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RESIDENTIAL AGED CARE CORONIAL COMMUNIQUÉ

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Next Edition: April 2008

EDITORIAL

Welcome to the first edition of the Residential Aged Care Coronial communiqué of this New Year. We took a brief hiatus due to changes in staffing and extend our thanks to foundation managing editor Zoe Davies who has moved on to a new position. We would like to extend our thanks to the outgoing State Coroner Graeme Johnstone who was critical to the establishment of the Clinical Liaison Service and promoted the vision of prevention and communicating with the public. We welcome the new State Coroner Judge Jennifer Coate who was appointed in November 2007.

The theme for this issue has been particularly challenging and focuses on common issues created by the interface between facilities and hospitals, emergency departments, general practitioners and community services. It is well established that the multiple interfaces involved in clinical care creates discontinuity and gaps leading to duplication of services, time wasting, readmission, additional costs, dis-satified residents, families, doctors, nurses, managers and complaints.

The care deficits are preventable with better management of interfaces which requires a systematic approach to ensure consistent, clear systems and planning that achieves facility understanding between the health service providers and the residential aged care facilities [RACF].

The cases, commentaries and expert contributions identify the frustrations we all face when communicating with dis-interested stakeholders and the complexity of co-ordinating care between the RACF and other acute medical services. There are many approaches to better manage the interface including advanced care planning that may negate the need for transfer and futile care, and developing a systematic & collaborative approach to transferring information. The residential aged care sectors have a responsibility of communicating issues about residents that others have little understanding of e.g., managing patient with dementia. The acute sector also has a responsibility to better understand the capacity, staffing and limited resources available at a RACF.

A list of resources relevant to communication and transfer between health services is provided. Ask yourself if the facility you work at has an emergency response plan and communication strategy required for transfers of residents at night, or on weekends? How is continuity of care maintained for chronic disease management of residents e.g., diabetes management, palliative care plans, transfer of patients with dementia? And are the facility staff able to assess and recognise changes in health status and act according to stated care plans?

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All publications produced by the Specialist Investigations Unit, including the Coronial Communiqué and WorkWISE can be found on our website at **http://www.vifm.org/n962.html**

FEEDBACK

The CLS 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**

UNDERSTANDING CARE NEEDS AT END OF LIFE

CASE NUMBER 3240/04

Precis Authors: Amanda Charles
Registered Nurse (CLS)

CLINICAL SUMMARY

Mrs C was a 93 year old female resident who required a high level of care at a RACF because of a medical history that included dementia, osteoarthritis, glaucoma and anxiety requiring frequent reassurance. She became increasingly confused and drowsy with resultant decrease in oral intake and was admitted to hospital.

On return to the RACF, she was still drowsy and a few weeks later found to have sustained a fractured hip after a fall. She returned to the hospital where this fracture was surgically repaired and she was returned to the RACF within four days. At the RACF she continued to be confused, restless and fell again re-fracturing the hip three days later, requiring another short hospital admission.

Mrs C developed an MRSA infection in the hip and over the next few months, her condition continued to deteriorate, falling several times. The final hospital admission occurred some months later. The hospital completed an incident report because of their concerns about Mrs C's condition on arrival, which included the presence of a skin tear, wound infection, dehydration and hypotension. She died the next day.

PATHOLOGY

An autopsy was not performed and the cause of death was established as hypotension, septicaemia and dementia on a background of recurrent falls.

INVESTIGATION

An investigation required statements from the RACF nursing staff and general practitioner about the RACF's wound care and falls prevention policies.

The GP caring for the deceased stated that he was not aware of the deceased's wound infection and that the staff at the facility are competent to assess and care for wounds. The DON at the nursing home described the care of the deceased's wounds as being in line with hospital policies and that wound management is a permanent item for staff training and development.

CORONER'S COMMENTS

The Coroner recognized that the limited information available made it difficult to assess the care provided. Therefore, the matter was referred back to the Aged Care Resolutions Scheme.

EDITOR'S COMMENTS

The frailty and multiple co-morbidities of this resident along with the multiple transfers create a situation for gaps in communication and care. Therefore, a well organized, simple, structured plan for information transfer is required. This case also highlights the importance of clear documentation that is vital to good care and provides a future reference to explain decisions and actions taken by health and aged care providers.

KEY WORDS

Clinical [Aged care; medicine; RACF; metropolitan; diagnosis and management; communication and policy]

Investigation [No autopsy; statements; comments]

SUPPLEMENTARY ARTICLES FOR THIS EDITION:

We have posted the contributions of Donna Whatmuff and colleagues who present a viewpoint of the RACF facility *Evidence based practice and interfaces or communication strategie*s and Professor Rhonda Nay who provides us with an aspirational vision for the future to remind us of what we should be aiming for and to keep working to improve the current situation *Gertie and Bertie: a vision of a future with integrated services* at:

http://www.vifm.org/attachments/o614.pdf

THE BENEFIT OF GUIDELINES FOR TRANSFERS

CASE NUMBER 123/05

Precis Authors: Amanda Charles
Registered Nurse (CLS)

CLINICAL SUMMARY

Mr L was an 84 year old male with a medical history of a stroke, dementia and gout. He required a high level of care and lived at a metropolitan RACF. In July 2004 his health began to deteriorate due to constant skin infections. These eventually resulted in extensive necrotic areas requiring admission to an acute care public hospital for treatment including intravenous antibiotics in December 2004. His clinical condition did not improve and palliative care was provided at the hospital where he died three weeks after admission.

PATHOLOGY

Cause of death following an autopsy was 1(a) Bronchopneumonia, 1(b) Immobility in the setting of treatment for widespread staphylococcal infections, 2. Dementia, cachexia, cerebrovascular disease and chronic obstructive airways disease.

INVESTIGATION

Concerns were raised by the hospital as to the level of care offered at the RACF and the decision making around transfer to other facilities. The Coroners investigation included a review of the RACF and hospital medical files as well as the statements requested and received from the general practitioner and the manager of the RACF caring for the deceased.

The facility provided evidence of the guidelines used to determine when residents should be transferred as well as information that the Aged Care Resolutions Scheme had found the management was appropriate. Also the RACF indicated that it complied with Aged Care Standards and Accreditation Agency requirements.

CORONER'S COMMENTS

The guidelines used to determine when to transfer residents appeared reasonable.

EDITOR'S COMMENTS

Development and regular review of policies and procedures relevant to common and high risk clinical areas are important for resident care. Documentation of adherence to these protocols and explaining when and why variation occurs assists in clearly explaining matters that may become contentious in the future.

KEY WORDS

Clinical [Aged care; medicine; RACF; metropolitan; management; communication]

Investigation [Autopsy; statements; comments]

COMMENTARY: GENERAL PRACTICE

Dr Wendy Bissinger General Practitioner, GPDV [drwendyb@hotmail.com]

Managing information transfer between residential aged care and acute hospital care is recognised as vital for maintaining good quality care for the aged. Lack of information leads to fragmentation of care, poor clinical outcomes and high readmission rates (1).

Through the Aged Care Panels Initiative funded by the Department of Health and Aging since 2004, Divisions of General Practice across Australia have had the opportunity to work closely with RACFs to address some of these challenges.

Divisions of General Practice have produced generic transfer forms in consultation with RACFs, GPs and hospitals. These transfer forms include the minimum required information needed to safely transfer a resident to hospital i.e., advanced care wishes, usual mental state and ability to perform activities of daily living, the capacity for care on return to RACF. This is all contained in a readily identifiable envelope. Contact your local Division of General Practice for further information about this.

As General Practitioners complete more comprehensive medical assessments, we will have a recent review of the resident's physical, emotional and functional status, as well as their complete medical history. Combined with a residential medication management review, this ensures the most appropriate and simplified medication regimen. Together, they are the backbone of the information package needed on transfer to hospital as well as providing a clear current picture for any provider involved in the resident's care.

The importance of sending a copy of the current medication chart with the resident cannot be overstated. Medication errors are common when elderly residents are transferred between RACFs and hospital. Once residents are taking 10 or more medications, they average two medication errors per transfer, most commonly inadvertent withdrawal of drugs (2). It is important to check and list non-prescription items (e.g., vitamins, herbal and 'over the counter' preparations), patches, creams and drops. The possibility of interactions between new and existing treatment is greatly reduced with this information (3).

Monitoring and documenting the mental state of residents is important because changes to mental state can be a sign of acute disease and will change the approach to medical care. Mental state documentation does not identify all patients with dementia, especially those who have not had a formal diagnosis. (4)

Despite anecdotal evidence to the contrary, most presentations of RACF residents to ED are appropriate (5). Their passage through the acute system will be smoother with better quality information transfer.

References (see website for full references)

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2. Midlov P et al. Pharm World Sci. 2005 Apr;27(2):116-20
3. Crotty M et al. Am J Geriatr Pharmacother. 2004 Dec;2(4):257-64
4. Boockvar KS et al. J Gen Intern Med. 2005 Dec;20(12):1146-50
5. Finn JC et al. MJA 2006; 184(9):432-35

RESOURCES

McDonald T. Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care? A report commissioned by the Aged Care Association Australia. ACU National September 2007 **http://www.agedcareassociation.com.au///organisation/page.cfm?id=25**

Commonwealth Department of Health and Ageing. Aged Care GP Panels Initiative. **http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-acgppi-index**

COMMUNICATION: A CHALLENGE FOR ALL.

CASE NUMBER 145/04

Precis Author: Carmel Young
Clinical Research Nurse (CLS)

CLINICAL SUMMARY

Mr. G was a 91 year old resident in a regional Residential Aged Care Facility [RACF] who required a high level of care due to the underlying medical conditions of falls, dementia and paranoid schizophrenia. The RACF provided both high and low care beds & at night there was staff of one RN Division 1 and one personal care attendant.

On the 6th January Mr G declined to take his prescribed night sedation and later appeared agitated, yelling out there was a fire in the facility. The nurse attended to calm him until a buzzer was activated requiring her to leave to attend to another resident.

The personal care attendant (PCA) who was new to the facility observed Mr G then fall and strike his head on the floor and bleed from the side of the head. The PCA recognized Mr G needed hospitalisation but was not aware of how to organise this from the RACF.

The ambulance staff attended and transferred the resident to a hospital emergency department. Although it is normal procedure for the paramedics to notify the hospital of an impending admission, the hospital staff stated that they had not received such notification from the ambulance or from the RACF. Further, the hospital explained that the next of kin had not been aware of the transfer. The doctor was called into the hospital to evaluate Mr G who was sedated with haloperidol and had the laceration sutured. A Glasgow Coma Scale score and neurological observations were not documented. Investigation for an underlying head injury was not undertaken because the hospital did not have CT scan facilities available at night and the doctor deemed Mr G was not a suitable candidate to transfer to a bigger hospital as this may cause further disorientation. This decision was not discussed with the next of kin who were at the hospital.

The doctor requested Mr G be admitted overnight for observation but was told there were no inpatient beds available. So, Mr G was then transferred back to the RACF with instructions to nurse him on a mattress on the floor but he was returned to bed and had another two falls.

The next morning Mr G was reviewed by his usual doctor who had received a verbal handover from the hospital. A decision was made to treat Mr G conservatively because of his frail condition, age and deteriorating medical state over the preceding month. It was judged that if there was any intracranial bleeding it would be unlikely that a neurosurgeon would have operated.

A phone call was made the next day to the next of kin about Mr G's deterioration and that he was likely to die in the next few days. The next of kin recollected that the phone call was about management options. Mr G died at the nursing home on the 12th January 2004.

PATHOLOGY

The cause of death was determined as bronchopneumonia and acute pulmonary oedema secondary to effects of a large subdural haemorrhage.

INVESTIGATION

This case is a 'reportable death' because the fall directly caused sub-dural haemorrhage leading to death. An investigation required statements from the nursing staff, doctors and the next of kin.

The statements received indicated significant issues related to mis-communication. (1) Within the hospital it seems a bed was available despite the doctor being told otherwise, (2) between the facility and hospital, specifically a lack of understanding by hospital staff of the staffing levels, qualifications or expertise at the RACF to provide ongoing care, (3) between the RACF and family, (4) between the medical staff and family.

The Coroner also sought an opinion from a medical expert who was asked to consider the appropriateness of the treatment and management of Mr G. The expert considered the doctors "treatment in a difficult situation was appropriate and it was appropriate to return Mr G to the RACF and let him stay in his familiar environment."

CORONER'S COMMENTS

The coroner accepted that an alternative approach to care would probably not have changed the course of events. "The concerning aspect about this case was that the next of kin was not given the choice or informed properly about Mr G's condition. If properly informed it most probably be highly likely that she would agree with the doctor's treatment plan." The Coroner commended the RACF for reviewing its practices and procedures on falls, care plans and general management.

CORONER'S RECOMMENDATIONS

Two specific recommendations were made about the need for (1) ongoing training for all staff about managing high level care residents with dementia and mental health issues and (2) increase in the number of alarm mats and concave mattresses.

EDITOR'S COMMENTS

The need for appropriate staff orientation with emergency procedures, documentation and communication is highlighted. The coroner was justly critical of the nature of communication between the RACF, hospital staff, general practitioners and next of kin. The concluding comments summarises the lesson from this case "In all likelihood the best option would have been to leave this man in his surroundings and environment and the palliative care was the best option. However it does not mean we cannot improve communication between all persons and treat all persons respectfully and considerately."

KEY WORDS

Clinical [aged care; medicine and surgery; residential aged care and general practice; rural; management; communication].

Investigation [statements; expert opinion; chambers; recommendations].

All cases that are discussed in the Coronial 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 individual clinicians and hospitals are de-identified. However, if you would like to examine the case in greater detail, we have also provided the coronial case number.