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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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Tracer Methodology

This day and age facilities have to stay "audit ready". To achieve this it is advisable to complete your own internal quality checks on an ongoing basis using tracer methodology.

What is this and what does it achieve.

Tracer methodology is an evaluation method.
Using Tracer methodology means that less time should be spend on areas such as document review and more time on tracing residents' stays in the facility.
The document review process is more intense only if during the tracer the auditor identifies an adverse impact on resident care and safety.

The tracer methodology affects the entire organisation. In tracer evaluations, the auditor selects a resident and uses that person's record as a road map to move through the organisation to assess and evaluate the facility's compliance with the standards and systems of providing care and services.

Residents are "traced" from their point of entry throughout their stay. Auditors assess resident care and safety by talking to staff. They follow the resident treatment path and assess the facility's compliance with the standards. Systems are reviewed for their delivery of safe, quality healthcare.

Residents with complex cares are generally chosen as tracers. Auditors evaluate what types of residents to select from data they collect prior to the on-site audit.

During tracer activities, the audit team may identify compliance issues in performance. Auditors focus on system-level issues in the organisation that arise from tracing individual residents. If appropriate, the auditors will speak with a resident. As always, the auditor asks for resident permission before speaking to him or her.

Tracing residents through the continuum of care requires an organisation to work as a team instead of preparing one particular area for an audit

Audit-Savvy Tips
In preparation for tracer methodology, you should keep up with internal self assessments/audits. This is done to establish a baseline for improvement.

A strategy to stay "audit ready" is to take the initiative and meet with staff to discuss tracer methodology and its effects on the organisation. Health information works as part of an interdisciplinary team during the tracer process.

In maintaining medical records that provide accurate documentation of a resident's experience in the facility. While moving to the tracer methodology is one component of the auditing process, it is important to increase awareness and begin planning for the future.

A goal without a plan is just a wish

Care Planning and continuum of care

Writing good care plans is a challenge and this criterion is second on the list of achieving partial attainments. That was my motivation to put something on paper that might help staff who are responsible for developing care plans. It has turned into quite a long part but I felt all the information is relevant.

Let's begin at the beginning: what is a care plan.
A Care plan **is:**

- A record of needs, actions, and responsibilities;
- A tool for managing risks;
- A plan used and understood by carers
- Based on a thorough assessment of needs;
- Produced in the most appropriate user friendly form;
- Concise and to the point.
- In a language that staff understand
- The written record of a plan of action negotiated with the resident and their representatives, to meet their needs.
- A tool for all staff to provide consistent care interventions to achieve a goal as agreed between the resident and the team.

A Care Plan **is not:**

- A bureaucratic exercise but an essential element in engaging residents and communicating what the service can and will do, and what responsibilities each person in the process has.

Why is a care plan important?
Individualised Residents Care plans are essential to the provision of client centred care.
They allow for continuity of care, by-pass constant repetition of verbal instruction and facilitate communication between staff.
Care plans are the holistic assessment and documentation of a resident's problem, the objectives, and the staff intervention/care to solve/treat the problem, achieve goals and evaluation of the same. Resident, family, whanau, agent and GP involvement should be encouraged throughout all stages.

What do we try to achieve?
That nursing care is delivered in a manner that ensures safety and enhances the individuality, dignity, confidentiality, and well being of the resident. At all times residents' needs, desired outcomes, goals and support requirements are assessed, planned, implemented and continuously evaluated in a comprehensive and timely manner.
To provide each resident with a suitable care plan which will cater for all personal needs and requirements.

- Care Plans are developed to assist staff to give the best quality care possible and ensure a cohesiveness of the care given. In plain language, easily understood by staff, the Care Plan states the problem, objective and care to be given, the same care by everybody, it gives the staff documentation at hand for them to refer to at all times. They do not have to remember all the care but need to know where to find it easily if they are unsure.
- The objective is the residents expected outcome following specific intervention planned in response to the identified problems.
- Objectives must be: resident centred - identify the desired outcome
- Care plans have input from resident and their nominees and staff.

How the care plan should be written
Care plans should reflect the needs of the individual
In put from the resident and/or their representative is vital in individualising the

If you're not using your smile, you're like a man with a million dollars in the bank and no chequebook

No Matter what you do there will be critics

plan. This can be promoted by:

- Using their own words and phrases (familiar and comfortable language, which avoids jargon and abbreviations);
- Recognising that care plans exist for the benefit of the resident, and should be based around the needs of that person, not just around the services available;
- Involving the person in agreeing and writing the care plan as much as possible
- Being flexible in the approach to the resident's involvement;

Often, concerns are expressed about the time needed to write comprehensive plans and, as a result, care plans often become jargonised shorthand for what services will do. This type of plan is often unhelpful to both residents and carers. These plans are a bureaucratic exercise.

Set realistic time aside for this important part of care planning.**Care plans for all residents should include:**

I believe that each care plan should start with a short introduction of who the resident is. If this is done well you should be able to get a feel for the resident and almost already know what to expect further in the care plan. This also personalises the care plan by making the resident "real" and not just a medical problem.

- Assessed needs/problems
- set measurable goals and Identify anticipated outcomes
- If behaviour problems are identified then: Crisis and contingency arrangements; Who to contact
- Early warning signs and indicators/triggers;
- Reflect individuals cultural and ethnic background as well as their gender and sexuality/intimacy
- Identify unmet needs (needs identified in the assessment, but not able to be met by current resources)

Writing Good Care Plans

We often use statements such as 'supervised' with no clear indication about what precise aspects of someone's condition should be supervised or how something is to be supervised.

Ask a caregiver what they understand the intervention means and is that what you intended it to mean.

Ensure that the care plans are legible. Nobody has time to decipher hand writing. If possible type the care plans. In the long run this will save time as they can be kept nice and tidy easier without somebody having to re-write them.

Know what the resident's disorder is all about. If you understand the disorder then you can understand why the resident has certain needs.

Read the history. The information you receive from reading through a file can help you make a critical decision regarding the care of the resident.

Speak with the resident and/or their representatives. Talk to the resident to obtain information, and let the resident feel you care for them.

Goal / Expected Outcome:

What is to be achieved by the intervention? Give a time frame for the resolution or re-evaluation of the problem, e.g. 'the wound to be healed in 3 weeks". Ensure goals are measurable.

Evaluation:

This is the measurement of success in meeting an objective. The Resident's status in relation to meeting the goal is to be evaluated at least six monthly.

Determine the effectiveness of the intervention, is the goal achieved. The plan is amended, as necessary, to ensure the intervention and goal are appropriate, congruent and achievable.

Each support need item is signed and dated by the person prescribing the

I don't know what the key to success is, but the key to failure is trying to please everyone.	care and at the time of evaluation and review including those instances when the plan was reviewed but no amendment was required. When a particular problem is resolved or due to amendment, requires rewriting, a line is to be put through the section, dated, signed and an indication as to whether the care is "resolved" or "amended" always keeping the care plan easy to read. If too many amendments are made the care plan is re-written. **Practical** There is nothing wrong with using a generic care plan format as long as the information in it is individualised and everybody knows what is expected under each topic. On numerous occasions I have seen "NA" in the sexuality box or none in the "spirituality" box. **Psycho-social**. Concentrate on the resident and answer these questions. What are the joys in his or her life? What are his or her regrets? What losses has he/she suffered? What sensory problems does he/she have, and how is this affecting his/her life. What activities does he or she enjoy? What can I do to make his or her life more meaningful? Is there a risk of Social isolation or depression? **Spirituality** Spirituality is about our existence, relationships with ourselves, others and the universe. It is something we experience and requires abstract thinking and will. *Example*: Marie has indicated that it is important for her to be able to have natural light coming into her room so she can see the sky and the plants, feel the sun on her face and hear the birds. Spending time doing her painting relaxes her and gives her a feeling of "inner peace". If she can't paint anymore she loves to be surrounded by her paintings. **Sexuality and intimacy:** *Example:* Marie was married to George for 55 years and they had a loving relationship. She misses his "cuddles" and the way George made her feel attractive. They had 6 children and loved each other to the end. Responds well to touch. Likes hugging, and holding hands. Loves wearing lipstick and her pearls which were a present from George on her wedding day. Hair has always been immaculate. Clothes always clean and color coordinated. She is very particular with her clothing and knows exactly what goes with what. Her presentation is very important to her. **Cultural/ Values and beliefs** Culture is the full range of learned human behaviour patterns. • Communicating with a verbal language consisting of a limited set of sounds and grammatical rules for constructing sentences • Using age and gender to classify people (e.g., teenager, senior citizen, woman, man) • Classifying people based on marriage and descent relationships (e.g., wife, mother, uncle, cousin.) • Raising children in some sort of family setting • Having a sexual division of labour (e.g., men's work versus women's work) • Having a concept of privacy • Having rules to regulate sexual behaviour • Distinguishing between good and bad behaviour • Having some sort of body ornamentation • Making jokes and playing games • Having some sort of leadership roles for the implementation of community decision

The difference between ordinary and extraordinary is that little extra.

Disposable gloves research

Introduction

There are many different types of gloves available for hand protection. They come in a wide number of different materials. In the healthcare situation the gloves are used for a wide range of different tasks i.e chemical use, handling blood or body fluids or protection against diseases and infections.

Disposable gloves in the healthcare setting are used to reduce the risk of contamination of the healthcare worker's hands with blood and other body fluids; to reduce the risk of transmission of organisms to the environment and from healthcare worker to the patient and visa versa.

Disposable gloves do not provide complete protection against hand contamination. Pathogens may gain access to the HCW's hands via small defects.

It is essential that hand hygiene is carried out before donning gloves and after removing gloves.

Types of disposable gloves

Ideal disposable glove properties

- Resist chemical penetration
- Prevent passage of pathogens through closures, porous materials, seams, pinholes, tears
- Gloves need to be strong, durable and reliable.

1. Latex

Latex gloves provide an excellent barrier that guard against contact with blood and body fluids and microorganisms. Latex gloves contain latex – natural rubber.

Latex gloves provide a strong barrier with very little leakage compared with other glove materials as well as maintaining their integrity longer whilst being used. The only problem with Latex is that many people have latex allergies or are becoming more sensitive to latex.

Single use only. The gloves must not be washed or hand gel applied. May contain defects such as pinholes.

Latex gloves (compared with vinyl gloves) provide more of a barrier against needle stick injuries due to its strength and provide some of the best barriers to blood borne pathogens.

2. Vinyl

Vinyl gloves are made from poly vinyl chloride (PVC). They are soft and comfortable to wear whilst also being economical to use. Vinyl gloves are latex free. Whilst they are not as strong as latex gloves, vinyl gloves are still practical for low risk tasks because they have good anti static properties and are highly resistant to fats, acids and alcohols. Vinyl gloves also minimise skin irritation which can cause eczema and other skin problems.

Quality levels of vinyl gloves will vary. Years ago, vinyl gloves were not recommended for healthcare use due to the poor quality of the vinyl. Today the technology has improved creating a 'stretch' vinyl material to provide almost comparable protection to latex gloves.

Gloves labelled as 'vinyl exam gloves' must pass through the same standard tests as nitrile and latex gloves.

Vinyl gloves provide a weaker chemical protection and should not be used for handling chemotherapy drugs or cleaning products. However, vinyl gloves are suitable for most settings in the hospital environment, but do not provide the same barrier for blood borne pathogens.

Try and fail, but don't fail to try

3. Nitrile Gloves

Latex free. Less likely to tear and a high resilience to being punctured. However they are not totally impervious. Resilient and work well in harsh, high stress environments. Provide protection against a wide range of chemicals and blood borne pathogens.

Conclusion

- Vinyl, latex and nitrile gloves can be used in healthcare settings. The choice of glove type should be based on the type of work they are to be used for.
- No glove can offer 100% barrier protection. Hand hygiene before donning gloves and after glove removal is essential. Glove reuse between patients or washing gloves or applying hand gel between patients, should be advised against.
- Good quality non sterile disposable latex gloves can be safely used for almost all patient care where Standard Precautions are used.
- Good quality non sterile vinyl gloves can also be used for patient care but not for chemical handling or for heavy prolonged exposure to blood and body fluids.
- Good quality nitrile gloves can be used as per latex and vinyl, and when staff have skin conditions caused by latex / vinyl. They demonstrate a higher resistance to puncture.
- For all the above types of gloves, always check for the FDA quality guarantee (leak test).

Barbara Davidson, Infection Control Nurse Specialist, North Shore Hospital

Dietary requirements

Residents in aged care facilities are likely to be frail. Additionally they will more often fit the profile of 'consumers who have additional or modified nutritional requirements or special diets', as set out in Criterion 3.13.2. Meeting the needs of these residents requires specialist dietary input.
If auditors find no evidence that dieticians are providing input to menu planning generally, or to any review of requirements for residents who have additional or modified nutritional requirements or special diets, then they will need other evidence to demonstrate how this criterion is being met. In particular, they will need evidence that:

- The person responsible for the menu has sufficient expertise in this area, is able to review the menu, and understands recognised nutritional guidelines for older people.
- Resident's nutritional status is assessed (undertake a nutritional assessment of residents) and followed up appropriately.

A Dietician's input is sought where nutritional problems are identified.

Waitemata DHB has made a very helpful booklet available to aged care providers, and can be downloaded from http://www.waitematadhb.govt.nz/HealthProfessionals/RACIPcareguides.aspx

I have found some interesting information regarding the requirements for an aged care menu. This is something that you can check yourself ensuring that the appropriate amounts are on your menu.

These are minimum recommended amounts per person.

Bread-	5-6 slices per day
Roast or sliced meats	90-100 g
Stew or casserole	90-100 g
Minced meat	90-100 g
Chicken	90-100 g

	Fish 90-100 g Eggs 3-4 a week Milk men 400-500 mls women 600-700 mls a day Cheese 40 gr a day Cream 15ml per day Potatoes 60g cooked weight Vegetables 60 g cooked weight Fresh fruit 2 servings Ensure that there is a choice of wholemeal bread and cereals. Have enough servings of vegetables and fruit available per day and serve some raw and deep coloured options. Include a fish option at least twice a week. Don't have too many foods high in saturated fat. Use mono or poly unsaturated fats. Limit deep fried food to once a week. Use convenience food not more then 3x per two weeks. Use iodised salt. Ensure your desserts contain fruit and milk at least 4x a week. Offer at least 7 times 200 mls fluids a day. Cream does not exceed 15ml a day pp. Resident's dietary requirements are readily available to kitchen staff. Recognise ethnic and cultural needs. Ensure the menu includes all meal items served including accompaniments and side dishes, also inclusive of in between meals items. Explain manner of preparation i.e. are potatoes bakes, scalloped, pureed etc. Establish satisfaction from residents and ensure that likes and dislikes are reflected in the menu. *Ref: Duncan & Jensen*
Never regret. If it's good, it's wonderful. If it's bad, it's experience	**WORDS OF WISDOM: *"Dealing with a crisis"***
	Become aware of the early warning signs. If you don't, you take the first step towards a potential crisis. Look at it this way: All of the work that you **do not** do can contribute to a crisis. **Your workload probably consists of:** • High priority jobs you must do now, and do well, or face the consequences • Routinely important things you must do this week or a crisis will occur • Tasks you can postpone indefinitely Here are some of the signs to look out in yourself or others: **Silent avoidance:** Hearing nothing from a particular source may be a sure sign of impending crisis. Most people who have been delegated work or are working on a project, want to let their manager know that they are getting on with it and do so by frequently updating them. If they are not doing that, it needs to be looked at quickly and changed. **Noisy avoidance:** Similarly, if people are doing too much complaining about the project it may reflect a lack of confidence in their ability to complete or manage the workload effectively. By making too many noises and excuses, they want to cover for the non-achievement. If this is happening, it needs to be picked up early and changed. **Catastrophic avoidance** Some people claim to be crisis prone. If you are involved with these types of people, you need to consider this; Nobody is "crisis prone". If people live from one perceived crisis to another, it is not sympathy they need, its self-

discipline.
You can reduce the damage to your workload from these people by regular reviews of their progress, by constant re-emphasis of the importance of the work and the timelines.
REMEMBER: Often, people perceive a situation's importance, but then fail to communicate that to others, until it's too late! Then they have to deal with the crisis that follows.
It is obvious that problem solving is a vital part of a leadership role. It is also important for leadership survival. So clearly a bit of forward planning and a sense of being prepared are a couple of good ideas in regard to preventing, solving or surviving problems. Plus, of course, problem solving applies to all aspects of our life.
What is important in regard to preventing a crisis is:
a) Does it matter? b) If so, to whom? c) What will happen if we act or what will happen if we do nothing?
Get the answers to those three questions right and you are half way there.

Ref: STEM

Dates to remember

SPARK OF LIFE
14 July Auckland
Barry Court Motel and Conference Centre 10-20 Gladstone Road, Parnell

15 July Hamilton
Assisi, 158 Matangi Rd

18 July Wellington,
Horne Lecture Theatre C&CDHB,

19 July Timaru
Comfort Motel Benvenue, 16 - 22 SH1 (Evans Street), Timaru

20 July Christchurch,
Addington Events Centre, Twiggers Street, Tower Junction

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

Celebrating New Age: a professional development conference for gerontology nurses. Wednesday 10 August 800am-400pm. Selwyn Village Point Chevalier, Auckland.
Contact Trish on 09 845 0838 #853, trishp@selwyncare.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.