MONASH University

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RESIDENTIAL AGED CARE COMMUNIQUÉ

SPECIAL EDITION: NETWORKING

VOLUME 7. ISSUE 2.
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CONTENTS

EDITORIAL

Welcome to the third and final edition in our series focussing on transferring knowledge. As you may recall the last two editions drew on case information from other parts of the world, the 'Office of the Chief Coroner' Ontario, Canada. This edition is much closer to home.

We describe the experiences of staff from a selection of Public Sector Residential Aged Care Services (PSRACS) in Victoria, Australia who participated in a small pilot program on learning through networking. The majority of participants completed the entire program and we are fortunate that they kindly shared their time to make this RACC edition possible.

In another departure from our usual format we do not have any new case reports of resident deaths from the Coroners Court and the edition is a little longer. However, we believe experiences of the RACS staff reported here will motivate and assist other RACS to consider networking with other organisations to improve our practice. We profile the experiences of two of the five groups in detail.

This issue includes a short description of the RACC pilot program and concludes with tips for networking.

FREE SUBSCRIPTION

The Department of Forensic Medicine, Monash University will publish the RESIDENTIAL AGED CARE COMMUNIQUÉ on a quarterly basis. Subscription is free of charge and the Communiqué is sent to your preferred email address.

If you would like to subscribe to RESIDENTIAL AGED CARE COMMUNIQUÉ, please email us at: racc@vifm.org

Next Edition: Sept 2012

Save the date Wednesday 28th November 2012

RACC and DoH will hold another networking training seminar in November.

The seminar is intended for staff working in Residential Aged Care Services to build or strengthen networking opportunities. We hope to have some of the participants from the first program attend as well as some guest speakers. Places are limited to 30 participants only.

Register your interest by emailing racc@vifm.org with your details.

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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**

DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organisations 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. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroner's Court jurisdiction.

RACC PILOT PROGRAM: MANAGING CLINICAL RISK THROUGH NETWORKING

Prof Joseph Ibrahim, Monash University

In 2011, Monash University co-ordinated a Department of Health (Victoria) sponsored pilot program to promote managing clinical risk through networking.

Essentially, we asked participants to see what, if anything, they could learn through networking, which is to talk and visit each other's organisations.

The pilot program ran between September 2011 and November 2011, and involved approximately twenty participants. The selected participants were mid-career level staff with responsibility for leading change practice improvement and education in PSRACS. A key requirement was the RACS executive and director of nursing would support the participants attendance at two seminars or "Masterclasses" in Melbourne and another two or three additional days off-site to visit their networking partners.

The first seminar, in September 2011, featured several guest speakers who helped to equip delegates with knowledge about engagement of staff, managing barriers to change, the nature of clinical risks and an approach to conducting site visits. We divided the participants randomly into five groups of three to five members. Each group selected their clinical risk topic. It was no surprise to find 'Falls Prevention" was selected by three groups with 'Pain Medication Management' and 'Cigarette Smoking' chosen by the remaining two.

We were not expecting them to solve these clinical risk issues; rather we wanted the groups to focus on networking to determine (i) if it was possible to network and (ii) whether it was helpful to network.

Following the first Masterclass, each networking group had twelve weeks to interact using email, telephone, video conference calls, face-to-face meetings or site visits.

At the second seminar, in November 2011, the groups reflected on their experiences and presented what they achieved. This is the basis for this edition of RAC Communiqué.

TRANSFERRING KNOWLEDGE FROM OVER THERE TO HERE

Recall the notes from our last two issues of RAC-Communiqué Volume 6 Issue 4 and Volume 7 Issue 1 "Is what happened over there likely to happen to us?" If we now apply it to the experiences of networking in your own region, much of the translation is done.

Clinical risk [Same] *Networking groups selected one clinical risk area to investigate.*

Time [Same] *The site visits are now! 2011! So reflect current practice.*

Place [Different] *Are all RACS the same? Participants argued differences exist between metropolitan, regional and rural settings. Also difference between low care, high care mixed services and aged person's mental health services.*

Person [Similar] *Residents at RACS are similar in age, presenting clinical condition and co-morbidities.*

Staff [Similar] *The health professional staff clinical training and practice are similar.*

Organisation [Similar] *This varied between the RACS sites visited, all public sector.*

Health care system [Same]

Legal and Coroner System [Same]

Society and geography [Similar] *No major social or geographic differences.*

Key message or lesson [Different] *Each RACS described their approach to the clinical risk.*

Recommendation for action [Different] *Each participant modified what they saw for their local conditions*

GROUP CASE STUDY #1

MAKING MEANINGFUL CONNECTIONS

Case Précis Authors: Fiona Kitching and Joseph Ibrahim, Monash University

Group Membership

Amelia, an experienced Quality Co-ordinator for Aged Care in a large public health service was nominated by the Operations Director for the pilot program. Amelia came expecting the usual conference format and was surprised to learn that travelling to other facilities was a requirement. Amelia was in a group of three, with James, a Nurse Unit Manager and Lucy, a Quality Manager.

Clinical Risk Area

The clinical risk area to be addressed was "pain management". You will recall from our RAC-Communiqué Volume 6 Issue 2 Dec 2011 theme included medication aspects of palliative care. http://www.vifm.org/education-and-research/publications/residential-aged-care-communique/

Networking

Once Amelia, James and Lucy returned to their individual RACS, they communicated through numerous emails trying to sort out the key topics to examine and confirming what documents to share on their visit. The group only completed one site visit, to a rural mixed care RACS which accommodates residents with both high care and low care needs.

On-site

Amelia, James and Lucy toured the RACS examining current observation charts and clinical documents, how medication was administered, how the medication trolley was stocked and discussed the RACS general approach to pain management. Amelia also took the opportunity to demonstrate the Key Performance Indicator (KPI) and operations reporting system she had developed for the whole RACS.

Personal observations: what new insights did each person gain?

Amelia gained a practical understanding of how short-term medication could be packed separately from regular medication for personal care workers to administer. She observed the use of the Wong-Baker scale, which was much simper than the existing '0-to-30' pain intensity rating scale Amelia's RACS were using.

James did not identify any new strategies for pain management that were suitable for translation into the RACS where he worked. Was it worth his time and effort to network?

Lucy was very impressed with the comprehensiveness of the KPI-reporting system Amelia had developed and saw that it covered some of the current reporting gaps at her own RACS. (Editor's note: not sure how they got talking about KPIs when the group was studying pain medication management!)

Translation of knowledge to their own RACS

Amelia took this new information back to share with the management group and the Deputy DON for Residential Services. With the support of the RACS and staff, Amelia was able to change the medication administration system and introduce the Wong-Baker pain scale as part of a larger project.

In regards to medication change, Amelia holds a regular meeting relating to the medication working party where they continued work with medication incidents and assess the systems implemented thus far. There are also quarterly Medication Advisory Committee Meetings where the project will be evaluated for improvement to the service.

James reaffirmed the belief and importance of ensuring procedures and clinical assessment tools are suitable for each RACS specific needs. He also gained a renewed level of confidence about how his RACS was managing pain medication.

Lucy trialled the KPI-reporting system and presented this to the quality team. Unfortunately, it was too complicated to completely change to the new system; instead it was added as a supplement to their current system.

Another major benefit of the Microsoft Excel database developed by Amelia was how it easily allowed for presentation of KPI data in an efficient and visual format.

Unanticipated benefits

Following the visit, this group continued sharing policies and clinical documents unrelated to pain management. Examples include "oxygen management" and "smoking management" policies. The challenge remained to translate one RACS experiences and approach to meet their own RACS specific systems and processes. At least now the group had something to work with and new people to debate the merits of their ideas.

Amelia's KPI-reporting system was distributed to all the participants in the pilot program, and was well received as it seemed to fill a gap that existed in many other RACS.

Following the pilot...

All three felt the pilot program was beneficial for making the initial contacts and setting up the networking with people in similar positions. Amelia stated it filled an existing gap by providing an opportunity to share information, documents and experiences. This group continues to work together today.

One of the limitations was being able to share "like with like" or keeping "apples with apples". Ideally, staff in similar positions would work together: James now has regular contact with a fellow Nurse Unit Manager from another networking group and Amelia has visited other RACS in the same region and service level.

GROUP CASE STUDY #2

A LONG AND WINDING ROAD TO THE UNEXPECTED

Case Précis Authors: Fiona Kitching and Joseph Ibrahim Monash University

Group Membership

Emily, a Deputy Director of Nursing from a small rural mixed care facility and Sarah, an Aged Care Manager from another small rural mixed care facility were nominated and supported by their RACS management to take part in the project.

Both were enthusiastic from the start, and when their third group member was unable to complete the project, Sarah brought in Amber, a Nurse Unit Manager from their same RACS.

Clinical Risk Area

The clinical risk area to be addressed was "falls management". You will recall from our RAC-Communiqué Volume 2 Issue 2 Mar 2007, the theme focussed on the clinical risks of falls. http://www.vifm.org/education-and-research/publications/residential-aged-care-communique/

Networking

This group exceeded everyone's expectations by completing three on-site visits and travelling 1136 kilometres in total! They visited each other's RACS and went on to do a third on-site visit to a large urban RACS. Interestingly, this group also brought along other staff from their RACS (a falls project manager and nurse unit manager) to the visits.

On-site

After recovering from the long road trip to each other's RACS this group took a very interactive approach to gathering information and comparing practice. This included a tour of each facility, looking at resident admission procedures and the facility layouts and decoration; speaking to the DON's, staff and residents; and sharing tools and resources around fall prevention strategies.

Personal observations: what new insights did each person gain?

Each member of the group commented that falls prevention management was a universal challenge in every RACS irrespective of size or type. The most common areas under scrutiny were prevention of falls in residents who are "frequent fallers" and those who have dementia. One approach recently introduced by the larger RACS had strength training for the vulnerable groups but it was too early to tell if this reduced falls.

Emily gained new insights by reviewing other RACS falls prevention policies and observations chart for head injury following falls. She also observed how one RACS was using local street names and local landmarks on the walls to help orientate residents.

Sarah and Amber explored the challenge of managing residents who are mobile and "wandering" during their visit to a rural facility. They observed the presence of environmental modifications that a few cognitively intact residents had chosen. They used a split door to their room i.e. "barn door" providing residents with a degree of security and yet retaining some openness to the rest of the building.

During the visit to the larger urban facility, Sarah and Amber observed a residents "virtual' walking program. This program is a virtual journey around the local area. Residents exercise in the RACS and keep track of how many steps are completed and equivalent distance is mapped onto local landmarks. After walking a certain distance, the residents have walked to "a nearby regional town, such as Ballarat and back".

Translation of knowledge to their own RACS

Emily found that the fall strategies observed at other RACS were not particularly effective for frequent fallers. Her RACS is now looking at staffing changes so as to have more observations during vulnerable times, particularly during hand over. However, Emily reviewed her RACS falls policy and implemented a new observations chart for head injury following falls. Emily is also considering introducing the "local street and landmark" concept.

Sarah and Amber brought the concept of the virtual walking program back to their RACS Activity Team, which then adopted and modified the program in the form of a daily 11 o'clock walk for residents. Additionally, they introduced a prize for the first person to reach their local landmark.

Sarah and Amber with the RACS maintenance staff are also in the process of considering implementing the "barn doors" concept. (see Editor's note below)

As with the other groups in the pilot program, this group reiterated the importance of adapting the information, tools or procedures to your RACS and not to waste time "reinventing the wheel"!

Unanticipated benefits

The group found the opportunity to observe other RACS and other aspects aside from falls prevention management invaluable. They found inspiration and a sense of collegiality seeing and understanding they all faced similar challenges.

The generosity of staff and each RACS sharing their time, knowledge and experience was extraordinary. This created a sense of "not being alone" and knowing that there is always someone else in the same position who is easily contactable and ready to help made a profound impact when facing the next new challenge at work.

Another unanticipated benefit was the confidence and reassurance of staff from the smaller rural RACS gained by seeing that larger and better resourced RACS were often no nearer to solving the challenges of falls prevention.

The rural RACS also swapped policies on smoking, falls and diabetes management.

Following the pilot...

The group members remain in contact with each other and in particular, the nurse unit managers. They continue to share policies, documentation and experiences, especially around accreditation.

Their key lesson to others is the need to make an effort to establish personal and professional relationships for networking to succeed. Also, this group highlighted the importance of having an enthusiastic and supportive executive management in the RACS. Without this support the time and resources required to complete the pilot program would not have been possible.

Editors Comments

Barn doors would not be seen as best practice as they are considered a form of restraint. Barn doors also often do not meet fire safety codes as they are makeshift and secured using 'bolts' rather than having a single action to exit.

See page 7 of the decision making tool 'person to person' restraint at http://www.health.gov.au/internet/main/publishing.nsf/Content/AE6A3DEC50534D27CA256F4700752CFF/$File/decisiontool04.pdf

COMMENTARY: TIPS ON NETWORKING

Networking is a term we use every day now predominantly in reference to the social networks on the World Wide Web. In essence, networking is a way for us to be known and to know others.

The reasons for networking vary dramatically. In the past year we all received invitations to join web based networks for either personal, professional, research or business reasons.

The way we network has also changed. In the past we used to network face-to-face whilst engaged in community work, at the local sports, school activities or seminars and conferences. Now it seems predominantly via telecommunications based modalities.

So, why did we implement a pilot program that mandated on-site visits? Especially since most of the information could be obtained from RACS web sites, telephone calls, emails, or from published practice manuals and guidelines. There are several reasons.

First, face-to-face visits are likely to build better and longer lasting relationships. To share the hard earned information and knowledge gained from making mistakes we must trust each other. It is in our nature to present staff, organisation and ourselves in the best possible light. This is not always helpful to another person who wants to emulate the same program. To help someone learn from our mistakes, so they avoid repeating the same mistakes, we need to give the whole story "warts and all".

Second, the unanticipated rewards, learning something you were not expecting. Each of our networking groups travelled with a clear purpose, to solve a specific problem. Yet, each came back having discovered something unrelated that was just as helpful. By going to another place you look and intuitively compare everything you see with what you do in your own workplace. These experiences are not easily described or passed on in an email or a telephone conversation. One group goes to look at medication management and comes back with a KPI-reporting system! Another group goes to examine falls prevention and return with a renewed sense they are doing a good job with their limited resources.

A third reason was to give all RACS a sense of perspective and that each place has strengths and limitations. That more resources are not necessarily the answer to the challenges we face. Many regional and most rural RACS were "doing a good job". The participants from rural RACS came away from the networking experience with a better understanding they are constrained by having to "wear several hats" that there could not be a specific staff member for every initiative. Most importantly, "even though we don't have all the bells and whistles, we are doing a good job with what we have".

The final and major reason was that we recognised that collegial relationships and networking opportunities existed at executive level, usually at Directors and Deputy Director of Nursing levels. We wanted to see whether networking with unit managers who are really at the coal face would be beneficial.

What tips did the participants give?

- Must be committed "heart and soul", will not succeed if you participate because your manager told you to!
- The opportunity to meet another person in the same position as yourself is invaluable
- It requires a lot of work, but it is fun and enjoyable
- Get executive support as networking takes time and requires time away from your RACS
- Ideally, find a RACS that is geographically close to yours
- Plan ahead to save time, use email and telephone to set up the visit
- If possible, tour the whole RACS and talk to staff, do not just focus on the single clinical risk issue
- One of the best aspects of the visits was learning from incidental discussions, topics we had not planned to discuss
- Whilst on the site visit remember to consider your strengths, don't simply focus on the gaps in your own practices
- Learn from their experiences and share your own experiences, do not reinvent the wheel
- Do not hesitate to adapt and modify according to the needs of your RACS

LIST OF RESOURCES

1. Previous editions of RAC-Communiqué http://www.vifm.org/education-and-research/publications/residential-aged-care-communique/

RAC-Communiqué Volume 6 Issue 4: Translation I

RAC-Communiqué Volume 7 Issue 1: Translation II

2. Wong-Baker Pain scale

The official home of the Wong-Baker FACES™ Pain Rating Scale at http://www.wongbakerfaces.org/

3. The guidelines from the Australian Pain Society: Pain in Residential Aged Care Facilities. Management Strategies, 2005, can be accessed at http://www.apsoc.org.au/owner/files/9e2c2n.pdf. It is worthwhile looking at the appendices that provide details of the different types of pain scales and assessments.