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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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Next issue: February 2014

EDITORIAL

Welcome to the third and final issue of RACC for 2013. This is our 26th issue and seventh year since we were established in October 2006. Time passes by very quickly and our subscriber base continues to grow.

This year is an opportune time for our editorial team to reflect on whether we are achieving our aims and an opportunity to look to the future for the RAC Communiqué. It may seem strange that we did not do this earlier, say at the 5-year mark or wait till a little longer till our 10th year. Seven years makes perfect sense if we accept the premise that our editorial team and readers are actively involved in a relationship.

Together we share an interest and direct our energy to improving care for vulnerable older people. The connection is perhaps more obvious to fans of classic romantic comedy films who will recall Marilyn Monroe in 'The Seven Year Itch'. The movie popularised the idea that a couple may lose interest in their marriage after 7-years. The other tragic connection is Marilyn Monroe's untimely death was reported and investigated by the coroner.

So, does our professional relationship have a use-by date? Will our readers leave us, seduced by the glamour and the allure of emerging media? Is the information we provide and how we deliver it still relevant? Throughout 2013 and 2014 we seek to answer these questions.

So far, we have completed a series of interviews with senior leaders in the aged care sector asking if and how we might use emerging media (i.e., Facebook, YouTube, Twitter) with RAC Communiqué. A short report will be in our next edition. The YouTube video posted on driving and dementia has been viewed over 1000 times and we got several favourable comments but did not achieve the discussion we expected. We are currently collating and reviewing all editions of RAC Communiqué into a single collected hard copy volume. An old fashioned book! To see if that helps get information to a wider audience.

Our next step is to conduct a comprehensive survey of our readers by email which we hope to send out within the next three months. I encourage you to contribute by completing the survey to help us make sure we deliver what you want and need.

The cases we present touch on the same issue of how we gather and use information. In each case, information was available about the hazards that contributed to the residents' death at least one year earlier. However, staff were not aware of this information or did not adopt the necessary change.

A YOUTUBE VIDEO: DRIVING AND DEMENTIA

Just in case you missed us mentioning the release of an animated YouTube video on 'Driving and Dementia' last time. Here is the link again. It is short, interesting and our first step into emerging media. Let us know your thoughts. The website is <http://www.youtube.com/watch?v=4F9z8mPhcTw.>

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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.

NEW RESEARCH PROJECT: DEATHS REPORTED TO CORONER IN RACS

The Department of Forensic Medicine, Monash University received funding this year for a 12 month research project to 'use existing information from medico-legal death investigations for improving care of older people in Residential Aged Care Services'. As we know, optimal care of the vulnerable older population requires advancing our understanding of their deaths.

The project will undertake an aggregated analysis of all cases reported to the Coroner's Court in Victoria over the last decade. New insights from this analysis will contribute to an evidence-base for policy, clinical practice and the prevention of injury and death in RACS.

The project team comprises Professor Joseph Ibrahim with clinical experience in Geriatric Medicine, A/Prof David Ranson a forensic pathologist and Dr Lyndal Bugeja who assists coroners with their role in prevention and public health and safety. We also have several research officers working on the project, Ms Briony Murphy, Ms Briohny Kennedy and Ms Fiona Kitching.

We are also seeking additional funding to extend the project to include all of Australia. We plan to provide short reports of our findings in the RAC Communiqué.

SUMMER IS HERE: PREPARATIONS FOR PREVENTING HARM FROM HEATWAVES

Preparation is key in preventing harm to aged care residents as a result of heatwaves. Our study into how heatwaves are being managed in the aged-care sector was recently published in the Australian Health Review.

In our study we interviewed 14 representatives from health service campuses located in non-metropolitan areas of Victoria. We found a documented heatwave plan, good air conditioning, a backup power generator and a regular maintenance program facilitated preparedness.

To help write a heatwave plan check out the Residential aged care services heatwave ready resource developed by the Victorian Department of Health's Ageing and Aged Care branch in collaboration with the Public Health Branch. <http://www.health.vic.gov.au/agedcare/publications/racsheatwave/>

If you want to read the journal article the citation is: McInnes JA and Ibrahim JE. Preparation of residential aged care services for extreme hot weather in Victoria, Australia [online]. Australian Health Review, Vol. 37, No. 4, 2013: 442-448. Availability: <http://search.informit.com.au/documentSummary;dn=566873440603094;res=IELHEA> ISSN: 0156-5788.>

CASE #1 THIS HAS NEVER HAPPENED BEFORE!

Case Précis Author: Joseph Ibrahim, Monash University

CLINICAL SUMMARY

Mr A was an 87 year old male resident with dementia and a history of falls requiring high-level care at a metropolitan Residential Aged Care Service (RACS). Past medical history included a leg amputation. Mr A had a single room and did not like being disturbed at night by people entering his room.

Bedpoles were fitted permanently to the left side of Mr A's bed to assist his independence with moving in bed and to assist in getting to a sitting position for transfers into a wheelchair. Mr A had several falls from bed, usually from the right side of the bed, so a bed rail was placed on that side, the bed was lowered and a mattress had been placed on the floor next to the bed.

Late one night in January 2008, a PCA checked Mr A's room on three occasions over the night. The PCA did not actually sight Mr A, instead relying on hearing the sound of his snoring as a sign he was safe. The last check was at 4:15am.

Two hours later, staff entered the room to arrange Mr A's morning shower and found he had fallen from bed. Mr A's head and neck was caught in the gap between the left hand bedpole and the side of the bed and mattress. Mr A's neck was suspended on the exposed section of the horizontal frame of the bedpole apparatus.

PATHOLOGY

The cause of death following an autopsy was asphyxia due to neck entrapment.

INVESTIGATION

An Inquest was held with three days in Court during 2009-10 and gathered statements from the RACS staff and manufacturer of the bedpoles. The investigation of this death also involved the Occupational Health and Safety Authority.

The Coroner found that Mr A's bedpole was positioned in 'an unorthodox position'. Usually, the bedpole which comprises two vertical poles connected by a horizontal U-shaped frame sits between the mattress and the base of the bed with the U-shape pointing towards the foot of the bed. This provides greater stability because the weight of the resident and mattress would tend to keep it in place. Mr A's bedpole had the U-shaped section pointing towards the head of the bed and was loosely fitted beneath the raised section of the bed. This allowed the bedpoles to move up and down as well as side ways and; located closer to the upper body and neck rather than the resident's waist. This freedom of movement was even greater when the head of bed is raised.

The RACS checked all the other bedpoles fitted and found these were fitted in the orthodox manner.

The Coroner noted that both the RACS and Occupational Health and Safety Authority thought this was the first known incident where a person had become trapped between a bedpole and a mattress, thus it could not have been predicted. However, another similar case had been the subject of a Coroner's investigation in another state, two years earlier in 2006. It appears no-one involved in Mr A's case knew of this previous incident.

The manufacturer of the bedpoles explained they provided practical training on correct installation and there were no written instructions.

The RACS had taken significant steps to reduce the risk posed by the use of bedpoles amongst the changes were: a risk assessment to be carried out on the use of bed poles; all residents are assessed by the physiotherapist/occupational therapist prior to implementation; consistent instruction with formal training for bedpoles; and that staff actually sight residents who are perceived to be at increased risk.

CORONER'S COMMENTS AND FINDINGS

The case was closed following an inquest. The coroner concluded Mr A had fallen from his bed at some time during the night and the fall had caused his neck to become entrapped in the space between a vertical bedpole and the side of the bed mattress. The coroner commended the RACS for implemented measures to minimise risk to residents.

The coroner made several recommendations amongst which were: "manufacturers, suppliers and distributors of the bedpole apparatus ensure that consumers of the product are provided with written instructions as to the correct installation of the product and the dangers associated with its use"; that the Australian Government Department of Health and Ageing draw these findings and recommendations to all RACS.

AUTHOR COMMENTS

In this case the Coroner's sent out preliminary findings to media outlets and aged care regulatory authorities to warn about the risks of using bedpoles.

Given there had already been a similar case several years earlier, it raises the questions about how information is disseminated and the response to information about preventing harm.

CASE #2 DIFFERENT TIME, DIFFERENT PLACE, SAME HAZARD

Case Précis Author: Joseph Ibrahim, Monash University

CLINICAL SUMMARY

Ms B was a 91-year-old female resident requiring low-level care with a past medical history of dementia, diabetes mellitus and stroke. Ms B had been living at this RACS for over 2-years and her bed was fitted with the identical bedpole described in Case One.

On 14th May 2010 the findings and recommendations into Mr A's (Case One) death was released by the Coroner .

On the 4th June the Department of Health and Ageing released an urgent bulletin about the use of bedpoles.

Almost two months later, Ms B fell from bed during the night and was found with the bedstick across her neck. She was transferred to hospital and died a few hours later.

The coroner recommended that the bedpole posed an unacceptable risk and should no longer be used in RACS.

CASE #3 LACK OF DISSEMINATION OF INFORMATION

Case Précis Author: Joseph Ibrahim, Monash University

CLINICAL SUMMARY

Ms C was a 59-year-old female resident, requiring high-level care at a Residential Aged Care Service (RACS) for the past seven years. Past medical history included Down's syndrome, probable Alzheimer's dementia, gastroesophageal reflux, hypothyroidism, epilepsy and obesity. Ms C was predominantly bed-bound, requiring assistance with all personal care including eating and positioning for pressure care.

Ms C slept on her side with a large foam wedge placed under her back to keep pressure off the sacral area, this had been used for about one year. One morning, Ms C was found dead, lying prone in bed with her face in a pillow.

PATHOLOGY

An autopsy was not conducted. The cause of death was positional asphyxia. Ms C may have had a seizure and rolled into the prone position, or the foam wedge allowed Ms C to roll over involuntarily into that position.

FINDINGS AND REDCOMMENDATIONS

After the death, a RACS wound care nurse explained the foam wedge used for positioning was unsafe. It had been trialed one year earlier and was considered to cause Ms C to roll into the prone position. Once in that position, Ms C was as unable to roll herself out. However, there was no written documentation of this event and no communication of this information to the RACS staff or family.

Recommendations included: positional asphyxia is a real risk with any type of restraint and with some positioning devices. These risks should be well understood by staff and discussed with the resident and family.

The RACS should conduct a detailed incident review to understand why the foam wedge was still in use after it was deemed unsafe.

AUTHOR COMMENTS

Information about this hazard was available a year earlier and either not communicated or not acted on - A situation very similar to the other cases reported in this issue.

COMMENTARY:

DIFFUSION OF INNOVATION

Improving resident safety and quality of care requires our active involvement and seeking information locally, nationally and internationally. Our modern society has the unprecedented capacity to access enormous amounts of information from our desk. We just 'Google it' or 'You Tube it', and 'it' can be anything.

However, documentation, communication and adoption of ideas remain slow and somewhat haphazard. Examples in the health and popular literature that you are probably already familiar include it takes 17-years to transfer knowledge from research studies to clinical practice. For instance, it took the British Navy 264 years to implement the cure for scurvy!

Why this occurs is the subject of scientific inquiry described as 'diffusion of innovation' and 'implementation science'. There are no definite answers yet.

Some of the ideas being considered are what we would consider to be commonsense, that is, we innovate if it:- will make something better; fits in with what we do or value; is simple or easy to do; can be tested or done on a small scale and; changes are visible. Communication of the innovation is also important, simply publishing information in the media is not enough. For an innovation to gain acceptance requires conversation and discussions between peers.

If you want to read more ask the library to get a copy or hardcopy of the book by Everett M. Rogers, Diffusion of Innovations, 5th Edition, or buy it as an e-book.

LIST OF RESOURCES

1. Industry feedback alert: bedpoles. The Office of Aged Care Quality and Compliance access at < http://www.health.gov.au/internet/main/publishing.nsf/Content/19A4B3990EE34365CA257BF0001BDBE1/$File/Industr%20Alert%20-NSW%20Coronial%20Bedpoles%20220312.pdf >

2. Pressure Ulcers Basics: for residential aged care workers. Pressure Ulcer Basics: for residential aged care workers is an online education program developed for certificate III and IV staff based in Victoria. Access at< http://www.health.vic.gov.au/pressureulcers/workers.htm>

3. Falls Prevention for Residential Aged Care Facilities. The Guidelines are designed to assist residential aged care facilities and health professionals working in facilities reduce the risk of falling for older residents. Access at < http://www.safetyandquality.gov.au/our-work/falls-prevention/falls-prevention-rac/>

4. Donald M. Berwick DM. Disseminating Innovations in Health Care. JAMA. 2003;289(15):1969-1975. A short journal article about disseminating innovation. Access at <http://www.ilr.cornell.edu/healthcare/Resources/upload/Berwick-Disseminating-innovations-in-health-care.pdf>