September 2014

Jelica's Link

Issue 45

An independent newsletter for people interested in Aged Care

In this issue:

jelica@woosh.co.nz

www.jelicatips.com

mobile: 021 311055

1/3 Price Crescent
Mt Wellington
Auckland 1060

4 YEAR CERTIFICATION

I am very pleased to mention more facilities achieving
4 year certification.
My compliments and congratulations to:

Glenbrook Rest Home, Waiuku

Eldon Lodge Rest Home & Hospital in Paraparaumu.

Lyndale Rest Home Ltd Masterton

All the best to my friends, who have an audit this month.

If you are one of the very few achieving this then please let me know as it deserves a special place and recognition! If you don't let me know I can not publish it.

AUDITING

The following are a few of the latest findings I have received:

Criterion 1.1.10.4
The service is able to demonstrate that written consent is obtained where required.

PA as: One of five resident files did not contain a signed consent form.

I am surprised that this is a PA as the criterion states "where required". But there is no explanation why the auditor feels that this should be required.

My advice is to document on the form if there is a reason for the form not being signed or completed. This could be for instance where the resident is incompetent or refuses to sign and there is nobody else to do so.

Criterion 1.1.10.7
Advance directives that are made available to service providers are acted on where valid.

PA: Two of five files do not contain an advance directive.
Comment: Ensure competent residents have advances directives in place

This auditor should be informed regarding the interpretation of this criterion. "Advance directive that are made available to the service providers are acted on!"
It doesn't state each competent resident has an Advance Directive.
Writing an Advance Directive is a choice and not a requirement!

Stay vigilant and be aware of the requirements. Auditors can and do get it wrong at times!

What seems like the right thing to do could also be the hardest thing you have ever done in your life

ON-CHARGING

There have been a couple of questions regarding the costs that can and cannot been on-charged.
Regardless if a person is subsidised or private.

If a person has been assessed as needing aged residential care then they are to receive contracted care services for the amount of the maximum contribution for that area.

The Social Security (Long -term Residential Care) Amendment Act 2004 discusses Liability to Pay (Section 139).

In this section it states:

(1) That a resident assessed as requiring care is liable to pay the cost of contracted care services provided to him or her

(2) The most that a resident assessed as requiring care may be required to pay towards the cost of contracted care services provided to him or her is the maximum contribution

(3) The amount that a resident assessed as requiring care is liable to pay under subsection (1) is reduced by whatever a funder must pay in respect of the resident under any of sections 140, 141, or 142.

(4) Nothing in this section affects the liability of a resident assessed as requiring care to pay, under an agreement between the resident and a provider, for any services provided to the resident that are not contracted care services

The maximum contribution is the most a person assessed as requiring rest home level care can be asked to pay for their contracted care services

The letter accompanying the 1 July 2014 ARRC contractual changes noted the definition of “subsidised resident”.

Section 6 of the letter accompanying the 1 July 2014 ARRC contracts clarifies the requirements around Clause A5.1 which states that the DHB will pay a Residential Care Subsidy for a Person:

a. Who is an eligible person, as that term is defined in the Social Security Act;
b. Who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely, in accordance with the Social Security Act; and
c. In respect of whom we are liable under the Social Security Act for all or some of the cost of age related residential care services you provide to that person.

"The best and most beautiful things in the world cannot be seen or even touched, they must be felt with the heart"
– Helen Keller Read

ON-CHARGING cont'd

This clause means that the ARRC Agreement applies to any person who has been needs assessed as requiring long-term residential care, and "private payers" who have been needs assessed as eligible for ARRC care cannot be charged for services which are covered under the ARRC Agreement.

You have to ensure that the requirements for ARRC Clause 5.1 are met to ensure that "private payers" who have been needs assessed are not charged for services which are covered by the ARRC Agreement. This should include GP visits (D16.5), transportation to services (D20), supplies such as pharmaceuticals, wound dressing and continence supplies (D18). Your Admission Assessment should reflect that the "private payers" are not charged for services under the ARRC Agreement.

The above are extracts from emails and letters sent to me by providers who received information from their DHB programme managers.

*It is important to read and understand the contract to know which services you have to pay for and what you can on-charge. For instance D16.5E regarding primary medical treatment. "*You must provide the treatment programme prescribed by a Medical Practitioner or Nurse Practitioner to assist the Subsidised Resident to develop and maintain **functional ability. "** *What includes functional ability?*
Also having access to services doesn't mean having to provide the services etc.

I am sure this will cause some interesting debates but I believe that the more we discuss it the better understanding we achieve.

ACTIVITIES

There are still facilities that achieve a partial attainment in the activities criteria. It is often around the reflecting of residents assessed needs and wishes in the programme. This does not mean that you have to provide a whole activity on each assessed need but incorporate as much as possible.
For instance; a resident has identified that they like sports and in particular everything to do with cricket. You can reflect this need in a number of activities.

For instance:

When doing a quiz, have a couple of questions about cricket.
During reminiscence, discuss the sport that each person played and/or are still interested in.
Develop a sports bingo and ensure that the sports that residents have identified as their favourite are reflected.
When important games are played i.e championships, make this known and allow the resident to get involved by watching the games, keeping scores etc. Display posters, make it a theme so everybody else might enjoy getting involved and developing a new interest.

If you have some good ideas email them to me so we can start sharing these.

Well behaved women rarely make history

ADVANCE CARE PLANNING
by Maria Taylor

Advance care planning (ACP) is more than ticking a box on a resuscitation form. It is a person-centred decision-making process that can empower residents to make informed choices about the treatment they would want to receive if they lost competence to make decisions, or were too ill to speak for themselves.

Primarily it is about conversations between residents, their health professionals and their whanau. Discussions are based on:

- The resident's personal values, beliefs, concerns, hopes and goals,
- A better understanding of their current and likely future health,
- The treatment and care options available.

Knowing this information reduces decision-making uncertainty and allows residents, family members and health professionals to respect the resident's informed preferences and prepare, both emotionally and practically, for a time when the resident's health deteriorates.

Advance care planning is a voluntary process and not everyone will be interested in taking part. Residents cannot be required to complete advance care documents. However it is important that health professionals offer to have these conversations, and that residents have the opportunity to talk about what matters to them.

Some residents may decide to document their preferences in an advance care plan. Advance care plans are general statements intended to inform treatment decisions when the resident is incompetent or unable to communicate. They may include statements about a resident's treatment goals and priorities; things they would like their loved ones to consider and remember about them; or specific end of life requests such as religious rites, special music, or the presence of a much loved pet.

Within the advance care plan a resident may choose to make an advance directive (sometimes referred to as a living will). These are specific treatment decisions that are intended to be binding. They may include the resident's wishes regarding treatments such as cardiopulmonary resuscitation or antibiotics. To be valid and legally binding an advance directive must be created when the resident is competent, informed, and free from undue influence (i.e. voluntary), and the advance directive must have been intended to apply in the circumstances that have arisen. However residents don't have the right to demand treatment in an advance directive that is not clinically appropriate or available. For advance directives to be workable we recommend that they are created with the assistance of a health professional within their scope of clinical expertise.

An advance directive and /or advance care plan comes into effect only when a resident is assessed and found to be incompetent to make health care decisions. Up until that point a resident has the authority to make their own treatment decisions. ACP conversations are ongoing, and a competent resident is encouraged to update their advance care plan and directives in line with changing circumstances and goals of treatment. We recommend that advance care plans are reviewed routinely, or as required if the resident's health or cognition is deteriorating. It is essential that the resident knows that they can update their advance care plan on request.

Further information about ACP, with online training (and professional development hours) is available online at: http://www.advancecareplanning.org.nz/healthcare/resources/ Also visit the Ministry of Health document, *Advance Care Planning: A guide for the New Zealand health care workforce*. Available at http://www.health.govt.nz/publication/advance-care-planning-guide-new-zealand-health-care-workforce

Maria Taylor, ACP Facilitator, Canterbury.

A good friend is hard to find, hard to lose, and impossible to forget.

DIFFERENCE BETWEEN a EPA (Enduring Power of Attorney)- **and POA (**Power of Attorney

Some providers seem to have to explain themselves to relatives who think that when they have EPA that they can start making decisions just because their donors are in a facility. Appointed EPA's need to understand that a resident does not automatically become incompetent when they enter an aged care facility.

People with EPA need to be informed and it might help to give them an information/fact sheet about their responsibilities and authorities.
The person drawing up the EPA would have explained all this but it might have been forgotten.

What is the difference between an EPA and POA
The difference between a normal power of attorney and an EPA is that an EPA will 'endure' if you become mentally incapable. A normal power of attorney is suspended on the happening of certain events. One of these is if the person granting the power of attorney (called the 'donor') becomes mentally incapable. However an EPA is not revoked if the donor becomes mentally incapable.

EPA personal care and welfare
The attorney must not act in respect of a significant matter relating to the donor's personal care and welfare unless a relevant health practitioner has certified or the court has determined that the donor is mentally incapable.
A 'significant matter' means a matter that has or is likely to have a significant effect on the health, wellbeing or enjoyment of the life of the donor, e.g. permanent change in the donor's residence, entering residential care or undergoing a major medical procedure.

MEDICATION ISSUES

Self-medicating residents: please ensure that the resident's competency is checked every 3 months as per medicines guidelines.

Controlled medicine:

- Ensure these are kept secure under lock and key. Key kept by senior staff
- Complete appropriate documentation in a controlled drugs register book
- Maintain a list of staff deemed controlled medicines competent (including RN's)
- Ensure controlled medicines are signed in and stock checked by person delivering meds with senior staff on duty.
- Expired and obsolete meds to be returned to pharmacy and signed by person receiving the meds and the senior staff on duty.
- No bulk supply to be kept in rest homes (only individual named prescriptions)
- Complete the weekly stock count in red.
- Six monthly stock take to be completed (June and December)
- Be vigilant and note any discrepancies and errors and records these.

Feelings change - memories don't.
- Joel Alexander

MEDICATIONS CONT'D

- Lost medicines to be reported and the reason for the missing meds to be investigated. Report to the appropriate authorities if not accounted for (HealthCert, Police etc)
- Train staff to monitor residents on controlled meds to ensure that adverse effects are identified at the earliest opportunity and that a health professional completes the appropriate assessment.
- If the medicine is newly introduced to the resident then assess for effectiveness

MENTAL HEALTH COMPULSORY ASSESSMENT

A provider had an acute problem with a respite resident and when she asked the CAT team to assist they were declined as there was no application completed by the provider. I thought this was very strange and I spoke with somebody who has a lot of experience in Mental Health and with a psychiatrist friend and both stated that as per Section 8 that this should not have happened.
See below part of Section 8.

Mental Health (Compulsory Assessment and Treatment) Act 1992
Compulsory assessment and treatment

Section 8 Any person may fill out application form

(1) Anyone who believes that a person may be suffering from a mental disorder may at any time fill out an application form asking the Director of Area Mental Health Services for an assessment of the person.

(2) An application is made under section 8A when the Director of Area Mental Health Services receives a filled out application form that complies with section 8A.

(3) In sections 8A and 8B,—

(a) the person who fills out the application form is called the **applicant**; and

(b the person who is the subject of the application is called the **person**.

Section 8: replaced, on 1 April 2000, by section 8 of the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999 (1999 No 140).

BOUQUET

For all the volunteers who gave their time freely to collect on Daffodil Day.

Without all these motivated lovely people we would not raise the much needed money for Cancer research.

A friend is someone who is there for you when he'd rather be anywhere else.	**TRAINING SESSIONS**
	If you need training provided on site please let me know as I am available to provide this on non clinical topics such as: Cultural safety, Spirituality, Sexuality, Privacy, Rights, Confidentiality, Communication and documentation, Abuse and neglect prevention, Restraint minimisation and safe practice, Behaviour management, Complaints and risk management, open disclosure, EPOA, Advance directive, informed consent and resuscitation, Health and Safety, Ageing process, mental Illness. If you are looking for a topic not listed here please drop me a line. I am happy to facilitate different times to suit evening and night staff. References available on request.
	NEWSLETTERS BACK ISSUES
	Remember there is an alphabetical list of topics from all my newsletters available on my website which refers to the related issue. This website is available to everybody: www.jelicatips.com No password or membership required. I believe in having the data available to everybody as it is important that as many people as possible get the information and that we help each other as much as possible in this very challenging sector. I don't mind sharing this information but I don't agree anybody making financial gain from this information!

Some interesting websites:
www.careassociation.co.nz; www.eldernet.co.nz, www.insitenewspaper.co.nz, www.moh.govt.nz; www.healthedtrust.org.nz, www.dementiacareaustralia.com; www.advancecareplanning.org.nz http://www.bpac.org.nz/Public/admin.asp?type=publication&pub=Best, http://www.open.hqsc.govt.nz; www.safefoodhandler.com; www.learneonline.health.nz

Please note these sites are not necessarily endorsed by Jelica nor is it responsible for the contents within them. The information contained in this publication is of a general nature and should not be relied upon as a substitute for professional advice in specific cases.

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*

SUBSCRIBE OR UNSUBSCRIBE

· If you do not wish to continue to receive emails from me, all you need to do is e-mail me and write "Unsubscribe". I will then remove you from my contact list (though I will be sorry to lose you from my list).

· If you know of others who you think would benefit from receiving my newsletter, please pass on my details and have them sending me an email with the subscribe request.