MONASH University

A Victorian Government initiative

Victoria

RESIDENTIAL AGED CARE COMMUNIQUÉ

VOLUME 6. ISSUE 4.
December 2011
ISSN 1834-318X

CONTENTS

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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.

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Next Edition: Feb 2012

EDITORIAL

Welcome to the final issue of 2011. After five years of focussing on cases from Victoria and Australia, we thought it was time to examine what happens in other parts of the world.

We have taken this approach to challenge pre-conceptions about the nature of clinical risk and reinforce that we are able to learn from approaches to manage risk from local, national and international experiences.

We are fortunate to have access and permission to use the information from the 'Office of the Chief Coroner' Ontario, Canada. Their motto "*We speak for the dead to protect the living*" is something to which we should all aspire. Canada and particularly Ontario's system of death investigation, is considered one of the most progressive in the world becasue of their focus on public health and prevention.

This issue of RAC-Communiqué also provides the opportunity to consider the important factors when we translate recommendations from one setting into our own service. We often see, hear or read about innovations in practice that we would like to bring into our own service. Sometimes we succeed in crossing-over an idea though never sure quite why it worked. More often we fall at the first step-"this could not happen here", or "we are different". If we get past that first step, we often find we need substantial more insight into the people, place and circumstances about why an innovation succeeded. The idea may be universal, the implementation is always local.

The three cases were drawn from "*Seventeenth Annual Report of the Geriatric and Long Term Review Committee to the Chief Coroner for the Province of Ontario. June 2007*".

The immediate difference established readers will notice is the term used to describe RACS in Canada, "Long Term Care Home". Another difference is in Ontario, Canada, the office of the Coroner has a Geriatric and Long Term Care Review Committee to review cases. Established in 1989 this committee consists of medical practitioners (General practitioners, Geriaticians and Emergency Medicine Specialists), a nurse, dietitian and Coroners. When a case requires specific expertise other health professionals are invited (e.g., psycho-geriatrics, infectious diseases).

SAVE THIS DATE: WEDNESDAY 23RD MAY 2012

Next year, VMIA with RACC and DoH will hold a "Dignity and Risk Management" an education and training seminar.

The seminar is intended to assist staff working in Residential Aged Care Services explore and manage the relationship between maintaining an individual's dignity whilst managing clinical risk in residential aged care.

Register your interest and receive further information by emailing: training@vmia.vic.gov.au with your details.

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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.

LOST DENTURES

Case Précis Author: Prof JE Ibrahim
Monash University

CLINICAL SUMMARY

Mr AA was a 98-year-old male resident requiring high-level care at a Long Term Care Home (what we refer to as Residential Aged Care Service) since 2001.

Past medical history included: stroke with residual right-sided weakness, difficulty with speech and swallowing; atrial fibrillation, diabetes mellitus and depression.

Early in March, staff noted increased difficulties with swallowing. This dramatically worsened in the last week of March, reaching the point that Mr AA was spitting food out and refusing medication. In early April, Mr AA's daughter expressed concern about dehydration. A transfer to the Emergency Department was organized.

In hospital a diagnosis of aspiration pneumonia was made and treatment initiated. The next day on the ward nursing staff discovered his dentures lodged in his throat. The dentures were removed with some initial improvement, Mr AA died about one week later.

PATHOLOGY

The cause of death was presumed to be aspiration pneumonia secondary to choking on dentures

INVESTIGATION

The Geriatric and Long Term Care Review Committee examined the case and reviewed the documentation from the RACS.

They found that Mr AA's choking risk was documented along with appropriate interventions to manage this issue. Specifically, the need for supervision, positioning, modified fluids and checking with pharmacy about medications. However, there was not any documentation that Mr AA owned dentures. Also there was no documentation the dentures are a potential choking hazard.

Documentation of oral care showed two entries only over the previous four months that indicated his dentures had been cleaned. When Mr AA's condition changed there was neither documentation that his mouth and throat were examined nor the location of the dentures.

COMMENTS AND FINDINGS

The Geriatric and Long Term Care Review Committee made the following recommendations to the Office of the Chief Coroner:-

Health care professionals be reminded of the importance of conducting a through examination of the orophraynx in the setting of acute dysphagia

Long-term care homes review their admission documentation to include specific questions about dentures especially in residents at risk of choking.

AUTHOR COMMENTS: FURTHER INFORMATION CLINICAL RISK

The following issue: *RAC-Communiqué Volume 2 Issue 2 May 2007*, focused on the clinical risks of dysphagia and choking. **http://www.vifm.org/education-and-research/publications/residential-aged-care-communique/>**

RAC-Communiqué –Special Edition Practice Change Volume 1 Issue 1 July 2010, described changes to improve the management of the clinical risk areas around dysphagia and restraint. **http://www.vifm.org/education-and-research/publications/residential-aged-care-communique/.**

CONSTIPATION, SERIOUSLY!

Case Précis Author: Prof JE Ibrahim
Monash University

CLINICAL SUMMARY

Ms BB, a former Olympic athlete, was now an 89-year-old female resident requiring low-level care at a Long-Term Care Facility (LTCF) since 2002. Past medical history included ischaemic heart disease, hypertension, diverticular disease, recurrent falls, osteoporosis with fractures of the thoracic spine and kyphoscoliosis.

Ms BB was cognitively intact, fiercely independent and reluctant to take medication preferring to "brave out" any illnesses.

In May 2005, Ms BB had several unwitnessed falls, fractures of the lumbar vertebrae were diagnosed and treatment with bed rest, analgesia and aperients instituted. Ms BB gradually improved and was ambulating to the dining room by mid-June. Early July, staff found Ms BB crying with abdominal pain, she also had a fever of 38C. The next day she was no better and was transferred to an acute hospital. A perforation of the bowel was diagnosed and this required surgery. The surgeon found necrosis in the lateral wall of the mid rectum with an abscess.

Post-operative care in intensive care was uneventful and Ms BB appeared to be progressing well on the general ward when she died suddenly.

PATHOLOGY

A post-mortem was not conducted. The cause of death was attributed to an acute cerebrovascular event complicating a bowel perforation from stercoral colitis most likely due to constipation.

The pathologist report of the bowel tissue taken at surgery indicated "perforated acute diverticulitis and pericolic abscess formation"..., "a large amount of hard stool in the intestinal lumen"..., and "stercoral ulceration"

INVESTIGATION

Further investigation was required to ascertain whether the overall management of Ms BB pain and bowel regimen contributed to the severe constipation.

It seems the cascade of events commenced in mid-May with Ms BB's having a fall. The initial treatment of pain with intermittent short acting opiods and paracetamol was reasonable. Ms BB had also been administered a 10 day course of a stool softener and had daily bowel actions until that medication was ceased.

However, throughout the month of June, Ms BB continued opiate analgesia without a regular prophylactic bowel regimen. Also, it appeared that the medical and nursing staff did not recognize Ms BB was becoming increasingly constipated. Ms BB's tendency to under-report or minimize symptoms was recognized as additional factor increasing the complexity of this situation.

COMMENTS AND FINDINGS

The Geriatric and Long Term Care Review Committee made the following recommendations to the Office of the Chief Coroner:-

Constipation is "common, preventable and treatable condition", untreated it can lead to death. Constipation in older people may present with atypical symptoms such as delirium or confusion. Also, the presence of bowel motions may be misleading, in that faecal impaction may lead to overflow incontinence.

Health care professionals need to be reminded of the importance of a regular prophylactic bowel regimen when using opioid medication.

Health care professionals caring for older people in acute and long term settings should receive training in early recognition and management of constipation.

AUTHOR COMMENTS

Stercoral is defined by Dorland's Medical Dictionary as "consisting of or containing faeces". This is a particularly tragic case because it seems so simple and obvious about what we need to do to prevent it from occurring. The additional challenge is "how do we approach, persuade, convince a person who is fiercely independent and reluctant to adhere to clinical therapy?"

How many risk factors did you identify for Ms BB developing constipation?

I will list the easy ones: pain, opiates, diverticular disease, reduced mobility.., and what else?

RESOURCES

SCORE: Strengthening Care Outcomes for Residents with Evidence is an initiative commissioned to support Victorian Health Services operating aged care homes to provide high quality care to residents. SCORE has a focus on managing some key areas of risk for residents and seeks to develop and implement evidence based standardised care processes.

http://www.health.vic.gov.au/agedcare/downloads/score/score_constipation_august_09.pdf

Recall the RAC-Communiqué Volume 3 Issue 5 Dec 2008 theme was around the clinical risks of anticoagulation. http://www.vifm.org/education-and-research/publications/residential-aged-care-communique/>

COMMENTARY: SUITABILITY FOR TRANSFER: "IS WHAT HAPPENED OVER THERE LIKELY TO HAPPEN TO US?"

As health professionals, our training in the basic sciences relies on the assumption that the anatomy and physiology of the brain, heart and lungs is the same in people throughout the world. Disease states and their treatment are also the same, i.e., having dementia; osteoporosis or a fractured hip in Australia is the same as it would be in Canada.

It is curious that every time we ask "Is what happened over there likely to happen to us?" We mostly answer, "No!" Especially, if it is something we don't like. The real question is not, whether the same thing could happen. It is "What can I learn from someone else's experience?" This process requires active thinking and learning. It also requires gathering information and understanding "over there" and determining the similarities and differences of "here".

In this RAC-Communiqué we have challenged you to learn from case reports in Canada. To help structure the conversation to have with colleagues consider:

[Clinical risk] Is the risk or hazard described present in our setting?

[Time] Are the cases scenarios current: i.e. did they happen this year, this decade or this century?

[Place] Are the places similar to ours? Are Long Term Care Homes similar to our Residential Aged Care Services?

[Person] Do the patients or residents sound similar to our residents? Do they have similar clinical risks?

[Staff] Is the health professional staff similar? Is their clinical training and practice consistent with our own?

[Organisation] Is the organizational infra-structure the same? If not, how relevant is it to the key lesson from the case scenario?

[Health care system] Is the health care system the same? If not, how relevant is it to the key lesson from the case scenario?

[Legal and Coroner System] We know there are differences in how deaths are reported, investigated and recommendations made. Is the health care system the same? How relevant is it to the key lesson from the case scenario?

[Society and geography] How are the people and country of Canada similar and different to Australia? Is this relevant? How does this impact on the case scenario?

[Key message or lesson] Is this very specific and local or can you see a general principle?

[Recommendation for action] Is this very specific and applicable to their local context? Are there elements that may be worth trying here?

We will award a prize to the reader with the best contribution addressing these questions on any one of the three cases.

LOST IN COMMUNICATION

Case Précis Author: Prof JE Ibrahim
Monash University

CLINICAL SUMMARY

Ms CC was a 98-year-old female resident requiring high-level care at a Long-Term Care Home (LTCH) since 2003.

Past medical history included dementia, ischemic heart disease, chronic obstructive pulmonary disease and a fractured right neck of femur.

In early 2005, Ms CC developed bronchopneumonia which resolved, a venous Doppler ultrasound of the leg was done and no abnormality founded. In June, staff reported bilateral leg oedema and the doctor ordered another venous Doppler study. One month later, the test was done and revealed a deep venous thrombosis. A week later treatment with oral warfarin 3mg daily was commenced along with subcutaneous anticoagulant. Nine days later, blood was taken for the first time to check the PT-INR (reported at 4.3). Three days later another PT-INR was requested, that evening Ms CC vomited coffee grounds, appeared pale, was hypotensive (BP 70mmHg systolic) and tachycardic (HR 118 bpm). The laboratory called through the PT-INR (6.0) and haemoglobin (91, had been 111 three days earlier).

Ambulance was called, dispatched and transported Ms CC to the Emergency Department within an hour. Blood tests were repeated and results were available 90 minutes later (PT-INR=10; Hb=80g/dl). However, it was another 4 hours before treatment for the over anticoagulation commenced with fresh frozen plasma and vitamin K. Ms CC died the following day.

PATHOLOGY

The cause of death without a post-mortem examination concluded "death as a result of complications of anticoagulant therapy prescribed to manage a deep venous thrombosis".

INVESTIGATION

The death was reported to the coroner and the investigation identified; Delays in: getting the imaging study done; reporting the results and acting on the result.
Management and follow-up of the anticoagulant therapy was not appropriate (usual practice after commencing warfarin is to order a PT-INR on the third day and a follow-up on fifth day for monitoring).

A delay instituting treatment to reverse the effects of warfarin at the acute hospital. It was not possible to ascertain if the initial abnormal test results where communicated by the LTCH to the acute hospital.

COMMENTS AND FINDINGS

The Geriatric and Long Term Care Review Committee made the following recommendations to the Office of the Chief Coroner:-

There is an obligation to follow-up laboratory tests and imaging studies; and that documentation of results in the medical record should be mandatory.

Direct and clear communication between medical and nursing staff, as well as, between laboratory and clinical staff. Especially for urgent investigations and where there are abnormal results.

Establish protocols for the management of deep venous thrombosis in long term care homes.