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Next issue: June 2014

EDITORIAL

Welcome to the first issue of RAC Communiqué for 2014. As we explained in our previous issue we are conducting a comprehensive survey of our readers by email this year. I encourage you to complete this survey to help us make sure we deliver what you want. We expect the survey will commence in late April or early May.

As promised we have a very brief report from our interviews with senior leaders in the aged care sector asking if and how we might use contemporary media platforms with the RAC Communiqué. Our plans for collating all the RAC Communiqué issues into an old fashioned hard book, is still in the conceptual stages.

The cases we present are in diverse settings including the community, emergency department, hospital and RACS. Our theme is communication - something we all recognise as important and in which we pride ourselves on doing well but for some reason it almost always goes awry. We found many approaches to professional communication limited evidence about what is the best approach, reinforcing the view that we should not take good communication for granted.

EMERGING MEDIA AND THE RAC COMMUNIQUE

Fiona Kitching

The aim of our study was to investigate whether there is a role for using the RACC in social media applications for furthering education in the aged care sector. We interviewed twelve senior clinical and executive staff from eleven organisations involved in aged care. Over half the participants were cautious about the use of emerging media for education and described barriers to using these platforms such as time constraints, need for training of staff and potential legal and privacy risks. We hope a full description of the study will be available later this year once it is published in an academic journal.

CASE #1 WELCOME BACK

Case Précis Author: Joseph E Ibrahim, Monash University

Clinical Summary

Ms A was an 87-year-old female with cognitive impairment living at home with her son and a past medical history of arthritis, falls, diabetes mellitus, atrial fibrillation, myocardial infarction, urinary and faecal incontinence.

Ms A was admitted to a local hospital with rapid atrial fibrillation and heart failure complicated by a myocardial infarction. Two antiplatelet agents were prescribed instead of warfarin because of concerns about adherence to medication and the risk of falling. A week later Ms A had improved enough to return home.

Within two weeks, Ms A had returned by ambulance to the Emergency Department with a vague history of abdominal pain and light-headedness. A diagnosis of community acquired pneumonia was made and Ms A returned home the same day with antibiotics.

Four days later, Ms A returned by ambulance to the Emergency Department with symptoms of nausea, vomiting and black stools. A rectal examination found no blood or stool. Ms A was commenced on a proton pump inhibitor (for presumed gastrointestinal bleeding) and told to cease one of the antiplatelet agents and sent home. The next day a neighbour found Ms A at home dead.

Pathology

No autopsy was conducted.

Investigation

An investigation into the death occurred because of concerns about the care provided prior to death. It seems that on the third visit no ECG or blood pathology tests were done. This is despite Ms A's recent myocardial infarction, the prescription of two antiplatelet agents and symptoms suggestive of possible melena. There were concerns about continuity of care and whether the patient's previous visits along with the imaging and blood tests had been reviewed and considered.

Coroner's Comments and Findings

Health service considers improving the management of information important in the care of a patient with repeat visits to Emergency Department especially for patients with cognitive impairment.

Author comments

Aspects of this situation will be familiar to many of our readers. The aspect I want to highlight in this case is about the importance of communicating with care givers and being aware of the needs of people with dementia. Clinical care requires a person and or their carer to understand the prescribed treatment, need for adherence, awareness of side-effects and when to return for follow-up. A person with dementia requires information delivered in a clear, structured and contained manner. The clinician has a responsibility to modify their communication to the situation and to ascertain if the information is understood, retained and to notify other persons (i.e., family or care workers) if this is not the case. There are additional internal Emergency Department communication issues about accessing, reviewing and integrating information from past presentations.

COMMENTARY: COMMUNICATION

Carmel Young RN, Ballarat Health Service

Communication is such an important topic these days. It seems everyone is running courses about how to communicate effectively and so we should be able to do it well. That does not seem to be the situation. I know because I spent a long time looking and eventually wrote this drawing on information from the Institute for Clinical Research Education, University of Pittsburg, available at https://www.icre.pitt.edu/mentoring/effective.html.

So, next time you have a complex message to communicate:

1. Frame the message clearly and directly. Use simple language that is clearly understood. By simple language I mean try not to complicate things with flowery descriptions. Most people prefer you get to the point. Unnecessary repetition is distracting and the thread of the conversation is lost.

2. Ask or tell someone to do something without evoking negative emotions on either side. Make sure no one is distracted by other things such as phone ringing, pagers going off, or call bells ringing.

3. Listen actively. Be aware of the other person's questions and answer these making you have the same understanding.

4. Be confident about the message and how to relay it. When others notice uncertainty and a lack of seriousness they are more likely to disregard the information. This doesn't mean you can't have a joke, but timing is important.

5. Consider body language, yours and theirs. Look for visual clues from people about their response to what is being said. If the listener is looking defensive, hostile or puzzled they may not hear the message. This is your cue to ask for their opinion, or come back to the conversation at a more appropriate time.

6. Are appreciative - don't think I need to expand on that one!

Some of the barriers to effective communication:

1. Preconceived judgements based on cultural or interpersonal relationships. It's important that both parties are open with each other and you dispel assumptions.

2. Defensiveness. In some cases, instead of hearing what is being said the listener may be preparing their response to you.

3. Mixed messages and imprecise language. If it is a message that you feel very uncomfortable in delivering perhaps have a practice run or make some notes beforehand.

4. Distracting environment. We work in a changing environment, if it is a difficult discussion set some time aside in a quiet area to discuss the issue.

All these pointers seem obvious. We get caught up in our busy days and sometimes forget how important it is to be as effective as we can when communicating with others.

CASE #2 I AM SO SURPRISED!

Case Précis Author: Joseph E Ibrahim, Monash University

Clinical Summary

Mr B was an 85-year-old man who lived at home and was the primary care giver of his wife who had dementia. Mr B's past medical history included surgery for carcinoma of colon that was now metastatic, ischaemic heart disease and atrial fibrillation.

Mr B was admitted to hospital due to a general decline and worsening symptoms of heart failure. Treatment to manage the heart failure and rapid atrial fibrillation were optimised and new medications for palliation of symptoms related to the carcinoma including midazolam and morphine commenced.

That evening Mr B was agitated, restless and anxious and disoriented. Over the next day or so the delirium continued and Mr B was not able to take oral medications due to drowsiness and the clinical team were considering a continuous midazolam infusion.

About 4 days after admission, during the middle of the night Mr B inadvertently received two medications ordered for his roommate (glycopyrrolate 200 mg and hydromorphone 1 mg subcutaneously). An hour later Mr B was pronounced dead.

The coroner was notified at the time of death because of the known medication error and the hospital also initiated a review. The coroner and the treating medical specialist considered the two erroneous medications did not contribute to the time of death of Mr B.

Pathology

No autopsy was conducted.

Investigation

Seventeen months later the family of Mr B wrote to the Coroner expressing concerns about the care prior to death. The family concerns were: (i) they had not been made aware that Mr B requested to be allowed to go home to die which they would have made arrangements for him to do so; (ii) family was not consulted about the administration of morphine and that this would hasten death and; (iii) there was a plan for 'terminal sedation'.

Coroner's Comments and Findings

Mr B died from the underlying disease. The medication errors did not contribute to death. Both medications were given in appropriate doses and could have also been used to manage Mr B's symptoms.

Mr B's symptoms were not stable for long enough to allow a return home.

There was no evidence for a plan of 'terminal sedation' and all of the prescribed medications were given to target specific symptoms.

Of interest, there were no clinical notes describing the nature or extent of communication with the family. The nursing notes did document that family members were at Mr B's bedside for most of the time. There were no recommendations.

Author Comments

It is not unusual for families to register concerns sometime after the events. This usually occurs after the bereavement period. It is a salient reminder about the importance of comprehensive written records particularly about end of life care, as family raised their concerns 17 months after death. There is no time limit for raising matters with the Coroner.

This situation happened in hospital, but could just as easily have occurred in a RACS. Being physically present, does not translate into good communication. We often fall into the trap and assume because we have spent long periods of time with families they understand what we are doing and why.

In times of stress our ability to take in and retain information is selective, some might say impaired. A miss-spoken word, or phrase with multiple interpretations takes on much greater significance for families that clinical staff realise.

The lack of documentation is also more common than we are willing to admit—we spend our time with the patient, resident and family. However, documentation provides us with an opportunity to reflect and consider what we have said and done. Writing notes requires answering questions; who was present? What was said? What was the reaction to the news? What was understood? What are the remaining concerns of the family and staff? What needs to be done next?

LIST OF RESOURCES

1. Communicating with people who have specific needs. NHS Scotland have produced an online tool to help train clinicians called Making Communication Even Better: Improving access to health and social care services for people who have hidden or explicit communication support needs. A DVD and learner's workbook is available at http://www.nes.scot.nhs.uk/media/2036508/mceb_workbook_interactive.pdf

2. Family meetings in palliative care: The Centre for Palliative Care Education and Research, Victoria produced a very helpful set of practice guidelines. Available at https://www.google.com.au/search?q=St+Vincets+Palliative+Care+family+meetings&trls=com.microsoft:en-AU&ie=UTF-8&oe=UTF-8&startIndex=&startPage=1&tgfe_rd=ctrl&ei=0yAqU_SilsuN8QeBg4CABQ&tgws_rd=cr

3. Care of older person in emergency departments may provide some relevant information and resources Available at <http://health.vic.gov.au/clinicalnetworks/emergency/older.htm>

4. Best care for older people everywhere – The toolkit, Minimising functional decline of older people in hospital. Available at http://www.health.vic.gov.au/older/toolkit/

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to: racc@vifm.org

DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health, Victorian Institute of Forensic Medicine or Monash University.

CASE #3 MEDICATION AS REQUIRED

Case Précis Author: Joseph E Ibrahim, Monash University

Clinical Summary

Ms C was a 100-year-old female resident since 2007 with a past medical history of gastric ulcer, depression, osteoporosis, heart failure, chronic obstructive pulmonary disease (COPD) and arthritis. The list of medication was extensive being 16 in total (6 were prescribed prn).

Ms C's doctor visited regularly and kept detailed notes at the clinic, rather than in the resident health record at the RACS. Ms C had numerous episodes of shortness of breath, wheezing and chest pain.

On this particular day, Ms C was sent to hospital because of worsening shortness of breath and irregular heart rate. Ms C was investigated for heart failure and an acute coronary syndrome. The initial investigations (chest x-ray, ECG and troponin) were within the normal range. Ms C died before a definitive diagnosis could be made.

Pathology

No autopsy was conducted.

Investigation

Family raised concerns that the RACS nurses did not follow the medication orders for the administration of nitroglycerin spray for angina. This was charted as 1 spray every 10 minutes up to a maximum of 3 doses for chest pain, diaphoresis, or dyspnea.

The Coroners' clinical committee review of the case discovered that when Ms C had shortness of breath, this was usually accompanied by wheezing, making obstructive lung disease or heart failure the most likely cause of death.

Wheezing was not considered to be a symptom of angina.

Coroner's Comments and Findings

This was not a systemic quality of care issue. It was unlikely Ms C was having angina and the decision to not give nitroglycerine spray was neither a causative nor a contributory role in Ms C's death. The recommendation was that medical staff document treatment plans of residents in the RACS health record, rather at local medical clinics.

Author comments

Medication prescribed 'as needed' or PRN basis creates complexities in therapy, especially if there are different understandings between the patient, nurse and doctor. Nurses must use their professional judgment when considering the application of a prn order when patients develop symptoms. Clear and timely communication written and verbal are important to ensure a consistent understanding and adherence.