THE COMMUNIQUÉS

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Editorial

Welcome to the third edition of the Residential Aged Care Communiqué for 2022. This edition focusses on two cases of premature death that occurred in circumstances that were so commonplace that they were seemingly low-risk, and yet, surprisingly the residents died. Both residents suffered head trauma - one while in a hoist and the other from being tipped out of a chair. The lessons in these cases are manifold and we explore these in the commentaries.

The ongoing COVID-19 pandemic is in its third year. As a consequence of the ongoing and central focus the pandemic has taken, many of us find that our attention for the everyday hazards has faded into the background. Also, the multiple pandemic guidelines have created an environment in which we have become so habituated to our practice being directed by policy makers, that we are waiting to be told what to do and how to do it.

The everyday hazards in aged care homes have not disappeared from practice, they have just become invisible to us. The two cases in this edition are drawn from the work of our colleagues in Canada who constitute the Geriatric and Long-Term Care Review Committee and assist the Office of the Chief Coroner in the investigation, review, and development of recommendations. This was an initiative we proposed and had hope would be adopted in Australia following the Royal Commission into Aged Care Quality and Safety. Unfortunately, this did not occur.

The two cases describe what could happen in any aged care home in any country—which highlights our first lesson about examining the experiences of others for the benefit of improving practice. The other lessons go beyond the actual cases and are accompanied by reflective exercises that help us understand how we can apply the lessons to our practice.

Too often we hear colleagues dismiss a case as something that would not happen to us because our residents are not the same, our staff practices are different, we don't use that equipment, we are more careful, and so on. This edition will examine the cases in four different ways to demonstrate just how similar and relevant the cases really are, and how we can optimise the information available for the benefit of our residents and care home. The first approach is examining the literal advice provided in a recommendation to better understand why an action should be taken. It addresses the familiar and exasperating issue of documentation. We present this through the lens of "recall bias" to give new insights and perhaps a more convincing argument for closer attention to documentation.

The second approach also addresses why we should not accept a logical recommendation at face value. That we need to contemplate the nature of the intervention, what is required for it to succeed if applied to our specific circumstances. We examine quality improvement rounds as an example of a strategy that is highly regarded and yet could have deleterious consequences if applied without staff and organisational commitment.

CONTENTS

Editorial *continued*

The third approach is to identify an interesting aspect of a case, that may or may not be central to the cause of death. It is what I call "an aside". Something that is important in our day-to-day work, where the case presents an opportunity to delve more deeply into the topic in an engaging way. We examine bedside cognitive testing, a subject that is often taught in a rote and pedestrian fashion. By bringing it into the case discussion and demonstrating the real-life consequences and benefits of in-depth knowledge, it may have a longer lasting effect on staff.

The fourth approach is looking at the principles of the case, a search for parallels in other settings. Going beyond the case. Often, we settle for a more cursory analyses of a case, it's quicker, and often more reassuring as we are not "looking for trouble" in other places. The fundamental challenge to improving care is for us to draw out the broader lessons to go above and beyond the obvious. We hope to convince you that the ideas from these cases could also apply to how we orientate and roster staff and how we manage motorised mobility scooters.

Finally, in this edition we have a new section titled "Brainstorming: views about the case from our nursing colleagues". This section comprises short dot points at the end of the case précis relaying our colleagues' first impressions of the case.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:
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Case #1 Four tales

Case Number 2017-3922
(GLTCRC 2019-05)
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i. Clinical Summary

Ms Aa was an 89 year old female who lived in a residential aged care facility (RACF) for the past seven years and required a high level of care due to being dependent on one-to-two persons to assist her personal activities of daily living. Her past medical history included: dementia, Parkinson's disease, hypertension, diabetes mellitus, coronary artery disease, middle cerebral artery stroke, chronic obstructive lung disease, osteoporosis, previous hip fracture that required surgery after a fall from a wheelchair, depression, and chronic pain.

Ms Aa's level of communication and mobility functions were severely impaired and she was aphasic and bed bound.

Late one afternoon, a registered nurse asked the nurse practitioner to review Ms Aa following a transfer from the bathtub to the bed with the mechanical lift. This transfer had resulted in a deep laceration to Ms Aa's head with profuse bleeding and with no loss of consciousness.

The family and ambulance service were contacted and a transfer to the hospital emergency department was arranged. The RACF clinical manager offered the family an apology and indicated that an investigation of the incident was underway.

At the time of transfer, the paramedics observed Ms Aa's Glasgow Coma Scale score was 10/15. The initial assessment at the acute care hospital also noted the presence of a comminuted impacted fracture of the distal third of the left clavicle. The initial CT scan of her head revealed multiple acute and chronic intracranial findings. The most substantive acute changes being a subdural hematoma with a subarachnoid bleed. The scalp hematoma and laceration were also noted.

> **"The initial CT scan of her head revealed multiple acute and chronic intracranial findings."**

The family declined surgical intervention. Ms Aa was admitted to hospital for palliative care and died a few days later.

ii. Pathology

The cause of death following a post-mortem examination was acute aspiration pneumonia in association with blunt impact injuries of the head and shoulders.

The findings in detail included:

- Significant acute aspiration pneumonia in the lower lobes of both lungs with positive bacterial cultures for Escherichia coli and Staphylococcus aureus.
- A large healing bruise on the upper chest that extended onto the left shoulder and neck overlying a comminuted fracture of the clavicle.
- A laceration of the left side of scalp overlying a linear skull fracture involving the frontal and parietal bones. Along the fracture line was a round defect in the skull that had features of an angiomatous meningioma.
- On the right side there was a subdural hematoma measuring approximately 25 to 50mL. There was also a subdural vascular malformation that must have been present for at least months.

iii. Investigation

The investigation by Geriatric and Long-Term Care Review Committee into the death considered information available from the coroner, the post-mortem examination, the records from the residential aged care facility, inspection reports by the regulator, the hospital records and incident reports.

There was a written plan of care for Ms Aa that described the need to review the lift and transfer techniques and have the appropriate pictogram at the head of the bed.

The care plan documented that two persons were required for the mechanical lift.

Determining the circumstances leading to Ms Aa's head injury was complicated by multiple late entries in the RACF's progress notes. Some entries were delayed by four to seven days and often varied in how the events were described. Five people provided their account of events:

- One care worker documented arriving in Ms Aa's bathroom, to find her lying down, conscious and bleeding moderately from a laceration and considered that Ms Aa had hit her head while bathing.
- The registered nurse documented being contacted by a care worker to assess Ms Aa. This nurse observed Ms Aa with her head at the foot of the bed.
- The medical practitioner had communicated verbally with staff and was given a report that there was an incident during bathing in which the woman had hit her head on the tub.
- The nurse practitioner reported being informed Ms Aa was transferred from the bathtub to the bed in the bathroom with the mechanical lift and had hit her head on the side of the bed.
- The clinical manager explained Ms Aa had made a sudden movement when lying on the bed in the bathroom after her bath and that she hit her head on a metal piece of the footboard.

The Ministry of Health and Long-Term Care conducted an inspection of the RACF over two days finding the facility was not compliant in several areas and specifically *'failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.'* The inspector concluded the RACF had failed to ensure the resident's transfer and positioning was safe. That, Ms Aa's head was positioned towards the foot part of the bed.

The RACF critical incident review made several findings including that there were old beds in use, and also raised the question of whether it was possible to remove the head or foot boards.

iv. Coroner's Finding

The Geriatric and Long-Term Care Review Committee ('The Committee') considered death was due to aspiration pneumonia in association with bunt impact injuries of Ms Aa's head after striking an object while on the bed, or when the mechanical lift was used to move and/or bath her. The cause of the fractured clavicle remained unexplained.

It was not possible to resolve the conflicting accounts reported by staff about how the injuries were sustained.

The post-mortem uncovered two other factors that increased Ms Aa's vulnerability to the head injuries. The small defect in the skull near the meningioma may have weakened the bone making it more likely to fracture. The vascular anomaly of the dura may have made it more likely that a subdural haemorrhage would occur following the blunt impact to the head.

Pre-existing comorbid factors such as dementia also increased her risk for aspiration pneumonia.

The Committee also noted that the fractured clavicle could also have contributed to a hampered recovery from pneumonia because the pain associated with the fracture would make it more difficult for a person to breathe and cough.

v. Recommendations

Four recommendations were made. All these were directed at the RACF with the first three also being sent to medical and nursing colleges. These included:

- Staff are reminded that documentation should be completed as soon as possible after an incident to avoid recall bias.
- The recommended safety procedures and individual patient care plans should be adhered to.
- Outdated and/or unsafe transfer and bathing equipment should be reviewed at regular intervals and replaced accordingly.
- RACFs should have multidisciplinary quality improvement rounds to review injuries (explained and unexplained) and to promote a culture of safety.

Brainstorming:

views from our nursing colleagues (Case #1)

- This is a challenging situation given the variations in accounts of what happened. The lack of documentation is especially alarming. The retrospective reporting and writing up makes people question the veracity of the information and question the motives of the staff and management.
- I would be concerned if residents were left alone when they have severely impaired communication and mobility.
- From experience not all equipment matches and works well together often posing safety threats. For example, some lifting hoists do not safely match to some beds due to their physical components. Therefore, using hoists with these beds can cause the hoist to tip over and drop the resident.
- Purchasing new equipment in large organisations needs to be done carefully to ensure it works well with the existing equipment.
- How is the need for ongoing education on manual handling managed? These machines like most technology, evolve, and staff should be regularly updated on their use and safety mechanisms. This is a responsibility of management to ensure the education is undertaken and of staff to undertake it.
- Do the agency/casual staff and regular staff have orientation to the workplace, and are there ongoing updates on safe patient handling, and is this recorded?
- Does the facility have registers that ensure lifting equipment is maintained regularly and document how long the equipment has been in service and when it should be replaced?
- Where are the policies and what type of reinforcement in terms of education and training do staff receive about ensuring the required number of staff be present when using the equipment?
- What is the care home's culture for supporting safety?
- I understand there could be staff shortages, but staff need to realise that tackling something by oneself which usually requires two people is fraught with danger – management need to consider safety issues when reducing or not replacing staff.
- Staff appear task focussed–that is concentrating on getting the task done rather than critically thinking through the situation. For example, if only one nurse/ carer is available, then it may be better to wash the resident in their bed rather than risk using the hoist by yourself.

A literal approach: *recall bias*

Prof Joseph Ibrahim
PhD FRACP

This commentary explores the literal meaning of "recall bias" as presented in the recommendations. By delving deeper into the meaning, we develop a better understand of the matter and are less likely to dismiss the value of that knowledge. Many readers are familiar with the importance of documentation and may have dismissed the idea of "recall bias" as simply the need to write notes before you forget. That is not correct. Let's explore recall bias in more detail.

It is important to understand this idea as it has implications for our day-to-day practice, especially when there has been an adverse event or a poor resident outcome. To help all readers to understand the concept we begin by examining each term separately and then in combination.

"Recall" describes *'the action or faculty of remembering something learned or experienced'*. In our daily lives we use the word "recall" when we are explaining something that has happened to us in the past. We rarely question if our memory is accurate. Sometimes we have forgotten, and when this occurs, we rarely pause to wonder why we cannot recall. Mostly we believe what we recall.

"Bias" describes the *'inclination or prejudice for or against one person or group, especially in a way considered to be unfair'*. Most people are familiar with the word "bias" in sporting contests or matches, how often have you described the umpire or referee as biased when a decision goes against your team? In science, the term bias is used to describe how the results of clinical research studies in aged and health care could be distorted.

"Recall bias" describes how we may systematically and disproportionately favour one idea more than another when we describe an event—and so our recall is inaccurate or incomplete. This typically happens at a subconscious level especially when we are involved in a traumatic event, or a situation where our actions or professionalism may be questioned. In these situations, we describe what we recall, and we believe that is what happened. When we are told that is not correct, we struggle to reconcile the difference.

It is unsurprising that there were as many different versions of what occurred to the resident Ms Aa as there are staff. It is important to understand and differentiate recall bias from situations where a person is deliberately making a false statement.

This is the reason for the recommendation that staff keep detailed, objective, and contemporaneous documentation. Detailed notes should paint a picture for the reader. Objective notes are those that describe the facts - not an opinion, it is not your interpretation or a conclusion. Contemporaneous notes are written as soon as possible after an event occurs.

Questions to contemplate:

- Does the RACF have a policy for documentation?
- Does the RACF have a process for reviewing the clinical notes written by staff with the intention of improving practice?
- What are the local factors that influence a staff member's capacity to document in a way that is detailed, objective and contemporaneously? Consider factors such as:
  - How much time is made available to staff?
  - When is that time—at the start or end of a shift?
  - Is the time to write 'protected'—that is, free of interruption?
  - Do staff have the right equipment and training if using an electronic format for documentation?
  - Are there any signals or alert systems to accommodate specific incidents of major harm?
  - Are staff paid overtime if they remain after their shift finishes to complete the documentation?
- Is there a peer review process to improve documentation?

Contemplating care:
quality improvement rounds

Prof Joseph Ibrahim
PhD FRACP

This commentary delves into why we should contemplate and not simply accept a logical recommendation at face value. The recommendation for implementing quality improvement rounds sounds sensible and aligns with what we know. Spending a little time to contemplate the nature of the intervention and whether it is likely to succeed when applied to our specific circumstances is always useful.

The idea of quality improvement rounds arose in the early 2000s as part of the broader movement in health care organisations to improve patient safety. The activity has a range of different titles including "quality and safety walk-rounds", "patient safety rounds", and "leadership or executive rounding". The basic principle involves a specific person or team walking around the health service to observe practice and to engage staff about matters that impact on patient care.

The person could be a member of a clinical team, a quality and safety manager, head of department, or a senior executive. The team is typical small and multidisciplinary in composition to provide different points of view. The overall aim is to improve patient safety through (i) building relationships between management and point of care staff, (ii) management staff being visible and demonstrating the organisation's commitment and, (iii) promoting an open culture, that is, one where staff are willing to share and are rewarded for reporting hazards that impact on care. The rounds can be structured to address a set number of issues or sometimes follow a checklist.

The success of these rounds depends on how the multidisciplinary team conduct themselves and the willingness of the point of care staff to engage. The team members must have a genuine interest, an ability to listen and respond to staff concerns, and an approach that does not seek to blame staff for gaps in care. The point of care staff must be willing to volunteer information and ideas about how care could be improved. This requires an organisational culture where there is a level of trust, a responsive and a just approach to managing patient safety.

It sounds simple enough in theory, in practice it is somewhat more challenging as it requires patience and a commitment to regular rounds to build the required relationships. Rotteau and colleagues reviewed the experiences of staff in two major teaching hospitals in Canada that had walkarounds in place for several years.

Interestingly they found three themes which describe a disconnect between the principles of the walkarounds and the attitude of the executive staff. These themes were *'a nominal respect for front-line concerns, executive presence without engagement and controlling the conversation'*. In plainer language, the themes could be described as "paying lip service", "pretending to listen" and "steering away from the hard issues". Rotteau and colleagues suggest that to succeed with walkarounds requires strong organisational commitment and involvement of clinical champions.

Questions to contemplate:

What is the nature of the relationship between management and care staff?

- How could that be improved?

Are staff willing to speak up about resident safety concerns in the care home?

- Why? Why not?

Are management willing to listen and respond to concerns?

- Why? Why not?

Could this idea be piloted on a small scale?

- Who would need to be involved? How would you know it was beneficial?

Case #2 Falling off the chair

Case Number 2015-1468
(GLTCRC 2019-18)
Case Précis Author
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i. Clinical Summary

Mr Bb was an 82 year old male who lived in an RACF. His past medical history included: chronic obstructive pulmonary disease and asthma (requiring home oxygen), diabetes mellitus, pulmonary embolism (requiring warfarin daily), chronic renal impairment, spinal stenosis with lumbar laminectomy, hypertension, and depression.

Mr Bb had entered the RACF almost 3-years ago after a seven-month stay in hospital for pneumonia and chronic obstructive pulmonary disease leading to respiratory failure and requiring admission to intensive care.

> **"Assessment of Mr Bb's cognition using a different scale, the Montreal Cognitive Assessment, scored 19/30."**

At the time of entry to RACF, he was cognitively intact with a mini-mental status examination score of 30/30, and he required a wheelchair for mobilization.

In the year he died during the month of August, Mr Bb's family noticed that he appeared more confused, had become despondent and frustrated with having to use oxygen all the time. Assessment of Mr Bb's cognition using a different scale, the Montreal Cognitive Assessment, scored 19/30.

In September Mr Bb had an unwitnessed fall in the bathroom and reported another during the night after waking up in front of his electronic power recliner chair. Staff expressed concerns because he had been found on the floor and was unable to get up independently. Mr Bb was over six feet tall and weighed over 150 kg.

In November Mr Bb had improved his standing balance as he continued to work with the physiotherapist with an aim to transfer independently. Mr Bb's mobility was aided using a high—low bed, a motorized wheelchair and scooter when outdoors. He would sleep in a lift-recliner chair each night and was able to reposition himself.

In December, his mood declined further often saying that he was "tired of living this way."

In mid-December he developed a fever with chills and was treated for a chest infection with antibiotics, corticosteroids, and bronchodilators. He remained unwell and lethargic over the following week with low oxygen saturation (88% on 3.5L oxygen by nasal prong) and high blood sugars (exceeding 30 mmol/L). Mr Bb was also noted to be confused and did not recognize staff.

About two days later, staff heard Mr Bb's telephone ring and then a thud. When they entered his room, they found Mr Bb on the floor, with a laceration on his forehead and elbow. He stated he had rolled out of his chair when putting the telephone back on the table. The staff noted that his recliner chair was vertical, that is "straight up."

The ambulance service was contacted, and Mr Bb was transferred to the emergency department of an acute care hospital. Preliminary investigations and imaging included a chest x-ray which revealed pneumonia and an International Normalised Ratio (INR) of 3.9. The family were consulted, and it was noted that Mr Bb had a 'Do Not Resuscitate' directive recorded at the time of his entry into the care home.

A palliative care approach was put in place with no further investigations or active interventions. Mr Bb died within a few hours of arrival to the emergency department.

ii. Pathology

As the coroner was not immediately notified, a post-mortem examination was not performed. The cause of death was listed as intracranial haemorrhage due to a fall with the contributing factor of delirium from pneumonia.

iii. Investigation

The investigation by the Geriatric and Long-Term Care Review Committee ('The Committee') into the death considered information available from the coroner, the records from the residential aged care facility (RACF), and acute hospital records.

The following aspects were elucidated by the review including that Mr Bb:

- was participating with physiotherapy to maintain or improve his independence for transfers,
- usually slept in a lift recliner at night,
- controlled the lift recliner,
- appeared to be gradually declining in his cognition,
- developed pneumonia with a delirium which would have impaired his judgement
- was found on the floor with the recliner chair being "straight up"

The Committee speculated that Mr Bb fell from the lift chair when it was inadvertently raised causing him to be rolled out. Possible explanations for this action included that he mistook the chair remote control for the telephone or, inadvertently pressed the button to lift the chair while leaning to place his telephone back on the table.

The Committee, in a review of commercially available lift chairs, noted there was typically a single button to activate the chair position and an absence of a locking mechanism.

iv. Coroner's Finding

The Committee found that Mr Bb's death was a result of injury sustained after falling from an electronic power recliner due to inadvertently pressing an incorrect button on the chair's control device.

They also found that when a resident is operating an assistive electronic device to facilitate their independence, that the user be assessed to determine they can operate the device.

v. Recommendations

Four recommendations were made including the need to report deaths of residents where an electronic/power lift recliner is involved. Two were related to design aspects, specifically, that the government reviews the classification of lift recliners and encourage manufacturers to modify these recliners. The modifications should prevent inadvertent activation of the chair as well as having a locking mechanism on the controls.

There was also a recommendation about reminding staff that when the cognitive status of a resident changes, their independent use of an assistive device may no longer be safe. In these circumstances the controls should be removed or locked to make the device inoperable to the individual.

Brainstorming:

views from our nursing colleagues (Case #2)

- If we start by focussing on the chair the following questions arise:
    - Does the facility have an available list of approved equipment to purchase or hire that meets Australian Safety Standards? Searching the web for purchase/hire of equipment is quick but not necessarily the safe approach.
    - Locking the chair could be an advantage to preventing the resident from inadvertently using it inappropriately if he became confused. There is a danger that if all staff are not orientated to this locking/unlocking mechanism, then in an emergency, they may not be able to unlock (or lock) the device.
    - We also need to consider if locking the chair could constitute a form of physical restraint?

- If we look at the lack of observation or acknowledgement of a change in the resident's cognition or care needs, the following thoughts come to mind:
    - Given the transient nature of the workforce with many agency/casual staff working in facilities, how does a care home monitor and keep track of a resident's cognition? And who decides when the resident is able to manage the controls on the chair?
    - This case exemplifies the need for regular resident review. Some care homes have a monthly review system that helps to identify what has changed in the last month for an individual resident. A regular review of resident capability – physical and cognitive, as well as adjustments to their care taking into consideration any changes, should be done regularly.

See an aside: *cognitive testing*

Prof Joseph Ibrahim
PhD FRACP

This commentary delves into a third approach to learning from these cases, that is selecting what others considered "an aside" and yet presents an opportunity address an important topic. In this case, discussing the use of bedside cognitive testing may have a greater impact than addressing it in isolation.

The use of standardised tools for cognitive assessment of residents such as the Mini-Mental Status Examination (MMSE) and Montreal Cognitive Assessment (MoCA) is good clinical practice. Another tenet of good practice is understanding the strengths and limitations of standardised tools as well as when we should be using these tools.

"If there were concerns that his underlying depression was a contributing factor to impaired cognition, then use of the Geriatric Depression Scale would assist in the assessment."

In the situation described, we should be asking a few questions before proceeding to formal bedside clinical testing. If the staff were concerned the resident, Mr Bb, had shown a recent change in cognition then it would be better to screen for evidence of delirium using a different and specific tool such as the Confusion Assessment Method (CAM).

If there were concerns that his underlying depression was a contributing factor to impaired cognition, then use of the Geriatric Depression Scale would assist in the assessment.

The MMSE and MoCA are two of the most widely used screening tools for cognitive impairment in clinical settings. These provide an overall indication of cognitive function only and are not diagnostic tests. A person's performance on these tests needs careful interpretation by an experienced clinician.

While the results from the MMSE and MoCA are often used interchangeably, as both have seemingly similar multi-item questions and are scored on a total of 30, this is not strictly correct. The development and design of the tests differ as does the cognitive domains assessed.

Two major differences are that the MMSE score is more likely to be influenced by a person's level of education and the MoCA assesses executive function which the MMSE does not.

Note that a screening test only indicates "something is not right" and/or "something has changed" when serial testing has occurred. These tests do not tell us the reason(s) for an abnormal result or a change in performance. The observed change in Mr Bb was clinically evident and confirmed with the substantive change in the cognitive screening test scores over the three years. Potential diagnostic considerations would include delirium, depression, dementia, or some other cerebral event such as a stroke or subdural haemorrhage.

Questions to contemplate:

- What are the beside clinical screening tools being use in your RACF?
- Are the staff who use these tools educated and trained in how to administer them?
- Are the staff aware and familiar with interpreting the results from the tools?
- Are staff aware of how to escalate concerns when the results are abnormal or inconsistent with the clinical presentation?

Drawing parallels: *beyond the case*

Prof Joseph Ibrahim
PhD FRACP

The fourth approach to learning from these cases is searching for parallels or principles that can be applied elsewhere. Imagine if instead of the lift chair it was a motorised mobility scooter, how would our approach differ?

I expect the RACF staff would be far more alert to the potential dangers of continuing to use a device such as a motorised mobility scooter when a resident's cognition changes. Often when we review a case of a premature death we fixate on the literal circumstances and do not explore some of the broader underlying principles. For example, if our facility does not have any powered lift chairs, we tend to consider there is nothing to learn.

Optimising the learning from any case requires looking more deeply into the key factors and general principles. Consider the essence of the case:

- resident with cognitive impairment
- device or equipment that could lead to harm when used within its usual operating range
- optimal use of the equipment's control mechanism requires understanding by the person using it

Questions to contemplate:

- How many residents in our care home have cognitive impairment?
- Do we understand the nature of that cognitive impairment? For example, the cognitive domain—executive function is assessed by the MoCA and not MMSE. Executive function is the domain that is important in making decisions.
- What are the range of devices or equipment that residents with cognitive impairment can access?
    - Perhaps start by thinking about each item by room.
    - What is in the bedroom, bathroom, and dining areas?
- Is it possible to place external controls or limits to improve safety?
    - A classic example of making a device safe, that the more experienced staff may recall, is the introduction of hot water tempering valves.
    - These valves premix hot water to reduce the temperature to 50-degrees Celsius before the water reaches shower heads and taps.
    - Water at this lower temperature prevents scalds and burns which occurred when people used hot water directly.
- If external controls are not possible, what mechanisms are in place to assess the competence of the person using the device?
    - A common example familiar to aged care professionals is the use of a formal occupational therapist assessment to determine if a resident can use a motorised mobility scooter.

List of Resources

1. The key resources available in any RACF are their staff. Convening a multidisciplinary team to review these cases of premature deaths and associated recommendations is a vital step to optimising what we could learn.

2. Rotteau L, Shojania K, Webster F 2014 'I think we should just listen and get out': a qualitative exploration of views and experiences of Patient Safety walkrounds. BMJ Qual Saf doi:10.1136/bmjqs-2012-001706.

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