

Public sector residential aged care quality improvement newsletter

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Strengthening Service Capacity Update

The previous issue of the newsletter included an article about the 'Strengthening Service Capacity' pilot project, which is being undertaken in conjunction with health services and DHS regional offices in Grampians and Loddon Mallee.

There are now two key nurse executives from each of these regions who are acting as regional health service representatives and providing information exchange with health services within their respective regions about many issues relating to the project.

The first phase of the project is well underway, and to date 13 nurse executives (participants) have undertaken a two-week placement with the Aged Care Quality Improvement Unit (QIU). Part of this professional development opportunity includes meeting with other key DHS officers within the Melbourne Office who have responsibility for areas that have a direct impact on areas within their health services including aged care policy, rural health, and nurse policy. The participants also accompany members of the QIU in an observatory role as they visit other health services across the State.

Initial feedback from participants illustrates that involvement in the project is a powerful mechanism to highlight key quality issues that need to be considered across the whole of health service, not just residential aged care. Other feedback from the participants is the importance of engaging senior executive nursing staff in the project to be the drivers of improvements across the whole of health service.

The other aspect of the first phase is the establishment of a regional quality aged care forum. The first forum was held in Maryborough on 11 February 2005 with representation from 75% of health services across the Grampians and Loddon Mallee regions.

The key nurse executive contacts and regional office staff have been meeting regularly with staff from the QIU to develop strategies to progress work on the pilot and key areas for further action during 2005.

We will continue to keep you updated with developments and learnings arising from the project as it progresses.

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Refusal of medical treatment

What do you need to know

This article follows a short article in the May 2004 issue of this newsletter on the *Medical Treatment Act 1988* and a presentation at the Aged Care Quality Improvement Seminar held in November 2004 to raise awareness of the Act.

The *Medical Treatment Act 1988* was created to provide clarity on 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.

Any competent person has a right to refuse medical treatment that they believe is not in their best interest. By using the Act, the refusal of medical treatment takes place through a formal process, providing specific information about a patient's preferences for their treatment, and protecting those who act in accordance with those preferences.

People refuse medical treatment by filling in a prescribed form (a refusal of treatment certificate). The refusal of treatment only applies to treatment for a medical condition that is current for the patient. A patient, who is over 18 years of age, of sound mind, and has been given sufficient information about the nature of their medical condition and the proposed treatment to understand the effect of their decision, may create a refusal of treatment certificate.

The certificate must be signed by a medical practitioner and another person, who are both satisfied that the decision of the patient to refuse medical treatment was voluntary, the patient appears to understand the information about the medical condition and the proposed treatment, and that the patient is over 18 years of age and is of sound mind. The refusal may be of treatment in general or a specific treatment.

The prescribed form, and all other forms referred to in this article, are available at no cost through the Department of Human Services' Medical Treatment Act website.

When a person is no longer able to make decisions for themselves about their medical treatment, the Act provides a way for an agent to act on the patient's behalf. This is done through the creation of an enduring power of attorney (medical treatment) certificate in the prescribed form. The enduring power of attorney (medical treatment) only comes into effect if the person delegating the power becomes unable to make decisions for themselves. It is signed by the person delegating the power and two witnesses but not by the nominated agent.

Although there are several types of enduring powers of attorney, the enduring power of attorney (medical treatment) is the only power of attorney that allows an agent to make decisions about medical treatment. Other powers of attorney may be about financial matters and/or lifestyle, but persons holding these powers alone will not be able to lawfully make decisions about medical treatments.

A refusal of treatment certificate may only be completed by a competent patient, an agent holding an enduring power of attorney (medical treatment), or a guardian authorised by the Victorian Civil and Administrative Tribunal.

Medical practitioners and people under their direction, like nursing staff, must comply with refusal of treatment certificates. If they do not do so, they are committing an offence. The Act protects medical practitioners and those working under their direction against charges of professional misconduct or liability for any civil proceeding relating to the refusal of treatment covered by a certificate.

A person's right to refuse medical treatment under the Act does not include the right to refuse palliative care using a refusal of treatment certificate. The Act defines medical treatment and palliative care. A Victorian Supreme Court decision in 2003 has helped to clarify practice (Gardner, Re BMV (2003) 7VR 487).

In a case involving an incompetent patient, the Supreme Court decided and declared the appointed guardian could refuse the artificial provision of hydration and nutrition via percutaneous endoscopic gastrostomy (PEG), as it constituted medical treatment within the meaning of the Act, and not the palliation of the patient through the 'reasonable provision of food and water'.

Where there is a concern that a refusal of treatment certificate or an enduring power of attorney (medical treatment) is being used in a way contrary to the patient's best interests, a case may be made for review by the Victorian Civil and Administrative Tribunal. The power of these declarations will also be limited when a person's medical condition changes, so the treatment is no longer relevant or a person regains their ability to make decisions for themselves.

The Victorian Government is informing the community about the Act and how it works. As part of this, posters and information booklets on the Act have been sent to nursing homes, retirement villages, supported residential services, palliative care facilities and other residential facilities.

The information provided outlines the responsibilities for residential facilities with a copy of any refusal of treatment certificate applying to a resident. The completed form must be placed with the resident's records kept by the home, a copy is required to be given to the head of the facility and a copy lodged with the Principal Register of the Victorian Civil and Administrative Tribunal within seven days of the certificate being completed.

For more information on the Medical Treatment Act visit:
www.health.vic.gov.au/mta

Did you know residents can say NO to a medical treatment?

Did you know that residents can CHOOSE another person to make treatment decisions for them when they are not able?

Falls – Lessons from coronial findings

From two incidents reported on by the State Coroner in October 2004 there are some important issues to bring to your attention about the management of residents' falls.

While one case concerned a 57 year old inpatient of an acute mental health unit, who had a history of brain haemorrhages and previously lived in an aged care residential facility, the Coroner's comments are equally pertinent for residential aged care regarding the requirement of specific guidelines for minimising the risk of falls for patients with cognitive impairment.

The other case involved a resident who had an unwitnessed fall in the dining room of a residential facility. The resident was admitted to hospital the following day with an X-ray showing a fracture, and passed away in hospital six weeks later. The Coroner made specific mention of the need to place a greater emphasis on the investigation of falls in hospital and residential aged care settings.

These cases follow on from an 'Investigation Standard for falls-related deaths in hospital' which was developed by the State Coroners Office and issued in late 2003. As this Investigation Standard is applicable to falls in all hospitals in Victoria, it also applies to public sector residential aged care services when falls are indicated as the direct or contributing cause of death.

The Investigation Standard details the information that is to be provided to the Coroner for an understanding of the many factors involved in such incidents. Specific information is required on the patient/resident's clinical course, the events leading to the fall, the facility's system for falls management including policy and protocol documents for risk screening and falls prevention, a list of staff who were involved in initial assessment or review of the resident's fall risk, as well as information on relevant procedures, work practices and equipment.

In addition, both cases emphasise the need for comprehensive falls prevention policies and practices including appropriate assessment and documented management plans for residents on admission with updates as circumstances change. The Coroner's report for the second case also recommends consideration of the Victorian Quality Council's guidelines pack for 'Minimising the Risk of Falls & Fall-related Injuries' in acute, sub-acute and residential care settings. This pack was launched in August 2004 and more information is available at:

www.health.vic.gov.au/qualitycouncil

Continuous quality improvement and your service

Understanding and embracing the principles of continuous quality improvement is essential for any organisation that strives to provide effective and efficient services that meet consumer and community expectations on an ongoing basis.

Critical to this success is having robust organisational systems in place for measuring, monitoring, reporting and responding to performance issues relevant to the services being provided.

Public sector residential aged care services are generally operated within a broader health service context. Health services may provide a range of services and, as such, may be required to manage a range of processes related to various accreditation systems. While the assessment process for the accreditation systems may differ, continuous quality improvement is commonly assessed as a key feature of all of these systems.

There is a strong focus on continuous improvement within the Aged Care Accreditation Standards and is central to what the Aged Care Standards and Accreditation Agency (ACSAA) assesses when undertaking visits to residential aged care services.

Many public sector residential aged care services will already be busy working on their application for the next round of accreditation being conducted by ACSAA. In preparation for the next accreditation audit it is important for services to be able to evidence how they are actively improving their performance and providing better care and services to residents.

Since the introduction of the Aged Care Accreditation Standards a number of services have experienced some challenges with implementing the principles of continuous improvement at a service level. The published accreditation reports on the ACSAA website provide valuable information about how well performing services operate and what problems some services experience that lead to non-compliance with the standards.

Some of the common themes relating to non-compliance in the area of continuous improvement include the following:

- A lack of understanding about the principles of continuous improvement
- Insufficient training of staff about continuous improvement
- A reactive approach to implementing improvements
- A lack of responsiveness to resident and other stakeholder concerns
- Insufficient engagement of staff and residents in improvement activities
- A lack of meaningful and measurable data and other information that is routinely obtained to identify improvement activities
- Limited analysis and reporting of the data and information that is collected
- Weak links between services' improvement activities and beneficial changes to the care and services for residents.

In order to show that you have an effective continuous improvement system with processes of ongoing evaluation and review, you might like to consider the following questions.

- What processes do you have to keep residents and staff continually aware and involved in improvement initiatives?
- How do you proactively seek suggestions, comments, and other contributions about service performance issues from residents, staff and other stakeholders?
- Do you provide a timely and satisfactory response to resident, staff and other stakeholder concerns?
- How do you inform stakeholders of any changes made?
- Do you have effective and easily understood policies and procedures in place?
- Do the policies and procedures effectively communicate the organisation's expectations of staff practice?

- How do you know that all staff are working within prescribed practices?
- What is the process for the review of policy and procedures, particularly in light of organisational and legislative changes?
- What training and resources are available to staff so they develop a good understanding about the principles of continuous improvement?
- Does your service have an up to date action plan to guide and monitor the progress of improvement activities?
- Does the plan consider the resources, timeframes and responsibilities associated with improvement activities?
- Are all staff involved in looking critically at how work gets done?
- Does the information and data you collect allow you to meaningfully measure, review and report service performance?
- What can staff and residents tell others about your achievements?
- Do your systems for continuous quality improvement deliver improved outcomes for residents in your service?

If you have answered positively to any and hopefully all of the above, what evidence can you provide to support your assertions?

The above set of questions is not inclusive of all the questions you could consider about the effectiveness of your systems. More helpful information on continuous quality improvement is available through ACSAA's website at:

www.accreditation.aust.com

and the Victorian Quality Council's at:
www.health.vic.gov.au/quality_council

Have you had any significant results for an improvement activity at your service? Would you like to share it with the sector? Let us know! The Quality Improvement Unit is keen to share information by publishing improvement initiatives here (with your permission of course).

High risk clinical indicators

Following on with our series on articles relating to high risk clinical indicators, this edition will cover issues relating to nutrition, hydration and weight change.

It is worth noting that the incidence of weight change (ie. significant increase or decrease from the norm) is currently being trailed as part of the Department's Public Sector Residential Aged Care Quality of Care Performance Indicator Project. There will be more about this project in future editions of the newsletter.

The following list of questions will assist staff in determining that residents receive adequate nourishment and hydration. The questions were generated by participants at a Quality Improvement Seminar held in 2003. They are indicative only and do not include all issues that could be considered.

Nutrition, hydration and weight change

- What processes are in place to assess residents' likes and dislikes for food and refreshments?
- How are all residents involved in exercising choice in their meal selection?
- Does the physical environment contribute to optimising appetite?
- Do meals and drinks look appealing?
- Are all residents being weighed regularly?
- Do any residents' weight charts indicate any unplanned or unexpected weight change?
- What is your process for follow up action when residents experience weight change?
- What are your protocols and processes for residents' on special diets?
- Do you have protocols for residents on enteral feeding regimes?
- What are your protocols for residents on texture-modified diets?
- Is there evidence about why the resident requires the modified diet?
- What review processes are in place to ascertain whether a modified diet is still appropriate?
- What are your protocols and processes for referrals to a dietician or speech pathologist if required?
- What process is in place to ensure information maintained by the kitchen on residents' nutritional and hydration needs and preferences is kept up-to-date?
- Is there clear evidence that all residents' nutritional and hydration status is regularly monitored?

For more information and tips about residents' nutrition you can refer to the 'Well for Life' Manual, which is also available at: www.dhs.vic.gov.au/phd/nutrition

Check previous editions of our newsletter for the evidence required to support the management of residents' medications including anticoagulant medications, pain, diabetes, and falls.

Business Performance Improvement Project – Stage 1

A report on the first stage of the Department's Public Sector Residential Aged Care Business Performance Improvement Project (BPIP) has recently been presented to a Sector Briefing, the Ministerial Rural Health Forum and distributed to each rural health agency.

The BPIP seeks to identify key performance factors and improve performance through the development of a common business planning and management framework for public sector residential aged care facilities, including relevant policies, reporting and key performance indicators.

The first stage of BPIP was undertaken with the assistance of The Nous Group, a management consultancy, who conducted extensive research and data collection, consulted widely within the sector and produced the report with their findings and recommendations.

Key findings suggest substantial system wide business performance improvements are possible, based on a break-even scenario for the sector following the implementation of a number of recommended strategies. Given the diversity of management practices and performance outcomes within the sector the report recommends that the Department adopts a system management approach to drive sector performance while reinforcing individual agency accountability and innovation.

Recommendations for agencies to address include improved management focus on aged care, optimising Commonwealth revenue, reducing and allocating overheads more consistently, participating in benchmarking and related data management, and developing stronger links between agencies to promote sharing of innovation and learning.

The next stage of the BPIP will focus on the implementation of these recommendations. At the same time, the Department is working with the common chart of accounts to ensure it reflects the funding and operating arrangements of residential aged care services and to enable financial benchmarking to commence within the sector.

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Did you know?

The following reports and resources are also available on the Internet:

Public sector residential aged care policy

Public sector residential aged care quality of care performance indicator project report at: <http://www.health.vic.gov.au/agedcare/publications/>

Decision-making tool: Responding to issues of restraint in aged care

Guidelines for a Palliative Approach in Residential Aged Care at:

<http://www.health.gov.au/internet/wcms/publishing.snsf/content/health-publicat.htm>

Copies of **previous public sector residential aged care quality improvement newsletters** can be found at: www.health.vic.gov.au/agedcare/newsletters/index

What's happening in 2005?

The following is a selection of key events related to health and ageing issues.

For more information see *What's On* at: www.betterhealth.vic.gov.au

July	3-10	NAIDOC Week
	10-16	National Diabetes Week
	17-23	National Glaucoma Week
August	1-7	Dental Health Week
	7-13	National Healthy Bones Week
	24-30	Hearing Awareness Week
September	1-7	National Asthma Week
	18-24	Alzheimer's & Dementia Awareness Week
October – Community Safety Month	1	International Day of Older Persons
	9-15	National Foot Health Week
	9-16	Mental Health Week
	16-22	Carers Week
	16-22	National Nutrition Week
	20	World Osteoporosis Day
November	14	World Diabetes Day
December	5	International Volunteer Day
Aged Care Quality Improvement Seminars	Thursday 6 & Friday 7 October	
	Monday 14 & Tuesday 15 November	
ACSAA Better Practice Event – Melbourne	Thursday 25 & Friday 26 August	