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Editorial

Welcome to the first issue of 2020 and a new decade. A decade where we should look forward with hope to better care of older people and a brighter future for the sector as a whole.

Last year was an exhausting and frantic time in the sector with the Royal Commission into Aged Care Quality and Safety in full swing, along with the Aged Care Quality and Safety Commission commencing the assessment of the quality of care and services against the new Aged Care Quality Standards.

Compounding the challenges of being continuously under scrutiny and having to adapt to a change in standards, has been the media portrayals that cast the whole sector in a negative light. We should not be surprised, as it is in human nature to seek out the negative, shocking and horrifying news stories. While the criticisms of the aged care sector that are based on objective evidence are well founded, what is often forgotten is the impact on the individual. This experience is similar to that which occurred in health care in the 1990s, when evidence emerged that the health system was a direct cause of significant harm to patients. The notion of systems of care, and recognition that health professionals did not go to work to hurt patients, was critical to improving patient safety.

This edition reinforces these notions with two cases where the residential aged care services did their best and yet harm still occurred to the resident. This was recognised by the coroner who highlighted that there were factors outside of the control of the aged care staff and service that impacted on the provision of care.

Our expert commentaries provide accounts from an individual health care worker — Carmel Young, a neuropsychologist — Kerrie Shiell, and an organisational psychologist — Simon Brown-Greaves, on how to cope when operating in a high stress environment. In addition, we have a clinically focussed expert commentary from a speech pathologist — Julie Cichero, who addresses issues around choking and food consistency and the importance of having a standardised systems approach.

Finally, we are looking for volunteers to help us road test a pilot podcast of the RAC-Communiqué. This is an exciting opportunity to have your say about the newest offering by the Communiqués team. Look out for the link to this project on page 13 of this issue.

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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: **racc@thecommuniques.com**

Beyond our control

Case Number QLD 2015/2405
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i. Clinical Summary

Mr NR was a 55 year old male who was an inpatient at a psychiatric unit in a regional town at the time of his death. His past medical history included schizophrenia (diagnosed during his 20s) which was chronic and treatment-resistant. Mr NR's psychiatric illness was characterised by delusions and paranoia with associated behavioural disturbances, resulting in multiple psychiatric hospitalisations throughout his adult life. Other past medical history included chronic obstructive pulmonary disease (COPD), cardiomyopathy, and he was a cigarette smoker.

Three years prior to his death (at the age of 52 years and following a 3-month psychiatric admission) Mr NR entered a residential aged care facility (RACF) in a regional town. This was considered the only accommodation option available to him due to the complexities of his chronic poor mental and physical health.

The RACF had difficulties meeting Mr NR's care needs. There were behavioural issues, including aggressive and sexually intrusive conduct, as well as targeting of a particular staff member.

Mr NR was maintained on clozapine to manage the schizophrenia and (despite regular blood tests indicating elevated levels of the medication) the prescribed dose was not adjusted.

After almost three years of residency, Mr NR was reviewed by the Older Person's Mental Health Service as his behaviour was deteriorating. The psychiatrist on that team felt that Mr NR was experiencing a delirium and suggested a reduction in clozapine doses, a rationalisation of other psychotropic agents and the development of a behaviour management plan in liaison with the aged care facility staff. It was also suggested that Mr NR's physical ailments also required assessment and management, including electrolyte derangement, anaemia and monitoring of his oxygen levels. None of these recommendations were followed.

Mr NR was moved to a new room, one closer to the nurses' station so as to cause less disruption at night to other residents. Ten days later, Mr NR was found to be drowsy during the day and was reviewed by his general practitioner (GP). The dose of clozapine was reduced and, a short course of prednisolone was also prescribed for shortness of breath.

A further 10 days later Mr NR struck a nurse in the face, causing a lip laceration. Mental health services were contacted, police informed and, Mr NR was transferred to the local emergency department.

Mr NR was described as agitated and aggressive. At the hospital he was shackled to the bed and administered olanzapine intramuscularly. Mr NR was deemed to not be suffering any physical illness that would preclude psychiatric admission and later that day he was transferred to the high dependency unit of the psychiatric ward. Mr NR remained physically restrained and received additional doses of olanzapine and clonazepam throughout the morning.

"Mr NR's oxygen levels were fluctuating, and it was recognised that clonazepam may have been causing respiratory depression."

In the afternoon, Mr NR's oxygen levels were fluctuating, and it was recognised that clonazepam may have been causing respiratory depression. Nonetheless, further doses of both olanzapine and clonazepam were administered. The following morning he was found not breathing, pale and with no recordable pulse. A Code Blue was called but Mr NR could not be resuscitated.

ii. Pathology

The cause of death (determined after post-mortem examination and toxicology tests) was cardio-respiratory arrest due to mixed prescription drug sedation in the presence of advanced emphysema and acute bronchopneumonia. A blood sample found toxic/fatal levels of clozapine and olanzapine.

iii. Investigation

Multiple concerns (both prior to and during Mr NR's psychiatric admission) were acknowledged. The coroner heard that the RACF had little expertise in managing Mr NR's complex behavioural and physical problems. There was minimal oversight of the prescribing of his multiple medications. There was discontinuity of care, with a reliance on locum psychiatric clinicians and general practitioners. This resulted in a lack of communication between mental health services, the RACF and general practice.

At the regional health service, it was noted that there was little recognition of Mr NR's significant physical co-morbidities, no evidence of an assessment to exclude delirium, and inadequate monitoring of Mr NR's oxygen levels in the setting of administration of multiple psychotropic and sedating medications.

iv. Coroner's Findings

The coroner found that the RACF was not suited to the care of younger persons with severe mental illness — being equipped and staffed to provide residential care to the elderly.

The coroner commented that the facility did its best to provide Mr NR with a safe and caring home. The coroner recommended the development of a suitable facility which could provide supported accommodation for persons suffering from mental illness who are unable to care for themselves.

We did our best

Case Number 0792/2015
Inquest Number 29/2018
Case Précis Author
Ms Carmel Young
RN Research Nurse,
Department of Forensic Medicine,
Monash University.

i. Clinical Summary

Mr S was a 68 year old male who entered a residential aged care facility (RACF) for persons with low-level care needs in August 2012, at the time his son and the Public Advocate were his guardians. Mr S had a past medical history of Korsakoff's syndrome (alcohol-related dementia), hypertension, hypercholesterolemia, falls and osteoporosis which resulted in multiple fractures.

The RACF allowed Mr S the freedom to come and go as he pleased. He frequently spent his days drinking alcohol at a nearby hotel. However, due to repeated incidents of being intoxicated, hiding alcohol in the garden, absconding, hoarding, non-compliance with medication and, conflict with staff and residents, Mr S was no longer able to be accommodated at the RACF.

In January 2013, Mr S moved to another RACF where he had two referrals to the Exceptional Needs Unit (Nov-2013 and Dec-2013). In January 2014 he was transferred once more, this time to a high-level secure area that provided constant care and supervision.

Almost 15 months later, one evening Mr S was served his meal, staff noticed he was stuffing food in his mouth. They reminded him to slow down and removed his plate so he could not continue eating. Soon after he collapsed. Staff attempted to dislodge the food in his mouth and an ambulance was called. He was in asystole when the paramedics arrived. Initial resuscitation commenced and a large bolus of food was removed from his airway. He was intubated and following a return of spontaneous circulation he was transferred to hospital.

There, Mr S had another cardiac arrest and could not be resuscitated.

ii. Pathology

A forensic pathologist examined the medical records and determined (without autopsy) that the cause was obstruction of airways by foodstuffs with contributing alcohol-related dementia.

iii. Investigation

The coroner directed that further investigation was required because Mr S was subject to a guardianship order (in South Australia) with special powers pursuant to section 32 of the Guardianship and Administration Act 1993 (the Act).

The order specified that Mr S be detained in such place as his guardians determined. This meant the case was treated as a "death in custody" requiring a mandatory inquest.The coroner obtained statements from the RACF staff for the purpose of the coronial investigation. The statements revealed that staff had noticed a deterioration in Mr S's eating habits, observing that he was not chewing his food prior to swallowing and was placing too much food in his mouth at meal times.

"The speech pathologist determined that the issue was due to cognitive impairment related to the dementia rather than an underlying mechanical problem."

The RACF staff had raised their concerns with the treating medical practitioner and speech pathologist who both assessed Mr S. The speech pathologist determined that the issue was due to cognitive impairment related to the dementia rather than an underlying mechanical problem.

The RACF nursing staff had completed a short functional assessment which included advice on Mr S's diet recommending: soft textured food cut into bite-size or smaller pieces; one-on-one supervision during meal times to prompt Mr S to chew before swallowing and; staff to regularly check his room for any evidence of food (given the history of hoarding).

Despite the efforts of the RACF staff, issues with eating continued for Mr S. On the day he choked, Mr S was served an evening meal of soup, sausages and vegetables. These had been cut into pieces the size of 10-cent coins. Staff reminded him to chew the food slowly. They removed his plate when he did not cooperate.

The coroner heard that when Mr S choked, the RACF staff initiated appropriate first aid measures, including attempts to dislodge food from his throat with back blows. These were unsuccessful and so they commenced cardiopulmonary resuscitation until the arrival of ambulance crew.

iv. Coroner's Findings

The coroner did not find any fault with the RACF's management of Mr S, stating that Mr S *"appears to have had an unmanageable habit of putting too much food in his mouth when eating."* The coroner determined that his death was not preventable, and no recommendations were made.

Working in an adverse social context

Simon Brown-Greaves
Chief Executive Officer
FBG Group Melbourne Victoria
Website: fbggroup.com.au
Biography: See Page 8

The aged care sector is going through a time where there are many real and complex stressors. The amount of external scrutiny seems like it is at an all-time high and social media has a daily commentary on how well (or not) we do our work.

Some commentators summarise the changes in aged care at this time with the acronym 'VUCA' that stands for—Volatility, Uncertainty, Complexity and Ambiguity. This acronym appears to be gaining traction in describing contemporary experiences of many organisations. In truth the use of the acronym can be traced back to management and military texts from the 1950s – so is it really anything new?

In our work at FBG Group however, there is no doubt that when an organisation, or group, is faced with unusually stressful circumstances, the impact on people is obvious and important. It is not the intent of this article to debate whether our work context is 'VUCA' or not, but to recognise that for many of our peers and colleagues – it sure feels like that!

The key focus for my team and I is to provide practical support and some constructive observations about what we might do when it feels like even getting to work every day is a struggle.

The underlying assumption of course is that feeling this way for extended periods is not conducive to our optimal state of mental health and wellbeing.

First and foremost, it is so important to remember that most of us choose to work in the aged care sector not for fame and riches, but from a deep sense of purpose and a desire to do something of value. It stands to reason then, that if we are subject to unrelenting or unreasonable criticism this strikes at the very heart of what gets us to work each day.

> **"Most of us choose to work in the aged care sector not for fame and riches, but from a deep sense of purpose and a desire to do something of value."**

We have found organisations that focus on ensuring a culture of recognition and appreciation are better able to counterbalance these negative external voices. For an organisation's leaders in particular, helping to ensure that staff are reminded and connected to their sense of purpose every day makes a real difference.

Second, it is a time to reach out and notice how those around us are travelling. As a psychologist, I am well aware of the power of purposeful conversation; of the immense value in asking someone – 'how are you going' and then most importantly listening to and engaging with the answer.

This is not a practice that is the sole domain of the therapist – rather, it is an attribute of a socially connected and aware 'village'—that is connected within our community or, workplace. It is no surprise that we are seeing a significant rise in the number of peer support programs in our health and other aged care frontline agencies.

Some organisations encourage proactive use of the EAP and suggest that staff could well use the service to develop their own wellbeing plan. Those of us with the privilege and responsibility to lead in our workplace, also know the responsibility we have to lead with positivity and balance; to encourage those around us and

"It is vital to help those around us keep some perspective when it seems all are against us. "

Third, it is vital to help those around us keep some perspective when it seems all are against us. Some effective strategies we have seen in such circumstances include shifting focus towards the medium and longer term, rather than the immediate social media 'moment'! Helping staff to think about their development plans and including them in discussions about the organisation and its future goals can be effective in both grounding them and taking a longer-term view. Some would suggest that shifting one's focus to a more purposeful and planful view can balance the often immediate, emotional response to perceived criticism or unhelpful commentary. Indeed, encouraging an analytical and insightful approach to feedback is a powerful way to build real resilience.

Lastly, of course, it is a time to ensure that staff are aware of the resources available to support them and in particular how to access these resources. If you have an Employee Assistance Program (EAP), now is a great time to promote it and encourage access — not just at times of crisis or distress.

to offer those words of gratitude – thank you for what you do, and never lose sight of the fact that you make a difference.

Simon Brown- Greaves is an Organisational Psychologist and the CEO of FBG Group — an Australian firm that provides strategic and practical support to the Wellbeing and Mental Health of organisations and those who work in them. He has been practicing in this space for over 35 years but remains optimistic and positive about the capacity of people to rise to the challenge. He avoids social media other than the odd surfing site on Instagram.

Impact of Chronic Stress on — Cognition and the Brain

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The Royal Commission into Aged Care Quality and Safety provides an opportunity for anyone in our community concerned about aged care to reflect upon models of care and standards of practice. This examination is crucial to improve the quality of services provided to residents. However, the prolonged scrutiny may also have an impact upon aged care staff stress levels, morale, and decision-making.

There is research demonstrating the negative impact of prolonged stress on a person's cognitive processing and brain function. There is also evidence of pathological changes to the brain tissue itself, with chronically high levels of the stress hormone, cortisol, associated with brain atrophy and cell death. This necrosis, or cell death, differentially affects parts of the brain. The areas often at greatest risk are those responsible for judgement, learning and memory.

In times of stress, the brain reallocates resources to areas deemed important for assessing threats and survival. Unfortunately, this means that as individuals, we are less equipped to think creatively about ways to manage challenging situations. Prolonged stress leads to a strengthening of pathways involved in threat evaluation and response, at the expense of other areas needed for more complex decision-making.

In cases of significant ongoing stress such as that experienced following armed conflict or wars, people may remain in a state of heightened alert. This situation, which can lead people to perceive threats in even the most benign encounter, is known as hypervigilance.

Hypervigilance hampers our cognition and may also lead to mental health problems, such as anxiety or depression.

Prolonged stress may also influence our decision-making in quite specific ways. Over time, individuals struggle to identify and evaluate the consequences of their decisions and often make less advantageous choices. Our thinking becomes more risk averse, with people focussing on their own needs and failing to identify the potential consequences on others.

There is also a positive argument for the benefits of stress. That is, addressing and overcoming challenges may lead to greater resilience and self-confidence. However, it is important to recognise that this will be influenced by one's sense of control and mastery over the stressful situation.

In order to modulate the damaging effects of stress we must determine whether we have potential control over the circumstances that are causing stress. As the adage goes, "we must accept the things we cannot change but have the courage (and fortitude) to change the things we can".

"Over time, individuals struggle to identify and evaluate the consequences of their decisions and often make less advantageous choices."

Experts have cited a range of simple, practical strategies to manage stress. These include:

- getting a good night's sleep to lessen the impact of fatigue on thinking,
- being organised and making concrete plans to work through areas of concern.

Sometimes we are able to do this by ourselves but occasionally we may need to seek support from a neutral professional. Someone who has some distance from the situation and is able to provide a new perspective. This may help us to change or reflect upon our attitude towards the stress, which in turn may reduce the sense of threat we feel and prompt us to see opportunities for growth and development.

Surviving work when under fire — a personal reflection

Ms Carmel Young
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I was asked to write this piece, imagining I was currently working as a nurse in RACS with the pressures of the Royal Commission and the popular media all focusing on the negative aspects of our care. How do I separate myself and maintain my morale from what feels like an attack on the sector?

While I know they're not intending to directly attack me or my work, and it is the whole system they are critically examining, am I able to step outside from that and not take things personally? How do you keep everything in perspective? We all have days where things just seem to get to us.

So, I did an online search. The American Psychological Association suggests tracking your stressors by keeping a journal for a week or two to identify stressors and how you respond to them. This sounds good but too much effort, for me anyway. Then they suggest developing healthy responses which don't include drinking alcohol but rather exercising, doing yoga and eating a healthy diet.

One of the points is to take time to recharge. When I asked a friend, who works in aged care how she manages stress she told me she locks herself in the treatment room and screams.

I initially laughed when I heard her response and then thought about the level of stress she must be experiencing, and realized that what she is really doing is giving herself some time out. I don't think we all should start screaming but

> **"Turning off when you leave work is a skill which I find hard to do. Keeping busy with activities not related to work does help. "**

I know removing myself from a situation and taking a couple of deep breaths does help me to bring myself back to the job at hand.

Turning off when you leave work is a skill which I find hard to do. Keeping busy with activities not related to work does help. Whether it be family activities, exercising, meditation, cooking, it all helps to relax and put things into perspective.

Nurses are used to helping others so we should not be afraid to seek outside help especially at a time that is so stressful. Many employers offer employee assistance programs which are independent entities and can be very helpful and understanding. What keeps me going is focusing on the needs of the person in front of me, whether you want to call them a patient, resident or consumer, they still need care and attention to promote their independence.

The IDDSI Framework: a common language to talk about food and drink for people with chewing and swallowing problems

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Choking presents as the second highest cause of preventable death in aged care facilities (1). Although choking risks are well recognised in young children, it is not as well recognised that the incidence of choking on food is seven times greater for people over the age of 65 years than it is for children aged 1 to 4 years (2).

To reduce choking risk, foods may be pureed, minced or chopped and drinks may be thickened. Broad descriptions such as 'soft diet' become confusing and can inadvertently result in foods that are inappropriate being given to people at risk of choking.

Recognising the importance of a standard approach, Australia has used a national terminology since 2007. In 2015, an international project to standardise the names, definitions and testing methods for food and drink used for people with chewing and swallowing problems was completed (3,4).

The International Dysphagia Diet Standardisation Initiative (IDDSI) Framework was formally adopted in Australia in May 2019 and is supported by Speech Pathology Australia, Dietitians Association of Australia, the Institute of Hospitality in Healthcare, and industry. The IDDSI Framework provides people around the world with a common language for texture modified food and thick drinks, in addition to simple but reliable testing methods to ensure that the right food texture or drink thickness is provided to the right person.

It takes less than 10 seconds to do the testing. The IDDSI Framework uses numbers, colours and descriptors to ensure good communication regardless of the language we speak. That said, the IDDSI Framework is also being translated into 27 languages other than English.

One of the major changes from the Australian National Terminology to the IDDSI Framework is the removal of bread and sandwiches from the Australia Texture A Soft, now IDDSI Level 6 Soft & Bite-Sized. Bread poses an extremely high choking risk based on summaries from coronial inquests in many countries, autopsy data and reports such as the NSW Ombudsman's report of deaths of people with disability in residential care 2013-14 and 2016-17 (5-7).

Although food can be modified, it is important to appreciate that eating is a mechanical activity as well as a cognitive activity. The case of Mr S demonstrates some of the complexity in this overlay. Staff raised concerns that were appropriately followed up by referral to a speech pathologist. Staff had noticed that Mr S was not chewing his food prior to swallowing and was placing too much food in his mouth at mealtimes. The speech pathologist identified that Mr S had the capacity to chew, but that his dementia affected his behaviour at mealtimes.

"Where people are unable to self-monitor the size of food pieces they attempt to eat, or eat too quickly, one-to-one supervision is critical."

Where people are unable to self-monitor the size of food pieces they attempt to eat, or eat too quickly, one-to-one supervision is critical. These steps were faithfully put in place by the aged care facility. At IDDSI Level 6 Soft & Bite Size food texture and particle size is specified. Food particle size is recommended to be 1.5 x 1.5cm, roughly the size of the thumb nail.

The size recommendation comes from information relating to the average size of the trachea.

If the food is inhaled, the piece should be small enough to enter the trachea without occluding it. Food must also be soft as determined by its ability to completely break apart when the back of a fork is pressed onto it with enough pressure that the thumb nail blanches to white.

Food that meets this softness requirement needs very little chewing.

With Mr S's mouth-stuffing behaviour, lots of food crammed into the mouth, regardless of its size will block the pharynx and airway entrance if not swallowed. While it may have been a possibility to trial Mr S with a Level 5 Minced & Moist Diet, where no chewing was needed, it is likely that the mouth-stuffing behaviour may still have resulted in a catastrophic choking event.

It is noteworthy that Mr S was eating sausages. Round foods are a particular choking risk and should be cut in half, regardless of their size. Staff attempted to optimise safety by providing supervision, verbal instruction and taking the plate away so that Mr S could not continue eating.

While the IDDSI Framework improves safety by providing a common language, definitions and testing methods, as this case demonstrates, the need for supervision must also be considered.

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Volunteers to test pilot podcasts of RAC-Communiqué

We are seeking the assistance of our subscribers to review pilot podcasts of the RAC-Communiqué. The task is simple. We require you to listen to our pilot podcast and provide feedback on how to improve it.

We need 10-20 subscribers and approximately 60 minutes of your time.

Please register your interest at: https://forms.gle/Gzn9V6HM6e5Zp34o6

Limitations of Care Resource

The Limitations of Care Resource has just been revised. The resource comprises our animated YouTube film presenting the topic of "Not for resuscitation and dementia" and a short information package to facilitate small group discussion within clinical teams and care providers. The film is just under ten minutes long and is a thought-provoking introduction to the topic.

It is available from the Dementia Training Australia website at: https://www.dta.com.au/resources/limitation-of-care-orders-making-an-informed-choice.

Resources

1. RAC-Communiqué Vol 1 Iss 1 Oct-2006 addresses the use of physical restraints.

2. RAC-Communiqué Vol 13 Iss 3 Aug-2018 addresses the issue of young people in residential care.

3. RAC-Communiqué Vol 2 Iss 2 Jun-2007 examines the issue of residents' choking on food.

4. RAC-Communiqué Vol 5 Iss 1 Feb-2010 examines the management of internal emergencies.

5. International Dysphagia Diet Standardisation initiative *https://iddsi.org/*

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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