

The Baron Report

Elder Abuse

It Won't Happen to Us

Elder abuse can be defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" .

Elder abuse can be of various forms such as physical, psychological/emotional, sexual and financial abuse. It can also simply reflect intentional or unintentional neglect.

World Health Organisation - www.who.int

The development of a website by an upset son and full details of the treatment his mother received prior to her death has caused quite a media stir in Alberta, Canada.

Surprising in some ways in that Alberta has long prided itself on providing better than others in care for its citizens.

An isolated case or the starting point of a consumer reaction to services being provided to parents and loved ones in care?

Oh, but that is Canada, it wouldn't happen here. We have an accreditation system and safeguards.

Wrong it has happened in South Australia and there is every expectation that, unfortunately, it will continue to grow.

The availability of the internet has radically changed the way we gather and accumulate knowledge and information. A journey to the Australasian Legal Information Institute website

www.austlii.edu.au and a search under elder abuse will demonstrate that it has been before the courts.

A visit to the Aged Rights Advocacy Serv-

any environment and attempting to correct issues after they have occurred is fraught with difficulties, staffing issues, potential for lawsuits and as in the case

tem is not letting down the very people that it is meant to serve.

With the start of a new year it is imperative that every facility ensures that the possibility of elder abuse is not present and will not be an issue. The best starting point is being aware that it can happen and then having a strategy to ensure that it does not.

As ARAS states:

A range of factors can contribute to elder abuse. Abuse of an older person:-

*** can happen to anyone regardless of gender, where people live, cultural or religious background or income**

*** is a breach of a person's rights. Some of these breaches may be criminal or civil offences**

*** can be complex due to the relationships involved, the possibility of more than one form of abuse occurring at the same time, or more than one alleged abuser**



ices website, www.sa.agedrights.asn.au will find a wealth of information on elder abuse starting with their definition; Abuse of an older person "is any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/ or neglect."

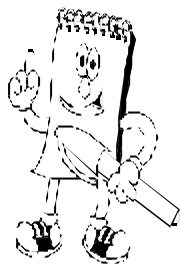
The potential for Elder Abuse is present in

in Alberta, public displaying of system failures.

Now no one would want to see a situation where relatives are so distressed with a system that they feel has let their loved ones down to the point where they believe their only recourse is to go public. But it will happen here if circumstances are such that someone believes that they have no other way of ensuring that the sys-

Lack of Good Leadership the biggest problem in Aged Care

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.



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As advisors and consultants in aged care we are often asked to define the single biggest problem that we see, the one area that if issues could be prevented or eliminated would result in greater cost efficiency and better overall outcomes for residents.

The question is complex, as is aged care, but without doubt the answer that we would give would be **leadership**. Or perhaps more correctly poor leadership is the biggest problem, good leadership is what every facility should aspire to have.

We have seen facilities deteriorate from good to bad in only a matter of months. Years of good systems, mentoring and relationships can be reduced or destroyed, by well meaning but inept persons taking over.

There is a lust factor when we mention position titles, especially in ones that have manager, or some variation on the theme in them.

Too often people that are neither sufficiently qualified or skilled are promoted to fix a vacancy problem. This quick fix solution quite often becomes a long and costly problem that usually ends in a lose lose situation for everyone involved.

"But we need to fill the spot" is the retort, "we don't have the luxury of finding the right person."

Imagine, if you will, that you had a prestige car that you valued, would you

let any mechanic fix it or would you ensure that the



person was suitably qualified and experienced to do the job right with that type of car.

After all the car is worth a lot of money. Yet we don't do the same when we are hiring senior staff that could cost the facility everything.

If it is not possible to replace like with like or ideally like with better then perhaps the best answer is to look for a short term 'temp'. Sure it will cost money but at least it allows for time to secure a long term asset.

So what constitutes good leadership and how is a facility able to ensure that it will have the right person doing the job?

The first logical suggestion would be in starting with the 'right' candidate. Someone who has the necessary **attitude, skills and knowledge** to do the job.

The next suggestion is to then ensure that the person is nurtured and allowed to grow, to feel that they can make a positive difference and that they are appreciated.

Many places have found after spending endless hours and dollars trying to find replacements for staff that have left, that had

they given the existing member the same considerations that they would have stayed.

Nurturing must include ensuring that the staff have the proper tools to do the job that is required of them and this is often sadly lacking.

Computers with internet access should be seen as essential as a telephone. The ability to use the tool effectively should also be encouraged and evaluated.

There is very little point in having a computer taking up space on a desk, if it is not being used to its fullest.

Another tool that should be used is incentives to keep senior staff with the organisation.

Training, education, conferences, cars and study tours are all being used to maintain good staff.

Unfortunately we still see places that fail to recognise this important element and refuse to acknowledge the good work that is being done. In so doing they are sending a message that they do not value the worth of the person. They then wonder why the person leaves.

Often the cost of the incentive is much less than would be the cost of a proper advertisement for a replacement, let alone the massive additional cost that are incurred with the entire recruitment and orientation process.

3.7 Leisure and Lifestyle

Who has the Problem?

Feedback from the Better Way Workshop on leisure which was held in late October 2005 indicates that while the need to change leisure documentation is overdue, there still appears to be barriers that must be removed.

The biggest barriers appear to be:

? the inability of some senior facility staff to understand leisure concepts

? the notion that residents are one homogeneous group and are all interested in the same things

? the belief that some or any form of activity has to be present or residents will be bored

? belief that to record attendance will indicate that residents needs are being met

? an apparent inability from some auditors to understand leisure concepts.

To highlight the last issue a perusal of a recent noncompliance of a facility (details are available on the Aged Care Standards and Accreditation website www.accreditation.aust.com) saw comments such as:

We observed during the period of review audit that:

? residents are taken to the main lounge/dining area for activities. Attendance ranged from 20 to 40 residents with one or two lifestyle staff present. We observed residents' participation levels, which ranged from active in-

volvement, passively sitting but not interacting, and non-involvement through to sleeping and fidgeting.

Well that is disgusting, what are these residents trying to pull? Sleeping, fidgeting and not being actively involved in the activity? You would think that they were old and infirm or something.

? approximately 20 residents in position chairs were sitting in the same position for long periods of time.

Again how dare they? Maybe they should be up dancing or standing at attention. Isn't the reason they are in position chairs due to their inability to move?

? at 4pm on day two of the review audit, 38% of the residents were in bed and a further 15% were in their rooms waiting to be positioned in bed.

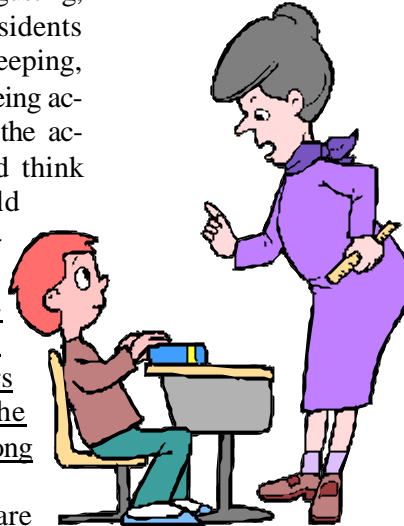
While facilities used to be concerned by this but 3.9 Choice and Decision Making indicates that residents can go to bed when they wish and many are tired or request bed at this time.

That is too much; residents not out being active, jumping skipping playing music or working in the garden. Incredible. Where to some facilities find these people to occupy their premises?

But wait there's more:

? approximately 60% of the home's residents have varying degrees of

dementia. There are no specific activities for these residents, particularly during the late afternoon when they become increasingly unsettled.



Throughout the review audit we observed:

- three residents wandering up and down the corridor

- two residents calling out

- four residents displaying various behaviours, either tapping their feet, fidgeting and rolling up their clothes or trying to get out of wheelchairs.

Oh my god, what can we say except residents behaving badly.

It appears, this report (written, vetted and then placed on the website for public consumption) concludes that these people are using the excuse that they are demented to behave in such an unsuitable manner. What next?

Obviously they were not taught how to behave in an aged care institution. This report would appear to be more appropriate in a primary school report

card on a student than in one dealing with adults living in residential aged care.

Now I find it hard to believe that anyone working or involved in aged care would find the behaviours unusual.

Wandering by people with dementia is typical and should not necessarily be seen as a negative. A facility that provides a safe and secure environment and minimises restraint should not be condemned.

But are these leisure issues that belong under 3.7 or are they behaviour issues that would be more appropriately placed under 2.13 Behaviour management - The needs of the residents with challenging behaviours are managed effectively?

Personally I believe that the accreditation system should be the best thing to happen to aged care. It will be a tragedy if we get so involved in counting the veins on the leaves that we forget why the forest exists, let alone seeing the trees.

And finally to ensure that residents are treated as individuals, not numbers or statistics.

It is incumbent on any auditor who writes a report that could end up in media reports to ensure that what they write is:

Factual
Accurate
Concise
Timely.

As should all documentation in aged care.

Measure Up Time Again

Comparative Analysis of Staffing Levels

by Carla Baron

No, this is not about your new year's resolution to slim down, but about the fourth year of N & C Baron & Associates' Measure Up program to assist facilities to compare their staffing levels with those of others.

As part of our continuous improvement and in response to participant feedback, we have made some changes. This year we will continue to collect and provide you with information on comparisons between your and other sites in key staff areas and RCS categories.

Some of you who attended last year's "Focus on the Future" workshop will recall that Judy Gilbertson, a DON with extensive experience in both the acute and aged care sectors, has developed a model to link staff hours to RCS categories and has successfully used this in her own organization.

This year, as an added service, we will use the Gilbertson model to provide participants with an opportunity to compare their hours to their RCS rates.

This will be in addition to our usual comparisons against other facilities and the ANF benchmark of 3.2 hours/resident/day.

Some have asked how relevant that benchmark is. We know from earlier discussion with the ANF that they had researched both nationally and internationally before choosing this particular method of hours per resident per day. It may not be perfect but to date, we have not found a better one.

You may also be interested to know that in

discussions with people in North America (as we plan our Canada Study Tour) that some areas that use a similar system are looking at raising their

benchmark for high care residents to 3.6 hours/resident/day. That certainly would pose a significant challenge within our funding constraints!

Why participate?

From this program, participants receive a large amount of data that may be used in numerous ways. Our original intention was to assist organizations in ascertaining compliance with Expected Outcome 1.6 – Human Resource Management and

how they compare against other similar facilities. We still believe this to be a valid and major purpose.

Some who have been involved in the 'measure-up' program since its inception have also found it a valuable resource that they use throughout the year when looking at staffing issues in various departments or in ascertaining whether compromised resident outcomes may be related to staffing levels.

It has enabled some managers to explain to their board why they need more staff and it has helped demonstrate to auditors during the accreditation visits how staff have been deployed and how you measure up against others.

How useful is the data? As useful as your analysis and subsequent action makes it.



Canadian Study Tour

OBJECTIVES

- To increase knowledge of:
 - Innovative and practical building design
 - Workable management and staffing systems
 - Areas of training and education, particularly with dementia and technology
 - Future direction opportunities

Tour Dates

May 14-27th 2006

Location

Canadian provinces of British Columbia and Alberta, including travel in the Rockies. There will be sufficient to be able to see the sites and enjoy the culture.

Land Component Cost

Approximately \$3500.00 includes land travel in an exclusive use fully equipped professionally driven coach. Twin share accommodation including breakfast, entrance fees to facilities, events and training sessions.

Airfares

Rather than restricting participants to rigid times and flights this tour allows individuals to tailor their flights to meet their needs. This may include stopovers on the way or return and to extend their times as required. Return economy on a range of carriers will be approximately \$3000.00.

Tax Deductibility

Some or all costs may be eligible for either individuals to facilities.

Contact

Neil on 8276 9763 for details.

Too often people point at someone and say, "aren't they lucky, look what they are doing, why can't it be me?" Usually it is not a matter of ~~luck, but of good planning and a desire to make dreams become reality.~~

~~Planning is well underway and the near dozen confirmed participants are excitedly counting down the days.~~

~~There is still an opportunity for a very few more people to join this not to be missed event, but they need to get in quick.~~

Clarifying the Confusion - Hopefully?

by Carla Baron

The “Successfully Clearing the Hurdles” workshop facilitated by N & C Baron & Associates in November 2005 was a resounding event as indicated by the 85 participants who attended and discussed issues relating to some of their concerns about Round Three.

Key Points

Participants were assisted to understand key differences between this round of accreditation compared to the last two. They participated in workshops assisting them to complete the new accreditation application self-assessment.

Issues of interest included:

- ? compliance with key areas of specified services.
- ? the difference between compliance and improvement with regard to continuous improvement requirements
- ? the fundamental element of evaluation in ensuring compliance. That is, unless your activities, care plans, strategies etc. are evaluated, an outcome cannot be expected to be compliant.

If you missed the day you did miss out, but not totally.

Concerns that were raised that needed an answer from either the Aged Care Standards & Accreditation Agency or the Department of Health and Ageing have been forwarded to the respective areas and their answers are published below as promised.

Continuous Quality Improvement:

Some participants indicated that through their own personal experience, or that of sister sites, that they were given to understand that a single major project in each standard was not sufficient but that there had to be three

projects for each standard.

Nancy Morelli, the Acting State Manager replied on the December 23rd 2005:

There is no specified number. The number is not the point of continuous



improvement. The Agency expects that the home will demonstrate recent examples of improvement activities related to systematic evaluation of the services the home provides to residents in each of the four Accreditation Standards. A home does not have to demonstrate improvement in each expected outcome but it should be able to show that the performance in each expected outcome is understood and or monitored. A home may be able to demonstrate that it has undertaken a significant and major improvement project that incorporates a number of expected outcomes or it may be able to demonstrate a number of smaller projects relating to specific expected outcomes.

Assessment and management of taste, smell and touch.

Nancy replied:

Assessment of residents should take into consideration taste and smell when assessing residents' sensory losses in order to identify and manage their needs. Where this is recorded and how it is done is up to the home and will depend on the individual residents' needs. A home must be able to demonstrate that these needs are identified and that staff are

implementing any strategies required to manage these needs.

[ed. note It would appear that the answers provided should give you a better understanding of

these areas of concern, the difficulty might be in the interpretation of what has been said and how each auditor might evaluate the facility responses.]

RN/EN assessment and care planning of high care residents.

Specified services, 3.8 Nursing Services to high care residents indicates that a Registered Nurse must carry out initial and ongoing assessment planning and management for residents.

There was unanimous agreement that in some instances where ENs had extra specific training, they may be more knowledgeable than the RN. Specifically discussed were:

- * mobility instructions - ENs having completed ‘no lift. no injury’ program
- * continence management
- * palliative care
- * wound management.

The question asked to the Department of Health and Ageing was:

Is it acceptable that in these cases, an RN co-signs work by EN? Could it be acceptable if the facility could demonstrate that the EN had this knowledge (by being able to produce suitable

‘certificates’)?

A departmental representative replied to this question verbally indicating that:

The specification is clear. Co-signing an assessment suggests that that assessment was carried out by the other person and approved only by the Registered Nurse.

An RN may choose to sign the work of an EN but cannot be required to do so by an organisation.

Our Comments

The key to handling the RN/EN problem may be addressed by the development of policies about your assessment and care planning processes.

Assessment is a two-part process of data collection and data analysis and it is probably useful for organisations to review where that split occurs.

For example, does the Enrolled Nurse carry out the continence assessment and make recommendations on the basis of that which the Registered Nurse will then determine whether to follow or not?

This configuration could be seen as a parallel to the decision making process that the agency uses between the auditor and the manager.

All of the findings of auditors are recommendations only to the manager who then makes and signs the decision.

Some of you have already had you accreditation audits and hopefully done well. For those still to go through the process we trust this information is helpful to you and wish you the best possible outcome in your accreditation pursuit.

Five Points to Better Incontinence Management

by Neil Baron

Not being of the nursing fraternity I have often been able to exclude myself from issues that are more suitable for them to handle. Good strategy but sometimes it leaves me wondering about issues. One such area that I keep hearing about is that of continence.

A definition provided by www.biology-online.org/dictionary/continence states that continence is "*The ability*

to retain urine and/or faeces until a proper time for their discharge." That sounds good to me and not a reason to go out and manage anything.

The problem is when that is not what is happening and we therefore have, incontinence.

Okay so much for correcting grammar, how do we correct the problem?

As someone who has chosen not to delve into the

area, or even to go through the motions, (oops) I felt the best tactic was to ask the experts, so I posed the question two days before Christmas to Joan Nemeth and Lesly Seymour from McNeils Surgical and suggested a quick answer would be great

Being wonderful people, they took me seriously and delivered. I thank them for their knowledge and kindness in

helping to pull me out of the proverbial.

They did tell me that continence promotion and management is complex but a starting point is correct pad management.

Pad use is common for both managing incontinence and providing a level of security to maintain dignity for those who are on programs to improve or maintain a level of continence.

Back to Basics - continence pad application

McNeil Surgical Incontinence and Wound Care Product Specialists Joan Nemeth and Lesley Seymour

As we go from facility to facility it becomes apparent that the basics in pad application have been forgotten.

This can be because we have less staff, less time and any number of other reasons.

We have compiled a list of the basics that should make your life easier, and a more enjoyable pad application for the resident after all it is about quality of life for them.

1. Correct size pad. (often the pad leaks if too large)
2. Thorough assessment so that there is correct product choice
3. Ongoing assessment, Resident's needs often change, just when you think you have it right, things change e.g. Weight loss or gain, UTI etc.
4. Being aware and implementing best practice manual handling techniques and resident comfort during pad application.

Such as staff trying to change & reapply pads while Resident hanging in a toileting sling. Also using pad to move resident.

5. Ensure two piece pad system is fitted correctly into groin with well fitting net pants or underwear.

Hope you find this helpful. Happy pad fitting.

For more information contact Joan or Lesley on 8363 0888, they know what they are talking about.

Lost and Found

Participants who have attended our functions are sometimes so overwhelmed by the valuable information they receive, the great networking opportunities and the fine catering that they forget to take

all of their possessions with them. When we can we track them down and ensure that the articles are returned.

We are still in possession of two items, quietly waiting to rejoin their owners.

1. Black fabric folder with notepad and pen. - Thorny Issues.

2. Stone wash jean jacket - Better Way Leisure Day.

Please contact the office on 8276 9763 to arrange to have the items returned.

