

# Residential Aged Care

# Communiqué

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## 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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**Next issue: December 2014**



A Victorian Government initiative



## EDITORIAL

Welcome to the third issue of the RAC Communiqué for 2014 in which we examine three cases involving falls. It has been some time since we addressed this topic. Our long-term subscribers will recall it was the subject of our second issue published in March 2007.

We would like to thank the hundreds of subscribers who completed the survey evaluating the RAC Communiqué. The responses are still being collated and we will publish the results early next year.

As promised we have given the RAC Communiqué and our website a 'makeover' and are pleased to welcome the return of our sister publication, which focuses on acute hospital care the 'Clinical Communiqué.

We also feature a short story on the findings from our systematic review of medico-legal deaths in nursing homes that was recently published in the Journal of the American Geriatric Society.

## CLINICAL COMMUNIQUÉ RETURNS

After a five-year hiatus in publication Professor Joseph E Ibrahim and Dr Nicola Cunningham are delighted to announce the return of the Communiqué, an electronic, quarterly educational newsletter, that uses a narrative case-study approach to report lessons learned from deaths in acute health care settings investigated by the Coroners' Court.

Our return to production is made possible through Victorian Managed Insurance Authority and Monash University who are supporting the return of the Communiqué as an educational resource for medical practitioners and health professionals with a focus on patient safety in acute health care settings.

The first issue of the Clinical Communiqué examines the National Standards while pulling together three clinical cases from our past issues. We do this to introduce ourselves to the newcomers; hail our return to past subscribers; and trial our new layout and presentation – in modern IT parlance, perform 'an alpha test of product'.

The first issue is now available. In that issue we present cases about: Medication and Safety - "Knowing what the right hand is doing"); Clinical Handover - "*Hard to swallow*"; and Recognising and Responding to Clinical Deterioration in Acute Health Care "*Measuring pain and sedation*".

Subscription is free, register at our website at: [www.vifmcommuniques.org/subscribe](http://www.vifmcommuniques.org/subscribe)

## YOUTUBE: 'Whether or not to resuscitate'

A second animated YouTube video has been released. This presents the topic of "not for resuscitation" and dementia. This was made possible with support from the Victoria and Tasmania Dementia Training Study Centre funded by Department of Social Services, Commonwealth of Australia.

It is just under ten minutes long and is intended as a thought provoking introduction to a small group discussion within your clinical team. If that is not enough reason to view it, then perhaps seeing your editor portrayed with a 1980s hairstyle will encourage you to do so. Preview the video at [www.profjoe.com.au/all-cases-list/to-resuscitate-or-not/](http://www.profjoe.com.au/all-cases-list/to-resuscitate-or-not/) and let us know your thoughts. The education information package is now live at: [www.dtsc.com.au/limitation-of-care-orders-making-an-informed-choice/](http://www.dtsc.com.au/limitation-of-care-orders-making-an-informed-choice/)

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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](mailto: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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# CASE #1 NO ONE SAW THIS COMING

Case Précis Author:

C Young RN, Ballarat Health

## Clinical Summary

Mr AA was an 82 years old male with dementia and high-level care needs who lived in a medium sized metropolitan RACS with a secure dementia specific section. Mr AA tended to 'wander' and was required to sleep in the dementia specific unit but had access to the mainstream unit during the day.

One day, early in Autumn Mr AA had a fall around breakfast time. The fall was not witnessed. The nursing staff observations following this incident were that Mr AA was able to ambulate and appeared uninjured and that the family informed of the fall.

Later that same day, after the family left the RACS after visiting Mr AA in the evening, he was found on the floor beside a chair. Mr AA was able to get up off the floor with minimal assistance and the subsequent neurological examination and regular neurological observations for the rest of the evening were within normal range.

That night, at handover, the night shift staff was informed of the second fall and that the observations were within normal range. Early the following morning, 0530h, Mr AA was found to be bleeding from the nose and transferred to an acute care service where he died later that day.

## Pathology

The coroner granted the family's request not to perform an autopsy. The forensic pathologist conducted an external examination and reviewed the CT scans done post mortem. The cause of death was an intracranial haemorrhage secondary to blunt force trauma.

## Finding

About seventeen months later, an Inquest was held and required one day in court with a number of RACS staff giving evidence. It became apparent that neither the afternoon nor night staff had been informed of Mr AA's first fall in the morning. The staff explained if this information was known they would have asked for the general practitioner to attend and review Mr AA.

The RACS explained what lessons had been learned from this situation and the nature of changes instigated to prevent a recurrence. The key areas were ensuring an adequate, comprehensive handover and communication between staff (this now occurs at the beginning of every shift) and; seeking an early medical assessment following a fall especially when multiple falls have occurred.

The Coroner noted that the RACS staff "was caring and professional. The shortcomings identified are not causative of death".

## Editor's Comments

Three points I would like to highlight from this case.

First, falls that are not witnessed are a regular occurrence; this does not mean we simply accept the situation. When these occur we must take a prudent approach and ensure regular observations to detect any changes. This was done. However no abnormality was detected to prompt an early medical review. We also should consider if there is something different about these types of falls.

Second, the Coroner granted the family's request not to perform an autopsy. In Victoria, a coroner must take reasonable steps to notify the senior next of kin of the deceased if an autopsy is required. The next of kin has, 48 hours after receiving notice, to ask the coroner to reconsider. So, contrary to what most people believe an autopsy is not always done.

Finally, handover and communication feature in another incident. While staggered shifts help with managing the workload during busy times on the ward. It is important that each staff member has a handover each time.



# CASE #2 BONES LIKE CHALK

Case Précis Author:  
C Young RN, Ballarat Health

## Clinical Summary

Ms BB was an 82 years old female requiring high-level care living in a small suburban RACS. Past medical history included severe dementia, cerebrovascular disease (strokes), heart failure, osteoporosis and skeletal deformities of both legs. Ms BB was mostly non-verbal, required assistance with all personal care tasks and generally confined to bed. A lifting machine was required for transport between the bed and chair.

On a spring day in September, a student enrolled in Certificate III in Aged Care attended to assist Ms BB's room to assist with the evening meal. The student found Ms BB in bed under the covers, sobbing and whimpering. The student spoke to a co-worker and the nurse in charge attended to assess the situation. On pulling back the bed covers a reddened area on the leg was visible, and appeared to resemble cellulitis.

The nurse asked two ambulance paramedics, who were in the RACS for another matter, to look in on Ms BB. The paramedics examined Ms BB and considered this may be a fracture. Ms BB was transported to an acute hospital where X-Rays revealed a shaft of femur fractures, the other leg was also x-rayed and an identical fracture was present. Ms BB had nails inserted in both femurs and died about four days after surgery.

## Pathology

The cause of death following autopsy was fat embolism syndrome and bronchopneumonia following nail fixation of bilateral femoral shaft fractures complicating marked osteoporosis.

## Investigation

About two years later an inquest, over two days in court, was required to elicit how Ms BB sustained these fractures. Statements were taken from RACS staff, the physiotherapist, ambulance paramedics, the orthopaedic surgeon, as well as an expert opinion from an independent consultant radiologist. The Coroner delivered the findings ten months later. The Coroner had to determine the circumstances in which Ms BB sustained the fractures as questions were raised about whether it was from the examination by the paramedics, due to the manual lift or some other mechanism.

The RACS staff explained Ms BB could be in a seated position if in a "princess chair" and that movement from this chair to her bed required the use of a mechanical

lifter. The operation of the mechanical lifter required two carers as Ms BB could not assist in anyway. This was reinforced by a physiotherapy assessment that made it plain that Ms BB was to be transferred by way of a sling-lifting machine with two people assisting.

On that particular afternoon, the carers lifted Ms BB manually. They did this because using the mechanical lifter was a time consuming process and they were concerned about being able to meet the needs of other residents. So the carers, each placed an arm under Ms BB's armpits and grabbed hold of the elastic waist band on her trousers to lift onto the bed in a sitting position. One supported Ms BB's upper body whilst the other guided her feet around onto the bed into a lying position. The carers reported Ms BB had given no indication of discomfort during this process and both carers acknowledged that they understood that Ms BB required a mechanical lifter.

The orthopaedic surgeon opined that Ms BB's degree of osteoporosis and non-weight bearing would make the bones very susceptible to fractures and that it would not take much force to cause an injury of the kind suffered. The expert radiologist who reviewed the x-rays noted the fractures were less than a week old. The forensic pathologist suggested the femoral fractures had resulted from minor trauma only or from "inadvertent injudicious handling of the deceased during normal nursing manoeuvres". There had also been histological examination of the tissue indicating the fracture was approximately 7-10 days old at the time of death.

The Inquest was very complex because there were different reports about the circumstances. One member of RACS staff claimed a 'crack' was heard when the paramedics examined Ms BB and that was when the fracture occurred. Also, the evidence provided by one of the carers in her written statement, about the nature of the manual lift, changed after the lunch adjournment, which was spent with her colleague. The carer denied they had spoken about this aspect of the case.

## Coroner's Comments and Findings

The Coroner considered the two fractures could have been caused at the same time. That this was due to the manual lifting performed by the carers and not by the paramedics who did the physical examination.

The manual lift had resulted in was an unusual application of force on Ms BB's legs by a lack of support to the legs leading to a gravitational forces being applied or that the force was due to the legs being lifted. Following this incident the prohibition against manual lifting was reinforced at

the nursing home with a written directive stating that under no circumstances are residents to be manually lifted. The two carers involved were subject of disciplinary measures for breaching the existing policy not to lift residents.

## Editor's Comments

Three points to highlight from this distressing case for all concerned.

First, the staff had not followed policy in an effort to save time with tragic consequences. We all tend to think that the 'no lift' policies are designed to protect staff from work related injuries; this case illustrates that the use of mechanical lifting devices are important for resident safety.

Second, the time to complete an extensive and comprehensive investigation takes time and is better than rushing to a premature or inaccurate conclusion. This is also seen in the case of Mr CC.

Third, it is important to document any incident clearly and comprehensively at the time these occur. When providing a statement during a Coroners investigation carefully read what is written and check it is accurate, this is a serious matter and should never be taken lightly.

## A SYSTEMATIC REVIEW

We searched all original, peer-reviewed research articles published between 2000 and 2013 describing the nature and circumstances surrounding death of older people in nursing homes.

We identified thirteen studies using information generated for medico-legal death investigations into: suicide; choking; restraint or bed-related injuries; falls and pressure injuries.

Deaths were more frequent amongst women with existing comorbidities. Suicide was predominant amongst men. Identified risk factors and opportunities to reduce harm were identified at individual, organisational, and structural levels.

The citation: Kennedy B., Ibrahim JE., Bugeja L., Ranson D., Causes of death determined by medico- legal investigations in residents of nursing homes, a systematic review. J Am Geriatr Soc. 2014 Aug;62(8):1513-26.

## LIST OF RESOURCES

1. Past editions of the RAC Communiqué worth exploring or re-exploring on these topics at: <http://www.vifmcommuniques.org/previous-editions/residential-aged-care-communication-editions/> are:-  
Vol 2 Iss 1 Mar 2007: Falls,  
Vol 5 Iss 2 Jun 2010: Health technology assessment,  
Vol 6 Iss 2 May 2011: Mobility aids,  
Vol 8 Iss 1 Mar 2013: Root cause analysis,  
Vol 9 Iss 1 Feb 2014: Communication
2. The Department of Health (Victoria) Falls prevention web page is located at [http://health.vic.gov.au/agedcare/maintaining/falls\\_dev/index.htm](http://health.vic.gov.au/agedcare/maintaining/falls_dev/index.htm)
3. Australian Commission on Safety and Quality in Health Care “Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Residential Aged Care Facilities 2009” located at <http://www.safetyandquality.gov.au/our-work/falls-prevention/falls-prevention-rac/>
4. Coroner’s Act and other information about the Coroner’s Court of Victoria are available at <http://www.coronerscourt.vic.gov.au/>.
5. Clinical Handover is addressed in the first issue of our sister publication the Clinical Communiqué Vol 1 Iss 1 Sep 2014. Subscription is free, register at our website at: <http://www.vifmcommuniques.org/subscribe>

## CASE #3 DOES ANYONE KNOW WHAT HAPPENED?

Case Précis Author:  
C Young RN, Ballarat Health

### Clinical Summary

Mr CC was an 86 years old male with high level care needs was living in a RACS in a regional centre.

On this particular day, a nurse instructed two carers to get Mr CC out of bed for a shower and to then sit him in a comfort chair to let the bed air. Staff used a hoist and sling to move Mr CC from the bed to a trolley bath. After the shower Mr CC was dried on the trolley bath and then placed into a sling to transport him to an easy chair. Mr CC fell out of the sling, fracturing both legs. The staff organized an immediate transfer to an acute care hospital where Mr CC died from these injuries the same day.

### Pathology

The cause of death following autopsy was coronary and cerebral atherosclerosis with the significant conditions of fractured leg bones following the fall as well as bronchitis.

### Investigation

An inquest was held. This took four days over six months to establish how the accident occurred, including a re-enactment to determine whether it was due to the design of the hoist used. Evidence was given by the RACS staff, the RACS-provider managerial staff, several medical experts, and a mechanical engineer, the manufacturing firm which supplied the hoist and Workplace Health and Safety investigator.

The RACS- managerial staff who investigated the incident concluded Mr CC was “*transferred without the use of the sling*”. The carers were distressed by this conclusion.

The two carers stated that they took a sling out of Mr CC’s cupboard and cradled the sling around him as he had an in-dwelling urinary catheter and thought it would be difficult to use the cross-over method. One of the carers was wheeling the hoist towards the chair the other was guiding his feet. Neither saw the fall.

Therefore the coroner considered four different possibilities one of which was whether the carers did not use a sling.

The coroner concluded that the nature of the injuries, fracture of the left femur, a comminuted fracture of the upper right and left tibias were consistent with Mr CC slipping out of the sling, configured in a hammock style, feet first.’

The coroner accepted the evidence of the two carers and “*did not find them in any way evasive, untruthful or attempting to protect themselves*” and rejected the notion the staff had used a sheet to transfer Mr CC.

The Coroner commented that although the carers had annual training in relation to the use of a hoist and lifting there was no actual evidence of their training.

### Coroner’s Comments and Findings

The Coroner recommended that the training program be reviewed in regard to the use of hoists and slings; professional input (e.g., physiotherapist or occupational therapist) to ensure the slings are the correct size and how the sling should be used for each individual.

The coroner also recommended a system should be established to review incidents and to liaise with the manufacturer of the sling to assist with improving design.

### Editor’s Comments

This case demonstrates the complexity of providing care for residents. In the case involving Ms BB, the manual lift by staff lead to injury, on this occasion the fall occurred even though a mechanical lifting device had been used. The difference is the staff followed the correct procedures and policy.

An important recommendation highlighted by the Coroner was review of incidents and liaising with manufacturers to improve equipment. If the staff of RACS do not do this who will?

Finally, this investigation took some time. Understandably so, because of the different interpretations about what happened. I imagine it was reassuring to the RACS care staff to have had an opportunity to present their evidence to the Coroner.

