

Residential
Aged Care

Communiqué

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Next issue: February 2018

 MONASH University



EDITORIAL

Welcome to the final issue of the RACC for 2017. It has been an amazingly busy year with residential aged care often being in the news. This is a mixed blessing as it highlights the dedication of staff and the need for change, but it also creates an atmosphere of fear and dread for those older residents and their families.

Issues of staffing levels, recognition of the complexity, need for specialist gerontic nursing and geriatric medicine training, as well as better support for all are now being debated. The results from the different inquiries will generate debate making this the best time since the year 2000 for everyone to become involved and have their say for future directions.

The case we present in this issue is multi-layered and requires time to contemplate and incorporate into improving practice. The family learn at the last minute their loved one is unwell and it is they, not the staff, that make the telephone call. The resident, a stoic man who was not one to complain, trusted and relied on staff to act to keep him well but showed all the signs of a person who was clearly unwell.

It is expected that experienced medical and nursing staff will document clear instructions about clinical monitoring and parameters for when to act. The need for good communication begins with knowing who is who, and what they do, and what they cannot do. It is more challenging for new staff who have to orientate themselves to the residents, local procedures and the staff. This adds further complexity as escalation of clinical matters requires an understanding of clinical practice as well as how, when, where, and who to escalate concerns!

Should we do what the teams in the operating room do before surgery where they go through a checklist and everyone introduces themselves? — when you read the case — ask yourself if that would have made a difference. For the management, the issue of staffing levels, experience, their expected level of assertiveness and ability to reach that level all come into play. Finally, the staff rosters deserve consideration — is continuity having the same person, or the same discipline provide care?

It is too easy to describe this case as a failure to recognise a deteriorating resident and failure to escalate care — and so it looks only like a clinical skill issue. Over the past ten years we have known that our readers are more sophisticated than that, and will see the cultural issues within the RACS and between the medical and nursing staff as contributing factors; as well as the structural process used to deliver care.

We are fortunate to have two expert commentaries, one from a senior nurse, Associate Professor Deirdre Fetherstonhaugh, and another from a senior General Practitioner, Professor Dimity Pond, who will explore the issues in greater depth.

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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@vifmcommuniques.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 and Human Services, Victorian Institute of Forensic Medicine or Monash University.

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Case: Not one to complain

Case No: 2013/751

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Mr Bb was an 86-year-old male who had been residing in a low-level care facility in a metropolitan location in Northern Queensland for about one year. The Residential Aged Care Service (RACS) was quite large, accommodating more than 150 residents, providing low- and high-level as well as dementia-specific care. Although these services were co-located they were geographically separate. The low-level care section had a registered nurse (RN) available to attend residents if called upon by the personal care staff.

Mr Bb had a medical history of an umbilical hernia, hypertension, coronary artery disease, pacemaker, gastro-oesophageal reflux disease, grossly impaired hearing requiring an aid, low vision, minor memory loss, decreased mobility and lymphoedema associated with his leg ulcers. Mr Bb was an intelligent and active man who was described as quiet, gentle, and stoic.

Late in the morning one Sunday, Mr Bb notified staff he was unwell and had vomited. The RN reviewed him and noted the presence of a small hernia that was not painful and advised staff to give Movicol to rule out constipation as Mr Bb had not moved his bowels for two days, and to give his regular paracetamol for possible pain and discomfort. The staff were asked to monitor and handover to the night shift RN.

The following day, on Monday, Mr Bb's GP examined him and concluded the symptoms were due to his umbilical hernia and constipation; not an obstructed bowel.

Later that Sunday evening Mr Bb vomited copious amounts and was complaining of pain at his central and lower left abdominal area with a prominent bulging of his umbilical hernia. He was administered oral morphine for analgesia. A facsimile was sent to his general practitioner (GP)'s office requesting a review.

The following day, on Monday, Mr Bb's GP examined him and concluded the symptoms were due to his umbilical hernia and constipation; not an obstructed bowel. The GP reduced the hernia, requested more Movicol be administered, and gave brief verbal instructions to contact him if Mr Bb deteriorated.

The same RN from Sunday completed the next set of observations at 16:30 hours and recorded the findings - BP 157/70, pulse 45 bpm and temperature 36.9 celsius. Staff noted Mr Bb had complained of nausea that morning, had refused some of his medications, and was looking generally unwell.

The following day, Mr Bb stayed in bed the whole day and was given Movicol on two more occasions. The enrolled nurse who cared for Mr Bb had not previously met him as this was her first shift in that unit, and had a verbal instruction only to 'take his observations and act accordingly'. The nurse noted that Mr Bb was confused to time and place, had not eaten dinner, and was not well enough to have a shower. His recorded observations at 22.00 hours were: BP 95/55, pulse 64 bpm, temp 36.4 Celsius.

At 23:00 hours, Mr Bb called his daughter who promptly drove to the RACS. On arriving, she discovered her father had vomited and staff were attempting to clean him up. Mr Bb suddenly collapsed and became unresponsive. Paramedics were called to attend and Mr Bb died shortly after.

Cause of death

A forensic pathologist completed a full autopsy and determined the cause of death was due to complications of an incarcerated umbilical hernia which contained about 120mm of ischaemic small bowel. The death most likely followed a cardiac arrhythmia induced by electrolyte imbalance in conjunction with sepsis due to the effects of necrotic and poorly functioning small bowel.

Investigation

This case was reported to the Coroner's Court because the cause of death was unclear. The Coroner considered this as a possible healthcare related death and investigated a range of aspects including the adequacy of medical assessment, the nursing handover, and nursing care.

Case: Not one to complain (Continued)

The inquest took four court sitting days and was held on two separate occasions three months apart. The RACS and the GP had separate counsel representing them.

At the inquest, it became clear that the GP had not seen or been informed of the facsimile sent to the surgery. And so, was not aware of the urgency for attendance and had scheduled a visit to Mr Bb during a lunch period.

On arrival, he did not review the progress notes nor obtain any history from the nursing staff. The GP also explained he was unable to differentiate the roles of the staff by their uniforms so was uncertain who he spoke with. After reducing the hernia, the GP was then accompanied by staff back to the nursing station where he told the female staff to contact him directly or via the surgery if there was increased pain, increased amount of vomiting, or general decline in his condition. The GP disagreed with the suggestion that it was appropriate to transfer Mr Bb to hospital when he reviewed him on the Monday. He also acknowledged that the death was a dreadful experience for Mr Bb's family as well as for him as the treating doctor.

Counsel for the RACS provider acknowledged it was regrettable that no contact had been made with Mr Bb's family simply to inform them that he had been sufficiently unwell to call the doctor to attend.

The RACS clinical nurse explained that her role was to oversee the enrolled nurses and the assistants in the RACS, as well as a range of other duties. This nurse knew Mr Bb well, unlike many of the staff who interacted with him in those last few days. The nurse stated that at the end of her shift on Tuesday at 18:00 hours, Mr Bb had taken 10 doses of Movicol which was a high dose. She did not hand over to the other registered nurse, explaining it was not the practice to hand over to someone at the level of registered or clinical nurse.

The RACS Service Manager detailed the arrangements in place and stated that the facilities have continuity of staff for residents.

The coroner noted this was not the reality for Mr Bb in his final days and the qualification level of staff involved in his care did not match the expected staffing qualifications said to be operative at the time. The RACS manager explained that subsequent changes made included having a greater number of clinically qualified staff.

Independent expert review

The inquest was assisted by three different independent expert opinions reviewing Mr Bb's care. The experts included an experienced GP and two consultant surgeons. The experts differed in their opinion about whether or not the hernia should have been reduced and whether Mr Bb should have been sent to an acute hospital.

One of the surgeons considered Mr Bb's clinical presentation to be consistent with classic bowel obstruction given the presence of the hernia itself, abdominal pain, vomiting and constipation. On this basis, the administration of Movicol was contraindicated and likely to have contributed to electrolyte imbalance and dehydration.

Counsel for the RACS provider acknowledged it was regrettable that no contact had been made with Mr Bb's family simply to inform them that he had been sufficiently unwell to call the doctor to attend.

Conclusions

The coroner made the following conclusions. The GP's assessment of Mr Bb was limited specifically in that the GP did not seek information from the nursing staff who had requested the review, did not read the nursing home progress notes and, had not seen the facsimile sent to his rooms, so remained unaware that oral morphine had been administered. It was also noted that the GP did not percuss the abdomen or listen for bowel sounds.

The effectiveness of the GP's direction to nursing staff about what matters should be communicated to him was questionable.

The experts' opinions varied about the overall standard of care provided. There was agreement that the history taking was inadequate however, it was not possible to reach a conclusion as to whether it was appropriate to reduce the hernia.

The experts also differed in whether Mr Bb should have been transferred to hospital.

The effectiveness of the GP's direction to nursing staff about what matters should be communicated to him was questionable. The GP made no note in the record about this and did not know the level of qualifications of the staff member he passed his verbal instructions on to.

The coroner considered Mr Bb's death was a healthcare related death, in that the hernia was either ineffectively reduced or had recurred. Nursing staff should have been monitoring Mr Bb and recognising the signs of deterioration, namely the drop in his blood pressure, his confusion, inability to self-care which was out of character, his disinterest in food and remaining in bed. The coroner noted the 'handovers' had a narrow focus on whether or not Mr Bb's bowel function had returned rather than assessing his overall condition.

Recommendations

The coroner made several recommendations.

First that the RACS provider "*introduces a requirement for personal carers and assistants in nursing to enter any variation in a resident's condition in the progress notes.*" This note should include to whom the matter was escalated and the subsequent assessment and response.

Second, that the RACS provider "*encourage visiting medical officers to document the diagnosis and management plan, including any planned review and indications for earlier escalation.*" The coroner went on to mention this would be an opportunity for introducing procedures and training for nurses "*to assist them in requesting visiting medical officers to state and preferably record their diagnosis and treatment plan*". There should be enough information to inform nursing staff on every shift what was required and when medical staff or emergency services be contacted.

Third, that the RACS provider considers further training of personal carers to enable them to make entries in the resident's records where appropriate.

Commentary: Through the eyes of a GP

Professor Dimity Pond BA, MBBS, PhD, FRACGP

Discipline of General Practice, School of Medicine and Public Health, Faculty of Health, University of Newcastle.

This case illustrates a number of vexing issues for RACS – both for nursing and other care staff and for general practitioners. The first is assessment of the very elderly. This may be complicated by the person being unable to articulate exactly where their pain is, how many times they have vomited, and how much or little fluids they have managed to keep down. Older people are often reticent to cause “trouble”, and may minimise or neglect to mention symptoms. Direct questions may be required to elicit this information.

Furthermore, symptoms and signs in the very elderly may be muted, so that it is more difficult to assess the urgency of a situation.

In this case, Mr Bb had profound hearing loss, so it is difficult to know if he understood any questions put to him, and is also reported as having dementia, which may further impair his history giving ability — especially in a situation that appears rushed.

Furthermore, symptoms and signs in the very elderly may be muted, so that it is more difficult to assess the urgency of a situation. Most elderly residents have multiple diseases, including heart and lung disease, and these may interact as in the case of Mr Bb, making the initiating problem much worse through a flow-on effect to the heart, lungs and so on.

The second is the variable training of staff. Many of the staff ‘on the floor’ in RACS do not have sufficient training to ask the direct questions that are necessary for clinical assessments. They may not be able to assess dehydration, for example. This situation is compounded by the difficulties an RN may have in doing an assessment when not familiar with the resident, and is rushed. The RN is then relying on the history given by staff who are not able to frame the presentation in a way that makes sense in clinical terms.

Consulting written notes may not help, as the same less well-trained staff have written these. In this situation the nurse may tend to veer towards a more common problem, such as constipation, with which they are familiar, rather than leaving open the possibility of a more complex and life threatening problem. Perhaps some ongoing training may help here, but it is important for clinical staff at all levels to keep an open mind to exclude serious conditions and avoid the cognitive bias of “common things are common”.

The RN role in RACS generally should be reviewed, as the RN is likely to have more advanced clinical training than any other staff member. It is no longer mandated to have an RN available on site in every RACS in Australia, despite the multi-morbidity, sensory impairment and high acuity of the residents. It seems preferable that an RN should be available at all times and that this clinically trained person should have sufficient time factored into their role to exercise their clinical expertise.

Lastly, the GP may also struggle in this situation. A fax sent to the GP surgery on a weekend evening is unlikely to be read, or result in urgent action.

The GP may be unaware of the status of staff he/she is talking to – particularly how much clinical training they have had.

Furthermore, the information included in a fax may omit important details and include other information that is not pertinent. In Mr Bb’s case, the information in the fax did not mention the amount of vomiting over a large number of hours, but did mention a leg ulcer.

The GP is also frequently rushed, as visits to RACS are less well funded than faster turnover consultations in the surgery. The GP may be unaware of the status of staff he/she is talking to – particularly how much clinical training they have had. The GP needs to keep an open mind about the quality of the history given by staff as well as by the patient, both because of varying levels of training and because of high rates of staff changes, and notes should be checked to fill in further details. Finally, the GP needs to take into account the multi-morbidity of residents encountered in the RACS.

Commentary: Through the eyes of a RN

Associate Professor Deirdre Fetherstonhaugh, PhD, RN
Director, Australian Centre for Evidence Based Aged Care (ACEBAC), La Trobe University

There are a number of important issues for RACS to consider, and address, in what happened to Mr Bb from the time he experienced the first symptom until he died three days later. These issues are concerned with inadequate assessment and examination, lack of documentation, and poor communication between nursing, medical and care staff and possible non-adherence to best practice.

Most direct care to people living in RACS in Australia is provided by care staff who therefore often 'know' the resident best as they have the greatest continuity of contact with them. These care staff are not nurses; often do not have a clearly defined 'scope of work'; are not registered; and their training and education is highly variable. Care staff should however, be able to recognise changes or variation in a resident's health so that any deterioration can be reported (both verbally and documented in the resident's record) to a registered or enrolled nurse.

Best practice would recommend that a comprehensive health assessment be undertaken with a resident when they first move into residential aged care.

It is then incumbent on the nurse to have the education and skills to be able to undertake a comprehensive or focussed health assessment with the resident. Best practice would recommend that a comprehensive health assessment be undertaken with a resident when they first move into residential aged care. This provides a baseline of their health status for comparison if the person deteriorates or presents with new or specific symptoms such as those experienced by Mr Bb.

Throughout the three days of Mr Bb's deterioration from the first onset of symptoms, there did not appear to be a systematic way of reporting and documenting what was happening to him.

Nor what various health professionals (both the doctor and the nurses) and care staff had done for him or what they expected other staff to observe and report in the future. There did not seem to be a documented plan in place that would ensure any future deterioration in Mr Bb's health would be noted, reviewed, and appropriate strategies and interventions implemented. As a result there appeared to be a disconnect between what was said verbally between health professionals and care staff, what was actually observed about Mr Bb, and what was done or reported to have been done. For Mr Bb this resulted in both a lack of continuity of care and reporting of his condition.

Constipation can severely impact on a person's health and quality of life and its treatment and prevention should be based on the best available research evidence.

Mr Bb was noted to have constipation which seems to have 'muddied' what was actually happening to him. Many older people living in RACS are reported to have constipation and it is not something that is generally reported statistically. In contrast, an incident such as a fall or a pressure injury are 'counted' and investigated for any underlying causes. In those scenarios, measures are implemented to prevent recurrence for the individual as well as to address practice in the RACS as a whole.

Constipation can severely impact on a person's health and quality of life and its treatment and prevention should be based on the best available research evidence. Mr Bb was given 10 doses of Movicol for his reported constipation without result. This of itself should initiate further inquiry and investigation into what is best practice in the area of constipation management, the implementation of that best practice, and the possibility of alternate diagnoses.

The case of Mr Bb highlights the need for RACS to ensure:

1. All care staff are trained in recognising and reporting changes in residents' health.
 2. All registered and enrolled nurses working in RACS should be educated and competent in undertaking comprehensive health assessments of the older person. In this context, a comprehensive health assessment is a systematic approach to the gathering of information about a person's health history and status including their physical condition, cognitive status, psychosocial well-being, spiritual and cultural needs and sexual health. It involves identifying care needs, actual and potential risks to health, and analysing and synthesising the information collected in order to make decisions about the most appropriate person-centred interventions and care as well as strategies to meet those needs.
 3. Management care plans need to be documented and accessible so that all staff involved in the care of residents know what needs to be done, and what needs to be reported and to whom.
 4. The care of older people in residential aged care should be based on the best available evidence. This evidence should be incorporated into the aged care service's policies and procedures and regularly reviewed.
-

Update on Inquiries

Review of National Aged Care Quality Regulatory Process

This review has concluded and the full report was released in late October by the Aged Care Minister, Ken Wyatt. As you recall this review was commissioned by the Federal Government in response to the events at Oakden. There were ten major recommendations:

1. Establish an independent Aged Care Quality and Safety Commission to centralise accreditation, compliance and complaints handling.
2. The Aged Care Commission will develop and manage a centralised database for real-time information sharing.
3. All residential aged care services in receipt of Commonwealth funding must participate in the National Quality Indicators Program.
4. The Aged Care Commission will implement a star-rated system for public reporting of provider performance.
5. The Aged Care Commission will support consumers and their representatives to exercise their rights.
6. Enact a serious incident response scheme (SIRS) for aged care.
7. Aged care standards will limit the use of restrictive practices in residential aged care.
8. Ongoing accreditation, with unannounced visits, to assure safety and quality of residential aged care.
9. Ensure that assessment against Standards is consistent, objective and reflective of current expectations of care.
10. Enhance complaints handling. We know from the Minister's media release that the "Government would move as soon as possible to implement Recommendation 8 as it considers the entire review in detail." That is, all visits to be unannounced and over two days rather than any scheduled re-accreditation audits.

Senate Community Affairs Reference Committee Inquiry and Report

This is examining the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. The report is due on 18 February 2018. We do not have any further updates.

More details available at:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality

Save the day: FRIDAY 15 JUNE 2018

Seminar on Elder abuse and Dignity of Risk

Including a screening of 'Dignity of Risk' a short film by Prateek Bando, Jeremy Ley and Joseph E Ibrahim.

The film is about Prof Joe, a geriatrician, who is faced with a difficult decision when he finds that his elderly patient, Mr Jones, can no longer live safely at home. Prof Joe decides to put Mr Jones in an aged care home to protect him from all the risks of living alone. Shortly after this, Prof Joe finds himself uneasy about his decision.

The film won "Best Narrative Film Category" at the 2017 Global Impact Film Festival (GIDC), a dynamic independent film festival in Washington, DC. USA. The film also won selection laurels at another five festivals including the 20th UNAFF (United Nations Association Film Festival) in California USA.

Recommendations for prevention of injury-related deaths in residential aged care services.

We thank all the people who responded to our call for comments in the Aug-2017 issue on the draft report of the Health Law & Ageing Research Unit, Monash University's "Recommendations for prevention of injury-related deaths in residential aged care services." We have made 104 specific recommendations for seven different circumstances of premature death and another eight recommendations that apply overall to reform of the whole sector.

This is now available on our website at: <http://www.vifmcommuniques.org>

List of Resources

1. The Victorian Department of Health and Human Services website has resources available for residential aged care services including:

- standardised care processes (SCPs) about important areas of clinical care for residents in aged care including constipation. These SCPs have been developed from evidence based guidelines. Available at: <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes>
- a comprehensive health assessment of the older person template to help nurses and other healthcare professionals to identify residents care needs and risks, and to make decisions about treatment and care options. Available at: <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/comprehensive-health-assessment>

2. The Carnell/Patterson report Review of National Aged Care Quality Regulatory Processes is available at: <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt20171025.htm>

3. Minister for Aged Care press release available at: <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt107.htm>