

The Baron Report

Volume 2, Issue 3, 2001

Roles, Rolls and Roles Areas for Future Comment

No it isn't a spelling mistake, we will be discussing more than one role in regards to aged care, but we will also be discussing rolls.

Firstly we will be looking at the roles of staff in aged care starting with that of the Registered Nurse.

This is an interesting area indeed because while there is general consensus that RN's are a basic requirement, it is difficult to explain exactly what we might be looking for. 'Oils ain't oils, Saul' and RN's are not RN's.

What exactly is an RN in regards to aged care and what duties does the position entail.

Rather than putting forth a stock answer, we will endeavour over the following months to try and put some framework around the position.

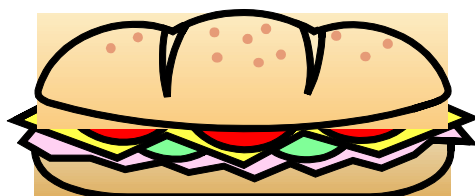
At present the Networking Group (and what a fine group it is) is attempting to define the role of the Enrolled Nurse. The last meeting had vigorous debate and the next meeting (17 May) the topic will be further investigated and discussed by having Lee Thomas of the ANF as guest speaker.

The role of personal carers as unregulated workers will also need to be examined as part of the matrix.

The next roll we wish to discuss is that of the bread roll (which figuratively is the symbol of all that we eat).

Food glorious food will be the focus of attention over the next few issues due in no small part to the important place it holds in aged care.

Changes to legislation have had an immediate effect on how we handle this area, but perhaps more important than mandatory requirement is the



general belief that the food area is one that needs to be further investigated so as to provide our residents with greater satisfaction. A proactive rather than a reactive situation.

To help facilitate this food enhancing process we will be introducing Yvonne Coleman (a very informed and talented nutritionist from Melbourne) firstly in a series of articles and then in person through two half day workshops being planned for July.

We will also be introducing you to Adrian Hill and some of his exciting innovations and suggestions for aged care. Adrian has recently struck out in his own consultancy after have been involved in a range of food and kitchen related activities in aged care facilities. He brings both academic skills and practical

knowledge which should be of benefit to us all.

The third role that we will be discussing is that of the Auditor in regards not only to accreditation but to follow-up visits.

Recently we have heard stories from numerous sources in different states that are

leading to confusion and frustration.

It appears that the role of the auditor is a bit cloudy, as is the advice that is being given.

In some instances the advice that is being given is in contradiction to advice given on the accreditation visit and sometimes apparently without a clear rationale.

It appears that most facilities have accepted the accreditation process very well and are working hard towards the next round. What they most need now is some positive reinforcement on what they are doing well and help and support on areas that need improving.

In some cases facilities are getting advice that leaves them scratching their heads in wonder.

Auditors do have a high

level of knowledge; they would not otherwise be in the positions they are in. However credit must also be given to DOC's as having a good working knowledge of their facilities.

In matters of 'required improvements' auditors have legal authority BUT the improvements should relate directly to the criteria NOT individual auditor wishes.

The auditor-staff relationship should not be one of master-servant but rather of professional colleagues who may discuss and debate complex issues with successful conclusions benefiting the resident.

The Agency has expressed the desire to work in partnership with facilities to improve care and conditions for residents. This is why they offer opinions and suggestions (unlike the old standards monitors).

What seems to be problematic is both facilities and auditors understanding clearly and recognising when comments are **DIRECTIONS** to be followed to meet the required criteria and when they are merely **SUGGESTIONS** that the auditor believes would be of assistance.

It is vitally important that this communication obstacle be addressed promptly if the Accreditation system is to be effective.

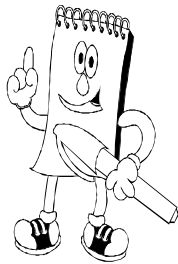
Current information for the Aged Care Industry

Menu Evaluations

by Yvonne Coleman
Nutrition Consultants Australia

Would you like to have something you have written or said published?

Simply mail, fax or e-mail us a copy with your details and we will try to make it happen.



**N & C Baron
& Associates**

ABN 35 041 713 303

PO Box 687
Mitcham SA 5062

Ph. (08) 8276 9763
Fax. (08) 8277 0300

www.ncbaron.com

E-mail:
neil@ncbaron.com

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Menu evaluation encompasses many aspects of meal provision, and assessments can be as simple or detailed as desired.

Nutrition Consultants Australia provides two levels of menu assessment: -

1. **Basic Assessment**
A basic "rule of thumb" nutritional adequacy tool is taught to all relevant and interested staff to provide a nutritional framework for guiding appropriate menu changes. Once this tool has been applied to the current menu, and relevant changes implemented, then application of a comprehensive assessment is appropriate.

2. **Comprehensive assessment**
The usual daily intake of three typical resident scenarios ie a small frail bed-bound lady, a large man, and a medium sized person with average activity, are analysed via a computer program to ensure their nutritional needs are being

met and that serve sizes are appropriate.

Other factors to be considered include:

- Quality of the menu
- Frequency of repeating dishes,
- The variety and quality of protein foods offered, range of between-meal snacks
- Appropriateness for therapeutic diets
- Appropriate modifications of the menu should result in relatively straightforward provision of specific diets

It is very difficult to introduce new dishes onto a

menu because of the acknowledged likes and dislikes of the residents.

An option is to trial *Chef's Choice/Mystery Meal* once in each menu cycle. This strategy has a couple of advantages enabling the introduction of new dishes and their evaluation without any ongoing commitment to that dish and permitting the unexpected meal - similar to dining out!

Menu assessments should not include external advisors dictating specific dishes on the menu. Each facility has its own culture, and their residents have very defined likes and dislikes that are known to the staff. A recommended dish that is acceptable in one facility is not acceptable in another facility.

Menu assessments are multifaceted and can be as complex as desired.



Vitamised Meals Need not be 'Tastless'

by Adrian Hill

In my experience many aged care homes serve lifeless blobs of colours on a plate to the resident that is not capable of swallowing solid food - the vitamised meal.

However these vitamised foods can take on a more attractive design pleasing the resident, their family and friends, enthuse the nurse feeding the resident; and inspire the cook that is painting the picture.

I have created many new designs that look very gourmet and not 'vitamised'.

Here is an example of a simple design.

Lasagne

a) Prepare a nutrient rich, tasty bolognaise meat sauce using basil, garlic, onion, carrot, celery, tomato etc

b) Vitamise the mixture

c) Line a tray, 3mm thick with the sauce, then freeze

d) Spread a layer of mash potato over the frozen bolognasie, 3mm thick

e) Repeat 3 times

f) Finish off with

bolognaise, grated cheese and chopped parsley on the top.

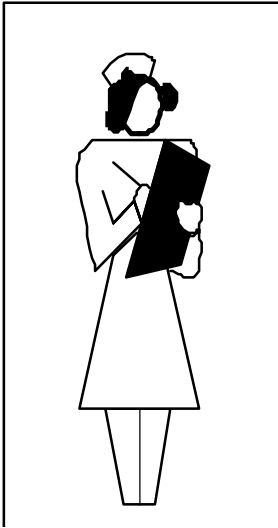
g) Cut into squares and serve in bowls.

h) To serve, place in steamer for 10 mins

It looks and tastes fantastic and fools everyone.

In my experience with new designs, the residents eat more, the family are very impressed, the staff are more enthusiastic about the food and I take greater pride in my work.

A win win situation.



THE CLINICIAN'S CORNER

The Role of the Register Nurse in Today's Aged Care System

by

Yvonne Kromkamp, DON

Mt St Vincent Nursing Home - Ulverstone Tasmania



Today Aged Care is very complex for Registered Nurses. Apart from the routine duties of dispensing medication, supervising staff and documenting there is now a great deal of emphasis on people and relationship management.

Administering Medication

Most residents in a high care facility require assistance to receive the right types and quantities of medication at designated times. The registered nurse needs to know drug interactions, dosage and side effects and ensuring the supply of medications is on hand.

Staff Supervision

Tasks such as replacing staff off sick, security issues, risk management and after hour maintenance requirements become part of the role.

The registered nurse is responsible for carers who may have no nursing training, and yet need to maintain the standards of care.

Documentation

Residents are required to have an individual care plan which states all their needs and expected outcomes which are reviewed and adjusted as health status changes. This care plan and exception reporting is used for the funding tool, RCS that each resident is evaluated on for the dollar amount of funding the aged care facility is provided.

It is a legal requirement that the Registered Nurse documents any exception reporting and ensures that care plans are current.

Managing Difficult Behaviours

Some residents may be manipulative and time is consigned in dealing with their various needs. Wandering residents with a diagnosis of dementia are a concern at all times.

Dealing with Acutely Ill Residents

Unlike their counterparts in the hospital, an aged care facility does not have the luxury of having a doctor on site. If the resident's condition warrants urgent attention this needs to be conveyed to their doctor and/or appropriate action to send them to the hospital.

The registered nurse has to be able to make this assessment based on

knowledge of the resident and their acute health status.

Palliative Care

More residents are being admitted that require palliative care, syringe drivers and emotional support. These residents are coming to the nursing home, as they and their families are unable to cope with the twenty-four hour care requirement.

Dealing with Grief

Grief is a large part of aged care, residents grieve when they enter into the home, missing their belongings, own space and family members. Staff grieve for residents.

Accreditation

Nursing homes have to be accredited and there are major changes to be made which no extra funding will be provided for therefore resources are being stretched. This impacts on the registered nurse as new systems are being implemented which they are expected to contribute to and be aware of.

Do we Utilise the Skills of the Registered Nurse to the Fullest?

The registered nurse is trained to care for the physical and emotional needs of a person. They have many skills, which are not utilised,

when doing paper work. Yes documentation is important but so are the pressing needs of residents. Should every nurse be expected to be an excellent written communicator? Surely those that should be utilised for this task, they could liaise with the team providing the care and document their assessment. There is a lot of repetitive documentation, maybe an over arching chart for the desired outcomes of possible deficits would be more appropriate.

How would their skills be best utilised?

Having the registered nurse in a position freer to do supervision and work along side for part of the shift with the untrained staff would I believe achieve better outcomes for the residents. Those working along side the registered nurse would be able to learn from example as well as have the opportunity to discuss any concerns.

Will they be Needed in the Future?

The ratio of registered nurses to residents is extremely low within an aged care facility compared to the hospital system and the workload the situation can become very stressful.

Registered nurses will continue to be needed in the future, however they need to be highly skilled and genuinely care for the elderly.

What's the Big Deal About Bedrails?

by Carla Baron

Debate rages over whether bedrails are or are not restraint.

The reality is that bedrails, in themselves, can not be definitively labelled one or the other. The deciding factor is the circumstances of their use as determined (and documented) during assessment.

However for many the real point of the argument is being missed; it is not whether or not bedrails are restraint, restraint alternative or movement aid. Whatever the label, we continue to have a duty of care to the resident.

Bedrails are pieces of equipment that have potential

to harm. Even where they are used at a resident's request for security or to assist with independent movement in bed, they can cause bruising and/or skin tears on movement.

In other circumstances, even competent residents have been known to fall in an effort to get out of bed (around or over the rails) because they thought they could and did not want to bother staff.

Bedrails therefore need to be identified as a risk with clear risk management processes put in place.

The challenge then becomes what processes you have to assess and review the

bedrail risk for each individual resident.

Questions you need to be able to answer are:

1. Is there an individual assessment of a resident's need regarding bedrail use?
2. Are residents/advocates involved in the planning process and their wishes taken into account? (consultation)
3. Is there clear indication of when the bedrails are to be used (ie at all times when in bed or nighttime only)?

4. Does your plan provide clear direction for 'checking' on residents when bedrails are in situ? (how frequently checks should occur, etc)

4. How often will you review or re-assess the bedrail need and risk?

Whether this information is documented on a Restraint Form, a Risk Form or in some other manner; this is the evidence you require to convince any 'outsider', be they auditor or court system, that you have indeed met your duty of care.

Upcoming Dates & Events

LAST CHANCE - A FEW PLACES STILL REMAIN

May 14 - Successful Documentation & RCS Update
1/2 day Seminars

Session 1 0900 - 1230 Sessions 2 1315 - 1645

Balyana Conference Centre

46 Strathcona Avenue Clapham

May 16 - Successful Documentation & RCS Update
Workshop 0900 - 1530

Note change of venue:

St Sava Church Hall

Mary Street Hindmarsh

(Next to the Entertainment Centre- lots of free parking)

Check on availability by contacting Neil on 8276 9763.

July Nutrition Education Day
(date to be announced)

September - Thorny Issues II
Cutting edge information that is necessary for all facilities

Networking Group

The next session will be on:

Thursday May 17th

1630 - 1830

Churchill Court ACF

470 Churchill Road

Kilburn

Special Guest Speaker

LEE THOMAS

South Australian State Secretary ANF

Further on the Role of the EN

Please confirm your attendance by calling Neil on

8276 9763

Humankind has not woven the web of life.

We are but one thread within it.

Whatever we do to the web, we do to ourselves.

All things are bound together. All things connect.

Chief Seattle

