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RESIDENTIAL AGED CARE COMMUNIQUÉ

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CONTENTS

EDITORIAL

Welcome to the third issue of 2012, in which we present one new case that potentially covers all the topics from the past 12 months. Our intention is to consolidate the lessons from the past five Residential Aged Care Communiqué (RACC) issues.

For the first time, we also broach the topic we have been avoiding for a long time, how to use numbers and statistics to analyse clinical care and manage risk. Our approach will help readers to a better understanding of measuring aspects of care and to interpret quality indicators.

Hopefully you are still reading and have not been deterred by the mention of statistics. First, a word of reassurance, we intend to maintain the longstanding existing format of the RACC by presenting the stories or narratives in our usual case reports. Second, we are introducing numbers slowly and in small steps. In this issue, there are no equations and; Dr Jeffcott describes why some of us prefer numbers and others prefer stories to improve care.

Finally, we value any suggestion or questions from our readers about aspects of statistics and quality indicators that we should answer in future issues.

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 issue: December 2012

SAVE THE DAY: WEDNESDAY 28TH NOVEMBER 2012

RACC and DoH will hold another networking training seminar later this year in November. The seminar is intended for staff working in Residential Aged Care Services to build or strengthen networking opportunities. We expect to have some of the participants from the first program as well as invited experts as speakers. The places are limited to 30 participants only.

A registration and information form were sent with this edition.
Register your interest by filling out the registration form and sending to: joseph.ibrahim@monash.edu

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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.

RESPONSE TO LAST ISSUE:

BARN DOORS ARE SURELY FOR BARNS

Prof Rhonda Nay

Aged care facilities are certainly not barns and are no place for barn doors. The only reason I imagine these may be in place is to stop people with dementia going into areas in which they are not welcome. This suggests a lack of awareness of appropriate assessment and potential interventions.

Let's imagine Bertie is forever pacing into Gertie's bedroom and she is not at all pleased. The first question to ask is 'Why is Bertie wandering'? In order to answer this question an assessment is required. For example, a physical assessment may find he has pain from arthritis, constipation and blocked ears that impair hearing; a social assessment demonstrates he is bored and lonely; an environmental scan shows it is not possible to distinguish one room from another and he cannot get outside to feed the birds or water the lawn.

Regular analgesia reduces the pain; addressing the blocked ears and constipation makes him a lot more comfortable – now what?

The RACS arranges for Bertie to join the group that works with the local school and he and the children love it. His boredom is replaced by something meaningful. The staff find out he used to paint houses so they set up an area where he can paint the wall every day. The garden area is assessed for falls risks and then he assists with gardening. A volunteer takes him for a walk; they have an ice-cream and watch the dogs in the park. After all of this he is tired but relaxed and ready to sit and watch his favorite program in his room with a lovely view. He knows it is his room by the readily identifiable clothing and pictures placed on and near the door. Now he is happy and so is everyone else!

Yes it takes some CSI (criminal scene investigation) skills to investigate beneath the surface and some HOUSE (Handover using scrutiny and evidence) to brainstorm and use all of the knowledge Bertie, staff and family can offer BUT it is worth it to see him and the other residents happy.

LIST OF RESOURCES

1. Pope C, Mays N. Critical reflections on the rise of qualitative research BMJ 2009; 339: b3425. This article explains how qualitative methods are integrated with quantitative methods and help us to feel less intimidated by numbers.

2. Royal Society Arts (RSA) Animate-The divided brain. This is an amusing and informative animated short talk about the brain. Well worth a look and at around 11 minutes duration easy enough to fit into a busy schedule. <http://www.youtube.com/watch?v=SbUHxC4wiWK>

3. Residential Aged Care Communiqué Volume 6 Issue 2 May 2011, focused on the use of mobility aids, specifically motorised scooters and wheelchairs.

4. Residential Aged Care Communiqué Volume 6 Issue 3 Sep 2011 focused on the 'Dignity of Risk' discussed the contentious issue of risk, rights and responsibility.

5. Residential Aged Care Communiqué Volume 6 Issue 4 Dec 2011 and Volume 7 Issue 1 Feb 2012; focused on what happens in Canada using the information provided by the 'Office of the Chief Coroner', Ontario.

CONSOLIDATING OUR LEARNING: APPLYING NUMBERS TO STORIES FROM THE RECENT PAST

Prof J E Ibrahim Monash University

The commentary by Dr Jeffcott described the importance of examining the story behind the numbers. This section will discuss how we apply numbers to help us manage risk after learning from the story.

Counting

In May 2011, RACC presented the case of a 90-year-old male with leg weakness due to a peripheral neuropathy. The resident entered a busy 4-lane roadway riding a motorised scooter and died from head injuries sustained in a collision with a motor vehicle. The coroner concluded the "deceased's own actions…, were the direct cause of his unfortunate death". One of the questions raised by this case was "Is there a need for assessment and training for all potential motorised scooter users?

How do we know if this is just "an accident due to bad-luck" or if there is a bigger problem with the use of motorised scooter?

We cannot tell if the only information we use is the "story" from that one RACS. However, counting all the stories, will give a number and that helps to answer the question. There were 30 deaths related to motorised scooter to a coroner in Australia between July 2000 and May 2006. Does this suggest a lot of 'bad luck' in lots of places or a national and 'systems' issue?

From counting to a ratio and then to a rate

In Sep 2011, RACC presented the case of a 78-year-old female heavy cigarette smoker with dementia who lived at a RACS requiring high-level care. She died from fatal burns when her clothing accidentally caught alight while smoking in a designated outdoor area and that the lack of supervision was a contributing factor. The coroner recommended that the formulation of a Care Plan about a resident's smoking habit must be properly documented.

How do we know if we are close to achieving this recommendation?

You guessed it! Statistics is the answer. Lets count. Say we have 30 residents in RACS-A, of whom ten are smokers, of those five care plans documented a risk assessment. Is that acceptable? Sometimes we need more than just a count.

What we want to really know is how close are we to achieving the objective, in this situation we have five out of ten care plans done (5/10) or 50%. Sounds simple and perhaps even unnecessary? That's because the number of residents is small. Now imagine you are in RACS-B have 167 residents, 63 smokers of who 36 have a completed risk assessment (36/63) or 57%.

Using rates to compare

In Dec 2011, RACC presented the case of an 89-year-old female resident and former Olympic athlete with diverticular disease, recurrent falls and osteoporosis with fractures of the thoracic spine. The resident died from an acute cerebrovascular event complicating a bowel perforation from stercoral colitis most likely due to constipation.

So how do we know what is happening with all our residents?

Statistics will answer the question. RACS-A reviews all 30 current residents' medication charts and care plans on the same day, finding 13 residents on opiate medication, 9 residents are receiving regular aperients. RACS-B reviews their 167 residents, 56 are on opiates and 41 are on aperients. We want to know who is NOT getting aperients.

If we compare counts, RACS-A has (13-9=4) four compared to RACS-B (56-41=15) fifteen residents not on aperients. What is your conclusion? If we compare rates RACS-A has (4/13) or 30% compared to RACS-B (15/56) or 27% not on aperients. What is your conclusion now?

Comparisons with incomplete information

In Feb 2012, RACC presented the case of an 84-year-old male with a myocardial infarction who was discharged from an acute hospital to a long-term care facility for convalescence care, where he subsequently died. Investigation of the death revealed gaps in documentation of clinical information, communication and medication management. One of the recommendations was for acute care general hospitals to provide comprehensive information when frail elderly patients are transferred.

How do you know if this is being done?

This is a bit trickier. Statistics from our RACS will only partially answer the question for the acute hospital. Let's say the hospital has transferred 112 residents to nine RACS in the past year. All five residents they transferred to our RACS-A had comprehensive documentation (5/5 or 100%). Does this give you confidence the hospital is doing well? Yes, but let's now assume that the nearest RACS-B tells you "we had the complete opposite experience only one of our twelve residents came back with comprehensive documentation." That is 1/12 or 8%. This example illustrates how incomplete counting may be misleading.

If the hospital checked on every resident transfer and found 90/122 (80%) had comprehensive documentation. We now have three separate numbers to interpret; (i) overall hospital transfers 80%-this sounds reasonable; (ii) RACS-A has 100%-fantastic! and; (iii) RACS-B has 8%-not so good! Therefore we should drill down and find out the real story, why is there a difference between RACS-A and RACS-B, what is the hospital doing that gives such different levels of performance.

Counting numbers then calculating rates tell us about the big picture, the experiences of everyone not just the single incident. By counting we can look at what happens over time (a week, a month, a year), in different places (a section, a wing, a facility, an organization) and in groups of people (staff and residents). Numbers give us an objective indication of the size of a problem or how well we are performing. The stories explain why things happen. We need both the stories and the numbers if we are to successfully improve care.

BATH TIME

Case Précis Author: Prof J E Ibrahim
Monash University

Clinical Summary

Ms AAA a female resident required high-level care at a Residential Aged Care Service (RACS) since 2000. Ms AAA was well organized and had an advance directive in place. Past medical history included: cerebrovascular disease, severe dementia, hypertension, osteoporosis, obesity and osteoarthritis. These medical conditions meant Ms AAA was unable to talk, had dual incontinence and required full assistance with personal care. For mobility and transfers Ms AAA required the use of a wheelchair and a mechanical lifting device.

One morning, in 2007, the personal care attendant who was bathing Ms AAA called for help. The Registered Nurse attended the bathroom and found Ms AAA in a tub chair on the floor in front of the bath with a deep laceration to the forehead.

Ms AAA was transferred to the Emergency Department and had X-rays of the cervical spine, right forearm and a CT scan of the brain as well as some laboratory tests.

The laceration to the forehead was sutured, the fractured forearm was reduced and a plaster slab applied. Ms AAA returned to the RACS around noon and on arrival was noted to be cold and clammy. Her doctor was called within the hour and requested that Ms AAA be returned to the Emergency Department, she was admitted to hospital where care was according to her advance directive and died the following day.

Pathology

The autopsy revealed traumatic internal and external injuries consistent with the fall. These included a fractured wrist, a slight retroperitoneal haemorrhage and minimal bilateral subdural haemorrhages. However, the pathologist was of the opinion that these injuries were not enough to be the direct cause of death.

Investigation

The investigation into the case revealed that after the bath was completed Ms AAA was raised out of the bath seated in the "bathtub lift chair". The PCA wheeled Ms AAA to the end of the tub and wrapped her in towels to stay warm. The chair was about 1 metre off the ground. The PCA then turned to rinse the bath; she also raised the bath to allow it to empty quicker whilst completing this task the PCA heard the chair hitting the floor.

An independent expert assessed the bathtub lift system and determined it was in good working order. The manufacturer's instructions noted that the lifting device should be lowered as soon as the resident is out of the bath, and the chair should be kept well clear of the tub.
The RACS policy and procedures were also reviewed and these noted that residents should not be left unattended in 'lifting device'.

Coroner's Comments and Findings

The coroner concluded that: as there was no other alternative explanation, the fall related injuries did contribute to death; that bathing of residents with significant cognitive and physical impairments was a high-risk activity that requires vigilance; that the bath chair was left elevated when it should have been lowered and; that raising the tub is likely to have tipped the chair.
Two recommendations from this investigation: RACS should review policy and procedures for the use of mechanical lifting devices and; staff that operate these devices should undergo training, certification and periodic re-certification in these devices.

Editor's comments

This case has aspects from all the previous five RACC issues: (i) Appropriate use and maintenance of equipment; (ii) Falls and harm minimisation; (iii) 'Dignity of Risk': would a sponge wash in bed be preferable? (iv) End of life planning; (v) Communication between acute hospitals and RACS and; (vi) Learning from other parts of the world, this case is from Canada.

RIGHT OR LEFT-BRAIN: NUMBERS & STORIES

Dr Shelly Jeffcott

Quality of care and managing clinical risk in aged care relies on numbers or measurement to monitor performance and an understanding of the stories behind the numbers.
Falls and harm minimization is a good example. Collating incident reports tells us about: how many falls occur; where the falls take place and; over what given unit of time (day, week, month or year). However, unless we also have the narrative information from those involved we are limited in our interpretation of numbers. For example, how do we interpret a high rate of falls? Do certain areas report more often or are they less safe? We need both numbers and stories, so why do we have a preference for one?
Psychological theory discusses and debates the lateralisation of brain function. A left-brain dominant person is often characterised as more logical, analytical and objective, while a right-brain dominant person is said to be more intuitive, thoughtful and subjective. Being even more simplistic, popular press commonly characterise 'left-brainers' as better organised and successful, whereas 'right-brainers' are dreamers who feel too much! The reality is both have strengths and weaknesses. Also, many of us, regardless of which side of our brain may be dominant, find numbers and statistics intimidating, boring or have just never gotten to grips with the mystery that is mathematics!
Another problem is that we incorrectly believe numbers don't leave us room to question how the organisation and culture of the organisation (i.e., factors that impact on individuals, teams and institutions) influence practice. Numbers and "number crunching" start the dialogue. It is important to use numbers to guide us to where in the system we need to drill down and find out the real story behind what is happening and why.
There is no shame in not liking numbers. It may come down, perhaps, to our natural tendencies to be more right-brained dominant or it could just be the poor ways in which we are often taught. Why else do we have books such as "Statistics for the Utterly Confused"? The good news is you are not alone and help is at hand. We are not asking anyone to like statistics. We are asking you to start using numbers to help improve care.