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SPECIAL EDITION: PRACTICE CHANGE

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EDITORIAL

Welcome to our first edition of "**Residential Aged Care-Practice Change**" which is a little longer, at five pages and focuses on learning from practice change completed at individual Residential Aged Care Services.

As you may recall in the December 2009 edition of the RAC Communiqué (Vol 4 Iss 3) we explained the Department of Health (Aged Care Branch) commissioned us to publish the stories of RACS that describe practical examples of innovation and changes to practice.

These examples of "changes to practice" are drawn from participants in the qualitative research study conducted in Victoria, Australia in 2009, in which subscribers responded to a request to provide details through semi-structured interviews about their self-reported practice changes. The participants verified the data collected during interviews and we analysed all the interviews to identify factors that facilitated or acted as barriers to the reported practice change. The common feature to have promoted change included the provision of evidence to justify change, and having the support of other staff. The most common barrier encountered was reluctance of staff to change established practices.

This issue describes two practice change studies drawn from this work using the familiar style and format of the RAC-Communiqué. Our hope is the experiences of these Residential Aged Care Services (RACS) will assist and motivate other RACS overcome the barriers we all face in changing practice.

The Residential Aged Care Services practice changes described relate to improving the management of swallowing disorders and the use of restraint.

The cases highlight that change is possible and depends on a number of factors aligning at the same time.

This issue opens with an expert commentary about change management and innovation from Dr Cathy Balding. We hope by reading the expert commentary first it will give our readers greater insights into the case studies.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to: **racc@vifm.org**

MANAGING CHANGE: THE SEVEN DEADLY SINS!

Author: Dr Cathy Balding, Director, Qualityworks PL and Adjunct Associate Professor, School of Public Health, La Trobe University

There's nothing like being asked to 'whip up' 500 words on change management. As you all know, there have probably been more than 500 million words written on the topic. What can be said in a page that hasn't already been explored from every conceivable angle? Is it better to discuss the complex environment within which we attempt change in health and aged care? Or, the importance of leadership and planning? Or, the useful change tools?

The first thing to note is that, as a result of the 500 million words, we know what works – and what doesn't. You don't need to re-discover this. Here's a handy list of 'change traps' to avoid:

1. Vague and overly ambitious goals (your change goals should be SMART: Specific, Measurable, Achievable, Realistic and Time limited)
2. Lack of clear, specified change roles: leaders, sponsors, agents, targets
3. Unfavourable context for the change (a good change project won't fix a bad environment!)
4. Plans not linked to existing values, social and governance structures and systems
5. Poor planning, project management and implementation skills
6. Inappropriate choice of change and measurement method
7. Top down and prescriptive approaches – must be top down and bottom up (see references i & ii)

Think of this as a basic 'not to do' list! If you do nothing else but avoid these seven deadly sins of change you will significantly improve your chances of success.

I also wanted to discuss one powerful tool for change that is underutilised in health and aged care despite being relatively easy and inexpensive to implement. It's the cornerstone of many change techniques advocated in the literature (see reference iii) such as persuasion, buy-in, enabling, empowerment, ownership, relationships and partnerships. That tool is empathy.

What are we talking about here? Empathy is the vital step of identifying those who need to alter their thinking and behavior to affect the required change - let's call them the change targets - and understanding their current situation and perspectives before we start selling the future.

Change is a journey that requires transition from one situation to another (see reference iv) usually crossing some stormy seas in the process. Both thinking and behaviour have to change – something that is often forgotten as we focus on the physical, concrete signs of change.

Empathy is a relatively easy, yet effective tool for motivating and supporting people to undertake the voyage. We are all capable of empathy. So why isn't this the basis of all our change efforts? It may be because empathy requires two ingredients that are in relatively short supply in healthcare: time and active listening. But this investment in the front end of the change process can lay a positive foundation for fewer implementation roadblocks.

It is difficult to chart a successful course to a destination if you're unclear about your origin and this is a common problem in health. (Sometimes we're also unclear about the destination – a separate but equally problematic change issue!) We plan the route, based on lots of assumptions about our knowledge of the terrain, and take off energetically only to run into weather and mountains (or volcanoes!) we hadn't counted on.

Avoiding this requires what I call the **SWTA** strategy: **S**tart **W**here **T**hey **A**re.

Not where you are! Not arguing, not persuading, just asking questions in the context of the proposed change and listening to the answers. What is really important to this person or group? What are the good and bad things about the current situation? What would people like to change if they could? What organizational and social structures maintain the status quo? What mountain ranges are hidden in the clouds? Human beings are likely to support the course of action that supports their best interests, and identifying this will provide valuable clues regarding their potential responses to the change.

Empathy helps you draw a realistic road map for your change and should be one of the key tools in your change toolbox. It applies equally to managing up - trying to persuade your manager to consider a change, or across and down - when seeking buy in from colleagues and staff. Investing the requisite time and energy creates a wealth of critical information to guide the change such as:

1. Finding out how the current system really operates. In the real world, day-to-day operations seldom work exactly as described in the procedure manual or as we assume they should. Change plans are often based on how things are supposed to happen – and come unstuck during implementation when theory and practice don't align

2. Creating a rich picture of the change destination -how the change will impact 'on the ground'

3. Understanding the social and values anchors that are important to the change targets and that maintain the status quo – and which of these are the non-negotiable. These are likely to vary considerably according to where people sit in the organization

4. Identifying the formal and informal leaders and influencers in the group – find out where the power really sits!

5. Detecting the aspects of the current situation that the change targets don't like – these provide leverage if they can be eliminated or improved as part of the change

6. Clarifying the driving and restraining forces for change. Performing an initial force field analysis of the change with the change targets – even if the 'restraining forces' column is three times longer than the driving forces – gets the potential roadblocks on the table early and also promotes some initial thinking about potential positives of the change.

More valuable than any of these advantages, however, is that the change targets will feel as if you have heard their point of view—and that is the critical first step to others hearing your point of view!

Of course, empathy is just one of a plethora of tools for change and should be used in conjunction with the many other proven approaches available in the literature. Equip yourself with as many skills as you can to give your change the greatest chance of success - with the least amount of angst.

REFERENCES

(i) NHS, 2008, Quality Improvement: Theory and Practice in Healthcare. NHS Institute for Innovation and Improvement.

(ii) Robbins H, Finley M, 1997, Why change doesn't work. Texere Publishing USA.

(iii) Borg J, 2004, Persuasion: the art of influencing people. Prentice Hall Business, UK.

(iv) Bridges W, 1997, Managing Transitions: Making the Most of Change. Addison-Wesley, USA.

"THIS HAS NEVER BEEN A PROBLEM FOR US"

Case Number One (1) Clinical Practice Change: Dysphagia

Case Précis Author: Ms J McInnes, Monash University

DESIRE TO IMPROVE CARE

The senior managerial staff of a small, rural, high-care Residential Aged Care Facility wanted to make changes to the management of residents with swallowing disorders. The staff were unaware of any episodes of choking at this facility and certainly nothing as dramatic as the cases described in the June 2007 RAC—Communiqué.

CLINICAL CASES DEMONSTRATING HARM

You may recall the June 2007 issue of the RAC-Communiqué reviewed deaths from choking on food and discussed the need for swallowing assessment, hazard recognition, contingency planning and emergency response.

Two of the four cases described included: a 76yo male with Parkinson's disease and dementia who had a habit of overfilling his mouth and removing food from the plates of other residents. This resident died after choking on chocolate cake.

The other case was an 84yo male who had been placed on a modified diet by the speech pathologist (i.e., no bread, cake and toast) however received a sandwich and died from aspiration of food bolus.

RECOGNITION OF THE RISK OR HAZARD

Concerns were expressed by staff at this particular facility that work-experience students were feeding two residents diagnosed with dysphagia: it was a case of the 'the least experienced feeding the most vulnerable'.

OPPORTUNITY FOR CHANGE

The senior managerial staff wanted to improve the safety of residents and tabled the RAC-Communiqué edition for discussion at their next quality improvement meeting.

PROPOSED CHANGES

To address this situation, two changes were proposed;

Firstly—it was decided that a dysphagia self-directed learning (SDL) package would be developed to better inform all new and existing Division 1 and 2 nursing staff of the need for adequate assessment and management of residents with dysphagia.

A division 1 nurse and a speech pathology student under the supervision of the facility speech pathologist would write the Dysphagia SDL package.

Second—a decision to change policy was made. This had two parts,

(i) Only Division 1 and 2 nurses who had completed the SDL would be permitted to feed residents diagnosed with swallowing difficulties.

(ii) That residents who had swallowing difficulties with their food and beverages during meal times could not be assisted by unqualified and untrained staff (this included personal care attendants, work experience students, volunteers or visitors); and

OUTCOMES

The dysphagia SDL package in the form of a booklet, was written and distributed to all current clinical staff, and included in the orientation program for new staff. All current staff are required to read the booklet, and the dysphagia SDL package was discussed with new nursing staff at their individual orientation sessions.

The booklet explains dysphagia, describes signs and symptoms of dysphagia, gives step-by-step first-aid instructions to follow in case of partial or total airway obstruction, provides risk assessment tools for dysphagia and malnutrition, and outlines food texture and fluid thickness grading scales with detailed examples.

Guidelines for the correct feeding posture and techniques, foods to avoid, and maintenance of oral hygiene is provided to assist clinical staff minimise the risk of choking and malnutrition.

The booklet is written in a simple, easy to understand style using accessible language.

No obstacles to implementing these changes in policy and education have been encountered. One explanation for the acceptance of change was that nursing staff are well aware of comments from the Coroner regarding choking deaths in residential aged care facilities.

THE LONG-TERM IMPACT

While there had been no episodes of choking at the facility prior to these changes, there were also no episodes post-implementation despite a significant increase in the number of residents with dysphagia (increase from 10% to 30% of residents).

The dysphagia SDL package is still in use, and was reviewed by the facility speech pathologist who found that no revisions were necessary. The practice of only Division 1 & 2 nurses who have completed the dysphagia SLD package being permitted to assist residents continues and trainee Division 2 nurses kept under direct supervision.

While not formally evaluated, the associate director of nursing of the facility has made the personal observation that staff members at the facility are more aware of the risks associated with dysphagia, and are more compliant with instructions given by the speech pathologist.

For example, while once it may have been common to find residents reclining after their meal, the nurse are now very particular to maintain residents in an upright posture for the prescribed length of time after eating or drinking.

CASE COMMENTARY

One of the major barriers to overcome in this situation is that the identified clinical risk may not seem real to staff because there had not been any cases of resident harm. Humans are more likely to change practice if they or their colleagues have had personal experience of the clinical risk situation.

Motivating staff to change practice when nothing bad has happened can be much more difficult.

The changes to practice required more than one strategy to succeed. They made at least two changes improving education and altering RACS policy to support and reinforce the importance of the education.

"REMOVING RESTRAINTS"

Case Number One (2) Clinical Practice Change: Removal of bed rails

Case Précis Author: Ms J McInnes, Monash University

DESIRE TO IMPROVE CARE

Before October 2006, there had been some use of physical restraint for residents in the form of bed rails and chair tables, at a hostel caring for both low and high care residents.

CLINICAL CASES DEMONSTRATING HARM

In October 2006 the RAC Communiqué reviewed deaths from physical restraint. The cases included a 68 year old female with Huntington's chorea who died of postural asphyxia in a restraint (i.e., a 'Zip-a-Bed'). Another case was an 82 year old female with a recent stroke causing left sided weakness and died after falling from bed after requesting that the rails of the bed be left down.

RECOGNITION OF THE RISK OR HAZARD

The facility manager recognised that although the risk of harm from restraint had been reduced there was the potential to reduce this even further. Fortunately a number of circumstances combined to make such a change possible.

OPPORTUNITY FOR CHANGE

First, an edition of the Residential Aged Care Coronial Communiqué discussing the use of restraints in residential aged care facilities, including findings and recommendations of a Coroner was received. This publication provided an impetus for change, and a focus for discussion at the facility.

Second, the facility was now 20 years old and many of the resident's beds needed replacing as a number of the residents were requiring a higher level of care.

Third, the Australian Government was encouraging residential aged care services to provide resources that allowed for 'Ageing in Place'. A number of residents had been at the facility for several years and now required a higher level of care.

PROPOSED CHANGES

The facility manager decided to reduce the use of restraints at the facility by removing all the bed rails. She met with senior executives of the health service and proposed that all beds in the facility be replaced with new 'high-low' beds.

These are beds that can be adjusted to a height deemed suitable to the needs of the individual resident. For example, they can be lowered very closely to the floor or adjusted to a height that enables the resident to be independent getting in and out of bed safely. Acquiring these beds would eliminate the possibility of any resident being caught in or injured by bed rails and would provide each resident with a new bed. The use of the beds would also enable the resident's environment to be modified within the facility as their needs changed over time.

The facility manager was able to put a compelling argument for the need for change and the senior executives were very receptive to evidence about risks of bed rail use. Permission and financial assistance for the purchase of high-low beds was readily provided.

OUTCOMES

It took about two years to replace all the beds in the hostel, and every resident now has a new 'high/low' bed, making them more suitable for the residents' changing needs and increasing frailty. These new beds also do not have sharp edges or levers to bump into.

There are now no bed rails in the facility, except for one or two residents who requested the rails because it made them feel more secure. In these cases, while the bed rails have been retained, the residents using them have been carefully consulted about the use of the bedrails and are closely monitored.

Initially it took a little persuasion to convince staff that removing bed rails from the facility was a good idea with some expressing concern that the new beds would make the facility look more like a hospital. With time, however, all eventually understood the benefits of making such a change.

THE LONG-TERM IMPACT

Statistics collected by the facility manager about the falls and skin tears at the facility have shown that these have not become more frequent since the new beds have been introduced. Staff reports they feel more confident now that residents at risk of falling can have their beds lowered closer to the floor, therefore having a decreased height to fall. Residents have also said they feel happier not being surrounded by bed rails.

CASE COMMENTARY

The practice changes in the two case studies are substantially different.

First—significant resources are required to change over the beds requiring a compelling business case be made to the executive. Second—the opportunity for change was present and the manager was astute enough to seize the moment. Third—the change is easier to sustain because it is an environmental or physical solution. Contrast this with the other Case Study where very little resource was required; the manager had to motivate staff change when nothing untoward had happened and; the change is much harder to sustain because it requires ongoing education and staff training.

LIST OF RESOURCES

1. Commonwealth Department of Health and Ageing titled "Decision making tool: Responding to issues of restraint in aged care" Commonwealth of Australia 2004. **http://www.health.gov.au/internet/main/publishing.nsf/Content**
2. DRAFT evidence based "Standardised Care Processes" for choking and alternatives to physical restraint are available through the Victorian Department of Health at **http://www.health.vic.gov.au/agedcare/services/score.htm**
3. Residential Aged Care Communiqué [electronic resource]: Department of Forensic Medicine, Monash University, Victorian Institute of Forensic Medicine. Available at: **http://www.vifm.org/communique.html**
   (a) Check the issue from October 2006 for information about restraint
   (b) Check the issue from June 2007 for information about choking