Bariatric Challenges in Aged Care

MANAGING OBESITY AT THE COAL FACE

A LOOK BEHIND THE SCENES INTO HEALTHCARE’S STRUGGLE COPING WITH THIS EPIDEMIC

www.ausbig.com.au
Presentation Aim is to:

1. Start bariatric conversations
2. Improve workplace discrimination
3. ‘Your Safety First’ Raise safety issues in your facility
4. Understand the process to be ‘Bariatric Ready’
My first case
AusBIG – Resource/discussion/networking

AusBIG
Australasian Bariatric Innovations Group

VIC BEG Q BEG NT BEG SA BEG
TAS BEG WA BEG NZ BEG ACT BEG

FOR HEALTH PROFESSIONALS

14-15th August 2014
Melbourne - Bell City
215 Bell St, Preston Vic,
Australia, 3072

PLUS 1/2 day
1-5pm Pre-Conference Movement Workshop
13th August 2014
Christine Galavotti PT
& Julie MacRae OT

1st National Conference on the
Physical Management and Care of the Obese 2014
“Strengthening the Bariatric Communication across Health & Emergency Services”


17-19th August 2015
QT-Gold Coast
7 Staghorn Ave,
Surfers Paradise
Qld, 4217

2nd National Conference
on the Physical Management
and Care of the Obese 2015
“RESPONDING IN AN EMERGENCY – THE BARIATRIC CHALLENGE”


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Other bariatric events

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Risk Management Unit 
Nepean Hospital 
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Phone 0247341538

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<th>Presenter</th>
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<tr>
<td>0800 - 0830</td>
<td>Introduction and overview</td>
<td>Michelle Hucker</td>
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<td>0830 - 0900</td>
<td>Interdisciplinary approach/care planning</td>
<td>Michelle Hucker</td>
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<td>0900 – 0910</td>
<td>Sleep apnoea</td>
<td>Dr Yasmina Djavadkhani</td>
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<td>0910 - 0940</td>
<td>Psychological care</td>
<td>Renee Grant</td>
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<td>0940-0955</td>
<td>MID</td>
<td>Sally Meier</td>
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<td>0955 - 1020</td>
<td>Morning tea</td>
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<td>1020 - 1100</td>
<td>Pressure injury and pannus management</td>
<td>Tina McEvoy/Michelle Hucker</td>
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<td>1100 - 1130</td>
<td>Occupational Therapy</td>
<td>Andrea Huang</td>
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<td>1200-1215</td>
<td>Mobility</td>
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<td>1215 - 1245</td>
<td>Lunch</td>
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<td>Equipment Expo</td>
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<td>Diet and Nutrition</td>
<td>Traci Cook</td>
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<td>Discharge planning</td>
<td>Anne Gallen and Asha Skinner</td>
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<td>Community care</td>
<td>Community nurses</td>
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<td>1615 - 1620</td>
<td>Get Healthy coaching service</td>
<td>Janelle Imber</td>
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<td>1620 – 1630</td>
<td>Evaluation</td>
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Always think of your........
“Australia's obesity problem a 'national tragedy’ “

Professor Collins - the Dieticians Association of Australia
spokeswoman

http://www.abc.net.au/news/2016-02-14
2014-15 National Health Survey found

- 63.4% Aust. adults overweight/obese ↑on 62.8% 2011/12
- A survey of more than 1,200 people was commissioned by the Dieticians Association of Australia.
  - It found more than half of Australian adults want to lose weight, one-in-three want to boost their vegetable intake, and a quarter are aiming to reduce portion sizes.
- Many here today would probably feel the same way
- This just highlights the increase in the numbers of obese we will be seeing in aged care each year.
Definition of obesity

The World Health Organization (WHO) states that obesity is a chronic disease defined as ‘a condition of abnormal or excessive fat accumulation in adipose tissue, to the extent that health may be impaired’. While there are a number of methods to identify obesity, the body mass index (BMI) provides the most widely used, albeit crude, way to measure population-level obesity.

Using Body Mass Index, BMI, the WHO established the classification system shown in the following table, which also shows how the likelihood of co-morbidities increases with BMI.

A study on the additional costs of obesity and benefits of intervention in Australia October 2015
## Weight classification of adults by BMI

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI</th>
<th>Risk of co-morbidities</th>
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<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.50</td>
<td>Low (but risk of other clinical problems increased)</td>
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<tr>
<td>Normal range</td>
<td>18.50 – 24.99</td>
<td>Average</td>
</tr>
<tr>
<td>Overweight</td>
<td>≥ 25.00</td>
<td></td>
</tr>
<tr>
<td>Pre-obese</td>
<td>25.00 – 29.99</td>
<td>Increased</td>
</tr>
<tr>
<td>Obesity class I</td>
<td>30.00 – 34.99</td>
<td>Moderate</td>
</tr>
<tr>
<td>Obesity class II</td>
<td>35.00 – 39.99</td>
<td>Severe</td>
</tr>
<tr>
<td>Obesity class III</td>
<td>≥ 40.00</td>
<td>Very severe</td>
</tr>
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1.2 Prevalence of obesity

- Males and females are equally likely to be obese, with 27.5 per cent of both populations identified as obese.

- By contrast, women are much less likely than men to be overweight, with 28.2 per cent of females identified as overweight, compared to 42.2 per cent of males.

- Globally, there is a trend that men have higher rates of overweight and women have higher rates of obesity.

- In 2011-12, there were 4,835,102 obese people in Australia.
Health and wellbeing costs

A study on the additional costs of obesity and benefits of intervention in Australia October 2015

- Obesity clearly has a negative impact on an individual’s health and wellbeing, with direct links to health care complications, lower quality and length of life, and mental wellness issues.

- An estimate based on the 2013 Herald/Age Lateral Economics Index of Australia’s Wellbeing found that obesity costs Australia $120 billion in collective wellbeing a year.

- This figure includes many measures outside of the scope of this analysis and cannot be considered for direct comparison; however, it illustrates the negative impact obesity has on health and wellbeing for Australia.
The impacts of obesity on wellbeing include premature mortality and the incidence of multiple co-morbidities, which create a complex situation with negative impacts on health and quality of life.

The Australian Institute of Health and Welfare, AIHW, found that high BMI was responsible for 7.2 per cent (or around 9,500 deaths) of total deaths in Australia in 2003, and obesity is now thought to be one of the leading causes of premature mortality in Australia.
What defines a bariatric patient, client or resident?

- The definition of what constitutes a ‘bariatric’ patient is a point of contention for a number of services within the journey of bariatric patient care.

- The Australian Safety & Compensation Council state the while a BMI of at least 30 is seen as a useful trigger point to implement bariatric care procedures, its use is limited in informing other procedures such as purchasing.

Source: Australian Safety & Compensation Council, 2009, p. 10
Language used

- Obesity
- Bariatric
- Patient of size
- What do you used or have heard used?
BMI & Obesity

- The index weight/height$^2$ was first described by in the 19th century (Adolphe Quetelet).

- It was reinvented in the 1950s and called the body mass index. (Ancel Keys)

- Obesity is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m$^2$).

- The WHO definition is: a BMI greater than or equal to 30 is obesity.

BMI is calculated using the formula BMI = kg/m2, where kg = person’s weight and m = height in metres.
First bariatric patient definition

- Guidelines for the Management of Occupational Health and Safety (OHS) Issues Associated with the Management of Bariatric (Severely Obese) Patients 2005

- **Bariatric Patient** - An internationally accepted term applied to patients whose weight far exceeds recommended guidelines, and where body size restricts their mobility, health, or access to available services. Their weight increases morbidity and mortality, and causes numerous care challenges1. (Morbidity refers to conditions inducing disease, and mortality refers to the increased likelihood of death2.)

Obese clients with bariatric needs

- Flag admissions who are defined as obese by BMI
- Use the Edmonton Obesity Staging System
- THEN use a bariatric needs matrix to best manage their care - 2017
- Nutrition assessment
- Skin
- Mobility
- Equipment requirements
- Language used in medical histories
EOSS: EDMONTON OBESITY STAGING SYSTEM - Staging Tool

**STAGE 0**
- **NO** sign of obesity-related risk factors
- **NO** physical symptoms
- **NO** psychological symptoms
- **NO** functional limitations

*Case Example:*
Physically active female with a BMI of 32 kg/m², no risk factors, no physical symptoms, no self-esteem issues, and no functional limitations.

**STAGE 1**
- **Patient has obesity-related SUBCLINICAL risk factors**
  (borderline hypertension, impaired fasting glucose, elevated liver enzymes, etc.) - **OR** -
- **MILD** physical symptoms - patient currently not requiring medical treatment for comorbidities
  (dyspnea on moderate exertion, occasional aches/pains, fatigue, etc.) - **OR** -
- **MILD obesity-related psychological symptoms** and/or mild impairment of well-being
  (quality of life not impacted)

*Case Example:*
38 year old female with a BMI of 39.2 kg/m², borderline hypertension, mild lower back pain, and knee pain. Patient does not require any medical intervention.

**STAGE 2**
- **Patient has ESTABLISHED obesity-related comorbidities requiring medical intervention**
  (HTN, Type 2 Diabetes, sleep apnea, PCOS, osteoarthritis, reflux disease) - **OR** -
- **MODERATE** obesity-related psychological symptoms
  (depression, eating disorders, anxiety disorder) - **OR** -
- **MODERATE** functional limitations in daily activities
  (quality of life is beginning to be impacted)

*Case Example:*
32 year old male with a BMI of 36 kg/m² who has primary hypertension and obstructive sleep apnea.

**STAGE 3**
- **Patient has significant obesity-related end-organ damage**
  (myocardial infarction, heart failure, diabetic complications, incapacitating osteoarthritis) - **OR** -
- **SIGNIFICANT** obesity-related psychological symptoms
  (major depression, suicide ideation) - **OR** -
- **SIGNIFICANT** functional limitations
  (eg: unable to work or complete routine activities, reduced mobility)
- **SIGNIFICANT** impairment of well-being
  (quality of life is significantly impacted)

*Case Example:*
49 year old female with a BMI of 67 kg/m² diagnosed with sleep apnea, CV disease, GERD, and suffered from stroke. Patient’s mobility is significantly limited due to osteoarthritis and gout.

**STAGE 4**
- **SEVERE** (potential end stage) from obesity-related comorbidities - **OR** -
- **SEVERELY** disabling psychological symptoms - **OR** -
- **SEVERE** functional limitations

*Case Example:*
45 year old female with a BMI of 54 kg/m² who is in a wheelchair because of disabling arthritis, severe hyperpnea, and anxiety disorder.

Sharma AM & Kushner RF, *Int J Obes* 2009
The Consumer

- Acknowledgement
- Partnership
- Show them you are there to improve their journey through the healthcare system
- Time to Care by Dr Robin Youngson
  - How to love your patients & your job
What are the attitudes towards obesity in health?

www.ausbig.com.au
A potentially vicious cycle

- Obese Condition
  - ↑ Health Problems/Co-morbidities
  - ↑ Need for Health Care/Interventions
  - ↑ Negative Feelings/Emotional Responses
  - ↑ Exposure to Bias in Health Care
  - ↑ Avoidance of Health Care
  - ↓ Self-Care/Esteem
  - ↑ Unhealthy Behaviors/

Look how fat they are! Can't they just stop shovelling food in?

How did they get like that?

www.ausbig.com.au
So how do we achieve respectful care of heavier people?
Breaking the vicious cycle with RESPECT

R - Rapport
E - Environment
S - Safety
P - Privacy
E - Encouragement
C - Caring/Compassion
T - Tact

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Obese residents in Aged Care

- Increasing
- Younger
- Bigger
- Challenges
- Funding
Bariatric Challenges in Aged Care

- Planning
- The Resident
- Buildings
- Facility design
- Guidelines
- Equipment
- Staffing
- Education
- Funding
Planning for bariatric admissions

- What sized residents do you want to plan for?
- Look at your current facility design and note what doesn’t work
- Have a bariatric planning committee
  - What have the injury rates been like?
  - Are there any bad attitudes towards obese residents or staff?
- Have a thorough admission process
  - We recommend meeting the resident

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The Obese Resident with Bariatric Needs

Two case studies
Aged care case 1

- 6 months to find placement
- About the resident
- The teamwork
- The dietary consultation
- The unexpected
- The results
- Lessons learnt
Aged care case 2

- About the resident
- The teamwork
- The OT consultation
- The unexpected
- The results
- Lessons learnt
Buildings

- Access
  - Driveway
  - Entrance canopy
  - Front entrance area and doors
  - Other entrances

- Floors
  - Coverings
  - Gradients

- Door openings
  - Widths

- Take a walk through your facility
Facility design

- Design layout
- Access
- Hallways floor coverings
- Door widths / lift sizes
- Equipment storage
- Room sizes – Hoist types
- Bathroom access

**Single Track Systems**
A single track system is installed in a fixed location and provides the possibility of transferring simply from point A to Point.

**Room Covering System (H Track)**
A Room Covering System is designed to give maximum flexibility and coverage within the room. It is often even less visible in the room as the rails are located in the corners of the room and the traverse rail can be parked at one end.

The Room covering system provides the possibility of transferring anywhere within the room, including being able to lift from the floor.

Testimonial: Liverpool Hospital installation of Guldmann GH2 (using H track)

**Fully Integrated, Multi-room systems**
Fully Integrated Systems are the ultimate in ceiling hoist systems. By using a comprehensive range of components we can provide the opportunity to cover multiple rooms with a single system including traversing doorways, hallways and corridors.

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Room design

Diagram 2

Bariatric patient room
Area 27.45 m² with caregiver area
or 23 m² without it

Diagram 3

Bariatric Washroom
Area 7.8 m²

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Design for Occupational Health & Safety

- Occupational health and safety issues are important to consider when architects are designing new buildings for the health care profession.

- There must be an understanding of how design can influence physical deterioration among health care professionals.

- It is important to design adequate space for nursing and patient handling into the building, and how we can convey the ‘hidden’ knowledge among health care to those who design.
Bariatric management guidelines

- Use your team
  - Appoint a facility bariatric champion

- Review the current practice and guidelines
  - Eg. Practices and Processes Guide August 2015. (2)

- Consult with others

- Ask questions
Bariatric Equipment

Shower Chair
- Rise and recline
- XXL 325kg

Bedside commode
- 325kg

Jazzy 1650
- 295kg

Maxicare walker
- 225kg

Gutter arm Rollator
- 170kg

Maxicare walker
- 225kg

LEJRELET
- Positioning cushions

Air Chair Evolution
- 300kg
- 530 width

Powerlift recliner Ashley
- 200kg & 275kg

Maxilift walker
- 300kg

King Single
- 250kg 1070mm width

Basic High
- 500kg
Your staff

- Safety awareness and risk management
- Bariatric education and support
- Use the RESPECT MODEL
- Team work/meeting
- Debriefing
- Reviews
Bariatric education

- No formal Australian Bariatric Education available yet.
- Many skilled people to tap into
- Access the available bariatric resources
- Attend bariatric conferences and seminars
- Obesity/bariatric associations and societies
  - AusBIG
  - AAMHP (Australian Association of the Manual Handling of People)
  - ANZOS (Australian & New Zealand Obesity Society)
  - Obesity Australia
Funding

- There are no easy answers yet
- AusBIG is involving government more
- There are some funds available from different areas
- Bariatric items often very expensive but save money in the long run by preventing injuries
- Each state’s pathway is slightly different
What costs are involved?

- Planning /management – committee time $$$$$$$$
- Access
  - Infrastructure – new builds – refurbish $$$$$$$$$$$$$$$$$$$$
- Staffing – 1-3 extra hands-on plus –more if lacking equipment
- Education - $$$$$$$$
- Equipment eg beds BUY $3-$20,000 RENT $70-$150/week
  - Management/training/maintenance/replacement $$$$$$$$$$
- Injury -
  - average injury payouts $60+
3 Recommendations

- First, resident and staff safety must be a priority.
- Second, appropriate equipment and supplies to prevent or minimize complications associated with obesity must be provided.
- Finally, appropriate staffing, support of an interdisciplinary team approach, and financial implications of caring for this population must be addressed.
References

3. Weighing the cost of obesity, Obesity Australia
References

12. Time to Care, Dr Robin Youngson
13. Obesity, Disability, and Nursing Home Admission
   Author(s): Holly C. Felix, PhD, MPA Issue Number: Volume 16 - Issue 7 - July, 2008
   http://www.annalsoflongtermcare.com/article/8961#sthash.Xlu2Jgco.dpuf
14. Caring for Obese Individuals in the Long-Term Care Setting –
   http://www.annalsoflongtermcare.com/content/caring-obese-individuals-long-term-care-setting#sthash.2MLZVze0.dpuf
16. Younger people with disability in residential aged care 2010–11 Retrieved from
17. Management of bariatric (severely obese) residents/clients in the aged care sector- Six fact sheets, funded by Employers Mutual, as part of their Member Benefits Program, and initiated by Elanora SYP Homes Inc.
   - Fact Sheet 1 Needs and considerations of the bariatric client in aged care
   - Fact Sheet 2 Designing a safe environment for the bariatric client in aged care
   - Fact Sheet 3 Weight bias affecting the management of the bariatric client in aged care
   - Fact Sheet 4 Needs and considerations of staff managing the bariatric client in aged care
   - Fact Sheet 5 Needs and considerations of the aged care industry when dealing with the bariatric client in aged care
   - Fact Sheet 6 Equipment required for the safe management of the bariatric client in aged care
18. NHANES
QUESTIONS?
GENERAL DISCUSSION