Victorian Institute of Forensic Medicine

Future leaders Communiqué

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CONTENTS

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GUEST EDITORIAL

Dr Kate Hurley

This issue of the Future Leaders Communiqué describes the case of an elderly female patient who developed leg ulcers in the final stages of her life, on a background of multiple medical co-morbidities. This is a common diagnosis, something we see as junior doctors on a regular basis. It is easy in clinical practise to be over familiar with 'run of the mill' or 'simple' cases, and this is when things can be missed.

This case is a good opportunity to reflect on the important role we play as junior doctors in communicating with patients and their families. Often, the consultant will talk to the family of the patient suffering from a rare or rapidly progressive condition, and leave the conversations about simple or common diagnoses to the junior staff. These are circumstances where things can be overlooked, where our familiarity with the diagnosis might mean we don't spend as much time with the patient and their family as we need to, or our documentation of the events isn't as detailed.

Communication is an important part of our education as junior staff. Teaching is often focused on difficult situations, such as breaking bad news, end of life care or dealing with conflict. However communication is just as important in 'simple' situations. The situation described in this case wouldn't necessarily be considered 'complex' communication. However because there was a lack of clear communication from the beginning, as time went on and the patient deteriorated; the lack of good communication became more of a problem and contributed to a poor outcome. Part of our care for every patient should involve a quick mental check. Does the patient and their family understand their diagnosis and management? Are they fully up to date on their progress? This is a simple action, which can make a big difference to the care of our patients.

As you read through this case, it will become apparent that poor documentation led to a poor outcome for this patient. As the junior members of the medical team, it is often our job to document the outcomes of a ward round, family meeting or reason behind a clinical decision. This case reminds us how essential this role is, no matter how simple or complex the situation may seem. Remember if it's not written down, it didn't happen!

One of the key clinical issues for the patient in this case is lower limb ulcers. This is a common issue for many elderly patients, with a significant contribution to morbidity and mortality. While on the surface they may appear simple, they can be challenging to manage and often have complex aetiologies. A thorough assessment is essential, as well as remembering to ask for senior help or refer to a specialist before things deteriorate.

In the course of a busy day at work, remember to slow down and take the time required with every patient. What seems clear to us as doctors, who have seen many similar situations before, may not be so apparent to the patient and family. Next time you see someone with a 'common' diagnosis, stop and think – have I missed something? Do the patient and their family understand what is happening? Is my assessment detailed and is everything clearly documented?

EDITORIAL

Welcome to the third issue of the Future Leaders Communiqué and the second for 2017. Our guest editor for this issue is Dr Kate Hurley who is in her fourth post-graduate year working at a large metropolitan hospital as a physician trainee. Kate completed this issue while living in Liverpool, United Kingdom and undertaking a Diploma of Tropical Medicine and Hygiene. Prior to her time in the United Kingdom, Kate also spent a year in Phnom Penh, Cambodia where she conducted research in global health. Her broad interests include general medicine, infectious diseases and palliative care.

This issue addresses the clinical challenges that occur around documentation and communication with families. We are fortunate to have an expert commentary from Dr Grant Davies, the former Health Services Commissioner for Victoria and Professor Carolina Weller, a NHMRC Public Health Fellow at Monash University. They provide unique insights relevant to junior doctors about communication, documentation and the importance of conducting a thorough assessment of patients.

PERSPECTIVES ON TRAINING

Professor Joseph Ibrahim

What I wish I knew when I was a junior doctor

When I was a trainee in the 1980s we all worried about calling the senior registrar or consultant at night when we needed help. When we did call, the response was variable, some were helpful and kind, others not so. Responses that were grumpy and cantankerous were the minority but they stuck with me and coloured my approach for the next time.

What I know now is that the senior registrars and consultants accepted on-call as part of their responsibilities. They expected and preferred to be called by the junior staff as knowing what was happening at night was better than being confronted in the morning with an unexpectedly sick patient.

What I understand now is that the first emotional response to being woken up from a restful sleep, or being interrupted while engaged in an engrossing movie, is one of displeasure. This can manifest as a harsh tone of voice and vagueness in the first moments of responding to a call. Neither are reassuring to a junior doctor who is calling for help with a heightened sense of anxiety.

So the next time you call for help, don't worry about the tone of first contact, it is just the raw emotion that occurs when we are disturbed, it has nothing to do with you or your reason for calling. And trust me when I say that viewed from the perspective of the following morning, a few minutes of disturbed sleep are much easier to deal with than a sick patient, especially if the late night call contributes to safer patient care and better outcomes.

ACKNOWLEDGEMENTS
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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: flc@vifmcommuniques.org

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CASE *THE COMMON DIAGNOSIS*

Case Number:
GLTCRC-2014-06 Canada

Case Précis Author:
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CLINICAL SUMMARY

Mrs M was a 93 year old female who had lived in a Long Term Care (LTC) home for 9 years. She was dependant on others for all her activities of daily living and her son was her power of attorney. She had an advanced care directive that stated "*level three-transfer to acute hospital without CPR. Do Not Resuscitate.*"

Mrs M had an extensive past medical history, which included dementia, with mild resistance to personal care, peripheral vascular disease, ulcerative colitis, chronic obstructive pulmonary disease, osteoporosis with previous fractures, osteoarthritis with knee contractures, macular degeneration, and recurrent deep vein thrombosis, requiring long-term anticoagulation with warfarin.

In January, a dietician assessed Mrs M. Her weight was recorded as 72.3kg. By April though, Mrs M had lost 3.6% of her body weight and had developed a small pressure ulcer on her left heel. In early May, two black necrotic wounds had developed on Mrs M's left heel, which were reviewed by her physician, who prescribed betadine dressings. At the end of May two large bullous lesions had developed on Mrs M's left heel. An annual case conference was held with Mrs M's son where he was provided with an update about the ulcers.

The physician discussed the ultrasound results with Mrs M's son, but did not write in the notes what the results showed or what was discussed with the son. The nursing notes stated the son had not voiced any concerns.

In early June the notes following a physician review stated '*visited, nursing report clear, no new problems.*' However, the nursing notes indicated there was increasing erythema around the left heel wounds and new wounds had developed on the left lower leg. Antibiotic treatment was commenced with cefuroxime 250mg daily for 7 days.

The physician reviewed Mrs M again a week later, and did not write any notes. The nursing notes indicated the wounds were deteriorating and the antibiotics were switched to metronidazole 250mg twice a day for 14 days.

Mrs M was assessed by a nurse practitioner two days after the change in antibiotics and she was diagnosed with two large arterial ulcers in the gaiter area of her left leg, measuring 4.5 cm x 5.5 cm and 3.5 cm x 2 cm. The ulcers had a necrotic base with surrounding erythema. The skin was cool and pale, and her pedal pulses were diminished. An Ankle Brachial Pressure Index (ABPI) was recommended. The physician saw Mrs M a week later and wrote 'awaiting ABI'.

Mrs M was resistive and agitated during the ABPI testing, and a result could not be obtained. At the end of the two-week course of metronidazole, the physician reviewed Mrs M in the presence of her son, however no notes were written. The nursing notes stated that the wounds were worsening and that her son was satisfied with the treatment plan.

Two weeks later, in early July, a nurse practitioner reviewed Mrs M and found purulent foul-smelling discharge from Mrs M's left leg wound. The surrounding skin was erythematous and warm to touch.

Non-compliance was found relating to wound care. This included lack of annual staff training in skin and wound care, lack of regular wound assessment and lack of appropriate escalation of care.

An arterial doppler ultrasound was recommended. The notes from a physician review two days afterwards stated *'leg wound not healing? Circulatory problem, did not co-operate with ABI and son did not wish to pursue further'.*

Although Mrs M was uncooperative during the ultrasound and results were difficult to obtain, the arterial doppler showed a 75% stenosis. The physician discussed the ultrasound results with Mrs M's son, but did not write in the notes what the results showed or what was discussed with the son. The nursing notes stated the son had not voiced any concerns.

In early August the wounds had worsened. There was purulent and foul smelling discharge with a moderate amount of blood in the wound, and surrounding erythema. Mrs M appeared to be in pain during the wound dressing changes.

Around that time, Mrs M became febrile, tachycardic, tachypnoeic and had a reduced conscious state. A transfer to the local hospital emergency department was organised with a presumed diagnosis of sepsis from the leg wounds. Mrs M was admitted and commenced on IV fluids and IV cefazolin, which was later escalated to IV tazocin.

During the admission, Mrs M developed fluid overload, pneumonia and a non-ST elevation myocardial infarction (NSTEMI).

The infectious diseases, orthopaedic surgery, and vascular surgery teams were consulted to assist in her management. The medical specialist concluded that due to the recent NSTEMI, Mrs M was a poor candidate for leg amputation or vascular repair. Following discussion with her son, the agreed approach was palliation.

Mrs M died two weeks after admission to hospital.

It was not clear if the son understood and appreciated the consequences of his decision not to pursue more aggressive treatment.

PATHOLOGY

An autopsy was not preformed. The medical certificate stated the cause of death as left lower extremity Stage-4 ulcer, cellulitis with clinical picture of sepsis.

INVESTIGATION

Mrs M's son raised concerns about the wound care received at the LTC home, and the case was referred to the Geriatric and Long Term Care Review Committee.

A compliance inspection of the nursing home was carried out, and Mrs M was one of the cases reviewed. Non-compliance was found relating to wound care. This included lack of annual staff training in skin and wound care, lack of regular wound assessment and lack of appropriate escalation of care.

The coroner reviewed a letter from Mrs M's son, the health records from the LTC home and hospital, the last will and testament of Mrs M and the report from the compliance inspection.

CORONER'S FINDINGS

The coroner considered that Mrs M had developed arterial ulcers in the terminal phase of life and that the ulcers were unlikely to heal, even with the best wound care.

Nevertheless, the coroner felt there was a lack of clear goals in this case, and it was not apparent that the physician had developed goals of care with the son. It was not clear if the son understood and appreciated the consequences of his decision not to pursue more aggressive treatment.

The coroner expected detailed notes in the medical record outlining an in-depth conversation with the son, which should have included an explanation of the current state of Mrs M and anticipated outcomes, such as maintenance or palliation.

There was also a lack of clear documentation of wounds, including status, location, contributing factors and interventions.

The coroner recommended that LTC homes have effective skin and wound care programs, which include regular meetings, staff education and channels of communication to allow for prompt re-assessment of patients.

The coroner concluded that doctors in LTC homes have an important role in leadership and development of goals of care that reflect prognosis. Communication with the patient's next of kin is essential, as well as clearly documented plans that demonstrate the process leading to a decision.

AUTHOR'S COMMENTS

As a junior doctor, we generally work in a hospital setting. This case takes place mostly in a LTC home, however the issues it raises are highly relevant to hospital practise.

There are many elements of this case we can relate to and I'm sure we can all think of a time we were involved in a similar situation. The majority of elderly patients in hospital have multiple co-morbidities, which may be common and familiar us. No matter how simple or complicated a situation; good communication, documentation and assessment are essential.

KEYWORDS

Arterial ulcers, wound care, long term care home, documentation, communication.

COMMENTS FROM OUR PEERS

"This issue reminds me about the importance of showing leadership in treatment of patients despite being a junior doctor. Wound care sometimes feels like a nursing issue however, ultimately our patient's welfare is our responsibility."

"I enjoyed the very practical inclusion of the principles of wound care, something that for me, was not allocated a great deal of teaching time in medical school."

"The case reiterates the importance of clear and detailed discussions with family members, especially for conditions we see commonly as junior doctors. That it is best to be discussing treatment options and goals of care with family members early on."

"Again, clear clinical notes are very important, and I think with the monotony of day-to-day note taking it begins to feel less important and easy to let slip."

COMMUNICATION IS THE KEY!

Dr Grant Davies
Director of Projects at Safer Care Victoria

Former Health Services Commissioner for Victoria

What strikes me immediately with this case is the lack of communication among the care team. The woeful absence of clinical notes from the Physician would raise serious concerns for me about that clinician's clinical practice. Under the Health Records Act 2001 (Vic), organisations are required to ensure the health information is accurate, complete and up to date. Organisation in this context also relates to an individual providing a health service.

There is no indication of what was communicated to the son or whether the son understood the likely outcomes of those decisions.

The Physician has failed in their legislative obligations here, let alone their clinical ones. Those considerations aside, it is unclear to me how they are relaying information about their assessment of Mrs M, the proposed treatment of Mrs M or the nature of the conversations with Mrs M's son. That in some ways can be implied by the nursing notes in the file but, that does not tell the whole story. There is a lack of adequate documentation by the nurses here too. It is also unclear whether there was any formal and regular case conferencing occurring given the deteriorating nature of Mrs M's leg wound. Such a meeting(s), had it occurred, would have assisted in care planning.

The lack of documentation around treatment is problematic enough but the lack of documentation about the discussions with Mrs M's son is particularly troublesome. There are some comments in the nursing notes that the son did not want to pursue things further or was satisfied with the treatment plan. There is no indication of what was communicated to the son or whether the son understood the likely outcomes of those decisions.

Dr Robert Arnold is a Professor and Director of the Institute for Doctor-Patient Communication at the University of Pittsburgh and has spent his career educating on communication at the end of life. He speaks about an 'ask-tell-ask' approach to clinical engagement. For example, in Mrs M's situation, the Physician might have asked the son to describe his understanding about what is happening to his mother. The Physician could then fill in any gaps in understanding, including any foreseeable outcomes of the treatment or the approach being taken and then, as a final step, asked Mrs M's son to again describe what they understand about what is happening to Mrs M and the likely benefits and disadvantages in the treatment approaches.

Poor or mis-communication form the basis of most of the complaints we see in the Office of the Health Services Commissioner.

Of course, this conversation, and it should be approached as a conversation, should be documented in the clinical notes and would have been a road map for the treating team. If we are serious about person-centred care, having conversations like this are critical as they allow the person receiving care or their representative to express their wishes.

Poor or mis-communication form the basis of most of the complaints we see in the Office of the Health Services Commissioner. Most clinicians are pretty good at doing the ask and tell aspects of this approach but where misunderstanding occurs is the last ask in the process. That last check ensures everyone has a shared understanding of the situation and the approach being taken. I am not suggesting these conversations are easy, particularly for junior doctors, but they are important ones and ensure that should deterioration occur, it does not come as a surprise and does not result in a coronial inquiry with adverse commentary.

A QUICK GUIDE TO LEG ULCERS

Professor Carolina Weller
Research Director
NHMRC TRIP Fellow

School of Nursing and Midwifery,
Monash University

Leg ulcers are one of the more challenging clinical problems that confront health professionals in Nursing Homes (NH) as well as in hospitals. Clinicians are often presented with difficult-to-heal chronic wounds of unclear aetiology.

This case brings to our attention the importance of timely assessment, diagnosis and referral of older people who live in NH. It highlights the interplay of many important factors that need to be managed to ensure best practice outcomes for an older person and demonstrates that lack of clear documentation and communication leads to adverse events and untimely death.

Wounds on the legs are slower to heal than elsewhere due to gravitational effects, less-than-optimal blood supply and vascular impairment.

Could a more thorough physical examination, communication and documentation of wound care practices and attempted treatments have aided a more accurate diagnosis in a shorter time frame?

If we use the three principles of wound management as our best practice base: define the aetiology; control factors affecting healing and; select appropriate local environmental management, we can highlight several deficiencies in the care of Mrs M from January to August.

1. Define aetiology: Initial ulcer evaluation to define the cause of the wound was lacking. Best practice would include a thorough history of presenting illness, medical history, and a review of systems with a goal of identifying complicating comorbid conditions that may be the cause the initial wound.

2. Control factors affecting healing: Mrs M has several documented predisposing risk factors for developing wounds. She was elderly, malnourished, on long-term warfarin and had several chronic conditions. PVD and recurrent DVT history increased her risk of lower limb ulceration and the risk of pressure injury over bony prominences while bed bound. Wounds on the legs are slower to heal than elsewhere due to gravitational effects, less-than-optimal blood supply and vascular impairment. Mrs M had a history of ulcerative colitis, which has been shown to predispose people to Pyoderma gangrenosum, which presents in a variety of guises and is easy to misdiagnose.

3. Select appropriate local environmental management (dressings): Necrotic tissue in the wound base indicates wound care is suboptimal. A dry wound bed will increase the risk of infection and delay healing. Inappropriate topical products (in this case Betadine) did not help her cause.

KEY POINTS

A comprehensive assessment should include:

- Clinical, pain and leg ulcer history.
- Examination of the person, the affected leg and the ulcer.
- Investigations to support diagnosis.

Refer patients with non-healing leg ulcers to specialist health professionals if there is:

- Diagnostic uncertainty.
- Peripheral arterial disease indicated by an Ankle Brachial Pressure Index (ABPI) less than 0.8.
- Ulcers have not healed within three months.
- Antibiotic-resistant infected ulcers.
- Ulcers causing uncontrolled pain.

FURTHER READING

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Please note an extended version of the expert commentary from Prof Carolina Weller is available on the Communiqués website.