MONASH University

A Victorian Government initiative

State Government Victoria

RESIDENTIAL AGED CARE COMMUNIQUÉ

VOLUME 5. ISSUE 3.
August 2010
ISSN 1834-318X

CONTENTS

FREE SUBSCRIPTION

The Department of Forensic Medicine, Monash University will publish the RESIDENTIAL AGED CARE COMMUNIQUÉ on a quarterly basis. Subscription is free of charge and the Communiqué is sent to your preferred email address.

If you would like to subscribe to RESIDENTIAL AGED CARE COMMUNIQUÉ, please email us at: racc@vifm.org

Next Edition: December 2010 (Special Edition #2 Practice Change)

EDITORIAL

Welcome to the August 2010 edition of the Residential Aged Care Communiqué. We postponed the release of this edition to allow our subscribers enough time to read and catch up with the June 2010 Edition (Volume 5 Issue 2) on how we use Health Technology Assessment and the special edition that described real world practice change; the "Residential Aged Care-Practice Change".

This edition features two cases from the Coroner's Office in South Australia, both required an extensive investigation and inquest. The theme we chose to explore is the management of residents with dementia who display behavioural patterns that place them at risk of harm.

One case involves a resident who wandered and absconded from the Residential Aged Care Service (RACS) and the other involves a resident who repeatedly placed items into his mouth.

One of the greatest challenges for clinicians in managing residents with dementia is recognizing that we all gradually become "acclimatized". That is, the repeated experience and observation of the behaviours of concern leads to a shift in our thinking. What is considered behaviour of concern when we first meet a resident eventually becomes perceived as "normal or usual". Especially after we have implemented apparently successful management strategies. This occurs with all health professionals and as a consequence we are slower to recognise or respond to changes that may lead to harm.

Consider how many of us would orientate agency staff to a resident's behaviour that has been present for years? Also, how often do we accept environmental hazards and work-around the limitation?

Management of these residents requires a holistic approach that incorporates the physical environment, staff, how we document and transmit information as well as the direct clinical and personal care aspects.

CORRECTION

In the June 2010 edition (Volume 5 Issue 2), the case titled "Complications of Catheterization" we inadvertently abbreviated the reference to the nursing service potentially creating confusion about the different organizations. The case involved the "Royal District Nursing Service of SA Incorporated". We apologise for any confusion this may have caused to other district nursing organisations.

PUBLICATION TEAM

Editor in Chief: Joseph E Ibrahim
Consultant Editor: Rhonda Nay
Managing Editor: Fiona Kitching
Designer: Caroline Rosenberg

Address: Department of Forensic Medicine, Monash University
57-83 Kavanagh St, Southbank
Telephone: +61 3 9684 4444

ACKNOWLEDGEMENTS

This initiative has been made possible by collaboration with the Victorian Institute of Forensic Medicine and Department of Health (Victoria) - Aged Care Branch.

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 organizations 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.

DO YOU HAVE EYES IN THE BACK OF YOUR HEAD?

Case Number: available on request

Case Précis Author: Prof JE Ibrahim
Monash University

CLINICAL SUMMARY

Mr C, a 71 year old male, was transferred from an acute hospital to a metropolitan Residential Aged Care Service (RACS) for secure high level care. Past medical history included Alzheimer's dementia with a tendency to wander, non-insulin dependent diabetes mellitus, depression and schizophrenia. Within a few days of admission, Mr C had absconded out of the RACS on two separate occasions and had been found climbing a fence. To manage the risk of absconding, staff were asked to check on Mr C at intervals of 15 minutes.

About a week later, just before the security alarm system was routinely activated, night shift staff saw Mr C standing outside his room. Some hours later Mr C was found with his neck wedged into the wooden slats of a picket gate adjacent to an external wall of the RACS. An ambulance was called but Mr C was dead.

PATHOLOGY

The cause of death was positional asphyxia.

INVESTIGATION

The coroner directed that further investigation was required and held an Inquest to find out how Mr C came to be in that situation. Statements were received from the relevant staff in ACAS, acute hospital, the RACS and the general practitioner.

The information available and the assessment completed by the RACS had identified Mr C's tendency to wander; the risk of absconding and the need for supervision in a secured environment. This was also evident from ACAS who had assessed Mr C as requiring high-level care, and noted his potential to wander and the need for secure accommodation. Also there was information from the acute hospital that admitted Mr C from his own home because of escalating agitation and had kept Mr C under constant observation by a 'special' (i.e., a one-to one carer).

The RACS staff felt confident that their facility was secure and Mr C would not be able to escape.

However, the investigation revealed that two of the doors, one leading to the laundry and the other to the garden, could be opened from inside the facility by using an internal latch. Mr C's room was adjacent to the garden door. The investigation also discovered that all the external doors were not connected to the security alarm system, in particular the laundry door (this had been disconnected). Finally the system was usually armed late at night, typically after 11pm.

CORONER'S COMMENTS AND FINDINGS

The coroner commented that the RACS staff had abundant evidence that Mr C was at risk of wandering and absconding and the securing of the premises was inadequate. Also, that staff operated under the incorrect assumption that the premises were secure, and so checking was not crucial.

Additionally, the request to staff that Mr C be observed every 15 minutes was not practical and there were no clear policies in relation to the checking of residents.

The coroner concluded that Mr C's death was avoidable and it was *"inappropriate for an aged care facility to rely on the security of the premises alone and there should be a regular check made of the residents to ensure their wellbeing and safety".*

These are some of the changes the RACS made following Mr C's death: improved building security (e.g., installation of coded keypads and sliding door locks); earlier activation of the alarm system and installation of a swimming pool type gate with rounded surfaces. Staff roles for security were delineated and documentation improved to better record the sighting of residents.

CORONER'S RECOMMENDATION

The Coroner made one recommendation that *"the Commonwealth Department of Health and Ageing and the Aged Care Standards and Accreditation Agency conduct a thorough review of the facilities, practices and policies".*

THE DANGERS OF THE FAMILIAR

Case Number: available on request

Case Précis Author: Prof JE Ibrahim
Monash University

CLINICAL SUMMARY

Mr B was a frail 77-year-old male resident with dementia and challenging or "unmet needs behaviour" requiring high-level care at a metropolitan Residential Aged Care Service (RACS). Past medical history included multiple cerebro-vascular events, traumatic head injury, alcohol abuse, depression, chronic obstructive pulmonary disease, impaired vision and hypertension. Mr B also suffered from the side effects of prescribed anti-psychotic medication with oro-facial dyskinesia.

On this particular day Mr B was attended by an agency care worker familiar with the RACS. The carer showered and dressed Mr B, taking a folded handkerchief from the wardrobe and placing it in his breast pocket.

In the morning, staff noticed Mr B was having problems with drinking fluids and an assessment was completed that he was not in respiratory distress.

During the day, Mr B's upper clothing was changed because it was wet from dribbling of saliva.

Later that day, Mr B was reviewed and staff suctioned his mouth out first with a hard "yanker" sucker which Mr B resisted and then with a softer tube which extracted some mucus. In the afternoon Mr B was reviewed by the General Practitioner who diagnosed a chest infection and prescribed antibiotics. The general practitioner did not notice anything untoward.

During the night, a carer entered Mr B's room and observed that his fingertips were purple and his breathing sounded unusual. The enrolled nurse attended with the carer, re-positioned Mr B on to his left side and performed some suctioning of the mouth. They summoned the registered nurse who suctioned Mr B once again using the hard plastic yanker sucker. Mr B's condition became worse, so an ambulance was called.

The ambulance crew initiated a rapid transfer to hospital. On route to hospital Mr B deteriorated and the paramedics decided to intubate him. The laryngoscope was inserted to visualize the airway and an obstruction at the laryngeal level was present. Forceps were used to extract the obstruction which was a handkerchief tightly compacted into a cylindrical shape, mimicking the shape of the airway. Mr B's condition improved immediately.

On arrival at the Emergency Department a diagnosis of hypoxic brain injury was made and he died the following day.

PATHOLOGY

The cause of death following a post-mortem examination conducted by the pathologist was: hypoxic-ischaemic encephalopathy and cerebral infarction due to upper airway obstruction by foreign body with contributing right lower lobe suppurative bronchopneumonia, cardiomegaly and dementia.

INVESTIGATION

The coroner directed that further investigation was required to ascertain how the handkerchief had become lodged in the airway. An Inquest was held and statements were received from the permanent staff of the RACS as well as the agency staff.

It was discovered that the agency carer had received an explanation of their duties for that shift from the permanent staff, and that the carer had not read the resident care plan. The carer assumed that the use of a handkerchief was allowed because it was in Mr B's wardrobe.

An RN employed by RACS stated most of the staff knew that Mr B, who had lived there for some years, had a habit of putting things in his mouth. The permanent staff knew to keep small objects away from him and precautions had been taken by removing buttons from his clothing.

The care plan only made reference to Mr B's habit of placing things in his mouth in "the dietary and nutrition" section. It did not make reference to the risk of choking and the need to keep small items away from Mr B. Also the care plan was last updated six months earlier.

CORONER'S COMMENTS AND FINDINGS

The coroner concluded that Mr B's airway was partially occluded by the handkerchief and the suctioning with the hard tube had the effect of compressing the handkerchief and forcing it further into the airway. The Coroner made no criticism of the RN for using the hard tube. However, the coroner did note that the RN should have visualized MR B's mouth before performing the suctioning.

The Coroner stated the care plan *"was inadequate in that it failed to properly set out, with appropriate prominence, his at risk behaviour in placing objects in his mouth which led to the risk of choking"*, suggesting that this information should be in a location that is more obvious and easily and quickly accessed.

The Coroner also noted that the handkerchiefs were inappropriately stored in Mr B's wardrobe.

The Coroner did not make any recommendations because the RACS had already made numerous system improvements.

- Changes to environment included the review and removal of materials that may be potentially harmful and dividing the RACS into smaller areas to improve the monitoring.
- Changes directed to staff included additional education and training about "at risk" residents.
- Changes directed to documentation and identification included placing key "at risk" behaviours at the front of the care plan and introducing the use of red armbands to identify residents who are at risk.
- Changes to clinical practice included ensuring regular review of the care plan, modifying nurses' handover to document "at risk" behaviours and improving the orientation of agency staff.

COMMENTARY: COULD IT HAPPEN HERE? EXAMINING THE EXPERIENCE OF OTHERS MANAGING RESIDENTS WITH UNMET NEEDS BEHAVIOUR

The clinical education and research literature around managing persons with dementia and unmet needs behaviour is enormous and cannot be sensibly summarized here. The focus of this commentary is to stimulate discussion with colleagues and RACS management about how we might approach "adopting changes to practice".

After reading the cases we should be answering the following questions for ourselves:-

Q1 Could the same or similar situations occur at our RACS?

It is human nature to say "No, this would not happen to us" because if we say it is possible, then we start to worry and have an obligation to change what we do. Also we tend to look at what makes us different, rather than look at what is similar.

Even if you are convinced it could never happen, it is best to make an assumption that it is possible and review the preventive strategies in your RACS.

Q2 Are the hazards that were identified in the cases applicable to our RACS?

For example consider whether the RACS doors are alarmed and what time they are armed? Once again, it is human nature to answer the question with what you already know e.g., *"the security bloke told me last year everything was ok and the alarm is turned on by night staff"*. Ideally we should verify information. We can do this by checking with the person who is responsible for that task, better yet we could test the system e.g., exit the building after the alarm is set and go through all the doors that are supposed to be alarmed.

Q3 Are the proposed solutions from the cases suitable for our RACS?

We should consider whether their solution would improve care; whether there is evidence that it removes the hazards, and whether it is feasible i.e., "can we do it here". We often need time, money or people to get something changed. It is our role as clinicians and carers to advocate to RACS boards and management about this rather than say, "*it is out of our control*".

Q4 Are we objective about how we examined the clinical risks, hazards and solutions?

We all have our own personal or organizational preferences about the "best way to do something" and this is often in our sub-conscious. The challenge is to be able to step back and examine the information impartially.

LIST OF RESOURCES

1. A Guide to Practice for Managers in Residential Aged Care Facilities. Alzheimer's Australia <http://www.alzheimers.org.au/content.cfm?infopageid=3614 >
2. Dementia friendly environments: a guide for residential and respite care. This provides a practical guide of physical and social design principles with research, case studies and other information <www.health.vic.gov.au/dementia>
3. Draft Standardised Care Process: Choking, Department of Health Victoria at <http://www.health.vic.gov.au/agedcare/downloads/score/score_choking_august_09.pdf>
4. Dementia Collaborative Research Centres provides a 'Dementia Outcomes Measurement Suite" that contains tools designed to assist professionals in assessing dementia and related issues within all environments http://www.dementia-assessment.com.au/