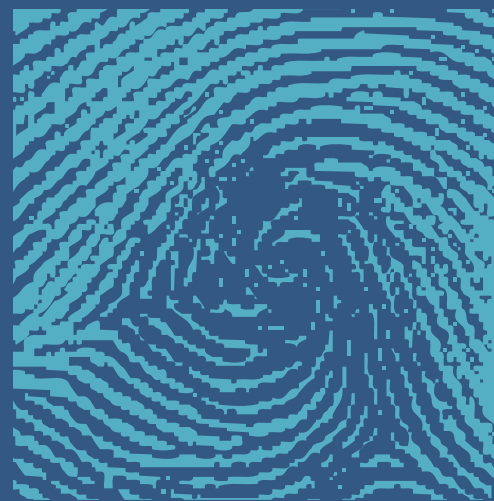


Public sector residential aged care quality improvement newsletter



Contents

<i>Did you know</i>	1 & 4
<i>Casterton Memorial Hospital</i>	2
<i>Diabetes and the elderly</i>	3
<i>An excerpt from 'The Clinical Biochemistry of Diabetes Mellitus in Singapore'</i>	3
<i>Coronial findings</i>	4
<i>Introducing and leading change in the workplace</i>	5
<i>Food contamination</i>	6
<i>Processing residents' personal clothing in domestic laundry equipment</i>	7
<i>Consumer focus in accreditation–project report</i>	7

Did you know?

Approximately 80 per cent of Aged Care Accreditation Site Audit Reports from round 2 have now been published on the Aged Care Standards Agency website. From this information it is clear there is less non-compliance than in round 1, with overall improvements throughout the industry. However, continuous improvement remains an issue, with this Expected Outcome rated the most non-compliant. On a positive note, there appears to be a marked improvement in compliance with Expected Outcome 4.4 – Living Environment. Let's hope this is related to the continued reduction in the use of physical restraint within our industry. The photo shows the new use Nathalia District Hospital discovered for bed rails.

Have you got any fabulous quality activities happening at your workplace that you would like to share with the sector? Maybe you have designed a great assessment tool or recorded amazing improvements in a particular area of practice through a planned approach to improvement. Let us know! The Quality Improvement Unit is very keen to facilitate information sharing within the sector to bring about improvements for residents and other stakeholders.



Nathalia District Hospital.

The dates for Quality Improvement Seminars for 2004 are as follows:

15 & 16 March 2004
17 & 18 May 2004
12 & 13 July 2004
13 & 14 September 2004
15 & 16 November 2004

The dates for CEO and Executive Management Seminars are as follows:

19 April 2004
11 October 2004

...continued page 4

The Quality Improvement Unit is situated at:

Level 10, 555 Collins Street
Melbourne, 3000 and can be
contacted on (03) 9616 6964.

Casterton Memorial Hospital

Have you ever considered using the services of the Quality Improvement Unit? Here, Casterton Memorial Hospital shares their experiences of the support they received from the Quality Improvement Unit.

Casterton Memorial Hospital Response to Quality Improvement Unit Visit of 7th and 8th August 2003

*Mary-Anne Betson for Owen Stephens
Chief Executive Officer
Casterton Memorial Hospital*

Casterton Memorial Hospital requested the input of the Quality Improvement Unit (QIU) approximately 8 weeks before our Aged Care Accreditation site visit was due.

Our decision to do this was based firstly on our previous experience with a visit from the unit (prior to our last accreditation), secondly because we had been rotating our RN Div 1 and 2s through the education sessions held in Melbourne (which we found to be of great value) and finally as a result of feedback from a professional colleague who recommended the value of the unit's input.

We made contact and even with the short time between contact and our accreditation, we were fortunate to have two members of the QIU visit within two weeks. This audit took place on the 7th and 8th August and we requested the focus to be on clinical care and documentation. I spoke with the members of the QIU who requested that staff interested in attending be available to undertake some scenario and case study work. 17 RN Div 1 and 2 staff presented for this session.

On completion of their stay and tour, they met with senior staff (Chief Executive Officer, Manager Nursing Services, Charge Nurse, Health Information and Quality Improvement Officers) and presented the recommendations, all of which were pertinent and achievable for our facility. The feedback from this has given all staff the confidence to continue with our quality activities. This reinforced the continuum of care model to our staff and they felt proud of what they have achieved especially in some areas such as nutrition and wound management.

We have taken on board the recommendations and we believe we will be able to use all this information in ensuring that the excellent nursing care provided is reflected in our documentation.

On behalf of the staff at CMH we wish to thank the QIU for their effort and interest in our facility and our staff. They benefited greatly from your visit, and this not only boosted their confidence in their clinical practice but general morale prior to what will be a stressful time for all our staff.

Diabetes and the elderly

Trisha Dunning

Professor Director Endocrinology
and Diabetes Nursing Research

Diabetes is a common disorder and the prevalence *increases* steadily with age. Twelve percent over 65 have diabetes and a further 11 per cent have impaired glucose tolerance. The diagnosis of Type 2 diabetes is often difficult and can be overlooked because the symptoms are non specific, or absent, and are often dismissed as ‘old age’. The majority of older people have Type 2 diabetes but Type 1 diabetes occurs in older people, and people with Type 1 grow older. Many older people already have diabetic complications and other coexistent morbidities at diagnosis.

Key management considerations:

- An holistic, collaborative management plan is essential.

- Persistent hyperglycaemia is not acceptable. It leads to lethargy, dehydration and constitutes a falls risk. It increases the risk of hyperosmolar coma and other complications.
- Regular monitoring of metabolic control, the individual’s complication status, self-care skills and medication regime are important.
- Polypharmacy is usually necessary, but can contribute to the potential for adverse events and interactions and the risk of falling.
- Hypoglycaemia can be difficult to recognise, especially in people using oral hypoglycaemic agents and constitutes a falls risk.
- Factors such as altered senses, mobility, drugs and nutritional status affect metabolic control and quality of life.

- Management should reflect individual needs and the person’s functional ability.
- Cognition can be affected by hypo or hyperglycaemia as well as dementia.
- Depression is common.
- Older people living in the community have different needs from those living in care facilities.

Management should focus on an holistic approach, achieving acceptable metabolic control, falls minimisation, appropriate timing of drugs and meals, adequate monitoring, ensuring adequate fluid intake in hot weather and giving medications and performing blood glucose monitoring to reflect meal and PEG feeding times.

© 2003 Trisha Dunning

An excerpt from ‘The Clinical Biochemistry of Diabetes Mellitus in Singapore’

The Clinical Biochemistry of Diabetes Mellitus in Singapore, Sethi SK, Wong MS, eJIFCC vol 13 no 4: <http://www.ifcc.org/ejifcc/vol13no4/130401005.htm>

Glycaemic control: monitoring of blood glucose

Diabetes mellitus is a chronic and complex disease, requiring continued life-long management aimed at reducing the high morbidity and premature mortality caused by chronic complications associated with the disease. To monitor the status of a person’s diabetes, the blood serum level can be measured on a regular basis. The measurement requires a 3- to 10- μ L drop of blood and usually takes <1 min. Although all meters take a whole-blood

sample to calculate blood glucose, some of the newer meters and/or test strips have been calibrated to provide the result as a plasma equivalent. Plasma-calibrated meters and/or test strips make it easier for comparison between glucometer and laboratory reported results. A plasma-calibrated meter will report a reading – 12 per cent higher than a whole blood calibrated meter.

The precision of such devices is highly operator-dependent and this requires meticulous adherence to the manufacturer’s instructions. Besides poor technique and inadequate amount of blood sample, other common errors are due to defective or expired test strips, incorrect calibration and instrument failure. Initial training for the use of blood glucometers should be provided by

qualified staff rather than just reading through the manufacturer’s manual. The importance of meter calibration should be highlighted. Annual reviews appear to be necessary to verify users’ competency, provide an update of the advances of glucose devices, and evaluate the correlation between capillary glucose levels on the glucometer with a simultaneous venous sample analysed by a central laboratory. Calibration checks of meters should also be conducted with standard solutions according to the manufacturer’s recommendations. Charting of day-to-day trend should form the basis of fine-tuning the appropriate therapy and to assess the efficacy of treatment for diabetes.

<http://www.ifcc.org/ejifcc/vol13no4/130401005n.htm>

Coronial findings

An incident reported on by the Coroner early this year is important to bring to your attention. The incident occurred in a private nursing home, and the resident concerned had been diagnosed as having a stenosed aortic valve causing severe cardiac failure. In addition, they suffered from renal impairment, atrial fibrillation, transient ischaemic accidents, diverticular disease and glaucoma. They were also an insulin dependant diabetic.

As we all know, insulin is administered to diabetes sufferers to respond to high levels of glucose (or blood sugar). If a diabetic has low blood sugars, the person is said to be hypoglycaemic. Insulin should be withheld in this situation and sugar given. Severe hypoglycaemia can cause coma and death. In a comatose patient, glucose has to be administered by injection or intravenously. Generally, a healthy range of blood sugars is approximately 3.0 – 8.0. It is standard nursing practice to withhold insulin administration at levels of 3.5 and below.

The resident concerned in this incident had a recorded blood sugar level of 2.6, and insulin was administered at the usual dosage. A further blood sugar was taken which showed the blood sugar level had reduced to 0.8. Glucagon was then administered. The Coroner found that the records supporting and following this period were neither accurate nor adequate.

The resident passed away the following day, with the death certificate stating the cause of death was a stroke. The attending medical practitioner did not have access to the Diabetic Management Chart that showed the administration of insulin.

Two recommendations came from the Coroner's report:

In the elderly diabetic, higher baseline values would usually be accepted to reduce the risk of hypoglycaemia. Medical practitioners, who attend residents in residential aged care, should specify individual baselines on particular charts, and the treating doctor should review these from time to time.

Routine appraisals of residents' files should be conducted in residential aged care services by senior nursing staff with the aim of improving practices in this regard.

This incident highlights the need to ensure that your assessment processes adequately identify and monitor risks associated with diabetes. Remember, it is a requirement of the Aged Care Accreditation Standards that management of the aged care service ensure residents receive appropriate clinical care and residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff (Expected Outcomes 2.4 and 2.5). Your existing processes and procedures should be able to be adapted to take the above recommendations into account.

Quality Improvement Unit

Did you know? (cont)

- The *Whistleblowers Protection Act 2001 (Vic)* is to protect people (known as whistleblowers) who come forward with a disclosure about improper conduct by public bodies or public sector employees. The Act requires public bodies to establish as soon as practicable, written procedures to facilitate the making and investigation of disclosures and to ensure the protection of whistleblowers from reprisals. Does your facility have these procedures readily available for all staff?
- The Translating and Interpreter Service, phone 131 450 toll free, provides 24 hours per day, seven days per week, on-site interpreting, phone interpreting and a translation service.
- 3RPH Information Radio broadcasts on the AM band at 1179 are designed for people who are print handicapped. Coverage includes news items from daily newspapers, the BBC World Service overnight and programs on a wide range of themes, including gardening, computers, books, travel and fashion.
- The Aged Care Standards and Accreditation Agency has two publications available on their website www.accreditation.aust.com; The Audit Handbook for Quality Assessors, and Results and Processes in relation to the expected outcomes of the Accreditation Standards.

Introducing and leading change in the workplace

‘The only person who likes change is a wet baby.’

*Lesley Whiteside
Senior Consultant
OSA GROUP*

The importance of managing change

Change management is no longer a specialist skill but one that every individual needs. With any form of change comes a degree of uncertainty. This uncertainty can often induce stress upon those affected by such change, as individuals feel insecure and not in control of their current situation. However, this associated stress response is not an inevitable outcome of the change process and, with adequate management, can be avoided.

Eight stepping stones to introducing change

Cole (1998) outlines eight key steps to managing change:

- Step 1:** Think it through first
- Step 2:** Create a common vision that defines the change exactly
- Step 3:** Communicate, communicate, communicate
- Step 4:** Address people’s concerns
- Step 5:** Develop a clear action plan
- Step 6:** Hold a ceremony to farewell the past
- Step 7:** Create a climate of certainty
- Step 8:** Follow-up

Dealing with resistance

Resistance to change may surface in a number of ways.

Passivity: People may just ‘give-up’ and go through the motions, withholding their energy, efforts and commitment.

Malicious Compliance: People may comply in a way they want to know will result in undesired outcomes.

Vocally: People may air their concerns openly, either positively and constructively or negatively and destructively. They may air them to you, their supervisor, or behind your back, to their workmates.

Top ten tips to manage resistance

1. Make sure your business vision and strategy are clear, and that the change is clearly linked to the organisation’s values.
2. Specify the change clearly both in terms of the ‘whats’ (goals, performance indicators, standards) and the ‘how’s’ (vision, behaviours, culture).
3. Involve people in designing and implementing the change.
4. Commit the necessary resources.
5. Build a ‘critical mass’ of supporters and internal champions who can ‘take hold’.
6. Ensure visible signs of early progress.
7. Manage the transition from the old to the new carefully.
8. Publicise the successes.
9. Ensure key people are fully supportive of the change.
10. Keep communicating and listening.

© 2003 L. Whiteside OSA Group

Food contamination

What is food contamination?

Food contamination falls into three areas: Physical, Chemical and Microbiological. Physical contamination occurs when foreign objects find their way into food. Chemical contamination comes from many sources found in everyday workspaces such as insect spray, rodent baits, detergents, sanitisers and lubricants.

There are safe micro-organisms such as yeasts used in making bread, wine and beer; bacterial cultures used in cheese, yoghurt, salami etc and moulds such as those used in making blue vein cheese. However there are harmful micro-organisms as well. They can be divided into bacteria and viruses.

Bacteria cause food poisoning either when live bacteria in food is eaten (called infective) or when toxins or poisonous chemicals are eaten (called toxic).

The environment where the food is stored, prepared and served can also affect food spoilage. Mould growth needs oxygen, which is why it grows on the surface of food. Mould can also grow in cooler temperatures so can be found growing in the fridge. Moulds can tolerate fairly high acidity and salt, meaning they can be found on a number of food items.

Food spoilage can also be caused by yeast. Yeast has useful purposes such as brewing wine or vinegar, baking bread or pizza dough, or vegemite production. However other yeasts can cause definite food spoilage. Yeast growths can also occur in the fridge, and in acidic

conditions. Yeasts do not need much water to grow either.

There are many environmental sources of contamination. Food being found in the temperature danger zone between 50oC and 60oC is particularly vulnerable as this is when bacteria grow best. The longer food is in this danger zone, the greater time the microbes have to multiply. In the right conditions, a single bacterium can multiply into more than two million bacteria in just seven hours.

How does food become contaminated?

Food may be contaminated because of:

- Poor handling and storage.
- Lack of personal hygiene by the people who prepare and serve the food.

Food poisoning bacteria are everywhere – in the soil, on animals, on people and on the things people touch and use. It is possible for foods such as meat or vegetables to contain food poisoning bacteria from the start. Even if food is free of bacteria, it can be contaminated by what is called cross contamination. This can happen in two ways:

During food preparation

Hands and equipment such as knives and cutting boards can be contaminated with bacteria from raw food. If the same hands or tools are then used to prepare ready-to-eat or cooked food, without first being properly washed, then this food can become contaminated with bacteria. If this food is not cooked again before being eaten, the bacteria will not be killed.

During storage

Bacteria from raw food can contaminate ready-to-eat or cooked food if they are stored together, so store them separately. If the two types of food are stored in the same refrigerator, the raw food should always be stored lower down than ready-to-eat or cooked food. This means the raw food cannot drip onto the cooked food.

Personal hygiene

An important way to prevent food contamination is to maintain a high standard of personal hygiene and cleanliness. Even healthy people carry food poisoning bacteria on their bodies. By touching parts of your body, such as your nose, mouth or bottom, you can spread bacteria from your hands to the food and spread bacteria.

Washing your hands thoroughly is a good way to reduce the chance of contaminating food with bacteria. Wash your hands with soap and warm water and don't forget the backs of your hands, wrists, between your fingers and under your fingernails. Dry your hands immediately after you wash them. Always dry your hands with a disposable paper towel, under an air dryer but never on your clothes.

Bacteria are commonly found on the skin and in the nose and mouths of healthy people. So it is important that everyone maintains high standards of personal hygiene when working with food. People with open cuts or wounds on their hands and arms must make sure that the injury is completely protected by a waterproof bandage.

<http://www.foodsafety.vic.gov.au>

Processing residents' personal clothing in domestic laundry equipment

*Grampians Region
Infection Control Group
Kevin. B. Fowkes
Linden R. Marland
Mary A. Smith*

An adequate level of disinfection needs to be achieved during laundering for all soiled linen. This applies to residents' personal clothing when it is laundered as a combined load. The 'gold standard' for linen disinfection remains hot water at 71°C maintained for at least 3 minutes, or 65°C held for at least 10 minutes. However, many residential care facilities are unable to meet this standard due to lack of water temperature or the use of domestic washing machines.

The conclusions from a project undertaken by the Grampians Regional Infection Control Group describe a generally acceptable washing method for residents' personal clothing when only laundry washers, which cannot achieve thermal disinfection temperatures, are available. Approximately 50 per cent of public sector residential aged care services in the Grampians region surveyed use top loading washers incapable of reaching the necessary water temperatures.

Significant problems were also identified with the education of laundry staff in the processes necessary to meet linen disinfection standards. A significant factor found was laundry staff have unreasonable fears of shrinking residents' clothing with hot cycles are used, and opt for warm or cold wash behaviours imported from home.

During the project, the contact plating method was used to ascertain the residual bio-burden of processed items. The standard for acceptable residual bio-burden was taken from the Laundry Standard AS/NZS 4146:2000 Laundry Practice Standards (<1 cfu/cm²)

If water temperatures are of the order of 60°C, the need for chemicals would be substantially reduced. Fill water at 70°C would allow a wash cycle at 65°C for 12 minutes, with probably little need for chemical disinfection.

Staged assessments were made of the efficacy of increasing water temperature levels from warm wash (approx 30°C fill temperature) to hot wash (approx 50°C fill temperature), the addition of a Quaternary Ammonium Compound (QUATs) to the final rinse, and escalating levels of 3 per cent Oxygen Bleach in the wash cycle. Stage 4 processes of 50°C water fill, 15 minute wash, cold water detergent, oxygen bleach, and QUATs in the final rinse, exceed post wash bio-burden reductions obtained in both commercial laundries and 70°C programmable washers. An education kit has been constructed for laundry staff using this washing process, and is available from the email site below.

Levels of linen disinfection were achieved which satisfied the Laundry Practice Standard, and compared favourably with linen processed by commercial laundries.

Address for copies of the project report:
bruce.fowkes@dhs.vic.gov.au

Phone: (03) 5333 6023.

Consumer focus in accreditation– project report

Consumer focus in accreditation – resource guide

The '*Consumer Participation in Accreditation - Resource Guide*' and '*Consumer Participation in Accreditation - Project Report*' were commissioned by the Commonwealth Department of Health and Aged Care as part of its consumer focus strategy and overseen by the Consumer Focus Collaboration.

The Consumer Focus Collaboration is a national body comprising representatives from consumer, professional and private sector organisations and all health departments. The aim of the Collaboration is to strengthen the focus on consumers in health service planning, delivery and monitoring.

While the project report and resource guide have an Australian Council of Healthcare Standards or Quality Improvement Council standards focus, the resource guide is nonetheless a useful general guide for organisations considering consumer involvement in aged care accreditation or quality committees, and consumers who are members of these committees.

These two publications are available by visiting the Consumer Focus Collaboration website at:
<http://nrccph.latrobe.edu.au>

References

www.osagroup.com.au
<http://www.ifcc.org/ejifcc/vol13no4/130401005n.htm>
www.accreditation.aust.com
<http://nrccph.latrobe.edu.au>
<http://www.foodsafety.vic.gov.au>
Coroners Record – Case Number 2906/01

Disclaimer

The content of this newsletter is provided for general information purposes only. No claim is made as to the accuracy or authenticity of the content of the newsletter. This newsletter is provided strictly on the basis that all persons reading it undertake responsibility for assessing the accuracy of its content, and its relevance to their particular needs and situation before using it. Neither the Department of Human Services nor the Victorian Government accepts any liability to any person for any harm caused by the information or advice or the use of the information or advice that is provided in this newsletter.

© State of Victoria 2003

Copyright in the newsletter vests in the State of Victoria. Apart from fair dealing for the purposes of private study, research, criticism or review, as permitted under copyright legislation, no part may be reproduced or reused for any commercial purposes whatsoever. Permission to reproduce any of the articles or reports referred to or included in this newsletter (or parts of them) should be obtained from the relevant author.

The views contained in articles reproduced in this newsletter are the authors' own and do not necessarily represent or reflect the views of the Victorian Government.

Residential Aged Care Quality Improvement Unit

10/555 Collins Street
Melbourne 3000

Phone: (03) 9616 6964

Fax: (03) 9616 8682

Email: acqiu@dhs.vic.gov.au