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Jelica's Link

Issue 2

An independent newsletter for people working in Aged Care

In this issue:

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What a start!

In first instance I would like to thank all of you who have responded to the first issue. The response has been overwhelming and positive.
I received some constructive feedback which has been very helpful. I hope this feedback will be ongoing as it can only improve the newsletter.
One of the points I have been made aware of is that I should give some more information about myself. A valid observation, thanks Gina. So for the readers that don't know me:

I have been involved in aged care since 1984 in different positions. During my involvement with the sector, as manager of aged care facilities and my seven years as a lead auditor visiting aged care facilities throughout New Zealand I have established many links with different groups and individual providers.

I started to develop a complete Quality Assurance Programme in 1990 which is now widely used in the sector.

After 7 years auditing I became a sector educator, advisor, consultant and representing and supporting the sector on a number of ongoing committees and work groups i.e HNZ education working group (Palliative Care), Committee member on the NZS 8134.7:2010 Health and Disability Services Pharmacy Services Standard, Aged Residential Care Review (steering committee), HealthCert provider forums etc.

Aged Care has become a complicated sector and it can be difficult to keep up with all the compliance and legislation. Ensuring that the residents in your facility receive good care, their relatives good information, your staff all the compulsory training and getting through audits just to name a few! Don't despair. Help is only a phone call or email away!

I am available to provide on site assistance / consultancy when required i.e. preparing for an audit, implementing a quality programme, staff training, analysing data collated and develop corrective actions as a result of deficits identified (closing the loop).

I hope this gives you enough information about me.

Another point was the name of the newsletter and so far I haven't been more creative then the above. Anybody with another suggestion please let me know!?

Now let's get on with the rest of the news. I have changed the outlay for ease of reading. I hope you like it.

Restraint

Recently, the Ministry of Health (MoH) reconvened the Committee which developed the Restraint Minimisation Standard.

This was done because of increasing concern at the practice by many aged care facilities of locking exit doors by key pads and other devices and thereby denying residents normal freedom of movement.
The document is still in Draft form, but it is important for providers to be aware that there will be increased scrutiny of this practice and providers will be expected to comply with particular guidance, including Part 2 of the Restraint Minimisation Standard.

Services providing dementia level residential care where locked doors are an accepted and permanent aspect of service delivery are able to do so without questions as to the whys and wherefores.

However, there are consumers who are entering care in a more confused state and providers who do not provide dementia level care are resorting to the practice of locking doors in order to keep them safe without realising that this constitutes environmental restraint.

There is still debate in the Committee as to the final form of the guidance but there will be a definite need for providers who continue to practice environmental restraint to develop organisational and clinical rationales for doing so; to document, evaluate and review all such restraint; to document the impact on any client whose freedom of movement is curtailed; to have residents reassessed to determine if the care is appropriate and so on.

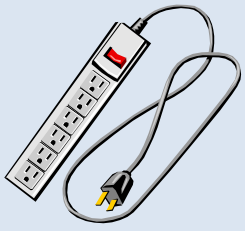
The MoH has undertaken to inform providers and the DHBs of these changes. The DAAs and the Committee have suggested some training re these new requirements for auditors might be in order.

Will keep you informed with more when the document is finalised.

Victoria Brown (committee member)

Electricity Checks

Compliance with NZS 8134.1.4.2.1 “All buildings, plant and equipment comply with legislation” includes electricity checks. HDSS criterion 1.4.2.1 Guidance states " This may be achieved, but is not limited to:
Meeting the following standards: AS/NZS 3551, NZS 3003.1, AS/NZS 3003, AS/NZS 2500. These Standards relate to medical equipment.
Ann Marie Bailey, Senior Advisor, HealthCERT responded to my question for clarification with the following: (quote)
“Medical appliances includes electric beds, hoist, scales etc., from my observations, DAA auditors all check these and make PA where they are not complied with, some also PA electric devices such as heaters and fans used in rooms if not certified safe for use, on the whole most providers are compliant with both medical and non medical devices, meeting not only HDSS but also OSH requirements. HDSS guidelines states "This may be achieved , but is not limited to" Employers are also required to comply with The Electricity Act 1992, The NZ Health & Safety in Employment Act 1992 and OSH regulations, these are covered by "but is not limited to:" (end quote)



Electricity checks would be considered good and safe practice as part of an effective OHSE programme. Testing and tagging to the AS/NZS 3760 standard is a highly effective control for electrical risks in the workplace.

If electrical equipment is in the workplace, then it can pose a risk and as such

should have some form of control in place. If electrical testing and tagging is not carried out then it would be recommended to have a documented risk assessment (to the AS/NZS 4360 standard) outlining the level of risk and the alternative proposed control to be implemented.

The following was sent to me by HealthCert as an explanation of their position.

How can I ensure electrical equipment is safe and meets OSH compliance criteria?

By having your equipment inspected and tested with appropriate test equipment by fully trained and experienced operators to AS/NZS 3760.

What is AS/NZS 3760?

This is the Standard that specifies safety inspection testing and tagging protocols for compliance with The Electricity Act 1992, The NZ Health & Safety in Employment Act 1992 and OSH regulations**.** The appliances that require safety testing are anything that plugs into a normal power point including computers, normal extension leads and power packs.

What is AS/NZS 3551?

This is the Standard that specifies safety inspection testing and tagging protocols for compliance with The Electricity Act 1992, The NZ Health & Safety in Employment Act 1992 and OSH regulations. for medical and dental electrical appliances. This standard is more stringent than AS/NZS 3760 and we use Registered Electrical Inspectors with appropriate training to do this inspection, testing and verification dossier reporting.

Who should comply?

In short every enterprise e.g. schools, government departments, factories, workshops, hotels, motels, restaurants, engineering & construction companies, offices, **health care facilities,** trades people etc.

Portable Appliance Testing - is it law?

Under OSH and the Electrical regulations **every employer** must provide an electrically safe workplace. **This is a statutory requirement.** Also many insurance companies require the insured to comply with all current regulations. The responsibility on the employer to ensure work equipment is safe is also covered by OSH regulations stating, "Every employer shall ensure that work equipment is so constructed or adapted as to be suitable for the purpose for which it is used or provided". This includes all work equipment (fixed, portable or transportable) connected to a source of electrical energy." Both OSH and Electrical regulations site AS/NZS 3760 as a means of compliance. **This is the law.**

What types of appliances need testing?

Basically any piece of equipment, which is powered by electrical energy and that, can be plugged into a wall socket.

Medication workgroup

In July 2010 Michal Boyd was given the contract to re-write the Safe Management of Medicines - A Guide for Managers of Old People's Homes and Residential Care Facilities which was published in September 1997
The manner in which this was undertaken was similar to the manner in which the care guides were developed with a large group of sector representatives.

We had quite a number of meetings to discuss the content. As the majority of people in the group were RN's there was a dangerous lean towards medication only to be administered by RN's which would have been very bad for the stand alones.

I believe that Michal understood that very well and she was also adamant that these are guides and not standards. In October, after several months of hard work and great feedback there were drafts for all of the Medication Care

Guides. We then had the final review of the drafts before they were sent to the Ministry of Health for expert review.

During the last meeting there was a last review of the Medication guides – considering feed back from experts in the field.

Looking back I liked the process and the democratic way this was done.

I believe that a lot was due to Michal's leadership which reflected on the way the group worked together.

Will keep you informed.

Hospice NZ Education Project "Fundamentals of Palliative Care"

The formation of an HNZ Education Working Group was finalised in May 2010. The members are:
Chris Murphy: Community Liaison, Mary Potter Hospice
Alison Roguski: Education Coordinator, Hospice Taranaki
Sandi Haggar: Palliative Care Nurse Specialist, Waikato District Health Board
Gina Langlands: General Manager – Quality and Risk, Bupa Care Services
Heather Johnstone: RN/Education Coordinator, Caughey Preston Rest Home and Hospital, AK
Jessica Buddendijk: Board member New Zealand Aged Care Association
A Content Coordinator, Anne Morgan, Palliative Care Nurse Consultant was contracted to liaise and work alongside this group throughout the project.

The Project manager is Maree Meehan-Berge, Hospice New Zealand who has done a great job keeping everybody on track and liaises between the different participants.

The Education Working Group is supported and guided by an Education Governance Group, who provides HNZ with the strategic advice on PC Education and provide and inform evidence base and research for planning PC Education.

Professor Rod Macleod: PhD, MMedEd, FRCGP, FAChPM, Honorary Clinical Professor Goodfellow Unit, School of Population Health, University of Auckland and North Shore Hospice.
Professor Merryn Gott: Professor of Health Sciences, Director of Research School of Nursing Faculty of Medical and Health Sciences, The University of Auckland.
Dr Michal Boyd: RN, NP, ND, Sr Lecturer Freemasons' Dept. of Geriatric Medicine University of Auckland and Gerontology Nurse Practitioner Community Services for Older Adults, Waitemata DHB
Kate Reid: RN, MA Nursing, Lecturer & Palliative Care Programme Convenor, University of Canterbury and Education Director, Hospice Education Trust.
Suzanne Brocx: RN, MN (Clinical), Northland Regional Palliative care Specialist Nurse Educator/Advisor based at North Haven.

This group has met to set out a general direction for the Education Package – with a working title "Fundamentals of Palliative Care for Health Care Providers". This is a shift from the previously mooted "RN Package", primarily due to the input from the aged care sector experts who encouraged HNZ to deliver a palliative care education resource for all health care providers in the generalist setting.
Draft documents were released for sector-wide consultation inviting palliative care providers from hospice, aged care, primary care, and hospitals

Modules:
Essence of palliative care, Ethical issues at the end of life, Pain and symptom management, Non cancer palliative care, Shared decision making and its role in end of life care, Palliative care for the older person, Palliative care in dementia Communication, End of life care- the terminal phase ‘
Caring for ourselves – *you matter too!!* Grief and loss, Resources, Further education

Each module is supported by detail on:

- the overview
- learning outcomes
- slides for each subject area within the module
- teaching notes to go with each slide
- and, trainer training material on each module.

Regional consultation workshops were held across New Zealand
Over 140 people have participated in either the workshops or online and the overwhelming support and encouragement from the sector has been heartening. An endorsement of the work carried out to date.

We are now in the stage of the last reviews.

Will keep you informed

Resuscitation

This is still a very confusing “grey” area.

The following is an extract from a speech Ron Paterson gave on the topic:
“It appears that the standard policy of New Zealand hospitals (public and private) and residential care facilities is for CPR to be attempted on ***all*** patients having a cardiac arrest unless a DNR order is in place. There are two types of DNR orders, 'patient initiated DNR orders' and 'medically initiated DNR orders'.
However, this approach may not be good medical or legal practice.
Finally, and effectively a by-product of these two situations is the 'slow code' phenomenon, involving delayed or token efforts to provide CPR. Slow codes tend to occur where there is no DNR order in place, and it is thought that CPR must be performed, even though the clinicians see attempting CPR on the patient having the cardiac arrest as clearly inappropriate and futile.

Advance decisions regarding CPR

By consumers

Advance directives in general
Right 7(5) provides that: "Every consumer may use an advance directive in accordance with the common law."
An advance directive records a consumer's choice about future care procedures, and only becomes effective when the consumer is not competent to make an informed choice and give informed consent.

Requesting CPR
A consumer may make an advance directive requesting the provision of CPR if they have a cardiac arrest in the future. However, this does not require health practitioners to provide CPR. A consumer cannot *require* the provision of a particular treatment.
However, if a consumer has expressed a preference to receive CPR, it will be important for the provider to consider when they are deciding whether it is appropriate to provide CPR.

Declining CPR
Right 7(7) provides that: "Every consumer has the right to refuse services and

to withdraw consent to services." Of course, this right would be far less significant if its effect lapsed once a person became incompetent. However, a competent consumer may make an anticipatory refusal of consent to a treatment in an advance directive. This is a patient initiated DNR order.
Where a competent consumer has made an anticipatory refusal of consent to CPR, in a clear advance directive, this will render the provision of CPR unlawful, as its provision in such circumstances would violate the consumer's right to refuse medical treatment. A DNR order (at least, a patient initiated DNR order) can be a form of advance directive. (As an aside, it is important that DNR directives are not framed as instructions for clinicians to remain completely "hands off", as this could prevent relief of distress and provision of comfort cares - for the benefit of the patient and family.
However, neither the clinicians in charge of a patient's care, nor the patient's legal representative (EPOA), can make an advance directive declining CPR, since EPOAs are not entitled to refuse consent to lifesaving treatment, under section 18(1)(a) of the PPPR Act 1988.

By providers
In the course of treatment planning, the health professionals in charge of a patient's care may decide that future resuscitation of the patient is not clinically indicated or appropriate. Having made this assessment, a medical initiated DNR order may be put in place as part of the patient's future treatment plan.

While medically initiated DNR orders do not require the patient's consent to be put in place, many CPR/DNR policies require health practitioners to attempt to inform patients of this situation and record that this attempt has been made.

The provision of CPR circumstances in which a medically initiated DNR order has been put in place is not, however, unlawful, in contrast to the position where a patient has given a valid anticipatory refusal of consent to CPR.
(end quote)

From what I understand the best advise is to add to the policy something like:
“All residents are regarded as being “for resuscitation” unless an explicit decision has been made in advance by resident only or if there is a medically initiated DNR order”

You can find the whole speech on:
http://www.hdc.org.nz/education/presentations/nz-resuscitation-council-consultation-meeting

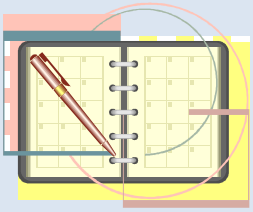
Sector menu/cookbook

From Glenda (Claire House Auckland)

I have been thinking for some time now that the industry at large may be interested in collating their recipes to create a Rest Home Recipe Book that could have menu planning (summer and winter) ingredient variation for larger numbers, purchasing quantities and of course dietician approval.

When one analyses the time and effort that goes into menu planning along with the trials and tribulations of new recipes that are often disregarded and considered out of generation range despite best intentions. Could this suggestion be of interest to other providers.

From editor: I believe this is a great idea so please email Glenda if you are interested: clairehouse@xtra.co.nz



Dates to remember

RVA events :
9 February 2011 RVA not-for-profit and trust forum, St Andrews Village, Glendowie, Auckland
16 February 2011 RVA Financial sector forum, ANZ Centre, Albert St, Auckland

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

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

Clinical Updates
Respiratory Study Day 17th February 10am to 3pm. Mt Albert Senior Citizens Rooms, Cnr Wairere St and New North Rd Mt Albert. Please bring your own stethoscope
http://www.careadvisoryservices.co.nz

18th March: IV Workshop 9am to 3 pm
St Columba Centre, 40 Vermont St Ponsonby

NZACA caregiver days
February:
16th Whangarei
17th Auckland
24th Hamilton
25th Tauranga

March:
9th Wellington
10th Wanganui
16th Nelson
17th Christchurch
24th Napier
29th Dunedin
30th Invercargill

For detailed information go to:
www.nzaca.org.nz

ARCCSS study days: HCA 28 February & 26 August
RN/EN 30 May & 11 November.
www.healthpoint.co.nz
At the clinical Education Centre Auckland Hospital

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

Some interesting websites:

www.eldernet.co.nz
www.insitenewspaper.co.nz
www.dementiacareaustralia.com
www.healthedtrust.org.nz
www.moh.govt.nz
http://www.careadvisoryservices.co.nz/clinicalupdates/respiratory-study.htm
http://www.careadvisoryservices.co.nz/clinicalupdates/iv-workshop.html
To register for clinical updates: email registrations@clinicalupdate.co.nz
www.census.govt.nz.
www.relayforlife.co.nz
http://www.fundraiseonline.co.nz/Jelica2011
http://www.youtube.com/watch?v=d8Bn1q43_rk

This brings me to the end of this issue. I hope you enjoyed reading it and welcome any feedback you have.

Looking forward to an overflowing mailbox, signing off for now with my quote for this month:

We make a living by what we get. But we make a life by what we give.

Jessica