ARNA National Committee
Email: C/- arna@arna.com.au
30/10/2015

The Australasian Rehabilitation Nurses' Association (ARNA) submission to the National Safety & Quality Health Service (NSQHS) Standards : Version 2 Counsultation Process.

ARNA appreciates the opportunity to provide feedback to the Commission on the proposed changes to the NSQHS Standards. As an organisation representing rehabilitation-focused nurses we are particularly interested in standards of care that improve the safety, quality and experiences of patients following life changing health events, and in particular oppportunities to advance valued principles of rehabilitation in nursing. The proposed new standards of Comprehensive Care and Reducing Harm, and the revised standard Partnering with Consumers incorporate principles and actions that have been core to rehabilitative practice for many years. There are some specific comments and recommendations we wish to make and where applicable are grouped under the relevant standard. We believe that the inclusion of these changes would help address the need for greater attention on the longer term person-level function beyond the inpatient period.

- We recognise and support the inclusion of vulnerable groups within the standards to provide added protection and guidance with the addition of cognitive impairment, mental health, Indigenous and for end of life care.
  In addition, it is recommended that other 'at risk' groups who are also particularly vulnerable within the mainstream health system be also specified and recognised such as:
  - ***non-English speaking background – culturally and linguistically diverse communities (CALD).***
  - ***people with disabilities and considering impact of contextual elements of environmental and personal factors, as per the ICF (*International Classification of Functioning*, Disability and Health)***

- **Governance for Safety and Quality (GS)**
  GS 17 (p17) Safe environment for the delivery of care – we fully support these new actions. Appropriate environmental design is essential for delivery of rehabilitative care, and elements can support or hinder therapeutic efficacy. Environmental design enabling functional performance assists in prevention of functional decline and other adverse events.
  It is recommended that the action statements be strengthened to include:-
  - ***enabling activity and maintenance of function and maximising therapeutic potential – need to be fit for purpose.***
  - ***be a requirement for new service design, not just "within the constraints of the existing facilities".***

- **Partnering with Consumers (PC)**
  Partnering with consumers is an established and important principle underpinning rehabilitative nursing and a core aspect of healthcare that focuses on life after hospitalisation.
  PC 6 (p21-22) - Working together to share decisions and plan care – through communication, planning, setting of goals that include preferences of the individual and their carers/family is supported. However, from experience in the rehabilitation setting we know time is required to

truly engage consumers in these activities and to do this effectively. Otherwise goals are set that are not relevant to the consumer; instead they are clinician goals or are a token to the requirement to have "a goal specified" with little real connection to the individual.

It is recommended that

- ***systems support and enable the actions and time required to engage consumers and their nominated support in activities of communicating, planning, and for meaningful person focussed goal setting.***

- **Comprehensive Care (CC)**

  In the preamble to this section 'Essentials of Care' and 'TeamSTEPPS' are mentioned as examples of the delivery of comprehensive care. In addition, we would suggest that the experiences of rehabilitation services in working to this model and implementing practices for goal setting, determining care plans and working collaboratively could be seen as a service type to learn from. These rehabilitation practices have been implemented, documented and researched both internationally and within Australia.

  We agree with and support the new standard Comprehensive Care, but wish to advise that for team collaboration, comprehensive care planning, and for implementation and review in partnership as described there needs to be recognition of the demands for enabling these actions to be achieved. Systems, management and resources are required.

  CC 4 (p26) "Support to clinicians to work and communicate in a coordinated, accountable and multidisciplinary way ", needs additional specific actions.

  As in PC (above) it is recommended that

  - ***systems support and enable the actions and time required for team operations, collaborative team and consumer communication***
  - ***provision of space for privacy for meetings and discussion with consumers and for multidisciplinary interactions***

- **Reducing Harm (RH)**

  Although issues of "maintenance of personal hygiene, continence, skin integrity, mobility and ambulation and nutritional status" were identified in Comprehensive Care (p22) as risks, these have not been specifically addressed (except for skin integrity and nutrition). The remaining issues are also of significant concern and should be specified for assessment and for preventative care strategies. Maintenance of personal hygiene, mobility and ambulation could come under a heading of prevention of functional decline. While falls prevention is important there also needs to be the positive perspective of promotion of safe mobility and ambulation. Continence needs to address both bladder and bowel functioning.

  Functional decline as a result of hospitalisation is common, studies report 30-50% of older adults lose ability to perform activities of daily living in hospital (Boltz et al.,2012; Graf, 2006). Immobility associated with functional decline can result in falls, iatrogenic infections, pressure ulcers, non elective rehospitalisation's (SA Health, 2014), dehydration, malnutrition, depression and delirium (de Vos, 2012). A 'cascade of dependency' leads to loss of function and new activity limitations or death, in one study 16% of those experiencing functional decline in hospital died within 3 months of discharge (Graf, 2006). 30% of functional decline was not due to primary diagnoses (SA Health, 2012), which leads to the supposition that something present or not present in the hospital experience is involved. Some have described this as the "hazards of immobility" (Graf, 2006). In the rehabilitation sphere there has been a

doubling of episodes of care under the category of 'reconditioning' over the last four years (AROC, 2014). Prevention of functional decline in the acute hospital setting would improve outcomes, reduce adverse events and reduce the need for further care – in rehabilitation and/or in residential care.

Bladder and bowel function

Prevalence of incontinence in hospital is difficult to quantify, however the Continence Foundation of Australia (CFA) reports that 30% of women and 20% of men aged 60 years or more suffer urinary incontinence. 42% of women and 44 % of men aged 75 years or more experience urinary incontinence (2012). Risk in hospital would be increased with the combined effect of the illness event, immobility, treatments, medication and use of catheterisation. Constipation in hospital which can lead to significant complications has been estimated as up to 80% in the older population (IMPACT, 2010). Poor bladder and bowel management leads to longer term dysfunction and increased need for residential care (in the older population).

It is recommended that

- ***prevention of functional decline and bladder and bowel functioning be specified and included within the standard Reducing Harm***
- ***consideration be given to including maintenance of personal hygiene, mobility, and bladder and bowel function in the standard Comprehensive Care for assessment and care planning***

We believe that maintaining physical and cognitive functioning and providing safe and quality care requires considering the risks associated with mobility, nutrition, hydration, skin integrity, bladder, bowel and cognitive functioning, as being interrelated. ALL need specification.

Approved Submission of the
National Committee of Australasian Rehabilitation Nurses' Association (ARNA)

References

Australian Rehabilitation Outcomes Centre AROC, (2014). The AROC Annual Report State of Rehabilitation in Australia

Boltz, M., Resnick, B. Capezuti, E. Shuluk, J. Secic, M. (2012). Functional Decline in Hospitalized Older Adults: Can Nursing Make a Difference? *Geriatric Nursing*, 33 (4), 272-279

Continence Foundation of Australia CFA, (2012). www.continence.org.au

de Vos, A. et al. (2012) Integrated approach to prevent functional decline in hospitalized elderly: the Prevention and Reactivation Care Program (PReCaP). BMC Geriatrics, 12, (7).

Graf, C. (2006). Functional Decline in Older Hospitalized Adults. *AJN* 106, (1). 58-67

IMPACT, (2010). A Guide to the Management of Constipation and Faecal Impaction in the Older Person. IMPACT Scientific Faculty

SA Health, (2014). What is functional decline? http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/older+people/care+of+older+people+toolkit/what+is+functional+decline++the+toolkit accessed 20/5/15