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mosAIC's Regular Reads aims to give relevant, useful information to Community Care partners for the improvement of their operations. This section features journal articles that highlight latest research findings as well as good, evidence-based and innovative practices. While the articles aim to keep Community Care partners informed of current developments in the sector, the views and opinions expressed or implied do not necessarily reflect those of AIC, its directors or editorial staff.

» Healing practices for nurses in LTC

Nurses need to attend to their own self-care and healing if they need to effectively care for others. The Watson's Caring Science and 10 Caritas Processes (2005, 2008) model supports nurses through self-grief healing in meaningful ways. Five of Watson's key processes include: practice loving-kindness, compassion and equanimity with yourself and others; be authentically present; enabling a faith/hope/belief system; cultivate and sustain spiritual practices; create safe healing environments on all levels; and be open to mystery and unknowns of life and death by allowing for miracles. Grief-healing is a personal journey with no prescribed timeline or process of grieving but it is important to acknowledge the grief and develop intentional healing practices to cope with it.

Wagner, L. (2015, July 29). Healing practices for nurses in LTC. McKnight's.

Search for the full-text article at www.mcknights.com

» Risk assessment and prevention of pressure ulcers: A clinical practice guideline from the American College of Physicians

This report presents guidelines developed by the American College of Physicians on preventive interventions for pressure ulcers. It recommends that: clinicians should perform a risk assessment to identify patients who are at risk of developing pressure ulcers; clinicians should choose advanced static mattresses or advanced static overlays in patients who are at an increased risk of developing pressure ulcers; and it recommends against using alternating-air mattresses or alternating-air overlays in patients who are at an increased risk of developing pressure ulcers.

Qaseem, A., Mir, T., Starkey, M. & Denberg, T. (2015, March 3). Risk assessment and prevention of pressure ulcers: A clinical practice guideline from the American College of Physicians. *Annals of Internal Medicine*. 162(5): 359-369.

Search for the full-text article at <http://annals.org>

» Malnutrition vigilance during care transitions

While nutrition screening is often carried out during admission to acute care hospitals or long-term care facilities, older adults' nutritional status may worsen during an inpatient acute care or rehabilitation stay. This article highlights that physicians should recognise malnutrition diagnostic criteria for patients and make appropriate recommendations to ensure proper nutrition following their discharge. Chronic disease such as cardiac disease, renal impairment, and malignancy can lead to significant loss of muscle mass. Furthermore, overly restrictive diets may be unpalatable or difficult to follow, leading to a decline in oral intake and eventually malnutrition. The Mini Nutritional Assessment Tool is the best age-appropriate tool for nutritional screening in older adults.

Mogensen, K. & DiMaria-Ghalili, R. (2015, July/August). Malnutrition vigilance during care transitions. *Today's Geriatric Medicine*.

Search for the full-text article at www.todaysgeriatricmedicine.com

» Wide beds: Added inches, added safety

Staff at Baptist Home Society's Mt. Lebanon Campus in Pittsburgh decided that they needed to lower the fall rates among residents. They researched and invested in new beds with risk-reduction features. The new beds were wider and more comfortable than the previous ones. They had upgraded mattress surfaces including firm mattress perimeters that provided stability for residents when standing from a sitting position and a viscoelastic foam top that envelops the body and redistributes pressure, thus preventing wounds. They also had side grip enablers to assist in resident transfers and in bed mobility. The home found a significant reduction in fall rates as well as severe injuries as a result of bed falls after using the new beds.

Fragala, G. (2015, August 4). Wide beds: Added inches, added safety. Long-Term Living Magazine.

Search for the full-text article at www.ltlmagazine.com

» Use of aged care services before death

This report uses data from the Australian Institute of Health and Welfare's Pathways in Aged Care to examine the use of aged care services in the eight years before people died. It found that on average, almost half began using aged care more than four years before death; in the last six months of life there was an increased take-up of care; around ten per cent stopped using aged care in the last quarter before death; and people used diverse care pathways to access aged care programmes, varying considerably both in terms of when care was accessed and the care programmes used.

Use of aged care services before death. (2015, March 18). Australian Institute of Health and Welfare.

Search for the full-text article at www.aihw.gov.au

» Efficacy of daily 800 IU vitamin D supplementation in reaching vitamin D sufficiency in nursing home residents: Cross-sectional patient file study

The Dutch Health Council, the Institute of Medicine and the Expert Working Group on Vitamin D recommend a standard daily vitamin D supplementation of 800 IU (20 mcg) for persons aged ≥ 70 years, with a target 25(OH)D serum concentration of ≥ 50 nmol/l. This study investigates whether this dosage that was designed for healthy adults/elderly is sufficient for frail nursing home residents. It found that for most residents, vitamin D supplementation once a week with cholecalciferol capsules containing 5600 IU (equivalent to 800 IU daily) resulted in vitamin D sufficiency (serum 25(OH)D ≥ 50 nmol/L). It highlights that when choosing a vitamin D preparation for routine supplementation for nursing home residents it should be noted that major differences may exist in efficacy, even when the various preparations contain the same amount of vitamin D.

Velva, B., Chel, V., & Achterberg, W. (2014, September 19). Efficacy of daily 800 IU vitamin D supplementation in reaching vitamin D sufficiency in nursing home residents: Cross-sectional patient file study. *Geriatrics*. 14(103). Retrieved October 3, 2014.

Search for the full-text article at www.biomedcentral.com



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» TB infection control in hospices

This South African study highlights measures that should be applied in all health facilities to control the spread of Tuberculosis (TB). There are three main methods of reducing transmission of TB in hospices: administrative, environmental, and personal. Hospices are required to draw up and implement policies and procedures to deal with screening of all hospice patients and staff; establish procedures for safe collection of sputum samples and referrals for treatment; as well as educate patients and staff on cough etiquette. Environmental factors like good natural ventilation is important and doors and windows should be left open as much as possible. Measures to protect personnel include: 1) educating staff and volunteers on TB, 2) conducting regular screening, 3) encouraging recognition of symptoms, 4) having a referral system, and 5) creating a follow-up and support system in line with workplace policy.

Mgudlwa, N. (2015, March 24). TB infection control in hospices. Ehospice.

» Hand hygiene and Clostridium Difficile infections

Patients discharged from hospitals or nursing homes with Clostridium Difficile may not get sick until after they are home. This has important implications for home care as the patient may become symptomatic and shed the spores. The strategies to prevent the transmission of Clostridium Difficile Infections include: 1) performing hand hygiene throughout the course of care, wearing gloves, 2) implementing contact precautions, 3) cleaning and disinfecting equipment after use, 4) using a surface barrier under a nursing bag (if it is brought to the home), 5) alerting others involved in patient's care, and 6) educating the patient and caregiver on prevention of spores spread at home.

McGoldrick, M. (2015). Hand hygiene and Clostridium Difficile infections. Home Healthcare Now.

Search for the full-text article at www.homecareandhospice.com

» Making health care safer: Stop spread of antibiotic resistance – Vital signs

Vital signs uses a mathematical model to project that a coordinated approach among healthcare facilities and health departments could prevent up to 70 per cent of life-threatening carbapenem-resistant Enterobacteriaceae (CRE) infections over five years as well as prevent 619,000 antibiotic-resistant and Clostridium Difficile infections. The infographic shows how facilities could work together to protect patients by sharing information and implementing shared infection control actions to stop the spread of germs from one facility to another facility. It highlights the actions that can be taken by the federal government; state and local health departments; healthcare facility CEOs/administrators; healthcare staff; and patients and their families to prevent the spread of infection.

Making health care safer: Stop spread of antibiotic resistance – Vital signs. (2015). Centers for Disease Control and Prevention.

Search for the full-text article at www.cdc.gov

» Nursing home infection rates on the rise, study finds: Columbia Nursing researcher offers tips for infection prevention

A study from Columbia University School of Nursing found that nursing home infection rates for pneumonia, urinary tract infections (UTIs), viral hepatitis, septicemia, wound infections, and multiple drug-resistant organisms (MDROs) are on the rise. It suggests relatively simple interventions to help reduce the risk of infection. UTIs can be prevented by reducing the use of



urinary catheters and increasing the frequency of assisted trips to the toilet or diaper changes for residents who are unable to use the bathroom. For reducing pneumonia and other infections that spread through air or contact with contaminated surfaces, proper hand hygiene should be maintained. Families should ask whether residents are routinely screened for bacteria like *C. difficile* and MRSA.

Nursing home infection rates on the rise, study finds: Columbia Nursing researcher offers tips for infection prevention. (2014, October 8). Columbia University School of Nursing.

Search for the full-text article at www.nursing.columbia.edu

» Could simple measures tip the balance against antimicrobial resistance in nursing homes?

A study conducted by researchers at the University of Michigan and VA Ann Arbor Healthcare System found that the level of illness among 1.5 million nursing home residents in the United States has increased substantially in the last decade and so has the risk of acquiring new infections. "Patients with devices that stay in their bodies, such as urinary catheters and feeding tubes, present an attractive habitat for 'superbugs', setting the stage for device-related infections." The study found that the number of catheter-associated urinary tract infections and methicillin-resistant *Staphylococcus aureus* (MRSA) acquisitions decreased among residents who participated in a three-year study. The targeted infection programme included: surveillance for infections and multiple drug-resistant organism (MDRO) colonisation with regular feedback to the nursing home; extensive and interactive staff education using adult learning theory about key infection prevention practices and hand hygiene; and use of gloves and gowns when providing assistance to patients for high-risk activities such as bathing and grooming.

Could simple measures tip the balance against antimicrobial resistance in nursing homes? (2015, March 19). University of Michigan Health System.

Search for the full-text article at www.technology.org

» Applying high reliability principles to infection prevention and control in long term care

This two-part 50-minute e-learning tool offered by the Joint Commission in the United States teaches staff in nursing homes, assisted living facilities or related healthcare settings how to apply high reliability principles to prevent and control infections in long-term care. It also highlights how each person's role contributes to high reliability through illustration of various scenarios. The first part talks about the importance of infection prevention and control and characteristics of a high reliability organisation. The second part talks about the James Reason Swiss cheese model and application of high reliability principles in a long-term care scenario.

Applying high reliability principles to infection prevention and control in long term care. (2014, September 5). The Joint Commission.

» Infection prevention and control commissioning toolkit: Guidance and information for nursing and commissioning staff in England

This toolkit provides information for healthcare professionals in the United Kingdom on infection prevention and control. It suggests a series of indicators to support performance management and assurance against provider contracts. These indicators ensure that the delivery of standards always reflects what is needed, what should be reported and how it will be



measured to fulfil the contract requirements. It also provides a healthcare associated infections (HCAI) reduction plan for commissioners to adapt for local use which includes four main requirements: development and leadership of the health and social care economy; contracting (including setting clear expectations of achievement e.g. compliance with the code of practice for infection prevention and control); performance monitoring against the contract (gaining assurance); and organisational accountability.

Infection prevention and control commissioning toolkit: Guidance and information for nursing and commissioning staff in England. (2014, July). Infection Prevention Society & Royal College of Nursing.

Search for the full-text article at www.rcn.org.uk

» Report to the President on combating antibiotic resistance

This White House report offers practical recommendations to the Federal government to combat the rise in antibiotic-resistant bacteria in the United States. It suggests focused efforts in three areas: improving surveillance of the rise of antibiotic-resistant bacteria; increasing the longevity of current antibiotics; and increasing the rate at which new antibiotics and other interventions are discovered and developed. The report recommends that to achieve better surveillance of antibiotics, it is essential to: ensure strong federal leadership; effective surveillance and response for antibiotic resistance; fundamental research; clinical trials with new antibiotics; significantly increase the economic incentives for developing urgently needed antibiotics by the federal government; improving stewardship of existing antibiotics in healthcare; limit the use of antibiotics in animal agriculture; and ensure effective international coordination.

Report to the President on combating antibiotic resistance. (2014, September). Executive Office of the President. Retrieved October 3, 2014.

Search for the full-text article at www.whitehouse.gov



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» National consensus statement: Essential elements of safe and high-quality end-of-life care

This report describes the 10 elements that are essential for delivering safe and high-quality end-of-life care in Australia. The first five elements relate to the way in which end-of-life care should be approached and delivered: patient-centred communication and shared decision-making; teamwork and coordination of care; components of care; use of triggers to recognise patients approaching the end of life; and response to concerns. The next five elements relate to structural and organisational prerequisites for the effective delivery of safe and high-quality end-of-life care: leadership and governance; education and training; supervision and support for interdisciplinary team members; evaluation, audit and feedback; and systems to support high-quality care.

National consensus statement: Essential elements of safe and high-quality end-of-life care. (2015, May). Australian Commission on Safety and Quality in Health Care.

Search for the full-text article at www.safetyandquality.gov.au

» Dying without dignity: Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care

Organisations in England continuously strive towards improving the experience of end-of-life care or palliative care. This report features 12 cases that illustrate the issues regularly seen by healthcare workers while providing end-of-life care in a range of healthcare settings. The key themes include: not recognising that people are dying, and not responding to their needs; poor symptom control; poor communication; inadequate out-of-hours services; poor care planning; and delays in diagnosis and referrals for treatment.

Dying without dignity: Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care. (2015, May). Parliamentary and Health Service Ombudsman.

» Insight and information are key to implementing palliative care

While palliative care is one of the fastest growing fields in medicine, it remains widely misunderstood and stigmatised. This article looks at what palliative care is really about and how healthcare professionals can engage with their patients on a sensitive issue like end-of-life care. Palliative care focuses on a person's quality of life, including his or her individual goals and values and what it means to live with a terminal illness. It is important to engage the patient and learn something new about them as a person by asking simple open-ended questions. It is important to get insights on individual goals and values to create a plan of care that reflects the patient's values in real time.

Thurston, A. & Arnold, R. (2015, July/August). Insight and information are key to implementing palliative care. *Today's Geriatric Medicine*.

Search for the full-text article at www.todaysgeriatricmedicine.com

» Case management in primary palliative care is associated more strongly with organisational than with patient characteristics: Results from a cross-sectional prospective study

The Dutch primary palliative care sector has introduced case managers who are nurses with expertise in palliative care to offer



support to patients and informal carers. This study finds that case managers provide flexible support with regard to the number, mode, persons present, and duration of contacts. Support covered all domains of palliative care, with most attention given to physical complaints, life expectancy and psychological aspects. The support offered by the case managers was prompted by characteristics of the organisation for which they work.

Plas, A., Francke, A., Vissers, K., Jansen, W., Deliens, L. & Onwuteaka-Philipsen, B. (2015, July 2). Case management in primary palliative care is associated more strongly with organisational than with patient characteristics: Results from a cross-sectional prospective study. *BMC Palliative Care*.

Search for the full-text article at www.biomedcentral.com

» **‘From activating towards caring’: Shifts in care approaches at the end of life of people with intellectual disabilities; a qualitative study of the perspectives of relatives, care-staff and physicians**

People with intellectual disabilities (ID) who are in need of end-of-life-care may require a different approach in participation compared to the ones that currently characterises the care of people with ID. This paper explores the shift in care approaches and attitudes that relatives and professionals perceive as the death of a person with ID approaches, as well as the values underlying these shifts. It found five shifts: adapting to a new strategy of comforting care, taking over tasks and symptom relief; interweaving of emotional and professional involvement; stronger reliance on the joint interpretation of signals expressing distress and pain; magnified feeling of responsibility in medical decisions; and intensified caring relationship between relatives and care staff. End-of-life care for people with ID saw an increase in teamwork featuring intensified comforting care, symptom management and medical decision making.

Bekkama, N., Veer, A., Hertogh, C. & Francke, A. (2015, July 25). ‘From activating towards caring’: Shifts in care approaches at the end of life of people with intellectual disabilities; a qualitative study of the perspectives of relatives, care-staff and physicians. *BMC Palliative Care*.

Search for the full-text article at www.biomedcentral.com

» **Advance care directives in residential aged care**

Advance Care Directives (ACD) allow people to plan ahead for their future health and personal care needs in the event of any future loss of decision-making capacity. An ACD may record: a person’s values, life goals and preferred outcomes; directions about care and treatment refusals; and appointment of a substitute decision maker. Some of the best practices in advance care planning in residential care facilities include: facilities having readily accessible written policies and procedures about advance care planning; the provision of regular education on advance care planning to aged care staff, residents, relatives and general practitioners; information on advanced care planning being provided to residents and families before admission; residents being offered advance care planning within 28 days of admission; and a skilled healthcare professional drawing up the advance care planning during an in-depth discussion with the resident or their family.

Leditshke, I., Crispin, T. & Bestic, J. (2015, April). Advance care directives in residential aged care. *The Royal Australian College of General Practitioners*.

Search for the full-text article at www.racgp.org.au



» What can we do to help Australians die the way they want to?

Between 60 to 70 per cent of Australians prefer to die at home and dying in residential care facilities is the least preferred option. Dignity, control, and privacy are important for a good death. People want personal, social, and psychological support with the ability to decide who will be present, where they will die and what services will they get. To achieve this, it is important to have a conversation about death; encourage people to plan for death; improve coordination of end-of-life care; and take into account the estimated cost of community-based palliative care packages.

Swerissen, H., & Duckett, S. (2015, January 19). What can we do to help Australians die the way they want to? *The Medical Journal of Australia*.

Search for the full-text article at www.mja.com.au

» Choice in end of life care

This report identifies the issues people approaching the end of life are currently facing and offers a blueprint as to how greater choice in end-of-life care can be achieved. The choices that are important to an individual at the end of life and after their death are: involvement in and control over decisions about their care; access to high quality care given by well-trained staff; access to the right services when needed; support for their physical, emotional, social and spiritual needs; wanting the right people to know their wishes at the right time; supporting and getting people important to them in their care; and wanting to be cared for and dying in a place of their choice. Each person in need of end-of-life care should be offered choices based on honest conversations with health and care staff that is consistently reviewed through conversations.

Choice in end of life care. (2015, February). Department of Health, U.K.

Search for the full-text article at www.gov.uk

» Dying in America: Improving quality and honoring individual preferences near the end of life

This is a study of the current state of healthcare for persons of all ages who are nearing the end of life. The experience of dying in the United States is often characterised by fragmented care, inadequate treatment of distressing symptoms, frequent transitions among care settings, and enormous care responsibilities for families. There are usually a lack of coordination among programmes and more intensive services provided than necessary, increasing the risk to patients. This report looks at the delivery of person-centred, family-oriented end-of-life care; clinician-patient communication and advance care planning; professional education and development; policies and payment systems to support high-quality end-of-life care; and public education and engagement.

Dying in America: Improving quality and honoring individual preferences near the end of life. (2015). Institute of Medicine of the National Academies Press.

Search for the full-text article at www.nap.edu



» **What a wish to die can mean: Reasons, meanings and functions of wishes to die, reported from 30 qualitative case studies of terminally ill cancer patients in palliative care**

This study explores the different motivations and explanations of cancer patients in palliative care who express or experience a wish to die (WTD). Three dimensions were found to be crucial for understanding and analysing the WTD statements: intentions, motivations and social interactions. This article analyses the motivations of WTD statements that are differentiated into: reasons, meanings and functions. Physical, psychological and social reasons for a WTD were identified. The nine typical meanings of WTD statements identified were: to allow a life-ending process to take its course; to let death put an end to severe suffering; to end a situation that is seen as an unreasonable demand; to spare others from the burden of oneself; to preserve self-determination in the last moments of life; to end a life that is now without value; to move on to another reality; to be an example to others; and to not have to wait until death arrives. The four functions of WTD revealed were: appeal; vehicle to speak about dying; re-establishing agency; and manipulation.

Ohnsorge, K., Gudat, H., & Rehmann-Sutter, C. (2014, July 31). What a wish to die can mean: Reasons, meanings and functions of wishes to die, reported from 30 qualitative case studies of terminally ill cancer patients in palliative care. *BMC Palliative Care*. 13(38).

Search for the full-text article at www.biomedcentral.com

» **Dying well**

This report examines how, where and with whom we die. Australian baby boomers are growing older and the number of deaths is expected to double in the next 25 years. Though they wish to die at home, dying in Australia is more institutionalised than the rest of the world. This report investigates the changing pattern of death in Australia; what a good death looks like; discussions on death; improvement in services; increased costs of a better death; and better dying. It highlights that public discussions on death should be encouraged; end-of-life treatment and advanced care planning should be widely implemented; and support should be given to people who choose to die at home.

Swerissen, H., & Duckett, S. (2014, September). Dying well. Grattan Institute.

Search for the full-text article at www.apo.org.au

» **The power of consoling presence – Hospice nurses' lived experience with spiritual and existential care for the dying**

Though integral to their job, many nurses feel unprepared to accompany people through the process of dying and report lack of skills in psychosocial and spiritual care, leading to distress, grief and burnout. This study explores the experiences of hospice nurses who work to lessen dying patients' spiritual and existential suffering. The two key care themes identified were: consolation, which included consoling through silence, consoling through conversation and religious consolation; and sensing, which covered sensing existential and spiritual distress, tuning in and opening up, sensing the atmosphere in the room, and being moved and touched. It found that consoling was a deeply personal and relational practice and nurses had the potential to alleviate suffering by connecting deeply with patients and their families.

Tornøe, K., Danbolt, L., Kvigne, K., & Sørli, V. (2014, September 3). The power of consoling presence – Hospice nurses' lived experience with spiritual and existential care for the dying. *BMC Nursing*. 13(25).

Search for the full-text article at www.biomedcentral.com