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Next Edition: May 2011

EDITORIAL

Editorial

Welcome to the first issue of 2011. This also marks the 15th edition of the Residential Aged Care Communiqué. The focus of this issue is to consolidate the learning from the previous four topics covered: extreme hot weather, emergency preparedness, health technology assessment and unmet needs behaviour.

There are two long cases reported in this issue. The case "Do you have eyes in the back of your head?" illustrates the risks associated with extreme hot weather, it and also reminds us all about the challenges of managing persons with unmet needs behaviour. The other case illustrates the risks from the use of health technology and demonstrates the importance of emergency preparedness.

The purpose of this consolidation edition is to reinforce the learning from previous editions. By reviewing the themes, it gives us all a chance to address the areas that we may have missed or deferred to a "quieter time". It also acts as a prompt or reminder if we decided to act and change practice based on a story from a past edition.

Management of the facility, services and staff to optimize care for residents requires constant review and reflection about what we need to do and whether we are achieving these goals.

So, take the opportunity in this "consolidation" edition to reflect, review and reinvigorate efforts to improve care.

We expect 2011 to be a busy year for everyone. We are hoping to publish four regular editions and one special edition this year. The special edition will be devoted to communicating the experiences of staff and managers in RACS in addressing areas of clinical risk.

The next regular edition in May, will examine cases involving motorised scooters and wheelchairs which are increasingly being used in the community and RACS.

"*You must be the change you want to see in the world*"
(Mahatma Ghandi)

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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 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.

LIST OF RESOURCES

Check the following RAC-Communiqués available at: http://www.vifm.org/n963.html

1. RAC-Communiqué Volume 4 Issue 3 December 2009. The theme was the health effects of extreme hot weather. This issue has comprehensive information about current practice in the prevention of the adverse effects of extreme hot weather.
2. RAC-Communiqué Volume 5 Issue 1 February 2010. The theme was Emergency preparedness. This has some practical information to consider for internal emergency preparedness.
3. RAC-Communiqué Volume 5 Issue 2 June 2010. The theme was about the need for Health Technology Assessments. It reminds us about how to improve the systems and practices for safer use of this equipment. It also includes an expert commentary examining the human and machine interactions.
4. RAC-Communiqué Volume 5 Issue 3 August 2010. The theme was unmet needs behaviour. This issue highlights the need to be proactive and reminds us that people see the world in very different ways.
5. RAC-Communiqué –Special Edition Practice Change Volume 1 Issue 1 July 2010. The theme described changes to improve the management of the clinical risk areas around dysphagia and restraint.
6. RAC-Communiqué –Special Edition Practice Change Volume 1 Issue 2 December 2010. The theme described changes to improve the management of the clinical risk areas around diabetes mellitus and falls.

A FATAL COMBINATION: SIMILAR NAME RESIDENT MEDICATION MIX-UP

Case Number: available on request

Case Précis Author: Dr Nicola Cunningham, Victorian Institute of Forensic Medicine, Department Forensic Medicine, Monash University

CLINICAL SUMMARY

Ms P was an 83 year old female who lived in a supported accommodation house. Past medical history included Down syndrome and intellectual disability, aortic valvular and ischaemic heart disease. Ms P was under the care disability support workers who provided assistance with meals, medication and personal needs of the residents.

Ms P shared the house with a 46 year old female whose surname closely resembled her own, but with the addition of an "a" at the end. Ms Pa had a past medical history that included schizophrenia, intellectual disability, agitation and epilepsy. Both Ms P and Ms Pa occupied their own rooms within the house and required daily administration of their medication. In the mornings, Ms P was prescribed 6 different medications consisting of 6 different tablets to be taken at 8am. Ms Pa required 6 different medications, in 7 tablets at 7am each morning. There were no medications that were common to both.

On one particular morning, Ms P did not receive her regular medication and was instead given the medication intended for Ms Pa (clozapine, risperidone, sodium valproate, lamotrigine, neulactil and benztropine). The error was realized soon after and Ms P was conveyed by ambulance to hospital where she developed hypotension and sedation. Her condition rapidly deteriorated and she was admitted to the intensive care unit. Following a discussion with her next of kin, Ms P was determined to be not-for-resuscitation and died two days later.

PATHOLOGY

The cause of death following an autopsy was - Congestive cardiac failure due to ischaemic and valvular heart disease. Probable contributing factor: hypotension resulting from mixed drug toxicity.

INVESTIGATION

The coroner held an inquest to investigate the circumstances of the incident, and the procedures outlined by the home for the administration of medication. The Chief Executive Officer (CEO) of the organisation provided a statement and gave evidence at the inquest. The CEO outlined that training in the administration of medication was provided to all workers and included the procedure of cross-checking the medication list with the tablets.

The coroner heard evidence that the medication for Ms P and Ms Pa were contained in blister packs that were identical in appearance. Both packs had the individual medications listed on the reverse side. The medication trays holding the packs were stored side-by-side and were correctly labeled with the given and surnames of both residents. The medication folders were also labeled with the given and surnames, and were located in the same room as the medication trays. Within the folders were sheets that allowed workers to signify by way of their initials each time medication was administered to a resident (i.e. am/pm of each day). There was no provision however, for recording the administration of each individual medication.

The medication lists between the folder and the blister pack did correspond for both residents.

The worker who had been on overnight prior to the morning of the incident gave evidence that ordinarily she would administer Ms Pa's medications at 7am before finishing her shift. On this occasion, Ms Pa had attended a function the previous evening and had slept longer than usual so had not been disturbed by the night-shift worker. Ms P's 8am medications would normally have been administered by the oncoming day-shift worker but that worker was running late so the night-shift worker decided to administer them instead.

As the day-shift worker arrived, she saw Ms P being handed medications. The worker then proceeded to retrieve Ms Pa's blister pack to administer her morning medication and found they had already been removed. The morning tablets were still present in Ms P's blister pack. She checked Ms P's folder and noted that the night-shift worker had initialed having given the morning medication, and realizing that an error had occurred, called the ambulance.

The forensic pathologist stated at the inquest that, "the timing in relation to the drugs and her diminishing conscious state in the emergency department all sort of fitted...while the deceased could have died suddenly at any time due to (her underlying) conditions, it is probable that her death was precipitated by hypotension complicating inadvertent mixed drug toxicity."

During the course of the inquest the home presented evidence of changes that had been made regarding the administration of medication. Included under the new practices, workers were required to specifically record the administration of each individual item of medication at any given occasion.

CORONER'S COMMENTS AND FINDINGS

The coroner commented that it was "clear that the consumption of the wrong medication set the scene for what later transpired and that but for that consumption, the chain of events that led to her death probably would not have occurred."

The coroner was satisfied that the changes introduced by the organisation were appropriate.

AUTHOR COMMENTS

This case clearly illustrates an adverse event resulting from seemingly innocuous changes to a daily routine within a residential care system. The use of blister packs can be a safe and efficient method of storing and dispensing medication.

This health technology was developed to make medication adherence easier and safer for an individual. However, errors do occur, even with seemingly basic type of healthcare technology.

This type of same patient or same medication name error is well known to pharmacists, nurses, doctors and other care workers. Ideally, a systems solution such as changes in labeling, resident photos, packaging and the use of written alerts would be helpful rather than reliance on staff to prevent this error.

EDITORS COMMENTS

Human vigilance is one of the safety nets for healthcare technology for resident care. When we use vigilance as our first and only line of defense against error it will eventually fail.

We would be interested in hearing from anyone who has encountered a similar situation and found a solution that does not rely on staff.

DO YOU HAVE EYES IN THE BACK OF YOUR HEAD?

Case Number: available on request

Case Précis Author: Dr Nicola Cunningham, Victorian Institute of Forensic Medicine, Department Forensic Medicine, Monash University

CLINICAL SUMMARY

Ms K was a 65-year-old female who lived independently in a regional locale. She had no known past medical history and was described as being in good physical health; however, she had been getting more forgetful in recent years.

On the day of her death, Ms K's partner was admitted to hospital for an operation so she moved in to her son's residence in the city. She enjoyed going for long walks daily and could not be dissuaded by her son from setting out for a walk that afternoon despite the heat. Temperatures were above 30 degrees Celsius throughout the afternoon and evening. She left the premises at approximately 4pm and had not returned by the time her son woke from a nap at 6pm. She had not taken anything with her for the walk. He searched for her in nearby areas and contacted the police a short while later when he was unable to locate her. She was found deceased just after 9pm on the grounds of a rental car depot that was approximately 8 kilometres west of the city.

PATHOLOGY

The cause of death following an autopsy conducted by a forensic pathologist was "undetermined presumed natural". The forensic pathologist commented, "In the absence of significant findings at autopsy, together with environmental temperatures at the time, the findings would be consistent with death from heat stroke."

INVESTIGATION

The coroner directed that further investigation was required as the manner of Ms K's death was not clear. The specific issues addressed by the coroner at the inquest were whether the precise circumstances of Ms K's death could be reconstructed and involvement of other persons excluded. In particular, the coroner examined whether Ms K had walked on her own to the depot and if so, why she had walked the considerable distance on such a hot day.

Statements were received from Ms K's partner and son who both described a gradual deterioration in her memory. They had been concerned enough about her memory loss to prompt the arrangements for her to stay with her son so she was not alone while her partner was in hospital. A statement was also received from a friend of Ms K's who detailed how she would go on daily walks that would last a couple of hours. Statements provided by the investigating police members outlined that public enquiries had not uncovered any direct sightings of her during the course of her walk. The police also confirmed that there was no sign of any struggle involving another person at the scene, and that the position she was found in and the markings on the ground suggested she may have suffered some form of seizure prior to her death. The forensic pathologist provided further information that seizures may be a complication of hyperthermia.

The coroner obtained documentation from the Bureau of Meteorology that showed the temperature in the city was recorded at 39 degrees Celsius and at the airport it was 34 degrees Celsius at 4pm that day.

CORONER'S COMMENTS AND FINDINGS

The coroner stated that Ms K had a propensity for long walks and it was possible she had walked the entire distance from the city to where she was found in the given timeframe. She had walked without money, a hat or water in extreme heat conditions. There was no evidence that any other persons were involved in her death.

The coroner concluded that it was likely that due to her memory deficits, she had become confused about her environs, and continued walking in a westerly direction until she "eventually succumbed to the elements" and died of heat stroke

AUTHOR COMMENTS

In this case, a physically well individual died as a result of extreme hot weather, highlighting that even the healthy are at risk of heat stroke. The concomitant aspects of physical exertion and lack of water proved to be a fatal combination. Older people with co-morbidities are at even greater risk of heat-related complications and attention to maintaining adequate hydration and protection from exposure to heat is vital.

This case is also a reminder of the issues surrounding patients with memory impairment or dementia. They may function reasonably independently within their own environment, but when placed in a new setting, can become easily disorientated and lost. These residents may be prone to wandering and unable to recognise potentially hazardous situations. Hospitals and residential aged care facilities should be mindful of the safeguards that can be implemented to meet the specific needs of this population.