



Public sector residential aged care quality improvement newsletter

Contents

Doing time with the Aged Care Quality Improvement Unit	1
Depression in long-term care: a challenge	2
Hot topic – occupational violence	3
Promoting continence and managing urinary incontinence	3–5
What's happening in 2004?	6
<i>The Medical Treatment Act 1988 (Vic)</i>	6
Did you know?	6
Check your practice – resident information	7
High risk clinical indicators	7–8

Doing time with the Aged Care Quality Improvement Unit

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During November 2003 I had the opportunity to spend two weeks, as an observer, with the Department of Human Services (DHS) Aged Care Quality Improvement Unit. The placement was organised as part of my University studies, which includes completing a professional practicum that relates to my work and area of study. I approached the Aged Care Quality Improvement Unit (QIU), as I had contact with them within my current work place, and believed I would be able to learn from the team and gain from their expertise. I was also interested to experience DHS from an 'insiders' perspective, as my only experience with DHS was from the health service 'external' perspective.

The experience I had with the Aged Care Quality Improvement Unit was valuable and interesting. I was welcomed into the Residential Services Unit and was included into the QIU team with enthusiasm. I was able to participate in team and unit meetings, review reports, meet managers within the unit, and gain an understanding of the role and scope of the Residential Services Unit. During the placement I was also invited to visit public sector nursing homes and hostels, and participate in reviews conducted by the Aged Care Quality Improvement Unit. I believe I gained the most from visiting other facilities,

and the discussions I had with the Quality Officers resulting from these visits were extremely useful in increasing my knowledge of Aged Care Quality.

The Quality Officers from the QIU visit and review all public sector residential aged care facilities, and therefore they possess a wealth of knowledge that can be accessed and used by the public sector. Unfortunately, as the Quality Improvement Unit is a DHS unit, some may view the QIU as another form of compliance system and consider them a hindrance to health service operations. This view is understandable, especially if a facility is having difficulty meeting Aged Care Standards Agency standards, and also has other pressures, such as funding and staffing issues. However, having spent time with the QIU, it was obvious the team are there to assist facilities to meet the Commonwealth aged care standards. I observed the team assisting facilities through gap analysis, education, and documentation review.

The experience I gained through the placement has given me a more thorough understanding of quality in aged care, and how the QIU can assist facilities. This experience was invaluable, and I would encourage others who are interested in enhancing their knowledge in aged care and quality to contact the Aged Care Quality Improvement Unit.

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The Quality Improvement Unit is situated at:

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Depression in long-term care: a challenge

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Elderly people in long term or residential care are often depressed, and sadly, that depression is not always recognised. Sometimes it is missed because people put on a brave face and keep their feelings to themselves. Sometimes it is missed because we do not look for it,

and sometimes it is missed because we take for granted that this is the natural state for an old person in care to be in.

While not all people who are depressed can be helped, many can. The first step in helping is recognising the problem, and sometimes it is easier to look for circumstantial evidence of depression rather than the depression itself. The survey carried out under the

Commonwealth funded Challenge Depression, provided information that allows us to draw a profile of the circumstances that contribute to most of the depression we see in residential care. This profile is based on 13 items from the national survey form that were strongly associated with depression. They are summarised as questions in the table.

	Yes	No
1. Did any of the resident’s relatives, the ACAT or the GP describe him/her as being depressed before they were admitted?		
2. Does the resident describe themselves as being unhappy about the admission?		
3. Did the resident have any problems settling in, particularly with establishing good relationships?		
4. Is the resident having any problems with the staff?		
5. Is the resident grieving over the loss of opportunities, or abilities, to take part in activities they value?		
6. Does the resident take an active part in activities when he/she attends them?		
7. Is the resident grieving over the loss of their privacy or dignity?		
8. Is the resident grieving over separation from a spouse or child?		
9. Is the resident in pain?		
10. Has the resident had a stroke?		
11. Does the resident have a visit from a friend or a relative at least once a week?		
12. Does the resident regularly help another resident or staff member?		
13. Is the resident having problems with other residents?		

These questions alert us to the need to ask relatives, GPs, ACATs etc about depression prior to admission. To be particularly alert to the effects of the admission. To watch for signs of grieving over the loss of opportunities, abilities, privacy, dignity, and intimate relationships. To routinely look for and treat pain, and to foster friendly relationships with staff and other residents, especially relationships that provide the potentially depressed person with the opportunity to help others. The survey indicated that when there are 3 or more ticks in the grey boxes there is a

strong likelihood that the person will be depressed, and should have a thorough assessment. This assessment may begin with the use of the Geriatric Depression Scale. If it becomes clear that the person is depressed then a referral to the GP or the mental health team should take place. However, as the questions show, there are circumstances associated with depression that fall outside of medical issues. These challenge us to ensure that we are designing and running our services to minimise the trauma associated with relocation and admission, to recognise

that people grieve over the loss of things that we can have some control over, e.g. privacy, dignity, and opportunities to engage in meaningful activities, and to provide opportunities for relationships that involve the person in helping others. Simple to say but a real challenge to put into practice. The ‘Challenge Depression’ video and manual are available from Richard Fleming for \$50 plus \$8 p&p. Orders may be emailed to rfleming@dementia.com.au.

Hot topic – occupational violence

Occupational violence is an increasing type of reported injury in the health and aged care sectors.

Occupational violence is defined as any incident where an employee is physically attacked or threatened in the workplace. The term applies to all forms of physical attacks on employees including:

- striking, kicking, scratching, biting, spitting, or any other type of direct physical contact;
- pushing, shoving, tripping, grabbing;
- any form of indecent physical contact.

The definition also covers situations where an employee is attacked by a person who may not be able to form intent, but is capable of violence. For example, a nurse is punched by a resident who has acquired brain injury.

In February 2003, WorkSafe Victoria released a 'Guidance Note on the Prevention of Bullying and Violence at Work'. The guidance note provides practical information on how to identify hazards, and assess and control the risks of occupational violence, and contains a three-part case study for an aged care facility.

A copy of the 'Guidance Note on the Prevention of Bullying and Violence at Work' can be downloaded from

http://www.workcover.vic.gov.au/dir090/vwa/home.nsf/pages/Publications_Main and search for 'Guidance Note on the Prevention of Bullying and Violence at Work' under 'General Publications'.

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Promoting continence and managing urinary incontinence

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Do you think the majority of residents in your care appear to have urinary incontinence? It would be easy to think that everyone living in an aged care facility – high level or low level – is incontinent. Incontinence problems account for one of the major reasons why individuals are admitted to residential aged care facilities – along with falls and impaired cognition such as dementia. However, we know that with good assessment and assistance with maintaining good bladder habits, many residents of aged care facilities can be helped to become continent, or have their incontinence minimised.

Urinary incontinence is estimated to effect one in twenty Australians (Continence Foundation of Australia 1998). It is a debilitating disorder, and can affect the sufferer physically, psychologically, socially, and economically. Although urinary incontinence can affect all age groups, women, the elderly, and the disabled are particularly vulnerable.

Urinary incontinence is commonly defined as the involuntary loss of urine that is a social or hygienic problem and is objectively demonstrable (Abrams, Cardozo et al. 2001).

To remain continent each person needs:

- A bladder that stores and expels urine;
- Urethral sphincters that allow storage and expulsion of urine;
- A pelvic floor strong enough to support the bladder and assist urethral closure;
- A nervous system transmitting information to and from the bladder and brain;
- A brain that can interpret body sensations and make appropriate decisions;
- Adequate mobility to get to and use the toilet;
- Adequate dexterity to use the toilet and clean her/himself (Hunt 1993).

Anything that interferes with the above can give rise to incontinence.

Incontinence compared with inappropriate voiding

Continence involves the ability to store urine and void at will, in suitable places and at convenient times. Elderly people may experience a need to void urine with greater frequency than younger people.

It is important to differentiate between *incontinence* and *inappropriate voiding*.

Incontinence is a failure of the mechanisms associated with normal storage and voiding of urine – so that *involuntary* passing of urine occurs in inappropriate places or inappropriate times. The involuntary loss of urine must be able to be objectively demonstrated

– which is where good observation of a resident and good recording on a continence chart is so important. A continence management plan, which may include a variety of strategies, for example, bladder re-education, one of the toileting programmes, as well as the use of absorbent products, will do a lot to restore the quality of life for the sufferer.

Inappropriate voiding, or urinating, however is characterised by failure to void appropriately following recognition of the need to urinate. For example, a person might recognise the need to void but use an inappropriate place or receptacle, perhaps the bottom of the wardrobe or a plant pot. Often this occurs in people with some form of impaired cognition – perhaps one of the dementias. Again good observation is needed. Often, a resident with inappropriate voiding can be re-educated to use the toilet, or helped with a habit toileting programme. Absorbent pads are often not a successful management plan for someone with inappropriate voiding – but a combination of a behaviour and continence programme can be highly successful.

Check for transient causes of incontinence

Because of the difficulty in deciding between *incontinence* and *inappropriate voiding* in older people, particularly if they have some form of impaired mental

status, it is necessary to try to assess for and treat the most common causes of transient incontinence.

DIAPPERS has been coined to help us remember what to look for (adapted from Fonda, Benvenuti et al. 2001):

- **Delirium** – a confusional state characterised by fluctuating inattentiveness and disorientation. Its onset occurs over hours to days and is often confused with dementia or depression. Delirium can result from the effects of medication, acute illness e.g. congestive heart failure, infection, or deep vein thrombosis. These illnesses sometimes do not present typically in older people – urinary incontinence maybe the first abnormality detected. The consequences of not recognising and treating delirium can be death.
- **Infection** – symptomatic urinary tract infection. However, not all UTIs are symptomatic – asymptomatic UTIs are not usually associated with incontinence.
- **Atrophic urethritis or vaginitis in women** – can result in urgency and pain on voiding. Treatment with low-dose oestrogen is usually very helpful.
- **Pharmaceuticals** – or medicines. This is one of the most common causes of incontinence in older people and given the number of medicines older people use, it is particularly important to undertake a medication review with the help of a pharmacist and the general practitioner for any resident who has

urinary incontinence. Medicines to look out for include long acting sedatives/hypnotics, such as diazepam; loop diuretics such as bumetanide; antidepressants, opiates, anti-parkinsonian drugs and anticholinergic agents. Do not forget to include any over-the-counter medicines that a resident might use – many contain anticholinergic agents.

- **Psychological states** – such as depression and anxiety states. This is definitely when you will need assistance from the general practitioner or local geriatrician.
 - **Excess fluid intake or output** – this may be caused by diuretics or other medicines. Excess fluid output is not common in older people – usually we are struggling to ensure residents in aged care facilities get enough fluid! However, if you suspect that excess fluid output is a problem you will need to talk with the resident's general practitioner. The key is an accurate fluid intake and output chart.
 - **Restricted mobility and/or a hostile environment** – termed 'hostile' because some environments are not helpful to an older person wishing to get to the toilet.
 - **Stool impaction or severe constipation** – this can be associated with both faecal and urinary incontinence. The key is an accurate bowel chart.
- Transient causes of incontinence may persist if left untreated.

Assessing the person and the problem

The assessment of a person in an aged care facility goes beyond a bladder chart – consider the following:

<p>Complete history</p> <ul style="list-style-type: none"> • Resident’s perception of the problem • Date of onset <p>Plus:</p> <ul style="list-style-type: none"> • Nursing history • Medical history • Medication review – many medicines can be the cause of incontinence • Previous surgery 	<p>Physical examination</p> <ul style="list-style-type: none"> • Mental awareness • Psychosocial • Physical status • Mobility • Dexterity • Activity tolerance • Environment <p>This is where the GP and the nursing/care staff can work together to assess the resident.</p> <p>Changes in the environment can make it easier for a resident getting to the toilet on time.</p>
<p>Bladder chart: check for</p> <ul style="list-style-type: none"> • Frequency? • Volume? • Urgency? • Circumstances? • Activity? <p>The aim is to have a well filled in chart so that it will help you make a decision about the type(s) of incontinence being experienced. A well filled in chart will also help you choose, if necessary, the size of absorbent pad that might be helpful – wearing too big or too small a pad is unhelpful and uncomfortable. It is also expensive.</p>	<p>Remember also to undertake a:</p> <ul style="list-style-type: none"> • Urinalysis, or • MSU <p>It is necessary to treat a UTI.</p>
<p>Bowel chart</p> <ul style="list-style-type: none"> • Constipation can be a factor in some incontinence – both urinary and faecal, so make sure that the resident is being monitored carefully for constipation. 	<p>Fluid intake</p> <ul style="list-style-type: none"> • Are you sure that the resident is having enough fluid? Many residents need a lot of encouragement to drink sufficient for their needs – enlist everyone’s help.

Getting help

Sometimes working out why an older person might be incontinent of urine is very difficult – it might not be clear or there might be several possible causes happening at the same time. Then a referral to others for help can make the

difference. The local Continence Clinic might be able to advise – information about the nearest one can be found by contacting the National Continence Helpline on 1800 33 00 66.

In addition, your local Geriatrician is a knowledgeable person. Don’t forget that

both a physiotherapist and an occupational therapist might be helpful to advise about mobility, changes to the environment, or about clothing that might make it easier for the resident to be self-sufficient.

What's happening in 2004?

2004 – International Year of Rice and the struggle against slavery and its abolition

May

2nd – 8th	Heart Week
7th	Heart Day
8th	World Red Cross Day
10th – 16th	National Volunteer Week
15th	International Day of Families
23rd – 29th	National Palliative Care Week
31st	World No – Tobacco Day

June

5th	World Environment Day
31st May – 6th	Multiple Sclerosis Week
20th	World Refugee Day

July

11th – 17th	National Diabetes Week
18th – 24th	National Glaucoma Week

August

22nd – 27th	Hearing Awareness Week
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September

19th – 25th	Dementia Awareness Week
21st	World Alzheimer's Day
21st	International Day of Peace
20th – 26th	National Stroke Awareness Week

October

1st	International Day of Older Persons
10th	World Mental Health Day
10th – 16th	Foot Health Week
17th – 23rd	Carers Week
24th – 29th	Work Safe Week

November

14th	World Diabetes Day
16th	International Day of Tolerance

December

3rd	International Day of People with a Disability
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The Medical Treatment Act 1988 (Vic)

The *Medical Treatment Act 1988 (Vic)* (the Act) clarifies law relating to the right of patients to refuse medical treatment, and allows a person to appoint someone to make decisions about their medical treatment when they are no longer able to do so. The Act also gives protection to medical practitioners, and people working under their direction, who comply with refusal of treatment certificates.

The Victorian Government is informing the Victorian community about the Act and how it works. In June 2003 all public and private hospitals and GP group practices in Victoria received posters and information sheets on the Act.

For further information see www.health.vic.gov.au/mta

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Did you know?

Tabulam and Templer Home for the Aged was the only residential aged care service in Victoria to achieve a commendable rating during the accreditation round of 2004. You can read their report at www.accreditation.aust.com

The following resources are available on the Internet:

Ageing in Place: a guide for providers of residential aged care
<http://www.health.gov.au/acc/publicat/ageplace.htm>

Guides for aged care leaders
<http://www.health.gov.au/acc/publicat/general/achse.htm>

Well for Life Kit – Improving nutrition and physical activity for residents of aged care facilities
<http://www.health.vic.gov.au/nutrition/wellforlife.htm>

Check your practice – resident information

Resident Handbooks or Information Brochures are an effective means of communicating important information about the care and services offered by your facility to clients and prospective clients. Below are some issues to consider when developing or reviewing the written information provided to residents. Please note, this list is not exhaustive.

- Does your resident information include the facility's street and postal address and telephone number, general information about the health service, and the aims of your residential aged care services?
- Would a description of the accommodation and amenities be useful, such as ensuite bathrooms, furniture and bedding available, areas to entertain guests, and details of the emergency call and security systems?
- What are the arrangements for residents who wish to install a telephone/air-conditioner, hang a picture, or use electrical appliances in their rooms?
- What provision is made for residents who smoke?
- Is information included about meal times as well as arrangements for morning and afternoon tea, supper and snacks; linen and laundry services, arrangements for dry cleaning and clothing repairs; cleaning and maintenance requests?
- What is the level of health, personal and specialised nursing care provided, and are there any conditions on residents being able to age in place?
- What medical, pharmacy, and allied health services are available?
- Is there a policy statement about the value of a restraint-free environment, due to the side effects and risks of restraint?
- When are resident fees payable and what are the arrangements when fees increase?
- Would it be useful to outline the conditions of social and hospital leave?
- Is there an outline of in-house and community activities, transport services, and contact telephone numbers for local services?
- What avenues are available to residents to make a suggestion, comment or complaint, and are details of external advocacy agencies provided?
- Would a statement of occupational health and safety considerations be helpful?
- What are the fire safety systems and the emergency evacuation orders applicable for residents?
- What are the staffing arrangements on a 24-hour basis, and would a statement about staff qualifications and training requirements be instructive?
- Does the information provided include a floor plan showing the resident's room?
- What are the service's security of tenure provisions?

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High risk clinical indicators

At the July 2003 Quality Improvement Seminar, the Quality Improvement Unit facilitated discussion regarding high-risk clinical areas, and the required evidence to support the management of these risks. Approximately 150 people participated in the exercise, and the group identified several key areas and associated questions that require answers, to ensure high quality care and services to residents. One or two of these areas will be included in each of the future editions of this newsletter. In this edition, we will cover pain and diabetes management. These are two very important areas for obvious reasons. No resident should be in constant pain in residential aged care, and this area is often not comprehensively addressed, as the Resident Classification Scale does not cover it. In the last edition of this newsletter there was a report from a coronial finding relating to diabetes management. This incident highlighted the need to ensure assessment processes adequately identify and monitor risks associated with diabetes. Please note, this list is indicative only and may not include all issues that may require attention.

Diabetes

Do all residents with diabetes have individual management plans including Blood Sugar Levels (BSLs) monitoring requirements with reportable levels?

Have BSLs been charted and have they been monitored correctly?

Do protocols/care plans list common signs to look for and action to be taken for hyper/hypoglycaemia?

Do any residents require a review of their diabetes management?

Pain

Are all care staff confident that all residents experiencing pain have been identified and that their pain is being managed to the satisfaction of each resident?

Check the progress notes for the last 6 months for these residents – do they identify ongoing pain issues?

Is there effective evaluation?

Have residents having narcotics or other form of analgesia, had a comprehensive pain assessment?

Do the care plans for these residents clearly describe the types of pain they experience, their pain management including alternatives to medication and complementary therapies?

Do the care plans reflect the current issues and management strategies?

Is the management of pain and palliative care in accordance with best practice?

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References

Abrams, P., L. Cardozo, et al. (2001). 2nd International Consultation on Incontinence. Paris, Health Publications.

Continence Foundation of Australia (1998). Urinary incontinence – What is it? Melbourne, Continence Foundation of Australia.

Fonda, D., F. Benvenuti, et al. (2001). *Urinary incontinence and bladder dysfunction in older persons*. 2nd International Consultation on Incontinence, Paris, Health Publications.

Hunt, S., Ed. (1993). *Promoting continence in the nursing home. A resource for nurses working in a nursing home*. Melbourne., Continence Foundation of Australia.

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