



RESIDENTIAL AGED CARE COMMUNIQUE SPECIAL EDITION: PRACTICE CHANGE

VOLUME 1. ISSUE 2.
December 2010
ISSN 1834-318X

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EDITORIAL

Welcome to the second special edition of "Residential Aged Care-Practice Change" focusing on learning from practice change completed at individual Residential Aged Care Services (RACS). This brings us to a total of five RAC Communiqué editions for 2010. Our plans for 2011 are to publish four editions based on cases and one special edition on practice change.

As you may recall, the examples of "changes to practice" are drawn from participants in the qualitative research study conducted in 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.

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 clinical care for diabetes mellitus and falls management.

This issue opens with an expert commentary about change management and evidence based practice from Dr Deirdre Fetherstonhaugh. We hope by reading the expert commentary first it will give our readers greater insights into the case studies.

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Next Edition:
Feb 2011 RAC Communiqué

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ACKNOWLEDGEMENTS

This initiative has been made possible by collaboration with the Victorian Institute of Forensic Medicine and Department of Health (Victoria) - Aged Care Branch.

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Residential Aged Care Communiqué [electronic resource]: Department of Forensic Medicine, Monash University, Available at: <http://www.vifm.org/communique.html>

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

DISCLAIMER

We have made every attempt to ensure that individuals and organizations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health, Victorian Institute of Forensic Medicine or Monash University.

MANAGING CHANGE TO EVIDENCE BASED PRACTICE

Author: Dr Deirdre Fetherstonhaugh
Australian Centre for Evidence Based Aged Care (ACEBAC)

Managing, or mitigating the clinical risks in all health care contexts is an important public responsibility and one about which there are increasing government, professional, and consumer expectations. Residential aged care is no exception. One way of demonstrating we are meeting our responsibilities and community expectations is to ensure that clinical practice is evidence-based. So, "How do we know if clinical practice is evidence-based?" and "How do we make the necessary changes if we find our current practice is not evidence-based and person-centred?"

Evidence is a term we use to describe the results or learning from academic research studies. This evidence is usually collated, summarised and published in the form of clinical guidelines, standardised care processes and best practice recommendations from medical, nursing, government and advocacy bodies. This is a synthesis of the best available research evidence around what 'works' (sometimes described as effectiveness and/or efficacy) in a controlled research setting.

It is the 'evidence' base on which clinical practice should be judged. However, it is not "evidence-based practice". Evidence-based practice requires interpretation of, and applying the evidence base alongside the resident's choice and in the context of the local setting.

HOW DO WE KNOW IF CLINICAL PRACTICE IS EVIDENCE-BASED?

Step One is establishing what evidence the clinical practice in your particular organisation should be based upon.

Step Two is finding out how your current practice compares to what is recommended in the evidence base by undertaking a clinical audit.

Step Three is interpreting the audit to identify the gaps between the current practice in your organisation and practices recommended by the evidence.

Step Four is highlighting and prioritizing the gaps that need a change in practice.

"HOW DO WE MAKE THE NECESSARY CHANGES?"

Practice change is not easy.

It requires a comprehensive plan that is flexible and responsive to changes in circumstances such as a change in the RACS management, staff resignation or retirement, unplanned events (e.g., extreme hot weather, infection outbreak, building renovations).

It also requires the RACS to be receptive for the change to 'happen'. In the language of management this is termed "organisational readiness". What it means is that the implementation of practice change needs the involvement and support of senior and middle management and more importantly those staff who provide the clinical care to residents.

Leaders of the practice change need to be visionary and to inspire others to see the possibilities. This requires a considerable investment of time and patience to ensure the planned changes are not seen as threatening or as an imposition. The challenge is inspiring others to see evidence based practice as a tool through which the management of clinical risks is an improvement leading to better care and quality of life of residents.

Often some specific knowledge and skills may be required in order to implement the evidence-based recommendations into practice. Therefore, it is important that the appropriate staff involved in the practice change have those skills and knowledge. It is unfair and foolish to believe the changes will occur when the staff is not equipped to perform the tasks required.

One of the most important aspects to practice change is to identify the enablers of, and barriers to these changes in your RACS with your staff. You need to be patient and take the time to consider who will and who will not help. Then ask yourself, "why do people not want to help?" and "what would overcome their objections?" The objections or resistance to change is often due to a lack of confidence, knowledge or skills to complete the required tasks. Other concerns about a perceived increased workload or lack of time should be considered and addressed.

The most important strategy to change practice is implementing a plan that takes into account your local context, that is, sensitive and specific to your RACS, your staff and the residents.

LIST OF RESOURCES

1. National Institute of Clinical Studies (NICS) is part of NHMRC and works to improve health care by getting the best available evidence from health and medical research into everyday practice <http://www.nhmrc.gov.au/nics/index.htm>
2. "Identifying barriers to evidence uptake" published by NCIS is a clearly written guide that is fascinating to read and helps with ideas about managing the barriers to change <http://www.nhmrc.gov.au/_files_nhmrc/file/nics/material_resources/Identifying%20Barriers%20to%20Evidence%20Uptake.pdf>
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 September 2008 Volume 3 Issue 4 for information about Diabetes Mellitus
 - (b) Check the issue from March 2007 Volume 2 Issue 1 for information about falls management

BETTER TO BE PREPARED...

Case Number One (1) Clinical Practice
Change: Diabetes mellitus

Case Précis Author: Ms J McInnes,
Monash University

DESIRE TO IMPROVE CARE

The senior nursing staff working at a large high-level residential aged care facility was keen to reduce any risks to the residents in their care. They noted with interest the September 2008 edition of the RAC-Communiqué focused on diabetes mellitus. At the time, there were a number of residents at the facility with diabetes mellitus including one whose condition was described as 'brittle'.

CLINICAL CASES DEMONSTRATING HARM

You may recall the September 2008 issue of the RAC-Communiqué reviewed deaths that illustrated the need for a comprehensive approach to management of diabetes mellitus in the residential aged care setting.

One case was of an 82 year old female with diabetes mellitus requiring insulin who was observed to be unresponsive to verbal and painful stimuli with a blood glucose level registered 0.8mmol/l. The resident died soon after. The Coroner stated that the absence of a diabetes mellitus management protocol was "an unsatisfactory state of affairs". A recommendation was made about the importance of establishing and specifying clear goals for glycaemic control and documenting the acceptable upper and lower blood glucose levels. Another recommendation was about having clear and comprehensive clinical information documented in the resident's file.

Another case was of an 80 year old female with diabetes mellitus who had recently been treated for a urinary tract infection, had become dehydrated and developed hyperglycaemia, hyperosmolar non-ketotic coma and died.

These two cases highlighted that optimal control requires understanding and having strategies to manage very high and very low blood glucose levels.

RECOGNITION OF THE RISK

The recommended standard protocols for management of residents with diabetes mellitus were already in place at the facility.

However, the senior nurses recognised that the clinical situation for each resident was different and care had to be tailored according to their specific complex co-morbidities. Another potential risk identified was the time lag that occurred when contacting General Practitioners after-hours or on weekends for assistance in managing deterioration in a resident's condition. This time lag was a source of concern and uncertainty for nursing staff and the resident.

OPPORTUNITY FOR CHANGE

A 'culture' of being receptive to advice and information to improve the safety of residents already existed amongst staff at this facility. Each new edition of the RAC-Communiqué was read and discussed by nursing staff, and the described situations compared with the risk profiles of residents in their care. After reading case studies and expert commentary in the September 2008 edition the staff wanted to decrease the clinical risks to residents with diabetes mellitus.

The area identified for attention was the risks associated with delays in management that may occur when a doctor is not available on site or was not easily contactable.

PROPOSED CHANGES

Two changes were proposed.

First, it was proposed that individualised management protocols would be written for each of the residents with diabetes mellitus.

Second, an education program would be developed to inform staff about the optimal management of residents with diabetes mellitus, and to inform them about the new individualised approach.

OUTCOMES

In consultation with each resident's doctor, an individualised management protocol that incorporated the resident's clinical profile and medical history were written.

The protocols included acceptable ranges for blood glucose concentration and a plan of action should there be a delay in contacting the doctor such as might occur on a weekend.

The clinical care manager developed an ongoing staff education program after discussions with diabetes mellitus educators and doctors at the local acute care hospital. The program was compulsory for the RACS staff.

The Director of Nursing explained that the nursing staff were very supportive because the changes addressed their existing concerns and provided clear instructions and guidelines to follow, especially when General Practitioners are not immediately available. This also gave the staff greater confidence with managing residents.

Another factor in the success of introducing and sustaining the changes was the concurrent education program that helped get staff 'on board'.

LONG-TERM IMPACT

After two years, the policy and practice of developing individualised protocols for managing residents with diabetes mellitus is still in place. No adverse events or referrals for acute care of these residents have been reported in this time.

CASE COMMENTARY

One of the major barriers to overcome in this situation is that resolving the identified clinical risk seems out of the control of the RACS. That is, the management of unstable diabetes mellitus is usually seen as the clinical responsibility of the General Practitioner.

This case illustrates that it is possible to address issues that "are not my responsibility".

Again we see that the changes to practice required more than one strategy to succeed. Somewhat understated but probably most critical to the success was the engagement of the key stakeholders or partners in clinical care of the resident i.e., diabetes mellitus educators, doctors and RACS staff.

Finally, a note of caution about mandating education, although well intentioned it may backfire if handled poorly. Human nature typically resists being "forced" to do anything, and our best learning is done when we are motivated. Therefore, it is important to ensure an education program meets the needs of the staff and they are rewarded for participating.

NOT FALLING THROUGH THE CRACKS

Case Number Two (2) Clinical Practice Change: Improving Falls Management

Case Précis Author: Ms J McInnes, Monash University

DESIRE TO IMPROVE CARE

The Nurse Educator and Quality Manager working with aged care staff of a large health service provider were well aware that falls are a major cause of injury amongst residents of aged care facilities.

Any falls occurring at the five aged care facilities administered by the health service were discussed at monthly quality meetings, and a Falls Committee regularly examined ways to improve falls management.

As a member of the Falls Committee, the Nurse Educator was very interested to read the March 2007 edition of the RAC-Communiqué, which was dedicated to the issue of falls.

CLINICAL CASES DEMONSTRATING HARM

The March 2007 edition of the RAC-Communiqué was about the assessment, management and prevention of falls that contribute to death of residents of aged care facilities.

One case was a 70-year-old female with a past medical history that included dementia who was found to have fallen in the bathroom off a shower chair after being left alone for approximately 10 seconds. The fall caused a fractured neck of femur and she died following surgery. Another case was a 91 year old legally blind resident with a medical history of Parkinson's disease who fell hitting his head on a coffee table. He was assessed and discharged from the local acute hospital Emergency Department, had a further fall and died of a subdural haematoma.

The expert comments emphasised that many falls can be prevented, and that a multi-factorial management approach appears most likely to be effective. Coroner's recommendations were that consideration be given to the development of comprehensive falls management programs.

RECOGNITION OF RISK

The case studies and expert commentaries in the 'falls' edition of the RAC-Communiqué illustrated that much can be done to prevent falls, however it was understood that the collection of good quality data was essential if gaps in falls management were to be identified.

It was also noted that the Coroner had questioned the strategies in place at Aged Care Facilities after a fall had occurred.

OPPORTUNITY FOR CHANGE

The RAC-Communiqué was used as an educational tool at the facilities, with copies of each new edition being placed on staff notice boards and tearoom tables, with important sections highlighted.

Heightened staff awareness of falls through receipt of this edition of the RAC Communiqué, along with concurrent Government initiatives to reduce falls and fall-related injuries in residential care settings, provided an opportunity for the Falls Committee and Quality Manager to introduce changes to falls management at the residential facilities.

PROPOSED CHANGES

Two changes to falls management at the five aged care facilities were proposed: first to improve the documentation of circumstances and outcomes of a fall, and second to provide staff with a clear protocol to follow when a fall does occur.

OUTCOMES

To facilitate complete and standardised reporting of fall incidents a new form for recording fall circumstances and post fall progress notes was developed and placed in dedicated 'Falls Folders'. An existing computerised database of falls information was also made easier for staff to enter data into.

Flow charts were developed to provide staff with a clear protocol to follow when a fall occurred, and placed on facility walls. The flow charts provided injury specific procedures to follow, and included information about frequency of observations, and who to notify.

Disseminating information about the new reporting system to a large casual workforce, and five separate facilities presented a challenge. One successful approach was to include superseded incident report forms in 'Falls Folders' but with a large cross through each.

LONG-TERM IMPACT

The improved documentation of falls circumstance has allowed a more individualised approach to risk management. Frequent fallers have been identified, and factors contributing to their falls investigated and addressed, for instance by minimising clutter, improving lighting and providing high-low beds. Documented information has also been used to facilitate communication with families, providing evidence that can be used when explaining why certain interventions, such as hip protectors or lifting machines, are recommended.

The flow charts are on the walls of all facilities and provide a clear protocol for staff to follow if a fall has occurred, ensuring a standard approach across all facilities.

The Nurse Educator believes there has been a change of attitude amongst nursing staff regarding falls; it is easier to record fall incidents, more information is available to inform risk management, and falls are no longer regarded as inevitable.

CASE COMMENTARY

The practice changes in the two case studies are quite similar in the nature of the intervention i.e., policy, protocol and procedure changes accompanied by education. However, there are some substantial differences in

- Who has control of the clinical risk?
- Where in the clinical pathway should processes/procedures be changed to improve outcomes?

Engaging staff successfully requires identifying and addressing their concerns. Most important is explaining how the changes benefit the care of residents.

Sustaining the changes and resulting improvements to care, however, is reliant on ongoing monitoring, education and staff training.