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Employee Relations News

Edition 31 **11 September 2015**

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SPECIAL BULLETIN FOR AGED CARE HOMES

Coronial Inquest: Quakers Hill Nursing Home

The tragic death of 14 aged care residents at the Quakers Hill Nursing Home in NSW provides a number of lessons for hospital operators and residential aged care operators, including in relation to:

- The recruitment and background/reference checking of potential staff;
- Mandatory reporting;
- Dealing with staff who are impaired with substance abuse and Schedule 8 medications; and
- Emergency evacuation procedures.

Findings of Deputy State Coroner H C B Dillon delivered 9 March 2015

On 18 November 2011 a fire lit by Mr Roger Dean, a registered nurse employed by the Quakers Hill Nursing Home caused death and serious injury to numerous elderly residents. A combined inquest was conducted into the fire and into the deaths of 14 residents. Mr Dean ultimately pleaded guilty and was convicted of 11 counts of murder by reckless indifference to human life. He also ultimately pleaded guilty and was convicted of recklessly causing grievous bodily harm to a further eight people. He was sentenced to life imprisonment without parole and has appealed against his sentence.

There were approximately 81 aged care residents at the nursing home. Many suffered dementia and some were bedridden. There were no sprinkler systems in the nursing home in 2011, but they have since been installed.

Staffing
Ordinarily, only one registered nurse was rostered onto the night shift at the Quakers Hill Nursing Home, assisted by four assistants in nursing. Mr Dean worked three or four night shifts per week, commencing on 13 September 2011 (after attending in-service staff training), on three months' probation. He was responsible for the medications cupboard and in particular he had the only keys to the Schedule 8 drugs of addiction cupboard.

Unbeknown to the Quakers Hill Nursing Home prior to employing Mr Dean, Mr Dean suffered from prescription medication addiction. The Coroner described him as a "drug-dependant doctor-shopper who was not identified as either before the fire". A forensic psychiatrist involved in his sentencing hearing also diagnosed him with a personality disorder with cluster B characteristics including narcissistic and histrionic features.

The Quakers Hill Nursing Home was also unaware that Mr Dean had previously worked at St John of God Hospital where in June 2011 he was suspended for appearing under the influence of drugs on one of his shifts. His suspension was lifted with medical clearance from his general practitioner. St John of God Hospital took steps to move Mr Dean onto day shifts so that he was under supervision while at work. Mr Dean resigned from St John of God Hospital on 19 September 2011 for "personal reasons". In the meantime he applied for and secured the position as a night nurse at Quakers Hill Nursing Home. In his application he omitted to mention his work at St John of God Hospital. He presented a curriculum vitae which was misleading, and his references were seriously out of date. No member of the Quakers Hill Nursing Home staff got in touch with his referees or his previous employers. Nevertheless he obtained a permanent part time position at the Quakers Hill Nursing Home as the registered nurse on night duty.

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Theft of medication

On the night shift before the fire Mr Dean was observed by an assistant in nursing to be spending a large amount of time in the treatment room (which housed the medication cupboard) with the doors closed. CCTV footage showed that Mr Dean went in there 36 times over that shift and spent approximately two hours of his shift in there. During the following day staff found there to be 237 tablets of Endone and one tablet of Kapanol (both opioid medications) missing, and Mr Dean was suspected. The Police were called and attended the Quakers Hill Nursing Home to investigate but were called away on more urgent calls and the matter was not dealt with on 17 November. Police were not informed of the staff suspicions that Mr Dean was responsible for the theft of the medication. Even though he was suspected, Mr Dean was allowed to remain on the night shift and in charge of the nursing home

The fire

In the early hours of 18 November 2011, at around 5.00 am, Mr Dean lit a fire in one wing of the nursing home. Shortly thereafter, he lit a fire in another wing of the nursing home which was not detected for some time. Firefighters were called by an automatic alarm. A "000" call was not made, which delayed the allocation of extra resources to the fire. The responsibility for making the "000" call was the responsibility of the registered nurse in charge (in this case Mr Dean), but no-one else checked whether or not it had been done. The fire and rescue personnel who first arrived at the scene were engaged in the evacuations of the residents. There were numerous difficulties with the evacuations. Some beds were unable to be wheeled out of the building due to the configuration of one of the exit ramps which were positioned at a 90° angle. There were logjams of patients at exit doors, and debris was on the floor making it difficult to wheel beds.

The fire was eventually extinguished and the residents were evacuated and sent to hospitals. The lack of identification bands made notifying next of kin difficult. Sadly two residents were found dead in their beds after the fire was extinguished and another lady who was evacuated was found to have died at the scene. Eleven other residents died later.

Destruction of evidence

After the fire was extinguished, later that day Mr Dean returned to the treatment room and retrieved the drug books which were still intact. He went home and shredded them and then threw them away in a rubbish bin at the local cheesecake shop where his partner worked. He then returned again to the nursing home. He was interviewed by Police but in the first interview did not mention lighting the fire or stealing the medications. Later that evening the Police informed him he was a suspect in lighting the fires and he then admitted lighting the fires but he did not admit to stealing the medication.

In his later criminal sentencing the Presiding Judge, Her Honour Justice Latham, found that Mr Dean's intention in lighting the fires was either to deflect management from further enquiring into the theft of the medication and/or to destroy the treatment room evidence. During the investigations undertaken after the fire it was apparent that a number of staff members had concerns about Mr Dean's competence and behaviour at various times during his employment at the nursing home. Some concerns had been reported to management, but not all.

Missed opportunities

The Coroner found with hindsight there may have been an opportunity to diagnose and address Mr Dean's polysubstance abuse if a mandatory report had been made to the Australian Health Practitioner Regulation Agency (AHPRA) by St John of God Hospital about him being under the effect of drugs at work. However, Mr Dean had convinced St John of God Hospital that he was suffering from side effects of prescribed medication.

Another opportunity was missed when the Quakers Hill Nursing Home did not make background checks into his previous employment or his references before employing him. There were also missed opportunities to uncover drug abuse behaviours when nursing staff at the Quakers Hill Nursing Home saw him doing worrying things such as waking up patients to give them medications in the middle of night that they had not requested, but did not follow up.

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Desirability of training and development of protocols for mandatory reporting

The findings point to the requirements of mandatory reporting under the Health Practitioner Regulation National Law (NSW) 2009 and the desirability of nurses and health professionals to receive routine in-house training covering the potential misuse of drugs by members of their professions, the signs of impairment due to drug misuse or dependency, and protocols and procedures for reporting any concerns that might indicate a health professional is adversely drug affected. Coroner Dillon noted a general hesitancy amongst staff members to promptly and decisively take action to quarantine a nurse acting suspiciously and possibly dangerously. While there was no suggestion that the nursing home could have possibly foreseen Mr Dean's extreme response to the discovery that large amounts of Schedule 8 drugs were missing, the nursing home should have taken decisive action to suspend Mr Dean while the missing drugs were investigated, given he was the main suspect.

Lessons learned

Many lessons can be learned from the Quakers Hill Nursing Home disaster. A comprehensive set of recommendations were made. Many of these relate to aspects of fire safety, including:

- The necessity of at least one "000" (and preferably more than one) call, instead of relying on automatic systems – personal calls portray the seriousness of the emergency;
- That removal of non-ambulant patients and residents should, if reasonably practicable, be done by wheeling them out of danger in beds or wheel chairs but that alternative dragging methods may need to be employed;
- That if patients are wheeled out of their wards or rooms efficiently, passage ways must be kept as clear as is reasonably practicable;
- That the facility's fire evacuation plan take into account potential impediments to rescuing non-ambulant patients, such as connection to medical equipment, and make specific provision for addressing those challenges in an emergency;
- That fire exits and doors be kept clear of obstructions that could hinder urgent movement of non-ambulant patients in the case of sudden emergency; and
- That facilities include in their fire and emergency training regular scenario-based practical training including practice of the urgent removal of non-ambulant patients and residents.

With respect to nursing, nurses and other health professionals working in environments in which Schedule 8 drugs are dispensed to patients should be educated to recognise the signs of possible drug-dependency in their professional colleagues. The table of signs and symptoms developed by the American Nurses' Association may provide a useful foundation for such education.

Until next time…

Greg Reiffel
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