Evidence-based practice in aged care: Is it abuse or neglect if we don’t do it?

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Abuse and neglect

Abuse includes financial, psychological, **physical** and sexual abuse, and neglect and should include failure to respect the quality of life choices of older people (Ibrahim, 2018)

- Abuse (verb)
  - use (something) to bad effect or for a bad purpose; **misuse**.
- Abuse (noun)
  - the **improper use** of something.
- Neglect (verb)
  - fail to care for **properly**.
- Neglect (noun)
  - the state of **being uncared for**. (online dictionary)
Australian Government

Department of Health

CHARTER OF CARE RECIPIENTS’ RIGHTS AND RESPONSIBILITIES – RESIDENTIAL CARE

Aged Care Act 1997, Schedule 1 User Rights Principles 2014

1. Care recipients’ rights - residential care

Each care recipient has the following rights:

a) to full and effective use of his or her personal, civil, legal and consumer rights;
b) to quality care appropriate to his or her needs;
c) to full information about his or her own state of health and about available treatments;

Importance of comprehensive assessment to determine ‘needs’
Patients, residents, consumers and the community trust clinicians, care providers, health service organisations and aged care services to provide safe, high-quality health care - UNTIL something goes wrong!
Improving the quality of aged care is in all our interests, writes Michael Bachelard.

Every day I think about the way my grandmother died.
- gangrenous, pressure sores
- poor infection control practices
- minimal action to address weight loss
- missed urinary tract infections

(The Age 2017)
Oakden

- Care was not contemporary or best practice (Groves et al, 2017 p. 80)

- There seemed to be a poor understanding among staff, as evidenced by the case files, in regards: modern falls mitigation, the use of trauma informed principles to avoid the use of restrictive practices, wound care, pain management, assistance with activities of daily living, management of wandering, the use of sensory modulation, management of agitation and arousal, management of disturbed sleep-wake cycles and the nursing management of common medical problems including how to undertake common medical procedures. (Groves et al, 2017 p. 80)

- What we found at Oakden does not meet best practice in most respects (Groves et al, 2017 p. 35)

- Recommendation Three

  ‘...a framework for clinical supervision is developed and delivered that incorporates as a minimum, elements related to comprehensive patient assessment and care planning, the Fundamentals of Care, person-centred evidence based care, cultural safety and competency and clinical documentation requirements (Groves et al, 2017 p. 67)
Clinical governance is the set of relationships and responsibilities established by a health service organisation (incl. aged care organisations) between its state or territory department of health, governing body, executive, workforce, patients, residents, consumers and other stakeholders to ensure good clinical outcomes.

(Australian Commission on Safety and Quality in Health Care, 2017)
Clinical governance ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality (best practice) health care, and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service and aged care organisations. It ensures that everyone – from frontline clinicians and carers to managers and members of governing bodies, such as boards – is accountable to patients, residents and the community for assuring the delivery of health and care services that are safe, effective, integrated, high quality and continuously improving.

(Australian Commission on Safety and Quality in Health Care, 2017)

* Does your Board know that care provided in your aged care service is best practice and evidence-based????????????????????????????????
• Quality care

• Evidence-based care/practice

• Best practice
What is evidence-based practice?

‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine [practice] means integrating individual clinical expertise with the best available external evidence from systematic research … and the more thoughtful identification and compassionate use of individual patients’ predicaments, rights and preferences’ (Sackett et al, 1996 p.71)

Evidence of effectiveness – does it work?
Challenges in aged care compared to health services re evidence –based practice?

- Culture of compliance? Minimal standards
- Research culture
- Unlikely to have academic affiliations – staff or organisation
- More difficult to locate best practice standards in aged care – plus not just disease or condition specific – older people in residential aged care often have multiple co-morbidities, dementia etc
- No medical leadership
- Less educated staff
Evidence-based clinical guidelines/care processes are systematically developed statements that provide evidence-based recommendations for practice and care.
Is current aged care practice evidence-based? And how do we know if it is?

- Need to know what is evidence-based practice in resident care
- Need to audit current practice in aged care services against the recommendations from best available evidence (guidelines, standardised care processes etc)
  - What are current audits in aged care based on?
- Identify practice gaps
- Implement evidence based practice to fill the gaps
Clinical audit

• is a process that clinicians use to examine their care practices and compare the results with evidence-based clinical guidelines or best practice statements

• compares the current practice with that which has been identified as effective and then identifies any inconsistencies.

• identifies the areas of needed practice change in sufficient detail that it can also be used as an implementation tool for instigating, and then evaluating, the improvements.

• provides evidence that the care currently being provided is of a quality standard and thereby gives positive feedback, which is just as important as identifying what improvements need to be made. A method of evaluating and improving practice
What questions does a clinical audit address?

• What should be happening?

• What is happening?

• What changes are needed?
How to do it

• turn an evidence-based recommendation/statement into something measurable – an indicator

• need to ascertain what you need (criteria) to meet the indicator. Criteria are those items necessary in order to achieve best practice and provide the more detailed and practical information on how to meet the indicator. Criteria refers to the resources (structure) which you need, the actions (process) that must be undertaken, and the results (outcomes) you intend to achieve.

  – The criteria need to be measurable.
• **Structure criteria** (what you need) – resources in the system that are necessary for the successful measurement of the indicator and may include a consideration of staffing levels and skill mix, tools, requirements for knowledge and expertise, organisational arrangements and the provision of equipment and physical space.

• **Process criteria** (what you do) refer to the actions and decisions taken by staff in conjunction with patients in order to measure the specified indicator and may include assessment, education, evaluation and documentation.

• **Outcome criteria** (what you expect) describe the desired results of the project from the perspective of the recipient of the service or care and are typically expressed in terms such as physical or behavioural response to an intervention, reported health status and level of knowledge and satisfaction.

(Morrell and Harvey, 2003 p28)
• Sometimes guidelines problematic as not context specific

• Guidelines etc. need to be user friendly – often problematic with traditional guidelines – like a PhD thesis!

• SO what were we commissioned by the DHHS to do???????
Identify areas of clinical risk for older people living in aged care

- Clinical risk is defined as ‘an action or inaction on the part of the organisation resulting in a potential or actual adverse health impact on consumers of health care’ (ACEBAC, 2009).
# Standardised care processes (SCPs)

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<td>4. Delirium</td>
<td>12. Polypharmacy</td>
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<td>5. Depression</td>
<td>13. Pressure Injuries</td>
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<td>6. End of Life Care</td>
<td>14. Skin Tears</td>
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<td>7. Falls</td>
<td>15. Sleep</td>
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<td>8. Hypoglycaemia</td>
<td>16. Unplanned Weight Loss</td>
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* Antimicrobial stewardship and responsive behaviours currently being developed
Standardised care processes (SCPs)

- evidence based: developed from existing clinical practice guidelines
- clear and unambiguous
- understandable to end user
- multidisciplinary involvement where appropriate
- include provision for resident/family decision-making, choice and preferences
- able to enhance quality outcomes
- reviewed every 2-3 years
Standardised care processes (SCPs)

• Do not just encompass immediate issue e.g. immediate threat of ‘choking’ but cover whole ‘care continuum’ which includes resident involvement & staff knowledge & education:

  • Recognition and assessment
  • Interventions
  • Referral
  • Evaluation and re-assessment
  • Resident involvement and
  • Staff knowledge and education
Pressure injuries
Standardised care process

Objective
To promote an evidence-based approach in the assessment, management, and prevention of pressure injury wounds for older people who live in a residential aged care setting.

Why the prevention and management of pressure injuries is important
Pressure injuries are potentially life threatening, decrease the residents’ quality of life and are expensive to manage. Prevention management is advocated for minimizing a resident’s risk of developing a pressure injury (Therapeutic Guidelines Limited 2015).

Definitions

Active support surface: a support surface that produces alternating pressure through mechanical means, thereby providing the capacity to change its load distribution properties with or without an applied load. This generally occurs through alternation of air pressure in air cells on a programmed cycle time. Also called an alternating pressure support surface or a dynamic support surface (AWMA 2012).

Pressure injury: a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, shear, or a combination of these factors (NPUAP et al. 2014, p. 12).

Pressure injuries usually result from pressure over a bony prominence. Shearing forces (produced by incorrect patient transfer technique) and friction (from repetitive movements by the patient) often contribute (Therapeutic Guidelines Limited 2015).

Brief standardised care process

Recognition and assessment
Complete a comprehensive pressure injury risk assessment with all residents on admission, whenever their condition changes or daily where there is a known risk or an existing pressure injury wound.

On presentation of a pressure injury:
- Assess the wound
- Classify the level of tissue loss using a validated classification tool
- Conduct nutritional screening and assessment
- Document the wound assessment and classification outcomes.

Interventions
- Clean the wound and surrounding area using universal precautions.
- Immuno-compromised residents and invasive wound procedures require aseptic technique.
- Debridement should be considered for removing necrotic or devitalized tissue.
- Before using topical treatment products (silver, medical-grade honey, antibiotics or antimicrobial) consider the clinical evidence that supports their use.
- Systemic antibiotics should only be considered where there is clinical evidence of spreading or systemic infection.
- Consider using adjunct treatments for stage 2-4 pressure injuries.
- Consider surgical intervention for unresponsive stage 3 and 4 pressure injuries.
- Implement an individualized pain management plan
- Choose an appropriate dressing based on the wound’s characteristics
- Promote a healing environment
- Prevent future pressure injury wounds.

Referral
- Wound care specialist (nurse or physician) or wound clinic
- Podiatrist
- Physiotherapist
- Dietitian
- Pharmacy
- Occupational therapist or physiotherapist
- Social worker
- Speech pathologist
- Social worker
- Dietitian
- Physiotherapist
- Occupational therapist
- Psychologist
- Geneticist
- Respiratory therapist
- Cardiologist
- Dermatologist
-GP
- Nurse

Resident involvement
- Support the resident’s involvement in preventing and managing pressure injuries.
- Educate the resident to recognize the early signs of a pressure injury.
- Encourage the resident to relieve or redistribute pressure through frequent repositioning.

Staff knowledge and education
- Prevention, assessment, and management of pressure injuries
- How to undertake a comprehensive skin assessment
- Use risk assessment tools for predicting and staging a pressure injury
- Development and implementation of an individualized skin care program
- Selection and/or use of pressure management devices
- Positioning/transfer techniques to decrease risk of tissue breakdown.
Full standardised care process

Recognition
Complete a comprehensive pressure injury risk assessment:
- within 24 hours of entry to the facility
- whenever the resident’s condition significantly changes
- daily where there is a known risk or an existing pressure injury wound

Assessment
A comprehensive assessment of risk factors should be undertaken by a health professional with training and expertise in this area and include:
- use of a validated pressure injury risk assessment tool (Braden scale, Norton risk-assessment scale, Waterlow score)
- a thorough assessment of the skin for:
  - frailty
  - blanchable or non-blanchable skin discoloration or erythema
  - change in tissue consistency (induration, hardness, edema) in relation to the surrounding tissue
  - variations in heat and moisture (for example, incontinence, acedia or infected skin)
  - changes in skin integrity
  - high-risk areas on bony prominences (sacrum, ischial tuberosities, greater trochanters and heels)
- identification of potential sources of pressure and shear including:
  - prosthetics and other medical devices that come into contact with the skin
- support surfaces
- negative pressure wounds
- nutritional screening and assessment using appropriate validated screening and assessment tools
- blood tests to assess the resident’s overall health status
- assessing any restrictions to the resident’s mobility and activity
- assessing the resident’s continence needs
- assessing the resident’s cognition
- the resident’s clinical history
- extrinsic risk factors (heating, air-conditioning, support surface microclimate)

Document all risk assessment findings.

Interventions
Pressure Injury wound management
- Clean the wound and surrounding area at dressing changes using universal precautions. Irrigate with warm sterile isotonic saline (sodium chloride 0.9 percent) or water.
- Use effective wound management techniques where the resident’s immune status is compromised or when invasive wound procedures such as conservative sharp wound debridement or biopsy are required.
- Debridement (mechanical, sharp, acidic or biological) should be considered to remove necrotic or devitalized tissue. This should be carried out by nurses who are knowledgeable and skilled in wound care.
- Topical silver or topical medical-grade honey can be used in heavily contaminated or infected pressure injuries.
- Topical antiseptics or antimicrobials should only be used where there is clinical evidence of infection or critical colonization.
- Systemic antibiotics should only be considered where there is clinical evidence of spreading or systemic infection (such as systemic sepsis, cellulitis, underlying osteomyelitis).
- Surgical intervention may be needed when stage 3 and 4 pressure injuries are non-responsive to contemporary management strategies.
- Implement an individualised pain management plan with appropriate pharmacological and non-pharmacological pain relief strategies.
- Adjunct treatments that can be considered in combination with regular care in stage 3-4 pressure injuries include:
  - electric or pulsed DC electrical stimulation
  - ultrasound
  - low-frequency ultrasonic debridement
- The choice of wound dressing will be guided by the goal of treatment and the size, depth and location of the wound and should take into account its ability to:
  - manage infection, exudate and exudate
  - maintain a moist wound healing environment
  - protect the wound and surrounding skin from shearing, friction, pressure and skin irritation
  - be cost effective

Promote a healing environment if this is the documented aim by:
- keeping the skin clean, dry and moisturised
- assisting the resident to remain hydrated and nourished
- inspect the skin daily.

Pressure Injury prevention
An individualised prevention plan should be instigated for residents who have, or are at risk of developing, a pressure injury. This should consider the following:
- Provide pressure-relieving or redistribution support surfaces (high-specification, reactive, constant low pressure) or active (alternating pressure) support surfaces on beds and seating.

Repositioning:
- Intimate regular repositioning for residents in bed – six-hourly for those at risk and four-hourly for those at high risk (at a minimum) or as defined by individual circumstances.
- Maintain the height of the bed at its lowest degree of elevation or below 30 degrees.
- Avoid positioning a resident on existing pressure injuries, on areas of erythema, on their heels or other bony prominences, or directly on medical devices (for example, tubes, drainage systems).
- Encourage seated residents to shift their weight every 15 minutes and limit their time in a sitting position, particularly if there is no pressure-relieving support system in place.
- Ensure seated residents are positioned to maintain a proper posture, foot support, range of movement and pressure redistribution.
- Protect residents’ skin from damage caused by friction or shear:
  - using correct transferring and manual handling equipment and techniques
  - avoiding rubbing or massaging areas of the skin at risk of a pressure injury
  - Protect residents’ skin from exposure to excessive moisture with a barrier product.

Referred
- Wound care specialist or wound clinic
- Podiatrist for specialised care of pressure injuries in the foot and ankle
- Orthotics for custom-made pressure-relieving boots/shoes
- Continence advisor
- Dietitian to assess and manage residents’ nutritional status
- Infection control specialist or microbiologist for non-contagious or unresponsive infections
- Physiotherapist or occupational therapist for pressure redistribution, seating, manual handling and mobility
- Surgeon for surgical intervention, surgical debridement, flap closures and vascular assessment

Evaluation and reassessment
- Regularly reassess the resident’s risk of developing or pressure injury, particularly when there is a change in their clinical status.
- Reassess the resident’s skin on an ongoing basis to detect the early signs of pressure damage, particularly on at-risk areas.
- Regularly reassess prevention strategies and adapt these as required.
- Evaluate interventions; consider if healing is in the aim and adjust the care plan as required.
- Monitor the signs and progress toward healing. Use pressure injury assessment scales and serial weekly digital wound imaging.
- Monitor the resident for any signs of infection and pain during wound care interventions.
- Regularly review repositioning schedules for at-risk residents.

Resident involvement
- Support the resident and their family’s involvement in preventing and managing pressure injuries.
- Educate the resident to recognise the early signs of a pressure injury.
- Encourage the resident to relieve or redistribute pressure through frequent repositioning.

Staff knowledge and education
Provide staff education on:
- the prevention, assessment and management of pressure injuries
- how to undertake a comprehensive skin assessment
- how to use risk assessment tools for predicting and staging pressure injuries
- development and implementation of a standardised skin care program
- identification and use of pressure management devices
- positioning and transferring techniques to decrease the risk of tissue breakdown.

Pressure injuries
Evidence base for this standardised care process


Department of Health 2012, Strengthening care outcomes for residents with evidence (SCORE), Ageing and Aged Care Branch, Victorian Government, Melbourne.


Registered Nurses' Association of Ontario (RNAO) 2016, Assessment and management of pressure injuries for the interprofessional team (3rd edn), RNAO, Toronto.

Therapeutic Guidelines Limited 2016, Therapeutic guidelines: Ulcer and wound management, version 1, Ulcer and Wound Management Expert Group, TGL, Melbourne.


**Important note:** This SCP is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

# Clinical audit using the Pain SCP

<table>
<thead>
<tr>
<th>Recommendation in SCP</th>
<th>Audit Indicator</th>
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<tbody>
<tr>
<td>Pain identification through direct enquiry about the presence of pain should occur on admission</td>
<td>On admission all residents are assessed for the presence of pain</td>
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**Audit indicator**: On admission all residents are assessed for the presence of pain

<table>
<thead>
<tr>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>A validated self-report pain assessment/measurement tools in accessible format is available in the facility</td>
<td>Staff ask residents who can self-report about the presence of pain using the validated self report assessment/measurement tool</td>
<td>100% of residents who can self-report are asked about the presence of pain using a validated self report assessment/measurement tool on admission</td>
</tr>
<tr>
<td>A validated observational pain assessment/measurement tool is available in the facility</td>
<td>Staff are educated and competent in the use of the validated observational pain assessment/measurement tool</td>
<td>100% of residents who cannot self report are assessed for pain using the validated observational pain assessment/measurement tool on admission</td>
</tr>
<tr>
<td></td>
<td>Staff use the validated observational pain assessment/measurement tool for residents who cannot self-report</td>
<td></td>
</tr>
<tr>
<td>Audit questions</td>
<td>Y/N</td>
<td>On admission how many residents who can self report were asked about pain validated self-report pain assessment/measurement tool</td>
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<tr>
<td>Is there a validated self-report pain assessment/measurement tools in accessible format available in the facility?</td>
<td>Y/N</td>
<td>How many staff have been educated and are competent in the use of a validated observational pain assessment/measurement tool</td>
</tr>
<tr>
<td>Is there a validated observational pain assessment/measurement tool available in the facility</td>
<td>Y/N</td>
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If aged care practice is not evidence-based, high quality, and best practice then we are abusing and neglecting the older people who live in RAC!
References


