A Victorian Government initiative

RESIDENTIAL AGED CARE CORONIAL COMMUNIQUÉ

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EDITORIAL

Welcome to the third issue of the RAC CC which will review and discuss deaths from choking on food. We are again fortunate to have key contributors like Professor Rhonda Nay provide a nursing perspective and to have advice from Senior Speech Pathologists, Ms Emma Beer and Ms Sam Pilling. They discuss the need for assessment, hazard recognition, contingency planning and emergency response, as well as debating quality of life issues and addressing nutritional needs.

This issue highlights that choking is a preventable hazard and is highly likely to occur in the residential aged care setting because residents are frail with multiple co-morbidities. The detailed case contributed to this issue by RN C Young illustrates the needs for managing residents, staff and the whole facility. The management of choking requires a systematic approach from the initial assessment to an emergency response plan.

With the large number of variables involved in managing dysphagia there is a need to develop investigation guidelines in order for coronial staff to standardise their approach to investigating deaths related to 'choking'.

For a summary of the key issues in managing swallowing difficulties please follow this link: http://www.vifm.org/attachments/o566.pdf

FROM THE ARCHIVES

2774/01: An 84yo male with a past history of dementia, diabetes mellitus and heart failure but who was independent with personal care was recovering from recent eye surgery. At the medication round the nurse found him to be sitting upright and in respiratory distress. A small piece of a sandwich had lodged in his throat. This was removed, oxygen applied and he was transferred to hospital where he died. The cause of death was upper airway obstruction secondary to aspiration of food bolus.

419/02: A 76yo male required a high level of care at a residential aged care facility because of a medical history that included Parkinson's disease, dementia and double incontinence. The staff were aware that he had a habit of overfilling his mouth and removing food from the plates of other residents. On this day he was found in the dining room choking. The staff contacted the emergency services who removed a bolus of chocolate cake from his airway. Due to his frail condition he failed to respond to the initial resuscitation.

1510/05: An 88yo female with a past history of dementia, aspiration pneumonia and urinary incontinence required long term high care as a resident living at a rural aged care facility. The case was referred to the Coroner's Office by Births Deaths and Marriages because the cause of death was listed as respiratory obstruction due to food inhalation. The Coroner reviewed the case and determined the cause of death to be aspiration pneumonia complicating Alzhiemer's disease and dysphagia.

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PUBLICATION TEAM

Editor in Chief: Joseph E Ibrahim
Consultant Editor: Rhonda Nay
Managing Editors: Zoë Davies
Adam O'Brien
Designer: Caroline Rosenberg

Address: Clinical Liaison Service
Coronial Services Centre
57-83 Kavanagh St
Southbank
Telephone: +61 3 9684 4364

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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**

COMMUNICATING DIETARY CHANGES

CASE NUMBER 849/05

Precis Authors: Carmel Young
Clinical Research Nurse (CLS)

CLINICAL SUMMARY

Mr R was an 84yo male with a past history including dementia. He was admitted to a hospital when he could no longer take care of himself. He was later transferred as an involuntary psychiatric patient to an Aged Mental Health Service as his behaviour was aggressive and violent.

All patients at the Service were assessed by a dietician and speech pathologist on their admission and each day while they were eating lunch. When a change was made to the patients' diet it was verbally handed over during the nurse's afternoon shift change. An electronic form was generated to inform the kitchen staff of the change to diet. When the menu monitors received notification of the change they printed new Diet Summary Sheets for the food services staff in the kitchen. The speech pathologist would check the Diet Summary Sheets at the end of the day and distribute them. One copy would be placed in a plastic sleeve on the white board in the kitchen and another copy placed in the patient's fluid balance chart. A Patient Special Drinks List was also generated and placed on the drinks trolley.

Mr R was assessed by a dietician and speech pathologist at the time of his admission. On the 7/3/05 Mr R's swallowing was noted to have deteriorated. A diet notification form was emailed to the menu monitor stating that Mr R was to "cease bread, cake and toast." The afternoon nursing staff were informed of the change. It was routine to verbally handover changes to diet in the nurses handover.

On the 12/3/05 Mr R was given a sandwich and a drink of Milo by the night duty nurse who stated that he was not aware of the Patient Special Drinks List. Mr R requested a second sandwich after which he coughed and collapsed. Resuscitation was attempted and was unsuccessful.

This case was reported to the coroner as it was an unexpected death and he was an involuntary psychiatric patient and therefore deemed to be a 'person held in care' (Coroner's Act, 1985) necessitating a mandatory inquest. He had a full autopsy at the Victorian Institute of Forensic Medicine. The cause of death was:

1(a) Aspiration of food bolus in a man with psychiatric disability

2 Coronary artery atherosclerosis

INQUEST

The nurse who administered the food had been working day shift on the ward for twelve months during which time the kitchen staff routinely distributed the meals. This was his first rotation to night shift. The coroner heard that night staff were expected to refer to the Diet Summary Sheet and the Patient Special Drink List before administering any diet or fluids themselves. The nurse said that he did not know about either document.

CORONER'S RECOMMENDATION

The coroner recommended that the Service "review their induction, training and supervision of nursing staff to ensure they are aware of all elements of their food management system, with particular emphasis on the procedures for notifying changes in diet made by the dietician and / or speech pathologist, and their heightened responsibilities for dietary intake during night shift".

AUTHOR COMMENT

This case highlighted the importance of communicating dietary changes to all staff. It is important to be able to give nutrition to patients after hours but it is also important to make sure all staff are aware of changes that were made to the management and to check charts at the beginning of each shift and to not rely on instructions present during previous shifts.

CHOKING AND NUTRITION IN RAC RESIDENTS

For an informative and referenced discussion by Y Coleman please follow: http://www.vifm.org/attachments/o565.pdf

NURSING MOTIVATION & MISCONCEPTIONS

Professor Rhonda Nay
Director Gerontic Nursing Clinical School and ACEBAC, La Trobe University / Bundoora Extended Care Centre; email: **R.Nay@latrobe.edu.au**.

The risk factors for choking are very prevalent in residential aged care. These include old age, cognitive impairment, stroke, Parkinson's disease, respiratory disease, being 'fed' by staff and various medications such as psychotropics and antidepressants. Often the older person is assisted to eat by the least qualified staff, volunteers and/or family. This makes it imperative that a registered nurse undertakes a simple swallowing screen on admission and if the resident's condition changes. If a problem is suspected then referral to a specialist should be made and documented. Medications should also be reviewed to ensure they are not exacerbating (or the cause of) the problem.

All staff should be aware of the risk factors for choking and signs of dysphagia. Signs identified in a JBI systematic review included:

- General signs such as drooling, absent or weak cough or swallow; frequent throat clearing; and
- Specific signs related to eating and drinking such as having to swallow many times for one mouthful, holding food, regurgitation and sneezing during or after eating (Ramritu et al 2000: 44).

Importantly, fear of choking can result directly in malnutrition. So it is also important that diet is monitored in terms of what is desired, required, provided and indeed consumed. Simple nutrition screening would include weight change, physical and mental condition. The malnutrition universal screening tool (MUST) can be found at **www.bapen.org.uk**. Proximity of a staff member may reduce fear as well as being good practice where risk has been identified. All staff, volunteers and family who assist residents with eating need education in relation to positioning, allowing time to chew and swallow, avoiding dry foods – such as cakes and biscuits and offering frequent sips of fluid – especially to moisten the mouth before eating commences. Oral hygiene is a priority and there are also saliva alternatives available that may be acceptable to residents with dry mouth syndrome: **www.sjogrens.org**

If dysphagia is an issue family and / or staff may push for vitamised food, nasogastric feeding or even a PEG tube because it is perceived to be safer and takes less time to ensure adequate nutrition. Such arguments ignore the social and sensory nature of mealtimes. The nasogastric tube feed is not well tolerated and has not been found to reduce mortality. PEGs are more acceptable to residents than NGTs but they have more complications. Eating is associated with much more than being nourished. So in devising a care plan, quality of life and resident choice must be balanced against the risk, nutritional and time imperatives. Where vitamised food is used texture, colour, aroma and sequence become even more important to consider to enhance the eating experience.

While withholding food and fluid is not permitted by law, if it is clear the resident is in the terminal stage of illness, forcing food and fluid to prolong the period of suffering is surely unethical. Comfort rather than nutrition may be the goal at this stage. Again, evidence that an advanced care plan is in place or that at least the person's wishes have been documented is vital. Neglect for the sake of staff convenience is not an option! Neither is ignoring the resident's choice in order to pacify anxious family members. Regular meetings between all concerned can facilitate consensus, reduce conflict and support a person centred approach to risk management.

The following resources provide more detail about risk, screening, assessment, interventions and useful protocols:

1 Ramritu, P et al. 2000 Identification and nursing management of dysphagia in individuals with neurological impairment. JBI. Adelaide;

2 Scottish Intercollegiate Guidelines Network. 2004 Management of patients with stroke: identification and management of stroke. A national clinical guideline. Edinburgh: **www.sign.au.uk**

EATING AND DRINKING – ITS NO CHOKING MATTER!

Emma Beer, Senior Speech Pathologist, Northern Health and **Sam Pilling**, Health Services Manager of Dietetic, Podiatry and Speech Pathology, Northern Health

It is estimated that the incidence of dysphagia (or swallowing difficulties) amongst residential care facilities is as high as 40-50%.[1] The most common causes of dysphagia in older people are neurological disorders such as stroke, Parkinson's Disease and dementia. Dysphagia can result in aspiration, which is the passing of food and / or fluid into the lungs.[2] Dysphagia and aspiration are associated with high mortality and morbidity, dehydration and malnutrition. It may also be associated with depression and deterioration in quality of life.

The usual symptoms of dysphagia include coughing and choking immediately after swallowing food or fluid, difficulty initiating a swallow, food sticking in throat, loss of appetite, drooling and chest infections.

A multidisciplinary approach is essential in the management of elderly people with dysphagia.[3] If residential care facilities are concerned about a resident's swallow they are encouraged to notify their local physician immediately who can in turn refer to a speech pathologist. Speech pathologists are trained specialists in the assessment and management of swallowing and communication disorders.[4] The speech pathologist will undertake a clinical swallow assessment to determine the need for dietary or fluid modification and therapy. Education for the patient, family and residential care workers in the management of dysphagic elderly people is essential. This usually includes education on modified diet and fluids, safe swallowing methods such as upright posture, small mouthfuls and therapeutic manoeuvres such as a chin tuck. Exercises that target the muscles of the mouth and throat may also be provided. Finally, enteral (or tube) feeding to maintain nutritional status may be considered. Dietitians should also be considered to assist in optimising the nutritional needs of an elderly dysphagic person.

The management for dysphagic residents varies according to history, findings from clinical investigations and cause and prognosis of the individual.[4,5] The following are useful guidelines for residential care facilities to consider:

- Notify physician of any swallowing concerns immediately;
- Once an individual has been identified as being at risk of, or having dysphagia, referral to a speech pathologist for a detailed clinical swallow assessment to assist in management and therapy as required;
- Knowledge of risk factors and signs and symptoms of dysphagia is essential for early detection;
- Oral intake should be monitored to ensure adequate nutrition and hydration;
- Care facility staff, including nurses, should ensure that the texture, consistency and type of food and fluid is provided and administered as recommended by the speech pathologist;
- An individual identified as being at risk of, or having dysphagia, may be safest not eating or drinking at all until assessed by an appropriate health professional; and
- Regular oral hygiene is required to reduce risk of aspiration pneumonia.

REFERENCES

1 Chan D, Phoon S, Yeoh E. Australian society for Geriatric Medicine. Position statement No 12. Dysphagia and aspiration in older people. Australia J Ageing 2004; 23:198-202.

2 Holas MA, DePippo KL, Reding MJ. Aspiration and relative risk of medical complications following stroke. Arch Neurology 1994; 51:1051-3.

3 Chan D, Phoon S, Yeoh E. Australian society for Geriatric Medicine. Position statement No 12. Dysphagia and aspiration in older people. Aust alas J Ageing 2004; 23:198-202.

4 Speech Pathology Association of Australia. Speech Pathologist working with older people. Fact sheet. www.speechpathologyaustralia.org.au

5 The Royal Australian College of General Practitioners. Medical Care of Older Persons in Residential Ages Care Facilities. 2006

6 Ramritu P, Finlayson K, Mitchell A, Croft G. Identification and Nursing Management of Dysphagia in Individuals with Neurological Impairment. The Joanna Briggs Institute for Evidence Based Nursing and Midwifery; 2000 Systematic Review No. 8

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.