



A Victorian
Government
initiative



RESIDENTIAL AGED CARE CORONIAL COMMUNIQUE

VOLUME 3. ISSUE 2.

April 2008

ISSN 1834-318X

CONTENTS

Editorial	1
Issue #1: Read the Instructions	2
Issue #2: Reporting Falls	3
Issue #3: Recently Closed Cases	3
Request for Feedback	3
Issue #4: Where is that urine result?	4

FREE SUBSCRIPTION

The Clinical Liaison Service will publish the RESIDENTIAL AGED CARE CORONIAL COMMUNIQUE on a quarterly basis. Subscription is free of charge and will be sent electronically to your preferred email address. If you would like to subscribe to RESIDENTIAL AGED CARE CORONIAL COMMUNIQUE, please email us at: racc@vifm.org

Next Edition: June 2008

EDITORIAL

This fifth issue is designed to remind and refresh our memories about the lessons learnt from the preceding four issues. You may recall the Minister for Ageing (Victoria) launched the Residential Aged Care Communiqué in October 2006 with the theme of preventing deaths from the use of physical restraint. The subsequent issues have focussed on prevention of deaths from falls, choking & gaps in the interfaces of care. We have been fortunate to have the continuing support of the Aged Care Branch of the Department of Human Services to publish this newsletter.

Reflecting on the cause and circumstances of deaths from each of our previous issues highlights how much improvement has occurred in the standards of care and in the work towards preventing harm. Those of us in practice 20 years ago would remember that deaths from falls, physical restraint or choking were considered by most if not all practitioners as inevitable, unfortunate aspects of aged care and prevention was not a serious option. Also our understanding of the gaps in the interfaces of care and how this leads to harm was virtually non-existent.

Clearly, these areas traditionally thought of as being unchangeable or beyond our control are not so. The cases presented in this and the past four issues cover a huge spectrum of clinical presentations. However, the common themes are often a failure to assess, implement or recognize acute changes as well as inadequate communication between RACF, families, GPs and hospitals. We would all benefit from reviewing our practice regularly and revisiting high risk clinical areas as it is usually when we are confident that we have things under control and become complacent that disaster strikes!

If you are a recent subscriber there are many resources available to assist with improving practice and preventing harm from physical restraint, falls, choking and the gaps in the interfaces of care. These resources are referenced in past issues which are available on our web-site: <http://www.vifm.org/n963.html>

PUBLICATION TEAM

Editor in Chief: Joseph E Ibrahim
Consultant Editor: Rhonda Nay
Managing Editor: Lisa Brodie
& Fiona Kitching
Designer: Caroline Rosenberg

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

ACKNOWLEDGEMENTS

This initiative has been made possible by the collaboration of a diverse range of organisations: The Department of Justice, the Victorian Institute of Forensic Medicine, the State Coroner's Office, Clinical Liaison Service and Department of Human Services – Aged Care Branch.

REPRODUCTION & COPYRIGHT

This document may be reproduced in its entirety for the purposes of research, teaching and education and may not be sold or used for profit in any way. You may create a web link to its electronic version. Permission must be obtained for any modification or intended alternative uses of this document.

If referring to this publication, the following citation should be used:
Residential Aged Care Coronial Communiqué [electronic resource]: Clinical Liaison Service – Connecting Clinicians with Coroners. Southbank, Vic. State Coroners Office; Victorian Institute of Forensic Medicine. Available at: <http://www.vifm.org/communique.html>

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

ISSUE #1 PHYSICAL RESTRAINT

READ THE INSTRUCTIONS

CASE NUMBER 3226/96

Precis Authors: JE Ibrahim
Consultant Physician, (CLS)

CLINICAL SUMMARY

A 33 year old male was discovered unconscious on the floor at a friend's home. It appeared that he had overdosed on drugs. An ambulance transferred the man to hospital where he was stabilised in the Intensive Care Unit, then transferred to a general ward.

On the ward he became agitated and difficult to manage. Staff initially tried physical restraints with shackles, then a 'Posey Poncho' vest type restraint (Model Number 3611). Staff were particularly concerned about the risk of falling due to his confusion. Over the next few days, two incidents were reported relating to the use of restraints. However, the 'Posey' restraint remained in place.

On the fifth night of using the restraint, eleven days after admission to hospital, the patient was found by nursing staff hanging over the cot sides of the bed strangled in the Posey Restraint.

PATHOLOGY

Cause of death following an autopsy at VIFM was determined as 1(a) Postural Asphyxia; 1(b) Restraint Device; 1(c) Delirium Post Drug Overdose.

INVESTIGATION

An extensive investigation was required to ascertain the cause and circumstances of this death. The Coroner sought witness statements from hospital staff and the manufacturer of the restraint device, J.T.Posey & Company who travelled to Australia to give evidence at the Inquest. The Coroner's findings included that the manufacturer of the restraint device had extensive in-service training videos and product information sheets warning of the risks associated with the use of the various models. The manufacturer's instructions clearly highlighted and described the risk of harm and possibility of death occurring in patients who are restrained. The poster and instruction videos were provided to the hospital.

Specifically, the Posey 'Poncho' type restraint was contra-indicated for a patient who was agitated. The incidents with restraints prior to the deceased's

death were timely warnings about the serious risk of injury and were not adequately heeded. The hospital did not have a documented management plan, or instructions to nursing staff as to what procedures to follow with the patient.

The doctor and nurse in charge of the deceased's management were not fully aware of the risks of restraint, had not read the hospital's restraint manual and did not view any of the safety information that was supplied with the product.

There was inadequate training for staff using restraints and the hospital's program of using experienced staff to teach others by demonstration was flawed; the product information was not supplied; and the system of observation and documentation was poor; and the documentation of observations was inadequate. There was a lack of understanding of the risks associated with the use of physical restraining devices, and some staff were not aware of the hospital's own procedures.

CORONER'S RECOMMENDATIONS

The Coroner made two detailed recommendations of which we have highlighted some key aspects. The first recommendation included that the Department of Human Services (Victoria) consider working with relevant groups including residential aged care facilities to ensure: (a) restraint equipment is audited and reviewed; (b) current and relevant manufacturer's information is provided with equipment; (c) there be a standardised protocol and training for the use of any restraint, (e) that all incidents be immediately reported to those in charge of the clinical management of a patient, (f) that all medical and nursing staff should have a sound working knowledge of the legislative requirements, risks, organisational protocols/guidelines and manufacturer's instructions when using restraining devices with patients.

The second recommendation was to the Therapeutic Goods Administration to consider researching the issue of injuries and deaths associated with the use of restraining devices.

KEY WORDS

Clinical [19-45 yo; medicine; HCO-ward; metropolitan; management; communication, training, policy & procedure].

Investigation [autopsy; statements; inquest; recommendations].

ISSUE #2 FALLS

REPORTING FALL-RELATED DEATHS AND THE REGISTRY OF BIRTHS, DEATHS AND MARRIAGES

CASE NUMBER 3575/04

Precis Authors: Lisa Brodie
Research Officer, Specialist
Investigations Unit (SIU)

Each year the State Coroner's Office receives a significant number of referrals from the Registry of Births, Deaths and

Marriages (BDM) concerning the death of an elderly person involving a fall. This indicates there may be a lack of understanding about what constitutes a 'reportable death'.

An example of a death referred by the BDM involved a 94 year old female high level care resident at an aged care facility with dementia who sustained a fractured neck of femur after experiencing a fall. She was admitted to hospital to undergo surgery, however her condition rapidly deteriorated and she passed away two days later.

The injury sustained in the fall evidently contributed to the patient's death, therefore the death should have been directly reported to the State Coroner's

Office by the hospital. Instead the hospital medical staff incorrectly completed the death certificate forms. The Registry of BDM however, would not issue a death certificate in this case as the cause of death given by the treating medical practitioner referred to an injury.

It is important to remember that not all incidents of falls need to be reported. However, if a fall has contributed to the cause of death, the death must be notified to the State Coroner's Office. In any event, the Registry of BDM reviews all death certificates issued and will refer cases to the Coroners Office and the Victorian Institute of Forensic Medicine for clarification if required.

ISSUE #3 CHOKING

Closed case [3325/05]

A 69 year old male with a past history of sleep apnoea, end stage renal failure secondary to diabetes mellitus & hypertension was eating dinner with his wife, when he began to choke on a piece of steak and was offered some water to assist with swallowing. However, before the glass of water got to him he stopped breathing and fell to the floor. He died two days later in hospital following a cardiac arrest. The cause of death was hypoxic brain injury secondary to a respiratory arrest and aspiration of food bolus.

Closed case [221/03]

A 66 year old male with severe Alzheimer's dementia requiring constant supervision at home and daytime respite 4 days a week, was found dead in the bathroom. An autopsy examination found a firmly impacted artificial grape in his airway causing acute obstruction.

Closed case [2227/96]

A 77 year old male who required a high level of care at a residential aged care facility because of dementia and heart failure had just returned from a day out with his family. Dinner had been placed in his room and staff moved on to attend other residents. A little while later staff noticed him having trouble breathing. Resuscitation commenced, an ambulance was called and on attendance the ambulance officers removed an intact meatball from the airway. Examination of the meatball showed that it had no teeth or bite marks to indicate it had been chewed.

FORTHCOMING SURVEY AND REQUEST FOR FEEDBACK FROM SUBSCRIBERS

Your feedback is important to us and in order to improve future publications we are asking our subscribers for their opinion of the Residential Aged Care Coronial Communiqué. We will shortly be emailing our subscribers a short on-line survey to gather your views.

We are also interested in hearing in more detail about how the Residential Aged Care Coronial Communiqué may have assisted to change practice in your facility. We have provided a template to assist you to write in to us and are looking for contributions of less than half a page.

Please access the feedback form at:
<http://www.vifm.org/n963.html>

We are looking forward to hearing from you.

ISSUE #4 INTERFACE

WHERE IS THAT URINE TEST RESULT? ENSURING THE TIMELY FOLLOW UP OF TEST RESULTS

CASE NUMBER 101/05

Precis Author: Marrienne Beaty
RN, MQIHC, Grad Dip Comm Nurs

CLINICAL SUMMARY

Mr V was a 72 year old bed-bound male resident with end stage Parkinson's disease requiring high level care at an aged care facility [RACF]. Other significant medical history included severe oesophagitis/oesophagitis and large bowel pseudo-obstruction causing recurrent abdominal pain.

Mrs V visited regularly and was a very attentive wife. One Thursday Mrs V notified staff at the RACF that she felt her husband had a urinary tract infection. A full ward test was positive for the presence of blood, however no other tests or treatments were initiated. The next day, Mrs V insisted that a sample of urine be sent for testing. Mr V remained stable over the weekend but started to deteriorate on Monday. On Tuesday the RACF Division 1 Nurse called in the locum doctor who decided Mr V was extremely unwell. Mr V was transferred to an acute care hospital where he was admitted and treated with intravenous antibiotics. He died the next day.

PATHOLOGY

An autopsy was not conducted and the cause of death as determined by the medical staff at the acute care hospital was 1(a) Overwhelming urinary sepsis.

INVESTIGATION

The Coroner opened an investigation into the death after the receipt of a complaint from Mrs V who expressed concern about the treatment provided by the medical practitioner and the RACF staff. An investigation initially commenced by obtaining statements. However, the complexity of the case required an open hearing in court (i.e., Inquest) of two days duration. A key issue was to determine when the mid-stream urine test results that confirmed the presence of a urinary tract infection were received.

The evidence at inquest revealed that results of the urine test were couriered to the RACF on the Monday morning and left at reception. The receptionist working that day was occupying the position as a temporary replacement whilst the regular receptionist was on leave. The RACF had not contacted the general practitioner despite existing RACF policies for notifying medical practitioners of abnormal test results. Also, it seemed that Mr V's general practitioner had either not accessed or acted on the copy of the test result that the pathology service sent to his practice.

At the inquest the RACF presented evidence to the Coroner about changes to their practice that resulted from this case. Specifically, all laboratory results are to be faxed to the responsible unit within the facility rather than couriered to the main reception desk. This ensures that the fax is delivered to the right person in the right place, at the right time. A copy is also emailed to the general practitioner.

CORONER'S COMMENTS

The Coroner found that both the facility and general practitioner had failed to appropriately manage Mr V's urinary tract infection. The failure was in either not accessing or not acting on the abnormal

urine test result in the 24 hours prior to transfer to hospital. Although better management with earlier antibiotic treatment may not have changed the ultimate outcome, Mr V should have received this therapy whilst at the RACF.

CORONER'S RECOMMENDATIONS

That both the facility and general practitioner need to review their communication protocols for co-ordinating the management of the residents under their care.

That both the facility and general practitioner work with the Division Of General Practice Aged Care Panels in developing quality improvement activities.

That the facility considers a review of and implement staff training for; (1) identifying and managing suspected urinary tract infections, (2) management of important patient information and files, and (3) enhancing communication with family members.

KEY WORDS

Clinical [aged care; medicine; residential aged care & general practice; metropolitan; management; communication, training & policy].

Investigation [no autopsy; family letter; statements; inquest; recommendations].

All cases that are discussed in the Residential Aged Care 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.