THE COMMUNIQUÉS

VOLUME 16. ISSUE 3.

Residential Aged Care Communiqué

August 2021 Edition

ISSN 1834-318X

VICTORIAN INSTITUTE OF FORENSIC MEDICINE

MONASH University

VICTORIA State Government

NEXT EDITION
NOVEMBER/2021

Editorial

Welcome to the latest edition of the RAC Communiqué which examines two cases where early attention and prompt responses to family concerns may have altered the fatal outcomes. Failures to listen to families often leads to situations where the clinical team does not escalate care as needed. Families and friends are often better at recognising subtle deterioration in a loved one than health professionals. Our responsibility is to listen and take their concerns seriously as it could save a life.

An interesting aspect of the first case stems from the investigation findings following a formal complaint to the Aged Care Complaints Commission by the next of kin. The matter was also raised with the coroner who determined that an inquest was not required.

Our expert commentary is by Dr Anne-Marie Mahoney, from the Australian Centre for Evidence Based Aged Care, who explains the new on-line education and training programs designed for the residential aged care sector. This initiative from the Victorian State Government addresses matters raised by the recent Royal Commission into Aged Care Quality and Safety about staff recognising imminent dying and preparing for the death of a resident.

CONTENTS

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The Residential Age Care Communiqué is distributed by the not for profit group 'The Communiques Australia Inc'. (COI--A0106775D)

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:
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Case 1 Ryan's rule and aged care

Case Number
QLD 2017/5035

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i. Clinical Summary

Mr GF was an 89 year old man with a gait disturbance and reduced mobility, who lived in a residential aged care facility (RACF). His past medical history included atrial fibrillation, chronic kidney disease, heart failure and cardiomyopathy.

One night, Mr GF was reviewed by the RACF staff and found to be unwell, sitting on a commode and slumped to the left. A little while later, around 2:45am he was found on the floor by his bed, with a reduced conscious state, and a large amount of blood around him from multiple head lacerations. An immediate transfer to hospital was organised.

CT scans of his neck showed partial subluxation of the C1 and C2 vertebrae (likely due to an acute injury) and after consultation with Mr GF's family it was decided that he would not tolerate an MRI scan or a rigid collar for immobilisation of his neck. The injury was managed with a soft spinal collar.

"Mr GF's medical records also indicated that he was frequently suffering from shortness of breath, especially after physical exertion such as going to the toilet."

Mr GF's family reported to hospital staff that he had been steadily declining over recent months and he had expressed to his family that he was *'ready to die'*. Mr GF's condition continued to deteriorate and after receiving palliative management he died in hospital two days later.

ii. Pathology

The cause of death after post-mortem examination was terminal congestive heart failure due to an ischaemic cardiomyopathy as a consequence of coronary artery atherosclerosis. The finding of the neck injury (subluxation of C1 and C2) and atrial fibrillation could also have contributed to Mr GF's death.

iii. Investigation

After an extensive review of detailed investigations completed by other agencies, the coroner considered *'that it would not be in the public interest to proceed to inquest'*.

A review of the RACF's clinical records showed that Mr GF had been medically unstable over the four months prior to his death, with recurrent falls resulting in injuries (including skin tears and a scalp laceration) as well as 5-day hospital admission with crush fractures in his spine.

On one occasion, Mr GF's family contacted the RACF to report that he was distressed. When staff followed up, Mr GF reported that he had slid out of his chair the previous evening and had required assistance from staff to transfer to his bed. There was no record of the incident in Mr GF's file.

Mr GF's medical records also indicated that he was frequently suffering from shortness of breath, especially after physical exertion such as going to the toilet.

In response to Mr GF's falls risk the RACF documented the following falls reduction strategies, including ensuring that only the top two bed rails were up while Mr GF was in bed, that staff were to answer the call bell promptly, and ensuring that the bed height was at Mr GF's knee height at all times.

The medical file demonstrated that Mr GF's health significantly deteriorated at the RACF 4 days prior to his death. He was short of breath, unsettled and constantly needing to go to the toilet. On the day of transfer to hospital (prior to his fall) Mr GF was unable to mobilise and had slurred speech.

The deterioration in Mr GF's condition was not reported to his next of kin.

Following his death, Mr GF's next of kin made a formal complaint to the Aged Care Complaints Commission (ACCC). The nature of these complaints centred around five key aspects relating to Mr GF's care, including that the RACF did not:

- Implement sufficient falls prevention strategies
- Inform Mr GF's next of kin about his deteriorating health prior to his fall
- Provide Mr GF with timely assistance for toileting
- Escalate concerns about Mr GF's medical condition or seek medical attention, including concerns surrounding an episode 12 months prior to his death (when Mr GF's family advocated for timely medical review of his red and swollen legs)
- Provide prescribed medications in a timely manner and that on at least two occasions his next of kin had to intervene by getting the prescriptions filled

Mr GF's next of kin cited a number of concerns relating to the management of Mr GF's continence. Mr GF had reported to her that the night staff were *'reluctant, too busy, not caring, not interested in taking him to the bathroom or dismissive'* if they had already taken him to the toilet that night. He recounted waiting between 10 to 30 minutes for staff assistance.

In one incident, Mr GF had asked to go to the bathroom at night, but the staff had told him he had already been, locking the bathroom door, which was distressing for Mr GF. Further, when Mr GF's next of kin arrived at hospital following his fall, he was reporting abdominal pain and was later found to be in urinary retention.

The Complaints Commission found that the RACF did not have adequate falls prevention strategies in place. Mr GF's urinary urgency and anxiety relating to his incontinence resulted in him independently attempting to mobilise, increasing his falls risk. The call bell and sensor alarms were not activated when Mr GF got out of bed by himself. Whilst the family had requested the top two rails of the bed to be left up, there was no restraint authority given by the family to allow for all four bed rails up which equated to a form of restraint.

The Complaints Commission found it was likely that Mr FG experienced multiple occasions where he was made to wait for assistance, specifically in relation to his toileting care needs which resulted in his subsequent self-mobilisation attempts. The RACF's records were deficient in the monitoring of Mr GF's toileting needs during the period he was unwell.

The Complaints Commission also found that the nursing staff failed to inform Mr GF's family about his clinical deterioration, nor investigate, escalate or respond to his altered health status.

iv. Author's Comments

This case illustrates many everyday geriatric medical and care issues that occur so frequently in aged care that they are almost considered inevitable. Falls, incontinence, fluctuations in health status and even cognitive decline may be incorrectly dismissed as part of the "normal ageing process" rather than being seen as significant health issues that require assessment and management. Of course, there is interplay between all of these syndromes - for example urinary urgency resulting in falls or delirium resulting in worsening mobility. One of the core skills for those working in aged care is to identify changes in a resident's usual clinical state and recognise that deterioration is a medical emergency.

The advocacy of Mr GF's next of kin also needs serious and genuine consideration. Families are often the first to notice changes in health status, yet find that escalating concerns to the right staff can be challenging. Queensland Health implemented Ryan's Rule in 2013 in response to the tragic death of Ryan Saunders in 2007.

Ryan died in a Queensland hospital from sepsis. The toddler's death was found likely to have been preventable, and his parents (who knew him best) felt their concerns were not heard when he was deteriorating.

Ryan's Rule is a 3-step process for families or carers to escalate concerns if they feel their loved one's condition is getting worse or not improving in a Queensland public hospital.

The three steps are:

- Step 1: Talk to a nurse or doctor about your concerns. If you are not satisfied,
- Step 2: Talk to the nurse in charge of the shift. If you are not satisfied,
- Step 3: Phone the designated HELPLINE or ask a nurse to phone for you, and request a Ryan's Rule Clinical Review.

This should have a nurse or doctor will undertake a clinical review of the patient and the treatment they are receiving. Similar processes have been implemented throughout Australia often called the REACH. It stands for Recognise, Engage, Act, Call, Help is on its way.

Whilst these processes for escalation of concerns currently only operate within some hospitals, the movement demonstrates partnership with families and advocates in the care of patients and accountability from health services.

v. Resources

Ryan's Rule

https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/ryans-rule.44

REACH NSW

https://www.cec.health.nsw.gov.au/keep-patients-safe/deteriorating-patient-program/reach.

Case 2 Inappropriate discharge

Case Number
VIC 2016/4087

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i. Clinical Summary

Mrs KS was an 88 year old woman who lived with her daughter. Her medical history included hypertension, supraventricular tachycardia, anxiety and depression, osteoporosis and deafness.

One day in the middle of August, Mrs KS fell whilst shopping and sustained a comminuted fracture of her right humeral head and was admitted to a private hospital. Soon after admission, Mrs KS went into urinary retention and required an indwelling catheter.

"Laboratory and imaging investigations revealed a normal white cell count, minor changes on a chest X-ray, and no growth in the urine culture and blood cultures."

A few days later Mrs KS had surgery for a shoulder replacement. The post-operative care was complicated by episodes of pain, hypoxia and confusion. Laboratory and imaging investigations revealed a normal white cell count, minor changes on a chest X-ray, and no growth in the urine culture and blood cultures.

Over the next few days, Mrs KS was anxious, intermittently confused, and in pain requiring daily morphine injections and extra (as required) doses of oral opioid medication in addition to the Fentanyl patch. Mrs KS's daughter expressed concerns to staff about Mrs KS's persisting confusion and pain, her high care needs, and the challenges of returning home.

About a week after the surgery, Mrs KS had improved sufficiently for medical staff to consider her as being ready for discharge. Although still mildly confused Mrs KS was being transferred for convalescence at a Supported Residential Services (SRS) rather than going directly home.

Mrs KS was discharged from hospital and transferred to the SRS in a taxi, unaccompanied, and wearing only a nightie and dressing gown. On her arrival, the SRS staff assessed Mrs KS and arranged for a visiting general practitioner, Dr CT to review her. Dr CT noted that she was experiencing right-sided chest pain attributed to bruising. Mrs KS appeared sweaty; and crepitations were heard at her lung bases. Dr CT was concerned about the possibility of delirium and withdrawal symptoms related to her recent opioid use. Her pain medication was increased to help ease her symptoms.

On the evening of the third day at the SRS, family members noticed Mrs KS was in pain and disoriented. Staff contacted Dr CT for a medical review, however, a few hours later Mrs KS was found pale and unresponsive. Staff requested emergency support and ambulance transfer to hospital. When the ambulance arrived, paramedics commenced treatment, but Mrs KS suffered a cardiac arrest and died.

ii. Pathology

The medical cause of Mrs KS's death was sepsis complicated by multiple organ failure in a woman with comorbidities in the setting of recent shoulder surgery. The sepsis was due to a urinary tract infection.

iii. Investigation

Mrs KS's daughter provided the coroner with written concerns about her mother's care. Some of the issues included: medical care, poor communication, inappropriate discharge, lack of care during the transfer and, a failure of the SRS staff to act on Mrs KS's deterioration.

The Coroners Prevention Unit reviewed the care and the statements from treating medical and other staff. In their opinion:

- Mrs KS was not fit for discharge due to her unstable and high pain management requirements, especially given that medical coverage is often limited over the weekend in

general and at the SRS. If she had not been discharged, the development of septic shock in hospital may have prompted a more rapid escalation of medical care, improving her chance of survival.

- There was a missed opportunity for the case managers at the private hospital to refer for publicly funded inpatient rehabilitation, geriatric evaluation and management or transitional care programs.

- It was difficult to be critical of the delay in SRS staff to escalate management due to the nature of the facility. It is not required to provide medical and nursing support and is staffed largely with personal care workers. Additional challenges included that the events occurred over a weekend and Mrs KS was not familiar to staff.

The hospital acknowledged their error and issued an apology to Mrs KS's family in relation to transferring her unaccompanied in a taxi in her night clothes. This also led to a hospital-wide education program regarding optimal transfer processes for patients.

iv. Coroner's Findings

The coroner found that Mrs KS was inappropriately discharged due to apparent shortcomings in clinical assessment and decision-making. In addition, the care staff had missed an opportunity to contact emergency services at an earlier time.

Recognising and responding when a palliative approach to care is needed

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The recent Royal Commission into Aged Care Quality and Safety (2021) reinforced what many working in aged care were already acutely aware of, that is, recognising imminent dying and preparing for the death of a resident presents many challenges for staff.

Take for example, the story of Allan, an 87-year-old man, who has been living in a residential aged care facility for the past three years, following the death of his wife. Allan has a history of Parkinson's disease, diverticulitis, and prior to his admission has had an increasing number of falls. Allan is fiercely independent and is sometimes referred to by the staff as 'difficult' and 'challenging'. His mobility is limited, and it is advised that he use a 4-wheel walker, but Allan prefers to walk unaided and is often rescued from falling by diligent staff.

Allan, his family, and treating doctor have met on many occasions to discuss the risks for Allan and that a fall could have catastrophic consequences for him. Allan's independence is important to him, and he, his family and his treating doctor agree that if it comes down to it – independence wins over limiting Allan's mobility. Every day Allan is at risk and staff monitor his movements as best they can, given the limitations of the facility environment.

It was inevitable! Allan fell in the bathroom and hit his head on the toilet bowl, causing a deep laceration to his forehead and loss of consciousness. Staff acted immediately to administer first-aid and call for help.

What now for Allan? Policy states that a fall with a head strike requires transfer to hospital and scans. Allan's advance care plan says no active treatment – comfort measures only. A dilemma for all concerned. Should Allan stay at the facility or be transferred to the nearest emergency department?

These dilemmas are real, and making decisions in the best interests of the resident can be challenging for staff and families. We know this from experience and from the evidence presented to the Royal Commission into Aged Care Quality and Safety (2021). Not implementing palliative care and failure to recognise imminent dying were issues consistent across much of the evidence presented by families. Some families reported not being prepared for the death of their loved ones because staff caring for them were unable to identify the signs of deterioration and impending death. Caring for residents like Allan requires specific skill and knowledge.

Adequate education and training of care staff is critical for the provision of quality care and ultimately resident safety. In 2020/2021 the Victorian State Government responded to this need for increased skill and knowledge by funding the Australian Centre for Evidence Based Aged Care (ACEBAC) at La Trobe University to develop a suite of on-line education and training programs for the residential aged care sector – nurses, personal care workers, and allied health staff. The program was launched on 1 July 2021 and is known as VACET (Victorian Aged Care Education and Training). VACET is free, modular, self-paced on-line education and can be accessed at: https://www.latrobe.edu.au/aipca/australian-centre-for-evidence-based-aged-care/workshops-and-training-packages/victorian-aged-care-education-and-training-vacet.

VACET has three key learning areas that cover the following:

- **A Palliative approach to care**
  - Palliative care introduction
  - Symptom management
  - Recognition and management of an actively dying resident
  - Loss, grief, and bereavement
  - Self-care and resilience
- **Dementia Care**
  - Understanding dementia
  - Understanding pain
  - Recognising and responding to responsive behaviours
  - Depression and dementia
  - Sleep and dementia
- **Oral Care**
  - Perspectives on oral care
  - Aged Care quality standards
  - Oral care and communication
  - Healthy oral structures
  - Oral screening and care planning
  - Oral health and links to general health and well-being
  - Personalised oral care
  - Oral sensitivity and comfort

A need for education in these areas was also identified through the Royal Commission into Aged Care Quality and Safety, Interim and Final reports (2021). VACET is designed in recognition of education and training needs of aged care staff and the important work that they do every day caring for residents and their families.

References

Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, Commonwealth of Australia (2021). Available at: https://agedcare.royalcommission.gov.au/publications/final-report.

Disclaimer

All cases discussed in the Residential Aged Care Communiqué are public documents. We have made every attempt to ensure that individuals and organisations are de-identified. The views expressed are those of the authors and do not necessarily represent those of the Coroners' Courts, the Victorian Institute of Forensic Medicine, Monash University or the Department of Health and Human Services (Victoria).

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Acknowledgements

This initiative has been made possible by collaboration with Monash University, the Victorian Institute of Forensic Medicine, 'The Communiques Australia Inc' and funding from the Department of Health and Human Services (Victoria).