Royal Commission into Aged Care Quality and Safety

SYDNEY HEARING

SCENARIO 2

1. The resident is a person living with dementia who is currently 84 years old with three adult daughters, one of whom holds her power of attorney. The resident has been in residential care for just over six years with a history of wandering. She has an LHH grading under ACFI.
2. The resident requires TED stockings, has an upper partial denture and her own teeth but requires supervision with oral hygiene. This involves the removal every night of her dentures and consequent oral care. From admission till around June 2015 she had no tooth decay or broken teeth roots. Assume that because of the progression with her dementia she is occasionally resistant to removing her dentures.
3. A dental care plan made on 28 June 2016 and prepared by her dentist noted that she had a high decay risk owing to a dry mouth and that staff, "*assistance was required to remove upper partial denture every night.*" Subsequently, when seen by the same dentist on 1 November 2016, he made a note of her teeth in these terms:

> "Note: Patients denture must be removed at night, teeth cleaned and denture (upper) should NOT be returned to mouth. On presentation today I believe patients dentures has been left in the mouth for weeks if not more. The result is significant decay in 4 months. Needless to say family is very unhappy. All the protocols were given for staff guidance and this has not been followed again."

4. In a further assessment carried out by the RACF staff on 28 November 2016, it was stated that "*the Resident has 1 to 3 decayed or broken teeth/roots, or teeth are very worn down.*" As a result the residential manager of the facility sent a letter of apology to the daughter which admitted, "*several breakdowns in our protocol for ensuring that directives received from external health professionals (are) carried out.*"
5. The resident has been a regular wanderer through the facility and can do so at any time of the day. Typically, when the resident is spoken to she will be confused and

might indicate that she is looking for someone to help her pack her own things so that she can go home. Often this occurs at the entrance reception to the facility. On other occasions she has been found in a teary state upset by negative thoughts from her childhood and the loss of her son who dies in infancy.

6. In January 2018 the resident left the ward and was found face down on a road within the nursing home, she was taken to hospital and discharged that day suffering from a moderate haematoma and abrasion over the L frontal bone. In June she was observed to be wandering near the front door of the facility. A nurse observed that the LMO was to consider PRN medications.

7. On 24 June 2018 the resident left the facility and could not be found for some three hours. Eventually she was found confused between two fences within the facility grounds. Following this incident, her GP made a patient record that queried whether the resident should be transferred to a secure unit for her own safety. Later that day she was observed to wander, again stating that she wanted to go home.

8. On 4 July 2018, the resident is observed to be extremely emotional and crying by the facility pastor, who passes on her concern to the care manager for the emotional wellbeing of the resident. Assume that this behaviour has escalated over the last few weeks and has reached the point where the pastoral carer is concerned for her well-being. When the GP sees her later that day, she makes the following patient note:

> Has been transferred to DSU for own safety. Pastoral Care worker has discussed with Care Manager that [resident] is emotional upset .Also upset about losing her baby son. Would suggest we commence Avanza 45mg nocte to assist with depression and anxiety. Medication Chart reviewed. (sic)

9. No test for depression is carried out and there has been no previous diagnosis of depression, only anxiety. Her ACFI assessment in November of the preceding year made no reference to depression and indicates that no Cornell Scale or other assessment for depression was undertaken.

10. Assume that both doctor and nurse try and contact one of the resident's daughters to inform them of the administration of the medication and of their view that the resident

should be moved to a secure unit, but cannot get through to her. Assume that they did not discuss, as between them, the need for consent for the treatment. Assume that the doctor's position is that she believed that the dose was necessary at the time to alleviate the anxiety that the resident is suffering.

11. On 6, 7, and 8 July 2018 the resident is given the prescribed dose of Axit, 45mg. The evidence of the care manager was that no enquiry was made of the GP to ascertain whether consent of the daughters had been given. The clinical notes make no observation of the resident from 4 to 11 July 2018 concerning her mental state or response to the medication.

12. On 9 July the daughter returns a second call from a member of staff at the facility to discuss the medication and the move to a secure unit. She explains that her mother is upset, reliving childhood trauma associated with abuse she suffered and the death of her son and suggested the resident goes on the medication Axit. The nature of the medication and its side effects were not discussed with the daughter. However she was told that the doctor thought it would help her mother. The daughter says that she provided consent for the medication to be used on 9 July 2018. Further doses are given on the evenings of 9 and 10 July.

13. On 11 July 2018, the resident's 84th birthday, she is visited by her daughter and grandchildren but could not be woken. A nurse makes this note:

> Staff reported that [resident] was very drowsy after breakfast but responding to verbal command and instructions. Had breakfast in dining room in the morning. Refused her Lunch. Not opening her eyes on verbal command. RN went to check. [resident] not responding to verbal command but responding to pain. Obs attended. BP 164/70, P 78/m, T 36.2, R 18, BSL 6.2, unable to check pupil as [resident] not opening her eyes. [GP] notified about the same. Updated Sam about the same. Daughter wants [resident] to be T/F to San Hospital if [GP] thinks its needed.
> Awaiting for [GP].
> at 1400 staff reported that [resident] was awake and she had few bites of muffin and sips of water and then got back to bed. [Resident] r/v by [GP]. [GP] has spoken to 2nd Nok and explained that [resident] doesn't need to go to hospital at this stage. [GP] will review her medication.

14. The GP is called and makes this note:

> Has had a period of being unresponsive.
> Now is responsive and talking.

> OE: Pupils reacting and equal
> Toes down going.
> ?? TIA
> Have discussed with the daughter and explained that we will keep her in the facility.
> Would suggest we reduce avanza dose as she apparently has been increasingly drowsy over the week.

15. Shortly after a decision is made to reduce the dose to 30mg per day. It is not clear whether she was given 45 or 30 mg that evening however on 12 July 2018, she was given 30mg at 8.24pm. The resident remained on that dose until early May 2019, at which time a decision was made to change the medication to 30mg every second day.

16. On 18 July 2018, the resident made a further unsuccessful attempt to escape following which the GP noted that the resident had been more alert that since the reduction in Avanza.

17. On 19 July the following observation is made by a care supervisor:

> [Resident] getting agitated towards evening she was crying and wanting to go home , she need a lot of reassurance from staff and lots of TLC. [Resident] had good meal at dinner time also enjoyed supper with others, retired to bed at 20:30Hrs.

18. Thereafter there a multiple occasions when the resident is observed to be agitated and/or found to be wandering the corridors of the facility and try to leave. On one occasion in November she took off her clothes and put on the clothes of another resident in that resident's room. She was taken to her room and settled but was later found to be wandering again. On 4 further occasions between November 2018 and March 2019 she sought to escape.

19. In early January 2019 the resident is observed to be holding food in her mouth, not swallowing it and then spitting it out. A decision is made to move the resident to a soft "cut up" food diet with thin fluid following an examination by a speech pathologist who observes that because of the residents dementia she fed herself at a fast rate and did not always completely chew up the food (a banana) adequately before attempting to swallow and did not clear food from her moth before having another mouthful.

20. The resident's daughters take issue with the decision seeking to ascertain whether tooth decay may be the cause of the behaviour. A dentist observed on 14 January that there was mild to moderate inflammation of the upper palate under the denture that may have been contribution to the spitting out of the food and that such inflammation can make the soft tissue quite sensitive. The dentist stressed previous advice regarding the importance of removing the denture at night.

21. In a subsequent examination by the speech pathologist on 23 April 2019, she observed that the resident in attempting to eat a full meal, including chicken, making no attempt to cut the food up into smaller pieces, and concluded that:

    a. Her cognitive impairment reduced her ability to inhibit her rate of feeding;
    b. She had limited awareness of food building up in her mouth and did not respond to prompts to the effect that she had too much food in the mouth;
    c. She made limited attempts to swallow the food left over after each time she swallowed; and
    d. She did not chew her food up adequately before she attempted to swallow.

22. The speech pathologist was concerned for the safety of the resident when eating and assisted her for the remainder of the meal explaining the need for staff assistance. An email from the speech pathologist notes that there was a "*significant choking risk due to the dementia*" that the soft cut up diet continue and staff to, "*continue to provide assistance/supervision to prevent overfilling mouth*" and "mouth care to continue, including after meals to clear food residues." The plan was subsequently explained to one of the daughters.