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Where to Begin Risk Management in Long Term Care in Australian Aged Care Organisations

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Objective:

To integrate the risk management concept into the care and service delivery of long term care in Australian aged care organisations.

Background/ Rationale

Introduction:

In Australia and other parts of the world, older adults are admitted to aged care organisations for long term care because they are at risk at home. Each individual resident faces a different kind of risk, whether at home or in an aged care organisation.

Looking after our older generation and providing the care they deserve is challenging. It is a process that we all need to consider very carefully in terms of risk management. In Australia, without any reservations we all agree that care and service delivery has improved since the introduction of continuous quality improvement into the aged care industry. However, the misconception of the continuous quality improvement is still evident in the industry where authorities, employers and employees put all their faith in numbers and believe that numbers must be at a high percentage to achieve compliance.

Risk management is well established in the business world as well as in health care. There are many strategies in the generic areas of risk management, namely: security; fire; occupational health and safety; equipment and system failures; natural disasters; industrial relations issues; non – compliance with legislative requirements; credit issues; insurance and property damages.

However, very little has been written about risk management in actual care delivery in the aged care industry. In Australia, basic care is being delivered to vulnerable residents by direct care staff. There is commonly only one qualified nurse (Registered nurse Div1) to oversee the care delivery for 30 residents.

The direct care staff's level of education and training varies from one training organisation to another. Some organisations may offer staff two weeks intensive training, while others provide six months training. Either way, their knowledge in identifying complex care needs is limited.

One might argue that highly qualified staff may not be needed to provide assistance to residents for their basic daily living tasks such as toileting, showering and bed - making. However, care needs changes are often identified when a nurse attends to these tasks. The risk is that most of the direct care workers are failing to identify these changes when attending to residents.

Risk management in care delivery is not new to health care. We provide yearly influenza vaccine to all older people to prevent or reduce incidents of chest infections in winter months. We do regular assessments on our residents, but we do not always carry out risk assessments systematically to avoid undesirable incidents. Mostly we do risk management on a reactive basis.

Little guidance available on how to collect data or how to approach risk management even from other industries. This is due to the uncertainty and unpredictability of the presence of risk. We do not know where or how it happens. We only know the potential of it happening. However, the literature search (Hann Dec 2003; Jablonowski Dec 2003; Mandel Nov 2002; Tolek Dec 2003)indicated that identifying potential risk and monitoring that risk are the main elements of risk management. So, valid and reliable data collection becomes pivotal in risk management. Data collection tools should be appropriate and adequate in identifying and measuring the risk involved.

The future of aged care is heading towards evidence-based and realistic practice. The evidence required must be objective, valid and reliable. Care provision always carries a certain degree of risk.

There is always a gap between the perceptions of what care delivery should be (perceived quality) and the actual care delivery (delivery quality). Thus, the greater the gap, the higher the risk for both consumer and care provider. To effectively reduce this gap, data collection must be objective and focused not only on what is being done but also on what needs to be done. Too much attention is paid to the level of compliance rather than focusing on continuous improvement through risk management.

Care delivery in any setting is a complex process, and aged care delivery is no different. The complexity of the process is due to the variety of factors involved in care delivery. First of all, aged care service delivery has many subtle and intangible emotional factors which can be neither eliminated nor controlled.

Secondly, residents' physical, mental and medical problems create higher risks, which require close and continuous monitoring.

In this paper, the writer explains a sequence of steps that the writer and others have taken to identify and monitor risks in aged care delivery. The writer has integrated the risk management concept into the continuous quality improvement process in aged care rather than looking at risk management as a separate issue.

The paper highlights the different perspective of risk management especially in aged care. The writer has developed a simple and practical way of managing clinical risks by implementing a risk assessment system which will monitor, measure and evaluate compliance to the aged care outcomes.

What is risk management in general?

Risk management should be a part of any general management strategy, regardless of the business. Risk has been defined in many different ways. The risk management standard AS/NZS 4360:1995 defines risk management as:

"A logical and systematic method of identifying, analysing, evaluating, treating, monitoring and communicating risk associated with any activity, function or process in a way that will enable organisations to minimise losses and maximise opportunities. Risk management is as much about identifying opportunities as avoiding or mitigating losses."

What is risk management in aged care?

The risk and uncertainty involved in aged care and service delivery revolves around the human factor. It is a labour- intensive process and most of the care being delivered by personal care staff who have limited education and training.

Elderly people living in residential care facilities have multiple medical problems, which need to be monitored and identified as soon as possible. The identification of such problems requires a great deal of knowledge and expertise.

Risk management in aged care is focused on the incidents and accidents which might occur during the delivery of care and services to our older generation in a residential care setting. The risks are embedded in the decisions that are made relating to residents' medical problems, the level of acceptable care, suitable treatment options if and when quality-of-life issues arise and the comfort and safety of the resident

Errors are regarded as a risk in any industry, and could take place at any stage of the task: input or process. When risk occurs at the input stage, it relatively easier to control or eliminate. But when it occurs at the process stage, it is much more difficult to control or eliminate (Berry 1995). In aged care, errors are made at both input and process stages. For example, one of the input errors is the employment of unqualified staff or their lack of knowledge in aged care. When such errors are made at the input stage, each sequent errors in the process of care can not be avoided.

There are a number of special areas of risk specific to aged care. These include, but are not limited to:

- Incidents of falls, behaviours, skin integrity
- Drug errors
- Treatment errors
- Misdiagnosis
- Epidemics (eg. Gastroenteritis)
- Staff injuries
- The lack of qualified staff

Two factors cause these risks - intrinsic and extrinsic factors. Intrinsic factors arise from residents' complex medical, physical and mental conditions while extrinsic factors arise from environmental issues, staff knowledge, skills and shortfalls in resources. Table 1 illustrates the most common intrinsic and extrinsic risk factors in aged care delivery.

Table 1: Most common Intrinsic and Extrinsic Risk Factors in aged care delivery.

Intrinsic Factors :		**Extrinsic Factors :**	
Residents' complex medical , physical and mental conditions	Medical conditions such as Arthritis, anaemia, dehydration, hypoglycaemia or hyperglycaemia, presence of arrhythmias, carotid bruits and other neurological problems, dizziness, vertigo, drop attacks, postural hypotension etc	**Environment, staff knowledge and skills, lack of resources**	Physical environment of the living environment – architecture of the building, Furniture and other aids use for living
	Electrolytes imbalance, blood urea nitrogen, creatinine, glucose, and vitamin B12 levels		Lack of staff knowledge and skills
	On psychotropic medications, cardiac drugs including class 1A antiarrhythmic agents, digoxin, diuretics and anti convulsants		Reduced staffing levels
	Use of four or more prescription medications		Untrained staff
	Impairment in gait and balance, Muscle weakness		Time constraints
	Impairment in skin integrity		
	Impairment in vision, hearing and sensation		
	Impairment in cognition, Dementia with challenging behaviours		

Source: Developed for this project

Risk management in care delivery is not being discussed in detail in the aged care industry, is mostly due to a lack of understanding of what constitutes risk management in care delivery. Little education is available to aged care providers and care givers in identifying risks, analysing risks and risk control in the delivery of care.

When using Continuous Risk Management, risks are assessed continuously and used for decision-making in all aged care outcomes. Risks are identified and dealt with until they are resolved or strategies and interventions are put in place to handle if they turn into problems.

Continuous quality improvement in aged care begins with continuous risk management strategies. The key questions that need to be raised are:

- What can go wrong? Are we sure that we are aware of all the risks that our residents face?
- What will we do to prevent it?
- What will we do if it happens?

The concept of risk management which has been adapted for this project is a process of identifying potential "risks'', in order to minimise the chances of re-occurring and maximising the opportunities for improvement.

Risk identification

Risk management starts with risk identification. The risk identification task is establishing what can happen, and how and why it can happen and developing the tools and techniques used to identify risks.

There are many tools and techniques used to identify various types of risk.

In this project, we have considered the clinical risks which effect residents (clients).

Today's complex challenges require a new approach. With the right system, process and tools, risk can be fundamentally turned round from a source of fear into an opportunity for improvement.

In order to manage risks in aged care successfully, the project team identified four key elements:

- The data collection tools to formulate "predictive data"
- The data for analysing and priotising risk drivers
- The tools for identifying process risks and
- A tool to compare the data

Development of Incident Report project

When risk is being considered in the elderly, the highest risk areas are falls, challenging behaviour issues and skin impairments. Considerable research has been conducted on falls in the elderly, behaviour management, skin impairments and so on, but incident rates remain more or less the same.

After analysing retrospective incident data, we believe that we need adequate data collection tools in order to reduce risks.

For this project, a cross-section of 50 staff from 10 aged care organisations were interviewed. Also, documents such as incident reports, incident investigation reports and residents' progress notes were examined to ensure that they met the key element of managing risk in aged care settings.

90% of staff interviewed stated that the current reports being used in aged care organisations do not specify sufficient relevant information to be able to analyse what could be done to prevent or reduce such incidents.

Many different types of incident and accident report are being used almost every day to report incidents or accidents which have occurred, or for near misses in Australian aged care organisations. Incident investigations are commonly conducted, but there seems to be no clear consensus on what specific information should be sought. Lack of common understanding and inconsistencies in data collection stem largely from four basic factors:

1. inadequate and inappropriate data collection tool (Incident reports)
2. absence of details of the actual incident – staff not completing the incident reports
3. lack of common understanding about risk management
4. lack of understanding of investigation process when the incident happens

The National Falls Prevention for Older People Initiative (2004) was established by the Australian Government to reduce the incidence, morbidity and mortality associated with falls in people aged 65 yrs and over living in community and aged care homes, as well as those being treated in hospitals (Institute 2004).

This research clearly showed that many aged care facilities have employed various approaches to reduce falls but further research is needed to determine the effectiveness of these approaches. The national initiative did investigate the clinical assessment method, which is very important in a pro-active approach to preventing falls. However, it is equally important to find out what happened immediately after a fall in order to develop strategies to prevent further falls. Moreover, the research did not investigate the type of data collection tools used to prevent falls. The report stated that "authors noted that strategies being employed for falls prevention were not consistent with the evidence about effectiveness."

Secondly, residents with challenging behaviour issues are a risk to other residents and staff if they are not managed appropriately. Undesirable or inappropriate behaviours such as wandering and / or pacing, repetitive behaviour (words and actions), physical and verbal aggression, hoarding, intruding and absconding are just a few of them.

The management of such challenging behaviour is a complex problem, and appropriate and adequate data must be collected to develop appropriate care delivery. Such behaviours are often a reflection of the person's emotions, intentions or expressive desires.

It is also a continuous challenge to maintain the skin integrity of the elderly, who have greater susceptibility to shearing- type injuries such as bruises, skin tears, rashes, excoriations and pressure areas. Frequent washes cause dry skin, which leads to skin irritation and break down. Skin tears are painful and could cause major damage if not looked after appropriately.

In general, fragile skin, advanced age, use of assistive devices, cognitive/sensory impairment, and history of previous skin tears can put a resident at risk of a skin tear. Research has shown that dependent residents who require total care for all activities of daily living are at greatest risk. Their injuries tend to result from such routine activities as dressing, bathing, positioning, and transferring.

Even independent, ambulatory residents aren't without risk; they sustain the second-highest number of skin tears, primarily on the lower extremities. Many of these residents also have edema, purpura, or ecchymosis. Sight-impaired residents are in the third-highest risk category of skin impairment.

Nearly half of all skin tears have no apparent cause. The other half can be caused by wheelchair injuries, accidentally bumping into objects, transfers, falls, and tape injuries.

Although nearly 80% of skin tears occur on the arms and hands, other areas of the body are also at risk. Be careful about skin tears on the back and buttocks, which could be mistaken for Stage II pressure ulcers. The etiology of a pressure ulcer is different from the etiology of a skin tear. A pressure ulcer is any lesion caused by unrelieved pressure resulting in damage to underlying tissue.

Managing risk becomes complex when two or more risk factors are involved with one resident.

Following case study is a prime example for complex risk issues.

> Mary White, 78, a resident at your aged-care facility, has early stage of dementia (Alzheimer's disease), but had been doing well until about a week ago. Now her confusion has worsened and she's started wandering at day and night. One morning, the nursing assistant informs that Ms. White has a skin tear on her right leg that she didn't have the day before. You assess the leg and discover that Ms. White has a skin tear and bruise on her buttocks, probably from bumping into a piece of furniture or had a fall the night before. Ms. White represents a significant nursing challenge in caring for elderly patients.
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> Source: (Baranoski 2003)

Description of the Project:

This project comprises six stages:

Stage 1: Development of a 'Client Related Incident/Accident Report' to collect data, while integrating both the risk control and management concepts.
Stage 2: Refinement of the 'Client Related Incident/Accident Report', using an action learning method.
Stage 3: Development of a risk assessment tool for Australian Health and Personal Care outcomes.
Stage 4: Refinement of the 'Health and Personal Care Risk Assessment Tool' by using an action learning method.
Stage 5: Conduct of a pilot study, using the 'Health and Personal Care Risk Assessment Tool'.
Stage 6: Evaluation of the results and confirmation of the validity of the 'Health and Personal Care Risk Assessment Tool'.

Stage 1: Development of a 'Client Related Incident/Accident Report' to collect data, while integrating both the risk control and management concepts.

Stage 1 is commenced in July 2004 to develop an appropriate 'incident reporting system' to collect data. Base on their industry knowledge, the team developed a 'Client Related Incident Report' to collect data on residents' falls, challenging behaviours, and skin impairment and medication management discrepancies. Data collection was aimed to collect what actually happened at the time of the incident, including the resident's mobility levels and mental condition. The report also noted details of the investigation process. Preliminary investigation revealed that data collected after the incident was not adequate to reach a conclusion on why and how resident had a fall, why such behaviour was displayed or how skin tear or bruises occurred. Considering some of the intrinsic and extrinsic factors of incidents, investigation of an incident is extremely important in all situations to identify what happened and why it happened and to prevent similar incidents.

Stage 2: Refinement of the 'Client Related Incident/Accident Report', using an action learning method.

The action learning method was used to refine the "Client Related Incident/ Accident Report'. The newly developed incident report form was given to three organisations to use. Education and training was given to all staff on how to complete the form. Written instructions and flow charts were provided and the staff were invited to give feed back on the new report form. Their feedback was that the new forms were easy to complete and did not take excessive time to complete but staff did not like the size of the report (A3). Staff responsible for collating, analysing and monitoring incidents believed that there was adequate data to identify the specific issues related to incidents. Most importantly, investigations were mostly conducted at the time of the incident by the nurse in-charge, where as previously, it had been carried out a few days later, by some-one else.
With staff input the incident report was modified. There were no significant changes to the format of the form but a few more questions were added to clarify some of the areas and the word 'client' was deleted so the report could be used in a variety of places.

Stage 3: Development of the risk assessment tool for Australian Health and Personal Care outcomes.

The third stage of the project was to develop a risk assessment tool for Australian Health and Personal Care outcomes. There are 17 outcomes in Health and Personal Care Standard including residents' mobility, dexterity, medication management, behaviour management and skin integrity.. Our next step is now to look at the process of the care delivery of these outcomes in order to manage risk. For this project, we are considering the process that the Australian Aged Care Standards and Accreditation Agency (2003) is using to assess aged care facilities. The process has been divided into steps, each being allocated a numerical value by taking into account of six sigma principle.
We have developed the Microsoft spread sheet to enter data in order to to see the overall level of risk in each outcome.

Stage 4: Refinement of the 'Health and Personal Care Risk Assessment Tool' by using an action learning method.

Currently, we are in stage 4. The tool has been used in two aged care facilities to identify the level of risks in health and personal care outcomes. So far, the project team has found that some of the process steps are repetitive and also a little ambiguous. Our next step is to go through the process steps and simplify the tool.

Current data entry can provide bar graphs, but the team is also investigating to develop process control charts.

Conclusion

The newly developed 'Incident reports' are providing adequate data to identify what actually happened, and strategies and interventions are in place to avoid such incidents and degree of their effectiveness better than any other form. 80% of the incidents have been investigated at the time of the incident rather than a few days later by some one else. Staff education and training are also needed in the strategy development section, as most of the staff do not understand the strategies and interventions required to prevent such incidents.

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