fraserhealth

Better health.
Best in health care.

WINTER 2009

infocus

David Lawson and David Handley succeeded in pulling off the first amalgamation of services between Fraser Health and Vancouver Coastal Health

The Collaborators

>>AN AVOIDABLE DEATH: Lessons learned
>>POST-SURGICAL INFECTIONS: The battle rages
>>DISPATCHES FROM QATAR: FH alumni's tales
>>GRASSROOTS GREENING: Starter projects
>>PASSIONS: Our chairman tangos

David Lawson (l), Fraser Health; David Handley, Vancouver Coastal Health

Dying to be Heard

Senior Esther Winckler died an avoidable death. This is the story of how Fraser Health learned from that regrettable incident. BY JOANNE SEVERN


Esther Winckler

Verizon Wireless launched its now-iconic TV commercials in January 2002. The Coroner's Judgment of Inquiry into the tragic death of Esther Winckler at Chilliwack General Hospital was released four months later. My imagination conjures up this vision of Esther 'up there', two years after she died, whispering to everyone involved – "Can you hear me now?"

Sadly, Esther's voice wasn't heard until long after she was dead. The Coroner's report was a disturbing rebuke of the treatment she received in an acute care hospital.

"It was devastating to read what actually happened," Esther's daughter Catherine recounts. "We were there. We knew that things had gone terribly wrong, but the details were quite shocking."

In hospital for hip replacement surgery, the 77-year-old was given a general anaesthetic, contraindicated by her history. Post-op congestive heart failure went unidentified and therefore untreated. She fell twice, suffering head injuries that were not thoroughly investigated. The fact that she had not had a bowel movement in over a week was uncharted. The delirium brought on by hypoxia was "managed" by restraining her in a wheelchair with a leather belt strapped around her painfully distended belly. Ultimately, the cause of death was "ischemia and infarction of the bowel and brain as a result of prolonged oxygen de-saturation and hypotension." Essentially, she died from a host of complications that culminated in a lack of oxygen and blood flow.

No one listened to Esther, or to her family. They had tried desperately to explain that, before her arrival at hospital, Esther was lucid, active, independent, and planning to take a cruise; that this now "difficult to manage" patient was an extremely sick woman presenting in an exceptionally uncharacteristic way.

Treating old people isn't sexy

Meeting the unique health care needs of older adults is a growing problem. There are more than four million Canadians over the age of 65 and fewer than 200 geriatricians. Marcia Carr, one of less than 100 Clinical Nurse Specialists (CNSs) in geriatrics in Canada, says that "treating old people just isn't sexy." The forthright Carr, who works at Burnaby Hospital, continues: "In truth, a geriatrician faces the most challenging and multifaceted cases in all of medicine, but our society undervalues seniors, and that gets reflected everywhere, including health care."

There are more than 186,000 people over the age of 65 in the Fraser Health region. According to Carr, "Close to 80 per cent of our hospital beds are occupied with older adults, and we have fewer than 125 beds on units that specialize in acute geriatrics." Carr fumes when she hears derogatory terms like 'bed-blockers' to describe these long-stay seniors. "These are *patients.* They *don't want* to be here. They are here because they *need our acute care*," says Carr emphatically. "If more people knew the big differences between how older adults present when they are sick, which includes the interplay of normal aging, pathology and chronic disease, older adults would get the timely, appropriate care interventions that they need, and a lot more of them would be able to get well sooner and go home."

From lawsuit to legacy

Following Esther's then-unexplained death, shock and confusion soon led to anger. Catherine's father and brother wanted to sue, but legal action couldn't be initiated until after the Coroner's inquest.

"It wasn't that we thought these doctors and nurses were bad people," Catherine says, "but they had done a bad job, and that wasn't something we were willing to stop talking about." Catherine put up a website and launched a personal campaign to tell others their story. She wrote letters and made phone calls – hundreds of them – but got little in response. It wasn't until the Coroner's report was released that they finally understood what had happened. It was an explanation so distressing that the family as a whole quickly agreed that their focus needed to be on saving others from a similar nightmare.

"Mom was a teacher," Catherine explains, "and we realized that we had to get beyond revenge to something she would be proud to have as her legacy. It made more sense to us to push for an open and honest dialogue that could serve to educate, than a monetary settlement that would likely come with a gag order."

Front page news opens doors

At 6 a.m. on May 22, 2002, Catherine was surprised to hear the door bell ringing so early in the morning. Her visitor handed her a cup of coffee and a copy of *The Vancouver Sun*, and said, "I think your life is about to change." The newspaper's front page headline read *Woman's illness, injuries went untreated: coroner. She died after routine hip surgery.* There were three full pages of coverage. Catherine's efforts had paid off. Esther's story was now front page news.

With the story now very much in the public eye and the family's rejection of any legal action, things started to happen. The Registered Nurses Association of BC was the first to call, saying that they'd assigned CNSs Pamela Ottem and Phyllis Hunt to investigate. Cathy Weir, Fraser Health's Director of Quality Improvement and Patient Safety, also said she would take action, and asked Marcia Carr to work with Hunt at Chilliwack Hospital. After two years, the proverbial ball was now not just rolling – some rather tenacious "pit bulls" had sunk their teeth into it and would carry that ball further than anyone, including Catherine, could ever have imagined.

ACGNN offers training and support

As Marcia Carr talks about her first encounters with the Chilliwack Hospital staff who were involved in Esther's care, her compassion for them is evident. "They were hearing the full story for the first time and they were devastated," Carr says. "They didn't want to do harm, but they didn't know what they didn't know, so how were they even able to ask what they needed to know?" Staff embraced the new knowledge.

Realizing the extent of the lack of knowledge, Carr and Hunt enlisted the help of two other CNSs: Sandra Whytock from Providence Health Care and Valerie McDonald from Vancouver Coastal Health. Over the next year, they expanded their Collaborative, obtained funding from the Ministry of Health Nursing Directorate, developed workshops, and launched the Acute Care Geriatric Nurse Network (ACGNN). By April of 2004 they had 11 CNSs. By June, they had trained 627 nurses. Amazing accomplishments since funding only covered their travel and materials, and all had full-time jobs with duties that didn't include their work with the ACGNN. With supportive employers though, and many hours of personal time, they made it happen.

Carr reminisces about those early days. "The stories that participants shared with us were incredibly distressing. At one workshop a nurse walked in the door crying! She was so burnt out. She felt totally helpless about what was happening at her facility. When we heard her story, we went straight to the Chief Nursing Officer, and that worrisome practice was changed – *the system changed* because she spoke to us. So we were not only educating, but were a conduit to the powers that be to implement systemic change.

"We ended every workshop really encouraging the participants to use us in whatever way we could possibly be of help, and they did. I got a phone call one day from a remote community with only three care staff. They had an older man who'd been catheterized for some time and that was creating problems, but they didn't know where to start, what to do first. I coached them over the phone. I explained a procedure; they tried it and called me back. Then I told them the next step. We just kept calling back and forth, and you know what? It

worked! After two weeks, that patient was catheter-free."

Three years after they'd begun, the Collaborative had an epiphany of sorts. As they taught, they also learned, and came to realize that most older adults enter the system through Emergency. They rubbed their collaborative magic lamp, and out came a GENI.

The Geriatric Emergency Nursing Initiative (GENI)

Marcia Carr attended a U.S. training session for Emergency department nurses and heard language she found abhorrent. Terms like GOMER – get out of my ER – referring to patients that presented with seemingly minor complaints. Questions like, 'Why do they come in to Emerg when they have a DNR?' In a room of 200, Marcia was silent, but in her head she screamed – 'Because they're not dead yet!' Most disturbing was that she'd heard all this many times before.

Back home, Carr rounded up an ED Clinical Nurse Educator, a critical care CNS, a pharmacist and a geriatrician. They developed a new training session and held a one-day pilot with 16 participants. "Very seasoned Emerg nurses started crying," says Carr. "They could all think of cases they had just seen in the days prior and felt horrible about their lack of knowledge."

"The tone is set in Emerg," Carr explains. "The triage nurse's initial assessment is crucial, and you can't assess older adults the same way you do younger ones. A complaint of indigestion and shortness of breath in a senior could actually mean that they are infarcting right there as you're talking to them!"

With additional funding from the Nursing Directorate, the Geriatric Emergency Nursing Initiative (GENI) workshop was expanded to two days and offered to nurses and anyone else eager to learn more. A GENI e-learning module was also developed so staff can quickly learn the high alerts needed when caring for an acutely ill older adult.

A binder of prompt cards was also produced on what Carr refers to as the Geriatric Giants, including delirium, dementia, depression, continence, falls, constipation, dysphagia, pain, unsettled behaviour, skin and wound care, and suicide prevention. The binder contains a tab for each, with assessment and diagnostic flow charts leading to best practice-based treatment plans.

Integration begins to evolve from initiatives

The ACGNN workshops continued for six years, the GENI program for three, with some 2,000 nurses in BC attending. When their funding for travel ended in March 2008, Carr looked to technology to continue the education process. The GENI workshop is available on video, along with a myriad of other resources, on the ACGNN website (www.acgnn.ca) operated by the CNSs on their own time.

The provincial Telehealth program also offers training, facilitated by Carr and others who present on specific older adult topics.

"Getting back to Esther," Carr continues, "her story is a part of everything we've done, and will continue to do. The Winckler family's commitment to forego legal action and their right to privacy was an incredible gift to us all. Instead of talking about a contrived and fictional case study, we talk about Esther – a real person that we failed to help. That really gets people's attention, because we've all encountered someone like Esther, we're all *going to be someone like Esther*, and that makes it personal."

Both Fraser Health and the ACGNN CNSs continue to tell the bittersweet tale in staff orientations, national conference presentations, and a variety of other learning opportunities. In November 2007, Fraser Health implemented a disclosure policy directing health care providers to promptly inform patients and their families when mistakes have been made. In March 2008 a "least restraint" policy was adopted along with clinical practice guidelines and assessment tools. The ACGNN CNS Collaborative is partnering with Fraser Health's Geriatric Clinical Services Planning and Delivery team to produce more e-learning modules on the geriatric giants. In August 2008, Abbotsford Regional Hospital, the first hospital built in BC specifically designed to be elder-friendly, opened its doors. Other programs to improve access and quality of care for seniors are underway.

Make Esther's credo your own

The silver lining of that heavenly cloud where I envision Esther now perched, continues to grow. In addition to the activity at the ACGNN and Fraser Health, Catherine still gets phone calls and emails from around the globe. Nursing students write to tell her that the website she set up, www.EsthersVoice.com, is required reading in their studies, and families call to ask for advice and to thank her for sharing her personal experience.

Is there more to be done? Yes, and it's up to you to do it. One of Esther's credos was that one should never leave to others what they themselves have the power to accomplish. You have the power. Watch the workshop or do the e-learning online, take part in the video conference training, attend presentations, ask questions, and most importantly, *listen*.

Find out what you don't know you don't know!

1. Read what Esther and her family went through at www.EsthersVoice.com.
2. Take the training and find loads of resources online at www.acgnn.ca.
3. Find out if there's a GENI manual accessible at your workplace.
4. Learn about the new Least Restraint policy and tools on the FH Intranet – click on Clinical Policy Office under Quicklinks.
5. Pay attention to what family members and friends have to say about your patients.
6. Assess, assess, assess!
7. If you need help, call any of the CNSs listed at www.acgnn.ca.