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EDITORIAL

Welcome to the first issue of 2010.

This issue focuses on how we respond to emergency situations due to internal hazards. As you may recall the last issue of 2009 explored the need for an organised response to an external hazard i.e., Extreme Hot Weather.

As you read this issue reflect on the similarities and differences between what we do in preparing for external and internal hazards. For example, bushfires or Extreme Hot Weather requires a large scale co-ordinated emergency response within the Residential Aged Care Service and the community as a whole. In contrast, a resident who develops upper airways obstruction due to aspiration of food requires immediate action by the small number of staff who happen to be present at the time.

Ensuring an adequate response to both situations requires planning, resources and training. However, is our approach to preparing and managing external and internal hazards the same?

External hazards are often very dramatic events more likely to attract our attention and resources. We also understand that staff will need specific education and training to manage these unusual events.

In contrast, internal hazards, for example choking, may be considered a basic clinical emergency and we assume staff know what to do and how to access the necessary equipment or assistance.

The two cases presented illustrate dramatic differences in teamwork during an emergency response. However, both cases highlight the need for practical "hands-on" training for staff to ensure protocols and procedures are put into action when the need arises.

The second case is an excellent example of how a high functioning team improves their practice after the death of a resident.

Our two expert commentaries address themes arising from the cases. The first is about respecting a resident's dignity to take risks, and the second discusses being prepared for a crisis through rehearsal and training.

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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

SMOKING IS ALWAYS DANGEROUS

Case Precis Author: Prof Joseph E Ibrahim, Monash University

CLINICAL SUMMARY

Ms N was an 81-year-old female resident requiring low-level care at a small regional Residential Aged Care Service (RACS) who was independent ambulating short distances with a walking frame and a wheelchair for longer distances. She was also a heavy cigarette smoker. Past medical history included cervical cancer, chronic pain and general frailty.

One morning after breakfast Ms N followed her usual routine. This was getting rugged up in a coat, taking a packet of cigarettes and lighter and being wheeled to the outdoor smoking area and positioned so that the nurse call button was easily accessible. Ms N would be left alone to smoke the cigarettes and then return inside with the help of a care attendant.

Later that morning Ms N went outside again to smoke a few cigarettes. A short time later the nurse call button was activated, staff responded immediately, and on arrival saw flames coming from the wheel chair.

Staff responded to extinguish the flames with blankets and a fire extinguisher.

Ms N was wheeled to the shower bay and placed under the running water.

Her General Practitioner was on site, attended and administered morphine.

The fire alarm was activated. However, there was a delay in emergency services responding due to a fault in the alarm system at the Fire Station.

PATHOLOGY

The cause of death was Thermal Burns while attempting to light a cigarette.

INVESTIGATION

The coroner received a detailed report from the Regional Fire Investigation Officer that included the results of a reconstruction using a mannequin dressed in similar clothing to Ms N.

It seems that the most probable scenario is the naked flame from the cigarette lighter came into direct contact with the jacket. This set fire to the clothes, caused Ms N to drop the lighter, which vented fluid near its base causing the fire to burn intensely.

CORONER'S COMMENTS AND FINDINGS

The coroner commended all those involved in this incident for the exemplary and professional response.

A number of improvements to the designated smoking area were made following the death of Ms N. Examples included: a fire retardant apron for age care residents; having easily accessible fire blankets; removing soft chairs from smoking areas; and training for staff in fire evacuations and emergency responses.

The Fire Station alarm systems were being upgraded prior to the incident and have been completed.

AUTHOR COMMENTS

This case demonstrates how a resident's right to take risks, in this case cigarette smoking was respected. It also exemplifies how risk may be mitigated.

TRANSLATING WORDS INTO ACTION

Case Precis Author: Prof Joseph E Ibrahim, Monash University

CLINICAL SUMMARY

Mr S, a male aged in late 70's with dementia, lived at a large metropolitan residential aged care service (RACS) for over a year due to the need for high level care. Mr S was non-ambulant, requiring assistance with personal activities of daily living and had to be fed all meals by an attendant using a spoon and sipper cup. Past medical history included a carcinoma of the throat that required throat surgery in the late 1990's and as a consequence he was only able to tolerate a "soft" diet of pureed foods and fluids.

One evening as Mr S was being fed dessert, he started choking. Mr S was sat up and encouraged to cough by the care attendant. A large glob of custard was successfully expectorated.

Shortly after Mr S' face turned 'a shade of grey'. Additional RACS staff attended to provide additional assistance. They examined his mouth and throat and saw this was clear. Mr S was transferred to a bed and placed in the recovery position.

All staff then left Mr S alone in his room. One staff member went to obtain oxygen and contact the Registered Nurse on duty. The other care attendants continued their evening duties to the other residents. A short time later staff returned to Mr S' room and found he was dead.

PATHOLOGY

The cause of death following an autopsy by a forensic pathologist concluded death was due to the aspiration of gastric contents leading to choking. Contributing factors included dementia and ischaemic heart disease.

The forensic pathologist observed "there was complete occlusion of both airways due to the presence of food material in the lower trachea and both main bronchi."

INVESTIGATION

The coroner held an Inquest to investigate several matters surrounding the circumstances of death, specifically the timing of the incident and emergency response, and to establish the clinical condition of Mr S when left alone in bed.

Statements were sought and received from the staff and management of the RACS. The RACS also provided an expert opinion stating Mr S may have suffered an arrhythmia and then aspirated food.

At Inquest the RACS staff differed in their opinion about whether Mr S had recovered or was still compromised at the time he was left alone, and the timing of events. The staff member who went to seek help explained that the Registered Nurse could not be contacted and that she was not aware of where oxygen cylinders were stored.

The RACS Director of Nursing (DON) provided evidence explaining the location of and access to an oxygen and suction unit. Only the enrolled and registered nurses are trained in using this equipment and the procedures required when calling for nursing assistance. The DON also explained there was a written protocol about emergency management of a blocked airway, which stipulated an ambulance be called if the airway cannot be cleared.

From the evidence presented by the RACS staff, it appears they were unaware of, or had not read, or were not trained, or not able to follow the RACS procedures.

The RACS management explained that since the death of Mr S some staff had been trained in the management of a resident who is choking and that the written procedures and protocols had been updated.

CORONER'S COMMENTS AND FINDINGS

The Coroner concluded that:

- Mr S was seriously unwell and in need of immediate medical assessment when put back to bed, and that he was left unattended for 15 minutes to 30 minutes;
- Mr S' life would probably not have been saved by prompt transfer to hospital. However, this does not excuse the failure to have him promptly attended by a registered nurse and be fully assessed;
- Immediately following the choking incident the management was reasonable although it may not have strictly complied with the RACS protocol; and
- The treatment and emergency response fell short of the standard of care that Mr S was entitled and could reasonably have expected.

Specific comments highlighted serious deficiencies in responding to a medical emergency and the uncertainty among staff members about their role in an emergency situation and their unfamiliarity with emergency protocols.

CORONER'S RECOMMENDATIONS

The Coroner recommended the RACS ensure all staff members are aware and are adequately trained for all emergency procedures. "*It is not, .., sufficient to merely produce written protocols and ..., read them.*"

AUTHOR COMMENTS

The forensic pathologist stated it was impossible to confirm or refute the suggestion of the expert opinion. This is because a cardiac arrhythmia does not leave any specific features that can be detected at autopsy.

Therefore, several different sequences may have led to death. If a cardiac arrhythmia occurred it may have led to aspiration. Alternatively, the aspiration and respiratory obstruction may have led to the cardiac arrhythmia, or there was no arrhythmia.

CRISIS PREPAREDNESS: REHEARSAL AND TEAM TRAINING

Author: Dr. Shelly Jeffcott, CRE in Patient Safety, Department of Epidemiology and Preventive Medicine, Monash University

We can learn important lessons from other industries about how to prepare and rehearse for crisis situations. A useful case of what not to do comes from the UK railways and shows us the importance of team and emergency training.

In the mid 1990's, the UK government decided to privatise its railway. This resulted in an increased emphasis on getting as many trains running on time as possible so that everyone made a profit.

Train drivers no longer had the same apprenticeship—"a rite of passage"—from sweeping the station platform to finally adorning the coveted driver's seat. Training was now only a few months and many came straight out of school, "wet behind the ears". The established drivers called these new recruits "boil in the bag", which was NOT intended as a compliment!

A series of major accidents occurred during those early years of privatization (e.g. UK Southall (Sep-97), Ladbroke Grove (Oct-99), Hatfield (Oct-00), and Potter's Bar (May-02) which in total claimed over 100 lives. Many people wanted to blame these new drivers for not being well trained and for not being focused on safety.

The truth is that the system had failed in one very important area: crisis management. New drivers had been taught the rules of normal operations but limited information was given about what to do when operations become abnormal: i.e., in situations when people can and do get hurt. The long record of safety in British Rail had left everyone feeling very pleased with themselves. And because the railways had become such a "safe" place for staff and passengers alike, it was only the old school of drivers, who had been working in the industry for years, and who had actually witnessed track deaths and other serious accidents.

The experienced drivers remembered what to do in an emergency but what about the new staff? Did they know how, when and where to seek help? Did they even have the skills and knowledge to recognise and assess the seriousness of a problem?

Everyone still cared about safety but had become complacent. Being safe for so long had made people blind or forgetful that the railways are a risky business. There was little overlap between (1) those that run the trains, (2) those that run the tracks, and (3) those that run the stations. These create many complex interactions but there was no sense of a shared responsibility for safety. It was difficult to shift people's focus to "how to stay safe?" when the question in most instances was "how to make money?"

It is important to remain vigilant to the impact/s of change at all times and ensure that managers lead by example in prioritising protection (safety) over production (profit).

Health care organisations are beginning to utilise new methods of learning for their staff, such as "simulation". This approach recreates an emergency situation for staff to practice with no real risk of harm to patients. The UK railways have mandated emergency training for new recruits in special train simulators, although time and resource limitations hamper their capacity to update and maintain staff skills.

The main message is that preparing for a crisis is much better than dealing with the aftermath.

[For any train spotters, who might want to find out more, 'Broken Rails' by C Wolmar is a great, novel style read!]

"DIGNITY OF RISK" FOR PEOPLE IN RESIDENTIAL CARE

Author: Dr Deirdre Fetherstonhaugh Australian Centre for Evidence Based Aged Care (ACEBAC), La Trobe University

Life is full of risks! Risk is interpreted as the chance of negative effect, for example, an outcome that is considered adverse, bad, onerous, burdensome or undesired.

Risks are typically described in terms of the likelihood of harm or loss from a hazard and usually include: (1) an identification of what is 'at risk' and may be harmed or lost; (2) the hazard that may occasion this loss; and (3) the likelihood that the harm will occur.

How individual people perceive risk influences their decisions and choices. Just because there are inherent risks in certain behaviour or course of action doesn't mean the behaviour or action should be stopped. Some people are risk takers and some are not. The question to be asked is how much risk people are prepared to undertake for a perceived likely benefit.

People moving into residential care are often very old, physically frail or cognitively impaired and reliant on others for care. However, remember that these people have been able to meet their own needs and have been in control throughout most of their lives. They have made autonomous choices about their families, their careers, their values, their health and the course of their lives, and these choices have often involved risks. The sorts of choices made and the risks they have considered worth taking throughout their lives reflect the values they hold dear and are part of their identity as autonomous individuals.

Many older people want to and are able to continue to make decisions and choices and exercise control over their lives, including balancing risks.

Old age, frailty, living in a residential aged care facility and the presence of dementia should not remove a person's independence and the right to take risks. We do not inhibit the rights of people living in the community to indulge in extreme risky behaviour such as sky diving, motor racing or sailing solo around the world, smoking and drinking alcohol. So why should we prevent people living in residential care from moving freely around their home because they are at risk of falling.

It is about managing and mitigating the risk rather than avoiding it. For example environmental changes are far more person-centred and have less injurious effects than physical restraint to prevent falling.

It is often better to risk an adverse outcome than to deny the inherent worth, dignity and autonomy of each older person living in residential care.

LIST OF RESOURCES

1. Salas E. et al. Teamwork Training for Patient Safety: Best Practices and Guiding Principles (Ch. 44). In: Carayon P. (Ed.). Handbook of Human Factors and Ergonomics in Health Care and Patient Safety. Lawrence Erlbaum Associates, Hillsdale, NJ, 2007.

2. Gaba D. The future vision of simulation in health care. Qual Saf Health Care 2004 13: i2-i10.

3. FDA Human Factors Section. Several documents about medical devices, errors, and the design process (e.g., "Do it By Design") http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm095061.pdf

4. The strange case of Penny Allison, National Blood Service, NHS. A great little video to show how apparently simple processes can become very complex due to multiple interactions in the system of care http://www.youtube.com/watch?v=0AuKxq625Gk

5. Office of the Public Advocate. Risk and Rights Forum 2005 available at http://www.publicadvocate.vic.gov.au/research/133/

6. SCORE Strengthening care outcomes for residents with evidence, Draft standardised care process: Chocking. Available at http://www.health.vic.gov.au/agedcare/downloads/score/score_choking_august_09.pdf

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.