Question:

I am not sure that this question pertains to using equipment so much as getting equipment. I just can't seem to get the appropriate equipment our bariatric patients need through conventional methods.

ASKQUIP Answer:

Consider the following excerpt from the article titled "The Challenges of Bariatric Care: A 1-size-fits-all care model fails to meet the complex needs of bariatric patients or prevent the risk of injury to their caregivers."

Some clinicians find that approaching introduction of equipment through conventional methods is fruitless. Although anecdotal, clinicians have been known to introduce specially-designed equipment for one specific patient by simply appealing to those in decision making roles. Consider, William, a 475 pound man with bilateral hip ulcers due to a bed that accommodated his weight but not his width. Ellen, the wound expert, knew she had met obstacles in introducing equipment house wide, but felt she could make a difference in William's outcome, so this is what she did: collected the equipment brochures of the equipment William was using , and the equipment he needed, prepared a single page sheet describing the differences in equipment, copied an academic article describing pressure ulcer formation among the obese patient with a detailed section on ill-fitting equipment, then she took photographs of the skin breakdown. Once she prepared the tools she felt she needed, she made 15 minute appointments to speak with the materials manager, her immediate supervisor, and William's unit supervisor. By the end of the day, she had the equipment William needed. This method is certainly unconventional and seldom useful for long term change, but as a patient advocate she was able to accomplish her goal. Taking this a step further, she could carefully monitor the patient and at a later date present the data to the Performance Improvement/Risk Manager to determine if this process should be in place for all patients meeting certain criteria.

Performance Improvement (PI), based on the principles of CQI seeks to make changes that improve the therapeutic, cost, and satisfaction outcomes associated with patient care. Decisions need to be made by those individuals closest to the patient, decisions must be customer-focused, and change must continue to be on-going. Ellen, the wound expert handling William's care, was in a perfect role for making changes for his care, but also to serve as an ad hoc member of the performance improvement effort when skin care among bariatric patients was discussed.

Gallagher S. The challenges of bariatric care: A 1-size-fits-all care model fails to meet the complex needs of bariatric patients or prevent the risk of injury to their caregivers. *ECPN: Clinical and Financial Strategies for the Extended Care Professional.* 2005; 101(6):18 - 25 Ba

Please submit your questions to ASKQUIP at, info@sizewise.net or fax them to 816-841-0109.

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Editor's note

One size does NOT fit all . . .

In making rounds late last year, I met several nurses who asked how they might best manage patients who refuse size- and -weight appropriate specialty equipment. As an advocate for reasonable accommodation, which includes use of equipment, I was perplexed and spent the next few days asking this question to other clinicians. This issue of XTRAWise addresses that subject, in particular: What is our obligation to patients and their families to successfully introduce the use of specialty equipment and what is the patient's obligation to accept equipment that is designed to promote patient safety and prevent caregiver injury? I recently put together a survey tool and asked nurses to help me discover *why this happens* and *how it can be managed*. At the heart of the isssue is Beuchamp and Childress' theory of paternalism, which is described as a conflict between patient autonomy and clinician beneficence. For example, patients have a legal and ethical right to refuse treatment, equipment and care, however, clinicians who have the patient's best interest in mind speak the language of beneficence. Tension always exists between respect for personal autonomy and beneficence—this is paternalism. Caregiver injury is reviewed as there are legal mandates and moral obligations to protect caregivers, further complicating issues of patient refusal. A case study is included that illustrates the topic, one size does NOT fit all.

I welcome your thoughts!

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FIRST PERSON ACCOUNT

Bill, a 38-year-old, 480 pound, frequently admitted patient, was being processed as an inpatient through the emergency department. The hospital had always had a little trouble managing Bill's needs and 18 months ago a committee had been formed to develop a criteria-based protocol which included a task force, pre-planning tool, education and outcome studies. Anna had been instrumental in making this happen—she had her reasons and they were both personal and professional. She currently works in the Risk Management department of the local hospital, but three years ago she was an Emergency department nurse at the large, very active, urban trauma center. She was injured helping the emergency transport team move a 320 pound laboring woman onto a gurney. Anna's injuries were extensive and costly, both directly and indirectly—her life would never be the same. At that time she promised to make things different, not only for the patients but for the caregivers as well. Imagine her sense of accomplishment knowing that the protocol would be tested today, with the patient the hospital never seemed to handle properly.

She began to contact the clinical experts and ordered size appropriate equipment as the new protocol outlined. She reached Bill's admitting unit just as he did and heard him shouting that he was not a "Big Boy" and he did not need a BIG BOY bed!!! His shouts filled the entire unit…"this is so uncomfortable, I can't move, I feel like a freak".

Anna was concerned in many ways. The first was her idea of reasonable accommodation, she was so surprised at Bill's response. Secondly, she was very concerned for the clinician's safety. Upon further investigation, Anna learned that the vocabulary clinicians use and the approach taken in describing size-and-weight-appropriate equipment could be as important as the equipment itself. All stakeholders involved in this situation learned the value of communication.

Clinicians in Bill's care learned several things once they actively listened to his concerns. The first was that a very professional, matter-of-fact approach might work better. Anna learned that terms commonly used by clinicians are overtly offensive to patients and their families/friends. She also learned that one size does NOT fit all. Every patient has a unique set of needs and it important to fit the specific qualities of the product to the distinctive needs of the patient. Additionally, she learned that patients want caregivers to be confident in use of the equipment so it must be simple to operate. Bill apparently heard the caregivers explain that, "this time they wouldn't be injured because Anna had ordered a really big bed, but they had no idea how to use it".

PATERNALISM A THREAT TO PATIENT CARE

Paternalism is best described as how a parent would care for a child. In health care decision-making it creates tension as it causes conflict between the ethical ideal of respect for personal autonomy and beneficence. Beneficence is doing good for the patient—it is more than simply removing or preventing harm. Beneficence is the goal of health care, but it comes into conflict when patients express their right to personal autonomy, as health care professionals have a moral obligation to respect this right. However, the role of caregivers is to provide patients with information to make an educated decision—asserting their right to personal autonomy. In Bill's case it was easy, Anna spent some time really learning what Bill's needs and concerns were and educating him on the benefits of the specialty equipment. As a result, Bill made the to accept the specialty equipment. It is not always that easy but it is in the best interest of patient and caregiver safety for organizations to consider patient refusal and have a plan in place to address this threat to patient care.

Source: Beauchamp T & Childress J. *Principles of Biomedical Ethics.* Princeton University Press: 2001.
Gallagher S, Langlois C, Spacht D, BlackettA, Henns T. preplanning protocols for skin and wound care in obese patient. *Advances in Skin and Wound Care.* 2004;17(8):436-443.

LET'S TALK TOILETS. . .

Terry's mother, Mrs. Wong, visited her daughter every day. Terry had her gangrenous appendix removed four days prior and was improving so dramatically that she was scheduled to go home the day before her mother injured herself. The injury occurred when Mrs. Wong used the toilet in Terry's bathroom. Mrs. Wong, at 415 pounds, exceeded the weight limits for the wall mounted toilet. The tragedy consequentially led to a fractured wrist and numerous porcelain splinters embedded in Mrs. Wong's hips and buttocks. The quality team at the hospital examined the reasons why this happened and methods to prevent future such injury. They learned that wall mounted toilets seldom accommodate weights greater than 300 pounds; however force exerted onto the toilet may lead to increased susceptibility to breakage and therefore injury. Mrs. Wong, as a visitor, was instructed to use the public bathroom, but the team recognized that occasionally visitors use the patient bathroom. Additionally, they learned 15 percent of all patients admitted to their facility exceeded 300 pounds. Heavy-duty, oversized commodes are not likely to address the needs of visitors, but the team recommended their introduction as an option to wall mounted toilets to protect patients from situations such that Mrs. Wong experienced. Clinicians on the team explained the commodes can either be placed over the wall mounted toilet in the bathroom, or at the bedside. Toilets, as all equipment, must accommodate the actual weight and width needs of the patients—one size does not fit all!

ONE HEIGHT DOES NOT FIT ALL. . .

The height of the bed determines how much bending and reaching a caregiver has to do. Clinicians are different heights, so a simple-to-operate, height adjustable bed is important to allow bed height to be ergonomically appropriate to the caregiver.

Source: Back care for nurses.
Accessed at: http://www.spineuniverse.com/displayarticle.php/article1509.html

THE REAL WORLD THREAT

Every day clinicians face the real world threat of improperly-sized equipment. The case study titled, "Obesity, Hyperkeratosis, Pressure Ulcers and Pressure Relief", illustrates this. JA, a complex patient for many reasons, had initially refused properly-sized equipment. Eventually, a government advocacy group mandated use of equipment. The bariatric equipment first introduced accommodated his weight but not width. Challenges related to the width of the bed persisted. Like JA, patients can develop abdominal (sidelying), hip (supine), and other areas of breakdown when pressure from siderails is exerted onto the soft tissue. See the above mentioned case study to read more about JA, his experience and the clinical solutions to equipment that fails to accommodate both weight and width requirements of obese patients.

Access Obesity, hyperkeratosis, pressure ulcers, and pressure relief at http://www.sizewise.net

Key to preventing refusal of special equipment

- **ONE SIZE does NOT fit all.**
- **Listen to the patient and ask questions.**
- **Be aware of offensive, descriptive vocabulary.**
- **Know how to use equipment, involve the patient when appropriate.**

Source: Gallagher S. Understanding why patients refuse specialty equipment. To be announced 2005.