RESIDENTIAL AGED CARE CORONIAL COMMUNIQUÉ

A Victorian Government initiative

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Next Edition: March 2007
'Falls in Residential Care'

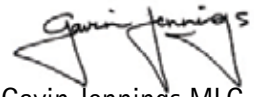
GPDV GENERAL PRACTICE DIVISIONS VICTORIA

FOREWORD FROM THE MINISTER FOR AGED CARE

Safety is a core feature of any strong service system, and the Victorian Government places a high priority on safe and quality care for older people.

In achieving this aim, the coronial system provides valuable information that helps to save lives and reduce accidents. The Residential Aged Care Communique highlights significant issues that impact on the safety and well-being of older vulnerable Victorians.

By sharing information and learnings from the coroner's office to the aged care community, we trust that this publication will assist all residential aged services and associated healthcare professionals to explore opportunities to refine and improve the safety and quality of care for residents.



Gavin Jennings MLC
Minister for Aged Care

WELCOME

Welcome from the State Coroner of Victoria, Graeme Johnstone and the Deputy Director of the Victorian Institute of Forensic Medicine, David Ranson, to the inaugural edition of the Residential Aged Care Coronial Communiqué. This is the sister publication to the Coronial Communiqué, a newsletter to promote patient safety in the acute health sector published by the Clinical Liaison Service (CLS).

CLS commenced its role at the Coronial Services Centre (CSC) in August 2002 as a joint initiative of the State Coroner's Office and the Victorian Institute of Forensic Medicine. The primary role of CLS is to assist the coroner with the medical aspects of investigating deaths that occur in a health setting. CLS is funded by the Department of Justice

This specialised edition of the Residential Aged Care Coronial Communiqué focuses on issues relevant to Aged Care that arise during the investigation of the death of older persons. The environment of Residential Aged Care is a challenging one and we want this Communiqué to help us to work together in promoting better care and learning lessons from the deaths we see at the State Coroner's Office.

The key theme of this issue is the use of physical restraint. There are summaries of two case studies highlighting the need for policies and procedures, and looking at care practices and bed rails. There is also a summary of evidence about the appropriate clinical use of restraint and finally, an overview of a research project completed this year on restraint deaths notified to Coroners' Offices in Australia.

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ACKNOWLEDGEMENTS

This initiative has been made possible by the collaboration of a diverse range of organisations brought together by people who are motivated to improve our community: The Department of Justice, the Victorian Institute of Forensic Medicine, the State Coroner's Office, Clinical Liaison Service, Department of Human Services - Aged Care Branch, the Australian Centre for Evidence Based Aged Care, Monash University, General Practice Divisions Victoria.

FEEDBACK

The CLS 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**

A POLICY FOR PROCEDURES AND PRACTICES RELATING TO RESTRAINTS

CASE NUMBER 157/99

Precis Author: Carmel Young
Clinical Research Nurse (CLS)

Ms V, a 68 year old female with a medical history of Huntington's chorea and dementia was living at a residential aged care facility. This facility catered for older people with a psychiatric illness, who require a high level of care. Ms V displayed significant behaviours of concern and was prescribed a range of medications, including antidepressants, anticonvulsants and sedatives with little improvement in her behaviour. Medical and nursing staff determined that it was necessary to adopt techniques of physical restraint.

At the time, the facility was trialling a restraint device known as a 'Zip-a-Bed' or 'cocoon'. The device comprises; a lower and bottom sheet and is used to prevent patients from falling out of bed. 2-3 hours after being placed in the Zip-A-Bed device, Ms V was found dead. Her body was located on the side of the bed with her arms, shoulders and upper torso outside of the strap and doona part of the Zip-A-Bed.

The cause of death following an autopsy was determined to be:

"Postural asphyxia in a woman with Huntington's Chorea wearing a therapeutic restraint". The forensic pathologist explained that, "death occurred as a consequence of abnormal position within the bed whilst restrained and most probably contributed to by the abnormal movement which occurs in Huntington's Disease"

INVESTIGATION

The coroner reviewed the use of restraint and the subsequent documentation. It was found that the facility had recorded the use of physical restraint used during the daytime but did not record similar information during the night. Whilst the Zip-A-Bed was on trial there were written comments by staff that the "cocoon appears inappropriate" and that it "wasn't used overnight".

During the inquest it became evident that the doctor was unaware of the restraint devices that were used by the nursing staff and that there was no standard for the monitoring of residents whist in a restraint device. The investigation also found that the doctor merely "rubber stamped" nursing staff recommendations by providing a general authority on the date of admission and did not exercise his own medical judgement about relevant matters.

FINDINGS AND RECOMMENDATIONS

The Coroner made the following observations:

"The decision of whether a patient ought to be physically restrained or not, involves a delicate balance of matters of personal safety of the patient on the one hand, with other issues of patient dignity, liberty and staff safety on the other hand."

- No evidence that use of restraint during the day or at night was inappropriate.
- A need for a regular and thorough medical and nursing assessment and review of the physical and psychological needs of the patient over time.
- A need for adequate recording of bed restraint selection, implementation and monitoring
- A decision regarding regular monitoring of residents being restrained needs to be made and documented,
- In summary, it is important to "ensure procedures and practices relating to restraints are uniform and best practice."

AUTHOR COMMENT

This case highlights the need to have clear policies and procedures about the use of restraints, the observation required whilst a resident is being restrained and the level of documentation to support these decisions. The policies and procedures about restraint use must include the need for thorough medical and nursing assessment at initiation of restraint and regularly thereafter.

RESPECTING RESIDENT CHOICE

CASE NUMBER 415/00

Precis Author: Amanda Charles
Clinical Research Nurse (CLS)

Mrs R, an 82 year old female was admitted to an acute hospital with a recent stroke causing left sided weakness. After a short stay in the acute hospital, Mrs R was transferred to a subacute geriatric service for rehabilitation.

Mrs R had already appointed an Enduring Power of Attorney to oversee her financial affairs who had also been involved in sanctioning the use of bed rails and a chair restraint for Mrs R, as required.

One night, Mrs R requested that the rails of the bed be left down. The nurse made certain a commode chair and the nurse call bell were within easy reach.

Later that night, the duty nurse heard a sound from Mrs R's room. The nurse found she had fallen and was on the floor with a small laceration to the head.

The laceration was dressed, the on-call doctor notified and neurological observations commenced. Mrs R's condition deteriorated and became unresponsive. An urgent transfer to the acute hospital was organised and a CT scan of the brain showed a large subacute subdural haemorrhage which caused her death the next day.

INVESTIGATION

The cause of death was determined as a subdural haemorrhage sustained in a fall with contributing factors of cerebrovascular disease, warfarin treatment and ischaemic heart disease.

Mrs R's Enduring Power of Attorney raised concerns that the sides of the bed should have been raised to prevent this fall. An inquest was held investigating these concerns.

The Aged Care Centre operated under the "policy of least restraint" for people who were "high risk" of falls. The policy stated "*the decision to restrain should take into account the client/residents civil rights and should reflect a balance between duty of care and the individual's rights to a degree of risk taking*".

An expert opinion of a consultant geriatrician was given about the desirability and efficiency of utilising bed rails. The expert said "***there is no clear consensus supporting the use of cot sides in conscious patients at risk of falling in either hospital or residential care settings***".

FINDINGS

The coroner acknowledges the need to balance respect for the resident's wishes with the potential for causing agitation by refusing her wishes. The coroner made reference to this being a matter of the professional judgement of the carer at the time of the request.

In view of this approach, the coroner did not support the notion that by leaving the bed rails down the nursing staff were negligent in their care of the deceased.

EVIDENCE IN SUPPORT OF RESTRAINT-FREE CARE

Professor Rhonda Nay
Director Gerontic Nursing Clinical School and ACEBAC

When I am teaching nursing students about restraint, I invite each student to have their colleagues tie them up in a public place. All who engaged in the activity said they would never restrain a resident again! Many found the activity too confronting and simply could not do it. Most residential care staff are caring and committed and want to do the right thing. So why do we still restrain residents?

The most common rationale provided is that it is 'to protect residents from falling and from injury'. But the evidence tells us that restraint is actually associated with more serious physical injury – not to mention psychological trauma. Using drugs to restrain is equally abusive of human rights. Restraint can only be justified for short term use when there is an imminent threat of injury or death.

Our duty of care is to the person. This includes their 'soul' not just their femur! Restraint can sometimes be viewed as an assault on the person and an indication of our failure to find more appropriate care solutions.

We may argue that families demand the use of restraint or that we fear litigation. Explain to families that people are less likely to suffer serious injury if they are not restrained, as restraints themselves can cause injury. If you apply the evidence to justify not restraining and demonstrate all of the more appropriate strategies you have used, you can stop worrying about litigation.

You cannot guarantee accidents and injury will not happen, but you can guarantee to support the dignity, human rights and needs of a resident.

Evidence based falls guidelines can assist: http://www.health.vic.gov.au/qualitycouncil/downloads/falls/guidelines.pdf.

Residential care has improved significantly over recent years – there is now an expectation that practice is based on good evidence. Evidence is available to support restraint free care – we have included some links to the evidence on the ACEBAC web site http://www.latrobe.edu.au/acebac/.

DEATHS REPORTED TO THE CORONER'S OFFICE LINKED TO PHYSICAL RESTRAINT USE IN OLDER PERSONS IN AUSTRALIA 2000-2005

Dr Alison Semmonds
Geriatric Registrar

The use of physical restraint is a potentially dangerous practice that may cause or contribute to the death of the person being restrained. Any deaths linked to the use of a physical restraint in Australia must be reported to the Coroner's Office.

Despite increasing evidence that physical restraints can cause injury and death and that removal of restraints does not increase the incidence of falls, physical restraint use, especially in older persons, remains a common practice.

A study was designed to determine the extent and nature of deaths linked to physical restraints in Australia in the five years from 2000 to 2005. A summary follows.

Deaths were identified using the National Coroner's Information System (NCIS). This is a systematic, standardised electronic database containing details of deaths reported to the Coroner's offices from all Australian states and territories from July 1st 2000 [Queensland January 2001]. The search included all reported deaths in persons older than 65 years associated with restraint use in hospitals, hostels and nursing homes. Each case summary was reviewed to determine the potential contribution of the physical restraint to the person's death.

Twenty one deaths were identified with a potential link to the use of physical restraint. Closer examination of the cases revealed restraint was directly implicated in the cause of four deaths. These four cases had the following similar features;
(a) deaths were caused by asphyxia, two from a belt or sash compressing the neck and two from being trapped in the mesh webbing of a bed restraint, (b) the deceased were unsupervised at the time of the incident and (c) all had a diagnosis of dementia.

Significantly, in seven cases the use of restraint was ineffective in preventing a fatal injury. The types of restraint in these cases varied. Five of the seven patients had a diagnosis of confusion or dementia.

In one case the Coroner specifically recommended using bed rails in radiology practices.

In the remaining cases risks and benefits of physical restraint, the use of a tracking device, doctors, nurses, family and carer understanding of restraint use was commented on.

The use of physical restraint remains a highly emotive and sensitive issue. This study clearly demonstrates that a treatment perceived to be beneficial has the ability to cause death. The number of deaths is likely to substantially underestimate the true nature of this problem. Better information is required and this can be achieved by ensuring all restraint deaths be reported to the Coroners. This will assist in identifying prevention strategies for the future and promote better care for older people.

I would like to acknowledge Ms Marde Hoy, NCIS Applications Officer, Professor Joseph Ibrahim, Clinical Liaison Service and Magistrate Jane Culver NSW.

RESOURCES

Australian Society for Geriatric Medicine
http://www.asgm.org.au/documents/POSITIONSTATEMENTNO2.PhysicialRestraint-Revision.pdf

National Ageing Research Institute Report
http://www.mednwh.unimelb.edu.au/research/pdf_docs/Restraint_Pamphlet_family_members.pdf

Decision-Making Tool: Responding to issues of restraint in Aged Care
http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/ageing-decision-restraint.htm/$FILE/decisiontool04.pdf

Physical Restraint - Part 1: Use in Acute and Residential Care Facilities
http://www.joannabriggs.edu.au/best_practice/bp11.php?mode=TEXT

Best Practice Volume 6, Issue 4, 2002
ISSN 1329 – 1874

Physical Restraint - Part 2: Minimisation in Acute and Residential Care Facilities
http://www.joannabriggs.edu.au/best_practice/bp12.php

Guidelines for working with people with challenging behaviours in residential aged care facilities - using appropriate interventions and minimising restraint
http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf

National Patient Safety Agency UK
www.npsa.nhs.uk/display?contentId=3550

The Clinical Liaison Service Website and copies of the Coronial Communiqué
http://www.vifm.org/research_cls.html

The Work-related Liaison Service website and copies of WorkWise
http://www.vifm.org/wrls.html

All cases that are discussed in this 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 individual clinicians and hospitals are de-identified. However, if you would like to examine the case in greater detail, we have also provided the coronial case number.