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RESIDENTIAL AGED CARE COMMUNIQUÉ

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EDITORIAL

Welcome to the first issue of 2013. In this issue we present a fascinating case of a resident who dies within an hour of admission to RACS. It captures a wide range of professional, organisational, clinical, pathology and legal matters.

The case should prompt vigorous debate amongst your friends and colleagues who are at the point of care and those responsible for managing and operating a RACS.

To cover the breadth of topics we expanded to six pages to provide three expert commentaries. A/Prof David Ranson gives a view from a senior forensic pathologist about the cause of death and evidence. Ms Marrianne Beaty describes the benefits and limitations of the clinical incident investigation technique, root cause analysis. Dr Cathy Balding's comments are on the importance of governance.

Finally, as promised, we have our part III on using statistics. This time we discuss what factors to consider when choosing an area of clinical risk to measure and improve.

FREE SUBSCRIPTION

The Department of Forensic Medicine, Monash University will publish the RESIDENTIAL AGED CARE COMMUNIQUÉ on a quarterly basis. Subscription is free of charge and the Communiqué is sent to your preferred email address.

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PUBLICATION TEAM

Editor in Chief: Joseph E Ibrahim
Consultant Editor: Rhonda Nay
Managing Editor: Fiona Kitching
Designer: Clair Richards

Address: Department of Forensic Medicine, Monash University
57-83 Kavanagh St, Southbank
Telephone: +61 3 9684 4444

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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 made available by Coroners Courts both within Australia and overseas. 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. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroner's Court jurisdiction.

PART III APPLYING NUMBERS TO WORDS: CHOOSING WHAT TO MEASURE

Prof Joseph Ibrahim, Monash University

In this third part of using statistics to improve care, we look at some of the factors to consider when choosing a clinical risk area to measure.

Most people are surprised to discover they have some choice in what to measure. Mostly, we have gotten used to being told what to do by quality managers, executive staff, regulators, accreditation agencies and government. We often forgot to ask why? I mean the real 'why', not the "because we have to do this to comply or get our funding".

The real 'why' is almost always about wanting to improve care for our residents. This important objective is usually lost in the transmission. It is lost because we simplify, misunderstand or just tell staff "I just need you to weigh everyone today".

Researchers argue long and hard about why we should measure, what to measure, how to measure and what the results mean.

There are many different attributes of what constitutes a robust quality indicator. The basic principles are encapsulated in the following questions:

1. Is what we are measuring relevant to the needs of the residents? For example, compare 'day trips and social activities' with 'pain management'. If you apply the rule of thumb that we should measure areas that are (i) dangerous-high risk; (ii) occur often-high volume and; (iii) expensive-high cost.

2. Does it have the required technical attributes i.e., is it valid and reliable? For example, we should all have the same understanding of what is a 'fall' and report this the same way every time in every RACS.

4. Is the measure sensitive enough to detect a real difference? Sometimes we demonstrate a 'significant difference' in the measurement. This often arises when we measure very large population numbers and is due to the inherent nature of the maths. Statistical significance does not mean it is clinically significant.

5. Is it user friendly? We should be able to understand the results and explain their meaning to others in plain language.

ALL THAT IN JUST ONE HOUR

Case Précis Author: Professor Joseph Ibrahim, Monash University

Clinical Summary

Ms IC was a 91-year-old female resident in low-level care at a large metropolitan Residential Aged Care Service (RACS) for 4 years. Past medical history included a fractured hip. In September, Ms IC was admitted to an acute hospital following a series of five falls and diagnosed with a cerebrovascular event (stroke). One month later Ms IC was discharged from hospital and admitted into a new High Level Care RACS located on the same site as the LLC RACS where she had previously resided.

Ms IC was admitted to the HLC-RACS just after lunch. The discharge documents noted that she had had a stroke, multiple falls, was confused, could only be given grade two thickened fluid and was a high risk for falls.

On arrival Ms IC was met by the duty RN, given a given a cup of tea, had the bed rails put up and initial observations taken. The blood pressure was measured by a student nurse and recorded as 203/74mmHg.

An hour later she was found by staff semi-conscious on the floor near her bed. A hoist was used to get Ms IC back into bed, and transfer to an acute hospital was organized. At the hospital the decision to withdraw active treatment was made and palliative measures implemented. Ms IC died the following day.

Pathology

The cause of death following an inquest was *"traumatic subarachnoid haemorrhage and an acute and chronic subdural haematoma as a result of a fall."*

Investigation

The coroner directed further investigation was required to determine (a) whether the care provided was in accordance to professional standards; and (b) what had been done to prevent a recurrence.

This included gathering of statements from the RACS staff and taking evidence in the courtroom at Inquest. This occurred over 18 months after the death of Mrs IC.

The coroner reported on three aspects of care: management of a high falls risk; management of special diet and response to abnormal high blood pressure reading.

The RACS staff indicated they were aware of the discharge summary notes that Ms IC was a High Risk for Falls and had special dietary needs. The falls harm minimisation approach was centred around the use of bed rails. The differences in the RACS staff statements made it very difficult to know the position of the bed rails. The Coroner concluded at least one of the bed rails must have been down.

The RACS had documented Ms IC was only to be given thickened fluids. However, they still gave her a welcome cup of tea.

The RN stated the progress notes documenting the high blood pressure were wrong and the student nurse had not completed the measurement. The coroner did not accept this version of events.

Ms IC had not been seen for 45 minutes of the total 1 hour and five minutes she had in the facility.

It is important to note the two nurses on the roster were subpoenaed to give evidence at this inquest about the bed rails however they both said they had no recollection of the incident. "I find this situation to be most strange."

The duty RN had given a statement the day after the incident and subsequently declined to be interviewed and gave evidence during the Inquest. The Coroner stated the RN was "not an open, clear, consistent witness and I could not describe the evidence as reliable".

The RACS consisted of three separate facilities owned by one organisation. The two Low Care and one High Care facilities operated independently and did not transfer the residents' records between each other.

The approved provider had not completed any internal review of this event. The only response over the next eighteen months was two lines written on an "Accident Report" made on the day, by the RACS manager. There was no notation that the outcome was fatal; no enquiries of anyone present; or whether the staff had adhered to the falls policy.

Coroner's Comments and Findings

The case was closed following an inquest. The coroner recommended the:

(1) Nursing Registration Board review the professionalism of the care provided by the RN who had admitted Ms IC.

(2) Commonwealth Department of Health and Aging (DoHA) review the response of the approved provider to the fatal fall.

(3) DoHA requires all RACS to undertake a Root Cause Analysis of all deaths and hospitalisations that occur following a traumatic event.

Author Comments

Looking back at this case, we all say, "thank goodness I was not there that day!" It is amazing how one hour, in an otherwise ordinary day so profoundly alters life for the resident, staff and the organisation. Two issues are worth commenting on.

First, we know whenever there is a transition of care there is an increased clinical risk. Whenever we change the location or staff providing care for residents we need a heightened level of supervision and monitoring.

Second, is the use of bedrails. Current practice is not to use bedrails at all. Instead, low beds and protection on-floor are solutions for falls harm minimisation. The assumption that bedrails protect residents from falls is widely disputed. Some argue bedrails increase the height from which a fall occurs if a resident goes over the top.

FORENSIC PATHOLOGY AND EVIDENCE

Adjunct Clinical Associate Professor David Ranson, Deputy Director, Victorian Institute of Forensic Medicine

Commenting on the cause of death in this case using only the publicly available coroners inquest finding is problematic. The inquest finding does not indicate whether the cause of death was arrived by (a) a review of the medical records and an external examination with or without post-mortem imaging and (b) an internal examination or autopsy.

An individual who has fallen and struck their head may well develop cortical contusions and subarachnoid haemorrhage. It is unclear from the clinical scenario whether a blunt head injury was present when Ms IC was found.

If there were no features of head injury noted at the time then it is possible that the subarachnoid haemorrhage occurred at a different time.

This is not the case for the subdural haemorrhage. Both the acute and the chronic components of a subdural haemorrhage can occur in association with a shaking type injury to the head in the absence of direct physical contact blunt trauma.

The very old and the very young are particularly vulnerable to this mechanism of injury leading to subdural haemorrhage. As a result Ms IC could have fallen without striking her head and the fall still have caused a fatal haemorrhage.

In the absence of details of the autopsy findings or of CT scans of the head the significance of the haemorrhage to the death is difficult to ascertain.

The presence of a pre-existing chronic subdural haemorrhage may increase the likelihood that further albeit relatively minor trauma may lead to acute subdural bleeding. Histological evaluation of a subdural haemorrhage may also provide evidence regarding its age, which may prove to be important in evaluating the circumstances of the death.

For the above reasons a full internal examination with neuropathological assessment of the brain and the membranes around the brain may be important in coming to an understanding of what caused or contributed to the death. Such information may be crucial to a coroner who is seeking to identify whether there are any preventable factors surrounding the death, but it may also be important for the RACS who may be seeking information in order to properly represent their position during a coroner's inquest or during any subsequent civil or criminal proceedings that could arise in relation to the patient's injury and death.

In such a situation it might be prudent for the residential aged care service to request that the coroner order an autopsy.

"THE PROBLEM OF RECALL IS A DIFFICULT ONE FOR COURTS AND COMMUNITY"

ORAL TESTIMONY AT THE INQUEST

From the perspective of the parties present at the inquest and the perspective of the coroner and the general public the fact that two nurses rostered on the day of the fall had no recollection of the incident and therefore could not comment on the position of the bed rails seems odd and smacks of self protecting bias.

Indeed the coroner states in their finding "I find this situation to be most strange". However, this needs to be looked at from the perspective of the ordinary daily work of a nurse in this environment and this issue needs to be explained very clearly to an inquest so that the lack of recollection of the nursing staff is put into a proper context. In order to do this other information is necessary. It should also be remembered that the death occurred in October 2009 and the inquest was held in May 2011.

The problem of recall is a difficult one for courts and the community. While some issues are of considerable evidential importance in court they may involve matters that are of such commonality that witnesses may not have a direct recollection of what at the time they considered to be a commonplace factor. Indeed one of the great risks of pressing a witness on such a point is that they may recreate a false memory of the events due to a variety of social influences or biases.

This is why contemporaneous notes that are dated and signed are so important. The accident report made on the day appears inadequate either as a record to assist in undertaking a preventative review of the events from a clinical care perspective or as a contemporaneous record of the details of the incident so as to protect the RACS and staff from any allegations as to the quality of their service.

Modern coronership is focused around determining the facts and identifying issues of death and injury prevention rather than attributing moral or legal blame. However, the fact-finding exercise will often uncover potential errors and service lapses on the part of individuals and organisations. It is for this reason that legal representation during an inquest is critical for organisations and their staff. Clearly from the public interest point of view the identification of an individual who has contributed to a death in a material way as a result of an overt action or potentially negligent inaction is important. If the negligence is very significant criminal charges could be applied and in other situations civil action could be taken in a claim for compensation. These civil and criminal procedures are outside the coroner's inquest. However, the inquest may be the point at which the civil and criminal issues become exposed to the community. As a result, although the coroner may be more focused on issues become exposed to the community. As a result, although the coroner may be more focused on issues surrounding prevention of a death, the coroners inquest may have wider ramifications for a number of witnesses.

In dealing with the legal issues surrounding this case it is the inadequate documentation of the incident and a lack of follow-up of the incident that has placed the RACS, their staff and residents at risk.

ROOT CAUSE ANALYSIS (RCA)

Marrianne Beaty, Manager Quality Improvement Projects (Agencies), Dental Health Services Victoria

Root cause analysis is an investigation method that looks into an event that has occurred leading to harm. The intention is to understand 'why' it occurred and what could be changed to prevent it happening again.

I learned about Root Cause Analysis (RCA) in 2002 from James Bagian and his team from Veterans Affairs National Patient Safety Centre (USA).

Healthcare professionals go to work each day aiming to do their very best and with no intention to harm their residents. People have many things going on in their life and these, as well as other things, "distract" us from doing our very best all the time.

On occasion things do go wrong. When this occurs, we all need to look back at what happened with an open mind (and without a "blame" approach) to find all the factors that contributed to the event. With this knowledge we are able to improve care and prevent a recurrence.

A few points about errors to keep in mind: we learn from errors; the best people sometimes make the worst mistakes; and changing the system to prevent errors from happening have a more lasting impact than blaming a person.

In health care RCA have been done on cases where: x-rays, CT scans or radiotherapy was given to the wrong patient; mix-up of the results of blood tests; use of an unsterile instrument on patients and; missed diagnosis on a patient which led to the patient dying.

The initial hopes in 2002 that conducting RCAs would make "everything better", has not happened. We continue to make the same mistakes, just in different departments or facilities or hospitals. We don't seem to learn very well from the mistakes others make.

RCA did not change everything, but it did help to make some things better, for example: better patient identification; "time out" before procedures; and techniques to minimise interruptions during medication rounds.

The RCA process may seem tedious and appear as if the organisation is "out to get someone to blame for what has happened". Done well, a RCA should make everyone feel that they have contributed to a change that will benefit both staff and their residents. Participation leads to feeling of empowerment that comes from contributing ideas to improving patient's lives and/or making the workplace better for one of my colleagues.

Participation and spreading the lessons learned with all our colleagues should be the aim of the exercise – not blaming a staff member or hanging them out to dry.

Participation requires being honest. This is hard at times as we have to admit having made a mistake - we all do – after all, we are humans not robots! Only by being honest and true to ourselves can we make a difference to our profession.

"We don't seem to learn very well from the mistakes others make"

COMMENTARY: CLININCAL GOVENANCE

Dr Cathy Balding, Director, Qualityworks PL

There are several definitions of clinical governance. One of the clearest is by Scally and Donaldson who described it as "a system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards and by allowing excellence in clinical care to flourish."

In other words, the key responsibility at each and every level of the organisation is to achieve and safeguard high standards of care. All staff are responsible along with the board of directors.

Although, the Board should not be involved in the day-to-day operations of the organisation, they are accountable for what happens in the organisation. How do they know, check and direct what happens? As a Board they should work with their Executive & Management team and the whole organisation to define 'safe and quality care' in terms that are concrete and clear. The more nebulous the definition, the less a Board will be able to govern, and quality and safe care quickly descend into reports on the things that go wrong, rather than a focus on supporting care to go right.

Once defined, the organisation's quality plan should clearly describe how this care will become the norm. Quality at point of care doesn't happen because of policies or audits. These are only tools. It happens because the Board and Executive decide that they want it to happen, and put the required components in place.

It requires a proactive mindset, to be actively crafted and supported through strong executive and middle manager leadership, including the provision of requisite training, standards, systems and tools to support staff to enact their responsibility. The Board's role is to seek assurance and evidence from their Executive that these components are in place, and to monitor the extent to which quality care is being created for each consumer through robust reporting on processes and outcomes.

When things go wrong, as in this case, the Board must be confident that the Executive will follow correct processes for dealing with the specific issue, and also that the experience is used to review and develop staff and management understanding of their responsibilities, organisational systems, training, standards and reporting, as required. It's not the Board's role to 'run the case'– but they are entitled to reports on progress with managing the case and application of lessons learned. Governance of the quality of care is a partnership across the organisation – the 'buck stops' with the Board.

LIST OF RESOURCES

1. Department of Veterans Affairs National Center for Patient Safety (NCPS) Root Cause Analysis guide. It helps teams in developing an understanding of what occurred and why the event occurred. Access at <http://www.patientsafety.gov/CogAids/RCA/index.html>

2. Governing quality in public sector residential aged care: An organisational tool, was developed by Dr Cathy Balding, Qualityworks, to assist boards and executives of Victorian health services to analyse the robustness of their governance and quality systems to support, monitor and improve residents quality of life. Available at http://www.health.vic.gov.au/agedcare/publications/governing_quality.htm

3. Victorian Department of Health, clinical governance policy framework released in 2008 gives a short sharp description of the concepts. <http://docs.health.vic.gov.au/docs/doc/4C6559130DA88FD5CA257902000D5EFA/$FILE/clin_gov_pol_framework.pdf>

4. The Legal Unit, Queensland Health have prepared and published a short 'Fact Sheet' on 'Good clinical documentation – Its importance from a legal perspective' It is less than 2 pages long so well worth a look.

http://www.health.qld.gov.au/sop/2documents/SOP011.pdf.

5. This is a lighthearted look at how our memory plays tricks on us. I doubt that many will be able to access this site in the workplace. Be warned that it contains crude images and language that may offend. http://www.cracked.com/article_18704_5-mind-blowing-ways-your-memory-plays-tricks-you.html

6. Health service governance, NHS, Handbook of Integrated Governance, Department of Health, 2006. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4128739

7. Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England BMJ 1998;317 61.

8. Bed rails are a form of restraint. Review the latest Commonwealth Department of Health and Ageing released a new edition in Dec 2012 of the Decision-Making Tool: Supporting a Restraint-Free Environment at http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-decision-restraint.htm