DECEMBER 2011

the Standard

Monthly newsletter from Aged Care Standards and Accreditation Agency

RSL ANZAC march

RSL Lifecare wins

four Better Practice in Aged Care Awards

RSL ANZAC Village and Peter Cosgrove House at Narrabeen, NSW have been awarded four Better Practice in Aged Care awards for RSL LifeCare.

The award-winning programs are:

- Veteran culture and special needs program
- Men's health in residential care program
- Transition to residential care program for residents and families
- Interactive music therapy program for residents with advanced dementia symptoms.

Veteran culture and special needs program

This program was developed in response to the increasing need to recognise the special needs of veterans' health issues, growing cultural diversity of the workforce, where staff have no knowledge of Australian and Veteran history, and an increased community interest in how RSL Lifecare provides appropriate care and recognition of veterans. The program has expanded to include new graduates, essential skills groups, enhanced intranet and website information for staff and visitors to increase awareness of the veteran experience and their needs.

With 77% of residents having veteran or war widow status, the RSL ANZAC Village has a strong focus on the veteran culture, and not just for the 'special' days like ANZAC Day and Remembrance Day.

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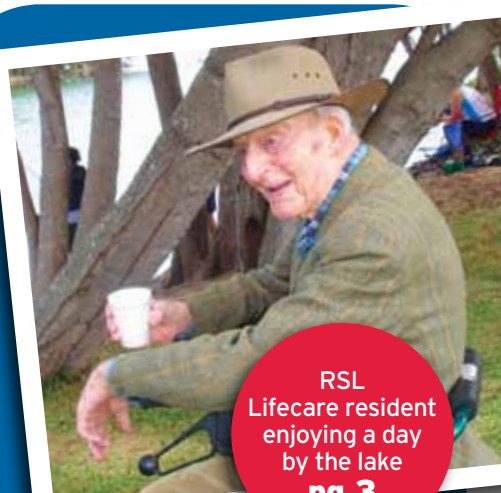

RSL Lifecare resident enjoying a day by the lake **pg 3**

In this issue...

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Just a word

We are sometimes asked for statistics on the aged care sector in relation to accreditation. This month we are publishing a selection of data which may be of interest to you.

For many, the Christmas period is a time to wind down, relax and celebrate the good things in our lives. For others, particularly aged care staff, there is no slowing down just because of the season. I hope you find the time to stop and enjoy the festive season, whether it be with your families at home or the residents that you care for all year around.

Mark Brandon
Chief Executive Officer

Industry performance

The data below provides a snapshot of the performance of aged care homes against the Accreditation Standards for the 12 months up to 30 September 2011.

The data shows homes' period of accreditation (or accreditation status), the number of homes with unmet expected outcomes and how quickly these were resolved, along with the top five expected outcomes most frequently not met. Also listed is the number of visits made to homes over the year.

Accreditation status of residential aged care homes

- There are 2758 accredited homes across Australia
- 2594 homes were accredited for three years
- 202 homes had a change to their period of accreditation
- 138 homes were given a longer period than previously
- 44 were given a shorter period than previously
- 2 homes had their accreditation revoked
- 18 homes had their period of accreditation reduced following a review audit

Homes on timetables for improvement

- 287 homes were placed on a timetable for improvement (plus 60 still on timetables for improvement carried over from the previous year)
- 269 were resolved
- 26 still had expected outcomes not met and 53 are on continuing timetables for improvement

Performance of residential aged care homes against the Accreditation Standards

- 2704 homes met the Accreditation Standards
- 54 homes did not meet some expected outcomes – most (33) did not meet one expected outcome

Most frequent expected outcomes not met

1.8 Information systems (83)

2.4 Clinical care (59)

1.2 Regulatory compliance (52)

2.7 Medication management (46)

4.4 Living environment (41)

Number of visits to homes

- 530 site audits; 53 review audits; 5201 assessment contacts and 3628 unannounced visits (assessment contacts and review audits)

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RSL Lifecare wins

four Better Practice in Aged Care Awards cont.

The Veterans' culture and special needs program began with research on what it means to be a veteran, and how to recognise veterans in the everyday environment.

Recreation officers take service history into account when designing and planning activities. Individual histories are incorporated into lifestyle and care plans.

Events such as the Village's own ANZAC Day march, dawn service, Remembrance Day and ex-servicewomen's luncheons, all recognise the importance of acknowledging and remembering service during war time.

Activities at other times of the year have included visits to and from HMAS Waterhen, book launches by residents about their war service and the book launch of RSL's 100 year history.

The village has also constructed a remembrance walk, sculptures, development of a war museum and cenotaph as well as military memorabilia and photographs placed in various homes within the village. A booklet on village monuments and place names helps everyone understand the history and relevance of veteran culture.

Particular attention is given to staff training around post traumatic stress disorder and recognising the symptoms of war induced anxieties as well as appropriate responses to assist residents during these episodes.

The village has also developed two scholarships:

- $500 to assist in nurse training and education for those who are involved with the nursing of ex-servicemen and women and their spouses – three scholarships are awarded annually.
- Up to $5000 to undertake further education – up to two scholarships per year.

Residents from RSL Lifecare

An earlier program that focused on residents with dementia had been designed to enhance relationships between staff and residents by creating a picture of residents' lives before the onset of dementia. This program has also been incorporated into the veteran culture program. It allows staff to truly understand the resident and their past history and respect their service.

The veteran culture and special needs program is not just about recognising veterans on special days. They need special care or consideration at all times. This program centralises veteran culture and their needs arising from war service as part of their lifestyle and the relationships that build between comrades.

Men's health in residential care program

Based on the "Men's Shed" concept, the Men's health project supports the needs of men living in residential care, who are often grieving and suffering from isolation and depression due to their changing circumstances. It is well documented that men are not as good as women at adapting to changing health and social needs and experience a higher rate of depression in residential aged care.

The men's program at RSL ANZAC Village recognises that men prefer unstructured activities and socialising, and a range of activities allows for casual social interaction.

RSL Lifecare wins

four Better Practice in Aged Care Awards cont.

Men's business group – an opportunity for intellectual stimulation, allowing men to discuss issues and topics that would not be as freely discussed in the presence of women.

Men's fishing group – provides an outdoor activity for men, and an opportunity to share stories and memories as well as for quiet reflection and camaraderie. The men share the tasks of baiting the hook and tying the lines.

Men's shed – a space for men to gather and socialise as well as work with tools on various projects.

Snooker – allows the men to gather and socialise as well as to maintain their hand-eye coordination and balance.

Men's gym – supervised sessions provide men with appropriate exercises while in the company of other men. Benefits are physical as well as mental, with men saying they feel happy immediately after a gym session while improving their general gait, posture and flexibility.

Art therapy – 'The Heroes Journey' – individualised therapy that provides opportunities for discussion of life goals and experiences and to express feelings about successes and disappointments in life – for residents with dementia.

"Bill is a good mate – I love getting out to watch bowls with him – he never misses – the beer's not bad either!"

Men's health resource folder in each care unit – a compilation of articles about issues relating to men's health and veteran health issues, ranging from hair loss to complex medical issues including mental health. The folder is available for residents, families and staff.

Other 'men-only' activities include: men's lunch group; morning tea in the Dugout; trip to Collaroy Services Beach Club; car washing; vintage cars; and one on one activities.

Each aspect of the men's health program is focused on providing mental stimulation, socialisation and avenues for men to be in control of their activities.

Transition to residential care program

This project has been developed by the New Residents team to provide a more formal support framework for residents and their families and carers during the transition from home to residential care. A bi monthly morning tea is hosted by the team to provide the opportunity for families and carers to discuss their concerns and share their stories and for RSL LifeCare to acknowledge their journey and provide the opportunity to form a support network for each other.

Entering aged care can be a challenging time, both for residents and their families. Often there is a crisis that leads to a sudden need for full time care. RSL LifeCare recognises the special needs of residents and their families at this time and has developed a program to cater for these needs.

Aspects of the transition to residential care program include:

- More helpful information at admission
- During the admissions interview residents are observed in terms of their self-efficacy and also family interactions – information is provided to the manager of the care home to help in smooth transition
- Relatives are invited to morning tea to discuss any concerns and meet others in a similar situation

Residents from RSL Lifecare gardening

"I am so glad I joined this group – when I go fishing I can talk about things I don't talk about to anyone else. I didn't think that would be possible but they make it possible here" - Tim

- Using the Positive Connections project to create a life story of the new resident – this helps care staff learn more about them
- Appropriate placements to ensure that residents can find the environment and resident mix that best suits them and their lifestyle as well as their care needs
- A pro-bono financial advisory service for families and residents
- A copy of the book *Caring for an Elderly Parent* by Kate Sumners is provided for all new residents' families
- A flexible approach is maintained so that individual needs can be met.

Residents from RSL Lifecare

Residents from RSL Lifecare out fishing

The program has been running since 1990, with many changes along the way, based on feedback and various changes in legislation. It began with a matron managing the process, the addition of a welfare officer, then the appointment of a registered nurse with nursing, welfare and social knowledge and skills. The role has now been shaped by resident and family feedback and is titled Manager, New Residents. The role includes resident contracts; charter of rights and responsibilities and advising on fees and charges; regulatory compliance requirements; the appropriateness of placements of residents; information giving; counselling; assessment and referral for clinical, welfare and financial services.

It is understood by RSL LifeCare that this service is unique in Australia.

Interactive music therapy program

In 2008 RSL LifeCare participated in a research project looking at the effects of music on spirituality experienced by people with dementia. Therapy sessions were conducted over the period of a year and results indicated that improvements were seen in many of the participants despite profound dementia in some cases.

Based on these findings, music therapy sessions were developed for use in Peter Cosgrove House.

The sessions are interactive, with participants playing instruments, listening to the stories and responding vocally or through percussion. The sessions are not passive, they encourage residents to make choices and comment on aspects of the music and activities.

During the sessions, residents are enthusiastic and happy to socialise with others. Wandering behaviours and agitation decrease during the sessions. Residents concentrate and follow directions and invitations to participate. A gentleman who does not speak English loves to sing and play the musical instruments while the music is playing; another will walk around and encourage others to join in.

While the effects are not long-lasting, there is clearly some benefit for the duration of the sessions, with participants enjoying a meaningful activity. ■

Case in point – dignity and capacity

Continued from last month's issue.

Last month we presented the story of Mrs Mary O'Reilly, a 72-year-old resident of Golden Pond Home for the Aged.

We provided our response to the scenario in last month's issue, along with *The Aged-care Rights Service Inc*, and the Adult Guardian, Queensland.

Below is the response from Professor Elizabeth Beattie, Director, Dementia Collaborative Research Centre (DCRC), Queensland University of Technology

The scenario

Mrs O'Reilly has mild hallucinations. During the day she often hallucinates that she is feeding birds, while in the evenings she is an opera singer. Staff at the home go along with the hallucinations, helping her 'feed' the birds and helping her select her costumes and dress for her opera 'performance' every evening.

Before entering the aged care home, Mrs O'Reilly had made a decision that she did not want to receive high levels of medications. She has been a resident at Golden Pond Home for the Aged for nine months and remains a patient of the same psychogeriatrician who was responsible for her care before she moved into the home.

Mrs O'Reilly is mild mannered and seems very comfortable and enjoys her daily 'rituals' along with the staff.

Mrs O'Reilly's only remaining relative is her son, who is extremely upset by the hallucinatory behaviour and thinks that his mother's dignity is being compromised. He suggested his mother see another doctor and she agreed. The second psychogeriatrician recommended higher dosages of medications which would stop the hallucinations.

However the treatment recommended by this second psychogeriatrician has its own set of side-effects which are likely to leave Mrs O'Reilly less cognitively aware, and less independently mobile.

Are the hallucinations, and staff joining in with the 'activities', compromising Mrs O'Reilly's dignity? What about Mrs O'Reilly's documented wishes before she became a resident? What about her son's concerns?

Response from Professor Elizabeth Beattie, Director, Dementia Collaborative Research Centre (DCRC), Queensland University of Technology

Mrs O'Reilly is seeing and feeding imaginary birds (hallucination) and also holds a fixed, false belief that she is an opera singer (delusion). It is unclear if these two things are a persistent feature of her mental status from her "long term mental health issues" or have developed over the last few months as part of a recent depression since her admission to the home. In reality there are no birds to be fed and Mrs O'Reilly is not an opera singer, unless her son can confirm that she once was. Hallucinations and delusions are both psychotic symptoms – they are not part of our shared reality – they are features of her illness and may or may not be able to be resolved in time with medication. Mrs O'Reilly experiences them as real.

Psychotic symptoms like hallucinations can compromise a resident's dignity because a person may behave in unusual ways that other residents, staff and visitors do not understand. Unusual behaviour may make a resident conspicuous, attracting ridicule, unkindness, laughter or infantalisation, or being ignored and not included. Staff collusion with her hallucinations and delusions, while creating a means of communication between the staff and Mrs O'Reilly and some pleasure, implies that those involved see the world the same way she does. In a depressed person with intact cognition this can lead to mistrust of the staff and a breakdown in open, helpful communication.

No information is given about what Mrs O'Reilly tells staff about the birds and the opera singing. Or the feelings she expresses verbally and by her behaviour if/when the staff interrupt her bird feeding activity and/or do not take part in the opera activities. Further, no information is given about what happens if staff gently explain there are no birds, distract her with other activities or do not participate in the opera dress up, or how she responds to her son about these matters. Understanding some of these things can help staff form a clear picture of how these behaviours fit with their overall knowledge of Mrs O'Reilly as a person. Her son's opinion about his mother's behaviour offers a valuable insight – when staff go along with her actions and beliefs his view is they are supporting her to behave in a way that she would find embarrassing and demeaning were she well. He may be right about how his mother may feel. Many people who experience psychotic symptoms are embarrassed when they are well again. Or he could be embarrassed himself, not used to seeing his mother's mental capacity changing and fearful of what this means for her future.

There are multiple perspectives on how best to respond to Mrs O'Reilly's needs and this is a conundrum about 'truth telling' – is it important to consistently be truthful in how we deal with another person about certain symptoms? Is it ever appropriate to go along with a resident's perceptions and beliefs when we know they are not based in current reality and we do not share them? In what circumstances, if any, is it OK? Will we cause suffering if we do not go along with Mrs O'Reilly's bird feeding and evening opera? When we enter the reality of another person fully do we share a deep bond as humans that transcends issues of 'truth' and 'reality'?

The meaning of Mrs O'Reilly's hallucinations and delusion is hard to determine. From a person-centred care perspective perhaps 'feeding the birds' is a way Mrs O'Reilly can tell us how much she misses the natural world where birds and birdsong gave her pleasure. Perhaps in the 'opera singer' she finds an identity that provides enjoyment, attention, self esteem and a role for her now that she is living in aged care and is having to develop new relationships and leave behind many familiar, possessions, people and rituals. Perhaps she has a wonderful singing voice and in her young life yearned to be an opera singer but was denied the opportunity. From the perspective of unmet needs Mrs O'Reilly may be telling us that she is isolated, bored or lonely and the activities we provide to occupy her time are not stimulating or fulfilling to her.

Mrs O'Reilly is described as 'mild mannered' and 'enjoys her daily rituals'. This description implies a level of habit, comfort and satisfaction in these daily routines. While the bird feeding and opera singer belief do not fit staff reality they appear not to be causing Mrs O'Reilly any distress or discomfort. However we need to be mindful that apathy associated with depression, can masquerade as being 'mild mannered' and compliant with staff requests. It is important to remember that rituals provide a sense of security and connectedness for us all in uncertain and stressful times such as in the first 12 months after moving to an aged care home.

In the older person antipsychotic medication in addition to antidepressant medication may be necessary to resolve depression and Mrs O'Neill might be willing to accept stronger or additional medication if her situation was more clear and well explained to her. Any explanation would need to include information about the undesirable effects of the medication as well as the desirable ones so that Mrs O'Reilly and her son can understand the implications of any decisions she may make, or he may make on her behalf.

What about Mrs O'Reilly's documented wishes before she became a resident?

Accreditation Standard 3: Resident lifestyle is based on the principal that residents *"retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community"*. Expected outcome 3.4 refers to support for the emotional adjustment of the resident in the aged care home while expected outcome 3.9 provides guidance on choice and decision making, that is *"Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people"*.

It is unclear from this case study what long term mental health issues Mrs O'Reilly has had in addition to her current depression. She has a longstanding relationship with her existing psychiatrist, whom she presumably trusts and who knows her well. We have no information about her physical functioning, current level of cognitive functioning and what decisions she is still able to make independently, what precise documentation (legal or other) of her wishes she has put in place and what legal role her son plays in her affairs.

Mrs O'Reilly agreed to see a second psychiatrist of her son's choice. The clinical opinion that psychiatrist provided conflicts with the clinical opinion given by her usual psychiatrist. An independent geropsychiatric evaluation organised by the facility is indicated, provided Mrs O'Reilly and her son, if he is her power of attorney, agree. This is consistent with Standard 2, Health and Personal Care, and the principle that "Residents' physical and mental health will be promoted and achieved at the optimum level, in partnership between each resident (or his or her representative) and the health care team". Her documented wishes prior to becoming a resident are important but may be affected by her cognitive status, which is unclear. The hallucinations and the delusion she has are less common in late life depression and more typical of dementia. An independent assessment can confirm her cognitive status and provide insight into how capable she is of making independent decisions.

What about her sons' concerns?

Her son's concerns for his mother's wellbeing are legitimate. The staff's role is to preserve the dignity and enhance the personhood of this resident while ensuring her optimal health and quality of life.

Depression in late life is very common.

Action:

1. assessment of cognitive status to determine if Mrs O'Reilly has dementia in addition to her other mental issues.
2. continue to relate to Mrs O'Reilly as a person, acknowledge her emotional reality despite the fact that we may not share it. This can be done by expressing support, and warmth, and using distraction to focus her attention on a variety of activities, not only birds and opera. ■

the Standard

E-learning success at Bupa

When Bupa decided to offer its mandatory training online, there were concerns that those staff with limited computer skills would feel intimidated and overwhelmed. But with a team approach, the e-learning program has been deemed a huge success by management and staff.

Margaret Ryan, Bupa's Learning and Development Manager said e-learning was introduced as a way to allow staff to complete training at their own pace, either at home or at work in the computer 'kiosks' set up in all Bupa aged care homes.

"We identified through our staff surveys, those staff who were confident with computers and who were willing to help others. We teamed them up with staff who were less confident and needed help. It became a part of their goals for the coming quarter – to help someone else with e-learning and improve their computer skills."

The e-learning programs vary in length, from 30 minutes to 90 minutes or so, depending on prior knowledge and computer skills. Courses include infection control; OH&S fundamentals; manual handling; bullying and harassment; communication skills; and understanding behaviours we find difficult and challenging.

Margaret said staff logon to the e-learning portal using their payroll details, and can complete the courses at their own pace. Each section is followed by a quiz. Each course has a required pass rate from 80 to 100% depending on the content.

"Staff can listen to the program as well as read it, and look at pictures and diagrams. They can even stop and come back to it later and go back and forth to check on their learning."

"The programs are based on active learning, with lots of 'drag and drop' exercises and explanations along the way. So during a quiz for example, there is an explanation about why an answer is correct or incorrect."

Bupa is waiting on the results of a recent survey to determine the overall success of the first year of e-learning, but initial responses indicate it has been well-received by staff and management alike. In fact in the first week of e-learning, 300 staff logged on and started a course.

Comments from staff included: "I enjoyed doing my e-learning on line, it gives me a lot of thinking and I am able to digest the contents of the courses without being pressured in any way;" "e learning has really helped us a lot to improve on our care to the residents," and "I would like to say thank you for this training, to be able to do this at our own pace is great, we all have families etc and life is busy, online training helps so much."

Since the introduction of e-learning, Bupa has developed new programs including staff induction and a course based on the organisation's policies and the Aged Care Act in relation to reportable assault, abuse and neglect. They have also partnered with various suppliers who have developed e-learning programs to improve knowledge about their products.

"An important thing to remember though with e-learning is that it does not replace face-to-face learning. In fact, by offering the mandatory courses online, it frees up our resources to develop more face-to-face learning, particularly focused on person-centered care," Margaret said. ■

Education 2012

Our Education calendar for 2012 is now available on our website.

Click on education to find out about our one-day workshops, Better Practice conferences and three-day course on Understanding accreditation.

New one-day workshops for 2012 are Managing risk in aged care and Information systems.

Dates and locations are listed on the website. You can even register and pay online. **www.accreditation.org.au** ■