

RESIDENTIAL AGED CARE

CORONIAL COMMUNIQUE



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Next Edition: June 2007
'Choking'

EDITORIAL

Welcome to the second issue of the Residential Aged Care Coronial Communique and the first for 2007. The theme of this issue is the assessment, management and prevention of falls that contribute to death. To this end, Professor Rhonda Nay (Professor of Gerontic Nursing, LTU Gerontic Nursing Clinical School) has the following message:

"We know old age is a significant risk factor in falls and that older people are more likely to fall in the last couple of years before death. Some falls are probably unavoidable, especially if we are to support the dignity of residents, but, and it is a big BUT, we have to question whether we are really putting in the best effort.

It used to be accepted that old people and senility went hand in hand; now we know better. Ask yourself what you do to mitigate the risk of falls. Do you evaluate what you do for an individual and revise it if a person is still falling; do you collect summary data for the whole facility and evaluate and revise practices if the facility is not achieving a reduction in falls?

If your evaluation shows that a particular resident usually falls in the shower then the RN needs to go into the shower and find out why this is happening. It may be that the resident does not have sensory aids available in the shower; the lighting may be poor; the overall bathroom design may be flawed or the cleaning products may be leaving the floors slippery. Care management must be prioritized so that the RN's assessment skills are put to best use – look at what else you can delegate safely to allow time for good assessment and planning.

The evidence on falls prevention is compelling, and we have excellent falls prevention guidelines, but we still have way too many falls. What we need is a way of getting those guidelines translated into everyday practice. Nurses in residential care have always been innovative and most really do want to provide quality care. Those facilities that have designated champions who can get other staff onside and involve as many stakeholders as possible tend to have most success.

Make sure you are an inspirational role model – show that you are aware of the evidence; know when to refer and to whom; scan the environment and advise staff of clutter; check residents' shoes and explain to staff how shoes can reduce or prompt falls; use staff meetings to talk about how important it is to assist residents to the toilet and either avoid/ or immediately remove any spillage from the floors. If you are lucky enough to be sharing drug administration with an endorsed Div 2, use your time more effectively to discuss with doctors any medications that may be increasing falls risks.

Practice change generally requires multiple strategies – so don't just bring out a policy and assume it will work. Show your Board/ CEO and staff how they can reduce falls AND invest the saved time and money back into incentives to encourage ongoing better practice."

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All publications produced by the Specialist Investigations Unit, including the Residential Aged Care Coronial Communiqué and the original Coronial Communiqué can be found on our website at <http://www.vifm.org/n962.html>

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

FALLS INVESTIGATION STANDARD

CASE NUMBER 3721/03

Precis Author: Adam O'Brien
FACEM, Clinical Liaison Service (CLS)

CLINICAL SUMMARY

Ms L was a 94 year old female who lived at a Residential Aged Care Facility (RACF) for three years with a past medical history including a hip joint replacement and short-term memory loss. Physically, she was independent in her mobility using a walking frame.

In 2003, she had an unwitnessed fall in the dining room at the RACF and was sent to hospital. A fractured pelvis was diagnosed and she was admitted for 6 weeks rest in bed. In the hospital Ms L became confused and was refusing to eat. All attempts to feed and hydrate her were unsuccessful and she died 15 days after the fall.

PATHOLOGY

The family's objection to an autopsy (known as a Section 29) was granted. Therefore, the cause of death was determined from the clinical diagnosis. The cause of death was bronchopneumonia with contributing factors of general frailty, dementia, cerebrovascular disease and a recently fractured pelvis.

INVESTIGATION

An investigation was required because the fall causing the fractured pelvis directly contributed to the death. An inquest was necessary to ascertain the circumstances leading to the fall of and management of Ms L.

The RACF explained that a falls risk assessment using the FRAT (Falls Risk Assessment Tool) had been completed, on the deceased seven months before this fall. The risk assessment indicated Ms L was in the medium risk category (score 14/20; 15 or more indicates high risk).

At the time, the RACF was part of a wider group that allowed its various homes to determine their own strategies for assessing and managing falls risks.

The Manager was of the view that a formalised program covering all the homes was necessary and accordingly appointed a Risk Management Co-ordinator to look at a systemic and holistic organization approach to risk management.

CORONER'S COMMENTS

Prior to this death the State Coroner's Office with the Clinical Liaison Service had invited a number of agencies associated with falls management to develop a collaborative Coroners 'Investigation Standard: Fall-related deaths'.

It was found that following receipt of the Standard the staff of the RACF sat down as a group to think "about what was being asked." The Manager stated that now, rather than focusing on the "scoring" system, the issue was about managing the risk: "if there is a risk, manage the risk". The RACF now adopted a "team approach" including the doctors, physiotherapist, family and care staff, in developing a "Care Plan" that "worked well for the individual."

CORONER'S RECOMMENDATIONS

The Coroner made two recommendations. First, that consideration be given to developing a comprehensive falls management program, guide or Code of Practice (or eventually a Standard), that as far as is practicable, applied to all RACFs. Secondly, this group of RACFs have a comprehensive and standardised program across all their homes.

AUTHOR COMMENT

The complete Coroners 'Investigation Standard: Fall-related deaths' is available at <http://www.vifm.org/cgi-bin/getObject.cgi?id=o412>.

KEY WORDS

- Clinical: adult, fall, residential aged care, metropolitan, management, policy
- Investigation; section 29, inquest, recommendations

DON'T MOVE, I'LL BE JUST A SECOND

CASE NUMBER 647/04

Precis Author: Amanda Charles
Clinical Research Nurse (CLS)

CLINICAL SUMMARY

Mrs M was an 70 year old female with a past medical history that included dementia, hypertension and epilepsy who resided in a nursing home. She was found to have fallen in the bathroom after she had been left alone for approximately 10 seconds. Mrs M was transferred to a metropolitan hospital with a suspected fractured neck of femur. Following the surgical repair of the fracture, her immediate recovery was complicated by a wound infection that required surgical debridement.

Once her condition had improved she was transferred to a sub acute facility for rehabilitation. During the rehabilitation

her condition deteriorated and following consultation with her family, Mrs M returned to the nursing home where she died a few days later.

PATHOLOGY

A full autopsy was conducted at the Victorian Institute of Forensic Medicine. The pathologist concluded the cause of death was bronchopneumonia and ischaemic heart disease in a person with dementia.

INVESTIGATION

The investigation was completed without the need for an inquest. The Coroners 'Investigation Standard: Fall-related deaths' was utilised in the investigation and which allowed for a more expedient resolution of the case. The time from the death to the date of the finding in this case was 8 months.

CORONER'S COMMENTS

In the finding the coroner referred to

the falls management protocols that were in place at the RACF, including the training of staff in falls minimization and prevention.

The Coroner made no specific recommendations.

AUTHOR COMMENT

This case highlights that forward planning is vital when residents are being toileted or showered and illustrates just how quickly falls leading to significant injury can occur. The facility had strategies in place to assess residents for falls risk and prevention of falls. These strategies had been followed and documented in the deceased's nursing care plan.

KEY WORDS

- Clinical: adult, fall, residential aged care, metropolitan, management, training/environment
- Investigation: autopsy, statements, chambers, comments.

FALLS PREVENTION – IT'S NO ACCIDENT.

Associate Professor Keith Hill,
Director, Preventive and Public Health
Division, National Ageing Research
Institute.

In many residential care facilities 50% of residents or more fall at least once each year¹, and this rate is substantially higher in some settings, such as dementia specific units. Many falls are the result of interaction between two or more intrinsic (health related) or extrinsic (environment or activity related) factors.

There has been considerable recent growth in the research evidence of effective strategies to minimise falls among older people, including:

- Multi-factorial interventions, which combine a number of approaches to reducing falls at the one time. In some successful studies, interventions have at least in part been selected based on a falls risk assessment². In others, a mix of interventions (eg staff training, monthly feedback of falls data, resident information sessions, environmental assessments, group exercise programs,

hip protectors) have been applied to all residents / staff, without tailoring of interventions using a falls risk assessment³.

- Vitamin D and calcium supplementation – many residents are vitamin D deficient. Vitamin D is important for a number of functions, including maintaining bone strength and muscle strength. The primary source of vitamin D is exposure to direct sunlight, and to a lesser degree diet. Vitamin D supplementation has been shown to reduce risk of falls⁴ and fractures⁵.

Hip protectors have also been shown to be effective in reducing fractures, but studies have consistently demonstrated difficulties with residents continuing wearing them long term⁶.

Other individual approaches that constitute current consensus of best practice for falls prevention in residential care⁷, but have not been evaluated with successful randomised trials include:

- Group or individualised exercise programs for residents;

- Staff training;
- Appropriate use and training with correct walking aids (eg stick or frame);
- Vision assessments and updating of lenses / cataract surgery;
- Continence management plans;
- Environmental assessment and modification;
- Foot care (podiatry assessment and management) and good footwear;
- Strategies to increase surveillance (eg bed / chair alarms); and
- Increased observation of residents during acute illnesses.

In summary, many falls by older people in residential care facilities can be prevented. Falls risk screening or assessment, and multifactorial management approaches appear most likely to be effective and there are several web-sites that provide a useful range of resources and tools for staff, residents and carers to help reduce falls in residential care facilities. These website addresses and the a full version of this article with complete references can be found at: <http://www.vifm.org/n963.html>

OF COURSE HE IS GOING TO FALL

CASE NUMBER 665/01

Precis Authors: Carmel Young
Clinical Research Nurse (CLS)

CLINICAL SUMMARY

Mr R was a 91 year old legally blind, hostel resident with a medical history of Parkinson's Disease requiring a walking frame and dementia. One month after becoming a resident at the hostel he fell hitting his head on a coffee table resulting in a brief loss of consciousness, multiple lacerations and skin tears to the head, arm and leg.

He was transported to a metropolitan hospital by ambulance; the paramedics described his initial Glasgow Coma Score (GCS) as 11/15. It improved to 15/15 by arrival at the hospital. In the emergency department (ED) he was examined and had an electrocardiograph (ECG), which showed atrial fibrillation and blood tests apparently within normal limits. The treating doctor was an intern who discussed the clinical circumstances with an Emergency Medicine Consultant. Together it was decided that a CT scan of the brain was not required, instead they would observe him for four hours. The head wound was sutured, the last neurological observations at 23:15 hours recorded his GCS as 12/15. Mr R was discharged from the ED arriving back at the hostel at 01:30 hours.

At 04:30 hours Mr R had another fall. The staff member who found him stated that the only injuries were a new skin tear to the arm. Staff frequently checked on him during the night but by 09:00 hours his speech was incomprehensible. Mr R was transferred back to the hospital for investigation with a CT brain scan. This revealed an acute left frontoparietal subdural haematoma with minimal midline shift. It was decided to treat him palliatively and he died from bronchopneumonia about 10 days after the fall.

PATHOLOGY

An autopsy was not done because the case had not been reported to the State Coroners Office by the medical practitioner at the time of death. Instead, it was referred by the Registry of Births, Deaths and Marriages to the Coroners' Office because it is a reportable death. The cause of death was aspiration pneumonia, subdural haematoma, fall with contributing factors of dementia, Parkinson's disease and blindness.

INVESTIGATION

The Coroner's investigation included an inquest and consultation with an expert witness. The forensic pathologist stated that without an autopsy it was not possible to say when Mr R suffered the acute subdural haematoma and therefore he was unable to identify which fall was responsible for the injury. He also noted that the ECG had a note on it about the atrial fibrillation being new and that this may have caused him to have the falls.

The Coroners office sought an opinion from an expert witness (2002) about whether a CT brain scan should have been performed on Mr R's first admission. The expert concluded that it was "appropriate for the hospital staff to assess the deceased's head injury as a scalp laceration, rather than a brain injury and hence to conclude that a CT scan of the brain and x-rays of the skull were not indicated" (Editors Note the indications for CT Brain scan have changed over the past 5 years).

CORONER'S COMMENTS

In his findings, the Coroner was critical of the doctor discharging Mr R back to the hostel. The discharge was inappropriate because it occurred in the early hours of the morning in a person with an altered conscious state. The Coroner stated that the doctor should have conducted his own neurological assessment before the discharge back to the hostel.

This was compounded by the lack of any documentation from the doctor who said he rang the hostel and gave a verbal handover to the RACF. The Coroner made no recommendations.

EDITOR'S COMMENTS

This case had an inquest before the inception of the Clinical Liaison Service (CLS). If this case presented today CLS would investigate numerous issues including communication between the hospital and the hostel, the appropriateness of transfer back to the hostel in the middle of the night, how the multiple family concerns had been managed, how the multiple risk factors that may contribute to falls were managed, the nature of the medical assessments at the time of entry to the facility, following the fall and prior to discharge.

In the past 3 years CLS have noted many cases where similar deaths have occurred following minor head trauma in older persons or persons on blood thinning medication. These cases are available in the Coronial Communiqué, Volume 4, Issue 1, which also refer to the Canadian Head Injury rules. These rules stipulate the need for more intensive investigation in cases of mild head trauma in older persons and that a CT brain scan would usually be done.

KEY WORDS

- Clinical: adult, fall, Hospital-emergency department, residential aged care, metropolitan, diagnosis, management, communication, training, policy & protocols.
- Investigation: BDM, Death certificate, statements, expert opinion, inquest, comments.

RESOURCES

The Victorian Quality Council has developed "Minimising the risk of falls and falls injuries: Guidelines for acute, sub-acute and residential care settings" to provide a framework (model) and supporting resources to support falls prevention activity in hospital and residential care settings. See <http://www.health.vic.gov.au/qualitycouncil/pub/improve/falls.htm>

All cases that are discussed in the Coronial 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.