Victorian Institute of Forensic Medicine

Residential Aged Care Communiqué

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CONTENTS

EDITORIAL

Welcome to the first issue of the RAC Communiqué for 2015. This contains one new case that you are probably already aware of involving a failure to disclose a reportable death of a resident to the Coroners Court of Victoria. The case raises many issues some of which include open disclosure, the reporting of deaths to the coroner, organisational culture and, the management of persons with dementia and their environment. The title of the case, 'truth will out', is a phrase from Shakespeare's The Merchant of Venice (1596) teaching us that the truth will always be discovered.

These are core matters for all providers and staff of Residential Aged Care Services to consider and reflect upon. We are fortunate to have A/Prof David Ranson, one of our most experienced forensic pathologists in Australia walk us through the case, and explain aspects of the investigation.

There is an enlightening commentary from Cathy Balding who has written, researched, practiced and advised about governance and quality of care. Lyndal Bugeja gives a brief overview of the death investigation process at the Coroners Court of Victoria and Elizabeth Beattie has a practical analysis and discussion of the management of people with dementia who like to walk.

I remind our readers that our sister publication has returned and another issue is due out shortly so remember to subscribe to the CLINICAL COMMUNIQUÉ, at www.vifmcommuniques.org/subscribe.

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Next issue: May 2015

MONASH University

A Victorian Government initiative

State Government Victoria

CASE #1 But at the length truth will out

Case 2011/2017
Case Précis Author: A/Prof D Ranson, VIFM and Monash University

Clinical Summary

Ms M was a 76 year-old female living at a metropolitan located Residential Aged Care Service (RACS). Past medical history included severe vascular dementia and this was complicated by coexisting medical conditions including hypertension, ischaemic heart disease, and atrial fibrillation. Ms M had a tendency to wander and the RACS staff were aware of and managing this behavior.

To complicate matters further, Ms M also had a history of falls and a month earlier had had a lifestyle/care plan review as a result of an increase in the number of falls. Following the review, Ms M wore hip protectors and arrangements were in place to ensure that she was assisted while walking and transported in a wheelchair if she had to move a longer distance.

On this particular autumn day, in the afternoon, Ms M went for a walk outside of the dementia unit. The unit was situated on the ground floor with access to an internal courtyard, which contained a decorative water-filled fountain in a pond of water. Sometime later, Ms M was found dead in the courtyard lying at the fountain.

The RACS manager told a nurse to ring the doctor and family saying "she's gone" and that it was too late for any medical intervention. A tub chair was used to help transfer Ms M from the fountain to her room, whereupon another carer dried and re-clothed her in preparation for the family.

Openness and transparency is a vital part of our health care system.

Ms M's General Practitioner (Dr E) was contacted by the RACS and informed that she had been found dead in the courtyard. Later that day Dr E attended at the RACS to verify the fact of death and examined Ms M who by that time had been placed back in her room. Dr E subsequently provided a death certificate that indicated a natural cause of death. The family members were informed that Ms M had died from a heart attack while in the courtyard. Ms M was collected by undertakers and subsequently embalmed as the death was initially not reported to the Coroner.

Subsequently, an allegation was made via the Nursing Federation and the death was reported to the Coroner.

A staff member (Ms SM) had seen Ms M in the courtyard and had observed her lying face down in the pond. This staff member independently contacted the coroner, via. the nurses union, concerned about the circumstances of the death as no incident report was made in the resident's record and the death had not been reported to the Coroner by either the general practitioner or the RACS management.

Pathology

An autopsy was conducted and the cause of death determined by the Coroner was *"Immersion (with underlying cause undetermined in circumstances of a fall into a courtyard water feature)"*.

Investigation

A police investigation was commenced on the instructions of the Coroner. During this investigation it became known there was a close circuit television camera directed at the courtyard. The recording was collected and reviewed. This footage revealed that Ms M had been walking unattended in the courtyard when she tripped over a garden light and fell headfirst into the pond. Approximately 50 minutes later she was found by staff and removed from the pond and brought back inside the unit.

The forensic pathologist who completed the autopsy found insufficient natural disease to account for Ms M's death. Noting that it can be extremely difficult to identify features of drowning at a post-mortem examination even in ideal circumstances, but where the processes of embalming have been performed, the determination of drowning at a subsequent autopsy is made almost impossible.

The pathologist identified a bruise to the forehead and considered two main possibilities. Firstly that Ms M had died as a result of immersion/drowning by being rendered unconscious from the blow to her head when she fell into the pond or secondly that she had suffered a reflexive cardiac arrest as a result of her face and airway being exposed to cold water during the immersion.

Two years after Ms M's death an Inquest was held. The coroner considered in some detail the circumstances of the death of Ms M including; how the reporting of the death to the coroner was delayed and; how Ms M came to fall and die in the pond. The Inquest took six days with evidence heard in court from a large number of witnesses including; RACS senior management, manager (Ms C), nursing and ancillary care staff, the deceased's general practitioner, and members of the deceased's family. Significantly, evidence was heard to the effect that some RACS staff were threatened that they would be sacked if they mentioned what had happened.

Also, the nurse in charge changed her statement when giving evidence explaining she was *"confused"* and given the police presence at the time, she was *"scared, like I was shocked, I was scared"*. The nurse in charge did not write an incident report and claimed that she was told by the facility manager to inform staff they would be sacked if they mentioned anything about how Ms M died. She claimed she was stood over by the facility manager to write false entries and records. The coroner found aspects of her evidence were concerning and unsatisfactory including falsifying the dispensing of medication and progress note record.

If a culture of secrecy or cover-up exists or if health care staff feel under duress with regard to speaking out regarding care issues there is a risk that adverse health care events will not be documented or subject to quality review.

The Coroners Prevention Unit undertook a review of the protocols in place at the RACS and the modification made in response to Ms M's death. The coroner noted that a range of safety measures had been implemented by the RACS prior to the inquest and these included; removal of objects from the courtyard capable of tripping residents, removing water from the courtyard pool and filling it with rocks, training for all staff on their legal responsibilities to accurately report and document any adverse event, amendment to the mobility and risk audit tool used to develop residents' lifestyle care plans, review of staffing levels to meet residents needs, safety and comfort, a review of the processes for monitoring and supervising residents in the courtyard, and additional staff training in ethics, medication management and legal requirements relating to documentation and health records.

Coroner's Comments

The Coroner stated that; *"As for the whistleblower Ms SM, she was sacked by Ms C on the basis that her probationary period had proven unsuccessful; in effect for an alleged breach of confidentiality in speaking up regarding the truth about the death."* In regard to some of the evidence the Coroner went on to say; *"There were some competing, inconsistent and sometimes unedifying accounts and explanations and the factual conflict left me in some doubt about the degree of knowledge and complicity of some staff"*.

At paragraph 6 of her finding the Coroner stated; *"The death of Mrs M was complicated by breaches of policy and procedure at [RACS].*

Indeed the actions of some staff amounted to little more than a cover-up with Dr E being called to attend the facility and certified the death of her patient without being fully informed by staff of all that had actually occurred. The family were similarly kept in the dark about the true surrounding circumstances and not surprisingly, they were left somewhat bewildered and concerned by the unfolding investigation."

The coroner found that there was a lack of understanding regarding the need to report certain deaths to the coroner making the point that if a fall was involved in causing the death then it should have been reported.

In addition it was identified that in order for nursing staff to rely upon the general practitioner reporting the death, the doctor would need all relevant information.

The coroner commented on the Victorian Department of Health publication *'Dementia friendly environments: a guide for residential care – gardens and outdoor spaces checklist'* and how many of these recommendations had now been implemented although concern remained regarding a number of features such as the continued presence of the fountain/ pool base in the courtyard.

The coroner was particularly concerned with how a range of staff were able to participate in the 'cover-up' and how staff from culturally and linguistically diverse (CALD) communities could be more susceptible to manipulation and exploitation unless strong organisational moral values were actively upheld by employers.

Coroner's Findings & Recommendations

There were three recommendations. First, that RACS improve the governance of reporting, monitoring and recording residents' deaths. Second, that the RACS adhere to the Department of Health checklist regarding dementia-friendly environments recommendations about outdoor spaces. Third the Australian Government Department of Health and Ageing (now Department of Social Services) Aged Care Complaints Scheme undertake an investigation into the actions of the facility once the activities undertaken by registered and unregistered staff regarding this death were known. The investigation should include whether referral to appropriate agencies to review individual professional registration(s) is a reasonable expectation within the Aged care Act 1997 and certified provider receiving subsidies by the Australian Government.

Response to Coroner's Findings & Recommendations

Some three months after the delivery of the Coroner's finding the RACS owners responded to the coroner's recommendations and together with the coroner's findings this response was published on the Coroners Court of Victoria's website.

If these agencies are excluded from reviewing adverse events and deaths due to a failure of reporting then the consequences for individuals in aged care could be dire.

The RACS responded to the effect that they had implemented the coroners recommendations including; amending their verification of death assessment form regarding falls and the need to report such deaths to the coroner, updated their employee information guide, implemented a monthly audit of the circumstances of the deaths of residents to ensure appropriate reporting of deaths to the coroner, landscaping of the courtyard to entirely remove the water feature and to extend the lounge room to enhance the visibility of the courtyard, reviewed their management and team structures, reviewed their rosters and working arrangements and implemented a 'values roadshow' to demonstrate key behaviours to staff.

The RACS also responded to the Department of Health And Ageing, Aged Care Complaints Scheme request for information on how the facility had responded to the coroner's recommendations. This response also included copies of the facilities notifications to AHPRA regarding the actions of staff in relation to the death.

Editor's Comments

This case raises a number of significant issues for aged care facilities. Openness and transparency is a vital part of our health care system. If a culture of secrecy or cover-up exists or if health care staff feel under duress with regard to speaking out regarding care issues there is a risk that adverse health care events will not be documented or subject to quality review. Independent investigatory agencies such as the Coroners Court provide a vital review process that can help to ensure patient safety and the provision of appropriate quality care. If these agencies are excluded from reviewing adverse events and deaths due to a failure of reporting then the consequences for individuals in aged care could be dire.

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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.

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COMMENTARY #1

CULTURE AND GOVERNANCE

Cathy Balding MHA, PhD, FCHSM,
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Adjunct Associate Professor,
La Trobe University School of Public Health

The most dramatic recent international example where organizational culture and governance failed older people happened in the UK at the mid-Staffordshire Trust. Between 2005 and 2009 the hospital received multiple complaints and there was a significant rise in patient mortality, leading to a large public inquiry (Francis Report). Not only did many patients unnecessarily lose their lives, but basic care at the bedside deteriorated to such a point that thirsty patients were reduced to drinking out of flower vases.

One of the (many) key findings was the executive and management focus on achieving financial and other external targets and standards at the expense of the wellbeing and safety of patients. Although, this occurred in another country and in a large hospital, it reminds us all about the complexities and challenges of providing safe effective health and aged care (often termed 'human services'). Equally, it illustrates the common lack of appreciation of the enormity of these challenges.

The lack of a purposeful direction, roles, responsibilities and support for achieving high quality care means that the fate of those who place their lives in the hands of those running the organisation is largely up to the discretion of individuals.

There are many demands and distractions in the provision of human services. Boards, Executives and Managers are required to juggle a complicated funding system with a rapidly evolving population, growing consumer demands and limited resources. Setting priorities requires balancing the financial side of the business with the business of care.

In this environment it is important for boards and Executives to be vigilant and recognize when the care provided in a human service becomes a by-product of the business, rather than core business, as occurred at mid-Staffordshire.

The Board sets the 'tone from the top'

Staff take their cues from the top, and notice what gets rewarded. If 'doing the right thing' is seen to be about saving money, reducing staff and improving efficiency, that will be the primary focus of the manager, no matter what the company emails and brochures say about 'caring' or 'safety'.

A key component of governance is accountability

If we want staff to behave in a certain way, and pursue a high standard of care for patients and residents, then the Board and Executive must define this expectation in clear and concrete terms, support managers and staff to achieve it and hold them accountable for the results. This may appear to state the blindingly obvious, however, organisational definitions of high quality point of care that shape the way daily work is done are not yet common in human services.

In the absence of this guidance, the standard of resident care, and corresponding staff behaviour, becomes dependent on individual managers and influential staff. The lack of a purposeful direction, roles, responsibilities and support for achieving high quality care means that the fate of those who place their lives in the hands of those running the organisation is largely up to the discretion of individuals. It also leaves staff exposed when catastrophes occur, as they lack clear organisational principles and signposts to guide their decisions and behaviour.

Creating safe, high quality care in the complexity of human services is difficult and requires understanding, training, focus and vigilance.

The culture of an organisation is never more tested than in times of stress and at these times it is a challenge to maintain compassionate and rational decision-making. In a culture of conflicting organisational signals, expectations and priorities staff may make decisions inconsistent with their professional values. This can lead to a culture, described in the Mid Staffordshire Review Report as *"inwardly focused and complacent, resistant to change and accepting of poor standards."*

Creating safe, high quality care in the complexity of human services is difficult and requires understanding, training, focus and vigilance. It requires a culture that sets safe, high quality care for every consumer as the ultimate destination, based on organisational values, and provides active support for achieving it. Efficiency, caring and safety don't have to be mutually exclusive, and managers probably don't intend them to be. But Boards and Executives may drastically underestimate the power of the messages they send about what's important, and the staff beliefs and behaviours they create by what they measure, reward – and punish.

Providing consistently safe, quality aged care is not as easy as some tend to think. Good care is more than the absence of bad. It requires more than good staff trying hard. Of course, good staff are important, but they are one piece of the puzzle which must also include high level strategic planning, dedicated leadership and skilled and supportive management. Achieving this in a competitive, resource-constrained environment is one of the greatest challenges any board and executive faces.

If you want to read the official report, the reference is:

Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust. January 2005 – March 2009. Chaired by Robert Francis QC, 2013. www.midstaffsinquiry.com

COMMENTARY #2

WALKING, WAYFINDING OR WANDERING

Professor Elizabeth Beattie
(RN, PhD, FGSA) Director,
Dementia Collaborative Research Centre: Carers and Consumers and Professor of Aged Care and Dementia, School of Nursing Queensland University of Technology.

Wandering refers to excessive and frequent walking associated with impaired wayfinding. People with dementia who wander may get lost unless accompanied, are often unable to sit down and rest and frequently cannot adequately evaluate and appreciate the potential risk of physical and emotional harm in some circumstances, e.g. in crossing busy roads, entering bodies of water, entering the private spaces of others, engaging with strangers. By contrast, independent, safe walking can potentially have positive effects.

Ms M's case report indicates she had a tendency to wander that the RACS staff were "aware of and managing", and a recent history of repeated falls. Following clinical review she was to be "assisted while walking and transported in a wheelchair if she had to move a longer distance". Clearly the management strategies in place were ineffective in preventing her courtyard fall and the timely discovery of what had occurred.

A simple pedometer can be used to work out at what times of the day the resident is walking the most and may need additional supervision.

All RACS residents with dementia need to have their wandering profile evaluated using a wandering history obtained from reliable informants and the resident where able. This history needs to include information about typical physical activity levels and sleep duration, historical and current exercise and leisure activities involving walking and details of any events when the person became lost and was unable to return safely on their own.

Additionally, staff can evaluate wandering status using the Revised Algase Wandering Scale NH Version, the only tool specifically designed to evaluate the behaviour. A simple pedometer can be used to work out at what times of the day the resident is walking the most and may need additional supervision.

Where a resident who wanders is evaluated as being at risk of falls and is still able to get up and walk unsupervised, additional caution needs to be used.

Physical and chemical restraint to manage excessive walking is poor clinical practice unsupported by high quality evidence.

One of the most effective strategies is staff education and role modelling by an expert clinician to know how to provide both discreet close supervision of the resident who actively wanders AND activities that engage the resident.

Supporting independent and safe wandering means working as a team and knowing the resident well- their wandering status, usual walking habits and favourite areas of rest and movement within the facility-and appreciating the elements in their environment that give them pleasure.

It also means having a clear staff plan to provide supported activities involving walking, and maintaining a systematic, effective way of knowing where the resident is at regular intervals, with 10-15 minutes considered appropriate for a person considered a low falls risk.

Increasingly, facilities are using wireless and other technologies to monitor exits - an exit monitor at the courtyard door would have alerted staff that Mrs. M was not only up and walking without support but had exited the building into the courtyard and the unsupervised pond area.

Although monitored on the existing video surveillance her unaccompanied walking was not acted upon in a timely way. There was a reported 50 minute delay between her entry to the courtyard, trip and fall into the pond and when she was found. Events after her discovery, discussed elsewhere, only compounded the tragedy.

There is an understandable tension in RACFs between imposing restrictions on the movement of residents who wander and being able to keep residents safe

High quality dementia care demands physical and social environments that support safe walking, engage the senses and provide pleasure and relaxation. Interaction with the natural world- especially water- can be soothing to many residents. Filling the empty pool with rock creates another potential hazard were a resident to fall.

One of the most effective strategies is staff education and role modelling by an expert clinician to know how to provide both discreet close supervision of the resident who actively wanders AND activities that engage the resident. With a resident who loves the outdoors and water, water play can be easily integrated into daily activities and visitors can be encouraged to be involved.

There is an understandable tension in RACFs between imposing restrictions on the movement of residents who wander and being able to keep residents safe- that is, between resident autonomy and independence and staff duty of care. Early discussions with RACF clinical leadership, the resident where able, and their legally responsible representative/s can help ensure that plans put in place are realistic, responsive and designed to avert preventable negative outcomes while enhancing daily quality of life.

COMMENTARY #3
DEATH INVESTIGATION

Dr. Lyndal Bugeja, PhD,
Manager, Coroners Prevention Unit,
Coroners Court of Victoria

This is a brief overview of the death investigation process at the Coroners Court of Victoria (CCOV).

Reporting

Any person can make a report to the Coroners Court of Victoria if they suspect a "reportable death" has occurred.

Each report is presented to the Duty Coroner by the Duty Forensic Pathologist to confirm that the death meets the definition of "reportable" and make decisions about the forensic medical and scientific procedures that are required to determine the medical cause of death.

Investigation

Once the cause of death has been established, where possible, the Coroner makes directions about whether they require any further evidence to assist them to make a finding. This evidence is typically gathered by members of Victoria Police, who are the Coroners' investigators.

This evidence may take the form of a sworn statement from the Coroners' investigator or a more substantial coronial brief comprising individual statements from witnesses, family members, medical practitioners, managers and staff at the point of care. Based on a review of this material the Coroner may: (a) seek further specialist advice either internally from the Coroners Prevention Unit and / or externally in the form of an expert opinion. AND /OR (b) hold a mention hearing, directions hearing or inquest OR (c) complete their finding without inquest.

Finding

The Coroner must make a finding that includes: the identity of the person, the cause of death and information to enable death registration. The Coroner may also include information about the circumstances in which the person died and may make comments or recommendations on public health and safety or the administration of justice.

Responses to recommendations

If the Coroner makes a recommendation to a public statutory authority or entity, they must respond in writing about what action has or will be taken. This response must be provided within three calendar months. This response, and the Coroners' finding must be published on the CCOV's website.

RESOURCES

CULTURE AND GOVERNANCE

1. ACSQHC, Draft guide for organisations implementing the National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Healthcare, Sydney, 2014. At www.safetyandquality.gov.au (Not specifically written for aged care, but Standard One describes best practice governance applicable to all health and human service organisations).

2. Taking safety on board: the board's role in patient safety www.health.org.uk/publications/taking-safety-on-board-the-boards-role-in-patient-safety (Not written specifically for aged care, but the principles and practices are equally relevant).

3. Balding, C, Strategic Quality System Overview. Qualityworks PL, 2014. (Available at no cost on request – email: cathyb@qualityworks.com.au).

4. Governing Quality in public sector residential aged care: An organisational readiness tool. This could be used by any aged care organisation and has been specifically developed to improve governance for care safety and quality in RACS. At http://www.health.vic.gov.au/agedcare/publications/governing_quality.htm

DEMENTIA FRIENDLY ENVIRONMENTS

1. Gardens and outdoor spaces checklist. Good practice for quality dementia care. At: http://www.health.vic.gov.au/dementia/strategies/gardens-outdoor-spaces-checklist.htm. This link leads to the Dementia Friendly Environments homepage, which contains other aspects and guides for a dementia friendly environment, in addition to the checklist.

2. Fleming, R, 2011. An environmental audit tool suitable for use in homelike facilities for people with dementia. Australian Journal on Ageing, 2011, 30:108 – 112.

3. Moore, K, et al, 2011. The state of physical environments in Australian residential aged care facilities. Australian Health Review, 2011, 35:412 – 417.

WALKING, WAYFINDING OR WANDERING

1. Algase DL, Moore D Helen, Vandeweerd C, Gavin-Dreschnack D and the IWC (2007) Mapping the maze of terms and definitions in dementia-related wandering. (2007) Aging and Mental Health. 11 (6):686-98.

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3. Beattie, E. (2010) Safer Walking for People with Dementia https://fightdementia.org.au/sites/default/files/helpsheets/Helpsheet-DementiaQandA09-SaferWalkingForPeopleWithDementia_english.pdf

4. Dementia Collaborative Research Centre: Assessment and Better Care (2012) Behaviour Management - A Guide to Good Practice Managing Behavioural and Psychological Symptoms of Dementia (BPSD) Module 12: Wandering. pp.178-188. http://dbmas.org.au/uploads/resources/DBMAS_Guide_21_05_12.for_USB_pdf.pdf.

5. United Kingdom Alzheimer's Society factsheet on walking http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1790

6. Futrell, M., Melillo, K.D., & Remington, R. (2010). Evidence-based guideline: Wandering. Journal of Gerontological Nursing, 36(2), 6-16.

7. US Alzheimer's Association Alzheimer's and Dementia Caregiver Centre website. At http://www.alz.org/care/alzheimers-dementia-wandering.asp