Victorian Institute of Forensic Medicine

Residential Aged Care Communiqué

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Next issue: August 2016

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EDITORIAL

Welcome to the second issue of 2016. We focus on the gaps in care that arise every year, in every human service, as a result of a much-anticipated occasion, the festive season. We also present the results from our subscriber survey conducted in 2014. The wheels of research and academia move slowly, we had to wait till the study was vetted and published in an academic peer review journal.

The cases in this issue highlight the everyday clinical issues that everyone faces in Residential Aged Care Services. The aspects we want you to consider are whether the care delivered in these two cases was influenced by the fact that the events occurred over the Christmas and New Year period. We think so, but this is hard to prove.

With 'Christmas in July' soon upon us, we thought now was the ideal time to ask the questions. Much like Charles Dickens' character Ebenezer Scrooge, we have choices in how we live and organise our work practice. It is silly to pretend that the festive season is 'business as usual' and that our systems operate exactly the same.

The festive season brings profound changes in peoples' work patterns, with responsibilities for childcare, and honouring family commitments, as well as the psychological stress so often common to these times. Regular staff are rewarded with time off, agency staff are often hard to find and expensive, the health clinics are closed, if you need a doctor it is usually a locum, and everyone wants to leave early to get somewhere, or start later to recover from the night before. Planning for the Christmas holiday period requires the same level of planning we would do for an external disaster.

How prepared are you?

CASE #1 THE GHOST OF CHRISTMAS PAST

Case Number: GLTCRC-2014-08
Case Précis Author:
Carmel Young RN,
Ballarat Health Service

Clinical Summary

Mr D was an 85 year old male with an extensive medical history including cognitive impairment, rheumatoid arthritis, polymyalgia rheumatic-a, diabetes mellitus, paroxysmal atrial fibrillation on warfarin, transient ischaemic attacks, deep venous thrombosis with inferior vena cava filter, hypertension, renal impairment and chronic anaemia.

He was living at home with the support of his wife whilst waiting for a place in a long-term residential aged care service (RACS). In November Mr D was admitted to an acute care hospital for management of back pain and his wife had "caregiver burnout." Four weeks later, after receiving treatment for cardiac ischaemia and atrial fibrillation, Mr D was discharged to a RACS which he had ranked fourth in his list of choices. At that time, he required substantial assistance with personal care to manage bladder and bowel continence. He walked with a walking stick but required one person to assist. He was on a modified diet.

> In the week leading into Christmas, his daughter expressed concerns to the staff that her dad was not eating. Mr D had also not wanted to get out of bed for two days.

Within one week of admission to the RACS, Mr D was walking unassisted from the dining room back to his bedroom when he fell to the floor sustaining an 8 cm laceration to his lower leg. He needed surgical debridement in an acute care setting and before surgery his warfarin was withheld. When he returned to the RACS post-operatively his INR was sub-therapeutic at 1.1. The discharge notes requested that the warfarin be recommenced and a hospital nurse telephoned the RACS to explain this as well.

In the week leading into Christmas, his daughter expressed concerns to the staff that her dad was not eating. Mr D had also not wanted to get out of bed for two days. On Christmas Day Mr D became febrile and was passing urine that was milky in appearance. The on-call medical practitioner was contacted, he asked about any recent laboratory tests and was told these 'were not back yet'. An antibiotic (ciprofloxacin) was prescribed to treat a urinary tract infection. Over the next few days Mr D remained unwell with several episodes of hypoglycaemia, and his wife was unable to visit due to being ill herself.

On New Year's Day Mr D had an epistaxis and his wife requested an ambulance transfer from the RACS to an acute care hospital. However, as the epistaxis appeared to be controlled, Mr D remained in the RACS and the deterioration in his general condition was not reported to the medical practitioner.

> Lack of assessment, referral and escalation was evident when Mr D's poor oral intake was not addressed appropriately, and a referral was not made to a dietitian.

Two days later, Mr D's wife requested a medical review for him. A new, rather than his usual medical practitioner, who was already on-site, reviewed Mr D. A transfer to hospital was organized. On arrival to Emergency Department Mr D was obtunded, dehydrated, hyperkalemic (K+ 7.2) and dangerously anti-coagulated with an INR>10. Despite initially responding to treatment Mr D died a week later.

Pathology

Mr D's wife did not request, and the coroner did not consider an autopsy necessary.

Investigation

The death of Mr D was investigated because of concerns raised by the family, and the Emergency Medicine physician about the provision of care by the RACS. Information was obtained from the patient/resident hospital and RACS health records, as well as statements from the family and the government department inspection reports. The investigation identified multiple gaps in care.

When Mr D returned to the RACS just before Christmas, the RACS care plan had not been updated and the information about the warfarin had not been communicated to the senior nurse and Mr D's medical practitioner.

> ...the transition from acute hospital care to a RACS is often a time of clinical instability and protocols should be in place to ensure timely assessment, and communication of any significant changes in health status to the medical practitioner.

The use of ciprofloxacin, while an effective choice for treating a urinary tract infection, is also known to prolong the INR in patients receiving warfarin. This necessitates close monitoring of the INR, which was not done. Also the potential drug-drug interaction did not appear to have been recognized by RACS staff or the dispensing pharmacist.

Lack of assessment, referral and escalation was evident when Mr D's poor oral intake was not addressed appropriately, and a referral was not made to a dietitian. When Mr D had the epistaxis the nursing notes also recorded that he was confused and with multiple bruises all over his body. Also, it was his family's insistence that eventually led to a hospital transfer.

Coroner's Findings and Recommendations

The Geriatric and Long Term Care Review Committee made general and specific recommendations. First was the importance of paying attention to, and listening to, the concerns of family. Second, the transition from acute hospital care to a RACS is often a time of clinical instability and protocols should be in place to ensure timely assessment, and communication of any significant changes in health status to the medical practitioner. This includes public holidays.

The more specific recommendation was that the RACS undertake a review of the care provided and report their findings back to the coroner. The RACS was instructed to identify how they intended to ensure safe medication management for residents and in particular for anticoagulation therapy.

CASE #2 NOT A VERY MERRY CHRISTMAS

Case Number: WA24-14
Case Précis Author:
Carmel Young RN,
Ballarat Health Service

Clinical Summary

Ms N was an 83 year old female with a past medical history that included osteoporosis with recent vertebral crush fractures and pulmonary fibrosis. She lived at home with her husband. Following the crush fractures Ms N wore a back brace, took regular analgesia but continued to have pain. Over the next few months, Ms N's condition gradually declined, becoming less mobile and experiencing cognitive impairment.

Her husband's health was also deteriorating and he was no longer able to provide assistance. A visiting nursing service was put in place and Ms N remained at home for another month. A week before Christmas, Ms N was sent to the Emergency Department by the visiting nurse because of ongoing severe pain. Ms N returned home where an ACAS assessment was completed with a plan to increase community services and approval for respite care granted.

A few days later, on Christmas Eve, Ms N was admitted to the RACS for urgent respite care. This was precipitated by several factors that included a fall the night before leading to bruising of her lower lip and left arm, her husband was exhausted by his poor health and was awaiting surgery, and Ms N wanted somewhere to rest.

It was 3pm when the RACS staff admitted Ms N, noting the fall at home. That same evening, Ms N was unsettled, disorientated, and walking about looking for her husband. Around 01:45 am on Christmas Day, Ms N was found on the floor of her room. The night duty staff assessed Ms N, and determined there were no new injuries.

Ms N spent Christmas day in bed and was visited by her husband in the morning. A few hours after he left, around 2:30 pm, Ms N was again found on the floor under her bed. The nurse who examined Ms N found no injuries.

At 7:40 pm the RACS staff heard a sound and went to investigate. Ms N had fallen for the third time. On this occasion a lump was observed over her left eyebrow.

As Ms N was very distressed, she was helped back into bed and the staff pushed the bed up against the wall. They also placed a bedside rail on the opposite side of the bed. The doctor was not contacted and the family's permission to use the bedside rail was not obtained.

In the early hours of Boxing Day, Ms N was found lying across the bed with her feet dangling through the partitions of the bedrail. Ms N was re-positioned to withdraw her legs from the bedrail and a second bedrail was pulled up to prevent any more falls.

The nurse noticed that Ms N had difficulty weight-bearing when she got up to use the commode during the night. The nurse recorded in the progress notes that she may "need further examination and intervention".

The morning nurse noted some facial bruising and was told Ms N seemed to be in a lot of pain. The pain was considered to be due to her longstanding back problems. Ms N was administered analgesia and placed in a more comfortable chair.

> The coroner noted the staff "were caring and well-intentioned" but went on to say that an appropriate standard of care was not provided.

When Mr N arrived that day, Ms N was sitting out in the lounge room. He asked the nurse what had caused the bruising to his wife's face and why she had pain in the hip. The nurse replied she was unsure as to the cause of the pain, and she was concerned that the confusion exhibited by Ms N may be due to the medication. The nurse went to contact Ms N's doctor but he was not available as it was a public holiday. Soon after, Ms N was taken back to her room and placed on a bed. It was then that the nurse noticed Ms N's hip was shortened and externally rotated.

An ambulance was called and Ms N was taken to hospital where an X-ray revealed a displaced intracapsular fracture of the left femoral neck. Ms N had surgery and died almost two weeks later in hospital.

Pathology

The cause of death following an autopsy was complications following fracture and surgical repair of the left hip in an elderly lady with underlying chronic lung disease and valvular heart disease.

Investigation

The death was not reported to the coroner and the hospital staff issued a death certificate. The death was eventually reported to the court, when a second doctor who was required to sign the cremation certificate declined as he considered the death 'reportable'.

The coroner directed that further investigation was required to establish: the quality of care following the falls, when the fracture occurred, and why medical assistance was not obtained. The amount of information gathered from the investigation comprised two volumes, and included a large number of witness statements and the medical records.

An inquest was held four and a half years after Ms N had died. This took three days in court with separate legal representatives present for the RACS and the hospital. The witnesses at the inquest included the family of Ms N, care coordinator, RACS staff and management, and the Head of Orthopaedic Surgery.

After hearing evidence from an expert witness, an orthopaedic surgeon, the coroner concluded that the fall causing the fracture probably occurred shortly before 7:30 pm on the 25th December. Which meant that medical treatment for the fractured hip was delayed by 16 hours.

The RACS provider and management conceded aspects of Ms N's care did not meet the required standard. Specifically, that staff did not follow the post-fall policy, where a doctor was to be notified. The coroner also found that there was not a formal shift-to-shift handover and that the existing verbal handover was not always comprehensive. Another finding was that bedrails were utilized without consent from Ms N's family or medical officer.

Since the death the facility made changes to their policy, including changing the shift-to-shift handover from a verbal to a written report, and notified the doctor and the next of kin after every fall.

Coroner's Findings and Recommendations

The coroner noted the staff "were caring and well-intentioned" but went on to say that an appropriate standard of care was not provided. As the RACS provider had been proactive and introduced several changes, the coroner did not make any recommendations.

IMPACT OF RAC COMMUNIQUÉ ON CLINICAL PRACTICE

Tony Pham BBiomedSc
Research Assistant Health Law and Ageing Research Unit, Monash University

Thank you to all the subscribers who participated in this evaluation and apologies for the time taken to release the information. This is due to the lengthy process of having the article peer-reviewed for publication in an academic journal.

As you may be aware, the survey was completed almost two years ago in May 2014. Our aim was to evaluate whether the RAC Communiqué had any impact on changing health and aged care professionals' clinical practice. The method was a cross-sectional study, using an anonymous electronic survey distributed to all subscribers of the RAC Communiqué at the time.

The response rate was great, with 58% of subscribers who opened the survey email, completing it. Most were satisfied with the information in the RAC Communiqué, agreeing that it was useful (89%), reliable (85%), timely (78%), and written in simple language (88%) at a level that was easy to understand (88%). The sections most found useful were the case summaries (89%) and expert commentary (89%).

The key result was that 56% reported changing their practice. This level of change is well above the rates for any other type of educational material. We crosschecked this result by asking what would have happened without the RAC Communiqué. Two-in-ten said that the practice change or project would not have occurred. Five-in-ten said that the project would have been on a smaller scale and seven-in-ten said it would have taken longer to initiate the project.

We want to thank all our readers, subscribers and especially the participants who generously gave their time for the survey.

Pham DHT., Ibrahim JE., Kitching F., Bohensky M., Aged care and health care professionals' self-reported impact of printed educational material on clinical practice. *Journal of Continuing Education in the Health Professions. 2016 Winter;36(1):38-45. doi: 10.1097/CEH.0000000000000030.*

Please email us if you would like a copy of the article.

A COMMENTARY IN THREE PARTS: TOO BUSY LOOKING FORWARD TO LOOK BACK

PART I: THE GRINCH

Joseph Ibrahim

We all look forward to the holidays and the celebrations that come at the end of the year. We are often so busy wondering how to get away and the preparations we need to organise travel, accommodation, preparing meals and getting gifts for loved ones that we barely have a moment to ourselves.

> Public holidays are something we all look forward to enjoying. However, someone has to be the Grinch, to be responsible for ensuring services are staffed appropriately and staff 'switched on'.

Sitting alone in an office organising the rosters and ensuring staffing for those days is no easy task. Most people want to have a rest from work, be with their family and friends and observe their faith. All this takes time. Public holidays are something we all look forward to enjoying. However, someone has to be the Grinch, to be responsible for ensuring services are staffed appropriately and staff 'switched on'.

> People take holidays, but diabetes and dementia don't.

Little direct information is available about how RACS run on public holidays but we do have information from research on hospital care. There is still debate on whether these effects are due to provision of care or other factors. What is obvious is that there are significant differences between how health and aged care services operate and the needs of patients and residents. Our models of care tend to be framed around the business hours of a working week for staff rather than the 24 hours a day 7 days a week of the person's care needs.

People take holidays, but diabetes and dementia don't.

What we know happens on public holidays is we often have reduced staffing, and those who are rostered on are less experienced or unfamiliar to the service. And it is not just our service, but all the services that are run differently, medical and allied health clinics are closed or working shorter hours, locum services may step in to cover the gap but often do not know the resident. The other aspect is that we and the people we work with may also be under stress and anxious because of the festive season which also affects our performance.

> Knowing this is going to happen each and every year provides us an opportunity to plan and prepare to minimise the consequences and ensure we have contingency plans in place.

Changing this is no small matter as it is a whole of society matter. Knowing it is a big problem that will take a long time to solve is not a reason to just accept it. Knowing this is going to happen each and every year provides us an opportunity to plan and prepare to minimise the consequences and ensure we have contingency plans in place.

PART II: SAFETY AND PUBLIC HOLIDAYS

Stuart Marshall MB.ChB. MHumanFact. MRCA. PhD, FANZCA.
Clinical Director, Australian Centre for Health Innovation, Alfred Health

There has been some debate, particularly in the UK about the exact risk of weekend and out-of-hours clinical care in hospitals. Research studies have found that the chance of a hospital-acquired condition such as falls and pressure injuries are more common if a patient is admitted on a weekend compared to a weekday; the chances of dying greater if an emergency admission occurred on a public holiday.

> Reinforce to all staff that the care of resident comes first and it is OK to call people to help.

However, this 'weekend effect' is hotly contested – particularly in the NHS in the UK at the moment. It seems the same number of people die at the weekend and because there are fewer admissions the ratio of deaths to admissions is higher. Nevertheless there are many instances of inadequate cover and poor handover leading to adverse outcomes in health. In some cases the covering clinician wasn't even aware they were covering the work!

- Plan ahead who will cover each aspect of the work and ensure all staff know whom to contact for routine and emergency situations.
- Ensure there's an adequate handover in both verbal and written forms. If the covering person doesn't know the facility, a visit to familiarize them with the physical and computerized systems is recommended.
- 'Planning fallacy' is the idea that you will be able to achieve more than you can in a period of time. Write a timetable of items to organize well ahead of time and stick to it!
- Reinforce to all staff that the care of resident comes first and it is OK to call people to help.
- Prepare staff with education and training to understand the stress and anxiety that occurs with self and co-workers.

PART III: COPING WITH THE PSYCHOLOGICAL STRESS OF CHRISTMAS

Kylie McKenzie BA(Hons)MPsych(Clinical)
Clinical Manager, Psychology at Ballarat Health

For all of its pressures, residential aged care work is rewarding and we make a difference in residents' lives. Working in residential care is also demanding work and requires attention, care, compassion and clinical knowledge. The additional work demands at Christmas time are a challenge for RACS staff. We know that distracted, busy minds lead to distracted behaviours.

So, what do we know about what helps at times when workplace demands increase?

It may not surprise you to learn that Australian research (Cameron & Brownie, 2010; Drury et al, 2014) has found that nurses in residential aged care report greater resilience when they have: strong social and collegial support, meaningful relationships with residents, the opportunity to talk with their colleagues about their work experiences and, a sense of humor.

> Appreciating each other and acknowledging the work that people do

Research into managing job stress and promoting greater job satisfaction in long-term care nursing also highlights the importance of supervisory support (McGilton et al, 2007).

So a few things that might help us all at busy times like Christmas, include:

1. Appreciating each other and acknowledging the work that people do
2. Reflecting on what you value most about the work you do
3. Making Christmas and other celebrations special for the residents

It is also important to remember that there is assistance available for times when stress is affecting your health and relationships. Talk to your supervisor or General Practitioner about mental health support that is available to you through employee assistance programs or community services.

WORKING TOGETHER WITH RESIDENTS, CARERS AND FAMILIES

Residents of aged care services, and their families and carers, need quality health information to help them participate in making decisions about their care.

A new series of information sheets on a range of common care issues have been designed to help residents, families and carers discuss these care issues and work together with staff of residential aged care services. This work recognises residents, families and carers as important and valued members of the care team.

The information sheets are available for download from the Department of Health and Human Services (Victoria) website at https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/participating-with-consumers

LIST OF RESOURCES

1. Beating Christmas stress and anxiety
   http://www.mindhealthconnect.org.au/beating-christmas-stress-and-anxiety

2. Shiftwork - How to devise an effective roster
   https://www.workcover.nsw.gov.au/__data/assets/pdf_file/0014/15161/shiftwork_how_to_devise_effective_roster_0225.pdf

3. Dickens, Charles. A Christmas Carol. New York: Bantam Books, 1997.

4. Past editions of the RAC Communiqué that explored related topics are available at:
   http://www.vifmcommuniques.org/previous-editions/residential-aged-care-communique-editions/

   - Vol 2 Iss 1 Mar 2007: Falls,
   - Vol 3 Iss1 Feb-2008 Interface,
   - Vol 3 Iss 5 Dec-2008 Warfarin,
   - Vol 9 Iss 1 Feb-2014 Communication,
   - Vol 9 Iss 3 Sep 2014: Falls,
   - Vol 11 Iss 1 Feb 2016: Respite

5. APS Stress and Wellbeing in Australia Survey 2015
   http://www.psychology.org.au/public/topics/stress-and-wellbeing/

6. Cameron, F., & Brownie, S. (2010). E*nhancing resilience in registered aged care nurses. Australasian journal on ageing*, 29(2), 66-71.

7. Drury, V., Craigie, M., Francis, K., Aoun, S., & Hegney, D. G. (2014). Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Phase 2 results. *Journal of nursing management*, 22(4), 519-531.

8. McGilton, K. S., Hall, L. M., Wodchis, W. P., & Petroz, U. (2007). Supervisory support, job stress, and job satisfaction among long-term care nursing staff. *Journal of Nursing Administration*, 37(7/8), 366-372.

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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.