



Disability Means Possibility



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Risk and Duty of Care versus Choice and Informed Consent

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The Case

Ms X died in hospital on 25th July 1999 following an incident in a bath at her residence in a 20 bedroom hostel.



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The Case

Agency employed an external investigator to review the incident.



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Preamble

- Ms x had been a resident at the hostel for 20 years
- She had cerebral palsy and was 76 years of age
- She had two relatives who were in regular contact - her younger sister and a niece

Summary of Incident

- 21st July 1999 at 9.45pm, Ms X was taken to the bathroom for her daily bath
- Rostered staff person commenced bathing routine, left her alone, returned, and after washing her then left her alone to soak

Summary of Incident (cont')

- Staff person returned after approximately 4 minutes

and found Ms X on her side, under the water with

bubbles coming from her mouth

Agency asked the Investigator to:

- Ascertain if relevant policies and procedures were established and implemented
- To advise if the staff in attendance at the time of the incident acted appropriately and within the policies as set down by the agency

Details sought by the Investigator

- Statements from staff on duty at the time
- Statements from staff on preceding and post accident shift
- Statements from the Coordinator
- Statements from the niece of the deceased



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Other Information Obtained

- Incident Report
- Client File
- Personal Care Plan
- Client Risk Assessment Checklist
- Policies and Procedures in respect of client care
- Rosters
- Sign-on sheets

Other Information Obtained (cont')

- Employee details, including records of training
- Photographs of the bath and bathroom
- Photographs of client's bedroom
- Any correspondence from relatives

Conclusions drawn from Investigation

- Appropriate handling by staff on finding Ms X submerged in the bath
- Ambulance was called
- Risk Taking Assessment (1990)
- Personal Care Procedure (details in safety precautions) when clients are left alone in the bath
- Manual Handling Profile

Safety Precaution Checklist stated the following:

- Clients must not be left alone in the bath unless the following safety precautions are in place:
 - An informed decision has been made by the client and is detailed in the client's file
 - Water level must be adequate to ensure comfort of client
 - A non-slip mat must be in position under the client

Safety Precaution Checklist stated the following:

- Clients must not be left alone in the bath unless the following safety precautions are in place:
 - The client is either self-supporting in the bath or a supportive harness is used
 - The client can summons staff immediately if required

Safety Precaution Checklist stated the following:

- Clients must not be left alone in the bath unless the following safety precautions are in place:
 - Hand rails are within easy reach of client
 - Staff discreetly check with the client to see if assistance is required



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In relation to the day in question, it would appear that:

- The water level was adequate
- The non-slip mat was in place
- Client X was self supporting in that she lay on the bottom of the bath and held onto the side of the bath
- A buzzer was in place with a cord which was placed in the client's hand
- The client was checked during the first half of the bathing routine



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Death of Client Occurred on 25th July 1999 in Hospital from:

- Bilateral Broncho Pneumonia
- Near drowning
- Coronary Artery Atheroma



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Evidence Received From:

- Staff
- Relatives of the deceased
- Coordinator



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The Coroner Found:

- Client had expressed a wish to die
- Letter to the agency from niece giving agency authority for her aunt to bath alone
- Resident demanded time alone in the bath



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The Coroner Found (cont'):

- Coroner examined water level mark in the bath in photos and cross examined staff in respect to water level on the day in question
- Coroner examined investigation done by the agency



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An examination of the evidence reveals that the bathing procedures conducted with the deceased were in accordance with a long established practice and in accordance with the informed consent of the deceased and her niece



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In respect of her wish to die, the fact that for over 20 years or so, Ms X regularly stated she wanted “to go home” (meaning put an end to her life), and nothing happened, the coroner felt staff were entitled to disregard such statements as not representing a threat to her life

Learnings

- Informed consent documented
- Informed consent supported by relative
- Risk Assessment
- Safety precaution checklist
- Monitoring of procedures
- Staff training
- Relationship with family members



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Learnings (cont')

- Client support needs
- Emergency procedure
- Incident Report
- Access to client records



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The End.

Thank-you for your time.