What is current medication management in district nursing practice?

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INTRODUCTION

During November 2002 the Royal District Nursing Service had 3454 clients who were registered for District Nurse visits. Of this total 1013 (30%) received support for medication management. From these statistics it can be demonstrated that medication management comprises a large part of the District Nurses role in the community however a comprehensive picture of current medication practice was lacking. National policy surrounding medication review and management in the primary health care setting is changing. District nursing practice needs to be in accordance with the principles of the National Strategy for Quality Use of Medicines 2002. This strategy supports the following principles: the primacy of consumers; partnerships; consultative, collaborative, multi-disciplinary activity; support for existing activity and system-based approaches (Commonwealth Department of Health and Aged Care 2002).

Older community dwelling people represent the largest group of medication users in Australia (Australian Pharmaceutical Advisory Council 2000). The majority of people receiving medications in district nursing practice are older people and these clients are more likely to be taking multiple drugs. The intent of this study was to lay the framework for informed decision-making about how RDNS can best meet the medication management needs of clients.

The primary aim was to identify current medication management in district nursing practice. In collaboration with District Nurses, the objectives were:

- To identify the concerns, claims and issues (CCIs) surrounding medication management
- To articulate current medication management and suggest recommendations
- To guide practice and policy within RDNS and influence the wider Australian community
- To identify a research agenda based on this exploratory study

The methodology was guided by participatory action and fourth generation research (Guba and Lincoln 1989) principles. The research team collaborated with District Nurses, clients and carers to meet the inquiry's objectives. Data were generated through observing District Nurses as they administered medications in the home (n=133), interviews with clients (n=18), interviews with nurses (35) and interviews with carers (n=5). Of the 133 clients observed 42 were reported in the form of case studies. These 42 clients had their case notes and blue folders analysed in addition to the observation account.

The analysis framework was based on concerns, claims and issues where these were clustered into major constructs or themes. Data was analysed concurrently and this was complemented with daily meetings for the research team to collaboratively discuss and record the emerging themes (constructs). A concern is any assertion that a stakeholder may introduce that is unfavourable about a local situation. A *claim* is any assertion that a stakeholder may introduce that is favourable. An *issue* is any assertion that a stakeholder may introduce that is unfavourable about a situation that describes the state of affairs. An issue was a situation whose resolution required wider community consultation and action. A *construct* is a full account of a main concern, claim or issue. Data from interviews, observations, journal data, and case studies were analysed and accumulated into common clusters.

In this document five case studies are reported, and ten constructs are discussed. In the final section of the report, the main findings are summarised, each with a set of recommendations.

Research Team

This project was internal to RDNS and funded by the RDNS Foundation. The Research Team was comprised of:

- Tina Koch, Chief Investigator / Professor of Nursing / Director, RDNS Research Unit
- Debbie Kralik, Senior Research Fellow, RDNS Research Unit
- Kate Visentin, Project Manager seconded from Royal Adelaide Hospital
- Linda Hayford, Research Nurse seconded from position as RDNS Liaison Nurse
- Katherine Trowbridge, Research Nurse seconded from position as Clinical Nurse Consultant
- Natalie Howard, Research Coordinator, RDNS Research Unit
- Jane Smith, Administrative Support, RDNS Research Unit
- Geoff March, Consultant to the study, Lecturer in pharmacology, University of South Australia

Project Management Team (PMT)

A Project Management Team (PMT) was convened monthly for the duration of the project. Membership of the PMT was:

- Tina Koch, Director, RDNS Research Unit
- Debbie Kralik, Senior Research Fellow, RDNS Research Unit
- Kate Visentin, Project Manager seconded from Royal Adelaide Hospital
- Jane Smith, Administrative Support, RDNS Research Unit
- Natalie Howard, Research Coordinator, RDNS Research Unit
- Anne Maddock, Quality Manager, RDNS
- Helene Martin, Clinical Specialist – Informatics, RDNS
- Cathy Isam, Senior Projects Officer, Business Development Unit (BDU), RDNS
- Anne Frewin, Modbury/LMHS Liaison Nurse, RDNS
- Connie Adsett, CNC General, Northern Public Programs, RDNS
- Judy Smith, Executive Director Nursing and Client Services, RDNS

District Nursing Teams

We would like to acknowledge the key stakeholders (RDNS Teams and Team Leaders) for participating in the project:

- Southern Public Programs Division Cityside Team 2 (Gwen Chambers)
- Southern Public Programs Division Hillside Team 3 (Di Kavanagh)
- Focus Health Care Division West Team 2 (Janelle Byrne)
- Northern Public Programs Division Salisbury Team 6 (Peter Carter)
- Northern Public Programs Division St Agnes Team 5 (Bernadine Stidwell)

BACKGROUND

Assisting clients with medication management comprises a large part of a District Nurse's role in the community. During November 2002, RDNS registered 3454 clients of which 1013 (30%) received support with medication management. RDNS has a computer system in place to monitor the number and frequency of visits however a comprehensive picture of current medication practice was lacking. There were also concerns about the increasing complexities surrounding medication administration in the community. These concerns included poly-pharmacy and complex medication regimens attributed to the increasing existence of multiple pathology in clients. In order to meet the changing medication needs of RDNS clients, development of new structures and processes for effective and safe medication management in the community needed to be considered. The intent of this study was to lay the framework for informed decision-making about how RDNS can best meet the medication management needs of clients.

One Observation Account

Betty was aged in her 80s and was blind. She lived with her husband Bob. RDNS visited because Betty needed administration of oral medications and eye drops. Sharon (RDNS nurse) went in the back door and walked straight into Betty's bedroom where we found her laying on top of her bed. There were warm greetings between nurse and client. On Betty's side table were three different shaped pots. Sharon divided medications into the different pots: one for breakfast, one for lunch and one for dinner. It was important that the pots were arranged in exactly the same way so that Betty could feel the shape and take the correct medications at certain times of the day. Sharon and Betty obviously had a close bond. Sharon carefully and gently guided Betty's hand to the tablets and a drink of water. While Betty was taking her morning medication, Sharon told Betty that it was raining outside. Betty expressed that she would love to be in the rain. This moment was not lost on Sharon who gave Betty a warm hug. Sharon made sure Betty was settled and comfortable before we left.

Betty lay on her bed for most of the day, a 'prisoner' in a dark world. Sharon confided that she often wondered what Betty's life must be like. Sharon stressed that medication administration is often a window to a much larger picture. Even though the visits are only for a couple of minutes, the therapeutic effect of the daily medication visit and the opportunity for ongoing assessment should not be underestimated.

RESEARCH QUESTION

The examination of the practice role for District Nurses in the Quality Use of Medicines (QUM) by clients living in the community was the focus of this study. The research question was 'what is current medication management practice in the community?' The term 'medication management' referred to the processes and support systems that were available to help people administer their medications. While the majority of clients were older people we were inclusive of all age groups. It was important to do this study in light of changes to policy and the realization that 30 percent of the activities of the District Nurse are in medication management.

AIM AND OBJECTIVES

The primary aim was to identify current medication management in district nursing practice. In collaboration with District Nurses, the objectives were:

- To identify the CCIs surrounding medication management
- To articulate current medication management and suggest recommendations
- To guide practice and policy within RDNS and influence the wider Australian community
- To identify a research agenda based on this exploratory study.

COLLABORATIVE INQUIRY

Utilising principles from participatory action and fourth generation research (Guba and Lincoln 1989), we collaborated with District Nurses and clients to meet the inquiry's objectives.

Data were generated from multiple sources:

- Observing nurses administering medications in the home, across shifts seven days of the week (n=133)
- Client case studies (n=42) - a case study was comprised of the observation account, and the analysis of the case notes and the client's blue folder
- Interviews of clients (n=18)
- Interviews of nurses at Clinical Nurse Consultant (CNC), Clinical Nurse (CN), Registered Nurse (RN) and Enrolled Nurse (EN) levels (n=35)
- Research team meetings (collaborative developments of common constructs)
- Interviews of carers (n=5)

The analysis framework was based on CCIs where common concerns, claims and issues (CCIs) were clustered into major constructs or themes. Data was analysed concurrently and this was complemented with daily meetings for the research team to collaboratively discuss and record the emerging themes (constructs).

The research team worked closely with five District Nurse teams who volunteered to be part of the study: two district nursing teams from the Northern Division, (Salisbury and St Agnes). a nursing team from Focus Health Care (West) which covered the Western side of Adelaide and two district nursing teams from the Southern Division (Cityside and Hillside), covering the Adelaide Hills to the coast. These teams of District Nurses gave permission for the researcher to observe their practice and to be interviewed. Most importantly, these teams were involved in reviewing the findings (consensual constructions) and deciding upon the actions from the findings.

REVIEW OF THE LITERATURE

National policy surrounding medication review and management in the primary health care setting is changing. The enactment of the Domiciliary Medication Management Review, known as Home Medication Review (Commonwealth Department of Health and Aged Care 2002) and the Enhanced Primary Care Program (EPC) has an impact on the practice of District Nurses, but as yet, this has not been studied. In addition, district nursing practice needs to be in accordance with the principles of the National Strategy for Quality Use of Medicines 2002. This strategy supports the following principles: the primacy of consumers; partnerships; consultative, collaborative, multi-disciplinary activity; support for existing activity and system-based approaches (Commonwealth Department of Health and Aged Care 2002).

Older community dwelling people represent the largest group of medication users in Australia (Australian Pharmaceutical Advisory Council 2000). The majority of people receiving medications in district nursing practice are older people and these clients are more likely to be taking multiple drugs. Drug related problems have been associated with a high proportion of hospital admissions (Johnson, Griffiths, Piper, Langdon and Stephens, 2002) and are implicated as a cause of morbidity. The QUM Statement of Priorities and Strategic Action Plan (2002:v) estimates that 80,000 hospital admissions per annum are associated with medication related problems and that many older people are at significant risk of medication misadventure. The National Health and Medical Research Council requires that consideration be given to the multiplicity of factors that influence the quality outcomes of medicine use by older people. What are these factors that impact on medication practice? The literature is adamant (Commonwealth Department of Health and Aged Care 2002) that primacy should be given to the consumer in medication decisions. There was also the argument that people with chronic illness self-manage medication and this may be viewed in a positive light in terms of taking control. Although self-management is the current mantra we do not know very much about the ways older people self-manage except to say that the majority of people receiving medication management in district nursing practice have some cognitive decline. When clients live with dementia the primacy of the consumer in these partnerships may need to be reviewed.

As previously mentioned polypharmacy is common for the older population. The term polypharmacy is often used in reference to unnecessary and excessive medication. Despite this the use of polypharmacy may be appropriate and beneficial in some instances. Complexity of medication regimes is thought to be directly related to the number of medications, differing doses and frequency of medications. The absolute risk associated with medication misadventure increases exponentially with increased drug numbers (Johnson *et al* 2000).

The complexity of medication regimes has been revealed to effect compliance. Compliance is a word that is frequently used when discussing the ability for clients to take their medications as prescribed. The term 'compliance' may not be the most appropriate term to use as it implies the client’s rights are being disregarded. Adherence may be more appropriate as it implies that the client is more active in a self-management role. One other term now being used is 'concordance' as it suggests that for clients to want to “comply”, an equal partnership needs to exist between them and the health professional (Royal Pharmaceutical Society of Great Britain and Merck Sharp Dohme 1997). An interesting point made by the National Pharmaceutical Association (1998) was that while compliance may be an important outcome it is not in itself the goal we seek because if medications are having an adverse effect it may

be "non-compliance" that saves the clients life. It is therefore important that clients and health professionals work collaboratively towards an understanding of how medications can be used appropriately and when help should be sought. The literature also recognises that the problem of adherence is multi-factorial and assessment that is inclusive of these factors is required.

Factors that may effect adherence include issues such as: costs of medications; perceptions of flexibility within regimes; the effect medications will have on lifestyle; difficulties in reading labels, opening containers or hearing instructions; acceptance of ageing; fear of addiction and beliefs that over the counter or complementary medicines are natural (Johnson *et al* 2002). In addition clients living with dementia have failing memory and/or confusion which can have an adverse effect on adherence rates. It is argued that the District Nurse is in an excellent position to monitor and assess the success of medication management in a community setting.

Despite the obvious benefits that District Nurses can offer their clients, there is a major gap in the research surrounding the role and practice of the community nurse in the medication review process. Community District Nurses can promote early identification of people at risk of medication misadventure. Through assessment of the clients' ability to cope with medication regimes District Nurses are then able to make decisions about appropriate referrals and intervention programs.

If District Nurses are to be effective in their practice it is important that effective partnerships are established and maintained. The multi-disciplinary team, comprising doctors, pharmacists and nurses, are the key players in community medication practice, but in practice little is known about the way in which this partnership works. There has been considerable progress on the interrelationships between GPs and Pharmacists through programs such as EPC and Home Medication Review (HMR). Unfortunately there has been less progress in the area of community nurses, GPs and Pharmacists. Nursing needs to be able to articulate the valuable contributions it can make to current schemes. This research will explore what is the collaboration between District Nurses, GPs and community Pharmacists.

The literature suggests that both GPs and Pharmacists have described their role in medication management but no such role definition has been articulated for District Nurses. While many referrals are made to the District Nurse by GPs with requests to investigate or assist with medication compliance issues, the way in which this is done nationally varies and appears to be ad hoc (Johnson *et al* 2002).

In summary there is clearly a need to describe current district nursing practice in the area of medication management. The National Strategy for the Quality Use of Medicines (2002) has been developed to promote best practice principles. It is important that District Nurses can describe their role in medication management and provide evidence that they too are following the guidelines set out by the National Strategy for Quality Use of Medicines. The research will also describe the way in which partnerships are functioning in the community, in particular between GPs, pharmacists and nurses.

METHODOLOGY

Collaborative inquiries rely on participation of stakeholders (those who have a stake in the outcome of the research). Stakeholders are defined as those who have a direct involvement with the group or setting to be evaluated. In collaborative inquiries, participants involved in the research have an equal right to be informed, and to engage in any decision-making that affects them. This process argues that all stakeholders have a right to place their concerns, claims and issues (CCIs) on the negotiating table. Hence, this research has endeavoured to be a joint collaborative process, aimed at the evolution of consensual constructions about what constitutes current medication practice.

The constructivist (hermeneutic or interpretive) methodology framing the medication project can be attributed to Guba and Lincoln (1989). Guided by the constructivist, methodology means the parameters and boundaries emerge from the study, but data are organised through responsive focusing. Named responsive focusing is looking at the questions to be answered: what are the CCIs? Responsive evaluation determines the boundaries through an interactive, negotiated process that involves the entire research team in the first round, the RDNS teams in the second round and RDNS (the organisation) in the third round. The aim is to collectively build the construction around CCIs as data are generated.

UNDERSTANDING OF THE TERMS

Stakeholder

A stakeholder is anyone involved in the study that has a stake in the outcome. Stakeholders in this project were the individuals in the research team, the clients/carers, the RDNS teams, Project Management Team (PMT) and the wider RDNS organisation.

Concerns

A concern is any assertion that a stakeholder may introduce that is unfavourable about a local situation. It may mean that further clarification is required so other questions are asked about a situation. For the purpose of this inquiry, a concern was identified as a situation that can be dealt with internal to RDNS.

Claims

A claim is any assertion that a stakeholder may introduce that is favourable. In this inquiry it related to what was working well.

Issues

An issue is any assertion that a stakeholder may introduce that is unfavourable about a situation that describes the state of affairs. An issue was a situation whose resolution required wider community consultation and action.

Construct

A construct is a full account of a main concern, claim or issue. Data from interviews, observations, journal data, and case studies were analysed and accumulated into common clusters.

RELEVANT INFORMATION ABOUT RDNS

District Nursing Teams

A team of nurses comprises:

- A team leader (usually a Clinical Nurse (CN) whose position is level two in the career structure), and
- Between 4-7 nursing staff (mostly Registered Nurses (RNs) that are level one in the career structure) but also some Enrolled Nurses (ENs).

All team members are involved in medication management. Each District Nurse has a round and visits approximately twelve clients, many of whom are being visited for medication management. A Clinical Nurse Consultant (CNC) who occupies level three in the career structure, provides professional nursing guidance to teams in his/her Division.

Nursing Divisions and Direction

Although there are separate nursing centres, RDNS provides a home nursing service in the Adelaide metropolitan area that spans 90 kilometres along the coast and toward the foothills. RDNS has a work force of approximately 350 nurses. The organisation has undergone restructuring in the latter half of 2002 (the physical relocation coincided with this study) and the metropolitan District Nurse services are now divided into two Divisions (Northern and Southern) and Focus Health Care (the private arm). Three Divisional Directors, as part of RDNS Senior Management Team, occupy level four in the career structure and oversee the Divisions. The Executive Director Nursing and Client Services works at level five in the nursing career structure and the incumbent in this position provides policy and practice direction.

Medication Practice at RDNS

RDNS, supported by a Nursing Practice Committee, develops and maintains current policies. These policies are contained in the Nursing Practice Manual (NPM), which is comprehensive and will be referred to throughout the report. Clients may be referred to RDNS for medication management for a variety of reasons. However, the most common reason for clients needing medication is memory loss.

Supervision and administration of oral medication is the most common activity (48%). However, RDNS provides medication management services dealing with cytotoxic and palliative medications given by a variety of routes including epidural, intramuscular, intrathecal, and intravenous. Staff have technical expertise in oxygen therapy, infusion pumps and syringe drivers. Other types of medications are administered via the ear, eyes, rectum and vagina. The table below gives the top seven percentages of what medication management services were being utilised as of February 2003. Some clients may have multiple medications listed such as oral medication, eyes and insulin.

Table 1 - Medication Management Services

Oral medication	48.1%
Dosette	22.2%
Subcutaneous	11.3%
Insulin	11.1%
Eyes	6.9%
Intramuscular	6.9%
Topical	4.5%

Referral/Admission Process (Policy 1.CR.15)

Although RDNS is involved with clients who do not have dementia, the majority of clients are referred with memory loss and there are established practices for admission to the service. When clients are first referred to RDNS for medication management and they have a diagnosis of dementia, the District Nurse usually trials a dosette or a Webster pack (in close cooperation with the pharmacist). If this intervention works, the client is discharged from RDNS with documented evidence of adherence, support and education. If the client forgets or mis-manages the medications, RDNS provides a service (daily visit) where the District Nurse visits the client's house and actually administers the medication as per medical authority (from a GP, specialist or both). As many of the clients receiving support with medication service have dementia, a locked container (a large red box with a padlock) may be provided for containment of medications. If the client has medication at times other than when nurses are available, labelled receptacles such as saucers, cups or glasses may be used to contain these medications. This practice has been referred to as *dosetting* throughout the report.

ETHICAL CONSIDERATIONS

The legally established RDNS Ethics Committee approved this medication project. Appendices 1 and 2 show the submission to the Ethics Committee and the letter confirming approval. There are a few ethical principles associated with this inquiry that require discussion. Researchers asked each District Nurse if they wanted to be involved in research and if they were willing to give up time for interviews and similar activities. The study requirements were discussed with the teams before informed written consent was requested. It was agreed that if promises were made to stakeholders, (e.g. weekly feedback and involvement) they would be kept. Of course participants had the right to say 'no' to an interview request. Whilst it was not possible to promise confidentiality, it was possible to promise that only common CCIs would be raised. Names of people and places are pseudonyms unless otherwise negotiated and agreed.

In this study we have involved all stakeholders in developing constructions that answer the question: 'What is current medication practice in the community?' Despite group diversity the principles of respect, equity and ability to be heard made this process possible.

IDENTIFYING AND PREPARING DISTRICT NURSING TEAMS

Initially we sought four District Nurse teams with which to work. We advertised in October 2002 using electronic correspondence and invited team leaders (in consultation with their

team members) to volunteer. Each team was provided with information about the study (Appendix 3). The following teams participated in the project:

Southern Division Cityside Team 2 - comprised a CN (team leader), two full-time RNs, two part time RNs sharing one round and two ENs sharing one round. One part-time RN and one EN were new to RDNS. This team covers the eastern part of Adelaide, ranging from fairly affluent to lower socio-economic areas.

Southern Division Hillside Team 3 - comprised a CN (team leader), three full time RNs, (all long term employees), one RN and one EN (who share a round, both on modified duties). This team covered an area close to Parkholme and extended to Belair in the Adelaide Hills. Again, areas ranged from very affluent with private assistance and family support to a lower socio-economic public housing area.

Focus Health Care West Team 2 - comprised a CN (team leader), two RNs and three ENs. This team covers the west of Adelaide and is in a low socio-economic belt but clients have additional health insurance or are Department of Veteran Affairs (DVA) listed. Most GPs provide electronic medical authorities and have good communication with RDNS, and this was well documented. The Focus team is currently crowded into the RDNS building at Beverley while the organisation locates some more appropriate accommodation. Many of the staff are new to RDNS. The Focus team is part of the 'private' arm of RDNS.

Northern Division Salisbury Team 6 - comprised a CN (team leader), five RNs (some part time) and one EN. Staff in this team have been employed by RDNS for quite some time, with the exception of one RN. Clients are often in Housing Trust accommodation and occupy a low socio-economic status. Generally, there is limited family support and poor communication between Pharmacist/GPs and client/nurse (this was well documented). In these rounds there were more clients with mental health conditions.

It transpired from the Northern Division, that the Salisbury team did not have the numbers of clients requiring medication management to satisfy sampling. We therefore asked for further teams to volunteer, and the St Agnes team self-selected.

North Division St Agnes Team - comprised a CN (team leader), three RNs and two ENs (both part-time). Most clients appeared to be middle class and live comfortably. The nurse researcher observed that pharmacists seem supportive and work collaboratively with GPs and RDNS to provide accurate authorities. Prescribed medicines are generally delivered. Families of clients in this team are generally supportive of the client and RDNS service.

DATA GENERATION

Collaborative inquiry is a local process. The outcomes depend on local contexts, local stakeholders and values that cannot be generalised to other settings. Experience suggests that this approach is not always a neat, orderly activity that proceeds step by step through the process. In this collaborative inquiry there were multiple sources of data. Data were obtained through interviews (nurses and clients), case studies, observation of medication practice and the associated documentation, medication reviews and researchers' journals. In addition, research team meetings and district nursing team meetings constitute data and these were subjected to analysis and incorporated into the findings. Concerns, Claims and Issues (CCIs)

were the organising foci. Constructs became evident as data were saturated around common CCIs.

Observation of Practice

Two research nurses were recruited from RDNS and seconded to the RDNS Research Unit for the month of November 2002. Although this was in-house research, both nurses researched in teams outside their own area of RDNS practice. The observation schedule (Appendix 4) was developed and piloted prior to the commencement of the project. An observation roster was developed for the intensive four-week observation period in November 2002. The roster was discussed with each Team Leader.

Methodological issues formed part of the orientation of the research team. We had only one month in which to generate quality data so the need to maintain a focus on substantive CCIs was discussed. Ethical issues were raised beyond those originally submitted and approved by the RDNS Ethics Committee. It was possible that ethical issues would emerge on a daily basis, hence it was agreed that we would bring these to the daily research team meetings. We reaffirmed that research participants should be made aware that they had a choice regarding their involvement in the study. The Hawthorne effect, the Halo effect, and the values and interests of each researcher was identified and discussed. In the first few days, we interviewed each other (recorded, transcribed and analysed) so that we could see the way in which our values, horizons and prejudices were operating. We noted that our own social and gender positions determined what was observed. Several people were generating data, therefore it was important to establish a standardised method for observation and determine reliability through:

- Understanding the methodology (CCIs, responsive focus, dialectic and constructions)
- Familiarity with the schedules: interviews and observations
- Agreed number of observations and interviews
- Discussion following observation (interview, clarification and confirmation) with the nurse during the interview
- Ongoing discussion and debriefing (daily meetings with research team)

Observing in the Field

The research nurses made arrangements with the District Nurse teams for observation to take place. A photocopy of the visit worksheet and the client's call sheet was arranged prior to the visit. The research nurse travelled with the District Nurse and observed the medication practice of four to five clients. Each visit to the client's home was approximately ten minutes in duration therefore efficient organisation was paramount. There were some guidelines for observation practice. It was suggested that the research nurse:

- Practice disciplined recording of field notes
- Separate the details from the trivia
- Record memory joggers
- Be mindful that it was very easy to become involved in the conversations between client and District Nurse. Observation in practice required skill to tune in and write at the same time
- Had an awareness that what was observed was highly dependent on own interests, biases and background
- Maintained personal notes of the researcher's experience during the research process

- Validated observations (supported by documentation in the client's notes and blue folder)
- Recorded observations which were to be typed the same day

The researchers handwritten observational notes were supplemented with a review of the client's case notes and blue folder (pending their permission). The Research Nurse also used a dementia classification (mild, moderate or severe) to assess the level of dementia (Appendix 5).

Journal Accounts as Data

A reflective journal or field diary was one way that a researcher could achieve insights and clarity of their project experiences. Reflective notes provided valuable stimuli for the formation of ideas on the process and progress of the study, responses to interactions with participants and a daily recording of events. Ideas from reflective notes were discussed at the research team meetings and incorporated into the study process.

Client Interviews

It was important to gain the consumer's point of view about medication practice. Researchers undertaking the observations of medication practice invited clients to be interviewed who were able to articulate their stories. Following the procedure outlined in the submission to the Ethics Committee (see Appendix 1), the researchers proceeded with the interview. The research team recognised that clients may not respond to actual CCI questions, hence a conversational approach to the interview was used. Interviews took approximately 15-30 minutes. To ascertain clients' CCIs we asked:

Concerns

- How are you managing your medications?
- Is there anything that concerns you about managing them?
- Can you give me an example?
- What is really important to you about your medication management?

Claims

- In your own words, what is good about the way your medication is managed?
- Can you tell me more?

Issues

- If we look at the bigger picture, are there aspects of your medication management that could be improved?
- Anything else you would like to talk about?

If the questions did not generate rich data, it was decided to ask:

- What do you like/do not like about the way medications are managed?
- What do you feel strongly about?
- What is really important to you?

The skilled interviewer used flexibility and insight to ensure an in-depth and detailed understanding of the participant's experience in the management of medications. We

permitted clients the time to talk. Prompts were used but at the same time we kept clients focused on CCIs. A recorder was used and the interview was transcribed verbatim.

During the data generation month, it became increasingly clear that the majority of clients had varying degrees of dementia, and that few could actually be interviewed if data were to be considered plausible. Only eighteen (18) clients could be interviewed, and of these seven (39%) had some cognitive decline.

We have made an attempt to include the clients in this collaborative process. However, the large number of clients with dementia was not anticipated when we planned the study. To address this, limited ethics approval (Appendix 2) was gained to interview the carers of clients with dementia so that a consumer perspective could be further articulated. Team leaders were involved in recruitment so that appropriate carers could be identified. Only carers of clients observed during the project were asked to be involved. Carers were offered phone or face to face interviews and consent was obtained to record and transcribe interviews verbatim. From those invited to participate five (n=5) carers agreed to a phone interview.

Interviews with Nurses

The research nurses negotiated with the round nurse regarding the most suitable time for the interview. In this study we used semi-structured interviewing (responsive focusing) so that CCIs could be ascertained. The major advantage of this type of interviewing was that data were generated systematically and comprehensively, while the tone of the interview remained fairly conversational and informal. The interview took no longer than 30 minutes.

In ascertaining nurses' CCIs we asked:

Concerns

- What are your concerns regarding medication practice in the community? Provide an example from your practice

Claims

- What is working well regarding medication practice in the community? Provide an example from your practice

Issues

- What are the issues that constrain medication practice? Provide an example from your practice

Other questions

- What is the most important to you in terms of medication management in the community?
- What would you really like to improve?
- Is there anything else you would like to talk about?

These interviews were recorded, transcribed within 48 hours and analysed.

Table 2 - Nurses Interviewed

Level of Staff	Number of interviews
CNCs (including Generalists, Mental Health, Palliative Care, Diabetes, Call Centre CNCs)	9
Clinical Nurse/Team Leaders	9
Registered Nurse	15
Enrolled Nurse	2
Total number of interviews	35

Nurses were reminded that their input was valued and that feedback would be provided at District Nurse team meetings. Common constructs would be explained at the team meetings and those participating in the research were provided the opportunity to enter the dialogue, and subsequently negotiate and reshape the constructions.

COMMITTEES AND MEETINGS

Feedback to RDNS District Nurse Teams

Findings were fed back to RDNS district nursing teams. Afternoon meetings with teams were organised, offering light refreshments. The team meetings were audio-taped, transcribed and analysed. Time constraints meant that researchers provided a brief overview of the major claims (praise for RDNS). Then we concentrated on the two dominant issues: (1) Medication Authority and supply and (2) the majority of RDNS clients receiving medication support have an altered mental state (dementia), lack nursing and comprehensive medical assessments and diagnosis of the altered mental state. Participating team members were provided the opportunity to challenge and change these constructs.

As the study involved District Nurses who will be affected by the evaluation, we predict that there will be a stronger sense of ownership of the actions and outcomes. Equally important is the conviction or assumption that the engagement of practitioners in researching their own practice will prompt action. Outcomes of the evaluation process are considered successful when changes prompted by the study have occurred. Whatever the outcomes, a transparent culture is created within the study process in which stakeholders and RDNS will have greater clarity about the way the medication management in the community operates.

Research Team Meetings

It was the task of the research team to identify common CCIs and bring them for discussion at daily research team meetings. The agenda for daily meetings was formulated:

- Problem solving session
- Debrief (all members of the research team)
- Rosters
- Ethical Issues (all members of the research team)
- Concerns, Claims and Issues
- Analysis: Common constructions
- Report progress
- Feedback to District Nursing Teams and Project Management Teams

DATA ANALYSIS

The Project Manager conducted concurrent analysis and then presented the CCIs to the research team at the daily meetings. This process of concurrent analysis and feedback to members of the research team signifies the collaborative nature of the study.

The daily research team meetings had an agenda for negotiation but consensus was not always reached. However, debate was promoted and the breadth of nursing experiences of the research team members provided a stimulating learning environment. It was therefore possible to create an agenda where common CCIs were clearly identified. It was noted that different stakeholders held different constructions with respect to any particular concern, claim or issue. Constructions continued to change shape based on negotiations between team members. The purpose of the daily team meetings was to develop the constructions collaboratively. The search for understanding of what is current medication practice was one

of the major aims of this study and occurred through dialectic between the understandings of stakeholders and data generated in the search for explanations. This resolved in a construction(s), which represented a newly formed perspective. The aim was to provide constructions of stakeholders' data that 'is as informed and sophisticated as it can be at a particular point in time' (Guba and Lincoln 1989:44). The research team identified ten common constructs.

OBSERVATIONS

Observation of Medication Practice

In the effort to observe practice continuum, morning and afternoon shifts were observed. The total number of nursing practice observations was 133. This included three weekend shifts and three evening shifts. We included observation of palliative care practice during two shifts.

The observations were transcribed, and each research nurse analysed their observations and documentation for CCIs. It soon became clear that four to five clients per day were too much if accounts were to be processed and analysed the same day. The research team agreed that the research nurse would continue observation of practice for four to five clients and that these observations would be recorded. However, only two clients would have their documentation reviewed. We have called these in-depth observation case studies (n=42). A case study is comprised of the observation account and the analysis of the documentation (case notes and the client's blue folder). Twenty-six (26) woman and sixteen (16) men comprise the case studies. The average age of men was 76 years old and women were aged 77. The data to follow provides demographic information about the 42 case studies.

Average length of stay, number of visits and re-admission to RDNS

Interestingly the average length of stay in days was 452 days for women and 764 days for men. Twenty-nine (69%) received daily visits, three clients (6%) were visited twice daily and one client (2%) three times a day. The remaining ten (23%) saw the District Nurse at least once per week but usually more often, every two-three days. Twenty-six percent (26%) of clients had been re-admitted to RDNS, most (14%) a second time and few (7%) a third time. Re-admission data are not accurate, as 29% did not have an entry against this question.

Diagnosis

Of the 42 clients, 31 or 74% had been admitted with memory loss. Diagnostic labels were varied, including Alzheimer's disease, confusion, mild, moderate and severe dementia. From the admission diagnosis it was not clear if clients had been formally assessed and diagnosed.

Living arrangements

The majority of the 42 clients lived alone (69%). Eleven percent (11%) lived with their spouse. Only one person lived with an adult child and one other with a friend.

PRESENTATION OF FIVE CASE STUDIES: WHAT IS CURRENT PRACTICE?

In an effort to describe the context of current medication practice, it is important to share some case studies. Most of the RDNS clients receiving medication support had polypharmacy issues. The average number of medication taken by the 42 clients was 6.34. The five clients whose case studies have been selected take more than six medications daily. The project team sought consultation and collaboration with a pharmacist to assist in the identification of the pharmacological issues. Fictional names have been used to honour confidentiality. The first person's voice is that of the nurse researcher. In each case the client's story line will be developed, medications listed and analysis given in the frame of concerns, claims and issues.

CASE STUDY ONE

Background
Murray has a past medical history of depression, peripheral vascular disease, hypertension and severe memory loss related to alcohol abuse. He has a liver mass, undiagnosed 08/01/02 and underwent a failed sympathectomy 18/05/02. Murray openly admitted to 'almost having Korsakoff's Syndrome due to the booze'. He was referred to RDNS on 16/06/00 by a hospital for medication management assistance. The reason for RDNS daily visits is his poor short-term memory resulting in his forgetting to take his medications.

He lives alone but has a supportive neighbour who attends to Murray's garden and a care worker from Anglicare who calls twice a week for support and 'outings'. His family lives interstate and has not made contact in five years. Although Murray ambulates independently it is recorded that he needs prompting to shower and take care of general hygiene.

On the day of observation Murray was fully dressed with slippers on but not shaven or groomed. He was sitting on the lounge drinking wine from a vegemite glass and rolling up a cigarette. He smelt of smoke and wine. The record player was playing an old record and the nurse started a discussion about the recent Melbourne Cup. The client was pleasant in conversation and appeared to be relaxed in his environment. Murray communicated that last weekend he was so intoxicated that he fell from his gopher (which he uses to mobilise for long distances) and the gopher ran over him. When the nurse tried to question him further Murray refused to talk about the issue and changed the subject.

Due to previous staff safety issues, Murray has an alert (**) status within RDNS, indicating that violence toward nurses can be an issue. For that reason RDNS do not visit after hours. It was noted the RDNS do not visit if the client has been 'binge drinking' because it is perceived that this poses a risk to staff.

His medications were in a locked box with a combination lock. The nurse discussed with Murray the pending GP review and the need to book a taxi. Murray sipped wine continuously during the visit. The nurse requested that Murray count with her the amount of Kapanol tablets (an opioid medication) left in the home and the nurse then proceeded to document this on the Narcotic sheet. Murray and the nurse conversed about his medications further, and he agreed to visit the pharmacy that day to buy some Thiamine tablets.

Current Medications:

Cardizem 240mg mane
Imdur 60mg mane
Aspirin 100 mg mane
Lipitor 10mg mane
Ciipramil 20 mg 3 tablets nocte
Campral 33mg 2 tablet TDS
Zantac 150 BD
Multivitamins one daily
Thiamine one daily
Diazepam 5mg 1-2 when necessary
Vioxx 25 mg one mane
Kapanol 20 mg BD

Blue Folder

The nursing care plan is used as progress notes and communicates that the client is 'at times' non-compliant with self-administration of his midday and evening medications dosette. The care plan describes daily visits to directly administer morning medications and all others are placed in a dosette for the client to self-administer. The care plan entries relate to discrepancies with authorities and ordering from the pharmacy. Murray collects all medications himself from the pharmacy approximately each fortnight. The authority is clear and dated 10/09/02. 'Support' care plan states all contract community agencies are involved in client's care. He has previously used alcohol withdrawal services but continued to discharge himself.

Case Notes

Assessment was not commenced. A previous admission involves wound management needs and it was noted that he had a skin tear that healed within three weeks. Entries in the case notes have identified a number of issues, such as authority discrepancies and the ordering of medications from the pharmacy.

Concerns

- Safety and quality use of medicines - Murray is living alone with some memory loss and is required to manage twelve medications. This client is at high risk of medication misadventure. No recent review of Murray's progress or ability to manage medicines documented
- Medication concordance - client often forgets to self-administer dosette medications (evening medications left by the District Nurse)
- No documentation of management related to the issue of missed medication
- All care plan documentation focuses on the ordering of medication. Support care plan has no documentation related to supporting the client related to his medication needs
- Client is self-neglecting and is open in discussion about this. Nurse has not discussed this today with client or documented her concerns
- Review of the documentation system used in the Blue Folder. What does this mean?

Issues

- This client would benefit from a Home Medication Review. One possible strategy to be assessed is the simplification of the medication regimen to maximize once daily dosing which can then be overseen by the RDNS nurse

- Some questions that could be asked are:
    - Can Murray's medication regimen be simplified in an effort to maximise once-daily dosing?
    - Is his angina well controlled? Are the angina medications causing dizziness?
    - Kapanol (opioid medication) – is he constipated?
    - Should he be on any other medications to help with arthritis?
    - What affect does the alcohol have on the combination of medications?
    - Is he having difficulty sleeping at night considering he is taking Cipramil then?

- Develop a system of case conferencing, care planning, clear identification of desired outcomes and subsequent monitoring, involving all health professionals who are caring for this patient.

CASE STUDY TWO

Background
Lyn is a 62 year old woman living alone in her own unit. She has a son and a daughter but neither offers much in the way of practical help. She has a medical history of type 2 diabetes on insulin, schizophrenia, a cerebral vascular accident and severe rheumatoid arthritis. She walks with the assistance of a walker however a wheelchair was in the lounge room. Her mobility is severely affected by rheumatoid arthritis. Her eyesight is poor, possibly due to diabetic retinopathy, but this is not mentioned in either the progress or case notes. Her mother is power of attorney.

She receives assistance from carers from an Options package. Paid carers change frequently due to her challenging behaviour. They provide showering assistance, cooking, shopping and cleaning for two hours twice a day. She has a mental health worker who, the nurse reports, has minimal contact and the name or contact number is not accessible in any of the notes. She has recently been assessed by another nursing home as suitable for placement, but is still deciding whether or not to go.

She has a history of involvement with RDNS in between extended stays in psychiatric facilities. The latest re-admittance occurred in 2002 after discharge from a nursing home.

On the day of observation the researcher noted that a drawer in the bedroom had ten boxes of Panadeine Forte, Digesic, boxes of Depot – Clopixol 200mg/1ml and a number of over-the-counter medications. The top drawer of a small bedside cabinet also contained full boxes of tablets. In the cupboard in her lounge Lyn had 14 Webster packs that she refuses to throw out. There was a box of Erythromycin on her traymobile that was half taken, dated November 2000. There was also a box of Fucidin, with her sons name on it dated 28/6/00. The locked box contained only some tablets with the rest in another box by its side. On the table were books on alternate therapies.

The nurse took the Lyn's blood glucose level prior to insulin administration. The nurse dialled up an insulin pen for her which the client used to self-administer the insulin. The nurse then dialled the evening dose ready for the client to use in the evening. There were two glass bowls on the table, in which the nurse placed her morning tablets and the evening medications were placed on the bedside cabinet ready for her to take that night. Lyn rings the pharmacy that holds her scripts. She rings the doctor when she needs more scripts.

Current Medications:

Coloxyl with senna nocte
Methotrexate 5 mg weekly
Clopixol Depot injection 300mg fortnightly
Avandia 8mg mane
Prednisolone 5 mg mane
Zantac 150mg twice daily
Asasantin 1 tablet BD
Vioxx 12.5mg BD
Karvea 150mg mane
Vagifem 1 pessary twice weekly
Lasix 120 mg mane
Panadeine forte half to one tablet 4 times daily
Lipitor 20mg mane

Slow K 1 tablet BD
Fosamax 70 mg mane
Ferro-Gradumet one tablet mane
Mixtard 18 units s/c pre tea
Mixtard 30/70 32 units mane

Blue Folder
The care plan is clearly written and instructions clear. Objectives are being achieved and they are documented. Twice daily visits were originally planned but in October, evening tablets were dosetted and trialed for compliance and to promote independence. The fact that Lyn had taken the tablets was noted. There is also a care plan for injections, which included the fortnightly depot injection and instructions for the insulin. Entries noting client's concern about changing of doses and high blood sugar levels were made.

Case Notes
The case notes contained a page titled "Lyn's conference" along with the attendees' names, but the outcomes of this conference were not noted. Of note was the fact that *RDNS was not involved in the conference*. This is alarming as Lyn is visited daily by RDNS for administration of oral medications and insulin, blood sugar level monitoring and pressure ulcer care. There is no evidence of measurement of quality of life (QOL) in her record.

There are two sets of case notes: Volume 1 contains old progress notes and authorisations. Volume 2 contains the admissions. There are entries in the progress notes dated September and October 2001 noting deteriorating mental state. Tablets were missing from the medication box and found in her handbag. Another entry noting late discharge from hospital, only four days later. It is questioned why the late discharge, and why was the information not communicated to RDNS? What happened whilst Lyn was in hospital? Further disturbing entries noting problems until the end of October 2002.

Other entries from previous admissions, noting lots of changes to medications, changes to mental state and phone calls to doctors (GP, psychiatrists). There is an assessment by the Mental Health CNC for RDNS dated 1998, requested by an RDNS nurse, where this nurse makes a number of recommendations. No documentation is available from any other facility or mental health worker. There is no evidence of any of the recommendations being successful. There are three letters/communications from RDNS nurses concerning Lyn refusing or querying medications and subsequently becoming angry.

Medication Authority
There is one medication authority dated July 2002 (two pages). It is unclear. Medications are crossed out, an unidentified person has written the days by the side of drugs that are given weekly or fortnightly. Insulin dose changes, possibly by an RN, were recorded alongside the original dose. There were three hand-written letters from the GP changing insulin dose, ordering vaginal pessaries and eye ointment. The GP (it is assumed) had also written/added these medications. The progress notes recorded the changes to medications, Lyn's reluctance to accept these changes, notes from the GP, and her constant high blood sugar levels. A psychiatry review (dated 28/8/02) was completed but there is no communication with RDNS concerning the outcome. It cannot be ascertained from the notes when the client last saw her GP and there is a no evidence of any communication between RDNS nurses and the GP.

Concerns

- Safety and quality use of medicines – Lyn is living alone with deteriorating mental state and is required to manage nineteen prescribed medications and a number of over-the-counter. Lyn is at high risk of medication misadventure. No recent review of Lyn's progress or ability to manage medicines
- Hoarding of medications (her own and her sons'), many of which may be out of date medications or no longer being used
- Concordance - Is the client taking her dosetted doses? It is noted that as her mental health deteriorates she does not take them
- Poorly controlled diabetes
- Client has questionable mental stability – with no communication from any mental health facility. Previous interventions (CNC) not evaluated
- Nursing assessment and evaluation of interventions are not routinely recorded
- Emphasis of the RDNS visits is on the tasks to be done (and there are many tasks) rather than comprehensive nursing

Issues

This client would benefit from a Home Medication Review. Some issues to be addressed:

- Review of diabetes management
- Role of diabetes education in a person who may not be able to self-manage their condition
- Psychiatrist might be involved in care
- Review use of medicines and monitor side effects
- Simplification of medication regimen
- Removal of out-of-date medicines and medication no longer required (with permission from client)
- Need for regular blood tests (with Methotrexate and diabetes monitoring)
- Initiation of a system of medication administration that is both safe and appropriate for the client
- Evidence that intersectoral communication is poor. Multiple services yet RDNS is excluded from the case conference. There is a need to develop a system of case conferencing, care planning, clear identification of desired outcomes and subsequent monitoring, involving all health professionals who are caring for this client
- Review all documentation procedures to improve the recording and flow of information between RDNS staff, and also between RDNS and other health professionals
- Multiple medical staff involved writing medication authorities and prescribing is confusing. The medical authority is very confusing, with medications crossed out and additions

CASE STUDY THREE

Background
Coral is an 84-year old woman living alone in a small unit in a retirement estate complex. The unit was well furnished, neat and tidy. The complex provides a house cleaning service in her unit once a week and she goes to the dining room for lunch and dinner. The unit is self-contained and has a small kitchen where she cooks breakfast. At this stage she showers herself. She has two supportive daughters who live close by.

She was referred to RDNS by the GP in January 2002 for medication management. The referral states that she either forgets to take a dose, or doubles the dose because she had forgotten that she had already taken them. Her medical diagnoses on the referral sheet are dementia, coronary ischaemia and peripheral vascular disease and she is allergic to penicillin.

On the day of observation the front door was unlocked and there was no answer to the knocking or the nurse calling her name. The television was on in another room but the door was closed. The nurse rang her phone number and Coral came out. She walked with the aid of a stick in the unit and a walker (with seat) was outside the door. She was friendly and was able to converse well. On the dementia scale she is at stage one. She quite freely admitted she forgot things and was very appreciative of RDNS nurses managing her medications.

- RDNS visits daily and dosettes the evening medication. Her medications are kept in a locked box on a dining table. The RDNS nurse rings the pharmacist when medications are low and the pharmacist delivers and places the medications in the locked box. The nurse put the evening tablets in a dosette box in the evening hold marked for that day.

Coral manages her own bowel care and there was a bottle of Agiolax on the table.

Current Medications
Macrodantin 100mg mane
Astrix 100mg mane
Indur 60mg mane
Losec 20mg BD
Tritace 5mg mane
Detrusitrol 2mg nocte (obtained under special authority from New Zealand and not on medical authority)
Thyroxine 100mcg mane
Caltrate 600mg one tablet nocte
Aricept 10mg mane
Lipitor 40mg nocte
Mogadon 5mg nocte

Blue Folder
An assessment had not been documented and quality of life had not been measured. The original care plan (filed in the case notes) dated 30/1/02 (date of admission) states that she is admitted for oral medication supervision.

Coral commenced with a dosette which the pharmacist fills. It was intended that the District Nurse visit three times weekly to see if Coral could manage the dosette. It was agreed that her daughter would prompt the administration of medication over the weekend. The first week it is documented in the outcomes section of the care plan that she is compliant and by 11/2/02

would be monitored for one more week and then visits would be placed on hold. However, 13/2/02 the nurse documented that the client claimed to have taken that morning's tablets yesterday and was not feeling well that morning. It is documented that the drugs in the dosette are correct and that the client was reminded to take the evening medication. Then there is a gap in the documentation. But on 18/2/02 a new care plan was written and in the outcome section was an entry stating the need to increase visits to daily.

Case Notes
The case notes contained the typed referral, admission sheet and RDNS client dependency information recorded on the Bryan Domiciliary Dependency Instrument (BDDI).

On 5/4/02 it is documented in the progress notes that a diagnosis of dementia has been medically confirmed following an assessment and Aricept has been subsequently prescribed.

On 5/5/02 progress note documentation stated that the client took morning and evening tablets together and that the locum GP and team leader were notified. The locum doctor had phoned to tell the District Nurse about the effects of taking Detrusitol tablets. The care plan was changed on 6/5/02 for the District Nurse to visit daily to directly administer medications. It was noted that extra visits are scheduled.

Entry 26/5/02 in the progress notes recorded that the client had been vomiting and had diarrhoea overnight (as a side effect of Aricept?) and was awaiting consultation with the locum GP. The GPs account of the visit is not entered. The next entry in progress notes was 12/9/02 about ordering medications. On the 9/10/02 the progress notes stated that there were problems ordering Detrusitol and that it comes from New Zealand.

Medical Authority
The medical authority was clearly written and legible.

Concerns

- Nursing assessment was not attempted (including lack of continence assessment)
- Documentation systems: Confusion between care plan and progress notes, what constitutes an entry into the care plan and what goes in the progress notes. Seems to be interwoven and therefore no continuity on one page
- Safety and quality use of medicines – Coral is at risk of medication misadventure. No recent review of Coral's progress or ability to manage medicines
- Medication concordance - client often forgets to self-administer dosette medications

Claim

- Evidence of good communication between pharmacy and RDNS

Issues

- Lack of understanding by GPs about authority procedure. An undated, unsigned entry onto the authority noting communication from GP. The question: is this a new authority being completed by GP? When the researcher interviewed the client, she noted that another note from the GP was on top of the locked box with a request to change medication.
- A Home Medication Review should be instituted to address the following issues:

    - Assess the current medications to ascertain if any are causing reflux / gastrointestinal problems
    - It is noted that the client has urinary problems and is taking a drug imported from New Zealand. A continence assessment has not been completed. The drug is available only from one doctor in New Zealand. There is no drug information about Detrusitol provided for the RDNS nurse in the blue folder to allow the nurse to monitor for unwanted effects
    - Review the need for Lipitor and Caltrate considering the age of the patient and the quality use of drugs
    - Continued use of Aricept – the client has been on this drug for six months. Evidence is that it is no longer effective after six month's of use. Do you need to reference this fact? The most frequent side effects include nausea and vomiting, diarrhoea, stomach cramps and headaches, dizziness, fatigue, insomnia and loss of appetite. The client did in fact have some of these symptoms but this is not assessed by any health professional
    - Review dosage regimen to ascertain whether this can be simplified to aid concordance
- Lack of communication between health professionals: The prescribing of Aricept requires a dementia assessment to be undertaken by the prescribing medical practitioner. However, no copy of this assessment was provided to the RDNS staff

CASE STUDY FOUR

Background
Ruth is 87 years old and lives alone in a ground floor flat. She has a supportive son and receives a Community Aged Care Package (CACP). The District Nurse visits daily in the morning and carers (CACP) visit daily each evening. She also receives Meals on Wheels.

The medical diagnoses on the referral sheet were mild dementia, type 2 diabetes (recently diagnosed), rheumatoid arthritis, unstable bladder, hypertension and anxiety/depression.

She was referred by an acute hospital in October 2001 for medication management. Also included in the request are for daily blood glucose levels to be checked. The referral states that she has been trialed with a dosette and this strategy had failed.

On the day of observation, the nurse picked up the newspaper from the front lawn and then shouted through an open window. When there was no response, she knocked vigorously on the door but still Ruth took a few minutes to answer the door. She had been in bed, and was in her dressing gown. It was 10.15am. The flat was small, cluttered, but clean. Ruth complained of a painful leg. The nurse commented that the client had been having problems with her hip. The medications were kept in a locked red box in a cupboard. In response to a question asked by the researchers about her medications she answered that she did not know what she was taking. There was an acute care pharmacy booklet in the locked box.

Ruth sat at the kitchen table, reading the newspaper while the nurse prepared and checked the medications and she did not initiate pouring a glass of water. The nurse filled a glass with water and gave her the tablets. Ruth went back to reading the paper as soon as she had taken the tablets. The nurse then checked her blood glucose level. The evening tablets were placed into a dosette box and this was placed in locked box. The carers would prompt her to take the evening tablets on their evening visit.

On the dementia classification scale Ruth is in the higher end of stage 1.

Current Medications

Assantin 20mg
Avapro 150mg
Burinex 1mg mane
Celebrex 200mg mane
Methotrexate 2.5mg, 6 tablets weekly
Folic acid 5mcg mane
Gliclazide 80mg mane and nocte
Aropax 20mg mane
Panamax 2 tablets when necessary
Galantamine 8mg mane
Vitamin B12 1000mg IM injection monthly

Blue Folder
The Clients Needs Assessment book had been commenced but not completed. A diabetes assessment was completed.

There are two care plans related to medications, one for oral medications and one for injection. The lack of ongoing, comprehensive assessment means that monitoring the client's condition (diabetes, depression, memory loss) was not considered.

The progress notes contained communication from the GP, the case manager from Collaborative Action Project (CAP), and the geriatrician who changed the Aricept to Galantamine. The geriatrician requested that the nurses observe for gastric symptoms and dizziness. Entries for October 2002 state that the nurses are concerned about the client's increasing confusion and deteriorating mental state. A urinalysis was done to exclude a urinary tract infection (UTI). A telephone call to her son who had also observed the client's increasing confusion is documented. It was agreed that the son would take the client to the GP that day for a review. There is no outcome recorded of the GP's assessment. The GP and Pharmacist are identified on the care plan and instructions for ordering medications is documented.

Medication Authority
The authority is legible and dated 31/7/02.

Case Notes
The case notes contain old progress notes, authorities and medication administration record. No other information relating to management of care or history.

Tracking Medication Misadventures
One entry dated 8/8/02 stated that last evening's medications had been dispensed into a white cup and not taken. Notes proliferate about problems associated with medication administration. This time there was a note to say that one nurse found the combination lock open on arrival, but again this has not been followed through in documentation. What follows is a record of the irregularities:

12 November 2000
Concern: Arrangements for medication support are not clear. As a consequence 25 tablets were still in the dosette from Sunday. Client has a carer.
Outcome: Discussion with carer about division of responsibilities and roles.
17 December 2000
Concern: Client had an unconscious state (RDNS Call Centre and ambulance involved but client declined admission to hospital).
Outcome: Not recorded. This raised the issue of whether client's GP or others were consulted. This was an ideal opportunity for all involved to have a case management conference.
3 January 2001
Concern: Vit B12 injection not available from pharmacy until late January
23 January 2001
Concern: Methotrexate bottle found sitting on the table with lock box open.
Outcome: Son contacted. Combination locked box requested. Missing tablet found on floor (Notes missing for one year)
24 January 2002
Concern: Chasing medication from GP and pharmacist. Need to review process for obtaining medications.
Outcome: not recorded
18 February 2002
Concern: Aricept ceased. Client has diarrhoea. Drug changed to Galantine twice daily *(with food).*

Outcome: Review not recorded**.** The prescribing of Galantamine requires a mental state assessment by the prescriber. Whether this assessment was passed on to the RDNS nurse was not recorded.

19 February 2002

Concern: District Nurse chasing medications (Galantamine), GP not available, no alternative medications available

Outcome: not documented

5 March 2002

Concern: carer noticed that medications were not in dosette (assumed that the client had opened the dosette)

Outcome: place the box in another location (on the bench). This new strategy was not evaluated

21 May 2002

Concern: Medication incident no signature.

Outcome: RN followed up with son.

14 June 2002

Concern: Agency nurse had not signed for medications.

Outcome: Not documented

8 October 2002

Concern: Nurse observes that client's mental state is worse and dementia is progressing. Nurse will discuss with GP.

Outcome: Not recorded.

5 November 2002

Concern 1: locked box combination lock open.

Outcome: not recorded.

Concern 2: Large amount of sugar on breakfast. Client says she always has done this!

Action: Not recorded in nursing notes but the nursing care plan on 18.6.02 requests that nurse should ensure that client starts breakfast as RDNS leaves.

Concern 3: Client had an unconscious turn (RDNS Call Centre and ambulance involved but client declined to be admitted to hospital).

Outcome: not recorded. Again this is an opportunity to undertake a case conference between all involved health professionals.

Concern 4: The client is still taking Galantamine. How long has this client been taking acetylcholinesterase inhibitors (Aricept and Galantamine) and how many months since this was reviewed, given that her mental state appears to have deteriorated this must surely indicate that this drug is not having the desired effect?

Concerns

- Social history incomplete in case notes, and in the blue folder
- Fragmented service delivery. Need for services to communicate
- Incidents are reported but their resolution or review is not documented
- Many medication management issues are not addressed in a timely manner
- Documentation: Some interventions are noted but outcomes are not documented

Claim

- There is evidence of good communication between the family and the CACP manager

Issues

- Opportunities for multi-disciplinary case conferencing are missed. Dementia is progressing but no plans are made for future management
- Seamless Care: Discharge plans following hospitalisation would be very useful for the District Nurse especially given the admitting reason being dementia
- Ongoing Care: Clients need regular medical reviews; dementia clients are less likely to be pro-active in using health care services, and therefore a system of regular reviews by all health professionals involved with the client should be instigated as a matter of routine
- Interprofessional communication: RDNS nurses need to be in the communication loop with GPs and Pharmacists
- This client would benefit from a Home Medication Review
- Galantamine (Reminyl) works like Aricept (acetylcholinesterase inhibitors). Prior to commencing this medication, a firm medical diagnosis needs to be established, based on the results of a complete battery of tests. These drugs prevent an enzyme known as acetylcholinesterase from breaking down acetylcholine in the brain. It has been suggested that increased concentrations of acetylcholine lead to increased communication between nerve cells that may in turn temporarily improve or stabilise the symptoms of Alzheimer's disease. Research has indicated that these drugs will only temporarily improve memory or delay memory loss for up to six months. Monitoring is required (regular Mini Mental test and other observations). A diary is available for carers (see Aricept web site www.aricept.com) to note behaviours while on the drug so that a decision can be made for its continuation. Maximum six-month course before the client is reviewed
- Concordance: New strategies need to be developed in conjunction with the pharmacist and patient to alleviate difficulties with concordance
- Methotrexate - Concordance is of critical importance when using this medication. If Methotrexate is inadvertently taken each day it can cause death. Further, regular blood monitoring is required to prevent liver damage. The client or carer needs to be reminded of these issues to ensure appropriate management of RA
- Aropax - check if the client is still depressed. Note that insomnia can be a side effect of this drug

CASE STUDY FIVE

Background

Robyn was referred by her GP on 23/10/02 for medication supervision post-admission to hospital for acute bronchitis. The GP reported the following; 'family unable to continue support, encourage client to move to hostel as client is afraid of being in house alone'. A past history was documented of confusion, osteoporosis, mitral valve prolapse and left cataract removal in 2000. The reason for RDNS visiting (by an enrolled nurse) is medication support as Robyn has stage 1 dementia. It is not clear whether Robyn had been medically diagnosed with Alzheimer's disease.

On the day of observation, Robyn answered the door in her dressing gown; she was well groomed and expecting the nurses visit. The front door was key locked and Robyn commented that she is often afraid when people come to the door so she always has it locked. The blue folder and locked luggage bag containing the medications were on the kitchen chair. The key to the lock was kept in the usual place. Robyn has daily visits from the District Nurse to directly administer morning medications and evening medications are dispensed and placed in a non-labelled saucer. A conversation initiated by the nurse regarding Robyn refusing to take prescribed multivitamins occurred. Robyn stated that she had decided to no longer take her multivitamins because she felt that they were expensive and not doing anything for her. Robyn felt that she could make her own decisions related to multivitamins and appeared agitated when the nurse asked if she could discuss this with Robyn's daughter (daughter is the contact person). The nurse did not pursue this conversation and did not document in the blue folder.

Current Medications

Orichol ? BD (illegible on authority)
Aricept 10mg mane
Tritace 10 mg mane
Cartia 100mg mane
Caltrate 600mg BD
Eusten ? one tablet BD (illegible on authority)
MG complete 2 tablet BD
Noten 50 mg BD
Sitriol one BD
Revenol ? mg BD (illegible on authority)
Temazepam 10mg nocte

NB the question mark (?) indicates that the researchers were unable to accurately decipher the name of the medication.

Blue Folder

The client's needs assessment (kept in the blue folder) was commenced but not completed and the care plan for oral medication states daily visits. The GP has been named and process of collection of scripts and medication from the pharmacy is described. The care plan was not dated when it was originally written. The use of the locked luggage bag was not recorded in the care plan. Review of her notes revealed that Robyn had been found to hoard medications. On 27/09/02 Robyn forgot to take her evening medications. It is not clear from the record why a locked luggage bag has been selected or necessary. Documentation revealed that Robyn does not like to take medication while the nurse is present. The reason for this is not documented.

The nurse and Robyn's daughter utilize the communication page in front of the folder. Supplies for medication and daughter involvement with administering medication on public holidays is documented.

Medical Authority

Medication authorisation was dated 17/07/02. It was not legible. The nurse has stated on the authority that the client self-administers her own night sedation, but there is no evidence that the GP is aware of this.

Case Notes

18/01/02 Robyn documented as non-compliant with taking 'health tablets'. 24/08/02 Robyn forgot to take all medications (one has to question if this should be documented and investigated as a medication incident because RDNS are directly administering medications). Despite earlier observations, on 02/10/02 her visits are reduced to daily in the morning and afternoon medications are dosetted. Documentation to support this decision is missing from the nursing notes.

Concerns

- Client stock piling medications; problem not addressed
- Client refusing to take medications in the presence of the nurse; problem not addressed
- Nurse documented on care plan that client self-administers own Temazepam; is this appropriate considering client has memory loss?
- Client refusing to supply and take multivitamins, documented for 10 months; problem not followed through with GP and authority not reviewed
- No documentation of nursing assessment or communication with GP re client visits reducing to daily when the documentation shows that the client cannot remember to take her medication
- Referral stated client scared to be in her own home, client stated that she often feels scared and always locks the door – no evidence of communication between daughter and nurse to discuss safety issues for the client
- Are criteria needed to increase or decrease RDNS visits related to medication management for clients with a cognitive diagnosis?
- Evidence suggests that nursing care is task driven and a comprehensive approach would serve this client much better. RDNS processes especially in the area of assessment and ongoing monitoring of expected care plan outcomes are in need of review

Claim

- RDNS nurses document each time a medication is ordered via the chemist. (Is this necessary?)

Issues

- Lack of timely patient care review: No assessment of clients' cognitive status from time of referral and admission when memory loss/confusion is a diagnosis. It is an issue precisely because so many of RDNS clients receiving medication management have dementia yet there are no guidelines for practice with regard to monitoring of mental status, and requesting a medical diagnosis and follow up review

- Illegible authority - where medications are illegibly written on authority sheet, the RDNS nurse needs to be contacting the GP and requesting that it be rewritten. In this particular case there were three medication that could not be accurately deciphered and therefore should not have been administered by nursing staff
- Institute a Home Medication Review; Patient is at risk of medication misadventure
- Concordance is a major issue for the client. Strategies need to be developed in conjunction with the client to assist with this issue
- Management of Caltrate and Sitriol combination (prevent hypercalcaemia)
- Developing the RDNS role to include monitoring of patient outcomes; Monitoring of mental state when Aricept is prescribed (see previous case studies for discussion). Once the doctor has diagnosed Alzheimer’s disease (assuming that this person has been diagnosed) and prescribed Aricept it is important to carefully observe and record the person's daily activities. Once-daily Aricept has been clinically proven to treat the symptoms of mild to moderate AD. In people who respond, symptoms may get better, stay the same, or progress at a slower rate. Symptoms of Alzheimer’s disease worsens over time, thus a treatment that slows the progression of symptoms is considered as a successful treatment

Summary

What is current medication management in district nursing practice? The five case studies describe current medication practice from the perspective of the research nurse and the pharmacist. They provide evidence for the ten main constructs to be articulated in the section to follow. The case studies suggest that the nursing process (assess, plan, implement and evaluate) may not be achieving its goals however, the lack of documentation makes it difficult to assess the extent of the problem. Medical authorities are often illegible and chasing them up is the subject of much documentation. Noted also is that intersectoral communication is problematic when the District Nurse is excluded from the information loop. More importantly, the sheer number of medications taken by clients is concerning. Although we have provided only five case studies, the majority of RDNS clients who have a diagnosis of confusion/memory loss or dementia and who are receiving medication support could benefit from the Home Medication Review.

TEN CONSTRUCTS – CONCERNS, CLAIMS AND ISSUES (CCIs)

Ten constructs are derived from the multiple data sources. These are four concerns, three claims and three issues. These are given in the table below and fully fleshed out in the section to follow.

Table 3 - Ten Constructs: Concerns, Claims and Issues

Concerns*	Claims**	Issues***
1. There are gaps in many aspects of the nursing process (including documentation); 2. RDNS has excellent structures in place to guide practice, but attention to process is minimal; 3. Nurses are concerned about the number of clients requiring medication management visits in a short time frame. Nurses have not taken control of time management in their practice; 4. Narcotic control and administration in the community. There exists a paradox of meeting practice requirements and client needs;	5. Clients and their carers claim that the service provided by RDNS was both trusted and valued; 6. District Nurses claim that they meet service aims (1) that they promote independence of RDNS clients, (2) that they have appropriate skills and competencies to provide a medication management service, and (3) that they are sensitive to the needs of older people; 7. Using an approach that is underpinned by primary health care principles it is possible to provide comprehensive care for clients requiring medication management;	8. The majority of RDNS clients receiving medication management have dementia. Few of these clients receive comprehensive care based on current nursing and medical assessment and review; 9. Medical Authority for medication administration is problematic in terms of legality, legibility and receipt of timely authorities; 10. Lack of intersectoral communication is evident. The District Nurse is often left out of the information loop in the transfer of client information, coordination of services for clients and post discharge from hospital.

*** A concern construct is one that can be addressed locally (within RDNS)**
**** A claim construct is a favourable statement made by stakeholders**
***** An issue construct is a problem that requires wider collaboration for its resolution**

CONSTRUCT 1 CONCERN

There are gaps in many aspects of the nursing process (including documentation).

Background
The RDNS NPM has a comprehensive policy (Appendix 8: NPM Policy 1.CR.14) outlining the organisation's expectations for clinical documentation. This policy clearly outlines the expectation that each client record will contain a client referral, admission, consent form, client needs assessment (CNA), hazard risk assessment, nursing care plan, progress notes and a client visit record. The paperwork is divided into the blue folder and the case notes. The blue folder stores all the current information and is kept in the clients' home. Included in the blue folder is a communication sheet that can be used by family, other agencies or the GP. Progress notes are stored in the blue folder so that the nurse and GP can record any information if they do a home visit. The CNA is also stored in the home unless a client or carer requests that it be kept in the case notes. The case notes are used to store all of the past information about the client.

The care plan contains an ongoing commentary of the client's progress with the long and short-term objectives associated with the identified problem(s). It is stated in the documentation policy (Appendix 8: NPM Policy 1.CR.14) that the progress notes are to be used to record a change in the clients situation and details of a visit admission. It is expected that the progress notes be used in conjunction with the care plan or clinical pathway. The case notes therefore contain information that does not directly fit into the care plan.

The RDNS model for nursing care is one of assessment, deciding on nursing diagnoses, developing a plan of care, implementing the plan and evaluating outcomes against established objectives. This model is based on the nursing process, therefore it was deemed appropriate to discuss observational data from the 42 case studies using this framework. Data was grouped depending on where it lay within the nursing process: assessment, planning, implementation or evaluation of care.

The assessment phase of the nursing process is an essential part as it guides the rest of the steps. From the assessment of the client the nurse is able to establish priorities and put appropriate plans in place. RDNS has adopted a primary health care approach to assessment as outlined in the RDNS NPM (Appendix 9: NPM Policy 1.CR.14A – Date of Origin March 2001). A primary health care approach is encouraged through a tool called the Client Needs Assessment (CNA). It is hoped that the CNA promotes care that is based on a combination of client and carer and the health professional perceptions of need (Appendix 9: Policy 1.CR.14A). However, it is acknowledged by Policy 1.CR.14A (Appendix 9) that the assessment is driven by the skills brought to the assessment process by the nurse rather than the documentation provided to complete the process. There is an expectation that if changes are identified in the client's functional ability, environment, or circumstance an updated assessment is processed.

Following completion of the nursing assessment the District Nurse, in collaboration with the client and/or carer, establishes the relevant nursing diagnoses. As defined by Perry (2001) a nursing diagnosis refers to a clinical judgement about an actual or potential health problem. The nursing diagnosis may relate to either the carer or the client and provide the basis for the selection of nursing interventions to achieve the desired outcome.

The RDNS care plan includes a section where the District Nurse is required to state the nursing diagnosis. Many of these diagnoses have been standardised for the nurse. For example the diagnosis for the medication administration reads:

Nursing Diagnosis: Need for client to receive medications as prescribed related to …..

The nurse is then required to complete the details as to why a client needs assistance with medication administration. A client may have numerous nursing diagnoses and each of them has a care plan.

Planning refers to the stage of the nursing process where the nurse, in collaboration with the client and/or carer, develops goals and outcomes. From these goals the nursing interventions are identified. The documentation used for this process at RDNS is the nursing care plan. As stated by Policy 1.CR.14 (Appendix 8) the purpose of the nursing care plan is to provide the information necessary for a nurse to care for a client and document outcomes that have been negotiated with the client and/or carer. As the planning of care needs to be negotiated with the client and/or carer it is expected that each care plan is signed by the client and/or carer. It is also envisaged that the care plan will take into consideration the interdisciplinary nature of the client's needs and provide for referral to other services.

Nurses can either choose to use a standardised care plan or a blank one that may be customised to the client needs. Medication administration is one situation where the nurse usually uses a standardised care plan. Within the care plan nurses can set short and long term objectives and then document outcomes accordingly. It is recommended by Policy 1.CR.14 (Appendix 8) that goals are set and reviewed at determined intervals. There is also a section for ongoing documentation related to the nursing diagnosis. Any other documentation should go in the progress notes.

Implementation describes the process where the nursing actions required to achieve the goals are actually carried out. Implementation is a continuous process carried out in partnership with the client and/or carer. The nurse responds to changes in the client's condition and adjusts the care provided depending on how the client is responding to the nursing interventions.

Effective implementation requires nurses to think critically, reflect on their practice, communicate and develop rapport with clients and take a comprehensive approach to care. Perry (2001) suggests that the implementation process requires thorough preparation to ensure safe, efficient, and effective nursing care. They contend it is important that nurses reassess the client, review and revise existing care plans, organise resources and care delivery, anticipate and prevent complications and implement nursing interventions. During the implementation phase communication, both written and verbal, is of utmost importance. Communicating concerns and working with other health providers in a timely manner is essential to ensure the trust of the client and quality care. Accurate and concise documentation is an effective communication tool and may safeguard the nurse in the case of an incident requiring legal investigations.

Evaluation refers to the process where the nurse determines the extent to which the set outcomes/objectives have been achieved. The Nursing Care Plan is the tool in which the nurse documents this process. If the evaluation identifies that objectives are not being met to the satisfaction of the nurse then the care provided should be adjusted to reflect this.

Concern
This study gave particular consideration to the importance of a thorough and comprehensive assessment and while there are wide variations in practice, important elements of the assessment process were deficient. Only a small percentage (approximately 5%) of the 133 clients observed had a completed CNA booklet in their blue folder. All clients had compulsory data entered (information that generates the call sheet) and an old BDDI in their case notes. Comprehensive assessment information was frequently lacking. Information gaps were also evident in documentation outlining planning, implementation and evaluation.

Is medication management just about administering medication? A majority of the clients who are receiving assistance with medication management have dementia and/or have complex social and medical conditions. To achieve a high standard of nursing care it is imperative that District Nurses systematically follow the nursing process to ensure an ongoing cycle of assessment, planning, implementation and evaluation. It is also important that nurses involve the clients and the carers in the process thus encouraging a comprehensive approach to care. Observational data revealed major gaps in aspects of the nursing process including a less than ideal level of documentation. The lack of documentation made it very difficult to ascertain what was happening to clients who are receiving assistance with medication.

Current Practice : Observational data

Assessment
We undertook 42 case studies, five of which are presented in detail (pages 15 to 29) to the reader so that the larger picture can give a better understanding of the CCIs unpacked by this project. The case studies (n=42) and observational data (n=133) identified that a large proportion of the CNAs (approximately 95%) were incomplete. The CNA was introduced in 2001 however many of the long-term clients receiving medication support were admitted before the introduction of this tool. This may, in part, explain the low numbers of completed CNAs. The low non-completion rate may also be attributed to the fact that a majority of the clients seen had significant cognitive impairment. Even so, it is expected that nurses carry out the assessment through the use of carers and through the involvement of other stakeholders. It could also be argued that even though the CNA was introduced after the admission of many clients, it presented a good opportunity for nurses to undertake a review assessment with the client.

The observational data of case studies (n=42) highlighted gaps in assessment of clients in respect to their medications, co-mobidity such as diabetes, community supports, medical history and carers. With a significant number of clients being seen by RDNS having dementia, the need for information about community supports, social history and carers is essential. It is important for nurses to be informed about other aspects of the client's care such as what medications are being taken and how they are managing with them. Having an understanding of the full medical history is also of utmost importance because it is only through a thorough assessment at admission that this type of information can be accurately determined and then built on throughout the planning, implementation and evaluation phases.

In addition to the CNA, there are also separate assessments for clients with other conditions such as diabetes, incontinence, leg ulcer or palliative care. There was evidence that other assessments were not being completed, in particular the diabetes assessment. It is expected that a client with diabetes is assessed and that this is documented. In consultation with the client and/or carer the care plan can then be formulated. Assessments of the client often did not encompass other health issues other than the reason for referral. Social history and support services were also lacking within the clinical documentation.

Nursing Diagnosis and Planning
As previously discussed the nursing care plan represents the planning of the clients care and evaluation of the clients care. The concerns raised by the observational data were varied but the underlying issue often related back to a lack of documentation. It is assumed that if no care plan exists for a recognised problem then care for that problem has not actually been planned, implemented and evaluated. Whilst there was always a care plan for medication management there may not have been a care plan for other conditions such as dementia, wound or diabetes. Within the observational data there were six (14%) examples of care plans not being written for other existing problems.

The actual standardised care plan for medication administration was often difficult to follow due to the amount of information it contained and the crossing out of old information. The care plan did not always reflect the care provided (four examples of this are provided in the case studies). Other concerns related to lack of information documented on the care plan such as the name of the person ordering medications, contact numbers and specialised information about a medication.

The setting of short term and long term objectives shapes the care that will be provided. Within the RDNS standardised care plan, the short and long term objectives have largely been preset. It is suggested that this diminishes the comprehensive approach of the client and the ability for the nurse to individualise care. One example of this can be seen with the care plan used for medication administration. The short term objective encompasses frequency of visit, mode of administration, correct authority, obtaining stock and the monitoring compliance. The long term objective states that the client will receive medication as prescribed. Does this narrow focus of standardised care planning encourage task oriented nursing? Is the long term objective simply to administer medications?

The other important point to make about the care plans is that there appeared to be confusion as to what information should be documented in the care plan and what should go in the progress notes. This confusion made it difficult for the researcher to accurately follow the clients care. Clarification of documentation is required.

Implementation
The implementation phase of the nursing process revolves around placing the nursing/client care plan into action. Assessment of the client during this phase should be ongoing and the care plan revised as required. It is during the implementation phase that the limitations of the care plan may be identified. Lack of information on the care plan means that care may not be provided as initially recommended. Similarly, if a care plan is not written at all then other nurses who are not aware of a secondary problem may not initiate the appropriate care. What this demonstrates is the importance of the initial assessment and planning as an imperative foundation of the implementation phase.

Due to the enormous amount of data generated in observation of practice this section has been subdivided under the following headings:

- Client Education
- Reassessing the Client
- Reviewing Care

Client Education

The District Nurse is in an excellent position to provide comprehensive and context-relevant education to both the client and the carer. It is also important to assess and communicate the effectiveness of that education through appropriate documentation.

The observational data and documentation review suggests that there may be many more opportunities in which District Nurses can provide education during their visits. Examples from the data included lack of education in areas such as inhaler technique, glucagon administration, care of central venous line and the importance of medication supplies being available. The lack of documentation also suggests that education is not being provided as frequently as is desirable. However, it is also possible that education is being provided but not documented.

Reassessing the Client

Assessment is an ongoing process that should occur each time the nurse interacts with the client. Observation data cited numerous examples of incidences where an assessment of the client was probably warranted but was not undertaken at the time of observation. Some examples were:

- Client has obviously been unwell over a number of days, no documented check of general heath status such as vital signs, abdominal assessment, pain scale
- Oversight of a basic nursing assessment being performed to ascertain the clients general ‘well being’ when a client who has impaired cognition (in this case stage 2 dementia) state that they are feeling unwell (or in similar terms)
- No new assessment made when a clients behaviour is inappropriate and bizarre i.e. a mental health assessment
- On two occasions the nurse did not query the client’s health status when the client stated that she was ‘poor today due to the heat’ and ‘didn’t feel energetic today’. Was her pacemaker failing? Does she have bradycardia. Were there cardiac symptoms?

There may have been reasons as to why nurses did not take further action in the above situations but those reasons were not clearly communicated either written or verbally. Many of the concerns from the observational data related to the lack of basic nursing assessments such as safety, skin integument, blood pressure, and psychosocial issues. Other concerns raised related to the ability of nurses to question medical care, such as, why clients were prescribed certain medications.

Reviewing Care

After the nurse has assessed a situation the care is then reviewed. Within the observational data there were numerous examples where care was not reviewed despite obvious problems in how care was being delivered. One significant concern relates to clients not remembering to take evening medications that have been dosetted by the nurse. The medications are left in a receptacle for the client to take later in the day and many clients seemed to struggle with this system.

It is concerning that whilst nurses are documenting that these medications are not being taken there was little case note evidence to show what action had been taken. Out of the 42 clients observed 12 clients (29%) had frequent entries documented by the nurse that evening medications were not being taken. This means that approximately one in four clients may not be receiving their prescribed medications. There is little documented evidence that nurses are

questioning the effect that this may be having on their clients outcome and/or discussing this with the GP. There may be other options that the GP can explore. It may provide the perfect opportunity to involve the community pharmacist and a request for a Home Medication Review.

Another time that a review of care may be warranted is when a current client has been discharged from hospital. Observational data (n=42) demonstrated that this was not routinely occurring. Examples were:

- No documentation in blue folder alluding to recent hospital admission. Was admission related to oral medication self-administration?
- Limited documentation of previous admission to Accident and Emergency (A&E) and follow up
- Need for documentation of recent hospital admissions related to care provision
- Discharge letter post-hospital admission states problems with hypertension, IHD and kidney disease and medications changed, but no evidence in case notes or blue folder that this information has been acted upon
- No evidence of hospital admission in early August. Entry in progress notes dated 7/8/02 states returned home from hospital yesterday. No notification of hospital admission to Liaison Nurse

Timely review of care may also assist to keep clients out of hospital and/or prevent further complications.

Evaluation

Evidence of evaluation can be seen through the written documentation that pertains to the achievement of short and long-term objectives. Observational data identified that quality documentation relating to objectives and outcomes were lacking. Long term conditions such as asthma and diabetes can be evaluated through discussion of symptoms and measurements such as blood glucose levels but this was not routinely done. Incidents were documented such as a client gaining access to a locked box but follow up and resolution of the situation were lacking. Case study four highlighted the possible ramifications of minimal review and evaluation of care.

The quality of the evaluation process is largely dependent on how the objectives are established. If the objectives are limited in their scope then the evaluation will also be narrow. Similarly, if the objectives are unachievable the evaluation will not be meaningful. The above examples demonstrate the importance of planning care and documenting outcomes. Without documentation the nursing care remains invisible. In situations where a client has been unable to manage a dosette and thus requires direct administration it is the evaluation which justifies the need for a change in the visit schedule.

Nurse Interview Data

As previously discussed the CNA is frequently not being completed by nursing staff. The reason for this is largely unclear but the comment below from one nurse clearly describes the perceived limitations:

> *This is regarding the expanding amount of paperwork and therefore, the time taken to do an admission, where we now have to do this extensive BDDI booklet, which isn't really used by anybody. Tick boxes don't really mean anything. When you go into a*

house, you don't quickly skim through 13 pages of tick boxes to find out what the problems are. It's just really not a useable tool. It does collect great statistics for who's up to what, which state of dependency when we admit them, but time constraints wise, it's really not a useful tool and as a result, the admission time is expanded, so you don't really get into useful collecting of information as regards what the client can benefit from. We're basically collecting stats for our interest and/or for government agencies, but we're not really finding out what the client needs, I feel. In theory, it's supposed to do that but I don't think it does any good.

It is interesting to note that this nurse suggests that the CNA is not used in practice. This comment certainly supports the findings from observational data. The compulsory statistics seem to be completed by the nurses as these provide a link with funding bodies. If nurses are not using the tool provided, the question is raised about the way in which they are carrying out the assessment? How are they spending the time allocated for admission of a client? Is the paperwork so cumbersome that nurses are running out of time? Do nurses view the tick box system as too restrictive? Do District Nurses want the flexibility to be creative when they carry out an assessment of a client? The answers to these questions may require further consultation.

Thorough planning of care in collaboration with the client and/or carer can save time and frustration during the implementation phase. There were a number of comments made by the nurses about the lack of information available to them in the care plan and how this affected the way they could care for clients. Nurses commented on the need for clear information about obtaining stock, information about drugs, pharmacy details and community supports. Nurses stated that information was often incomplete and this is particularly problematic for relieving staff.

The importance of assessment is recognised by nursing staff as described below:

Again, it's around the areas of staff's ability to conduct basic mental state assessment and to use that finding to either negotiate for alteration in medication administration styles, dosettes or direct administration or depo injection or whatever, or to lobby with service providers for changes in doses or types of medications.

The above comment is an excellent example of what District Nurses are able to do in their role. The clinical pathway for clients living with dementia may assist nurses in the decision making process.

Concerns about documentation were raised by a number of nurses that we interviewed. Most of the comments made by nurses revolved around the tools for documentation. Nurses are concerned that the volume of documentation may take them away from client care:

Well I think the major constraint is to have enough staff to be able to see all of these clients, but under the limitations that we have, one of the things we need to be careful of is that we don't have so much documentation that it ends up that we do spend more time than caring for the client. I believe that we do need adequate and clear documentation but there are times when we want to be so perfect with what we do, that we have so many audits and so many other things that we've got to put in place, that the focus comes off the client and onto whether all that's in place, whereas that should be more used as a record and as a prompt. The emphasis should be upon the client and upon their care.

Other nurses felt that the design of the medication forms should be reviewed and that there was confusion as to when to document in the case notes rather than the care plans.

A Comprehensive Approach to Care

The literature surrounding the use of the nursing process questions whether it is the best way in which to achieve a comprehensive care approach. It is for this reason that the nurses' concerns and comments about comprehensive care have been included here. The researchers observing practice found that there were different approaches taken when nursing clients in a community setting. This observation is not surprising but it is of concern if some nurses use solely a task-orientated approach to client care.

Some of the nurses interviewed were able to recognise the limitations of the service being delivered. Time restrictions were a significant factor according to the District Nurses:

> *I feel we've really become very task oriented, in that we just go in, do the pills and get out. We've got a huge list, we haven't really got time to find out how people are managing. Often if you spend that little bit of time or you're that little bit more observant, you actually notice other things that often get missed. But if you race in and race out, you're not really being there for the person.*

One has to assume that nurses do not really want to work in this way. These comments confirm that some nurses would like medication practice to be more inclusive of the client. Unfortunately it seems that nurses believe that they do not have enough control over the timing in their practice (see construct 3).

The comments support observational data that clearly demonstrates that in many instances a comprehensive approach to care is not occurring. What does RDNS need to do to influence the way in which nurses approach medication management? In discussing this situation with CNCs it seems that nurses can have the control to change their appointments and allocations of time for their rounds, but few if any request changes.

Discussion

The nursing process provided a framework to shape these data and the discussion likewise will be guided by this process. Ironically whilst we talk about the nursing process, the way in which it is used in practice resembles only the structure whereas the actual process (assess, plan, implement and evaluate) appears to be frequently missing in both the delivery of care and its documentation.

The low number of recent CNAs that were observed to have been completed is concerning. As the project was concerned with medication administration, the nurse interviews shed little light as to what the barriers might be. It will be quite a challenge to assist nurses to view the CNA form as a useful guide for the entire nursing process rather than viewing it just as more paperwork. It is anticipated that the implementation of the Client Information Management System (CIMS) throughout RDNS will greatly reduce the amount of paperwork that the nurse must do at admission. The program will also provide a much more comprehensive call sheet, which will be pre-prepared by administrative staff prior to the District Nurse visit.

Data indicated a standardised approach to diagnosis and planning care. The involvement of the client and/or carer in the planning of care was not observable. Care plans were difficult to read and often lacked the detail required to carry out the care required. The short and long term objectives were task-oriented partly due to the design of the care plans. A community care pathway for clients with confusion/memory loss is soon to be introduced and it is hoped

that this may improve the level of assessment and the referral patterns for these clients. Again a task-orientated approach to care often meant that other care plans were not included such as diabetes, wound, asthma or support.

Data demonstrated that the system of using standardised care plans for medication management may require review. Terminology, such as 'compliance', could be replaced with alternative terms including adherence, cooperation, mutuality and therapeutic alliance, however the meaning attached to these words refers implicitly to the authority of nurse over clients. Hence, clients are denied the right to participate in decision-making regarding their care. These terms have been rejected because of its paternalism and its implication that nurses have the right to authority over the patient's behaviours and actions. These terms do not help our understanding of how changes in patient behaviour can be facilitated. The same patient behaviour may be the result of very different processes. People may comply with treatment regimens to a different degree in different situations and over the course of long-term treatment. Also, they may comply with one set of treatment recommendations but refuse to do so with another. Compliance needs to be evaluated within the context of the life of each client. Personal reasons for non-compliance may be understandable (such as a fear of side-effects) once they are brought to the surface and acknowledged. Some clients may believe they comply with treatment regimens but actually fail to do so because they have not been given adequate instructions. We contend that the context of ‘non-compliance’ should not be reduced to and adequately reflected in the labelling of the individual as being either compliant or non-compliant.

Narrow long-term objectives that only address the issue of receiving medications as prescribed could be replaced with objectives more specific to the condition for which the client is receiving medications. For example if a client has dementia the long-term objective may be related to management of dementia. Ways in which medication will be monitored could also be outlined in the care plan. Is it enough to just assume a client’s ‘compliance’ because the medications are not in the container the next day?

The data around implementing the care plan clearly demonstrated that ongoing assessment and review of care was frequently lacking. Providing education, reviewing techniques and assessing the client post-discharge from hospital or when the client states they feel unwell are all-important skills. It is through this ongoing assessment and review of care that problems can be prevented. Being aware of other factors beside the administration of medications is part of that comprehensive approach to care. It was also difficult to assess how much of the care was provided but not actually documented. Again observational data suggest that evaluation of care is narrowly focused around compliance, obtaining medication authorities and supply.

Does the Nursing Process Encourage a Holistic (comprehensive) Approach to Nursing?

The nursing process has been used in Australia since the 1970s but since its introduction there has been much discussion as to whether it is the best approach for delivering holistic care (Oreo 1994). It was hoped that the nursing process would result in improved communication among nurses, the provision of quality care, and a system for evaluating this care. Some nursing scholars believe that the nursing process actually confines nursing practice and ignores the intuitive approach to care. Another criticism is although the nursing process aims to be holistic, the design of it actually splits the person into pieces in the name of holism (Oreo 1994).

A comprehensive or holistic approach to nursing implies respect for persons, openness, reflection and seeing comprehensively. Holism in medical and nursing contexts rejects the

domination of science and technology and the impersonal treatment of patients by health care professionals (Griffin 1993). The nursing process has been based on the biomedical view of health yet holism rejects this concept of medical dominance. It is therefore not surprising that it can be difficult to view the nursing process as a primary health care approach and be comprehensive in its aims.

If comprehensive or holistic processes are to be integrated into practice, organisational support and direction is vital. In line with the organisation's mission and strategic direction, its primary health care philosophy needs to be translated not only into the structures but also clear processes. Nurses working in the community need to have an understanding of primary health care principles and a sense of ownership of the same. Whilst we may reject the nursing process as the most suitable structure to guide district nursing practice there are currently few alternative models for community nursing. Further research is required to articulate a process that is guided by primary health care principles and more importantly, one that is specific to district nursing practice.

Despite the limitations of the nursing process, it will have to suffice as a structural framework for district nursing. It is important that the concepts of comprehensive assessment of client and carer, early intervention, client advocacy and 'holism' are part of the process. Probably the most important point to include here is the need for the clients to be active participants in their care and that nurses strive for collaborative partnerships with clients, carers and the community at large.

Summary

District Nurses are increasingly expected to work at the boundaries of health and social care with an increase each year in the numbers of frail older people visited. However with the faster transfer rate of patients from acute care to the community, there is a growing emphasis on technical as opposed to personal aspects of nursing. Technical care and task-orientation to care is the outcome of these changes in service delivery. Based on observation and interview, the personal side of nursing is in danger of being overlooked and devalued. Indeed, data indicate a task-orientated approach to medication management. Of course it must be acknowledged that not all nurses are task-driven and not all nurses are task-focused all of the time. However the nursing notes should provide a comprehensive picture of the client's situation and medication management. Clinical documentation can provide a timeline of the care provided as long as events are accurately recorded. Unfortunately, the clinical documentation reviewed for the project was sparse and difficult to follow. Nursing progress notes focused predominantly on the history of the difficulties in obtaining the medical authority or the medications. Data from nurse interviews also depict stories of task orientation with the main reasons being cited by nurses as lack of time.

RECOMMENDATIONS

1. It is recommended that all clients be given a comprehensive nursing assessment that is guided by the RDNS CNA tool. Lines of responsibility for the initial comprehensive nursing assessment need to be clearly articulated so that ownership of the assessment process occurs.

2. Implement a systems approach (within the CIMS) to flag the need for clients to have an assessment or review e.g. new admission, post-hospital admission, thus ensuring continuity of assessment, review and evaluation.

3. Implement a monitoring and feedback system to ensure that clients are comprehensively assessed and care is evaluated.

4. Nursing Practice Committee reviews its practice policies for congruence with the nursing documentation requirements.

5. Nursing Practice Committee reviews and streamlines nursing documentation in conjunction with the implementation and evaluation of the CIMS.

6. Further research is needed to identify a model of care that is specific to the practice needs of District Nurses.

CONSTRUCT 2 CONCERN

RDNS has excellent structures in place to guide practice, but attention to process is minimal.

Background

For the purpose of this study, structure is defined as the policies, standards and clinical pathways that guide nursing practice. It refers to advisory committees convened for instituting quality control in both professional preparation and in practice. It also refers to the certification of health care practitioners and the laws that require practitioners to be graduates of specified education programs. Continuing education is viewed as a means of controlling quality. One other way of describing structure is the formal and visible foundations of the organisation, usually accompanied by documents as evidence of their existence. In this study we have been guided by RDNS structures to question medication practice.

Process refers to the series of events and actions that produce change or development, which includes the continuous monitoring of structural elements. Process relies on involvement with stakeholders who can provide short loop feedback on the progress of structural elements, for example, that policies are implemented, monitored and evaluated. Progressively since the year 2000, clinical pathways for constipation, bereavement, leg ulcer management and terminal phase palliative care have been implemented. The year 2002 has been designated as Year of Clinical Focus for RDNS and as part of this the evaluation of the uptake and impact of the clinical pathways is being developed. Clinical audits have been conducted for a number of projects such as the Carer Assessment Project (1998), Client Needs Assessment Project (2002) and outcomes from the Graduate student audits (2000-2002). RDNS is also involved in a process for external reviews such as Department of Veterans Affairs (2000) and the Australian Council of Health Care Standards (yearly). Data quality reports are conducted monthly and sent to staff to address issues for improvement. Quarterly trend reports are also being implemented as a way for RDNS to make improvements. Clinical outcomes with national benchmarks are reported monthly and actions discussed and attended to through divisional management.

Nurses are also guided by the standards set by the Nurses Board of South Australia in addition to the policies set out by the organisation.

It is important that as an organisation RDNS provides not only a sound structure for nurses to work within but also articulates clear processes that sustain the structures.

Concern

RDNS has excellent structures in place to guide practice, but attention to process is minimal. During the nurse interviews many concerns related to the structures and processes at RDNS were raised. Interestingly some of these concerns have actually been interpreted as misconceptions due to the fact that RDNS has already addressed these issues and put structures and processes in place. Examples include medication incident reporting, continuity of care, reporting lines and appropriate guidelines for the use of the locked medication box in the home. The fact that not all nurses fully understand the mechanisms in place warrants further discussion and is central to this construct. The observational data revealed some concerns as to the legalities of some of the nursing practices at RDNS. The construct has been divided into four main headings as based on interview and observational data:

- Role of the Enrolled Nurse in medication management
- Client safety
- Organisational structures and processes
- Legal issues

Current practice : Observational Data

Role of the Enrolled Nurse in Medication Management
The interview data suggests that the role of the EN in medication management was a concern for both RNs and ENs. The ENs raised concerns about the limitations of their role and the impact that these restrictions can have on them doing their job. The RDNS Procedure Manual contains two policies that clearly outline the scope of the EN role in relation to medication management. The clinical restrictions of the EN in medication management as per Policy 2.CP.43 (Appendix 12) and 2.CP.16 (Appendix 11) are:

- First dose medication is not to be delegated to an EN.
- The EN may not administer any drug intravenously.
- An EN may only administer a medication following assessment of both the client and the drug by a RN.
- An EN may not withhold any drug or administer "as needed" (PRN) medication without consulting an RN.
- The EN should have a working knowledge of the medication administered.

Despite the above policies, the actual scope of the EN role appears to be interpreted differently within the organisation. One nurse provided an example:

> *... the majority of RNs within the organisation, do not understand the role of the enrolled nurse. They do not understand that you've got to use your common sense with the enrolled nurses, but the rules and the policy says that an EN cannot…. But also, the only other things that they can't do, is epidurals, intrathecal and IV and a lot of the nurses within the organisation think that that includes, they can't give, they can't draw up morphine - they can't give the first dose of it, that's right. But they won't let ENs do anything by themselves for the palliative care, even if there's no drugs involved.*

Interpretation of the policy for ENs appears to be somewhat subjective as the examples below suggest:

> *So we use our ENs on evening service and we stretch the rules to the limit, I won't get her to go and set up a syringe driver for a first time but I will get her to do drug counts and check them with me. I will get her to go and see the client we've seen for the last five years, who's on 5mg of morphine break 3 hourly, I will get her to go and draw up that medication and check with me over the phone and check with the carer. But as far as narcotics are concerned, it's not policy, and so it concerns me that ENs are not being utilised to their full potential, because I do think they have a lot of potential.*

This RN has confidence in the EN's ability to play a larger role in medication management than what the policy suggests. If RNs are not consistent with the boundaries for EN practice then it can be very confusing for the ENs. It is important that there is consensus across the organisation so that ENs are not practicing outside their scope. Perhaps as this nurse suggests

it is time to review what that scope should be. It is time to accept feedback from nurses and articulate clear processes. Current information on the role of the EN is being organised in each division.

Client Safety
Many clients visited for medication management have dementia. A diagnosis of dementia places them at considerable risk of a medication related incident. One of the major areas of concern for the nurses interviewed was that of safety for their clients and the legitimacy of their practice. As District Nurses it is important to respect the wishes of the client even if it means that there is a lack of control over some situations. The important point is that clients are provided the information required for them to make an informed choice. As explained below the choice may not always be how nurses want it to be:

> *The other concern is what clients will allow us to do with their medications or within their homes, and whether it is safe or unsafe. What we see as unsafe, they see as perfectly safe.*

Some nurses were concerned about the safety of the locked box. The use of locked boxes was established to protect clients who were at risk when self-medicating (Appendix 12: Policy 2.CP.43). From observational data it was noted that there were situations where clients had accessed the locked box. The combination and/or location of the key to the box should be recorded on the call sheet. The key is supposed to be kept in the grey folder that the nurses carry with them (the recommended location of the key is not noted in the policy). However, observational data suggests that current practice is for the code and the key to be kept in the blue folder at the client's home. This practice could be compromising client safety due to the fact that clients may gain access to the locked box. Safety can also be threatened when medications are left out (dosetted) for the evening and clients forget to take them as prescribed. One nurse's concern was:

> *… the fact that we can only go in at certain times and because many clients are living on their own in the community, we don't often know what's happening in between visits. Once a client has dementia, we use locked boxes. But there's still the possibility that clients can access these. Even with dosetting (eg the evening dose of medication). There is the problem that we don't really know what clients are doing with medications when we're not there.*

It was evident that nurses do not have complete confidence with the locked box process. Nurses are unable to observe clients 24 hours a day but through appropriate structures and processes clients' safety may be enhanced. This study revealed that 60% of clients had their medications locked away in some way, however of concern was that not all medications were stored in a locked box. For example, one couple had their medications locked together in a toiletry bag. The researchers were led to question, is this best practice? If these clients require their medications to be locked would it not be safer to store them in a locked box? Would nurses feel less concerned if they felt confident that clients could not access their medications?

One other concern raised by the observational data related to a couple who were obtaining drugs of dependence and anti depressants from the chemist and then waiting for the nurse to arrive before they were locked away. The same couple had Diazepam and Nitrazepam stored at their bedside. The question arises as to how nurses assess the safety of medications that are left out for the clients to access. Could a Pharmacist be involved to deliver these medications and lock them away? Again nurses are forced to challenge the process of their practice.

It is common practice for RDNS clients that are visited in the morning to have their evening medications left in a saucer or cup for them to self-administer later. Leaving medications out for clients to take later is fraught with risks when the client has dementia.

> *I do have issues with putting medications into labelled saucers, I really do. I don't feel that's good practice. I would rather have extra nurses on to do that. I don't feel happy leaving medications out. I've got a client at the moment who rarely takes that evening medication. I have found a saucer in another area of the house that had about 15 Coloxyl tablets belonging to her husband. It's just messy. I really think we need to tighten it up and just be a little bit more diligent.*

The example below illustrates another situation where the nurse feels concerned about the safety of the client:

> *…probably that we're not doing enough for the clients. When you're seeing the clients, it's only a small part in their day and the rest of the 24 hours is left basically uncovered. We've found clients have pills that they've taken independent of what you have on the authority and we've got no way of monitoring. We cannot interfere because then it's abuse of their lifestyle and an insult that that they can't make those decisions for themselves.*

Nurses taking the appropriate action such as contacting the GP and suggesting a referral for a HMR (Appendices 6 & 7) can be the change agents to the improved safety of the client. The client can then discuss their needs with a pharmacist.

Once again the lack of control causes concerns for nurses:

> *A particular client has many different types of medications but we are not directly administering these. They are her property and she will not allow us to return those medications to the hospital or the pharmacy... I don't know what medications she's taking throughout the day, some could be detrimental to her health. That's something that I have no control over.*

Currently, there are few processes to guide responses to these queries. These issues may need to be raised through the Nursing Practice Committee.

Organisational Structures and Processes

Nurses perceive that some of the structures could be improved. Clients with dementia benefit from some routine and familiarity as described below:

> *The other thing I have a problem with is continuity of staff. Often with demented clients, they develop a relationship eventually of trust, even if they can never remember your name, or what you've really come for, they recognise your face and that you're someone kind that's come to help them and it often throws them a bit if there's lots of different staff members coming in. With the rosters as they are sometimes, it's not ideal.*

Continuity of visiting nurses is always going to be difficult to achieve in a large organisation that offers 24 hour care and has a wide range of skill mix. Whilst continuity of nurse may be the ultimate quality aim, RDNS is satisfied that a continuity of care focus is realized.

Concerns were also raised about the processes for reporting medication incidents and whether all incidences were in fact reported. RDNS does have a comprehensive incident reporting system in place that promotes a 360 degree feedback mechanism. When an incident occurs the nurse is required to fill out the appropriate paperwork and discuss it with their CNC or team leader. In collaboration with the staff member individual strategies to address the incident are instigated as required. The Quality Manager compiles trends on the numbers and types of incidences occurring and these are reported broadly to the Client Care Committee, Nursing Executive and Divisional Management. A quarterly report is also sent to the Divisional Management and this addresses the impact of activity and staffing factors on client outcomes. Specific actions required are discussed at the Divisional Management and fed back to that group once the action has been implemented. One nurse made the point that incident reporting is 'not a punitive thing, it's a learning thing'. However, this same nurse did have concerns that nurses were not fully aware of the processes for medication incident reporting.

Within the organisation there are structures in place to deal with issues such as difficulties with clients or other health professionals. When nurses are not aware of the structures and do not know how to proceed this can cause concern:

> *It's very difficult when we have these problems because there are no avenues that you can bring problems to anyone's attention at the moment. No one knows we are having these problems. That they can be ongoing problems with you know, with one doctor or several doctors but it's making it very difficult for us. There's no avenues to follow it through, you know..... Yeah, there's no reporting mechanism for that sort of issue.*

There are structures in place within RDNS but these are not well understood. Team leader meetings can be a venue for discussion of concerns, as can Divisional Meetings, however these are not utilised.

The rules of the organisation appear to place pressure on nurses to discharge clients and the comment below clearly articulates this:

> *Basically, we admit and discharge too rapidly.... To expect people to change their lifestyle in two weeks, it's pathetic. It's not on really and yet we try to have a turnover and have the numbers of clients and the pressures of people coming on, we care better for dying people than we do for living people.*

This nurse views organisational constraints as an obstruction to the delivery of quality care. We need to question what this nurses can do within the practice setting to change these situations.

Legalities of Practice

Observational data demonstrated some legal concerns around district nursing practice:

- Phone orders from nurses that are not signed
- Do RDNS require a progress note entry at admission related to the medication administered?
- Nurses involvement in illegal practices of making changes to client medication authorisations
- Six nebules dosetted four times a day (QID) nebs prescribed but there was no documentation of how many actually used or symptoms

- Enrolled nurse administering PRN medication
- Changes made to care plan without signatures or dates
- A client signed a care plan but there was no assessment documented of cognitive abilities even though they had an intellectual disability

The concerns arising from the observational data are varied and many of them relate to documentation practices. It is important to nurses that doctors sign phone orders and write a new authority when changes are made. Nurses need to also be diligent about signing and dating when information has been crossed off of a care plan. Enrolled Nurses who are administering PRN medications without consulting the RN are also placing themselves at risk of legal consequences should a mistake occur.

Discussion

Data suggest that there may be some misconceptions held by the nurses that were interviewed. These misconceptions could be addressed through improving communication across the organisation. Other misconceptions have arisen throughout the report and a list of these will be compiled and addressed within RDNS. Other issues were raised within this construct that indicate the need to improve the processes so that structures are sustainable in the long term.

Data suggest that even with policies that outline the role of the EN there appears to be some variances in how nurses are interpreting the role. Nurses feel concerned about the safety of their client given that they only visit for ten minutes once daily in the space of 24 hours. Although this concern is being verbalised there is little evidence that suggests that nurses are carrying out adequate assessments of the client and the care they are receiving (refer also to construct 1). The use of locked boxes to improve safety is being compromised by the easy access that clients have to codes and keys. The practice of dosetting evening medications does not appear to be monitored closely enough to promote safety of the client. From observational data some concerns were raised as to the legalities of some practices. Nurses need to be diligent with their documentation and the following through of medical orders. Phone orders need to be signed and ENs need to be careful that they do not practice outside their scope.

RECOMMENDATIONS

1. For RDNS to facilitate a structure and process that includes medication management and/or dementia as a nursing practice core competency.

2. The Nursing Practice Committee acts as a conduit for discussion of nursing practice issues that have been raised in the field. The communication pathway for identified practice issues needs to be clearly articulated and incorporate a 360-degree feedback loop.

3. There is a responsibility to rectify misconceptions about medication management that have been identified in the report. A list of common misconceptions has been supplied for communicating within RDNS.

CONSTRUCT 3 CONCERN

Nurses are concerned about the number of clients requiring medication management in a short time frame. Nurses have not taken control of time management in their practice

Background
The RDNS NPM only contains one policy pertaining to the scheduling of visits (Appendix 14: RDNS NPM Policy 3.CM.16). The policy outlines the role of the nurse in negotiating a mutually acceptable time for the client and the nurse. Visits for medication management are usually scheduled for a ten-minute duration. Nurses are expected to use their professional judgement to decide what length of visit they require.

The nurses call sheets outline which clients are priorities for that round. Clients are a priority if their medications need to be given more than once or a day; or before a meal; or if the client was likely to wander later in the day.

Concern
Time is the actual amount of time taken to undertake ‘a task’ and time management refers to principles underpinning practice that can, in the main, be controlled by the District Nurse. Nurses were concerned about the number of clients requiring medication management within a short time frame. Nurses do not appear to have taken control of time management in their daily practice.

Current Practice
From the rounds observed during the project, it was found that District Nurses could see up to 14 clients in a morning for medication management. Nurses are claiming that there are too many clients to see in such a short time frame.

> *A lot of the time we go in with our medication people, but they have so many other issues, but we're only going in for the channelled effect of giving a tablet. We don't have time to delve into a lot of problems, there are social issues, a lot of dependence. Sometimes you just don't have the time to look at the whole picture…*

The concept of comprehensive nursing care and the philosophy of primary health care has been discussed previously in this report. Comprehensive nursing practice does not need to be time consuming. Even in a ten minute time slot a nurse can pick up many cues that indicate how a client is managing. Cues such as the client’s hygiene, how they are mobilising or does the strong smell of urine suggest an infection are a few examples. While it is important to spend time with clients, much can be gained through observation. So the question is posed; Is it that nurses don’t have the time or is it more about how nurses choose to use their time? This construct endeavours to explore these questions and put forward recommendations.

One of the stronger themes within this construct was that nurses felt that their practice was constrained by geography. The passage below aptly describes this concern:

> *The geography of the people, you know the people who require the care, live all over Adelaide...So the physical task of getting a body there all the time constrains medication practice. We can't see as many people as possible and perhaps we, you know, the big push on at the moment is you know, trying to get relatives etc to go there. That puts more pressure on the relatives or the carers or whatever. Just simply because you can't necessarily get to the volume of people that might benefit from some assistance.*

Rounds will vary in terms of travel times and for some rounds the issue of geography may need to be addressed. Again the comment below describes the problems with travelling times:

> *The traffic, it will take me 45 minutes to an hour and an example is if you get held up travelling, you might be half an hour late for someone with insulin and they might be hypo. I've had incidents where I've gone out to people and maybe there were two and because they're waiting, they won't eat until I've done their blood/glucose level and I guess that can be overcome by education, but there are issues there with travelling and not having adequate backup of a family member that knows what they're doing and these people are living alone.*

This example demonstrates the importance of working closely with clients and/or carers so that they can take control.

The client's needs are the most important part of medication management and so visits are best scheduled to fit in around the client. Unfortunately, as this nurse explains, there may be instances where the nurses can not fit in with the client's routine:

> *I guess in an ideal world, clients' medications can probably be given at times that better suit the client, as in "I have my breakfast at this time, I like to have my tablets, I should take my tablets after breakfast", so we fit in with the clients' life, rather than the client having to fit in with us. Like eyedrops at night, we might have to get there at 6.00pm at night or we get there a bit later and the client usually goes to bed before that, that type of thing. But I guess that comes down to there are so many clients that we're now helping, that we need to fit them all in.*

Are there ways that District Nurses can better fit in with client's life? Is this not best practice? The reality may be that a compromise is reached when reviewing the timing of visits:

> *I'd say that my main concern would be time constraints. To be able to attend to clients in a clinically appropriate time and also socially appropriate time for them. Also making sure that the people who need their medication at a certain time in the day are serviced within that time … and she goes out to day care, but she often because of her dementia will leave home long before the bus is due, so I know that I have to get to her and I need to there … both of them at the right time and that's fairly much duplicated throughout the team. There's always this juggling, so we have to compromise that and some people … early, at a certain time, they may get it later. So now our insulins are tending to go after breakfast, rather than before breakfast. Sometimes a compromise has to be reached.*

Compromise is often the reality. District Nurses and the client may need to weigh up the pros and cons to decide what are the priorities of care. The organisation has now introduced early morning shifts which means more clients will be able to have medications pre-breakfast as prescribed. One nurse described the common scenario where clients are taking polypharmacy and there is a risk of side effects from medications. Nurses need to have a good understanding of pharmacology so as to reach an appropriate decision based on which tablets are likely to cause a problem if they are not taken at exactly the time prescribed. For example if Metformin is not causing nausea or diarrhoea then it might be suitable for the client to take

it immediately before the meal. If, however, it was seen to be causing diarrhoea then it would be important to take it post-meal.

Another concern for nurses relates to the increasing demand for medication management services due to an ageing population. Clearly District Nurses and the organisation will need to be innovative in their approach to managing their teams and workloads. Nurses suggested alternative service delivery models such as four hour shifts in order to address the heavy workloads around the medication administration times.

Workloads do need to be reviewed, particularly for the weekend shifts. Using short shifts and timing of shifts is one way that workloads could be distributed more evenly through the day. The weekends as described below are particularly problematic and short shifts may be useful:

> *I do find, particularly on a weekend, when you're managing medications, that medications that were spread over say six nurses are now combined into one nurse trying to manage 20 medications, you know. And they all technically should be morning medications but we're there, when they're daily, we're getting there up until lunchtime when during the week, we'd be getting there by 9.00am. So I guess that's, I guess a big issue in any team on the weekend, so maybe if we had, ideally if we had an extra two staff that worked four hours in the morning, everyone could get their tablets in the morning. But I guess we've just kind of learned to live with that and prioritise those that are twice a day (BD) earlier in the morning and those that are daily, later in the day.*

Workloads within the organisation need to be continuously reviewed so that the focus of medication management can be comprehensive and supportive for clients and their carers. This nurse would like to spend more time with clients as described below:

> *I'd like to see more time given to clients with their medication needs and to be able to offer support as well in many ways. The organisation needs to be funded for supporting clients and it isn't really, so I'd like to see time made available, so that we can sit and talk to clients. Also when we're giving them their medication, not be constrained by a 10 minute visit. So I think funding needs to be looked at.*

When asked what he/she would do with the extra time allocated he/she replied:

> *Well, it would be just asking the patient if they had any problems and then we would have that time to sit and listen, if they started to tell you the problems that they have. Not being constrained to a 10 minute visit for medication. Some medications you can give in 10 minutes and there is no problems but others you go in, you can see from the minute you set your foot in the door that something's wrong and you've really got to be able to have time to work out what the problem is.*

Do the nurses feel that they have control over their visit schedule? From the comments it could be deduced that many nurses actually feel as if they have little control over the time that they can allocate to medication management. Again the comment below paints the picture that perhaps nurses do not feel empowered to make changes to client visit schedules:

> *Well, I'd have to say a concern is about the amount of time and resources that are made available for the practice of medication administration. We are expected to get in and out of houses in a very short amount of time and often we can, but it is very unpredictable, as to how much that time will be, as was evidenced today. You can end up spending quite a bit extra than the 5 or 10 minutes allowed. If the person has run*

out of medication or hasn't got an up to date authority, or has started a new tablet, because they saw the doctor yesterday, lots of reasons, that are not factored into the District Nurses days, that they just assume that there'll be those gliches. Very rarely is there much margin for error allowed in a morning of a District Nurse's round. This is even more apparent on a weekend, where you might have 15 medication priorities before lunch that are spaced at 10 minute intervals, but may actually not live very close together. So our practice is constrained in so far as we just get behind and then we work later and longer and that's what we do, because you get the job done. You don't leave it undone, you spend the time where it's required and make up the time elsewhere. But there's never going to be any more money put into the situation, so I don't want the result of this research to come out as we should be spending lots more time in those homes, because it isn't going to happen. There is no more money, they're not going to give us any more time and in fact, I think we do a very good job given the time that we do have.

The example also demonstrates the importance of planning care and prioritising problems on the day of the visit. A longer visit may then be booked for the next visit. However, through planning ahead and booking a longer visit the nurse can keep abreast of issues as they arise. Once again it is about nurses being creative about how they work.

Discussion

Data from the nurse interviews provide a clear picture of the nurses' concerns about the time available for medication management. Concerns raised were focused around the number of clients seen within a short time frame and the perceived quality of care that can be provided in that time.

Nurses felt that the ten-minute time frame was too short to provide comprehensive nursing care. Although District Nurses can actually adjust the time schedule to suit their clients, there was no evidence that nurses were utilising this option to increase visit lengths. From the comments made by nurses it was difficult to know whether nurses felt able to increase visit times if needed.

Concerns around timing of medications suggest that District Nurses may not have considered some alternate options. In collaboration with the pharmacist, medication times can be negotiated. This is certainly the case with the drug Aricept. Whilst this drug is best given at night, in consultation with the pharmacist and the GP, a compromise can be reached. The referral of clients to the HMR may assist nurses to prioritise medications in a way that is more conducive to the overall workload.

Working with clients to find the most suitable time for visits is important. If there is more planning put into which clients are priorities there may be more scope to be able to fit in better with clients' requests. This would obviously be more satisfying for both clients and nurses.

In summary, data demonstrated a need for future planning around the issue of time and time management. With an ageing population and the emphasis on keeping people in their homes longer the need for services such as medication management will continue to increase. We know that medication management is not just about administering medications and so the question is posed: How will RDNS respond to the growing need and continue to strive towards primary health principles? The answer lies in creative and innovative thinking that utilises resources efficiently and effectively.

Data suggests that nursing workloads are unequally distributed over the day due to the timing of medications. It is also the case that many nurses strive to complete the 'medication run' in the morning and that many have not considered alternative practices. Perhaps the introduction of short shifts to assist with heavy workloads at certain times of the day would be useful. Another way to address the actual lack of time would be to introduce a standardised system of allocating periodic longer appointment times for nursing reviews of care to take place. This would assist the nurses to take on the case manager role more effectively.

RECOMMENDATIONS

1. Prepare District Nurses to take control of their own time and time management.

2. RDNS continues to undertake travel surveys and make changes to rounds and boundaries as required.

3. RDNS continues to investigate and implement shift configurations that assists in delivering client-focussed services.

CONSTRUCT 4 CONCERN

Narcotic control and administration in the community. There exists paradox of meeting practice requirements and client need.

Background

The RDNS policy for the administration of Narcotic and Psychotropic Drugs (N&PDs) (Appendix 12: Policy 2.CP.43) is based on Regulation 19 of the Controlled Substances Act 1984. The policy clearly states the responsibilities of the nurse administering narcotics. The important points to note are that RDNS requires:

- Countersignature from a responsible person (may be carer or client)
- Clients/carers may co-administer N&PD, and should be encouraged to complete the N&PDs form
- Whenever N&PDs medication is administered by persons other than RDNS nurses and not recorded, the RDNS nurse must print this information on the N&PDs form

The narcotic count is recorded on the N&PDs Administration Record form. For subcutaneous infusions an additional form needs to be completed.

Concern

- Narcotic administration and recording has the potential to be problematic in a community setting. Unlike the use of narcotics in a hospital setting, the use of narcotics in a community setting is more difficult to control. The reality for many nurses working in the field is that there is not always someone with whom to check narcotics. Nurses also felt that they have little control over maintaining an accurate count of the stock due to the fact that clients and carers co-administer breakthrough doses.

Current Practice

This nurse describes the dilemma when there is no-one to count the N&DPs with:

> *…you've got to fill out the narcotics medication for dangerous drug medication and, there's no-one there to check it with. And I think that's a bit of a, like I know you can check with the carer, but often we don't and I know that can sometimes be a bit scary.*

The policy for administration of narcotics clearly states that the carer should check the narcotic with the nurse and sign the count sheet. It is therefore interesting that the comments made suggest that even though the carer is with the client, they are not being asked to check the narcotics. Data from the observations (n=133) also indicated that nurses were not always getting the narcotics countersigned. One other concern raised was that of clients countersigning for narcotics when they may not be mentally able, *'they might not have insight and that sort of thing'*.

As stated in the policy, carers and clients can co-administer N&PDs and they are encouraged to document this on the record form. Nurses explain how they find it difficult to know what is happening with the count as this nurses account illustrates:

> *…we've got RDNS and the carer [and clients] having access to the same narcotic stocks and as you can understand, with our narcotic drug count, there can be discrepancies and that puts the RDNS staff in the position where they're policing the use of narcotics that the carer has.*

The message being sent by the nurses in their interviews was that they are ‘accountable for the correct stock and count on the narcotics sheet’ when in actual fact ‘they're policing narcotics that they aren't directly using’. According to the nurses interviewed, clients and carers do not always record when a narcotic is administered. To make this situation more complex nurses may not be aware of what stock clients have purchased thus making it difficult to keep track of the count. Nurses felt that this can lead to confusion and a lot of investigation into where did these drugs go. This concern is further supported by medication incident data which shows that there are one to two incidents per month where the narcotic count is incorrect. The incident reports usually indicate that the count is out due to another source other than the nurse. This is a concerning issue because there may not be enough information available to ascertain if the narcotics have legitimately been misplaced or if there is someone taking the stock whether it be carers, clients or nursing staff.

Some nurses raised concerns around the storage of narcotics and the safety of keeping them in the home particularly when there are children in the house. Narcotics are only locked in the home if the client is deemed to be unsafe. However, clients with children may decide to keep their stock locked.

As stated in Policy 2.CP.43 nurses are not able to transport any medications in their car including narcotics. If N&PDs are no longer required it is the families’ responsibility to dispose of these by returning them to the local pharmacy. The nurse then records who has been organised to return them on the N&PDs Administration Record Form. The excerpt below clearly describes the nurses concerns about the process for disposal of narcotics:

> *…when the client dies and then the family actually have a lot of dangerous drugs left in the house and how we actually inform those clients how to dispose of those drugs…. A lot of people don't realise that, once again, we can't carry those drugs somewhere and so therefore, it's up to the family to dispose of those drugs. But sometimes if the carer is actually at risk regarding bereavement process, it is pretty important that sometimes we get those dangerous drugs out of the house. The other thing is that dangerous drugs in the house depending on who is actually in the house, you need to be wary of potential for stealing unfortunately, and therefore, counts will be out again.*

The nurses’ concerns of misuse of narcotics by family members or the community may be valid however it must be acknowledged that these drugs do belong to the next of kin of the person who has passed away. Again the issue of the count being inaccurate is raised. This seems to be a significant issue for nurses because it was raised many times during the course of the research.

The fact that nurses are unable to carry medications in the car is also perceived to be a problem if the client or carer doesn’t drive and needs supplies:

> *Our inability to actually carry dangerous drugs in our car. That's been restricted in regard to often the families, the elderly and the carer doesn't drive and we are trying to access drugs in a hurry if people are getting terminally restless etc. So we actually have to find some sort of other avenue to access picking up drugs from pharmacies or palliative care services. So that can be a bit of constraint at times.*

Although this may be a constraint at times it is a far safer option for staff if they do not carry medications in their cars.

Due to the number of people accessing the narcotics and filling in the forms the documentation needs to be clear and easy to use. Suggestions for improvements to the paperwork are outlined below:

> *For any one day, there's not enough space on the form to actually record it and if you've got multiple, if you've got 3 shifts of nurses going in on one day drawing up breakthrough doses for carers, you can see that if they have to get all that information in that little space, it gets very confusing and difficult to understand. Well I feel there could be a separate sheet for the nurse to record how many medications she's drawn up for the carer to give and then the next day, the nurse would see how many have been used in that 24 hours and record it again.*

As many of the concerns raised relate to the issue of carers and/or clients using the documentation correctly, the suggestion of having a separate sheet for recording breakthrough makes a lot of sense.

Discussion

The interview data demonstrates the concerns that nurses have when using N&DPs within a community setting. The concerns are unique to the community setting because narcotics are not locked and other people can have access to the stock. This means that the environment can not be controlled in the same way that a hospital setting is.

It appears that nurses are concerned about whose responsibility it is if the drug count is not correct. Nurses are aware that drugs of dependence need to be accounted for. Working in a community setting means that they do not have the same support systems that you would have in a hospital setting. However, District Nurses do need to keep in mind that the N&PDs actually belong to the client. We need to look at what is reasonable in community practice when dealing with narcotics.

Clearly, the two major issues were the difficulties associated in finding a suitable person to countersign the N&DPs form and the lack of control nurses have over the stock. The frequency in which nurses are not getting N&DPs countersigned is unknown. The implications for nurses who do not get N&DPs countersigned is unclear. The fact that carers and clients may be administering breakthrough doses of narcotics often makes it difficult for nurses to keep an accurate log of the stock used. The question then arises as to whether nurses can be held accountable for stock that they have little control over? The fact that there are regular incident forms being generated around an incorrect narcotic count suggests that the current system needs addressing. The data also suggest that documentation for N&DPs may need to be reviewed with the emphasis being on how the carers/client use the form.

RECOMMENDATIONS

1. That the Nursing Practice Committee review the Policy for N&DPs in the community.

2. That Palliative Care staff in conjunction with the Nursing Practice Committee reviews the documentation for administration of N&DPs.

CONSTRUCT 5 CLAIM

Clients and carers claim that the service provided by RDNS was both trusted and valued.

Background

Clients and Carers' Perspectives

It was important to interview clients, to hear their accounts of medication management as care receivers and key stakeholders. Out of the 18 interviews conducted only 11 were able to clearly articulate their perspectives. The other seven clients (39%) had some degree of dementia. It is acknowledged that interviewing clients with dementia presents many ethical and interpretive issues. However, when the older person starts to experience memory deficits, insight into the problem is common and they may welcome an opportunity to discuss their situation. Rather than simply dismiss the claims from clients with dementia, we have tried to make sense of their accounts.

To further strengthen the data the research team decided to interview some of the carers of those who were observed during the period of the study. Five carers were interviewed. All of the carers interviewed were daughters of female clients who had a diagnosis of dementia. All of the clients lived alone and up until the time that RDNS commenced visits the carers were responsible for ensuring they took their medications. The carers all ensured that medications supplies were adequate, arranged medical appointments and usually visited their mother most days. RDNS visited daily and for one client twice daily. From the interviews it was evident that the carers attempted to assist with medication administration whenever possible as they were aware of how busy the District Nurses were. This meant that on public holidays and/or on weekends they took over the visit.

Claim

Clients made substantial claims.

Clients claimed that the service provided by RDNS was both trusted and valued. They claimed that hospitalisation is prevented through regular District Nurse visits to the home. As a result, clients claimed that their quality of life had improved due to the support provided by RDNS.

Praise for District Nurses

Regardless of mental ability, all of the clients interviewed praised RDNS. While some of the statements may be interpreted as being made to please the nurse researcher, the extensive number of these comments make it a substantial claim. The comments below indicate the extent to which RDNS was praised. Each point signifies the voice of a different client:

- *She helps me do the medication into the pump, but I'm learning to do it myself so that I can be a bit more independent... She helps me communicate with the doctor, she writes letters to the doctor so I can take them to the doctor. Generally, she just makes sure I'm all right.*
- *I'm happy the way they come and the way they do it.*
- *Well I think it's a comfort to have somebody come in and just make sure that everything's working.*
- *I'm happy that they come to my home. So I don't have to keep going to the hospital.*
- *I told them the other day when I rang up and cancelled them, I said "thanks for what you've done. I think you've done a good job".*

- *I'm very thankful for the service that the District Nurses perform.*
- *I think I'm privileged to have the help that the nurses are giving me.*
- *It is all working well at the moment.*
- *Yes. I'm quite happy. I'm quite happy with the girls what they do for me.*
- *RDNS provide a very good service. The nurses are always here to help me. They are very good.*
- *We think the girls are lovely. It does help us, because we don't have to worry going to the chemist or having to worry about whether we have enough medication, all that type of thing. And it's a great help to us ... it really is.*
- *It takes a lot off my shoulders with my partner as well. And since they've been coming, he's improved out of all sight. You know, he's going really well with the medication.*
- *The girls are all very nice. Every one of them ...*

As discussed, we tried to make sense of accounts of care including those from the perspective of clients with dementia. The following statement summarises the claim of praise for District Nurses:

> *I think with the help of the nurses that come, they make sure I've got the night tablets, because I have got a lack of memory, but they are all sitting there waiting for me at night and I manage on the whole pretty well. I just feel that everything is covered. I've got loss of memory, which drives me silly! That's how it is. I can't deal with how it isn't, so you know I do the best we can that way, but the nurses are very good. They are most helpful and I appreciate what's done for me, I really do.*

Trust

The District Nurses are viewed with the utmost trust. Although this trust was seen as a burden by some of the District Nurses interviewed, for clients it was with confidence that responsibility of medication administration was being assigned to the District Nurse. Some examples of clients' trust in the professional ability of RDNS nurses are illustrated here:

- *I don't get involved in the paperwork. They just do their own thing. You know, that's their job…They know what they're doing.*
- *Well the District Nurse is a very responsible person and makes sure he has his medication every day. And even on public holidays, she arranges for someone to make sure he has his medication.*
- *You've got the person who's got the knowledge and the understanding of what they're doing.*
- *The nurse said 'Don't leave it until it gets too bad, take it every hour if you need it'. I'm not a believer in a lot of medicines and medications. I've never been one for taking a lot and I used to let it (pain) get too bad. And she spent quite a long time here.*

George provided another example of the importance of RDNS service to clients. George was visited by RDNS each morning for his oral medication. The District Nurse leaves his evening tablets in a container. When George was questioned about how he manages his tablets he states, *'I'm not doing it, the nurses do it, the RDNS do it... It works quite well'*. He appeared to be quite happy to relinquish responsibility for his medications. Although George was unable to state what his medications were, he claimed that *'it's good that they put them out for*

me to take'. When the person feels as if they are losing their memory it is of comfort to them to 'know' that a nurse is available to assist.

The notion of the client relinquishing self-management and control over the situation is viewed as:

> *It's excellent the way they do it. You know they help me. I know how to do it but some days I just don't feel like doing it you know. So I let them do it and other days they watch me do it and see that I've got it right and obviously, if I haven't got it right they fix it, but I haven't had it wrong so far. But no, it's excellent what they do for me.*

The role in reminding clients to take medications was relevant for the majority of the clients interviewed. This is tied to the next major theme.

Avoiding Hospitalisation
Certainly RDNS involvement with these clients means that medication mis-adventures are prevented and hospital admission avoided. As one client said:

> *…the nurse comes and hands them to me, so it means that you don't get muddled … I've got no memory any more, so that's good. I can just go ahead and have confidence in what's already been done for you.*

Again confidence in the nurse is revealed in the conversation with a client. The importance of sustaining clients in the community and preventing hospitalisation is a theme that came forward during the interviews with nurses, and some clients had the perceptiveness to voice this claim. This is confirmed by this client's response:

> *I do, from time to time, get shutdowns. I end up having to go to hospital for a few days while the doctors re-stabilise (me). But in the more recent times, these shutdowns have become further apart.*

This client maintains that the regularity of medications arranged by District Nurses was the single most important reason preventing re-admission to hospital.

Having insight that their memory was failing and that they needed some support, these clients valued the visit of the District Nurse. One client with stage one dementia was able to contribute the following:

> *I think it's marvellous. It saves me having to worry about what time I'm going to take them, did I take them, if I did or I didn't, or if I've got it there, if I'm not sure if I did take them, just shake this, nothing in it, so I know I've taken them. But actually, my memory isn't quite as bad as that. I mean I wouldn't forget so quickly, I don't think. Sometimes, I have episodes where I'm worse than others, but I can go for days and be perfectly rational.*

Another client with stage one dementia said:

> *Oh yes, yes. Well it stops me worrying about did I take them or didn't I take them or you know, or sometimes, I'll find a tablet here or possibly on the floor. I don't know if it's fallen out of my morning tablets or out of my evening tablets. I might find it at night. But I tell the nurse the next morning what's happened.*

It is clear from these examples that hospitalisation is often prevented through regular District Nurse visits.

Improvement in the Quality of Life

Another common expression was that RDNS visiting was a *'means of my continuing to enjoy a reasonable standard of life'*. One man, who receives enemas frequently confided that *'without it (enemas) I would be more or less confined to bed'*. On reflection some of the activities provided by RDNS nurses are quite small but the outcomes of these therapeutic relationships may mean that the client can actually have a life beyond their bed.

For others, RDNS visits provided a sense of security that improved their quality of life:

> *Well, the District Nurse coming and doing this, works into the other parts of my medical management by my doctors and so on and it's given me an overall sense of security as an ongoing part of surviving with the condition I have.*
>
> *Feeling secure was important to several clients, 'it makes me feel really good [having RDNS visit] because it relieves the stress. I suffer from schizophrenia and I can't take a lot of stresses'.*

One client's account has been selected to demonstrate the overall claims. Doug had some important things to say that were common to other clients.

Doug's Account

Doug agreed to an interview conducted on 06/11/02. Doug lives with a chronic illness (Parkinson's disease). With support from his wife, he self manages his ten oral medications. The District Nurse visits daily at 9am to set up the Graseby pump used for the subcutaneous medication of Apomorphine. This drug is drawn up by the District Nurse (diluted in 5 vials of normal saline) and is infused at 3mm/hour via the pump over 24 hours.

Continuity

The first important claim was that RDNS provided continuity, not only with providing the same nurse when possible, but also in the delivery of efficient and professional care. Continuity is important. *'I've been on it for four months now and I know most of the nurses, some do it a little bit different and have their own way of doing things but it all works out'*.

Appointment Times

Doug said, *'It is important that I am seen on time'*. Doug's main claim was that nurses arrive at the agreed appointment time in order that he has the Apomorphine treatment drawn up on time. He said, *'because the simple reason is, if they come too late, I have to take the syringe out later at night, at 12.00 at night instead of 11.00 at night'*. That would mean that he settles down to sleep one hour later. Importantly for Doug, *'they come at breakneck speed to get here in time'*.

Being Acknowledged

It was important for clients to be acknowledged. Doug prepares for the visit and the nurse appreciates this action. Doug explained, *'I generally put them (all the ampoules etc) out so that everything goes all right. Not that I don't trust them or anything but I like to get it ready'*. He said, *'nurses are always grateful'*.

He ensured that the interviewer understood that he would not want to 'interfere'. When continuity of the visiting nurse was not possible, Doug liked to demonstrate his self-

management knowledge. ‘If I have somebody that’s not familiar with it, and it might only be a little thing, I am able to show the nurse’. When clients live with a chronic illness it is important that they are recognised as the expert in their own management and its treatment. Here, the nurse makes clear to the client that his input is valued and this in turn validates the importance of his role in the management of his illness. This may be interpreted as part of the therapeutic relationship. He is viewed as the expert in his self-management.

Building Relationships
Doug feels that he is in partnership with health care professionals. Relationships with the pharmacist was important to him, ‘*we’ve got good relationship with the chemist at St Agnes’*. The pharmacist has direct contact with the client and advises him of generic and proprietary names. The client also has a good relationship with his GP and this is very important to him. When people like Doug are involved with multiple services, it is important that these services work together to achieve the best possible outcomes.

In this example the client "directs the traffic" and it seems as if the three services collaborate to maintain the client as central. Doug valued continuity of the nurse, set appointment times and validation of his knowledge and experiences by nurses.

Continuity
Building relationships is also building social capital that is enhanced by continuity of nurses visiting clients. Irene provides another example below:

> *It's tops! Especially now that Vanessa is the one continuous nurse that comes out and on the weekends, well it's mostly been the one nurse there too. I am kind of used to seeing one nurse.*

On the other hand, continuity can be provided through the structures that RDNS has in place. The blue folder/book (client record in the home) is one such structure. This was Murray's view:

> *At one stage, I got used to a nurse coming in and they seemed to come for many months … perhaps a year. However, they started changing more regularly and it's like anything else, at first you sort of think ‘Oh well, will I have to explain what goes on...' if it's a new person. However, the blue book has everything laid out in it for them to know what has to be done. It's only a matter of me explaining where the stuff is for them to do the procedure and we get on with the job. So when a different nurse comes in, it's another new face to chat to.*

Fee For Service
Only one person commented about the RDNS fee for service:

> *I felt that the charge that was brought in, was to me, nominal but necessary to be able to keep the service functioning and I'm grateful that this is working the way it is and I thank the District Nurse for being here.*

Carers made substantial claims
The carers (n=5) stated many claims about the service provided. The comment that stood out above the rest was that the carers all felt reassured that there was a professional coming to visit their relative every day. To the carers this was a great support and gave them a sense of relief. The comment below is an excellent example of how the carers felt:

Now what's working well for me is that I know somebody is seeing her each day. So that's just peace of mind for me that if there was any sort of a problem, it would be seen, it would be covered. That is such a help, even if no medication had to be given. Knowing that she's regularly getting her medication and keeping her in good health. Knowing that if there was anything wrong that you know, that was obvious, the nurse would pick it up and let somebody know, or something would happen about that.

This is a powerful statement because it highlights the pressure for carers who feel responsible for their loved one's well-being. It is clear from this type of statement that the RDNS service not only improves the QOL of the clients but also for their carers.

Praise for District Nurses

The comments below indicate the extent to which carers valued the service being provided by RDNS:

- *I'm just grateful for the service. I think it's wonderful service and I'm very thankful for it.*
- *And I find it a relief too, …because it means that someone with medical training is going in and if they look at her, and think well "she doesn't look right", I know that they will contact me and I find that reassuring*
- *Family are now sure that she gets her medication regularly and it has meant that she has not needed to go on insulin (diabetes control has improved since the commencement of District Nurse)*
- *It's a wonderful service*
- *You know, we know that mum's been taken care of, whereas as a family, we can't do it every day. They pop in and if anything's wrong when they get there, they know my number, they, yeah, it's just sort of an extra feedback with mum*
- *Yes, they're very good, they're very nice in the office. You've only got to ring up and, it's interesting out of all the people they must have contact with every day, you just say who you are and your mother, and they sort of click straight away. So they're very nice there at the office when you ring through*
- *She loves the nurses, she looks forward to them coming every day and they are very nice to her*
- *She has a professional look in on her daily and that is very reassuring. I think the District Nurse do a wonderful job and I'm immensely grateful*
- *I'd like to say that I'm really appreciative of the service, really appreciative. And also that I find that the nurses who I have contact with are caring, are very caring. So, I can't speak too highly of that*
- *Peace of mind knowing that a nurse is going in each day*
- *I appreciate very much the service from the District Nurse. It's great!*

The carers also felt that continuity and routine was helpful to their mother in light of their memory loss. Most of the time continuity occurred and that was evident by the carers looking at the nurses signatures for the visits.

And I particularly think that it's helpful that we have a regular one. You know, if that can continue, that's really good and very helpful. Yes and especially with people who've got memory loss to have that same person who they recognise, yeah, and not just different people coming all the time.

One carer felt that the nurses kept a really good check on her mother which was important because of the risk of her mother wandering:

> *…we're really happy with the whole support, because there's been times when we'd had perhaps messages gone astray, when my brother's taken mum out in the evenings and he's rung through, but they haven't got the message. They've rung us and we've been able to sort of see what's going on and let them know and I think that's really good, because there is a chance that mum at some stage, might start wandering or you know, that sort of thing and at least we know that they're keeping a really good check on her.*

Some of the carers felt very conscious of the fact that the District Nurses were stretched in terms of their resources and therefore tried to help out as much as possible. The comment below aptly describes the emotions of one carer:

> *Yeah, because I know they're pretty stretched and I don't, you know. Initially, I felt a bit, that it was a bit a bit of a cop out for me, because I know that the service is in great demand but at the same time, from the point of view as I said of mum having that professional contact and I know that they will ring me straight away if there's something amiss for whatever reason. So it's very reassuring.*

Having the District Nurse come each day relieves the burden on the carers as described below:

> *And if I'm not well, as I haven't been particularly well. Earlier last month I was unwell and it was just such a relief to know that well, if I didn't get up to see mum, it wasn't the end of the world, because I knew the District Nurse would be calling in, and I would soon hear if there was anything amiss.*

The above comments highlight the importance of carers feeling supported in their role. The comments also demonstrate how the positive rapport that has been built between the District Nurse.

Effective Communication

The carers suggested that overall communication with District Nurses worked well. The communication sheet was utilised or notes were left and placed in the blue folder. One carer stated that 'I'm finding them quite accessible in ringing the 1300 number and I can send messages across to them if I need to.' One carer described the importance of reading the communication sheets regularly and perhaps following up any message with a phone call:

> *Well, I do communicate through the sheet folder, but I also, quite often I will write down something in that and then I will also ring, just in case, you know, I guess just to double check the message. I'm not always very good at reading, or I wasn't and I'm better at it now, checking to see if there are any messages from them, so because I was late in responding to a couple of those, or seeing that they were there and they had to follow up with a phone call. I tend to read it more regularly now.*

There were a couple of comments made by carers that indicated that at times communication was less than optimal. On both of these occasions it appeared that messages had not accurately been relayed to the appropriate field staff. An example is provided below:

... my mother is taken on Mondays and Wednesdays to a club and she's picked up at half past 9. Now there have been some occasions, not very often, but some occasions in the past, where the nurse has actually not arrived till about 10.00am and I've received a call "we can't raise mother, we don't know whether she is alright" etc etc. And if it's a Monday or a Wednesday, she's picked up and she's gone and so she doesn't get her medication that day.

This example highlights the importance of communication and the need for nurses to refer to their call sheet prior to visits. By checking this information it is less stressful for the nurses, the clients and the carers.

Another incident cited by a carer was a mix up on public holidays which resulted in the client not receiving medications. The confusion occurred when RDNS did not visit on Saturday or Sunday and then came on the Monday. However the carer was of the understanding that RDNS would continue with weekend scheduled visits and she would do the public holiday. The client was anxious as she did not get her tablets and the outcome has been that the carer is now hesitant about changing the days of the visits in case there is confusion. According to the carer this type of situation has occurred on more than one occasion:

So it's just a little bit of communication I guess that I find perhaps is not working. It's sort of made me a bit loathe now to do any public holidays because I think, oh gee if it's not right, then she'll be without all her medication. And it's not always easy just to get in the car and go.

The above communication breakdowns resulted in clients not receiving medications for that day. This is a medication incident and can have adverse affects for clients. It is anticipated that with the introduction of the CIMS that some of these documentation type oversights may be reduced. It is also difficult to know whether these are just isolated incidents or if they happen on a more regular basis.

Most of the carers felt comfortable with the system of documentation and indeed found it easy to follow as seen below:

When I have to give her any medication if I'm taking her out or anything, I can always follow what they've got as far as doses and that sort of thing. And I usually check their little notes, because at the moment she's got a problem with her kidneys and there's notes there which is really good, because we know what's going on. Yeah, so we keep an eye on the folder.

On the other end of the scale this carer felt that the documentation could do with an overhaul:

It actually could do with a bit of an overhaul I think... The folder itself doesn't seem very well organised. There are no clear sections and there's always a clear section about the medication and I follow that fine. There's a pink sheet that has all the days and the different medications on that and I can follow that. But the other communication, there's different pages and different dates, that's a little difficult to follow, so a bit of a re-vamp of the actual communication sheet in there and perhaps pages taken out when they're redundant. Yes, perhaps a bit of a clean up and I don't know how it works for anyone else of course, I can only talk about my mum.

The concern for this carer was that she might miss something if she didn't read through all the documentation. The lack of date order meant that she wasn't sure where communication

would be filed. These comments are consistent with observational data discussed previously under the construct two.

Quality service is being provided by pharmacists and GPs
Carers felt very satisfied with the services being provided by the pharmacist and particularly liked the fact that medications were delivered to the home. All of the carers were happy with the service provided by their mothers GP:

- *He is well aware that you know, she's having the service, so if he changes the medication, he makes sure he faxes through a copy of the changes and any details that he wants them to have a look at, he's excellent.*
- *He's brilliant! Absolutely brilliant.*
- *Oh he's marvellous. He's a great man. He's been quite a support to us as a family.*

RECOMMENDATIONS

1. For funders to be made aware of the satisfaction that clients and carers have with the service provided by RDNS.
2. District Nurses should be made aware that they are highly regarded by clients and carers.

CONSTRUCT 6 CLAIM

District Nurses claim that they meet service aims (1) that they promote independence of RDNS clients' (2) that they have appropriate skills and competencies to provide a medication management service and (3) that they are sensitive to the needs of older people.

Background
A major contemporary social goal is to maintain frail older people in their chosen environment, which is usually their own home. Current government objectives promote three central aims:

- Enable people to live as normally as possible in their own homes
- Provide the right amount of care and support to help people achieve maximum independence
- Using the language of coordinated care, promote inter-agency collaboration and referral in order that the client has the best possible service options

The influence of these themes remains evident in current district nursing practice.

Claim
District Nurses claim that they meet service aims whereby:

- They promote independence of RDNS clients'
- They have appropriate skills and competencies to provide a medication management service; and
- They are sensitive to the needs of older people

It is not surprising that data derived from close observation of practice contradict some of the claims made by nurses. The methodology used for this inquiry thrives on contesting constructions and this occurred through discussion with stakeholders prior to the final recommendations being written.

Promoting Independence
The drive toward promoting independence and preventing the need for more costly service features prominently in data generated by interviewing nurses. Nurses claimed that the service being provided was keeping clients out of institutions and they felt good about being able to do this. Nurses felt the service was *"valuable"* and *"positive"*, because *"it keeps people in their own home where they are happy"*. The following exemplar provides an excellent account of the claims made:

> *I think we enable clients to be independent. Often they function in all other aspects of their life, even when they are demented, ... yet medications need to be managed. It's something that can affect their whole health if it's not done correctly... Even if it's going in daily, it actually helps keep them out of hospital. It keeps them safe from any harm of incorrect medication use.*

RDNS Structures Support Staff
RDNS has excellent structures in place (see construct 2) and nurses were appreciative of this. One structure highly recommended by District Nurses was the Call Centre. If nurses have a concern about a client, they are able to contact the Call Centre on their mobile telephone and receive pertinent information.

Also appreciated by District Nurses were the locked boxes for storing medication in the home when clients are at risk of medication misadventure. *'I like the locked box with the combination lock. I think that it has assisted greatly in keeping our patients safe'*. Occupational Health and Safety measures were important on the list of structures to support RDNS staff. As one nurse said *'I think everything is in place that covers us. If there's any incident or difficulty within the home, then we know what to do. I've never had a negative response'*.

Having access to the policies in the boot of the RDNS vehicle was considered a resourceful strategy. Many nurses felt secure that policies were in place (eg that a new medical authority was required every three months). Contrasting the observation of practice where blue folders were in disarray, the interviewed District Nurses valued the blue folder. *'The blue folders are excellent because you know exactly what you're looking for in each client's house'*. This construction competes with observational data.

Documentation was a major concern in the observational studies (refer to construct 1). The construct draws attention to the lack of documentation for many aspects of the nursing process. Nurses also have a voice in the documentation debacle. Nurses want less, not more documentation. One nurse suggested that there was a *'need for a better system of documenting things... so that the guesswork of some of the things that we have to try and work out, like what other community supports are in place'*.

The volume of documentation expected of nurses exceeds that of other health professions. Why is this so? Research supports that more experienced staff need fewer practice documentation guidelines (see Benner's work from Novice to Expert 1984). Remedies for not complying with the documentation standards are usually more guidelines for practice. Further standardisation of documentation reduces the responsibility of individual nurses to think critically and creatively as a reflective practitioner. At the same time, we should not confuse documentation with assessment and care provision. The observational studies revealed that much of the documentation is prolific and considered inane, such as the chasing of authorities, scripts and people to collect the scripts.

District Nurses Claim That They Have Appropriate Skills and Competencies to Provide a Medication Management Service

One nurse expressed this claim very well, stating

> *'I really want it on the record to say that we provide an excellent, safe and very professional service out there, given the time and resources'. 'There was evidence to support professionals doing it as opposed to care workers [medication management] …you're getting that review of the person constantly'.*

Observational skills based on adequate preparation are viewed as important:

> *The thing that I notice is that medication delivery is very important for clients. But I think that it's more significant that we have trained staff... It can make an enormous difference to a person's health status. How many times have we prevented hospital admissions because they've had good medication? A skilled person can monitor people's health and note medications as they are ordered. I have one woman who had very bad gastritis ... now that she is having her medication every day her symptoms have disappeared and she has had no further hospital admissions. In actual fact, she doesn't need to see her GP anywhere near as often.*

Nurses argue that they are better prepared educationally for a District Nursing role:

> *We also have a nursing workforce now that are much more conversant with the ways of thinking about how we work and what would be the best utilisation of our resources.*

There was emphasis on the five rights of medication management. As one nurse said: 'we are expert at following the five "vital rights" – right client, route, drug, dose and time'. Another nurse said that 'when people are put on silly doses or the medication doesn't match what they used to be on, we know and we ring and we fix it'.

Although the competency of an annual drug calculation review of all nursing staff is mandatory, a few nurses felt more secure with this structure in place. Moreover, *'the reporting system for medication errors is quite good and thorough'*.

In addition, several nurses perceived that improving their assessment skills and including mini mental examination with clients with memory loss could expand their professional scope, *'because at the moment we don't have baseline data'*. Nurses argued for the ability to conduct basic mental state assessment and to use that finding to negotiate for alteration in medication administration styles.

Interestingly, while most District Nurses value the expertise they bring to medication management, other see it as a task that could be delegated to ENs:

- *I don't necessarily believe it's the work of a registered nurse... Many care workers are in the homes who are going in and should be able to provide that service*
- *I think we should employ more ENs or third level workers for medication management and leave RNs free to review care*

When listening to the voices of nurses, most agree that additional education is required, and clinical updates were preferred. One nurse said:

> *I think education of nurses in drugs and pharmacy is required. Like an update ... And we could revise the paperwork that we use. It would make paper work more user friendly and to suit the task ahead.*

District Nurses' Claim To Foster Inter-Agency Collaboration And Referral So That Clients Have The Best Possible Service Options

District Nurses, as pivotal practitioners in front line care for older people, bemoan the lack of a coherent, seamless service in community care. While cross sector commitment is limited (refer to construct 10), nurses claim that they are doing their utmost to coordinate and communicate within RDNS and across agency boundaries. They recognize that this requires a greater emphasis on social and interpersonal skills. As one nurse claimed: *'one thing that we do really, really well, is to get everybody involved*'.

Communication and coordination within RDNS was important for nurses. Here follows one nurse's perspective:

> *The other thing that works quite well is making sure there's open communication between the nurses going in the client's house... We have not only a day service, but we have an evening and a night service. So therefore we need to make sure that we do have adequate documentation in the house, and that we have highlighted areas of*

concerns or things other nurses need to look out for. We often email night service about problems and that works quite well. And the other thing is we need to make sure that the carers are aware of where they can access information after hours and so we always make sure they know about the Call Centre or the Palliative Care services after hours number, which is important as well.

Internal communication was considered important. Nevertheless data were predominantly focused on nurses attempting to connect with external agencies and resources. Ensuring that a medical authority is current was a frustrating issue for nurses (refer to construct 9). In contrast, working collaboratively with pharmacies was noticeably seen in a positive light. Nurses claimed that delivery services worked well and that the *'support that we get from pharmacies …is really good'.*

District Nurses also claimed to be working closely with GPs. Nurses felt that 'RDNS staff liaise well with GPs' and claimed 'we are excellent at following up any concerns we have with local GPs'. Another nurse felt that 'we advocate for our clients with their medications fairly well and on the whole we have a fairly good rapport with most doctors'. The three month medication review was also viewed as one point of contact with the GP.

Most nurses were aware of the resources available to them to facilitate care for their clients. 'I have access to a federally funded scheme for disadvantaged persons, which is fantastic, because many of my clients, they're homeless, they're disadvantaged, they have a mental illness'. Social health concerns were communicated to the research nurse. Most nurses viewed the family as an entity rather than responding only to the client, 'when we've got our regular clients on regular medication, everything runs very smoothly and we do rely on supportive family or friends to help us out and that usually works well'. Working closely with available carers or relatives was important, however, it should be emphasised that the majority of clients lived alone.

Discussion

District Nurses claimed that their practice promotes client independence, that they possess and apply the skills and competencies necessary to provide an effective medication management service and that they are sensitive to the needs of older people. Nurses claims placed RDNS central to the coordination of community health care services, although there was acknowledgment that maintaining effective lines of communication with GPs and Pharmacists was an ongoing process. Exploring further, we see that medication administration is part of a process, it is not a 'product' of or in itself. Several key players impact upon the process (inclusive of the client) who all bring their own expertise to the situation, whether it be the expertise of personal and collective experiences or the more theoretical expertise carried by health workers. The effectiveness of this process is built upon communication and mutual respect. The principles articulated in the claims of nurses demonstrate the importance of a supportive partnership approach when working in the community.

The claims made by nurses about their practice are substantial, however the observational data generated during the study clearly contradicts many of the nurses' claims. It may be timely for RDNS to develop a culture of evaluation, to promote critical reflection as an integral component of community nursing practice.

RECOMMENDATIONS

1. That RDNS continues to provide the appropriate amount of care and support to help people achieve maximum independence.

2. That RDNS continues to foster inter-agency collaboration and referral so those clients have the best possible service options.

3. That RDNS promotes a culture of evaluation and critical reflection as an integral component of community nursing practice.

4. As part of the Divisional Clinical Education and the continued professional development system, provide clinical updates on pharmacology and its related legislation.

CONSTRUCT 7 CLAIM

Using an approach that is underpinned by primary health care principles it is possible to provide comprehensive care for clients requiring medication management.

Background

The dictionary tells us that compliance is ‘to do something that someone orders or wishes’. Placing that term in the context of the practice of medication administration, nurses are ordering clients to do something. Hence the very meaning of the word tells us that it is a contradiction of terms in the scope of caring, comprehensive community nursing practice. Holistic nursing practice has, as a foundation, an understanding of the context of people’s lives. These understandings emerge when we engage with people, ask questions when we genuinely want to hear the answers. In contrast, expectations of compliance are often communicated in direct statements. Stressing to our clients or ‘educating’ them about the importance of taking their pills is a common but mostly ineffective approach to the issue of ‘non-adherence’ to medication. One example may be the suggestion of interventions for medication administration that are unrealistic or unattainable for the client. Advice without questioning and understanding life context often has little meaning for the client.

We are concerned that the very notion of holistic care has become both rhetorical and mechanised. Within the RDNS organisation the preferred term to holistic care is comprehensive care but for the purpose of discussing the background and history of holism this construct will utilise the term holistic. Without doubt, this research exercise has revealed that nurses have an ongoing concern about time. Holistic nursing practice does not need to be ‘time consuming’. Rather it is an approach that requires a framework of creativity, when the contexts of people’s lives are absorbed and considered as part of the nursing care provided. The observations to follow will provide examples from Sharon’s nursing practice.

The time has come to challenge the actual framework of our nursing practice. Nurses talk about primary health care principles and holistic practice but what do they really mean in the scope of our every day practice? Do we talk of these principles but then act according to the traditional biomedical model where we as professionals are the ultimate decision makers, failing to offer the resources that clients need to be active participants in decision making?

What are the Common Understandings?

Nurses are frequently exhorted to care for the ‘whole’ person. We are often told that the very essence of ‘good’ nursing is to help a person attain or maintain wholeness in every dimension of their being. To further explore this construct we were guided by the following questions, which emerged from the project group meetings. Has 'holism' become a ‘buzz word’ without adequate understanding of the meaning? Is this a new direction or focus for nursing, or are we simply revisiting something that we have always known to be important? What does holistic practice mean in the context of community nursing and medication administration?

We contend that the nursing profession has traditionally aimed to view persons holistically, even though the term itself was not introduced into the nursing literature until the 1980s by Rogers, Parse, Newman and others. As community nurses, we have all observed that a physical condition can affect the mind and spirit. We are also aware that when a person is hurting emotionally or spiritually, all sorts of physical ailments may be manifested.

If we accept that restoring wholeness is a legitimate goal of nursing, the term 'holistic' from the Greek 'Holos' meaning whole or complete, is a very appropriate way to describe what we

aim to do. Even so, we may not always stop to consider the full implications of that concept. Holism has many definitions and, broadly, is concerned with the inter-relationship of body, mind and spirit in an ever-changing environment. So if we, as community nurses, are aiming to work 'with' clients to attain or maintain wholeness in all dimensions of their being, we need to be prepared to provide care acknowledging each of those areas of our clients lives.

We suggest that holistic care is not only the responsibility of the community nurse clinician. RDNS as a community health care organisation is accountable for the facilitation of comprehensive or holistic nursing care because it provides the structured context in which aspects of the human health experience are enacted (or the process of care provision). Nurses need to be cared for and care for themselves in order to promote creative, comprehensive care with clients.

Current Medication Practice in a Comprehensive/Holistic Context

A comprehensive approach to medication administration places this as a task within a wider well-being continuum. The context of community nursing care is changing. Nurses are challenged to respond to the fact that the number of older people in the population is rising and that nursing care is needed to help people with degenerative diseases and disability to remain in their own homes and to enjoy as much independence as possible. Increasingly, the community nurses' role requires front-line responsibility for the assessment and management of long-term conditions (including dementia). Medication management is often central to the clients well being and/or maintenance of these conditions. In light of such trends, the importance of nurses' ability to work with clients in the area of medication becomes clear. Comprehensive medication education is the provision of information to facilitate informed decision-making conducive to individual's needs, desires and preferences, as opposed to an activity designed to foster compliance with professionally determined outcomes. One outcome of this activity may be that an individual decides to take medication. On the other hand an individual may make a decision not to take medication. The key issue for the individual is that the nurse's educational role has provided and contextualized information for them to make either of these decisions and to explore alternatives. This can only be achieved within the context of comprehensive nursing practice. The story of Marg provides illustration to this claim:

> *We headed off to see Marg. Sharon (RDNS nurse) warned me that this visit would be an eye opener and visiting Marg was essentially one big occupational health and safety issue, but at the same time visits from RDNS had made a huge difference to Marg's life. Sharon visited Marg daily. The road to the house was winding and rocky up the side of a hill. We drove for 20 minutes. There were sharp bends that Sharon needed to sound her horn to warn any on coming traffic. The scenery was stunning.*
>
> *We arrived at the house…. It was raining quite heavily and there were many plastic pipes taking water away from the house. The house itself seemed little more than a shed. There were things everywhere (an understatement) and the house had quite an overwhelming smell. A cat had 5 newborn kittens on a lounge chair in the doorway, Susie the dog was barking and jumping all over us, but Marg was nowhere to be found. Sharon kept calling for her, and then a minute later she emerged from the rain. Marg was no more than 5 feet tall of extremely small build, and cropped silver hair. She gave us a warm welcome and growled at Susie the dog for barking. Sharon gave her the medications reminding her of how many tablets she took and engaged in friendly conversation. The connection that Sharon had made with Marg was obviously important to them both. We then made our way back to the car (with Susie at my heels all the way) and made our way down the winding road.*

Sharon explained that Marg lived alone, and although she had a son, 'he was a bit weird'. Sharon went five days a week to visit Marg so she could administer 2 tablets. If Sharon did not go then Marg often would not take her tablets and Sharon claimed that the medication had made such a difference to her quality of life. When Marg did not take her medications she was nauseous and vomiting with gastritis. Marg had RDNS visit 5 days a week, because Sharon felt that it was not fair to nurses on the weekends to have to take the long and precarious drive to visit Marg. Sharon had been in close liaison with the prescribing doctor and they had arrived at mutual agreement that if Marg took her medications 5 or 6 times a week then that was much better than not taking them at all.

Sharon had previously talked with Marg about getting some help to fix up the house but Marg had refused. Sharon had accepted that Marg was happy living the way she was.

Nurses made the claim that it was important for the provision of comprehensive care that where possible, the same nurse visited the client. In this way, knowledge of the client's life builds context and develops rapport and ongoing monitoring of the client is more effective. Joan's story illustrates:

Joan had dementia and had been referred by the Collaborative Action Program (CAP) scheme. She had been alerted as having aggressive behaviour in the past. Sharon has been visiting her for several weeks now and has not seen any aggressive behaviour but says that she is always aware of that potential. Joan is visited twice daily for medication administration even though she lives with her husband.

When we arrive, Joan is waiting for us, dressed up, with striking silver hair and a large smile. She says she is going to the hairdressers. Sharon greets her with a bright smile and compliments her on her appearance. Joan is pleased about the compliments and she straightens her back to improve her posture. Sharon counts out Joan's tablets. She tells Joan that she is taking 13 tablets. She is being started on a new medication for dementia called Aricept. Sharon had previously asked her doctor what were the signs and symptoms of the side effects of the medication. Sharon wanted to know what she should be looking for. I asked Sharon how she finds out information about medications. She says that it is something that she would like to have more time to do but does not see time as an excuse to being uninformed. Usually she looks the medication up on the Internet, talks to the pharmacist or contacts the prescribing doctor.

On the way out of the house Sharon makes comment on Joan's beautiful blooming azaleas. Joan appears vague but I would not have guessed in the short time we had been visiting with her that she had severe dementia. Once we were in the car, Sharon says that it was interesting that Joan had not appeared to remember the long conversation they had had the day prior about azaleas. She looks for cues such as that in her clients with dementia.

I had noticed that Sharon had not provided information about medications to Joan. Sharon said that she talks a lot about the medications and what they are for when clients first come to her. This included Joan. She spent a long time with Joan on several occasions, and found that when she went the next day that the people with dementia could not recall that information and sometimes became agitated. As a consequence, Sharon tries to get them to recall how many medications they are taking as some way of orientating them.

Sharon's nursing approach is shaped by an underlying philosophy of Primary Health Care. Her concern was that she would like to see more of a focus on creating opportunities for health and not just about managing illness. Sharon feels strongly that visits to clients for medication management is not just a task, but '*is a Primary Health Care issue … there is a lot more to it… I can do a lot in that two minutes.'*

Medication visits from a comprehensive perspective are about providing healthy environments. Sharon claims that fundamental to her nursing practice is to facilitate healthy environments which have as a foundation a relationship of trust (between nurse and client/family and nurse and organisation), and develop an environment where the nurse can advocate for and with the client.

RECOMMENDATIONS

1. Primary health care education is provided for all RDNS nursing staff.
2. That RDNS recognises the potentially strategic position the District Nurse holds in the management and monitoring of the quality use of medication in the community.

CONSTRUCT 8 ISSUE

The majority of RDNS clients receiving medication management have dementia. Few of these clients receive comprehensive care based on current nursing and medical assessment and review.

Background

It is estimated that fifty-five percent of people with dementia are living in the community (ACSA Fact sheet). It is usually when the person with dementia requires medication support that a referral to RDNS is made. During November 2002, RDNS registered 3454 clients of which 1013 (30%) received support with medication management. Of the 133 observations 77% were thought to have dementia as assessed by the researchers (either observed or evidence derived from the case notes). This is consistent with the 42 client case studies where 74% had an RDNS coding for confusion, memory loss, dementia or Alzheimer's disease. From this sample of clients (102) with dementia 20% were men and 80% were women. The RDNS data base also indicated that 69% of the 42 client case studies lived alone.

Issue

The focus of the District Nurse visit is to administer the authorised medications. Not surprisingly, observational and interview data suggest that the medication task dominated at the expense of working 'with' this client group more extensively. Best practice dictates that all RDNS clients are comprehensively assessed but data indicated that few received a full nursing assessment. Literature suggests that these clients are at risk of adverse events and therefore need regular monitoring and assessment. Although District Nurses are in an excellent position to monitor the effects of medication and their client's general and mental state, data indicated that few routine observations were noted. Whilst it is recognised that symptoms associated with memory loss can interfere with daily routines or social activities these were not observed routinely. In addition there was often inadequate information provided about the client's social activities and involvement with other health care professionals in nursing documentation (call sheet and blue folder in the client's home). When the client is not able to remember which activities of daily living have received attention, clear communication strategies between all stakeholders is required. Clear lines of communication were minimal in observed data. From the observational data it was noted that involvement of clients, their carers and/or next of kin in planning care was negligible. Many of these clients were on more than four medications yet a Home Medication Review had not been instigated. About 10-20% percent of all dementias are the result of treatable problems, including depression, but from the 133 observed clients, few clients had received a medical assessment and diagnosis.

Consequences are obvious. These clients who are often living alone and receiving minimal services, are at risk. A narrow focus on administration of the client's medications means that few clients benefit from early therapeutic approaches. Early assessment and confirming of a diagnosis is essential for establishment of an ongoing treatment and care plan. A care trajectory and plans involving all stakeholders is the standard of care to which we could aspire. A comprehensive model of care is required.

Dementia Scale with Three Levels

Prior to observations, researchers discussed ways in which they could scale the level of dementia. We utilised a dementia scale with three levels from Klebanoff and Smith 1997:144. Generally the scale items overlap and vary. These observations are approximate given that the average observation time available to the research nurse was ten minutes in the

client's house. As discussed, based on our observations of 133 medication management routines, 102 clients appeared to have memory loss (either observed or evidence derived from the client's notes). Surprising was the number of clients who were still living at home and who were at moderate and the moderate to severe cusp of 2-3 on the dementia scale.

Table 4 - Dementia Scale (n=102)

Dementia Scale	No	Percentage
Level 1	37	36%
Level 1/ 2 cusp	4	4%
Level 2	47	46%
Level 2 /3 cusp	14	14%
Level 3	0	0%

Current Practice: One Weekend Shift

In the table to follow we illustrate clients visited on one weekend (Sunday). This table represents a microcosm of the larger picture and will assist with the discussion of age of clients, multiple labels for dementia and show where these people rate on the dementia scale. Most of RDNS activity at the weekend is medication management. On one weekend shift, 11 out of the 13 clients requiring medication support had dementia. This number of medication visits is not unusual for the weekend. The District Nurse travels long distances between clients each morning and the route is determined geographically unless the client is given priority status (e.g. has diabetes and requires insulin before breakfast). There were no priority clients on this particular weekend round.

Table 5 - Profile of Clients on a Sunday Shift

	Client	DOB	Diagnosis	Dementia scale
1	Reginald	1911	Confusion	1
2	Joan	1921	Alzheimer's	2/3
3	Daniel	1929	Parkinson's disease	NA
4	Kenneth	1910	Memory loss (mild)	1
5	Ruth	1919	Alzheimer's	1
6	Frederick	1922	Memory loss	2
7	Winnie	1916	Memory loss (severe)	2
8	Merl	1925	Alzheimer's	2
9	Geoff	1920	Memory loss (mild)	1
10	Dulcie	1915	Confusion	2
11	Ruby	1925	Alzheimer's	2
12	Stefan	1932	Paranoid, COAD	NA
13	Evelyn	1918	Dementia	2/3

The total number of clients with dementia was 11 or 85%, women (63%) and men (36%). Average age for people living with dementia is 84 years old. Eight people lived alone. Two clients were living in married relationships (Merl and Geoff) and here the partner also had mild dementia. Using the dementia scale provided, four clients were at stage 1, five at stage 2, and two on the cusp of 2 to 3. What is particularly interesting here is the variety of labels used to describe dementia. This is not unusual for this client group, and often the labels change depending on the type of documentation. The blue folder is the client's record in the home and often indicates that the client has 'confusion', which we gather is more acceptable for both client and relatives who may read the notes. In the client's case notes, the label is

more likely to reflect the referral diagnosis e.g. Alzheimer's or memory loss. What is extremely important to note is that few clients had appeared to have actually been medically diagnosed. This may also explain the diagnostic terminology used by RDNS for its database.

Current Practice

What is current practice? We will commence with a finely drawn out example of what can be achieved in terms of observation practice in just ten minutes. This is an excerpt of the nurse researcher's journal. Val's name is fictional and the account is verbatim and includes colloquial language:

> *Val was a young looking, 68-year old woman, living alone. She has a very supportive family. Her daughter cooks and stocks up the freezer and fridge weekly. Val had great difficulty in expressing herself and used her hands to express that her son lived "outside" and "not here". She was very neatly dressed and said she was able to shower and dress herself. She did not know what the nurse was there for or what tablets she was on. Her tablets were kept in a locked box on top of fridge. She had not had breakfast and the nurse had to remind her to have something to eat. The RN explained each tablet and she had to remind Val to drink some water and take the tablets. The RN reported that the day before the client had lost her keys and the locksmith had come to change the locks and provide new keys. The neighbours were very supportive according to the RN and took her out and made sure she had meals and didn't get lost. When we were leaving, Val walked out, without locking the door, and walked absent mindedly into another building. In her blue folder was a CNA and quality of life assessment. It is assumed this was because she was admitted in May 2002. The medication authority is not legible, and some nurses could have problems reading it. The RN rings the pharmacy to order drugs, and the pharmacy delivers and puts them into a locked box. The pharmacy knows where the key is kept. In the nursing care plan objectives were reviewed and documented. Entries also include GP changing medications from BD to daily and nurses ringing to confirm that it was correct.*

The above journal entry is exceptional in its comprehensive focus, where the entire client picture is available. Predominantly visits are task driven, that is, the medications are given as per authority. A visit takes ten minutes on average. This concerns some of the nurses interviewed who stated that they would like more time to spend with clients. A typical visit was recorded by the researcher as:

> *Ellen was a woman living alone with stage two dementia. She required oral medication and inhaled medications daily. The client was dressed and well groomed when we arrived. The nurse needed to re-orientate the client to time and day on a number of occasions and inform the client that she would be attending day care later that day.*

Another visit was recorded by the nurse researcher as:

> *Mary looked very shocked that the District Nurse was visiting her home. The client did not speak to us but motioned to her kitchen where the biscuit tin containing oral medication was and the blue folder was in the cupboard next to the oven. The nurse commented to me that she felt sure that the client did not need her medications locked away so that is why she did not have a locked box. This assessment was not documented. The nurse washed her hands and administered the oral medication into the eggcup. It was at this point that the client initiated conversation and asked what day it was. At this point the client appeared a lot more relaxed. She asked why the nurse was coming to see her and the nurse explained the need for the visit. The client seemed to*

accept this and she took her medication with a glass of water that the nurse had provided her with. The client has stage two dementia.

Another nurse researcher observation, this time an account of a man with stage one dementia:

Reg was a large ambulant man with a stage one dementia. He lived alone with minimal community supports. He was well groomed, dressed, with slippers on. The TV was on when we arrived. The client motioned a hello but he did not move from his chair in the lounge room, however, he did stand for the national anthem (cricket was on the TV). All medication stock was on top of the fridge in an ice cream container. He has more than ten medications spread over the day. These were placed in labelled saucers on the kitchen table. The nurse stated that the client doses not like the staff to watch when he self-administers medication from the saucer. He takes them when the nurse has left. This is not documented in the notes in the home and the administration chart is signed as 'directly administered'.

Lack of Information to Guide Practice

In many situations there was inadequate information about the client in the nursing documentation provided (call sheet and blue folder in the client's home). With this client group there needs to be clear instructions and information in the client's home, otherwise we are putting clients at risk, especially because many of them are living alone. As one nurse said:

Another big concern is that we are dealing with many confused and demented clients. We (the District Nurse) just walk in (their house) and we could be anybody! It just highlights that sort of vulnerability. That's my big concern in a sense, really, that a lot of the time they (client with dementia) don't understand their medications and no matter how often you go through them, it just doesn't click basically.

It was observed that the level of dementia places clients at risk if support systems such as a neighbour or carer were not available. Often the District Nurse is the only person to call on the client, whether at the weekend or during weekdays. The details about carers and next of kin documented in the blue folder are basic. It is important to know the name of the person the District Nurse can contact. Who will prepare their lunch and dinner or check to ensure that the client is safe? This information is vital if we were to consider RDNS as providing a comprehensive service. If the client has a carer it is important to know how often they call on the client and the extent of their involvement. Sometimes there are relatives in the house but it was not clear from existing documentation why relatives cannot administer the medications. What other avenues for medication management had been tried for clients? This information was not available for the researcher and more importantly for the District Nurse making the call.

One District Nurse suggested that the quality of information was more important than quantity. It was suggested that concise and easily located paragraphs noting these essential details in the blue folder or on the call sheet be provided for each client at risk. This could be established as a documentation standard.

Clients with Dementia and Problems with Medication Management

Nurses expressed concern over the quandary experienced when clients with dementia refused medications 'even though it's obvious they require them'. One nurse gave the example of a bed bound client with dementia 'who regularly spat out or refused to open her mouth' to take medications, including analgesia. Moreover, when a client has only a morning visit but is

prescribed evening medications, the District Nurse does not know if the dosetted afternoon medications have been taken. As one nurse said:

> *The client could take the medication at an inappropriate time. How would the nurse know? Unless the client is showing signs of "missed medication" or "double dosing" nurses cannot be 100% sure that authorised medication regimes are working.*

The Majority of Clients with Dementia Live Alone

We have discussed the number of clients who live alone, often with the next of kin living many kilometers away and seeing the client infrequently. One interviewee said about people receiving medication:

> *I guess we're sort of still talking about some people with dementia and memory loss. People that live alone. I know I had one particular client who didn't have any family at all to pick up her medications. Try to get someone to organise a script! It took me weeks!*

Another said:

> *Older people who live alone have limited support. You know, getting scripts, getting in the stock'. One of my pharmacists used to do home deliveries and all of a sudden, he couldn't do home deliveries any more and then I tried to organize delivery. It just takes time.*

Nurses talked about arriving at closed doors and not knowing whether the client was home and safe. A nurse explained:

> *… sometimes there is a 'no access' visit as well. Because they've got dementia, sometimes they don't remember that you're actually coming. One person used to go out all the time. So two or three times a week, she wouldn't be home. Do we go back or say that's our one visit. Do you know what I mean?*

Lack of Formal Assessment and Diagnosis

As previously discussed in construct one (The Nursing Process) comprehensive client assessments were frequently incomplete as evidenced by the missing documentation in the blue folder or case notes. Similarly, many clients observed appeared to lack formal medical assessments and/or a definitive diagnosis. When clients lack the combination of nursing and medical assessment their care is severely compromised. Assessment is the corner stone of nursing practice.

Increasing Number of Referrals for People Requiring Medication

One nurse said:

> *One of the trends appears to be the increasing numbers of referrals for people requiring medication. Possibly that's a reflection of the changing demographics, that is the ageing population. So people are living longer and probably have got more complex health issues. We are probably on the end of the receiving line in trying to assist people managing their medications. I'm not quite sure the numbers of people with dementia but certainly chronic illness and I think those co-morbidities that people are living with are impacting. Polypharmacy is the end result in that multi prescribers add to the complexity and perhaps less family and other resources available for care. I think*

that's one of the issues our organisation needs to grapple with is how do we best provide that service to those people.

Discussion

A task-orientated rather than a person-centred approach appeared to drive nursing practice. Other than the medication visit, plans for future management have not been considered for a majority of the clients observed. The main link for the client with dementia is the District Nurse and this link needs to be maximised through a planned collaborative approach.

How can the process of care be improved for people with dementia? First there are many different types of dementia eg Alzheimer's disease, multi-infarct dementia, alcohol dementia or HIV dementia. It is a syndrome that has great variation in clinical features. The primary assessment tool is the Mini-Mental State Examination (MMSE). In addition to nurses completing a full nursing assessment, a MMSE should be completed. As already stated in the report a community care pathway for clients with confusion or memory loss is currently being piloted at RDNS. The pathway has been designed to provide nurses with a tool to assess and arrange referrals for new clients referred to RDNS with memory loss or confusion who require assistance with medication management. The pathway is designed to run for approximately two weeks and by the end of this time the District Nurse should be able to decide if the client can manage at home with a dosette or if they require ongoing support from RDNS. It is recommended that this pathway be implemented throughout the organisation as planned. It is also suggested that a model of care be developed for those clients who require ongoing and long term care with RDNS. These strategies together could prove to be very effective in the management of the client with dementia. For successful implementation a dedicated education program that is framed by the practice principles of primary health care, and a strong process evaluation (with a feedback loop from staff) will be required.

The first hurdle to be addressed is ensuring that a nursing assessment for clients with dementia is carried out routinely. The District Nurse then needs to consider suitable interventions. Interventions include behavioural, social and environmental therapies. There are a number of services that District Nurses appeared to have not considered. Intervention may mean involving a range of core services in the intervention network, such as the Carers Association and Local Hostels. Alzheimer's Association Australia also provides education and support groups for people living with memory loss and their family and friends. Depending on local contextual factors, the network should also include specialist services such as: health services (community and mental), domiciliary care, respite accommodation, ethno-specific and indigenous community organisations.

Before planning is commenced, clients need to have a firm medical diagnosis. This is the second hurdle. If a nurse has noticed a progressive decline in memory, a decrease in the client's ability to perform activities of daily living, psychiatric problems, personality changes and problem behaviours, referring the client to the GP is fundamental. RDNS will need to work collaboratively with GPs in order to achieve this early diagnosis and planning for future care. One way that RDNS could do this is to involve GPs in the development of a community care model, thus inviting a collaborative response to the management of dementia in the community.

Once diagnosis has been made, the second stage would be to prepare and plan the future in collaboration *with* the person with dementia, their family (if they choose to do so) and health service personnel. At the moment several RDNS clients are clearly at risk because they live alone in the community. It is argued that for some of these clients, complex packages of care are required. This raises several significant questions about the organisation's ability to

respond to the needs of this group. How can District Nurses support higher levels of care? What additional knowledge and skills are required to deliver optimum care? Most importantly, what processes are necessary to shift the attitudes of District Nurses to see that their primary health care role is only partly fulfilled if they continue to view the client with dementia purely as a medication visit? There appear to be formidable barriers, both attitudinal and organisational, that inhibit practitioners from realising primary health approaches to care.

An important point here is that although we believe early assessment and diagnosis is crucial for appropriate interventions and future care planning, it will depend on the client's and family's readiness for the tests. This is the third hurdle to challenge the District Nurse. The District Nurse will need to be convinced that assessment and diagnosis (preferably early diagnosis of those clients with stage one dementia) is best practice. It is the opinion of the researchers that the District Nurse has a professional responsibility to assist key stakeholders in exploring the options for future care.

In establishing a medical diagnosis, there are clear diagnostic steps, which include a detailed medical history, mental status test, neuro-psychological testing, blood work, urinalysis, chest x-ray, electroencephalogram, computerised tomography (CT scan) and electrocardiogram. However, when this detailed examination is done, the accuracy of diagnosis is 90%.

The above requires a revision of the time schedules. It may be possible to allocate one person per week for an extensive visit during which relatives, GPs and all other stakeholders (including the client) are advised of the need to establish a firm diagnosis and RDNS offers assistance on future planning. This assumes that RDNS staff are conversant with the latest diagnostic, treatment and planning nursing interventions for people with dementia. Recommendation is that ongoing educational support is provided.

Working with the client and their family is central to community nursing practice. Once a medical diagnosis is established, the nurse can be expected to engage with the client and family and offer assistance in planing the future. As most clients live alone, this forms the fourth hurdle.

This report and the information it provides to the organisation is timely, in terms of immediate policy direction and the planning of future services. The prevalence of dementia is expected to increase dramatically in future years as life expectancy continues to increase and the baby-boomer population ages. Between 1995 and 2041 the number of people with dementia in Australia is expected to increase by 254%. This is because the old (who are most likely to suffer from dementia), are expected to increase at a faster rate than either the total population or the young old (Australia Dementia Facts).

RECOMMENDATIONS

1. Clearly articulate the expectation that all staff will complete a comprehensive nursing assessment and regular, systematic review of clients with dementia.

2. Time allocation for working with clients with dementia is negotiated. The District Nurse initiates negotiating additional time with Team Leaders and Consultants.

3. Review the dementia clinical pathway in light of this report's findings.

4. Instigating a planned intersectoral (e.g. with GPs and Pharmacists) collaborative approach for assessment, referral and review of clients with dementia.

5. Provide educational support for RDNS staff in Primary Health Care Principles to guide comprehensive nursing practice (Primary Health Care Package to be developed and evaluated by the Research Unit and rolled out across all RDNS staff by the Education Centre).

6. Ensure District Nurses are conversant with the latest diagnostic, treatment and planning nursing interventions for people with dementia (educational preparation of all staff in dementia care is the professional responsibility of each staff member with support and resources from the Education Centre). Refer to core competency recommendation construct 2.

7. Articulate clear referral guidelines for Home Medication Review that includes all clients.

8. The organisational ability to respond to the needs of this client group (particularly those with stage 2 dementia) should be reconsidered.

CONSTRUCT 9 ISSUE

Medical Authority for medication administration is problematic in terms of legality, legibility and receipt of timely authorities.

Background

The RDNS NPM policy for Registered and Enrolled Nurse responsibilities related to medication administration (Appendix 12: Policy 2.CP 43) states that 'RDNS requires the medical officer to supply a legible authorisation when requesting medication administration and following alteration of any medication' (Reviewed 2000).

The medication policy also states that 'a complete updated authority is obtained at least three-monthly, whenever there is change to the clients medication regime or when orders become confusing, compromising safe practice'. The RDNS policy for the three-monthly update of authorities (Appendix 12: Policy 2.CP. 43) is based on Australian Medical Association (AMA) and Royal Australian College General Practitioners (RACGP) guidelines that recommend regular medication reviews. The RACGP guidelines (1999:1) states that a resident who is medically stable should be reviewed on a regular basis (for example three-monthly). A medication therapy review should also occur on a regular basis as per the guidelines although no actual time frame is suggested. The rationale for regular review of medications being that the writing up of drug orders enables a review of the need for any ongoing medications especially psychotropic, cardiovascular or NSAID medications (RACGP guidelines 1999:16). The RACGP guidelines (1999:17) also clearly state that 'the guiding principle in medication review is that the resident and the clinical situation require review; it is not just the drug chart which needs signing'. The guidelines for medication management in the community are currently being developed by the Australian Pharmaceutical Advisory Council (APAC).

RDNS has developed its own authorisation form. In November 2002 medication administration practice is guided by policy 2.CP 43 (Appendix 12).

Issue

The most problematic issue in medication practice in the community is the authorisation of medication by the medical officer. The difficulties associated with obtaining a legal, legible and timely authority has made this issue a strong theme in both the observational data and the nurse interviews.

Current Practice

Referral and Admission of Client

The current practice for medication authorisations involves a medication authority being provided at the time of referral of the client. Referrals to RDNS are channeled through the Call Centre and the authorisation is usually a facsimile. When admitting the client, the District Nurse (registered) then transcribes the medication list onto the medication administration record for the purpose of noting administration (Appendix 12: Policy 2.CP.43). The administration record and authority are kept in the blue folder and reside in the client's home. However, District Nurses are required to administer medications from the medication authority form and not the administration record.

The Three-Month Review

The process of updating authorities every three months has been in place for approximately seven years. It is the role of the District Nurse to request regular updates (three-monthly) of

the authorisation record. One way this is orchestrated is through sending a facsimile to the GP or medical officer requesting an authority update. This request describes the need for three-month review and asks the medical officer to fill out the new form and return it (usually by facsimile). Another way to gain a three-monthly update authority is when GPs do a home visit. A blank authority should be available for use in the blue folder.

In gaining an authority, the policy 2.CP.43 (Appendix 12) states preference for doctors to use the RDNS Medication Authorisation Form. However, RDNS does accept computer print outs of medication lists as long as it is signed and dated.

The Issue

Nurses interviewed (n=34) declared that the authority was a concern in one way or another. Interestingly a few nurses actually referred to the authorities in a positive way as they felt the system worked well. However these comments were definitely the minority. The observational data raised many concerns about legibility and time wasted by nurses having to chase authorities. A review of the nurses' notes indicate that a large percentage of the documentation refers to obtaining authorisation. Within the construct of medication authorities four main concerns were identified

- Timely authority
- Legalities
- Legibility
- Supply

Timely Authority

For the process of a three month authority to work it must occur in a timely manner. That is, the nurse needs to give the doctor adequate time to review the medications and then the doctor needs to return an authority that is of a satisfactory standard. The data generated from the nurse interviews and the observational data describes the current situation where there is an enormous amount of time and effort put into trying to obtain authorities. There seems to be a lack of understanding about the rationale for the authorities from both the nurses and the medical officer (usually the GP).

It should be noted that the majority of RDNS clients receiving medication support are people who have varying degrees of dementia. Some of these clients may be stable and their medication record may not change in that three-month period. However, few of the clients observed appeared to have been medically reviewed since admission to RDNS and some clients have been 'on the books' for many years. What is best practice concerning these clients in terms of a medical assessment and review? Obviously the rationale behind the RDNS policy has always been that clients and their medications should be reviewed regularly. However the nurse interviews clearly demonstrated that this frequently was not the case:

> *…getting an accurate authority, getting some logical view of what medications people are having and what they are taking, as opposed to sometimes the GP just repeating the same medication on and on and on without really looking at the issues involved in medication, why we're giving it and do they really need it and all that sort of stuff. I think there's not enough review of the medication as it were.*

The idea that the GP is just repeating the same medication on and on without really looking at the issues involved demonstrates that the process, in its current format, is frequently a time wasting exercise for the District Nurse and the GP. If the goal is to encourage GPs to review

their client then clearly in cases like this no progress is being made in that direction. However not all the nurses viewed the three monthly review as an opportunity for a medical review as seen below:

> *If I could wave a magic wand, I think the main thing that I would do would be for the doctors every 3 months to slip into robot mode and re-write the drug authorities, so you're not chasing them all the time.*

The above comment is further supported by other data in which nurses describe the way in which the authorities are obtained. It seems that nurses often photocopy the old authority and send it to the GP for it be rewritten. This practice negates the rationale for a medication review and is also a time wasting exercise for both the District Nurse and the GP. The following nurse's comments clearly depict the time wasting associated with three monthly authority reviews:

> *My biggest concern is the time that I think field nurses are experiencing in terms of wasting time in chasing up doctors or GPs for the medication authority. …in my experience, that it would normally take at least two or three phone calls plus faxing the doctors, reminding them to update the medication authority for the clients.*

If nurses are having to contact doctors three or four times for a review of the authority, what sort of impact does that have on the relationship between the nurse and the GP? At what point do nurses say enough is enough and document that an authority could not be received? Again the strain that the three-monthly review is having on the working relationship between the nurse and the GP is clearly a problem:

> *I just find that we get feedback from the GPs that "I just did this a couple of months ago. Why am I doing it again?" type of thing.*

Perhaps if the GPs were made aware of when the authorities were due, this would give them the opportunity to tie the medication review with other appointments for the patient. The way in which nurses obtain the authority also needs to be addressed so that the process is more efficient for doctors and nurses.

Legalities

The nurses interviewed were very keen to ensure that they obtained legal documents for the administration of medications. A big problem for the nurses is that authorisations were frequently not legible and/or were incorrect, no date or signatures. This nurse describes the problems below:

> *My biggest concern probably would be to get legible and legal authorisations from the GPs and from the hospitals. And often, we'll get doctors popping in and just jotting down things without signing, without dating it, onto our, you know, in our blue folders, or get authorities sent out that don't have the legal requirements. They're illegible [incorrect doses] and often doctors can be a little bit stubborn or difficult to deal with when you're constantly ringing them up and saying "Oh sorry, this authorisation you've given us is not suitable because blah, blah, blah, blah".*

From the above example you can put yourself in the position of both the GP and the District Nurse. Did the GP have access to appropriate paperwork when in the house? Are mistakes happening because they are having to rewrite the authorities so frequently without taking the time to review the client as a whole? There were various examples given by nurses of GPs

writing incorrect doses on the new authority ‘despite them sending the old one’. Nurses claim that ‘it just seems we're for ever chasing them up and also forever correcting them’. The transcription errors by GPs could be avoided through the use of computerised updates or getting the GPs to sign the same authority if there are no changes required.

Some nurses held the misconception that they could not use an authority if it had not been updated in the last three months as shown below:

> *What is RDNS’ position, I mean if you get to someone’s house and it’s 4 months overdue, you can’t get a medication authority, do we have a sort of, a clear position where, I mean give it or not give it. Because it can be a little bit a judgement thing as well. If someone’s having a medication once a week, okay, you might be able to get medication authority tomorrow or something like that, but if someone’s say on something like Digoxin or similar sort of medication, it leaves you in a bit of, you know, that client needs that medication. So that is something that I haven’t quite resolved within the hierarchy.*

The questioning of whether the nurse can still use an authority after the three month period has passed indicates that there is not full understanding of the rationale for the policy. It is also suggests that when nurses are put into this position they actually ring the GP and say they need an authority urgently. This then puts the GP under pressure with no real reason for that pressure.

Another practice related to legalities that warrants some discussion is that of transcribing from the authority onto the medication administration form by the Registered Nurse. There are some inherent risks in transcription which is why an audit by Department of Veterans Affairs (DVA) highlighted the process of transcribing as a concern. As explained below the authority is not always used for administration, particularly if it is of poor quality:

> *As someone who works in the DVA team, one of the things that came up when DVA audited us, was, well they thought of transcribing. We go by medication authority and then we have a medication administration chart and when DVA audited us, they were concerned about the fact that we write on our medication administration chart the drugs, the dose, how often we're giving it and they could possibly see that as transcribing, because we should be giving off the medication authority but in the real world, it probably doesn't always happen. If someone has trouble reading the medication authority, they may actually well go to the medication administration chart. Or there could be errors in transcribing that over. So I guess that was raised and when you think about, we do write those charts out every 28 days or more often, just depending on when we're doing medications. When in previous community nursing agencies where I worked, we only ever wrote the drug name on the medication administration chart, so whoever gave that drug, they would always have to refer to the authority for the correct dose. It just saved the transcribing error of doses and people not going off the medication authority and things like that. I mean that was just one issue that was brought up by DVA as something that could have potential problems from transcribing errors.*

The idea of only transcribing the name of the tablet has some merit as it would significantly lower the chance of a transcription error. It would also force the nurse to refer to the medication authority, as they wouldn’t have direct access to the dose.

One other legal issue is the administration of medications without an authority. The exemplar below explains the dilemmas that nurses may face when they go into the home and the authority is not there:

> *I guess I haven't actually relieved as yet, but I know I will be relieving soon and I've heard from other relievers that quite often, they do rounds and the medication authorities are out of date or if there isn't one, for like SSD cream or something like that and I guess most people are okay with going, with administering that, but also the ones who are careful about their, or looking after themselves and not getting into any trouble.*

Senior nurses need to set an example for junior nurses by ensuring that situations such as that above do not occur. Nurses need to think about the next shift by ensuring an authority is available for all of the medications even when it might only be a steroidal cream.

Due to the frustration that nurses are experiencing in getting a correct authorisation the example below describes how nurses are resorting to writing the medications themselves and then asking the GP to sign it. This is clearly not a legal practice:

> *And what often happens in that situation is that the nurse writes out the authority on an RDNS form and asks the GP to sign it and in fact, that's not a legal practice. Our policies state clearly that that shouldn't be done. So I'm concerned that often RDNS staff are almost pressured into wrong practice, to save time, to get around … you know, they don't want to hassle GPs, they don't want to annoy them and also, that we're doing something that's illegal really.*

Nurses who are writing the authorities out for the doctors are putting themselves and the doctors at risk. The practice should be strongly discouraged.

From the nurse observations the following similar issues arose such as illegible authorities, nurses adding to medication authorities with verbal orders, and confusing authorities with some medications crossed out. Some authorities did not have dates but the nurse told the researcher that it is acceptable to use the date from the fax. Other observations made were changes to authority forms without a GP signature. These examples demonstrate that there are some legal issues that may need to be addressed within the recommendations.

The nurse observations cited many examples where GPs had demonstrated a lack of understanding about the process for authorities. One example was documentation in the case notes about the GP’s poor reliability related to the up-dating of medication authorisations. Another example described the practice of a GP leaving notes to change medications, perhaps because there was no form for him to fill in.

Legibility

Nurses rely heavily on a legible authority when administering medications. Doctors’ illegible writing increases the chance of error and also wastes time for the nurse who may even need to request that another form be written. To provide a general guide the authorities were graded by the researcher as good, average or poor. The grading was based purely on legibility and did not take into account other legal issues such as date and signature. Authorities that fell into the category of good were typed, while average were handwritten and legible. Poor authorities were bordering on illegible or were illegible. Of the authorities available for viewing (n=39), 15% were good, 40% were average and 43% were of poor quality. These

statistics demonstrate the widespread problem of poor quality authorities. The process of facsimile also influences the readability.

This nurse relies on the transcribing from the registered nurse due to the illegibility of the authorisations:

> *Well as I showed you this evening, one of my concerns is medication authorities that haven't been re-sent to a doctor when medication changes have happened. Some of the faxes are quite blurry, some of them are illegible and I rely heavily on the transcribing from the registered nurse, which is an issue.*

If nurses have made changes to the authority form it is important that they send it to the GP for an update otherwise it is not a legal document and that makes it very hard for the next nurse who comes along. In addition, if the quality of the authority is so poor that the nurses are relying on someone else's transcription, then mistakes are more likely to occur. Nurses suggested that a computer print out would be the preferred solution to illegible authorities. However one issue with computerised print-outs was that doctors often forgot to sign them which meant that nurses had to send them back for signing

Supply

Clearly the gaining of correct authorities was a major issue for staff. Obtaining the supply of medications did not feature as strongly but is nevertheless worth mentioning. The clinical documentation held frequent references to the task of getting the supply of medications.

The nurses in their interviews described the difficulties associated with getting the supply in a timely manner particularly if the medications are not in stock at the pharmacy. The examples cited by the nurses highlighted the importance of pre-planning. If the chemist receives the script and the medication needs to be ordered it is only a problem if the tablets are needed that day. The example below highlights the ramifications of letting stock get too low before deciding to order:

> *And just getting a supply of the stuff, which can be incredibly difficult with people with very little mobility and often dealing with people with dementia. They don't necessarily remember what you said so you're often trying to get hold of carers or relatives etc., who are not home and not there. I don't think nurses in general pay enough attention to making sure there is sufficient stock and you go from the sublime to the ridiculous half the time, which drives me nuts, in that in some houses, there'll be 10 boxes of everything and the next house, there's nothing. And I think that people need to be frugal when they're ordering medication that they know it's a need to make sure there's enough there. So that's probably the biggest thing. You know people on the weekend will come back and someone's been there Friday and there's nothing. You know, they've run out of X, Y and Z. Huge complaints we've had.*

The communication between the pharmacist and the District Nurse is important when obtaining medication supplies. The case below is one example of what can happen if communication is not maintained:

> *The main concern I have I would say would be the medications not being there. Like ringing pharmacies and getting them to deliver, but then they don't get delivered and I had one the other week that I ordered the medication, rang up, ordered them, they said "Yep, not a problem" and then it was like 4 days later, after the weekend and no medications. So I rang them again and they said "Oh we went twice and she wasn't*

there". Oh okay. Then they said "Well we'll only go once more and then we won't deliver anymore" and then they went the third time and said she still wasn't there. But when I asked her, she said "Yes, I was here, I was here all day". So I don't know what the problem was with the chemist, but we finally got the medications there, but that was the main thing. I was thinking "Ohhhh if I run out of medications, what am I going to do?"

In this situation the pharmacist could have contacted the District Nurse to inform them of the problem. The pharmacist could then have arranged to have the medications delivered when the District Nurse was going to be in the home.

For clients on specialised medications there may not be the facilities for them to get the medications from the local chemist. The stock is therefore arranged by hospital pharmacies. The problem that has arisen relates to hospital pharmacies requesting that RDNS fill the dosette. Obviously the filling of dosettes places an extra strain on RDNS resources and is currently being addressed by RDNS.

Discussion

Timely Review

The comments made by the nurses around the practice of three-month updates clearly articulate the frustrations felt by the nurses. They feel an obligation to adhere to 'RDNS policy' although the rationale for the practice is being questioned by some of the nurses. The nurses have recognised that while an authority may be written this does not confirm that a client's medication have been reviewed.

It was evident from the nurse interviews that the relationship between the District Nurse and the GP is being compromised by the negative connotations associated with the medication authority updates. GPs do not understand why the nurses need to obtain updated authorities and the nurses then become frustrated with the GPs because they're not receiving the authorities in a timely fashion.

The rationale behind the need for a three-monthly update is not clearly stated and while it may be best practice for clients to be medically reviewed every three months, is it the role of RDNS to enforce this onto the GPs? Is it really serving any purpose in its current format? The researchers would argue that the current practice does not appear to increase the likelihood that the GP will review the client or the client's medications. While it is strongly argued that best practice would ensure a three monthly review the need for improvements in this process is evident.

From the interviews and the observational data it became very evident that the chasing of authorities takes up a considerable amount of time for nurses. The time also relates to authorities being incorrect and not legible. Much of the case note documentation pertains to issues around ordering, receiving, discrepancies and requesting authorities.

Legalities

Nurses involved with medication administration are acutely aware of the legalities associated with medication administration. Nurses feel as if they are being put into a difficult situation when they go into people's homes and the authority is not "in date''. The nurses are incorrectly interpreting the policy as a legal document that states they must obtain an authority every three months.

From the interviews and the observations it is evident that there are some practices occurring within RDNS that are not legal. Practices, such as the nurse writing out the authority and then asking the GP to sign it, and nurses writing changes on the authority, need to comply with the policy guidelines (2.CP.43).

The RACGP guidelines (2000, p.17) actually state that the transcription should not be routine practice and that if transcription must occur then it should be reviewed and authorised by the doctor. The guidelines also state that in some states legislation forbids nurses to transcribe. Nurses also need to be aware that the transcribing of medications onto the administration form does not negate the need to use the authority when they administer. From analysis of data it would seem prudent that the practice of transcribing be reviewed.

Through the interviews it became evident that the GP's understanding of the processes by which RDNS nurses practice is limited. It is argued that the lack of understanding may be partly due to the way in which nurses go about obtaining the authorities and that perhaps if nurses had a better understanding of the rationale then there would be less animosity.

Legibility
Legible authorities are of utmost importance and the data suggests that signed computerised print-outs are the best way to obtain a legible record. Poor legibility increases the risk of transcription errors and medication incidents.

Supply
Obtaining a medication supply in a timely manner requires a clear plan and a good relationship with the pharmacist. The difficulties arise when organising the supply is left until the last minute, particularly when it is a medication that needs to be ordered by the pharmacist.

RECOMMENDATIONS

That the Nursing Practice Committee reviews documentation and guidelines for current medication authority and considers:

1. On the authorisation form, increasing the space to write dose, frequency and updated phone numbers.

2. On the authorisation form include a statement outlining the intent of the authority and state preference for signed computerised print out.

3. On the authorisation form, place a review section on the bottom of the authority which enables GP to sign and date that she/he has reviewed medications (space for 4 review dates to ensure new authority written every 12 months).

4. Review wording of the policy for medication administration 2.CP.43, ensuring that the rationale for three monthly review is included.

5. Changing policy 2.CP.43 to read that signed computer printouts are the preferred method of authority as this will improve readability.

6. That nursing staff be instructed to include a spare blank medication authorisation form in the blue folder at all times.

7. Review the process and safety of the transcription process taking into consideration guidelines endorsed by organisations such as APAC and DVA.

8. That a recall system be set up to ensure three monthly review of authority occurs in a timely fashion. A reminder could be placed on the call sheet as to ensure that the GP has plenty of time to review the medications properly.

9. That the organisation consider ways of engaging General Practitioners in discussion and debates around the issues of medication authorisations so that client safety can be assured.

CONSTRUCT 10 ISSUE

Lack of intersectoral communication was evident. The District Nurse is often left out of the information loop in the transfer of client information, coordination of services for clients and post discharge from hospital.

Background

Intersectoral communication refers to the communication channels across different sectors, such as hospitals, pharmacies, community agencies and general practitioners. Due to the complexities of the clients visited by RDNS there are usually multiple health providers involved. Medication management is often only one aspect of client care.

The District Nurse visits the client regularly, and is in a prime position to assess clients in their home and communicate with other health professionals about the abilities and intentions of clients to self-manage at home. The volume of RDNS clients requiring medication support and the sheer size of its workforce means it is imperative that structures and processes are in place to facilitate effective intersectoral communication. Further, 74% of the 42 clients observed had various degrees of dementia and it is even more urgent that communication between services and sectors is flawless. It is apparent that RDNS has good internal structures in place. Of concern however is the gap between RDNS and other sectors. Let us review what RDNS provides.

One of these structures is an RDNS employed hospital liaison nurse whose role is to ensure effective transition from hospital to the home and vice versa. When an RDNS client is admitted to hospital there is a form completed by the round nurse to inform the hospital liaison of the admission. The way in which this process works is outlined in the "policy notification of admission to hospital form" (Appendix 13: Policy 3.CM.15). The liaison nurses are also responsible for arranging new referrals to RDNS and they work closely with the RDNS Call Centre.

One other structure central to intersectoral communication is the RDNS Call Centre. Staff are available by telephone 24 hours a day. The Call Centre staff have access to current client information, can track client visits made by District Nurses, vet new referrals, provide health care information and deal with inquiries about care of clients. The aim of both these structures is to facilitate a smooth referral process and admission to RDNS and assist with ongoing communication between health care professionals.

In addition, the RDNS NPM has policies to guide admission, discharge and communication. The referral and admission policy (Appendix 10: Policy 1.CR.15) clearly outlines who should be admitted for RDNS services. Specific criteria for referral to RDNS for medication administration are outlined in policy 1.CR.15 (Appendix 10). This policy states that to meet the criteria for admission to RDNS, clients are unable to self-manage their medication, are confused, have no carer able to assist with medication management, or have no access to pharmacy/Webster pack services.

Yet another structure in place is the referral form requesting RDNS services. This form can be used by any health professional to request RDNS visits. The introduction of the CIMS will simplify this process for both referrers and District Nurses. On receipt of the referral form administrative staff will collect information via telephone from the client or carer. Nurses will consequently have more information available to them at their first visit. The referral form has been simplified so that it is in line with the new information system.

One more structure that RDNS uses for communication with other health providers is the Report to Medical/Health care officer (in triplicate). As outlined by policy 1.CR.14 (Appendix 8) the aim of this document is to facilitate continuity of care between the inter-disciplinary team and the client. The District Nurse can write his/her communication and then the health professional can write a response and give it back to the client. This process is reliant on the client's memory to give correspondence to health professionals. It is not likely to work for the client group with dementia that we have profiled.

Finally, communication can be enhanced through the communication sheet left in the client's home (blue folder). Other care workers, GP or family are encouraged to utilise this form as a means of communicating to the District Nurse (Appendix 8: Policy 1.CR.14).

Issue

The provision of seamless care requires a coordinated approach to medication management in the community. The lack of intersectoral communication was a strong theme throughout the observational and interview data. Data suggests that the District Nurse is often left out of the information loop and the reasons for this may need further exploration. A major concern was that there was a lack of communication and frequently poor coordination of services for clients particularly post-discharge from hospital.

Current Practice

Nurse interviews and the observational data describe current practice. Highlighted is the chasm in communication between sectors. The example below clearly describes one nurse's view about the lack of collaboration between sectors:

> *It's not a collaborative approach, I think, probably what I'm trying to say is that there isn't a group of people [health professionals] who sit down …and say "okay, this is what we want, we want to treat these symptoms, we want to prevent this disease, we want to try this, we want to try that, and this is what we're going to do and this is what we're going to achieve by that" and looking forward and saying "okay, this is now a really good regime of medications for this person …". There's none of that, it's just sort of like higgledy-piggledy, just pommel it together, "try this, try that, oh the drug rep came round today, we'll give them one of them" You know? There just doesn't seem to be a consistent approach and there isn't a team approach from specialists and GPs and hospitals and GPs to medication management. It's just sort of like "whatever you reckon".*

As indicated, the scene above is one of chaos and inefficiency. The lack of collaboration and/or coordination is a common thread throughout both the interview data and the observational data.

Complexity Of Intersectoral Communication

Complexities of intersectoral communication are problematic in terms of providing an accessible account. For the purpose of this report, the construct has been divided into the different types of communication:

- How do we get off the merry go round?
- The importance of being in the information loop.
- Establishing rapport with medical officers.

How Do We Get Off The Merry-Go-Round?

The GP could be the pivotal point for the coordination of care for clients requiring medication management. Indeed, the Commonwealth, through provision of financial support for case conferencing and Home Medication Review, reinforces the role of the GP. The reality is that GPs do not use these provisions adequately and the District Nurse is often the defacto coordinator of care. Data suggests that the GP appears to be a reluctant partner in communicating the client's treatment details with the District Nurse. When further information flow is impeded by the lack of hospital discharge information the client can be placed on a merry go round as described below:

> *And a number of times people come home without discharge summaries. That means we operate without any idea of events while they were in hospital. Whole medication regimes are turned upside down and they're back home. There's no communication whatsoever with the person's GP. ... I can think of a client who goes to hospital and ceases his medication then returns home with another authority. The GP comes in, gets rid of that authority and starts the original up again. Then the client goes back into hospital, the hospital staff stop medications again, you know. Like it's all, it all gets tossed and diced around the place.*

We argue that client care is compromised and that clients are 'mismanaged' through lack of coordination. However, communication between medical staff is a difficult issue for nurses to effect change. One problem that District Nurses encounter is clients who have multiple doctors prescribing and writing authorities. Multiple prescribers can result in confusion and an increase risk of error for the community nurses. One could speculate that readmission to hospitals might be related to the very medications prescribed and taken by clients.

The GP not being aware of changes made to clients medications post-discharge from hospital was frequently reported by the nurses who were interviewed. As explained by one nurse:

> *... the usual scenario is that the hospital send an authority to RDNS and you phone the GP for an updated authority and find the GP didn't know they were on three other medications.*

If the GP does not know the full range of medications that a client is prescribed or taking (including over the counter substances) then the question arises as to who is coordinating the client's overall care. The example below demonstrates the aftermath of poor communication between hospital and community:

> *One of my concerns is that there is not enough liaison between hospital medicos and the GPs. Giving you an example from practice, a woman with an intellectual disability went to hospital for surgery on her hands. She came out of hospital after a few days with a change in medication authority for the dose of her insulin. She said to the visiting nurse that she felt that the dose was wrong. So the nurse rang the hospital and asked the medical officer. The medical officer said that it must have been a mistake in transcribing! We were advised to give her the medication the GP had ordered. That was the sum of our information. So we went back to giving the dose of insulin that the GP had originally requested. Meanwhile, we again contacted the GP to ask about the dose of insulin. The GP said to put her on the dose that the hospital had organised! To complicate matters even further, a locum that told another nurse (who was also seeking clarification) to use the same dose ordered by the GP. It wasn't until a few weeks later, somebody found the new medication authority behind the GPs authority in the client's*

blue folder. This situation became an incident requiring reporting. So there was a lot of confusion, a lot of chasing information and a lot of paperwork that didn't need to be done. So I think that if there had been more liaison between the medical staff and the hospital to say why they wanted her on medication referral change, it would have been easier and safer for all concerned.

This example demonstrates that not only the clients can be on the merry go round, but also the District Nurse and the GP. Apart from the nurses being out of the information loop, it is also argued that the clients are being put at risk when changes to medication are not communicated to the appropriate health professionals.

Direct communication with RDNS post-hospitalization or outpatient visit appears to be problematic. It was evident that RDNS do not routinely receive a copy of discharge letters and that discharge planning from hospital is frequently less than optimal. Appropriate communication, discharge planning and documentation are of utmost importance particularly when the client has a diagnosis of dementia and/or is a poor historian. The end result of poor intersectoral communication is time wasted, frustration for community nurses and their clients, and may even result in an adverse event for the client.

From the observational data there were numerous examples of situations where client care was compromised due to poor discharge planning from hospital and lack of appropriate communication across sectors. Situations such as a client being sent home from hospital without discharge medications, poor information at admission and complex clients being sent home without any form of case conferencing.

Gaps in current service delivery are evident. The link between hospitals and the community are shown to be important.

The Importance Of Being In The Information Loop

The client group receiving medication support often involves many community stakeholders. It is essential that District Nurses are included in the information loop if they are to provide quality care for clients. Data indicate that nurses are often excluded. This is not to say that District Nurses are the only excluded group as we have shown the way in which GPs are casualties of defunct communication between themselves and the acute care sector. It is not a novel observation that community agencies, such as domiciliary care, GPs, mental health workers, pharmacist and carers from various organisations all have a role to play both individually and as a team in provision of seamless health care. This study further demonstrates that fragmentation of services is rife. The question is how we can address the problems of fragmented care in which clients are the main victims.

The interview data suggests that many nurses have a desire to be more involved in case management and discharge planning for clients. The example below describes one nurse’s view:

I think I would like to be much more involved in discharge planning for clients.... I have many clients who come in and out of hospital or see other agencies and I never get any information fed back to me. I had a client who had been out of a hospital a month. Prior to him going in, he actually tried to commit suicide. He'd been out of hospital and no one even told me. He came to me a month later, telling me that he'd been in hospital. So I would like to be involved perhaps in the discharge planning team with these people. Maybe even to have regular meetings with them, to find out what's going on.

There is an opportunity for case conferencing but this process relies on a GP's willingness to convene the multidisciplinary team. Case conferencing is an effective way to bring together key players in the client's health plan. Despite the Medicare rebate (which incidentally other health care workers do not receive) GPs infrequently use case conferencing as a resource to improve client care coordination. Alternatively, any stakeholder within the health care team can initiate case conferencing but the GP remains central to this process. Case conferences are not widely used and when they are used, RDNS are frequently not involved. One nurse said:

> *I have concerns about not being involved in case conferences with some of our clients. They may access other agencies and they might have a case conference. I have one client where there was a case conference. I am directly involved in administering his medication for his schizophrenia and yet I wasn't invited to the case conference... I thought...Well how can I not be involved? It happened.*

The case above highlights again the misconceptions in the community that the nurse is "just administering the medications". The notion that nurses need to be involved in the whole picture is perhaps missed by other agencies involved in the care of the client. As the client's advocate, perhaps District Nurses need to be more assertive in communicating their role to other health professionals in particular to the GPs.

These examples highlight District Nurses' aim for a collaborative approach to the care of their clients. Examples also suggest that District Nurses are left out of the information loop. It is argued that there is never too much information when providing a service for a predominantly mentally disadvantaged client group.

When RDNS receives a new referral the information supplied is a base for prioritising what is needed at the first visit to the client. Often it is the only information the nurse receives on which to plan care. This information shapes the initial basis for their assessment of the client. Having adequate information is of particular importance when the client has dementia and is unable to contribute information. We have shown that most clients with dementia live alone, so the assumption that a carer is available or on standby is suspect. Data revealed that there was often a lack of medical information from the referrer such as medical history, test results and assessments (particular when the client has memory loss).

Interestingly, the pharmacist's role was one aspect not discussed by the nurses interviewed other than in the delivery and supply of medications. However, the case studies highlight a need for many of the clients to have their medications reviewed. Understanding the role of pharmacists in the Home Medication Review program is vital if management of medication equates with best practice ideals. As previously stated the average number of medications for each client (n=42) was 6.34 and this in itself is a trigger for a HMR.

Building Rapport With Medical Officers

It is also important to remember that District Nurses also have a responsibility towards maintaining communication channels from their own end. In some instances there was evidence that the District Nurses may not have been assisting the communication process. Although there is evidence that some nurses push for improved communication through case conferencing, it is also clear that others do not feel confident to raise the idea of a case conference with the GP. It is uncommon for nurses to book appointments with the GP to discuss management plans. In light of the volume of clients with dementia, the perennial problem of addressing disaffected communication between District Nurses and GPs is urgent.

Communication with the GP is perhaps one of the most important communication channels to establish when working in a community setting. The GP, as the 'sanctioned' coordinator of care for the client, needs to be consulted with on a regular basis. Although the client's case notes are rife with communication demonstrating the District Nurse's need to obtain a medication authority, other types of communication were less frequently documented. Observational data identified many situations in which critical information about clients was not communicated to the GP and vice versa. Examples of information that had not been communicated to the GP included; unstable blood glucose levels, ongoing need for anti-diarrhea medication, contusion to forearms, medications on authority not being dosetted by the District Nurse, uncontrolled asthma and the client not taking medication as listed on authority. This apparent lack of communication is not only compromising client care but also the relationship that the nurse will have with the GP. The GP needs to feel confident that the nurse has adequate assessment skills to ensure that problems are identified and acted upon at the earliest possible time.

Nurses stated that one of the barriers to communication with GPs is access. GPs tend to have back to back appointments and so it is difficult to speak directly with them, particularly when you work in the evenings. This nurse describes the difficulties faced in trying to develop a rapport with the GP:

> *I find it difficult getting access to GPs. Often when you ring them they're busy and they have very limited time to talk to you over the phone and are always in a hurry. So you don't have a lot of time to talk to a GP about the client.*

There are many barriers to effective communication in the community but as District Nursess it is important to keep working at improving intersectional communication.

Recommendations From Team Meetings

As part of the consultative process the research team met with Southern, Northern and Focus District Nursing Teams to provide an update of the developing constructs. At this meeting the research team asked for feedback. Within the construct of intersectoral communication the teams made the following recommendations:

The nurses were keen to set up more formal channels for communicating with GPs:

> *There should be a relationship between nurses and GPs. Is there any form of meeting between them, even CNC and GPs or is it just us following up through phone calls?*

The nurses wanted more information at referral:

> *It would be good to get more information about our clients, about past history to know why they were commenced on medication then we can make judgment, because at the moment we don't have past history. We only have basic information when they are admitted and that's usually yes they've got dementia.*

Nurses suggested that RDNS could work more closely with other agencies in order to take some of the workload off of RDNS. Theses nurses were questioning the need for nurses to deliver certain aspects of care when carers were available:

> *I wonder whether we can look at strategies in sharing care? I don't automatically take on daily medications seven days a week. My recommendation would be exploring better use of community services and included in that is the family. I think we can easily take*

on the whole burden of the work. It doesn't need a nurse in there every day to make sure a person's health remains stable. We should be investigating ways in which we can handle the high volume in a way that's manageable.

Discussion

Data suggest that inter-sectoral communication is fragmented and that nursing is often out of the information loop. The role of the District Nurse in medication management does not appear to be valued by other health care providers. The nurse who is going in to visit clients regularly for medication management is in an excellent position to provide ongoing monitoring and assessment of those clients needs. The communication channels need to be strong so that the information gathered by the nurse filters through to the appropriate health providers. Clients who require assistance with medications may be unable to communicate pertinent information to other health professionals. It is for this reason that effective community links are established in order to deliver seamless care.

Data demonstrated a fragmented approach to health care. Numerous examples were cited that highlighted the lack of communication between hospitals, GPs and District Nurses; the end result being that the client's care is compromised due to lack of coordination of services and collaborative health care planning.

District Nurses are frequently left out of the information loop. RDNS appears to receive limited information about clients from other health professionals. The District Nurse is rarely involved in case conferences despite the large role they play in the clients care. If nurses want to take on a case manager role and utilise primary health care principles, it is essential that they be kept up to date with relevant information.

Although the GP receives a typed auto-faxed discharge letter from hospitals, this information is not routinely shared with District Nurses. The possibility of RDNS also receiving a copy of the discharge letter could be explored further.

The community pharmacist is a key player in the successful management of the client requiring assistance with medications. There are currently no formalised lines of communication between the pharmacist and RDNS. The community pharmacist can provide a Home Medicine Review for a client who is identified as being at risk of a medication incident. District Nurses can request referral for HMR through the clients GP. The GP may then organise for the service to be provided if the client agrees. After the review has been carried out the pharmacist discusses the report generated with the GP and they can then work together to put the plan into action.

The HMR service has been in place for approximately 12 months. Since its inception many reviews have taken place. The program only funds one visit by a pharmacist and the rest of the follow up is done by the GP. For clients with dementia the monitoring of the changes to the medication management may be difficult to achieve and so this is an anticipated gap in the current model. There may in fact be a place for District Nurses to be more involved in the monitoring of these clients after the medication review has taken place.

Within the current model the District Nurse is not always informed as to what the outcomes of the HMR may have been. If District Nurses could play a greater role in the identification of clients requiring HMR and the consequent follow up of the clients, perhaps the service would be of even more value than it already is.

Interview data suggest that District Nurses find it difficult to stay in the loop when the service is one of a multitude of agencies involved in the care of the client. Nurses need to upgrade their consultation, sustain their advocacy role for this group of clients and improve their documentation surrounding intersectoral communication.

Data suggest that the rapport between nurses and the GP is often lacking. Most of the communication that nurses have with GPs revolves around the gaining of new authorities. As discussed in the construct of medication authorities this practice can have a negative effect on building rapport with GPs. Observational data also highlighted many situations where nurses had not communicated valuable information to the GP about their client. The reasons why changes in condition were not communicated to GPs are unknown. The nurse interviews highlighted the difficulty associated in accessing GPs, particularly after hours, and the difficulty in developing rapport. Some nurses felt that that face-to-face meetings with GPs would assist to improve communication.

RECOMMENDATIONS

That the organisation consider:

1. A grant proposal, to explore ways for collaborating with other agencies to provide an improved model of care for this group of RDNS clients with dementia, be submitted to appropriate funding bodies. Collaboration partners are being identified.

2. Explore funding possibilities from the Pharmacy Guild to look at how we can collaborative with GPs and pharmacists towards improving care for an RDNS client group with dementia. Collaborative partners will be the Quality Use of Medicines and Pharmacy Research Centre (QUMPRC), Divisions of General Practice and the Pharmacy Guild. The proposal will explore the addition of District Nurses as partners in the current Home Medication Review model. A proposal was submitted to the Pharmacy Guild 21 March 2003.

3. To improve access to medical and pharmacy information for current RDNS clients, utilising the guidelines from the recently published *"Principles for the Continuum of Quality Use of Medicines between Hospital and Community"*.

OVERALL RECOMMENDATIONS

1. That RDNS Nursing Executive responds to the above recommendations and implements structures and processes for ongoing review of medication management

COMPLETE LIST OF RECOMMENDATIONS

1. It is recommended that all clients be given a comprehensive nursing assessment that is guided by the RDNS CNA tool. Lines of responsibility for the initial comprehensive nursing assessment need to be clearly articulated so that ownership of the assessment process occurs.

2. Implement a systems approach (within the CIMS) to flag the need for clients to have an assessment or review e.g. new admission, post-hospital admission, thus ensuring continuity of assessment, review and evaluation.

3. Implement a monitoring and feedback system to ensure that clients are comprehensively assessed and care is evaluated.

4. Nursing Practice Committee reviews its practice policies for congruence with the nursing documentation requirements.

5. Nursing Practice Committee reviews and streamlines nursing documentation in conjunction with the implementation and evaluation of the CIMS.

6. Further research is needed to identify a model of care that is specific to the practice needs of District Nurses.

7. For RDNS to facilitate a structure and process that includes medication management and/or dementia as a nursing practice core competency.

8. The Nursing Practice Committee acts as a conduit for discussion of nursing practice issues that have been raised in the field. The communication pathway for identified practice issues needs to be clearly articulated and incorporate a 360-degree feedback loop.

9. There is a responsibility to rectify misconceptions about medication management that have been identified in the report. A list of common misconceptions has been supplied for communicating within RDNS.

10. Prepare District Nurses to take control of their own time and time management.

11. RDNS continues to undertake travel surveys and make changes to rounds and boundaries as required.

12. RDNS continues to investigate and implement shift configurations that assists in delivering client-focussed services.

13. That the Nursing Practice Committee review the Policy for N&DPs in the community.

14. That Palliative Care staff in conjunction with the Nursing Practice Committee reviews the documentation for administration of N&DPs.

15. For funders to be made aware of the satisfaction that clients and carers have with the service provided by RDNS.

16. District Nurses should be made aware that they are highly regarded by clients and carers.

17. That RDNS continues to provide the appropriate amount of care and support to help people achieve maximum independence.
18. That RDNS continues to foster inter-agency collaboration and referral so those clients have the best possible service options.
19. That RDNS promotes a culture of evaluation and critical reflection as an integral component of community nursing practice.
20. As part of the Divisional Clinical Education and the continued professional development system, provide clinical updates on pharmacology and its related legislation.
21. Primary health care education is provided for all RDNS nursing staff.
22. That RDNS recognises the potentially strategic position the District Nurse holds in the management and monitoring of the quality use of medication in the community.
23. Clearly articulate the expectation that all staff will complete a comprehensive nursing assessment and regular, systematic review of clients with dementia.
24. Time allocation for working with clients with dementia is negotiated. The District Nurse initiates negotiating additional time with Team Leaders and Consultants.
25. Review the dementia clinical pathway in light of this report's findings.
26. Instigating a planned intersectoral (e.g. with GPs and Pharmacists) collaborative approach for assessment, referral and review of clients with dementia.
27. Provide educational support for RDNS staff in Primary Health Care Principles to guide comprehensive nursing practice (Primary Health Care Package to be developed and evaluated by the Research Unit and rolling it out across all RDNS staff by the Education Centre).
28. Ensure District Nurses are conversant with the latest diagnostic, treatment and planning nursing interventions for people with dementia (educational preparation of all staff in dementia care is the professional responsibility of each staff member with support and resources from the Education Centre). Refer to core competency recommendation construct 2.
29. Articulate clear referral guidelines for Home Medication Review that includes all clients.
30. The organisational ability to respond to the needs of this client group (particularly those with stage 2 dementia) should be reconsidered.
31. That the Nursing Practice Committee reviews documentation and guidelines for current medication authority and considers:

    31.1 On the authorisation form, increasing the space to write dose, frequency and updated phone numbers.

    31.2 On the authorisation form include a statement outlining the intent of the authority and state preference for signed computerised print out.

31.3 On the authorisation form, place a review section on the bottom of the authority which enables GP to sign and date that she/he has reviewed medications (space for 4 review dates to ensure new authority written every 12 months).

31.4 Review wording of the policy for medication administration 2.CP.43, ensuring that the rationale for three monthly review is included.

31.5 Changing policy 2.CP.43 to read that signed computer printouts are the preferred method of authority as this will improve readability.

31.6 That nursing staff be instructed to include a spare blank medication authorisation form in the blue folder at all times.

31.7 Review the process and safety of the transcription process taking into consideration guidelines endorsed by organisations such as APAC and DVA.

31.8 That a recall system be set up to ensure three monthly review of authority occurs in a timely fashion. A reminder could be placed on the call sheet as to ensure that the GP has plenty of time to review the medications properly.

31.9 That the organisation consider ways of engaging General Practitioners in discussion and debates around the issues of medication authorisations so that client safety can be assured.

32. That the organisation consider:

32.1. A grant proposal, to explore ways for collaborating with other agencies to provide an improved model of care for this group of RDNS clients with dementia, be submitted to appropriate funding bodies. Collaboration partners are being identified.

32.2. Explore funding possibilities from the Pharmacy Guild to look at how we can collaborative with GPs and pharmacists towards improving care for an RDNS client group with dementia. Collaborative partners will be the Quality Use of Medicines and Pharmacy Research Centre (QUMPRC), Divisions of General Practice and the Pharmacy Guild. The proposal will explore the addition of District Nurses as partners in the current Home Medication Review model. A proposal was submitted to the Pharmacy Guild 21 March 2003.

32.3. To improve access to medical and pharmacy information for current RDNS clients, utilising the guidelines from the recently published *"Principles for the Continuum of Quality Use of Medicines between Hospital and Community"*.

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APPENDICES

1. Application for Approval of Research involving Human Subjects
2. Ethics Approval Letter
3. Information for Team Leaders and Teams
4. Observation Schedule
5. Dementia Classification
6. Home Medicines Review Fact Sheet
7. HMMR Flow Chart for GPs
8. RDNS Nursing Practice Manual (NPM)– 1.CR.14 : Nursing Documentation
9. RDNS NPM – 1.CR.14A : Client Needs Assessment
10. RDNS NPM – 1.CR.15 : Referral & Admission Policy
11. RDNS NPM – 2.CP.16 : The Role and Principles of Employment for the Enrolled Nurse in RDNS
12. RDNS NPM – 2.CP.43 : Registered and Enrolled Nurse Responsibilities Related to Medication Administration
13. RDNS NPM – 3.CM.15 : Notification of Admission to Hospital Form
14. RDNS NPM – 3.CM.16 : Scheduling Visits