The voice of the Case Manager

CMASANOW

June 2022

Note from the desk of the Chairperson

Yvonne Bredenhann - South Africa

Hi all

For me the build up to conference was just so unreal, so much time and work went into the arrangements and planning. And then "poof" it was all over done and dusted.

A big thank you to all that attended, without you CMASA would not be where it is today. To our sponsors and speakers, a big shout out to you all as well.

To our award winners' congratulations, I know it is hard work but really making a difference in a patients and their families lives is all that counts so please continue to stand tall, walk the walk and talk the talk, case management is an ever changing profession and we are proud of the difference YOU make in our industry.

So, from my desk to yours, please start looking for your case study for 2023. The board will have a short break and them we will start planning our next conference, sponsors and speakers. So, if you have any feedback or ideas you would like to share please feel to contact us we will love to hear from you.

Stay safe and keep on being the difference you want to see in the world.

Yvonne

Winners at the 10th Annual CMASA Conference

Its always great to be able to recognize the stars of our industry and this year was no exception. The anticipation and excitement was palpable.
Congratulations to you all, its time for you to shine, you deserve the accolades.

1. Case Manager of the Year 2022
Mary Radebe
Nelson Mandela Children's Hospital

2. Case Manager of the year 2022 - Runner Up
Judy Sayed
Dundee Hospital

3. Service Excellence & Innovation Award 2022
Rae Adkins
Eastern Cape DOH

4. DUXAH/CMASA Student of the Year 2022
Mario Fourie
Netcare Garden City Hospital

Complexity leadership: A framework For leadership during disruption – Part 1

Written By: Dr Karen Nel

This is a four-part series on Complexity Leadership and Operational Systems pertaining to private hospitals in South Africa

What is the ideal leadership approach for an industry in disruption? How can you lead while you maintain the current reality and create a new reality?

The healthcare industry in South Africa is a large, complex, fragmented, and diverse industry grappling with increasing costs, perceived inefficiencies, technology shifts, and limited financial and human resources. Organisations must identify, develop, and position talent to achieve sustainable results. The disconnect between private and public healthcare, poverty, the implementation of National Health Insurance (NHI), private healthcare legislation, and now COVID-19 are fuelling disruption. Healthcare in South Africa is a VUCA industry, described as being Volatile, Uncertain, Complex and Ambiguous

TRADITIONAL LEADERSHIP DURING TIMES OF DISRUPTION

The traditional approach to dealing with disruption is to implement order and control, more rules, and more discipline, preventing leaders and employees from displaying innovation and creativity. Most healthcare organisations have enough managers, with authority, to execute effective action and give instructions, but not enough inspiring leaders that influence the team to follow them without being told. Because employees often lack exposure to anything else, they never learnt to be adaptive and could only function within the strict ambit of hierarchies and centralised decisions.

Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

This often results in a toxic workplace with low collaboration and communication, fear, and forced formal power, leading to short-term success but the long-term cost to people and the organisation.

When destructive leadership occurs, employees become silent. Rudeness and bullying are deemed acceptable with terms such as: 'toughening up' or 'getting a thick skin'. Destructive leadership occurs across all levels and is often endorsed or undertaken by the nurse leader or General Manager. Absent leadership is one of the main reasons co-worker conflicts develop into bullying resulting in a steep hierarchical/authority gradient, with juniors not having the authority to confront the errors of seniors. In healthcare organisations where nurses are regarded as subservient to clinicians, a steep hierarchical gradient exists, resulting in a hostile working relationship and conflict avoidance.

LEADERSHIP IN COMPLEX ORGANISATIONS FACING DISRUPTION

Leadership in complex organisations must engage team members in the quest for a common objective, wherever the aim resides in the organisations' structure and whoever takes responsibility for delivering it through people. Rapidly changing markets demand a new generation of leaders with different skills. The aim of leaders during disruption must be to create organisational change in order to achieve adaptability and long-term survival. Role-based leadership, which is based on an individual's role, must become action-based leadership distributed between all members of a group.

Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

The adaptability in complex organisations needs the display of opposites. It requires complete analysis and quick decisions, centralised and decentralised decisions, bureaucracy and innovation. Leadership for organisations in disruption must focus on developing new routines and initiatives (exploration) whilst focusing on improving current processes (exploitation).

COMPLEXITY LEADERSHIP FOR ORGANISATIONS IN DISRUPTION

Leadership in complex organisations must engage team members in the quest for a common objective, wherever the aim resides in the organisations' structure and whoever takes responsibility for delivering it through people. Rapidly changing markets demand a new generation of leaders with different skills. The aim of leaders during disruption must be to create organisational change in order to achieve adaptability and long-term survival. Role-based leadership, which is based on an individual's role, must become action-based leadership distributed between all members of a group. The adaptability in complex organisations needs the display of opposites. It requires complete analysis and quick decisions, centralised and decentralised decisions, bureaucracy and innovation. Leadership for organisations in disruption must focus on developing new routines and initiatives (exploration) whilst focusing on improving current processes (exploitation).

Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

Complexity Leadership (CL) is a leadership framework that allows the leader to adapt the approach to what is required in a specific situation. This framework enables organisations and leaders to constantly move from being more operational and hierarchical to being more flexible and creative. Furthermore, this framework views leaders not as managers to implement top-down directives but as collaborators who enhance the system's overall adaptability. This framework consists of three types of leadership, namely:

1. **Entrepreneurial leadership (EntrL):** informal leadership, aligned with transformational leadership and an innovation focus, that aims to create new skills, products, processes or knowledge (exploration).

2. **Operational leadership (OperL):** formal leadership, aligned with transactional leadership, focused on production within traditional structures and processes, delivering efficiencies and refinement (exploitation); and

3. **Enabling leadership (EnabL):** leadership that enables adaptability by creating and protecting the adaptive space. The adaptive space is a safe space where leadership can be questioned and conflict can be managed, leading to increased adaptability.

Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

Fig 1 displays a simplified graphic of CL and the specific concepts that form the three leadership approaches within complexity leadership.

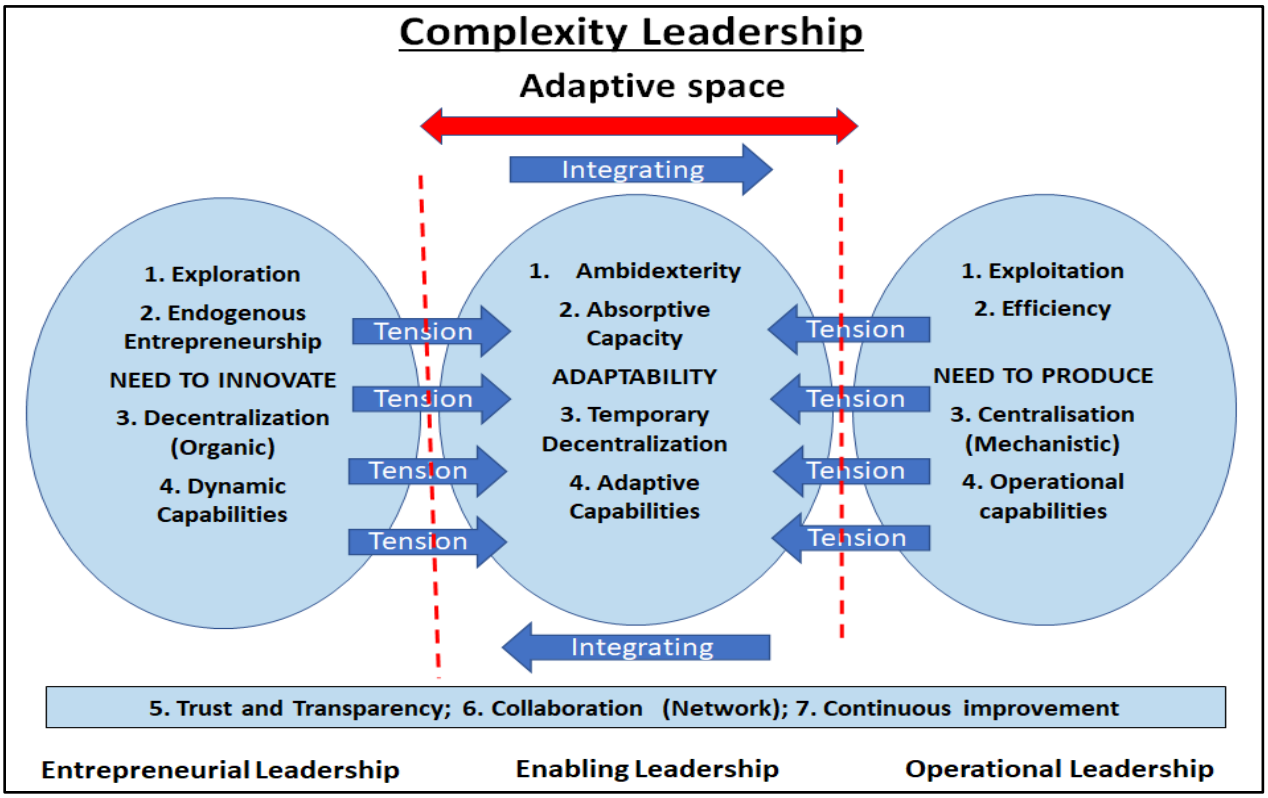

Fig 1: Simplified Complexity Leadership framework

Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

OperL is the traditional hierarchical leadership found in conventional organisations. This is also the leadership most often displayed in healthcare organisations in South Africa. OperL focuses on driving efficiencies within the current organisational processes. Within OperL, the decision-making is central, and questioning of the decisions by subordinates is mostly poorly tolerated. The focus is on building operational capabilities. During a resuscitation, OperL will be the ideal leadership to be displayed.

EntrL explores new creative alternatives to situations. This leadership creates entrepreneurship within an organisation with decentralised decision-making displayed. This leadership allows the team members to give their input and views. EntrL creates capabilities that are flexible and can change quickly. This type of leadership should be displayed in team meetings and during brainstorming exercises in the hospital.

EnabL is the leadership approach that brings change. Ideally, ingrained operational processes will, through a process of EnabL, shift to the entrepreneurial space where process change and innovation occur. New innovative processes will then again, through the enabling space, become part of the day-to-day operational running of the organisation. EnabL creates the adaptive space, a safe space where employees and leaders can question the current status quo and where change and innovation can be debated.

Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

By creating the adaptive space, organisations allow employees to develop as leaders at all levels, regardless of whether they have been officially appointed as leaders in the organisation. Within the adaptive space, change and innovation are promoted within the organisation.

The relationship between these three leadership approaches is fluid and dynamic, with a constant movement between OperL and EntrL. EnabL is the space where employees can challenge the thinking of the organisation, and safe tension can occur between the extremes of OperL and EntrL.

In the CL framework, all three leadership approaches are underpinned by trust and transparency, collaboration and continuous improvement.

Complexity leadership is the ideal framework for organisations and industries in disruption. Complexity leadership will provide the platform for maintaining the current but also developing the new.

What is your leadership approach? Do you allow growth within your team? Do you allow your team to challenge your thinking?

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Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

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Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

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Complexity leadership: A framework For leadership during disruption – Part 1 – Continued.

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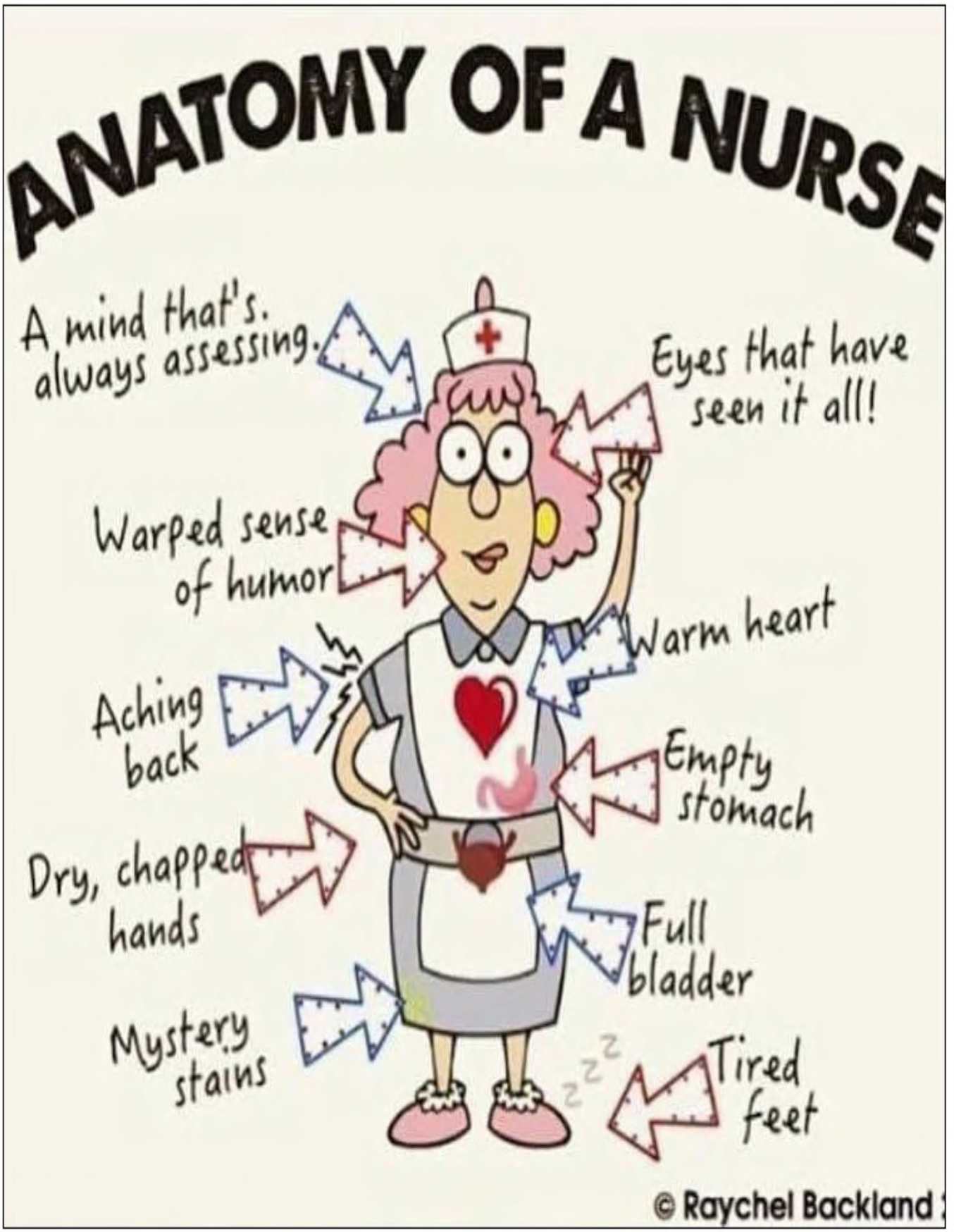

ANATOMY OF A NURSE
A mind that's always assessing.
Eyes that have seen it all!
Warped sense of humor
Warm heart
Aching back
Empty stomach
Dry, chapped hands
Full bladder
Mystery stains
Tired feet
© Raychel Backland

Recipe

Lekka Warm Chicken amore

Ingredients

500g macaroni

1 chicken – roasted or cooked

1 Red bell-pepper

2 cups broccoli florets – cooked (use only the small dark green 'florets', not the hard stalks)

2 x 400 g tins chicken or mushroom soup (concentrated)

1 cup mayonnaise

2 tablespoons lemon juice

1 tablespoon finely grated lemon rind

1 tablespoon curry powder

1 large clove of garlic – crushed

1 cup grated cheddar cheese

How to make it

Cook/roast the chicken with salt and pepper and chicken spice till cooked.

Cook the macaroni as per the package instructions.

Cook the broccoli until tender.

Preheat the oven to 180□C and prepare a large oven dish with non-stick spray or margarine. (or three 1 litre dishes)

Remove the meat of the chicken from the bone and break into small bite-size pieces. (Skin can be used or removed).

Deseed the red bell-pepper and chop into small pieces

In a very large mixing bowl (at least 4L capacity), combine the undiluted soup, mayonnaise, lemon juice, lemon rind, curry powder and garlic.

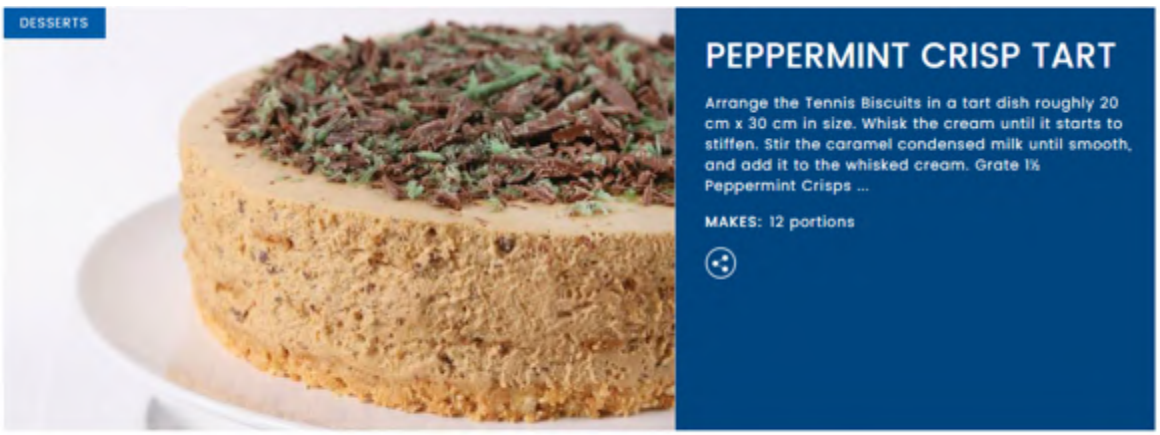
Mix well and then stir in the chicken pieces, red pepper pieces and broccoli florets.

Add the cooked macaroni and mix very well.

Spoon mixture into a greased oven proof dish and sprinkle with cheese.

Bake in preheated oven for 20-30 minutes.

Serves 8-10 people.



INGREDIENTS

300 g (1½ packets) Tennis Biscuits
500 ml (2 cups) CLOVER fresh cream
720 g (360 g x 2 cans) caramel condensed milk
2 large Peppermint Crisps

Method

Arrange the Tennis Biscuits in a tart dish roughly 20 cm x 30 cm in size.
Whisk the cream until it starts to stiffen.
Stir the caramel condensed milk until smooth, and add it to the whisked cream.
Grate 1½ Peppermint Crisps roughly and stir it into the cream mixture.
Spread half of the mixture over the layer of Tennis Biscuits.
Place another layer of Tennis Biscuits on top and spoon the remainder of the mixture onto the layer of Tennis Biscuits.
Smooth over the top layer.
Grate the remainder of the Peppermint Crisps over the top.
Place in the fridge overnight.

Commemorating Nurses Day

As we commemorate Nurses Day on 12 May 2022, we look back at the Woman who started it all.

Florence Nightingale
12 May 1820—13 August 1910

The Nurses Pledge

1. I solemnly pledge myself to the service of humanity and will endeavour to practice my profession with conscience and with dignity.
2. I will maintain by all the means in my power the honour and the noble traditions of my profession.
3. The total health of my patients will be my first consideration. I will hold in confidence all personal matters coming to my knowledge.
4. I will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient.
5. I will maintain the utmost respect for human life. I make these promises, solemnly, freely and upon my honour.

Pressure sores – an overview

Written By: Dr. Werner Smith
Plastics and Reconstructive Surgeon, Kingsbury Hospital, Claremont

Pressure Sores are wounds that result from ischemic tissue loss due to pressure against a bone prominence.

The incidence of pressure sore formation is highly variable. Approximately 9% of all hospitalised patients develop pressure sores. Therefore, we should aim to provide the best possible care to prevent their formation.

The association of pressure sores with other medical problems is very high:
Cardio vascular disease (41%)
Acute Neurological disease (27%)
Orthopedic injuries (15%)

Age is another associated factor, with more than 60% of pressure sores occurring in patients older than 70 years. In Chronic care facilities, the occurrence can be as high as 50%. Paraplegic patients usually develop ulcers of the ischial, trochanteric and sacral areas, whereas bedridden, supine patients develop wounds of the sacrum (36%), heels (30%) and ischial and trochanteric areas in only 6%.

Pressure sores are the result of constant pressure on an area which cause the small vessels to collapse (more than 30mmHg pressure). Necrosis of the tissue is dependent on time and pressure. Muscle is more sensitive to pressure and begins to necrose after 4hours of ischemic, whereas skin can withstand 12 hours of pressure.

Pressure Sore formation can therefore be contributed to Environmental as well as Systemic factors.

Pressure sores – an overview continued

Environmental factors:

Pressure – direct load on an area of tissue causing deformation and mechanical damage to blood vessels.

Shear forces – mechanical stress parallel to the plane by stretching the small vessels (i.e. dragging a patient)

Friction forces - resistance of two surfaces moving over one another by abrading off the skin (i.e. sliding a patient).

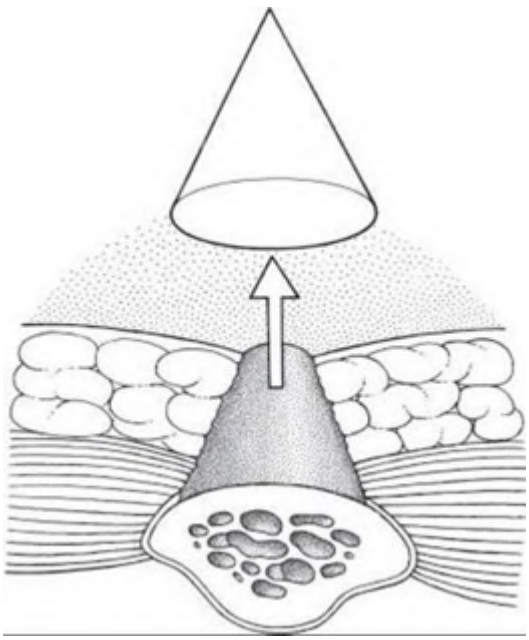
Systemics Factors

Neurological – Sensory loss, decreased autonomic control, impaired mobility, impaired mental status.

Degenerative – age, malnutrition, feacal and urinal incontinence. (5x increased risk).

Diseased – Infection, oedema, spasms and contractures, diabetes, arterial disease, anemia.

Due to the fact that muscle is more susceptible to ischemia, we see the "Ice Berg" effect in the development and depth of pressure sores; more damage and necrosis deeper down than on the surface.



Pressure sores can be classified or graded as follow: (Shea Grading System)

Grd1: Ulcer is confined to the epidermis and superficial dermis (red area) Grd2: Ulcer extends through the skin into the subcutaneous fat

Grd3: Ulcer extends into the muscle

Grd4: Ulcer invades bone/joint structures.

Pressure sores – an overview continued

Considering the common occurrence of Pressure Sores and the known risk factors, we must be vigilant to identify patients who are at risk on admission. Every Unit / Ward / Hospital should have an admission protocol like the Waterlow Pressure Sore Prevention Score to identify the patients at risk. The necessary steps can then be taken to prevent such wounds, but daily assessment of the skin when the patient is washed, is vital. Patients who are admitted with or because of the Pressure Sores should be treated as follows :

Wound Assessment : The wound should be measured with a ruler and photos taken. This is important to document and is very useful to see if a wound is improving over time.

Pus Swabs for microscopy, culture and sensitivity (MC+S) should be taken.

Blood work: Pressure sore patients should have a Full Blood Count (Hb, WCC), Urea & Electrolytes (UtE), Liver function test & Albumin and Prealbumin and CRP on admission.

Pressure Care: Patient should be rolled every two (2) hours to avoid constant pressure on one area. Air mattresses are very helpful in this regard (i.e. Nimbus Mattress).

Skin Care: The patient should be cleaned immediately if the patient had a stool in case of poor feacal control. The same applies for patients with loss of urinary control. This single factor increases the development of pressure sores by 5 times!

An indwelling urinary catheter and or a colostomy should be considered in such patients.

Pressure sores – an overview continued

Nutrition: Often the patient is malnourished or neglected. If the Albumin is below 30 umol/l, the poor nutritional state will delay wound healing. High protein diets and supplementary high protein drinks (ie Fresubin) should be started with the help of a Dietician. Supplementary Zinc and Multivitamins should also be given to help wound healing. Patients who smoke, must quit immediately.

Wound Infection and Cellulitis: Any surrounding soft tissue infection (cellulitis) must be treated with antibiotics.

Wound Preparation: If the wound has excessive necrotic material, this should be debrided and treated with the right antibiotic according to the MC&S result of the puss swab taken. Chemical debridement with agents like Iroxil / Honey based products, are be helpful but can be painful to the bone on joint spaces, should be investigated for Chronic Osteomyelitis with an ESR test and MRI scan. These cases need long term (6weeks) of antibiotics before any surgery is attempted.

Physiotherapy: This will help to prevent contractions, decrease Deep Vein Thrombosis (DVTs), decrease respiratory problems like atelectasis and will increase mental activity.

Spasm and Contractures: These need to be addressed and treated before surgery, as it will increase the recurrence of other or the same pressure sores. Medication like Valium, Baclofen and Dantrolene can be very helpful. Longstanding contractures might need surgical tenotomies and tendon releases.

Pressure sores – an overview continued

Wound Care: A very simplistic, yet effective way to think about this is the "Red, Yellow, Black" system. If the wound is RED (Grd1&2), a Hydrocolloid like Comfeel or Biatain can be placed over the wound and inspected every 3 days.If the wound is YELLOW, one must evaluate the amount of exudate (wound fluid). Small amounts of exudate can be managed with a Hydrocolloid dressing. Moderate amounts of fluid produced, a Hydrogel (i.e.Intrasite / Elta) with an absorbent foam dressing (i.e. Allevyn / Biatain) on top will help. If the wound produces large volumes of exudate, an alginate (ie Kaltostat) with an absorbant foam dressing should be considered. Negative Pressure Wound Therapy can also help in these cases but can be very expensive on the long run. BLACK Wounds should be rehydrated to lift and soften the eschar with a Hydrogel and Transparent film (ie Tegaderm / Opsite) every 3rd day.

Surgical Care: Grade 3&4 Pressure Sores will mostly need surgical closure. Once the wound bed has been properly debrided (surgically or chemically), and there are no more organisms on the pus swabs, the surgery can be performed. Remember that up to 30% of chronic pressure sores can become malignant. (Squamous Cell Cancers / Marjolijn's Ulcers). Tissue biopsies should therefore be sent for Histological evaluation. The white cell count should be less than 10^3 and the Albumin more than 30umol/d. Direct closure of a wound is rarely an option due to the underlying pressure points and excessive tissue tension. Skin graft are also not strong enough over pressure areas. Therefore, the gold standard to close pressure sores, are

Pressure sores – an overview continued

either musculocutaneous or fasciocutaneous flaps. Depending on the position and availability of tissue, the Plastic and Reconstructive Surgeon will decide which type of flap is most suitable to get closure. Pressure Sore prevention is better than cure! Remember up to 50% of pressure sores will recur if the underlying circumstances are not addressed. Therefore, it requires a multi-disciplinary cared approach from nurses, doctors, dieticians, physiotherapists and social workers. It will be of no value if the patient is discharged home to the same circumstances which brought him/her to hospital!

BUILD/WEIGHT FOR HEIGHT	*
AVERAGE	0
ABOVE AVERAGE	1
OBESE	2
BELOW AVERAGE	3

CONTINENCE	*
COMPLETE/ CATHETERISED	0
OCCASIONINCONT	1
CATH/INCONTINENT	
OF FAECES	2
DOUBLY INCONT	3

SKIN TYPE VISUAL RISK AREAS	*
HEALTHY	0
TISSUE PAPER	1
DRY	1
OEDEMATOUS	1
CLAMMY (TEMP ↑)	1
DISCOLOURED	2
BROKEN/SPOT	3

MOBILITY	*
FULLY	0
RESTLESS/FIDGETY	1
APATHETIC	2
RESTRICTED	3
INERT/TRACTION	4
CHAIRBOUND	5

SEX AGE	*
MALE	1
FEMALE	2
14–49	1
50–64	2
65–74	3
75–80	4
81+	5

APPETITE	*
AVERAGE	0
POOR	1
N.G. TUBE/ FLUIDS ONLY	2
NBM/ANOREXIC	3

SPECIAL RISKS	*
TISSUE MALNUTRITION	*
e.g. TERMINAL CACHEXIA	8
CARDIAC FAILURE	5
PERIPHERAL VASCULAR DISEASE	5
ANAEMIA	2
SMOKING	1
NEUROLOGICAL DEFICIT	*
e.g. DIABETES, M.S., CVA, MOTOR/SENSORY, PARAPLEGIA	4–6
MAJOR SURGERY/ TRAUMA	*
ORTHOPAEDIC– BELOW WAIST, SPINAL	5
ON TABLE>2 HOURS	5
MEDICATION	*
STEROIDS, CYTOTOXICS, HIGH DOSE ANTI-INFLAMMATORY	4

SCORE:	10+ AT RISK	15+ HIGH RISK	20+ VERY HIGH RISK

Fig 1. Waterlow score.

The Orphaned Aged

Written By: Carol Garner

An elder orphan is defined as an older adult who is childless and without family to care for them in their old age.

How many of us have or know of children living in foreign countries because parents have encouraged this? This now poses a huge medico social risk for South Africa.

South African elderly are an increasing percentage of the population with the over 60s growing at a compound rate of 2.7% annually , of this

- 15 % are childless
- 40% are alone without a spouse
- 32% of the employed children outside of the country
- 70% have not identified long term care

Typically, the cause are children are encouraged to spread their wings

- Take a gap year
- Play sport
- See what employment opportunities there are
- Looking for greener pastures
- “Get out of here”

The result is that the traditional family circle is broken, support structures are diluted, and grandchildren have no relationship with their grandparents.

Zoom, Skype or video calls replace the human touch as a poor alternative

Parents live in the delusion that their children will always be there for them no matter where in the world they are, however, the reality is often very different.

When parents become ill and dependant on assistance and care, the children can often not come to the assistance due to their own busy lives and commitments and then rely on 3rd hand information passed down from friends and medical staff.

The additional cost of long-term care is frightening, an average cost of a frail care centre is R 30 000 per month per person. This is often much more than the income of the patient and then the family needs to step in to help.

The Orphaned Aged Continued

There are tools to assist the healthy aged patient such as:-

- Mobile devices
- Alert bracelets
- Phone applications

These all assume a level of cognitive ability and alertness and must not be seen as a replacement for a human touch where needed.

As case managers we need to empower ourselves to

- Identify these patients proactively
- Enquire by asking probing questions
- Observe who visits and who is the support structure
- Communicate with the healthcare team on the concerns
- Check the discharge plans and involve the family.
- Build a network of carers

Our role is not to be the solution but to find it

It takes a village to raise a child

It takes the same village to protect the aged

We don't have the community care structure available elsewhere

CMASA*NOW*
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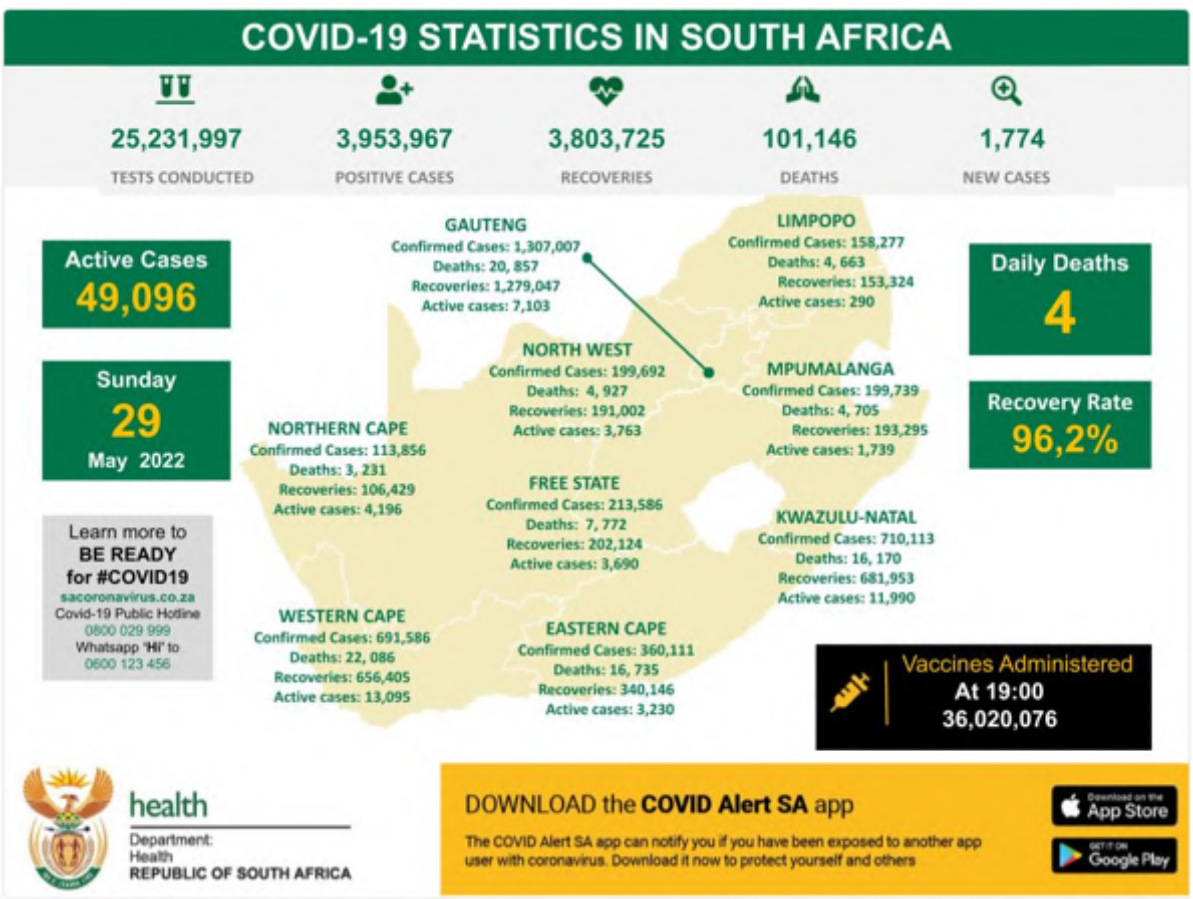
The Latest Stats of Covid 19 in South Africa

As of 29 May 2022
Written By: Kay Cupido

Even though the recovery rate of Covid 19 is still way above 90%, doesn't mean we must take our finger off the pulse.

Please!!!

- Vaccinate
- Social Distance
- Wear a mask
- Disinfect your hands



Recognition of Prior Learning

Written by: CMASA

This will be a once off opportunity!

Why RPL?

STANDARD OF PRACTICE # 15: PROFESSIONAL RESPONSIBILITIES AND SCHOLARSHIP

The professional case manager should engage in scholarly activities and maintain familiarity with current knowledge, competencies, case management-related research, and evidence-supported care innovations.

The professional case manager should also identify best practices in case management and health care service delivery, and apply such in transforming practice, as appropriate.

To provide an avenue for "mature "case managers with many years of experience and who are beyond the years of study, to be recognised as Case Managers and awarded with **CCMSA** credentials

Who would Qualify?

Paid up members of CMASA for at least 3 years

15 years concurrent Case Management experience

Currently working as a Case Manager

Recognition of Prior Learning Continued

How?

- Partnering with DUXAH
- Application form
- Portfolio of evidence
- Case Study/Assignment
- Online completion of some of the existing modules of the CM course
- Evaluation/Exam

Proposed Time Fame

- Commencement Date 3rd Quarter 2022
- Completion date December 2023

Cost

- Application fee
- Duxah fee

*Full details will be communicated once CMASA and Duxah have finalised the process and costs

Note from the desk of the Exco Chairperson

Carol Garner - South Africa

And so, we reach the end of our long-awaited, 10th conference, and I am sure you will agree it was really awesome to reconnect, re-engage and re-unite

To see 165 case managers in one room again was quite an emotional experience. The variety of speakers was wonderful from Inspirational leadership to testosterone, was truly appreciated by all.

Our sponsors once again came in support, and they really appreciated your interaction with them, and they have all promised to be back again next year.

For those of you unable to join us we have included some snippets in this newsletter, and we look forward to seeing you all next year in Gauteng.

Until we meet again

Stay Passionate about your Profession

Carol