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Jelica's Link

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An independent newsletter for people working in Aged Care

In this issue:

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Analysis of Medication Issues from Ministry of Health Aged Residential Care Certification Data

As some of you will know I have been trying to find out what the specific issues were in medicine management scoring badly during audits. I am pleased to report that I received an email from Marion McLaughlan, who was following up on outstanding emails, to ask me if I had received that data which I didn't and Marion promptly send me the report, thank you Marion. As far as I understand this report was finished in October of last year. The following is a extract of the report but a good reflection of what the issues are according to the audit outcomes.

Prepared by: Dr Michal Boyd, RN, NP, ND
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Research Data Manager, Freemasons' Dept. of Geriatric Medicine Faculty of Medicine and Health Sciences The University of Auckland.

This report summarises the medication issues from aged residential care certification data collected on behalf of the Ministry of Health (MoH) from June 2009 to July 2010. The data were collected from 238 facilities across New Zealand and focuses on 7 specific aspects of medication management best practices and legal requirements.
All data was anonymous and specific facility names or other identifying information was blinded to the researchers. Data were classified into the main areas that were judged to have 'not attained' or 'partially attained' (PA) the standards expected by the MoH.
The seven audit data fields for medication management are:

- Medicines Management Systems (144 PA)
- Policies and Procedures (16 PA)
- Staff Competence (71 PA)
- Allergies Procedures (23 PA)
- Self Administration Procedures (31 PA)
- Recording and Communicating Medication Management Information (109 PA)
- Accounting for Resident and Others' Views (0 PA)

Results of this analysis show that overall there are three fields of evidence representing significant portion of non-compliance issues: **Medications Management Systems; Staff Competence; and Record Keeping.**

Within these the main themes are:

- Ensuring all documentation is appropriately signed;
- Checking and recording controlled drugs;
- Secure and appropriate storage of medications;
- Ensuring all records are kept up to date;
- Providing evidence for 3 monthly reviews of resident medications; and
- Currency (or evidence) of staff competence.

The results of this analysis of audit data identified objectively measured facility level issues. The results of this analysis provide information which can inform interventions to improve facility level medication management processes and procedures.

Think of the beauty still left around you and be happy

The main issues with medications management are identified as:

- The main **storage** issues related to either the security of storage (8), the maintenance or checking of an appropriate fridge temperature (9) and the storage of medications within the main fridge used for foods (9).
- Over half (17) of the issues with the **management of controlled drugs** pertained to carrying out the weekly controlled drug checks on a regular basis.
- **Documentation and record keeping** issues related to a failure to document various procedures (medication reconciliations, fridge monitoring, controlled drugs checks) as having taking place.
- Issues with **signing documentation** included GPs failing to sign prescriptions and other documents and issues with signing for medications once administered (either left unsigned or block signed at the end of the round).
- **Administration of medications** issues mainly related to the unsecure storage of drugs during the medications round (6 instances, plus one noted under the staff competency field), staff not observing residents taking their medications (3) and medications being administered at the wrong time of day (3).

Policies and procedures:
The main reason for partial attainment was for one aspect of the medications management policy to be either absent or not compliant within MoH guidelines. Medications reconciliation was identified as an area of policy missing for 4 providers (and in 2 instances specifically relating to short term or respite residents this was the most common aspect of policy that was found to be absent). Others included Diabetes Management, Verbal Orders Procedures, Standing Orders Policy, Disposal of Medications and PRN policy.

Staff competence
Thirty percent of providers only partially attained the required standards.
The main issues in relation to staff competence relate to the currency of competency assessments and the ability of the provider to show evidence that staff competency assessments are up to date.

Allergies procedure
23 providers did not fully attain the required standards with regards to processes of identifying, recording, and communicating a consumer's medicine-related allergies or sensitivities.
The main issue is that not all residents have an allergy history recorded. In many instances this relates to a failure to document that the resident does in fact have no history of allergies. This should, however, be recorded.

Self-Administration
There were 31 providers that only partially attained the required standards for the facilitation of safe self-administration of medicines by consumers.
The main issues were around the storage of self administered medication. GP approval not recorded. Self administration training not provided. No policy detail or policy not followed. No consistency in the formal checking of self administered medication.

Recording and communicating medicine management information
There were 109 providers that only partially attained the required standards for recording and communicating medicine management information effectively.
The main issues in terms of provider record keeping related to the signing of documents (medication charts, prescriptions etc) and the recording of the 3 monthly reviews of resident medications by GPs. Controlled drug checks were also often not recorded and in ten instances documentation was noted to be illegible or unclear. Stock taking of medications not completed.

No photo ID for all residents for recognition when administering medications. Recording times and dates of medications. Block signing of documents

Conclusion:

This paper reports the results of an analysis of certification data collected from 238 aged residential care facilities between June 2009 and July 2010. The most commonly reported compliance issues involved medication management, staff competence and documentation. The highlighted issues indicate important overall quality issues in the medication management systems at the facility level. This analysis found many repeated phrases and terms in the free text boxes and future medication certification data could be more effectively and efficiently collected and analysed with the addition of standardised electronic reporting templates. This analysis increases the overall understanding based on the certification data of the current issues with medications in New Zealand.

See website for full report: www.jelicatips.com

National Dementia Co-operative

More than 70 people from the health sector attended a one day workshop in Auckland last week which was facilitated by Bupa. I was very pleased to be one of these people. Senior clinicians, planners, funders, a range of health professionals along with senior representatives from NGO's and the MOH met to discuss the possibility of establishing a national dementia co-operative which would be based on the model currently working so well for advanced care planning

There were a number of high profile speakers through the day but a significant amount of time was spent in groups gaining feedback on the initiative.

Gina Langlands – Bupa's GM Quality and Risk proposed the formation of a national co-operative whose membership is open to anyone who is or will be involved in the design or delivery of dementia care and services

The co-operative would work together as a group and be tasked with driving a collaborative approach throughout NZ

A friendly look, a kindly smile, one good act, and life's worthwhile

Hospice NZ Education Project

This project is well on the way to producing the new HNZ Fundamentals of Palliative Care education resource that will assist member Hospices to support and educate residential aged care staff who are working with residents requiring a palliative approach.

The new HNZ education resource will sit alongside both the HNZ Syringe Driver and HNZ Care Assistant education resources and will be administered in a similar way.

HNZ was assisted in developing the resource through collaboration with the residential aged care and health of older people sectors, ensuring the learning packages are 'fit for purpose'.

Our focus is initially on aged residential care however the resource will be modified and offered to all settings where end of life care is provided, such as general practice and hospital/acute care settings, within the next two years.

Most of the information is aimed at all staff within a residential aged care facility, registered and unregistered, including administration (management, reception, etc). It is a truly multidisciplinary education resource.

There are recommended timeframes for each learning package however individual facilitators will take a flexible approach to the length of each session in order to meet the needs of the facility/participants.

Everyday is a gift, that's why they call it the present	It is envisaged that the learning agreement and the facilitation of educators for each learning session will be jointly delivered by a local hospice educator and gerontology educator (DHB GNS or on-site facility nurse educator, depending on the local arrangement). The following are the learning packages: 1. Essence of palliative care 2. Ethical issues in palliative care 3. Pain and symptom management 4. Palliative care for people with chronic illness 5. Palliative care for people with dementia 6. Communication skills 7. Last days of life 8. Loss and grief 9. Caring for ourselves Session 1 is an important introduction before any other package – introduces the model of total suffering. The rest of the packages can be done in any order to meet the needs of the participants and the facility. Each learning package will have a self learning component which will be completed prior to the formal training sessions. The pre-learning packages will be tailored to meet the needs of anyone wishing to complete the modules ie: RN's/EN's, care assistants, allied health staff, support staff, volunteers, etc. The suggested post-learning activities will include discussion groups, journal clubs, critical incident appraisal and case reviews. Pre-session learning activities will assist participants to focus on what they already know about caring for residents requiring a palliative approach as this relates to each of the learning packages. Post-session learning activities will ensure participants translate the information and experiences of the session back into the working environment and the care of both themselves and residents. **Current status of the project** Hospice NZ has the support of member hospices to move to the pilot phase of the Ministry of Health contracted education project. The pilot will test the "Fundamentals of Palliative Care" learning package material prior to publishing the resource and releasing this out to all member Hospices. The pilot will run from 2 May and will run through until 1 July. Educators will deliver pilot training in 2-3 aged residential care facilities throughout May and June. Educators and facilities will select 3 learning packages from the 9 available. An introductory learning package will be compulsory in each setting, but the other two packages may be offered based on the training needs of the staff in the facility. Pilot evaluation processes will be agreed and completed, where possible. We anticipate every hospice working with appropriate aged care and gerontology educators when establishing the training needs of an aged residential care facility and delivering the training. Post-pilot we will incorporate the feedback and learning from the pilot into the learning packages and finalise the education resource by 17 July. The design and publishing of the final resource will be completed by early September. National trainer training in 7 regional locations will occur throughout September. From October onwards hospices can roll out the HNZ Fundamentals of Palliative Care to residential aged care facilities throughout their local community at a pace dependent on resourcing. **Hospice NZ regional education representatives** In discussions with both the Ministry of Health and the National Health Board we have been advised that future Health Workforce training initiatives will be rolled out regionally, Northern, Midland, Central and Southern. HNZ would like to use a similar structure for our educator/trainer training and support systems, although for resourcing and practical purposes we will likely have eight regions.

"Good health and good sense are two of life's greatest blessings

Our goal is to grow and support the team of educators delivering the full range of HNZ education resources, increase the range and number of community palliative care providers that we support, while ensuring consistency of both quality and material delivered. This format and support is already in place in some areas and we hope to replicate these systems in every region. The 'Regional Representative' educator support role will link in with the Hospice NZ national educator support person, Anne Morgan and establish quality and support systems.

Anne Morgan and Maree Meehan Berge

Noro Virus

These guidelines outline steps that should be taken to ensure the prevention and control of norovirus gastroenteritis outbreaks in healthcare settings.

Norovirus—the stomach bug

- Norovirus is a highly contagious illness caused by infection with a virus called norovirus.
- Norovirus infection causes acute gastroenteritis (inflammation of the stomach and intestines); the most common symptoms are diarrhoea, vomiting, and stomach pain.
- Anyone can get norovirus, and they can have the illness multiple times during their lifetime.

Norovirus illness can be serious

- Norovirus can make people feel extremely ill and vomit or have diarrhoea many times a day.
- Most people get better within 1 to 2 days.
- Dehydration can be a problem among some people with norovirus infection, especially the very young, the elderly, and people with other illnesses.

Norovirus is highly contagious and spreads rapidly

- Noroviruses are highly contagious, and outbreaks are common due to the ease of transmission.
- People with norovirus are contagious from the moment they begin feeling ill to at least 3 days and perhaps for as long as 2 weeks after recovery, making control of this disease even more difficult.
- Norovirus can spread rapidly in closed environments like aged care facilities

Many sources for norovirus infection

Noroviruses are found in the stool and vomit of infected people. People can become infected by

- Eating food or drinking liquids that are contaminated with norovirus.
- Touching surfaces or objects that are contaminated with norovirus, and then placing their hand in their mouth.
- Having direct contact with an infected person; for example, by exposure to the virus when caring for or when sharing food, drinks, or eating utensils with an infected person.

Tips to prevent the spread of norovirus

Avoid exposure to vomitus and diarrhoea. Contact precautions should be implemented and affected patients should be placed in a single room if they have symptoms that are consistent with norovirus gastroenteritis. Personal protective equipment such as gloves, gowns, and possibly face masks, should be used when entering patient areas under contact precautions. Also, during outbreaks, symptomatic patients should be placed on these precautions for a minimum of 48 hours after resolution of symptoms to prevent transmission to other susceptible patients.

I have enjoyed life a lot more by saying yes than by saying no

Secondly, consider minimizing patient movements within a unit during outbreaks and consider suspending group activities (such as dining events) for the duration of the outbreak. If staff members become ill, exclude them from work for a minimum of 48 hours after the resolution of their last symptoms.

Practice proper hand hygiene: Wash your hands carefully with soap and water, especially after using the toilet and always before eating or preparing food. Alcohol-based hand sanitizers (containing at least 62% ethanol) may be a helpful addition to hand washing, but they are not a substitute for washing with soap and water.

Take care in the kitchen: Carefully wash fruits and vegetables, and cook oysters and other shellfish thoroughly before eating them.

Do not prepare food while infected: People who are infected with norovirus should not prepare food for others while they have symptoms and for 3 days after they recover from their illness.

Clean and disinfect contaminated surfaces: After an episode of illness, such as vomiting or diarrhoea, immediately clean and disinfect contaminated surfaces by using a bleach-based household cleaner as directed on the product label or a solution made by adding 5–25 tablespoons of household bleach to 1 gallon of water.

Wash laundry thoroughly: Immediately remove and wash clothing or linens that may be contaminated with vomit or faecal matter. Handle soiled items carefully—without agitating them—to avoid spreading virus. They should be laundered with detergent at the maximum available cycle length and then machine dried.

Sexuality in Aged Care

Sexuality in elderly is often a neglected area.
We often prefer not to think about it.
As you are expected to have a policy around this and provide staff with training at least on a two yearly basis what do you include? What is expected?
I have seen the topic in care plans and written next to it comments as: nil, not applicable, or just left blanc.
For a lot of people the term is often just about the act itself.

World Health Organization working definition: "Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors."
We are sexual beings from birth till death!

Sexuality is inclusive of sexual desire, intimacy, sexual behavior, the relationships we have and our self image and identity

Sexuality and sensuality go hand in hand.
Being close, feeling wanted, needed and valued. Developing and maintaining friendships, physical closeness, touch, feeling attractive. Identifying who we are and what we believe which can be achieved through the clothes we wear, the perfume we use, the way we present.

The best and most beautiful things in the world cannot be seen or even touched – they must be felt with the heart.

In the elderly it is often about intimacy like sitting together, holding hands, companionship. Physical closeness, emotional, intellectual, social and spiritual bond. Where thoughts, needs and feelings can be expressed without fear of judgment

Having these feelings met have a great impact on health and wellbeing. This shows that we should promote relationships. Allow people to feel special, attractive and loved again.

Expressions of physical intimacy have not received favourable responses and are widely viewed as 'abnormal or inappropriate behaviours' among the elderly.
Staff don't often receive in-depth training and are expected to "deal" with it or "discourage" it. Whatever "it" is.
Ask yourself what your own beliefs, thoughts and opinions are.
When does holding hands and having a cuddle stop being cute?
Can we say sex and older people in same sentence?
Do we ensure privacy? Knock on doors and waiting to be invited before going in.
Respect individual needs. Ensure clothes match or wearing the correct scarf?
Our attitudes arise from our own personal experiences, either positive / negative.
Despite being more aware many of us still find it challenging to allow the elderly to express themselves sexually.
A set of negative attitudes reported by staff, earlier studies found that older people's sexual expressions were met with apprehension, disapproval, judged as misbehaviour, and punished using restraints or segregation (Butler & Lewis, 1987).

Promoting open, comfortable, and safe discussion of sexual concerns among staff would be an important first step to creating a tolerant environment for accepting elders' sexual expression.
Understanding older person's perspective.
Comfortably discuss sexual concerns and have their sexual issues resolved

Perhaps the biggest step forward for the elderly will be when the population at large, care workers, and medical professionals realise that being old, disfigured or crippled does not of itself abolish desire for love and its sexual expression and that all people are entitled to the joy of it.
"There is nothing wrong with being, old, crippled or blind…..and in love. What is wrong is to keep apart two people who together could face the world better than each could alone"

Ref: Faruque, C. (2011). Senior sex: how old is too old to be sexually active? Self help magazine.
Low, L., lui, M., lee, D., thompson, D., & Chau. (2004). Promoting awareness of sexuality of older people in residential care. Electronic journal of Human sexuality, 8.
Nay, R. (1992). Sexuality and aged women in nursing homes. Geriatric Nursing, 13(6).

Budget in relation to *Kiwisaver*

- The $1,000 kick start remains unchanged.
- Effective 1 April 2012, the tax-free status of the employer contributions to Kiwisaver will be removed. In future these contributions will be taxed at the employee's marginal tax rate.
- The Government annual tax credit will reduce from a maximum of $1,040 per annum to $520 per annum.
- From 1 April 2013, the minimum contributions to Kiwisaver for both employees and employers will rise from 2% to 3%.

Dates to remember

RVA events :
13-16 June 2011 RVA Annual Conference, Langham Hotel, Auckland
More info on:
http://www.retirementvillages.org.nz

Masterclass by Dr Hans Becker (Humanitas, in Rotterdam) on 16 June

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Activities seminar
Registrations closed!
Proceeds go to Cancer Society

Spark of Life Auckland seminar
14 July 2011
Barry Court Motel and Conference Centre, 10-20 Gladstone Road, Parnell (see attached registration form)

Separate details for out of Auckland seminars will be emailed as soon as I receive confirmation from Jane.

NZHHA conference
3-5 August 2011, James Cook Hotel Grand Chancellor, Wellington.
More info on: www.nzhha.org.nz

NZACA conference
29-31 August 2011
SkyCity Auckland
More info on: www.nzaca.org.nz

Health & Disability Expo
Dec 2nd & 3rd, 2011
World of Possibilities, Disabilities, Healthy Aging and Independent Living EXPO ASB expo Centre, Greenlane, Auckland.
For information how you or your group or business can be involved, email adpnexpo@gmail.com

Some interesting websites:
www.eldernet.co.nz
www.insitenewspaper.co.nz
www.moh.govt.nz
www.dementiacareaustralia.com

REMEMBER!
Send your feedback, suggestions and articles showcasing your local, regional and workforce activities for publication in future issues.

This brings me to the end of this issue. I hope you enjoyed reading it and welcome any feedback you have.
With your help I hope to keep this a very informative newsletter with something for everyone.

Signing off for now. *Jessica*

If you choose not to receive this newsletter and wish to be taken of the data base please send me a return email.