



Public Sector Residential Aged Care Quality Improvement Newsletter

Message from the Minister Bronwyn Pike MP

Welcome to this inaugural issue of the Quality Improvement Newsletter. The Department of Human Services Quality Improvement Unit is a new program for this Government. There is a real commitment to quality in public sector residential aged care services in Victoria. My vision is to see the public sector lead the field in the provision of quality care and services to residents living in residential aged care services.

I believe this newsletter, along with other quality initiatives will facilitate Public Sector Residential Aged Care Services to improve the quality of care and services to residents who live in those services.

I consider this newsletter will serve you well to achieve continuous quality improvement and look forward to following the issues explored in future issues.

The Quality Improvement Unit

Welcome to the first edition of the Quality Improvement Unit's bi-monthly newsletter. The Quality Improvement Unit was established in September 2000, as part of the State Government's commitment to providing quality residential aged care in the public sector. The Unit's role is to assist services to meet and exceed the requirements of accreditation, and implement sustainable quality improvements. We seek to achieve this by conducting on-site visits to individual services and facilitating bi-monthly education workshops. To date, the Unit has been primarily working with service's awarded less than three years accreditation. However, the Unit plans to visit remaining public sector services within the next eight months, as well as open up our education workshops to these services. In the meantime, we hope our bi-monthly newsletter serves as a good vehicle to communicate with the sector on a range of issues affecting aged care. In this issue we feature articles by two different seminar presenters that explore the issue of resident restraint.

Victor Harcourt, Partner, Russell Kennedy Solicitors explores some of the medico-legal issues surrounding restraint use; and, Christine Culhane, Pharmacist from the Mental Health Research Institute's Psychotropic Drug Advisory Service, writes about Chemical Restraint.

Also in this edition is information on kitchen and laundry practices, as well as an excerpt from a service's accreditation report. We plan to print an 'unacceptable' finding from these reports in each edition so you can compare your own service's performance against an outcome rated unacceptable by the Aged Care Standards Agency. While we don't wish to dwell on the negative, we believe a great deal can be gained from sharing these findings.

The Aged Care Standards Agency also makes its own contribution to this edition of the newsletter, with an article on support contacts. We hope you enjoy the first issue of our newsletter and look forward to your feedback!

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MORE ABOUT US

- The Quality Improvement Unit was formed in September 2000
- In the last ten months the Unit has grown in size to five full-time project officers and a number of part-time consultants
- The Unit has over 30 years combined experience in the aged care industry
- The Unit is managed by Maree Cameron

The Quality Improvement Unit is situated at:

**Level 10, 555 Collins Street
Melbourne, 3000**

**and can be contacted on
(03) 9616 6964.**

Lessons from Standards Agency Reports

The below excerpt is taken from a 'Statement of Major Findings' from a recent accreditation audit conducted at a public sector facility. The outcome, Information Management, was rated unacceptable. How do you feel your service compares in this area? Are improvements required in your information management systems?

"Effective information management systems are not in place. There is no policy and procedure in relation to document control, and there is no mechanism to formally control the distribution of documentation.

The team found outdated documentation in a number of areas including cleaning routines, cleaning product information, fire orders and external contractor listings. System documentation is not always controlled to indicate its current status or its authorising agent.

Resident and staff handbooks have no issue date, and are not identified as being authorised documents. Changes made to documentation are not always made in accordance with documented procedure, nor are they authorised by signature or initial.

There is no procedure to guide staff in the care planning process, and there are inconsistencies in the documentation of the various components of this process.

There is no procedure to guide staff in the archiving and disposal of records, and to clearly nominate the person(s) responsible for such activities. The team observed records stored in boxes without clear identification. Old records are currently stored in various locations owing to recent change of location and building works. The team were advised that a central location for record storage has been identified. The team was also advised that no records have ever been disposed of to date. Resident and staff records are appropriately stored to maintain confidentiality.

Required Improvements:

Develop systems to ensure that all management system documentation is authorised and controlled to clearly identify its status. Develop systems to ensure that outdated or superseded documentation is removed from the system. Ensure that changes to records are made in accordance with documented procedures. Develop systems to control

the archiving and storage of documents that clearly detail legislated time frames and allocate appropriate responsibilities".

Permission was obtained from the service to print this finding.

Physical Restraints and the Medical Profession

A Legal Perspective

The Australian Medical Association has recently published a Position Statement that states that the ultimate responsibility for the decision to restrain a patient is that of the treating medical practitioner. The Statement notes that the decision involves the health care team and the consent of the patient, and it must be made within an ethical and legal framework.

The Statement, entitled 'Restraint in the Care of Older People', clearly outlines the AMA's expectations of doctors considering the implementation of physical restraints on the aged. It highlights that the decision to restrain should be the exception although it concludes with a recommendation that there should be research to determine what is 'best practice'.

"...the effective implementation of proper restraint procedures requires staff education and training..."

The Statement commences with a simple definition of restraint which encompasses any 'intervention which controls or limits movement and/or behaviour.' This definition is in my view too general as it does not recognise that there is a difference between a device used to restrict individual liberty or behaviour and a device which may be used for the safety or comfort of the resident. The latter may not in certain cases be properly viewed as a restraint.

The AMA has recognised that restraints may be harmful to residents and the potential risk or harm must be outweighed by the benefit before restraints are imposed. The restraint should not be used for convenience or to patch up deficiencies in the staffing arrangements. The Position Statement suggests that doctors should investigate the underlying causes of the need for restraints to assess whether there are more suitable alternatives and that they should only be used to facilitate patient care and to assist in the management of aggressive or challenging behaviours.

The Statement is notable for its emphasis upon having in place review mechanisms including the discussion of contentious issues and decisions. Of course, the effective implementation of proper restraint procedures requires staff education and training, a point not lost on the AMA.

The use of restraints in aged care facilities poses many clinical, ethical and legal dilemmas. The effect of the Position Statement is not to abdicate responsibility for the decision to the doctors because approved providers must still be involved in the process of assessment, review and monitoring. At each level there is considerable responsibility left with the facility and its employees.

The Position Statement can be found at the AMA website: (<http://www.ama.com.au>).

Victor Harcourt, Partner, Russell Kennedy Solicitors

Quality Action Plan

The activities of the Quality Improvement Unit complement other initiatives being developed within the Department of Human Service's Aged Care Branch to improve the quality of public sector residential aged care services.

The Department's Quality Action Plan articulates the vision and values that will drive the way in which public sector residential aged care services are provided. It also describes quality initiatives currently underway and planned for 2001/02 and identifies possible future initiatives in five key areas.

1. Identifying and promoting best practice in governance, management and service delivery.
2. Developing and implementing workforce development and education strategies.
3. Providing opportunities for information sharing and networking to support a culture of continuous improvement and peer support.
4. Undertaking or commissioning research into care and workforce issues, and
5. Policy development to promote access to quality services that are sustainable.

A copy of the Quality Action Plan will be sent to services shortly, with an invitation to provide feedback and suggestions regarding its future development. Ask to have a look and offer your input.

Aged Care Standards and Accreditation Agency Support Contacts

The Aged Care Standards Agency (Agency) conducts support visits to Aged Care Residential Services for three purposes as outlined in the *Accreditation Grant Principles 1999*. These are a) to supervise the residential care service's process of continuous improvement; b) to identify whether there is a need for a review audit; c) to give the approved provider additional information or training. Determining the need for a review audit is determining the services level of compliance with the Accreditation Standards.

The Agency conducts 3 styles of support contacts, a notified site visit, an unannounced site visit and a desk support contact.

A notified site visit is where the service is given prior notification that the visit is going to take place on a given date. This notice is approximately 7 days in advance, often longer. The date for a notified site visit will be sometime within the month identified on correspondence from the Agency outlining schedule of support contacts. The specific day of the month is not known by the service until they receive the notification letter.

An unannounced support visit (spot check) is when up to 30 minutes notice is given to a service that an assessor team will be visiting the service. The Agency conducts spot checks on services that may have a history of non-compliance or current non-compliance with the Accreditation Standards, as well as randomly on any facility that is accredited.

Receiving a spot check does not necessarily mean the service is non-compliant with the Accreditation Standards. Desk Support Contacts are conducted as per the stated schedule, these contacts are notified as arrangements need to be made to ensure the appropriate personnel can be available by phone. The process of the desk support contacts is one of taking the service contact through the Priority Action Plan or progress report and receiving a verbal report on their progress. These contacts generally take 1 to 1.5 hours.

" Receiving a spot check does not necessarily mean the service is non-compliant with the Accreditation Standards."

The process of a site visit or spot check generally take a standard format of reviewing the services continuous improvement systems and improvement outcomes. Reviewing the services progress on any required improvements outlined from previous contacts then time permitting assist the service with information on areas they could be seeking assistance with. A site visit can take from 3 to 4 hours to one or more days. Again depending on the matters that require following through.

This process can take two directions:

- If unacceptable progress with continuous improvement and or the required improvements are a finding of the quality assessors then their focus must, by obligation under the Act, focus on identifying any non compliance with the accreditation standards.
- If the quality assessors find the progress is acceptable and compliance with the Accreditation Standards is evident then they are freed up to take on a more informative/educative role.

So clearly the process of the support contact is determined by the service, in that it is the services' responsibility to be compliant with all of the Accreditation Standards and Expected Outcomes at all times. If this responsibility is met then the support visit process can be flexible.

Service providers must ensure their continuous improvements systems remain active and effective. This also is a specific requirement under the Act. The Agency is paying particular attention to services improvement through continuous improvement since their last site audit.

Victorian and Tasmania Office

Aged Care Standards and Accreditation Agency

Check Your Practices Infection Control in Laundries and Kitchens

Every newsletter we plan to include information about good practice in all areas of service delivery. We encourage you to check your practices against this information. In this edition we look at kitchen and laundry practices.

Laundry

The below information is taken from the Australian/New Zealand Standards for Laundry Practice (AS/NZS 4146:2000). The collection of soiled linen and the delivery of clean linen should, where applicable, comply with the following:

- Where soiled linen is handled in a mobile trolley, the loading and unloading operation should be carried out on a flat surface.
- Soiled linen and clean linen should be transported on different trolleys, bins, bags or other transport means. If this is not practicable, then trolleys, bins, bags or other transport means that were used to transport soiled linen should be thoroughly cleaned and dried before being used for transporting cleaned linen.
- Bags containing soiled linen should be handled carefully to avoid damage and the release of possible contaminated aerosols into the air.

More information on Australian/New Zealand Standards can be obtained from the Standards Australia website:

www.standards.com.au

Kitchen

The Guidelines for Safe Food Preparation in Health Care facilities state that it is best to minimise the handling of cooked food after cooking. To prevent cross-contamination of cooked foods, food handlers should:

- Cover all food during storage.
- Store raw meat cooked meat and ready to eat food in the refrigerator.
- Wash and sanitise utensils like knives, boards and meat slicers after each use.
- Have separate utensils for raw and cooked food wherever possible.
- Sanitise all food contact surfaces
- Thoroughly wash all garnishes such as raw parsley, and
- Practice good personal hygiene.

Copies of the Guidelines for Safe Food Preparation in Health Care Facilities can be obtained from Food Safety Victoria, telephone 1300 364 352. The publication is also available on the internet at www.foodsafety.vic.gov.au (a very informative website that is well worth a visit).

Chemical Restraint-Demystifying the Myths

In discussing or considering the issue of chemical restraint there are a number of issues that need to be addressed.

1. What is chemical restraint?
2. What drugs are used to restrain?
3. How effective are they?
4. When to do it?
5. What to document?

Definition:

The available literature does not provide a definition of chemical restraint, however, the Federal Aged Care document outlining the rights of residents in aged care facilities implies that any time you administer a medication to modify the behaviour of a resident then it is deemed chemical restraint.

The Drugs

The agents used to modify behaviour are primarily the medicines used as psychiatric treatments. When these agents are used to manage a diagnosed psychiatric disorder, it is not considered chemical restraint. For example, an antipsychotic administered to treat delusional beliefs or hallucinations associated with psychosis is appropriate treatment for psychosis. It may also relieve anxiety and reduce aggressive behaviour resulting from the psychotic symptoms. But that same antipsychotic used to sedate a person because they are agitated or aggressive where there is no psychosis is considered restraint.

There is considerable overlap of symptoms of dementia patients and those with primary psychiatric disorders and the boundaries for various treatments can be blurred. There is the added complication that many elderly people have a number of physical ailments that require medication. This increases the possibility of adverse effects and drug interactions. Dosing medications can be problematic because of altered sensitivity to drugs and other age-related physical changes such as metabolism and excretion.

Antipsychotic Agents

Both typical (old) and atypical (new) antipsychotics have been used to manage behavioural symptoms in dementia patients. The older antipsychotics (Largactil, Melleril, Serenace, etc) have a small but significant efficacy advantage over placebo but the side effect burden was comparable to their efficacy. There was no difference between agents so tolerability defines choice of agent. New antipsychotic agents (Risperdal, Zyprexa, Seroquel) have comparable efficacy to the older agents but the targeted symptoms can differ, for example, Risperdal was more effective than Serenace for managing aggressive symptoms in one comparative trial. Side effects can be problematic. The elderly are more susceptible to drug induced Parkinsonism, tardive dyskinesia, etc and there is an increased risk of falls. Drug interactions with other medicines can be an issue.

Antidepressant Agents

Correct diagnosis and management of an underlying depressive or anxiety spectrum disorder can alleviate associated distress and behavioural problems. Symptoms that can improve include restlessness, confusion, irritability, anxiety, fear-panic and depressed mood.

Mood Stabilising Agents (anticonvulsants)

Both Epilim and Tegretol are modestly successful for the management of physical agitation and aggressive behaviours. Monitoring blood levels is most useful for compliance and toxicity rather than therapeutic effect. There are a number of clinically significant drug interactions with these medicines that can limit their usefulness. Occasionally, these agents cause blood disorders so the resident must be monitored.

Anxiolytic Agents (sedatives/hypnotics)

The most common agents are benzodiazepines (Serepax, Ativan, Normison, Temaze, etc). They can alleviate symptoms of anxiety but do not address the cause of the problem. They are associated with ataxia, slurred speech, sedation and an increased risk of falls.

Other drugs have been used to try and modify behaviour in nursing home residents. With an increasing amount of data becoming available, chemical restraint practices should be reviewed often.

Documentation

Where other behavioural management techniques have failed, chemical restraint may be the only remaining option. Problem behaviours should be documented over a period of time to determine whether there is a pattern that may give clues to a cause and possible solution. Appropriate changes to the physical environment and behavioural techniques should be tried before restraint (either physical or chemical). The techniques employed and the outcomes should be documented in the person's case notes. Where practicable consent for restraint should be obtained from the person or their primary carer/family and this should be included in the case file.

...any time you administer a medication to modify the behaviour of a resident then it is deemed chemical restraint".

Conclusion

Restraint may be necessary and appropriate to protect the resident or others from potential harm. Appropriate changes to the physical environment and behavioural techniques should be employed before restraint. Consent should be obtained whenever practicable and the process documented in the resident's file. Where chemical restraint is used, the effectiveness or otherwise of the intervention should be documented to minimise the risk to the patient. Many behavioural problems in the elderly are ultimately self-limiting, so medication reviews should be performed regularly to ascertain whether on-going treatment is necessary and if there is no longer a need, it can be discontinued.

*Christine Culhane, Pharmacist
Psychotropic Drug Advisory Service*

Do you know of any good aged care related web sites? Let us know and we will print them in future editions.

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References

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Australian/New Zealand Standard AS/NZS 4146:2000—Laundry
Practice
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Guidelines for Safe Food Preparation in Health Care Facilities
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Residential Aged Care Quality Improvement Unit
10/555 Collins Street
Melbourne 3000

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Phone: (03) 9616 6964

Fax: (03) 9616 8682

Email: kathryn.mcnulty@dhs.vic.gov.au
(0161001)

