

Residential Aged Care

Communiqué

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EDITORIAL

Welcome to the third issue of 2016. This issue focuses on some of the legal aspects of providing care for older people. Specifically, the two cases examine situations involving a guardian or another surrogate decision maker. The involvement of a third party sometimes over complicates an already difficult situation and increases the potential for misunderstandings. At other times it is a relief to have an objective third party involved who will help to break a deadlock situation or be the much needed advocate for a vulnerable person.

Phil Grano OAM provides the expert commentary in this issue. Phil is the Principal Legal Officer, Office of the Public Advocate in Victoria, and has written an engaging article so don't be put off by his legal background. I am sure you will enjoy reading it as it will open your eyes to the issues facing the people who take on the role of being a guardian.

The 10-Year Anniversary of the RAC Communiqué is being celebrated at a seminar in Victoria on Friday 28-Oct 2016. The seminar is about engaging frontline staff and the speakers will address topics about how health and aged care staff seek, access and use information. Keynote presenters include her Honour Audrey Jamieson who has a background in nursing and is a full-time Coroner at the Coroners Court of Victoria, the Australia's Aged Care Complaints Commissioner Rae Lamb and the comedian, broadcaster, novelist Rachel Berger.

Places are limited!

See links below:

Flyer - <http://www.vifmcommuniques.org/wp-content/uploads/2016/08/RACC-Oct-Flyer.pdf>

Registration page - <http://aireys.its.monash.edu.au/medicine/product.asp?plD=751&cID=1>

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Next issue: November 2016



Case #1 - In care but not 'in care'

Case Number: 6/2015 (1365/2012) SA)

Case Précis Author:

Dr Chelsea Baird

BSc (Med) MBBS (Hons) Advanced Trainee Geriatric Medicine

Clinical Summary

Mrs O was a 75-year-old female who lived at home with her husband. Past medical history included being a cigarette smoker with chronic obstructive pulmonary disease (COPD), dementia, diabetes mellitus, depression, osteoarthritis and oesophageal ulceration.

In December, Mrs O had a fall sustaining a fracture of the left wrist. The fracture required closed reduction and so she was admitted to a metropolitan acute-care hospital. This was the third time in a month that Mrs O had a hospital presentation with a fracture.

On this occasion, Mrs O remained a hospital inpatient for almost 12 weeks. This was due to the complexities around returning home. Mr O her husband and carer, felt unable to meet Mrs O's ongoing care needs, but Mrs O wished to return home. A hospital psychiatrist assessed Mrs O and determined that she lacked the capacity for decision-making.

This led to an application for guardianship being filed and the Public Advocate was appointed to make medical, accommodation and lifestyle decisions. The guardian directed that Mrs O be discharged into the care of her daughter and that be at Mrs O's home.

Nine days after discharge, Mrs O was readmitted to hospital with respiratory depression secondary to an overdose of a prescribed antipsychotic medication. Mrs O required intubation for respiratory support and was managed in the intensive care unit. The psychiatry team reviewed Mrs O and concluded that she was not depressed or suicidal. Also, they were satisfied with the current care arrangements at home. After a five-day admission, Mrs O was discharged to her daughter's care once more, this time to the daughter's home.

About one month later, in April, a duty worker at the Office of the Public Advocate applied to the Guardianship Board for an urgent hearing as Mrs O's daughter indicated that she was no longer able to continue to care for her mother.

Interim orders were granted for 14 days (until a full hearing of the Guardianship Board could be held), this was under *Section 32 of the Guardianship and Administration Act 1993*.

These provide special powers to an appropriate authority to direct where a person may reside, to detain a person and use such force as is reasonably necessary to ensure the proper medical treatment, day to day care and wellbeing of the person. The Tribunal cannot make a Section 32 order unless it is satisfied that, if such an order were not to be made and carried out, the health or safety of the person or the safety of others would be seriously at risk.

The orders were exercised and (at the direction of the guardian) Mrs O was transferred from her daughter's house back to hospital via ambulance and was thereby 'detained' there. Four days later, the guardian consulted with the hospital staff, Mrs O and her daughter. Mrs O agreed to discharge to a Residential Aged Care Service (RACS) and this was done the same day. Later, a full hearing of the Guardianship Board extended the Section 32 powers for a period of 6 months (until October).

In mid-August, Mrs O was transferred to an acute hospital suffering from shortness of breath and a productive cough. On admission her conscious state was impaired and oxygen saturation levels were low. Despite treatment Mrs O's condition deteriorated and the decision was made for palliative care. The advocate guardian requested that Mrs O be transferred to hospice. However, hospice beds were not available. Mrs O died the following day in the hospital.

Pathology

Following a pathology review of the clinical history the cause of death was determined to be an exacerbation of end-stage chronic obstructive pulmonary disease.

Investigation

The death was reported to the Coroner because at the time of her death, Mrs O was subject to a Guardianship order with Special Powers. That is, there was a direction for detention in place of residence. This was in both the interim and substantive orders made by the Guardianship Board.

This was interpreted as suggesting Mrs O was in a state of detention at the time of her death and that therefore, this was a 'death in custody', and so would mandate a full inquest under the Coroner's Act 2003 South Australia.

The coroner determined that the substantive Section 32 order granted for 6 months was never exercised and the 4-day period of detention in hospital (covered by the Interim order) ceased upon the discharge to the RACS.

The coroner accepted the guardian's assertion that while Mrs O had been 'detained' in a dementia-specific, secure wing of the RACS, this was not a directive of the guardian. The coroner also accepted that as Mrs O's final days were in an acute hospital she was not in detention. Therefore, the coroner was satisfied that this was not a death in custody.

The coroner noted that the informal nature of guardian's decisions (often communicated verbally) made it difficult to determine whether at the time of death a protected person was being detained pursuant to section 32 of the Guardianship and Administration Act 1993. The coroner recommended that all future directives be made in writing.

Author Comments

This case highlights one of the important and traditional roles of the coroners' court for our society. There is a specific requirement to report deaths that occur "in care" or "in custody". This is intended to ensure that authorities responsible for the care of vulnerable people are accountable to an objective and external body (Coroners Court).

Confusion often arises as the interpretation by clinical staff of the term 'in care' tends to be quite literal. Also, the circumstances are becoming more complicated each year as the number of older people with dementia increases, as they often have a guardian appointed and may reside in secure units in residential care. However, it is rare that the persons in these situations are 'in care' in the legal sense.

It is important to be aware there is a legal definition, that we should refer to the formal definition and, if in any doubt seek advice from the Court. Also note that the laws governing the Coroners Court and Guardianship vary between jurisdictions and countries.

Case #2 - Keep me informed

Case Number: 2012/4591

Case Précis Author:

Dr Alfredo Obieta

MD FRACP

Consultant Specialist in Geriatric Medicine

Clinical Summary

Ms C was a very frail 90 year old female, with a medical history including advanced dementia, heart failure, reflux oesophagitis, osteoporosis, poor mobility being wheelchair bound, and malnourished from having lost 13kg in past 12 months. On admission to the RACS in September Ms C was noted to have small pressure injuries on her sacrum, to which topical cream was applied and changes made to her resting position in bed.

Ms C 's residency was characterised by intermittent and increasing occasions of declining to take medication, food or fluids. This also included declining assistance from staff for personal care (bathing and dressing). Sometime during her second month in RACS, Ms C experienced a collapse. A review by medical staff was not completed and her family were not notified.

Ms C's condition improved, but six days later she fell, hitting the left side of her head, sustaining a bruise and a skin tear which was dressed.

In the third month in RACS, Ms C's health again deteriorated, evidenced by a 5kg loss of weight and an overt sacral pressure injury had developed. This prompted more concerted pressure care management strategies, including multiple small dressings, heel protectors, frequent turning and repositioning. Ms C's general practitioner (GP) noted her to be unwell, coughing and not eating, and commenced treatment with antibiotics and subcutaneous fluids.

Ms C's condition improved, but six days later she fell, hitting the left side of her head, sustaining a bruise and a skin tear which was dressed. A few days later, new black necrotic areas were observed in the sacral ulcer. The next day, the GP was made aware of the large area of necrosis.

The GP attended, and prescribed an opioid patch to manage the pain. The GP considered whether to transfer her to hospital or debride the wound at the RACS and decided to try organising equipment and materials for a possible debridement the next day.

The GP also organised blood tests to investigate the ongoing deterioration. The results of these tests were received two days later and indicated severe hyponatremia likely from dehydration. Ms C was then transferred to an acute care hospital for management.

At the hospital, medical staff diagnosed Ms C with severe dehydration, malnutrition and deep pressure injuries. Ms C continued to deteriorate and died a few days later.

By coincidence that same day Ms C's daughter contacted the nursing home to arrange to take her mother out for the day. It was then that the daughter found out about the transfer to hospital.

At the hospital, medical staff diagnosed Ms C with severe dehydration, malnutrition and deep pressure injuries. Ms C continued to deteriorate and died a few days later. It was just before Christmas and approximately three months after entering the RACS.

Pathology

Following a full autopsy, the cause of death was considered to be due to the infected sacral ulcer and fluid imbalances from poor hydration and nutritional status. Both causes were deemed related to dementia. Additional contributing factors included cardiac failure, recent pulmonary embolus compromising lung function, and advanced age. There were pressure areas noted on both heels, right elbow and an infected 8 x 7.5cm necrotic, foul smelling, gangrenous ulcer at the base of spine that extended to bone but without osteomyelitis.

Investigation

The death was reported to the Coroners Court because both the hospital medical staff and Ms C's daughter were concerned about the care provided at the RACS. The Coroner investigated the nursing and medical response to Ms C's deteriorating health. An Inquest was not held, however, an expert opinion was obtained from the Clinical Forensic Medicine service following a review of the medical records and autopsy report, and the general practitioner provided a statement. The Coroner also had information from the outcome of a complaint lodged by the daughter to the Commonwealth Department of Social Services (DSS) which had imposed sanctions on the RACS about 6 months after Ms C's death.

DSS found the RACS deficient in the identification, assessment and management of residents' skin care needs including wound management. This included: a failure to communicate with next-of-kin / Enduring Power of Attorney (EPOA); a failure to provide appropriate assessments and interventions to address hydration & nutrition needs and, a failure to provide appropriate equipment and adequate pressure area care.

The GP explained he had not been contacted about the fall, nor was he made aware of the sacral pressure injury until some months after Ms C entered the RACS.

The Coroner concluded that Ms C died from a combination of factors primarily related to dementia, including poor nutritional status, immobility and advanced age.

The expert opinion revealed that throughout Ms C's stay at the RACS, staff did not proactively or formally contact her daughter. There were multiple occasions to do so, such as, updating changes in Ms C's condition and in the formulation or revision of care plans. The GP also did not contact the daughter to discuss any assessments or treatment. An important aspect discovered was the RACS staff and the GP were not aware that an EPOA existed. Further, that the EPOA had not been involved in any of the decision-making about the care and treatment plans.

Coroner's Findings

The Coroner concluded that Ms C died from a combination of factors primarily related to dementia, including poor nutritional status, immobility and advanced age. The Coroner also noted that Ms C would not have died at that time if the necrotic sacral wound and nutritional status had been addressed.

The Coroner did not make any formal recommendations but noted that the daughter who also held the EPOA was largely not consulted and not informed of her mother's deteriorating condition – and should have been.

The GP was also found wanting in the decision-making around the management of the sacral injury. However, as the general practitioner had retired from active practice, a referral to the Office of the Health Ombudsman was not necessary.

The RACS was found wanting in their lack of initiative in investigating the resident's poor oral intake and not seeking to better understand why resident was declining or unable to take food and drink – there was neither a speech pathologist nor dietician review.

Author's Comments

It is not unusual that people in the terminal stages of dementia become bedbound, unable to eat and drink, and die. In this case, failure in having an early comprehensive multidisciplinary assessment and intervention, including an earlier appreciation of the early stages of pressure ulcer development, reduced the ability to ensure optimal physical health.

This was compounded by the absence of regular formal involvement and communication with the next of kin, who should have had the opportunity to prepare and contribute to decision-making.

People who are no longer thriving at home are often admitted into RACS in the hopes that the care and intervention will at least improve their physical health and quality of life. Advanced frailty is a challenge, as these people do not necessarily put on weight even with appropriate interventions. But even when they do, they should not die with any significant decubitus ulcers – the advanced stages are always preventable.

Write to us to celebrate a decade of the RAC Communiqué

With our 10-year anniversary in October, we are looking for contributions from our subscribers to share in the next issue.

Perhaps you have a story to tell about the impact of the RAC-Communiqué on improving practice or, maybe you just want to share your thoughts about what has changed in the world, or just in aged care.

Write and tell us something you are happy for us to publish. It could be a sentence or a short paragraph. Keep it to a few sentences aiming for between 25 to 50 words. Make it something from the heart that takes a couple of minutes to do.

Your comments will sit alongside commentaries from Emeritus Professor Rhonda Nay and Associate Professor David Ranson. How often do any of us get to say we shared the page with national and international figures in aged care and forensic pathology?!

If you are wondering what to write about, think of something that made you laugh or, made you cry or, made you angry or, inspired you or was just surprising and unexpected. There must be something as 10 years have passed with almost 40 issues, which comes to about 120,000 words or 200 pages we have sent your way. That's big enough to be an old fashioned PhD thesis!

So there must be something there that made you react and want to comment on. I look forward to including a selection of your comments in our bumper 10-Year anniversary issue.

Please email comments to racc@vifm.org Also let me know if you are happy for us to acknowledge you in print or if you wish to remain anonymous.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:
racc@vifm.org

DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health, Victorian Institute of Forensic Medicine or Monash University.

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Expert Commentary - Leaving home

Phil Grano OAM
Principal Legal Officer,
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Victoria

Victoria's Public Advocate is the guardian of last resort for a person who lacks capacity to make decisions about moving into an aged care facility.

It's not a foregone conclusion that once an assessment by the Aged Care Assessment Service (ACAS) acknowledges the person could enter a facility that a guardian will agree to it. A guardian in Victoria has, amongst other things, to advocate for the client, to encourage them to participate in the life of the community, to protect them, to consult with them, to give effect to their wishes wherever possible, to act in a way that is least restrictive of the client's freedom of decision and action, and to act in their best interests.

Few people want to leave their homes and possessions, to forego their independence, to be dependent on others, to conform to another's rules or to live with others they have never met. So when a guardian agrees to a person moving into aged care, it is hoped the facility will provide the best sort of care for this particular person.

Living may be compromised by diminishment in abilities and sickness, but a good facility will labour to provide opportunities to be, to do, to grow, to expand.

When entering a facility, visitors recoil if they sense the service provided to residents is that of "*death's midwife*". This can show in the myriad ways; residents' wishes are ignored, staff conversations are functional (do this or that) or perfunctory (how are you? – don't answer because I'm not interested), people sit in silence waiting for something to happen (I remember a Ronnie Corbett skit about a party that was so boring when a light bulb blew people talked about it for hours – at some facilities one fears it could occupy conversations for days!).

Food is a great pleasure, more so when the capacity for other pleasures has diminished. Its anticipation can be as exquisite as the experience. Bland offerings cruel the moment and crush desire. Dining room meals are social occasions and the food is a fresh topic (perhaps only topic) of conversation. Residents can unite in mutual joy or communal disdain. Each can be bonding, but I know which one happy residents prefer.

We expect the facility is able to engage in those conversations and planning, to engage doctors and relevant others.

Residents know which staff like them and which ones don't, which ones care, which ones are looking for the end of the shift. They remember the harsh word, the slight, the avoidance.

Sometimes they ruminate on these, sometimes they complain, many times they just shut up shop hoping to get through that person's care with minimal engagement.

Residents remember the good things, too. The confidences, the laughs, the attentiveness, the apology when something goes wrong (it happens!).

People with dementia may forget the specifics, but emotions linger.

Residents want to get on with living as best they can. This is individual and dependent upon how people feel. Living may be compromised by diminishment in abilities and sickness, but a good facility will labour to provide opportunities to be, to do, to grow, to expand. It may be activities, outings, music, films, choirs, prayers services, book readings, family events, companion animals, bowls, bingo. It may be opportunities for contemplation, reverie, whimsy, beauty. It may be maintaining the person's links with activities they undertook prior to taking up residence.

We are obsessed with health in aged care, probably because poor health so affects the quality of our lives. How to be healthy, to remain so; how to cope with poor health, getting good assessments and treatments; guardians expect services will be really skilled at these things.

If you quarantine someone in their room, please visit them often and engage with them. Life in quarantine is so lonely.

It is difficult to avoid discussion of death and we hope residents will have a good death. We look for good planning around likely scenarios for the particular resident. We expect the facility is able to engage in those conversations and planning, to engage doctors and relevant others.

List of resources

1. Victorian Government's Office of the Public Advocate website has everything you need to understand guardianship, EPOA and have some great resources for Victorian RACS and hospital staff. Available at <http://www.publicadvocate.vic.gov.au>
2. The National Aged Care Quality Indicator Program introduced for Australian aged care homes from 2016 includes measures for pressure injuries and unplanned weight loss. More information is available at:

<https://agedcare.health.gov.au/ensuring-quality/quality-indicators/national-aged-care-quality-indicator-programme-resource-manual-for-residential-aged-care-facilities>

<http://www.myagedcare.gov.au/aged-care-homes/quality-indicator-pressure-injuries>

<http://www.myagedcare.gov.au/aged-care-homes/quality-indicator-unplanned-weight-loss>

3. Past editions of the RAC Communiqué that explored related topics are available at: <http://www.vifmcommuniques.org/previous-editions/residential-aged-care-communique-editions/>
 - Vol 3 Iss 3 Jun-2008 Pressure Ulcers
 - Vol 9 Iss 1 Feb-2014 Communication,
 - Vol 9 Iss 4 Dec-2014 End of Life
4. The Victorian Department of Health and Human Services resources to promote safe, high quality person-centred care to older people living in residential aged care services are available at: <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality>