve their health and wellbeing; no matter their condition, this typically takes the form of three key areas: self-care, productivity and leisure (Hammell 2009). This is widely recognised through guidelines promoted by The National Institute for Health and Care Excellence (NICE) who emphasise the importance of OT’s as one of the leading professionals to improve general health and quality of life for those living in care homes (NICE 2015). Despite the strong and varied role which OTs can bring to care homes, many documents and policies tend to over emphasise the role of OT in increasing “activities “and have neglected the “occupational” aspect in activity. For example, a key focus of many documents centres on leisure and improving leisure activities. Examples of this can be found in: the College of Occupational Therapy’s living well through activity in care homes toolkit (2013) and in NICE’s OT interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care (2015) document. However many of the referrals received by OT’s in the LYPFT CHT also centre around two other key aspects: self-care and productivity.
Over the last nine months the author (Rebecca Haythorne) and Occupational Therapist Tamara Babij and Tracy Kielty have received substantial referrals for adults living in care homes. The majority of referrals are for individuals struggling with symptoms of dementia and/or depression which is impacting on their quality of life. The COT evidence fact sheet entitled occupational therapy evidence: occupational therapists work with people living in care homes, reported that the most common reason residents in care homes are referred for OT input is for social activity (50%). 30% are related to training needs and 20% involve environment and orientation advice. However recent data gathered by the CHT reflects that over 50% of OT referrals are related to behavioural and psychological symptoms of dementia (BPSD). This has included challenging behaviours during personal cares, disinhibition, agitation and aggression, pacing and loss of function and productivity. This was followed by around 25% for lack of motivation and decreased ability to participate in meaningful activity and roughly 15% for orientation advice, about 10% resulted in generic referrals.

**Assessment**

The OT processes in the CHT involves standard initial assessment and the use of person centred assessments to further inform intervention and care planning. The Pool Activity Level (PAL) designed by Jackie Pool is a regular instrument used by OTs in the CHT as it aims to understand the three main areas of occupational activity described above. The PAL draws on models of development such as the dialectical model of person-centred approach to the interplay of social, neurological and psychological factors and the functional information processing model. The assessment is based on the underpinning principle that individuals with cognitive impairment still have the ability to carry out meaningful occupations; all they need is an enabling environment. The PAL aids in understanding the impairments and level of ability for individuals to help them better engage with occupations (Pool 2008). The Pal is often used by OT’s in the team alongside observed washing and dressing assessments to advice carers in supporting residents who are exhibiting verbal and physical aggression in-conjunction with high levels of anxiety and distress at time of personal care interventions. Alongside this, the OTs often receive referrals for residents who
have reduced physical and cognitive functioning which in turn is impact on their productivity, motivation and well-being. For difficulties in this area the Model of Human Occupation Screening Tool (Parkinson, Forsyth and Kielhofner 2006) can support OTs in assessing for motivation, performance and organisation of occupational behaviour in everyday life. OTs in the CHT have found this tool particularly useful in assessing residents motivation and functional ability to carry out occupational activity in a given environment. Outcomes of this assessment have supported OTs in providing further assessment and the introduction of adaptive aids into care homes. Decreased motivation and disengagement from occupational activity is a regular referral for OTs in the CHT. The Bradford Well-Being Profile developed by the Bradford Dementia Group (2006) enables practitioners to monitor how residents are faring psychologically and socially. In its original form the profile helps to observe and record positive and negative indicators which residents experience, through these carers can learn to spot patterns and routines of residents behaviours and offer them support when it will be most valuable.

**Therapeutic Interventions**

Although doll therapy is often seen as a controversial intervention for those with dementia (Higgins 2010), in the CHT doll therapy has been used with varying degrees of success as a distraction method for those with sexual disinhibition and reduction of agitation. Alongside this, the use of sensory cushions/aprons and soft toys have proved a meaningful activity and appropriate calming method for those who have reached the later stages of dementia and who rely heavily on sensory input. The COT living well through activity in care homes toolkit (2013) and Sue Parkinson’s (2015) recovery through activity book has been useful in providing education in care homes around meaningful leisure activities and along with the above assessments have been used when working 1:1 with individuals to improve motivation and target activities at the right level to increase occupation in these meaningful activities. Additionally, the OTs work closely with carers and residents to develop behaviour activation techniques and graded exposure to occupations helping residents build up a manageable and varied routine to their day. Often this can
include education with carers around reality orientation, validation techniques and sleep hygiene.

A combination of both assessment and intervention is used to provide care home staff with an OT specific care plan to help them meet the resident’s needs. The challenge and difficulty of working in such a setting often revolves around providing a person centred care plan which carers will be able to maintain given the challenges in the care home environment once the OT intervention has come to an end. This can include: limited resources, poor staffing levels, high turnaround of staff and staff reluctance for change and following care planning advice. In order to reduce some of these concerns and build a professional relationship with care staff ahead of the older service redesign OTs in the CHT have been compiling evidence for clinical audit highlighting the value of OTs in the care homes team. Additionally work has started to develop a training package to better support the engagement with care staff and their residents which OTs can deliver in the care home setting. This training coincides with recommendations from the COT (2013) that OT’s should be involved in the design and development of locally relevant training schemes for those working with older people, as a way to ensure that staff have the skills to support older people to carry out daily routines and retain independence. In turn this can help to reduce the cost of care in care homes by supporting carers in their management techniques of challenging behaviours and aggression. Better understanding and management of these behaviours could reduce the number of referrals into the CHT, resulting in lower costs for the National Health Service.

References:


