Victorian Institute of Forensic Medicine

# Residential Aged Care Communiqué

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## EDITORIAL

Welcome to the first issue of 2019. This will be a busy year for all our readers with the Royal Commission and the introduction of the new standards for accreditation. This edition focuses on one case with so many issues it is almost too difficult to comprehend. Each gap in care probably would not have led to the resident's death, but together, the combination was fatal. The case exemplifies the complexity of issues confronting the Royal Commission and highlights that improving aged care requires an approach that involves the whole community as evident by the recommendations made by the coroner to multiple organisations.

Consider for a moment the following occurring over a period of two months, a resident with dementia who is unable to advocate, transition from home to respite to permanent care, the prescription of sedative medication, escalation of dosing, involvement of two RACS, two visits to an acute hospital, the care divided among several general practitioners, and delays in accessing specialist medical support. Each point in the provision of care represents a potential source of risk to the resident.

The case also highlights issues we have addressed in the past including the challenges of managing residents entering respite care, management of behaviours and psychological symptoms of dementia (BPSD), monitoring of high risk medication, gaps in communicating relevant information between residential aged care and other health services. Despite the complexity of this case, this is not an uncommon reality for RACS staff and is noteworthy because of the absence of safety nets to identify the overall risk and clear stewardship for managing the resident.

In particular, I want to emphasise a fundamental aspect of clinical care which is the importance of following-up the initiation of any treatment. This is easily overlooked with the common use of high risk medications as we become complacent about these agents. In every medical, nursing and allied health school, students and practitioners are taught and reminded to ensure the indications for initiating treatment are identified and valid. Further, that initiation or change in treatment requires timely evaluation of the patient's response to treatment and to assess for the presence of any adverse effects.

Our expert commentaries are written by Dr Margaret Bird and Dr Chelsea Baird, both geriatricians with a profound interest in good patient care. Their contribution is a reminder of the next generation of health professionals that will lead us towards better care of older persons. This is timely with the confronting and depressing evidence currently emerging at the Royal Commission for Aged Care Quality and Safety.

Medication safety is a huge topic, one need only refer to the comprehensive report by the Institute of Medicine. Preventing medication errors. Washington, DC: National Academy Press; 2007. While the focus is often on the administration, it is essential to justify the indication for prescribing and to review whether the medication has the desired and not any untoward effects. On a more personal and historic note, this is our 49th issue of the RAC Communique and we are intending for our 50th to be reflective and practical. Keep an eye out for our 2019 seminar and a book of all 50 issues of the RACC in one volume!

# Case Précis: Too Much Too Soon

**Case No:** Victoria 2015/1527
**Précis author:**
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## Clinical Summary

Mrs MB was an 83-year-old female who entered one metropolitan residential aged care service or RACS (Facility #1), for respite care in a high acuity section for persons with dementia, to await a permanent place in another service (Facility #2) that was in the same region.

Mrs MB's past medical history included advanced Alzheimer's dementia, ischaemic, heart disease, osteoarthritis, hypertension, hypothyroidism, aortic and mitral valve regurgitation. Mrs MB also had multiple fractures involving both forearms, the pelvis and thoracic vertebrae (T2 and T12).

On commencing respite care Mrs MB was anxious, agitated, disruptive and aggressive, consistent with the behaviours and psychological symptoms of dementia (BPSD). For this, the general practitioner (GP) prescribed Oxazepam 7.5 to 15mg twice daily 'as required'. This medication was administered by staff once per day on most days and this appeared effective at reducing the acute behavioural symptoms with a 15mg dosage. Three weeks later, the same GP reviewed Mrs MB and prescribed Oxazepam 15mg three times a day (6am, 2pm and 8pm) to be administered strictly.

> This death was reported as it was 'unexpected and not from natural causes'.

Soon after, Mrs MB had three unwitnessed falls over three days and a second GP was notified on each occasion. This GP ceased the 2pm dose of Oxazepam. A metabolic and septic screen (blood and urine tests) was completed to exclude an underlying organic cause. This was mostly unremarkable except for a mildly raised C-reactive protein (CRP) level. This GP prescribed Escitalopram 5mg daily to treat a possible underlying depression and anxiety.

Several days later, Mrs MB entered permanent care in the 'dementia specific wing' of Facility #2 where she was reviewed by a new GP.

This time the GP recommenced three times a day dosing of Oxazepam with changed times (8am, 12pm and 5pm) and later included doses for 'as required' use. Mrs MB had seven falls with multiple head strikes over the next few days.

Approximately one month later Mrs MB had another fall with a head strike lacerating her left eyebrow and necessitating admission to an acute care hospital emergency department (ED). Mrs MB continued to be agitated and had a right forearm haematoma. The ED staff assessed her as being of low risk for significant head or neck injuries hence no computed tomography (CT) brain or spine scans were conducted.

Mrs MB was discharged to Facility #2 where she was very agitated. It was assessed that she required one-to-one staff supervision. Of note, the RACS staff did not receive information about what investigations had occurred at the hospital.

> 'Oxazepam is not a commonly used long term medication for management of advanced symptoms of dementia'.

Approximately two and a half weeks later, Mrs MB was assessed by a locum GP early in the morning which led to her being transfered back to hospital for investigation and management of her delirium.

The Aged Care Psychiatric Assessment Unit attributed her delirium to medication changes, altered environment, falls and fractures. Mrs MB had multiple rib fractures likely subacute in nature, and a compression fracture of T11 vertebra visible on the chest X-ray.

A few days later, Mrs MB was moved to the general medical ward for ongoing management of BPSD, poor oral intake, dehydration and weight loss. Mrs MB was referred to the palliative care team following a family meeting. She died shortly afterwards.

## Pathology

An autopsy completed by a forensic pathologist revealed bilateral bronchopneumonia on a background of pulmonary emphysema and fractures of the right ribs with evidence of healing. The cause of death was pneumonia caused by rib and pelvic fractures sustained in the setting of multiple falls and comorbidities.

## Investigation

This death was reported as it was 'unexpected and not from natural causes'. The family also wrote twice to the court to express their concerns about the care provided at both facilities.

The coroner obtained statements from all the general practitioners involved as well as the facility managers of both facilities.

The coroner also referred this case to the court's Health and Medical Investigation Team (HMIT) to address a number of concerns including:

- What sedative medication was Mrs MB receiving and was it appropriate?
- Why did Mrs MB have so many falls and were the prevention initiatives sufficient?
- Was Mrs MB managed appropriately at both RACS?
- Did the Oxazepam hasten Mrs MB's physical decline and death (i.e. did it cause the falls)?

The HMIT responded with the following information: that 'Oxazepam is not a commonly used long term medication for management of advanced symptoms of dementia' and the total daily dose prescribed and administered had been increased significantly from 15mg to 45mg. That the cause of Mrs MB having so many falls was unclear and that the prevention initiatives were appropriate.

> The coroner found that Mrs MB's Oxazepam regimen contributed to her physical decline and death.

That Facility #1's failure to develop a long term care plan for Mrs MB because she was a respite resident was not satisfactory. That there should have been an escalation to a specialist team to support management sooner. The HMIT also noted that there was 'sufficient correlation' between the multiple falls and the administration of Oxazepam to conclude this contributed to her physical decline and death.

The statement from Facility #2 outlined multiple changes to practice which arose following their internal review of Mrs MB's death.

> The nursing home staff also did not promptly notify doctors or family of Mrs MB's family of the falls.

These included:

- Improved clinical leadership with a Clinical Nurse Manager overseeing all resident care and providing support to the nurses on duty;
- Closer liaison with family of newly admitted residents; better documentation and communication;
- And that GPs document their assessment and orders directly rather than rely on nursing staff to perform this task;
- And holding weekly multidisciplinary meetings for falls prevention and management.

**Coroner's Findings**

The coroner found that Mrs MB's Oxazepam regimen contributed to her physical decline and death. He also noted there was a lack of follow-up from the GP who initially prescribed Oxazepam and then significantly increased the dose.

The nursing home staff also did not promptly notify doctors or Mrs MB's family of the falls. There was also a lack of details in the handover between the two RACS about Mrs MB's recent falls.

Recommendations included: an updated and more robust falls management policy in the RACS with more frequent neurological observations and internal education for staff on medication administration; and a review of documentation to ensure information about residents when transferred is readily accessible.

The coroner also directed recommendations to the Australian Aged Care Quality Agency (AACQA), the Australian Health Practitioner Regulation Agency (APHRA), and the Royal Australian College of General Practitioners (RACGP). These are discussed in detail elsewhere in this edition.

**Keywords**

Falls, fractures, agitation, RACS, sedative medications, dementia

## Commentary #1: The coroners recommendations and requirement of organisations to respond

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This case demonstrates how the coroner can make recommendations to any Minister, public statutory authority or entity of any matter connected with a death which the coroner has investigated, including recommendations relating to public health and safety ((*Coroners Act 2008* (Vic)).

The coroner is in a unique and powerful position to identify areas of concern following death in an aged care facility with a broad scope of recommendations ranging from an examination of the conduct of individuals, to the wider education of health care workers including general practitioners, and to refer these to the most relevant agency to implement.

> Engagement of peak bodies and regulatory agencies ensures that the learnings from individual deaths are communicated as a prevention opportunity to the broadest possible audience and to allow for reflection on appropriate standards of care.

In this case, the coroner has provided specific recommendations to the aged care facility management, the Australian Aged Care Quality Agency (AACQA) now the National Aged Care Quality and Safety Commission, the Australian Health Practitioner Regulation Agency (APHRA) and the Royal Australian College of General Practitioners (RACGP).

Engagement of peak bodies and regulatory agencies ensures that the learnings from individual deaths are communicated as a prevention opportunity to the broadest possible audience and to allow for reflection on appropriate standards of care.

In addition to making recommendations, the Coroners Act mandates that a written response is provided in response to the coroners' recommendations, specifying an action that has, is, or will be taken in relation to the recommendation made.

> The death of Mrs MB highlighted the challenges of providing quality care to residents with agitated behaviour in aged care facilities, and some of the gaps that were subsequently identified.

In this case, the public can be reassured that AHPRA has initiated an investigation into the practices of individual health practitioners, and that the RACGP will provide updated resource material to assist general practitioners in managing complex behavioural problems in aged care facilities. In response to the coroners' recommendations, the AACQA provided a targeted audit of the information systems and use of 'as required' medication at the involved aged care facility, and was able to report that the aged care facility had initiated improvements and was now meeting expected outcomes.

The death of Mrs MB highlighted the challenges of providing quality care to residents with agitated behaviour in aged care facilities, and some of the gaps that were subsequently identified. The need for skilled staff supported by appropriate governance and regulation was promoted by the coroner directing the recommendations to management, regulatory bodies and peak bodies, recognizing the importance of systems based approach to public health and safety.

# Summary of organisational responses to the coroner's findings and recommendations

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The coroner directed that the findings into Mrs MB's death and the recommendations be provided to both RACS facilities, the Australian Aged Care Quality Agency (AACQA), Australian Health Practitioner Regulation Agency (AHPRA) and Royal Australian College of General Practitioners (RACGP). The following information is a summary of their responses which were posted online by the Coroners Court of Victoria.

The key aspects of each response from the five organisations are described below. By reading through these responses we see how the roles and scope of each organisation influences what is possible and their view on the coroner's recommendation. For example, the response from AHPRA considers the role of the health practitioners only. Also, the level of information provided is limited due to the rules governing privacy and confidentiality for their operations.

> An education program has been organised to be conducted early in the year. This program will cover neurological observation and when to contact medical staff.

The coroner recommended Facility #1 review their policy for (management of a resident after a fall) and their internal communications about transfers of residents. Facility #1 responded by describing the existence of a policy covering both witnessed and unwitnessed falls and indicated that this policy had been updated. Management of falls within the facility are discussed at registered nurse (RN) meetings and is now a regular agenda item.

An education program has been organised to be conducted early in the year. This program will cover neurological observation and when to contact medical staff. The facility is looking at having a handout to distribute to staff that are unable to attend this session and to give to new staff as part of their orientation.

They have also changed systems and processes to ensure a more thorough handover procedure occurs. The clinical co-ordinators send a fax to the GP and a copy is given to a family member.

The coroner recommended Facility #2 review its admission policy for residents received from another health or aged care service and provide education for staff regarding medication use.

> The coroner asked that AHPRA review this case with respect to the governance of medication, the inappropriate administration of medication and the absence of follow-up.

Facility #2 responded by showing they had included two new points in their New Resident Admission and Discharge Policy and Procedure for Permanent and Respite Care. Specifically, they now collect information relating to specific care and services the day before admission and all residents admitted to the facility from another aged care facility or health care service are required to provide a current written care plan or health summary. They also stated that all Personal Care Attendants and Direct Care Workers responsible for the administration of medications must complete a medication competency assessment. Also, an in-service has been provided to cover specific requirements associated with high risk medications and consideration related to aged care clients.

The coroner asked that the Australian Aged Care Quality Agency (AACQA) review the clinical governance of medication administration and adequacy of communication between the facilities. AACQA responded by writing that the facility was able to demonstrate that since 2014 they have revised their medication policies, procedures, documentation and training for staff. They were also satisfied that they have made adequate changes to their admission and discharge process.

> The coroner recommended the Royal Australian College of General Practitioners (RACGP) use this case as an example for education and training of their membership.

The coroner asked that AHPRA review this case with respect to the governance of medication, the inappropriate administration of medication and the absence of follow-up. AHPRA responded that they were investigating staff involved in this case but declined to give further information to protect the staff being investigated.

The coroner recommended that the Royal Australian College of General Practitioners (RACGP) use this case as an example for education and training of their membership. The RACGP wrote that an update of their 'Silver Book', more formally titled "Medical care of older persons in residential aged care facilities", was being updated and that they will consider using this case as a learning tool for GPs in the new edition.

# Management of BPSD: A refresher

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Behavioural and psychological symptoms of dementia (BPSD) are distressing and often considered the inevitable complications of advanced dementia. BPSD can result in suffering, premature institutionalisation and a reduction in quality of life for people with dementia and their caregivers.

Whilst common (affecting nearly every person with dementia at some point throughout the course of their illness), behavioural symptoms should not simply be accepted as a natural consequence of progressive dementia. Rather, behavioural symptoms are often an expression of unmet needs or emotion.

> The ABC framework is a simple yet effective model for assessing BPSD.

These symptoms are often managed pharmacologically; a form of treatment that can cause significant harm. Misuse and overuse of antipsychotics and sedatives in the elderly has provoked justifiable interest and concern in the community recently, and should prompt nurses and medical practitioners to review their practise. Detailed and extensive evaluation of the resident or patient and surrounding circumstances should occur in all situations prior to embarking upon a pharmacological management approach.

Assessment of the agitated or distressed older person is not straightforward. Unlike other populations, older people with cognitive impairment present unique challenges, including communication difficulties and atypical presentations. They may have multiple co-morbidities and are vulnerable to the effects of polypharmacy. Assessment needs to take into account the circumstances surrounding the presenting symptoms, rather than just the symptom itself. It is time consuming and may need to occur over multiple occasions.

Where possible, including family members or loved ones in the assessment process is important. They provide crucial and unique insights into who the resident is and their life story. They can help with overcoming communication barriers and provide an understanding of the resident/patient's usual level of function. Failure of health professionals to understand what is 'normal' or 'usual' for an individual can lead to assumptions and errors in diagnosis.

For example, dementia can be misdiagnosed in the acutely unwell older person suffering a delirium.

> There are a number of physiological precipitants for behavioural disturbances in dementia, which must all be considered and excluded in any assessment.

A multi-disciplinary approach to assessment is often useful, particularly where behavioural symptoms are complex or severe. This may involve engagement of geriatricians, psychogeriatricians or external agencies such as the nation-wide Dementia Behaviour Management Advisory Service (DBMAS). Effective clinical communication between general practitioners and all involved health professionals is essential.

The ABC framework is a simple yet effective model for assessing BPSD. "A" is the Antecedent event immediately prior to the behaviour. It may help identify triggers or precipitants. "B" is the Behaviour and should include a detailed description of the witnessed behaviour (not merely agitation or wandering). "C" is the Consequence of that behaviour and includes interventions and their outcomes. Applying this framework has many benefits. It allows us to identify and target specific behaviours of concern. It may identify triggers, patterns or solutions to problematic behaviours. It also separates the behaviour from the individual, allowing caregivers to recognise that the behaviour is not a deliberate act.

There are a number of physiological precipitants for behavioural disturbances in dementia, which must all be considered and excluded in any assessment. These include delirium secondary to acute medical illnesses or medications. Pain, dehydration, constipation and major mood disorders may also present with behavioural changes.

Pain, in particular, can be difficult to assess in persons with dementia. It may manifest in facial expressions, verbalisations, loss of appetite, crying, irritability and gait or mobility changes. Physical examination may be limited and a high clinical suspicion for potential injuries should be maintained (particularly in those who have a history of recurrent falls).

Using the 'ABC' model to clearly identify the target symptoms can help direct management. For example, simple wandering is unlikely to respond to medications and their use may result in excess sedation and an increased risk of falls. Non-pharmacological approaches (such as physical therapy, music therapy and therapeutic touch) are effective interventions that should be the first line of management of an older person with BPSD.

> Due to the potential for harm with anti-psychotics, a deprescribing plan (where the medications are tapered and withdrawn) should be considered after three months of treatment.

If a pharmacological approach is deemed appropriate then starting at low doses and slow titration, monitoring for side effects (such as sedation and increased confusion) is best practice. After initiating treatment, the effectiveness of the intervention must always be reviewed. Because BPSD change over the course of the disease, it is important to re-evaluate the use of medications at frequent intervals. Due to the potential for harm with anti-psychotics, a deprescribing plan (where the medications are tapered and withdrawn) should be considered after three months of treatment.

## Resources

These editions of the RAC Communiqué have relevant information on aspects of the case described.

RACC Feb-18 Vol 13 (1)

RACC Feb-16 Vol 11 (1)

RACC Jun-14 Vol 9 (2)

RACC Feb-08 Vol 3 (1)

Jokanovic N, Ferrah N, Lovell J, Weller C, Bugeja L, Bell S, Ibrahim JE: A review of coronial investigations into medication-related deaths in Australian residential aged care. Research in Social and Administrative Pharmacy 06/2018;, DOI:10.1016/j.sapharm.2018.06.007.

Ferrah N, Lovell J, Ibrahim JE: Systematic Review of the Prevalence of Medication Errors Resulting in Hospitalization and Death of Nursing Home Residents. Journal of the American Geriatrics Society 11/2016; DOI:10.1111/jgs.14683.

Institute of Medicine. Preventing medication errors. Washington, DC: National Academy Press; 2007. Available at: **https://www.nap.edu/read/11623/chapter/1#xi.**

Dementia Training Australia has some excellent resources. In particular an evidence-based resource suite is designed to assist health professionals or support staff involved in the introduction, management and withdrawal of antipsychotic medication use for responsive behaviour. Available at: **https://www.dta.com.au/resources/optimising-medication-management-for-responsive-behaviour/.**

Dementia Support Australia, which provides the Dementia Behaviour Management Service (DBMAS) and Severe Behaviour Response Teams (SBRT) nationwide. More information available at **https://www.dementia.com.au/.**

Burns K et al Behaviour Management. A guide to good practice. Dementia Collaborative Research Centre. University of NSW 2012. Available at: **https://www.dementia.com.au/getattachment/947c82e7-841f-49cd-bdb8-43486b446b01/Behaviour-Management-A-Guide-to-Good-Practice-5.aspx.**

Royal Australian College for General Practitioners. Medical care of older persons in residential aged care facilities. Available at: **https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book.**

## In the news recently

Our team was recently in the media with a national TV interview on resident-resident aggression (ABC 7.30 Report, 11th February 2019). Available at: **https://www.abc.net.au/7.30/aged-care-royal-commission-public-hearings-begin/10801400.**

The accompanying article was on ABC Online (11 February 2019). Available at **https://www.abc.net.au/news/.**

There is a podcast of an interview about the Royal Commission on radio (February 2019) at: **http://thewire.org.au/story/royal-commission-into-aged-care-begins/.**

## 'Dignity of Risk' Film Screenings and Education

Our team was overwhelmed by the interest in screening the film 'Dignity of Risk' and the education workshop/ short course we recently held. We are delighted with the support from the sector and are slowly getting around to contacting everyone who expressed an interest. We ask for your patience and hopefully we will be able to meet the expectations of most, if not all our readers.

We were excited by the news that our film 'Dignity of Risk' was one of only ten films selected from all the entrants screened at the Seattle Festival to be toured as the 'Best of the Fest. It screens at the Spokane Social Justice Film Festival - with the Canadian feature, 'The Guardians', on March 3 at 3:30PM, at the Magic Lantern Theatre. See: **http://www.socialjusticefilmfestival.org/?tribe_events=best-of-the-fest-the-guardians**.

### PUBLICATION TEAM

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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@vifmcommuniques.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 organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health and Human Services, Victorian Institute of Forensic Medicine or Monash University.

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