Victorian Institute of Forensic Medicine

Residential Aged Care Communiqué

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CONTENTS

EDITORIAL

Welcome to our first issue of 2017. We have kept this issue simple. Three cases are presented without any formal expert commentaries. This 'back to basics' format is intended to challenge you to be an expert. What do you think are the lessons? and, What would you have done differently in these situations?

One of the few downsides of using 'experts' is we tend to defer to their opinion and may at times 'switch our brains off' rather than challenge or debate the advice. Context and setting are very important whenever we want to change or improve care. Experts offer us general principles, the translation of these principles into practice requires the people who do the work, to determine how changes are made and sustained. We each know our service better than any one else. Our building and how it flows along with the available equipment. The people we work with, their strengths and limitations. The residents and their families as well as what is important to them, and the many other local factors that influence what changes are desired and possible.

How we translate knowledge or ideas to enable transfer from one place to another is an emerging area, sometimes referred to as 'implementation science'. This is usually used in reference to knowledge from formal research studies that have tested an intervention. The basic principles involve exposing ourselves to new ideas, deciding to apply the idea, putting it into practice and then troubleshooting to make it work and become part of our routine.

Future Leaders Communiqué

We are also delighted to announce that the introduction of the Future Leaders Communiqué has been a great success. Future Leaders Communiqué was launched in October 2016 and joined our two other educational resources to improve clinical care, resident and patient safety.

The Future Leaders Communiqué is designed for junior medical practitioners and any other recently graduated health professionals. Each issue is developed, written, reviewed and edited by a junior medical practitioner to ensure we have provided the relevant clinical context combined with accessible language and up-to-date expertise. Subscription is free, subscribe at www.vifmcommuniques.org.

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Next issue: May 2017

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Case #1 - It's nice outside

Case Number: 2010/0814
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Department of Forensic Medicine

Clinical Summary

Ms M was an 87-year-old female resident requiring low-level care at a metropolitan Residential Aged Care Service (RACS) for the past year. Past medical history included ischaemic heart disease, acute myocardial infarction and stent insertion in May 2009, anxiety, paroxysmal atrial fibrillation and dementia.

Ms M's health began to deteriorate in October 2009 when she complained of headaches and was noted to have a fluctuating blood pressure. A medical review by the General Practitioner (GP) resulted in modification of the prescribed medications.

A few months later, Ms M had a fall and was admitted to hospital for approximately two weeks where blood tests revealed hyponatraemia. On returning to RACS, the staff noticed deterioration in cognition, paranoia, restlessness and agitation. This was thought to be due to worsening dementia. Ms M also appeared to be unsteady on her feet.

Approximately one week later, the nurse who was starting the night shift received a running sheet and verbal handover that Ms M had not settled into the facility and tended to wander. After a restless night, Ms M was found in the courtyard of the RACS lying on the ground under a tree approximately 25 metres from her bedroom window.

Ms M was first sent to the local hospital and then referred to the trauma centre when a CT scan of her neck revealed a cervical fracture.

Ms M had a bruised eye, bruising to her right shoulder and grazes to her ankle, left shin, calf and both knees and toes. She was able to ambulate back into the facility with assistance. Ms M moved around the facility whilst the nurse and PCA completed their work till the morning when the GP was notified soon after 09:00 hours.

Ms M was first sent to the local hospital and then referred to the trauma centre when a CT scan of her neck revealed a cervical fracture. Despite ongoing treatment, Ms M's condition did not improve and two weeks later she became unresponsive. Active management was withdrawn and she died.

Pathology

The cause of death determined by the pathologist following an external examination of the body in conjunction with the medical deposition form: *Was multiple injuries with ischaemic heart disease with the antecedent cause being a recent fall.*

Investigation

The coroner directed that further investigation was required as there were numerous letters from the family complaining about the lack of care at the facility. The coroner conducted an inquest over two days and heard from the night nurse, the approved providers, the GP and the Director of Nursing.

Ms M had gained access to the garden by pushing the flyscreen out and climbing through the window.

The RACS staff explained that Ms M was reassessed on returning to the facility following the hospital admission and that when residents returned they were often more confused. As such, their usual practice was to give residents time to settle back in before conducting an assessment for any new care needs. This assessment was scheduled to occur within a few days, however the change in circumstances and readmission to hospital did not allow such an opportunity.

The Inquest revealed that Ms M had been found 'wandering' in the garden the day before the incident leading to hospitalization. Ms M had gained access to the garden by pushing the flyscreen out and climbing through the window. The nurse who discovered Ms M explained that on this occasion she did not complete an incident report because no injuries were sustained.

Case #1 (Continued)

On the night Ms M was found in the garden on the ground, there had been an incident at 02:00 hours when she was found wandering the corridors of the facility in a confused state. At first Ms M was left to wander whilst being observed at a safe distance. Eventually at 04:15 hours Ms M agreed to return to her room. Shortly after Ms M returned to her room the nurse heard a knocking sound. She could not see anything on the CCTV.

The nurse walked around the facility but could not locate the source of the sound so returned to the nurses' station. The nurse read the previous entries in Ms M's medical file and through this became aware of the incident the day before. With this new information, the nurse went to Ms M's room to check on her at 04:30 hours, to discover Ms M was not in her room.

The bedroom window was opened and the flyscreen pushed out and so the search extended to the garden where Ms M was found.

This examination revealed that each bedroom in the facility had an external sliding window that opened to an internal courtyard.

In response to the question of why Ms M was not immediately transferred to hospital, the nurse explained that at that time Ms M would have had to go unaccompanied, and this was not desirable due to Ms M's confused state.

The coroner also considered the security at the facility. This examination revealed that each bedroom in the facility had an external sliding window that opened to an internal courtyard. The bedroom windows were not fitted with any limiting device and the drop from the window ledge to ground was 790mm. There were CCTV cameras at various locations inside and outside the facility. The night shift had one Registered Divisional 1 Nurse and one PCA for 24 residents in high care and 13 residents in low care.

Coroner's Comments and Findings

The coroner identified a number of issues, one of which included the lack of an incident report relating to Ms M's first occasion of leaving through her bedroom window. This critical information about Ms M's vulnerability to cause inadvertent harm to herself was not widely known and so a plan to manage it could not be put in place.

In addition, the incident did not make it to the running sheet or verbal nursing handover. This meant the night staff did not have the pertinent information for providing care for Ms M.

The lack of handover about a contemporaneous event and the absence of an incident report and the lack of relevant information transcribed onto the running sheet were contrary to the systems at the RACS.

The coroner was also critical that the family were not notified and were therefore denied an opportunity to provide input to risk minimisation strategies.
The coroner noted that changes have already been made at the RACS to: *Limit the opening of windows in all bedrooms, that one extra person is rostered to night shifts and, that it is policy to report all near misses via an electronic incident reporting system.*

Case #2 - Staying Warm

Case Number: 2015/4244
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Clinical Summary

Ms T was a 91 year old female who resided at the same RACS since 2008. Past medical history included cerebrovascular accident with a residual dense right-sided paralysis and she was non-verbal. Other past history included heart failure, atrial fibrillation, hypertension, chronic obstructive pulmonary disease and hypothyroidism.

In the middle of winter of 2015 (June) Ms T was found on the floor close to the heater. A lifting hoist was used to put her back into bed. The RACS staff noted Ms T's leg from her knee to ankle was injured. The cause of the injury was debated. One Personal Care Attendant (PCA) considered it looked like it had a skin tear, another PCA described blisters from her knee to foot with a lot of fluid leaking. The team leader described the wound as a skin tear or burst blister and that Ms T did not appear to be in any pain. The injury was dressed and bandaged.

The GP reviewed Ms T a few days later and considered the wound was a large second-degree burn. The GP believed this was due to the outer right lower leg having rested against the heater. The team leader informed the GP that as a result of this incident all residents' beds were moved away from the heaters.

The GP ordered blood tests to be done urgently. These revealed acute kidney injury, hypernatraemia, mildly deranged liver function tests and white cell count elevated.

Over the next four weeks, reviews of Ms T were completed by RACS staff, residential-in-reach staff and the GP. Ms T had no signs of infection, the pain was managed effectively and the wound appeared to be improving. About six weeks after the event the GP noted Ms T had lost 9 kilograms in weight, had poor food and fluid intake. The GP ordered blood tests to be done urgently. These revealed acute kidney injury, hypernatraemia, mildly deranged liver function tests and white cell count elevated.

Ms T was transferred to a major metropolitan hospital for further assessment and treatment. There she remained hypotensive despite aggressive fluid resuscitation. Following discussions with her family a decision was made to keep her comfortable with palliative care and Ms T died in hospital within two weeks.

Pathology

The cause of death determined by a forensic pathologist following an external examination, a review of the e-medical deposition, police report and, a routine whole body CT scan was:
Kidney impairment and dehydration following thermal injury to right leg in an elderly woman with cerebrovascular disease.

Investigation

The case was considered a reportable death due to the burn on her leg.

Statements were requested from the facility manager, the clinical care co-ordinator, team leader, personal care assistants, in-reach clinical nurse, the GP and physician at the hospital.

they were aware of two other cases whereby residents sustained burns from hydronic heaters in RACS, within a short period of Ms T's death.

The coroner received a letter of concern from Ms T's daughter complaining she received a phone call from the facility requesting permission to move her mother's bed from the heater. However, the family say they did not learn of their mother's injury until two weeks after the event.

The coroner also received documentation from the Aged Care Complaints Scheme stating they were aware of two other cases whereby residents sustained burns from hydronic heaters in RACS, within a short period of Ms T's death.

The coroner also had minutes from a meeting at the facility which took place prior to this incident where residents having burns from beds being located near heaters was discussed.

The coroner was satisfied that the RACS had since introduced a policy in place stating that all residents' beds be placed at a safe distance from heaters.

Coroner's Comments and Findings

The case was closed without holding an inquest. The coroner was satisfied that the RACS had since introduced a policy stating that all residents' beds be placed at a safe distance from heaters.

A recommendation was made to the Commonwealth Department of Social Services and the Minister for Aged Care to consider the need to regulate the configuration of rooms in aged care facilities, to ensure that residents' beds are not placed in dangerous positions, such as near hydronic heaters.

Case #3 - The fault's in the equipment or the user

Case Number: 2014/6026
Case Précis Author:
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Clinical Summary

Ms B was a 99 year old female residing at a RACS. Past medical history included osteoarthritis, osteomyelitis, anaemia, hypertension, cataracts, leg oedema, anxiety, hearing loss and depression.

One morning, two nurses placed Ms B in a lifting hoist. Ms B was approximately 1 metre from the floor when she fell. One nurse protected her head during the fall. The other one called for help. Ms B had no loss of consciousness or head strike but did complain of pain in her buttocks.

The ambulance service was contacted and when the paramedics arrived Ms B was still lying on the floor in the lifting belt. On arrival, Ms B's Glasgow Coma Score (GCS) was 14/15 and within 20 minutes had deteriorated to 10/15 (at 10:30 hours).

> A Computed Tomography (CT) scan of her chest, abdomen and pelvis showed bilateral insufficiency fractures in the sacrum and a ride sided pleural effusion.

Ms B was taken to an acute private hospital's emergency department. When assessed at 13:00hrs her GCS was even lower (7/15) and she was hypothermic with a temperature of 34.1 degrees celsius, heart rate 60 beats per minute, respiratory rate 18 breaths a minute and oxygen saturations were 89% despite being on 8 litres of oxygen.

A Computed Tomography (CT) scan of her chest, abdomen and pelvis showed bilateral insufficiency fractures in the sacrum and a right sided pleural effusion. Blood tests revealed an elevated white cell count. Ms B was admitted to the ward with a diagnosis of probable pneumonia. After discussions with her family it was decided to palliate her, and she died later that afternoon.

The medical practitioner contacted the coroners' court to ask if the death was reportable because of the fall from the hoist. The advice provided was that, as the fall was not directly linked to death, cause of death being pneumonia, that it was not a reportable death.

Pathology

A death certificate was issued with the cause of death being pneumonia. An autopsy was not performed.

> The Coroner directed that further investigation was required because the death had occurred so soon after the incident.

Investigation

In November 2014, Ms B's daughter wrote a letter to the coroner's court requesting an investigation into her mother's death.
The coroner directed that further investigation was required because the death had occurred so soon after the incident.

The coroner requested assistance from the Coroners' Prevention Unit and a Forensic Pathologist. As well as this, statements were obtained from the medical practitioners who assessed Ms B in the Emergency Department and the one who managed care on the ward.

The forensic pathologist considered that the pneumonia may have been a pre-existing condition and in the absence of a post-mortem evaluation further comment on the cause of death was limited. He did, however, say that the sacrum injury may have to a small extent increased the speed of her death from pneumonia.

> The investigator could only surmise that the hook may have been placed in the incorrect position, which placed an uneven load on the hook and latch, causing it to fail.

The incident was reported to the Victorian WorkCover Authority (Worksafe Victoria) and their final report was made available to the coroner.

A senior engineer within the Workplace Hazards and Hazardous Industries Group found that a self-closing hook fitted to the lifting sling on the hoist had separated from the extension arm that connects to a ceiling tract system. The investigator could only surmise that the hook may have been placed in the incorrect position, which had placed an uneven load on the hook and latch, causing it to fail.

Coroner's Comments and Findings

The case was closed without holding an inquest. The coroner was comfortable that the RACS took all reasonable restorative and preventive steps in response to the lifting hoist accident involving Ms B's fall.

The coroner commended the RACS for independently having the lifting device checked and after the WorkSafe check was done, that they decommissioned the device. The coroner also noted that all RACS staff using the hoist had been trained in its correct use in the previous 12 months.

Questions to consider

What are the most important risks or hazards described in each case? Why?

Are these risks or hazards unique to the particular context or indicative of situations in most RACS? Consider the interplay of resident, clinical conditions, staff, environment and organizational factors.

What are the relevant lessons from the case scenario? Consider the lessons at the different levels of RACS, for example, board of management, manager, director of nursing, the nursing and personal care attendants.

What is the general principle at play? For example, is it a technical clinical skill, a professional quality, a legal or regulatory responsibility or an interpersonal aspect of care.

What is a recommendation for action that is specific and applicable to your local context?

List of resources

1. RAC-Communiqué March 2007 Volume 2 Issue 1: Falls
2. RAC-Communiqué September 2014 Volume 9 Issue 3: Falls
3. RAC-Communiqué June 2010 Volume 5 Issue 2: Health technology assessment
4. RAC-Communiqué December 2011 Volume 6 Issue 4: Translation
5. RAC-Communiqué February 2015 Volume 10 Issue 1: Information and culture
6. Department of Health, Industry Alert: Beds in aged care homes placed in dangerous positions. Issued 16 September 2016 available at http://us10.campaign-archive2.com/?u=1108de8332cef333bc1956686&id=9b1c6fdfac

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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 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, Victorian Institute of Forensic Medicine or Monash University.