Citizen Watch Continuing Care in Alberta and the Seniors' Action and Liaison Team
www.continuingcarewatch.com

November 30, 2008
From: Citizen Watch on Continuing Care in Alberta and SALT
Subject: MLA Bulletin 6: Keeping Seniors Safe in Long Term Care

According to the Research and Prevention Unit at UBC, unintentional injuries reported by acute care hospitals are a major cause of death and ill health among seniors, and nearly 40% of seniors' deaths. In Alberta, there has been a 44% increase in the number of seniors seen in an emergency department due to a fall from 1998 to 2006, while the number of Alberta seniors has increased 32% since 1996.

The 12,500 Alberta seniors in continuing care centres, 3,000 in Designated Assisted Living facilities and another 20,000 in assisted living facilities are those most at risk for unintentional harm. These Albertans (and their families, friends and communities) rely on facility operators to provide safe and appropriate quality care. How safe are these very vulnerable seniors?

Every now and then, a story about an accidental injury or death in a long term care facility is reported by the media. Disturbing headlines tell us a woman died after being scalded in a bath; an Alzheimer's patient killed another resident; a man's leg was amputated because of an uncontrolled pressure sore; a woman was raped; a man died after drinking a toxic cleaning product.

Are these just isolated accidents or an indication of preventable systemic problems in care facilities that make accidents possible?

The Task Force appointed after the Auditor General's 2005 report heard concerns about the health and safety of these patients (renamed "residents" in the early 1990s), their social and mental well-being, and the safety of the staff who care for them.

In 2005, the Health Quality Council of Alberta (HQCA) initiated a *Long Term Care Resident and Family Experience Survey* as a priority issue, and we expect to see that report this year. Although the survey doesn't address the specific issues of safety and quality of care, it may reveal cause for concerns.

In 2007, the Canadian Patient Safety Institute expanded their agenda to include long term care, identifying falls, medication issues, infections, pressure ulcers and resident aggression as common concerns in care facility environments.

This Bulletin is about those major safety risks in long term care, most of which are preventable. Patient safety in long term care is a complex issue urgently needing leadership and action.

Failure to provide timely and quality care, and the care we do provide, should not harm seniors.

Sincerely,

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MLA Bulletin 6, November / December 2008

from Citizen Watch on Continuing Care and SALT

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Keeping Seniors Safe in Long Term Care

The shift from traditional models of long term care to assisted/supportive living and Designated Assisted Living appears to be a positive response for less de-personalizing and controlling "institutional" care and more opportunities for privacy. In the absence of resources and appropriate care practices, a "home" or "community" setting can be as problematic as any traditional institution. Finding the right balance between independence and safety for those who are reliant on others to meet their needs is a challenge, but failing to recognize the potential for harm in any setting will not make these problems go away. [1]

Seniors in residential care facilities (continuing care centres, assisted living facilities, and lodges) tend to be older, with a high level of frailty, multiple illnesses and multiple medications, a high rate of dementia impairments, and reduced ability to care for themselves or to communicate care needs.[2]

As seniors with more complex care needs are placed in these "alternative" care facilities and as they age, the "risk exposures" (including falls, medication errors, and decubitus ulcers) are increasing to the same level as more traditional care facilities.[3]

What do we know about safety risks in long term care?

The risk of falling for patients in all long term care settings is more than double the risk for seniors living in the community.[4] 10% of falls result in serious injury[5]; injuries sustained in a fall can undermine the individual's health so that other diseases and illnesses (such as pneumonia and infections) prove fatal.[6] Falls can be a consequence of medications.[7]

Injuries from adverse drug events, including prescribing and monitoring errors, drug interactions, and failing to identify side effects, are more common in long term care than previously documented, and are largely preventable. The data indicate a rate of nearly 10 adverse drug events per month for every 100 residents.[8]

> Antidepressants, antipsychotics and benzodiazepines are the most common medication cause of increased falls.[9] These drugs have been marketed as "reducing the nursing burden"[10] of caring for patients with dementia, despite earlier and well-documented warnings about their safety, including the risk of increased falls. One-third of nursing home residents are given an antipsychotic drug.[11]

The most frequent endemic infections in long term care facilities are respiratory tract, urinary tract, skin and soft tissue, and gastrointestinal.[12]

> The rate of infections in long term care facilities is 4 times the rate in the general population. 3 to 15% of long term care facility patients will acquire an MRSA infection each year, and these patients are more likely to die than younger persons.[13]

Pressure ulcers are common among people with impaired mobility. In long term care, the prevalence is 30% - higher than in any other setting – and increasing. Pressure ulcers are caused by pressure due to lack of mobility (in bed or a chair) and poor blood circulation, and can develop in a few hours. If left untreated, a pressure sore may lead to chronic infection, and can cause or contribute to death.[14]

Resident aggression can be the result of many factors, including loss of control, physical and emotional discomfort arising from lack of toileting/basic hygiene, thirst, hunger and an inability to communicate (poor hearing, unable to speak, etc.). Fear, unmanaged pain, medication–induced confusion or side-effects or drug interactions, unrecognized injury or illness, changing health status,

loneliness and boredom, inactivity, perceived lack of respect from caregivers and constantly changing caregivers are other underlying causes of aggression.[15]

> ***"Too often, illness in older people is misdiagnosed, overlooked, or dismissed as the normal process of aging, simply because health professionals are not trained to recognize how diseases and drugs affect older people."***[16]

Injuries are predictable and preventable, and not the result of chance occurrence.[17]

> ***"The majority of medical errors do not result from individual recklessness or the actions of a particular group–this is not a "bad apple" problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them."***[18]

According to the Canadian Patient Safety Institute, staff skills to meet the increasing clinical complexity of care needs and the recruitment and retention of staff are priorities for safety in long term care.[19]

> ***"All provinces report that since 2000 they have experienced an increased prevalence of the following factors that contribute to increased risk of injury: complexity of care, major healthcare restructuring and amalgamations, reduction in the number of patients/resident care beds, and increased workload in an aging workforce . . . while there has been an increased focus on prevention and safety programs, their impact has been undermined by general changes within the healthcare sector."***[20]

Limited funding has resulted in fewer professional care staff, impacting the clinical care of patients, supervision of the personal care aide staff, monitoring of services, and updating and implementing care plans.[21]

Is funding for seniors' care being rationed, to accommodate other priorities?[22]

A culture of patient safety is lacking – and victims are nameless and faceless. Other barriers to safety include difficulty recognizing errors; lack of information systems to identify errors; and fragmentation of care delivery.[23]

The current CPSI long term care safety initiatives are the Medication Reconciliation and Falls Prevention programs. Neither addresses the basic safety issues which would be resolved by attention to individual toileting needs and hygiene, regular oral care and foot care, supervised daily physical activity and exercise[24], attention to pain management, careful investigation of changes of behaviour, response to symptoms of illness and possible adverse drug reactions, or prompt response to need for assistance, however communicated.

> **The InterRAI MDS system** itself (on which $36.4 million has been spent to date) does nothing to measure care actually provided, assess the reasons for an adverse incident, or improve the adverse incident rates.[25] To some extent, the system has added to the problems by diverting nursing staff from patient care to administrative duties.[26]

> **In short, we already know many of the factors resulting in compromised patient safety and quality of life in long term care settings. Isn't it time we collectively rolled up our sleeves and got to work?**

Prepared by Carol Wodak for Citizen Watch and SALT, November 2008

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Drugs seniors should avoid: The Beers criteria from http://www.cbc.ca/news/background/seniorsdrugs/beers_table_more.html

Ethical choices in long-term care : what does justice require? World Health Organization 2002 http://www.who.int/mediacentre/news/notes/ethical_choices.pdf

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Patient safety law: from silos to systems (website and PDF) http://www.energyk.com/healthlaw/

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