Government of **Western Australia**
Department of **Health**
Clinical Simulation Support Unit

Interprofessional Learning Through Simulation Project

It's just a fracture! – Acute episode with underlying chronic conditions and social considerations

Facilitators' Guide

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The filmed scenario has been developed from the experiences of the Interprofessional Learning in Simulation Project Steering Group. All due care has been taken to make the scenarios as realistic as possible. The characters in the filmed scenarios are fictitious and any resemblance to persons living or dead is purely coincidental.

Government of Western Australia
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Contents

How to use this resource

This resource (the Facilitators' Guide) provides the framework to support the development of communication and problem solving, together with problem-based learning scenarios that encompass some challenging (but quite typical) patients that clinicians could expect to encounter as part of their practice. The goal of this interprofessional learning experience is to help prepare all health professionals – be they students or beginning clinicians – for working together.

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This resource is intended to develop your understanding of the principles of interprofessional practice and raise your awareness of opportunities for implementing interprofessional practice in your own environment. Throughout the resource are opportunities to consider how notions of interprofessional practice affect your current work practices and activities that enable you to reflect on these.

Interprofessional learning through simulation

This resource utilises simulation as a means to facilitate a learning experience; one that re-creates events that are closely linked to reality. Gaba[1] defined simulation as a technique, rather than a technology, to replace or amplify real life experiences with guided experiences, often immersive in nature, to evoke or replicate aspects of the real world, in a fully interactive pattern.

Simulation provides a safe learning environment for students to practice, where they are free to make mistakes, correct them and improve the processes of care.[2] Simulation is the bridge between classroom learning and the real life clinical experience, allowing students to put theory into practice.

Interprofessional learning through simulation provides learning opportunities to prepare future health care professionals for the collaborative models of health care being developed internationally[3] and can encompass a range of environments and resources that harness technologies, including multimedia and online applications.[4]

Resource contents

There are four sections within this resource. Information presented in Section One and Section Two is largely focussed on interprofessional learning and Section Two also contains an introductory section on duty of care.

- Sections One and Two of this resource contain questions that require users to reflect on the content they have covered.
- Scenarios included in Section Three require users to watch the associated audiovisual resource ‘It’s just a fracture!’ and complete the questions that relate to interprofessional learning, duty of care and discharge planning.
- Section Four provides a literature review about duty of care, which can be used as reference material.

Learning objectives

The key interprofessional learning message of this resource is:

How far does duty of care reach?

The learning objectives of this resource are based on **five competency domains** from the Australian audit of interprofessional education in health:

- Teamwork;
- Understanding roles and respecting other professions;
- Role clarification;
- Understanding of Interprofessional Education (IPE); and
- Reflection.[5]

Learning outcomes will be addressed through the consideration and discussion of material presented in Sections One and Two in relation to interprofessional practice generally, and the case study presented in Section Three which is focussed more specifically on duty of care.

Learning outcomes

On completion of this resource, participants should be able to:

- Identify the key elements of interprofessional practice;
- Differentiate between interprofessional practice and current ways of working;
- Understand the importance of 'human factors' and appreciate how non-technical factors impact patient care;
- Develop an awareness of tools to enhance successful communication with patients/patients and carers;
- Describe strategies necessary to develop a deeper understanding of other professions roles and responsibilities;
- Identify what changes are required to promote interprofessional practice;
- Identify the range of health professionals involved in the care of a patient with multiple co-morbidities and inadequate home support;

- Distinguish between the roles of the health professionals that may be involved in this case study, including areas of possible overlap;
- Discuss the difficulties that may prevent interprofessional collaboration when planning care for a patient with multiple co-morbidities and inadequate home support;
- Develop an interprofessional care plan for a patient with multiple co-morbidities and inadequate home support;
- Analyse duty of care in the context of both patients and carers, and in relation to discharge planning;
- Assess the impact of team communication and team relationships on patient care; and
- Reflect on own and other health professionals' practice.

Section One: What is 'interprofessional'?

Why the need for interprofessional learning?

In today's health care setting, human service professions are facing problems so complex that no single discipline can possibly respond to them effectively.[6] The World Health Organization (WHO) has stated 'It is no longer enough for health workers to be professional. In the current global climate, health workers also need to be interprofessional'.[7]

What does the term interprofessional mean?

Interprofessional learning (IPL) is defined as:

- Learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or education settings.[8]

Encourages professions to learn with, from and about each other

Interprofessional education (IPE) is defined as:

- Occasions where two or more professions learn from, with and about each other to improve collaboration and the quality of care.[8]

Interprofessional practice (IPP) is defined as:

- Two or more professions working together as a team with a common purpose, commitment and mutual respect.[8]

When interprofessional practice is working well it is thought to achieve the following six outcomes:[9]

1. **Works to improve the quality of care:**

   No one profession, working in isolation, has the expertise to respond adequately and effectively to the complexity of many users' needs and to ensure that care is safe, seamless and holistic to the highest possible standard.

2. **Focuses on the needs of service users and carers:**

   IPL puts the interests of service users and carers at the centre of learning and practice.

3. Encourages professions to learn with, from and about each other:

IPL is more than common learning, valuable though that is to introduce shared concepts, skills, language and perspectives that establish common ground for interprofessional practice. It is also comparative, collaborative and interactive, a test-bed for interprofessional practice, taking into account respective roles and responsibilities, skills and knowledge, powers and duties, value systems and codes of conduct, opportunities and constraints. This cultivates mutual trust and respect, acknowledging differences, dispelling prejudice and rivalry and confronting misconceptions and stereotypes.

4. Respects the integrity and contribution of each profession:

IPL is grounded in mutual respect. Participants, whatever the differences in their status in the workplace, are equal learners. They celebrate and utilise the distinctive experience and expertise that participants bring from their respective professional fields.

5. Enhances practice within professions:

Each profession gains a deeper understanding of its own practice and how it can complement and reinforce that of others. This is endorsed where the IPL carries credit towards professional awards and counts towards career profession.

6. Increases professional satisfaction:

IPL cultivates collaborative practice where mutual support eases occupational stress, either by setting limits on the demands made on any one profession or by ensuring that support and guidance are provided by other professionals if and when added responsibilities are shouldered.

How is interprofessional practice different to how people currently work?

The Australasian Interprofessional Practice and Education Network (AIPPEN) have identified a number of terms currently that convey a similar but different intent and meaning to the term interprofessional.[10]

Interdisciplinary

- Interdisciplinary has been used by researchers and practitioners when they attempt to analyse, synthesise and harmonise the connections between disciplines, to generate a coordinated and coherent health delivery system.[11] 'Interdisciplinary' is said to lack the inherent depth of collaboration implied by the term 'interprofessional'.

Multidisciplinary

- Health professionals represent a range of health and social care professions that may work closely with one another, but may not necessarily interact, collaborate or communicate effectively.[12]

Multiprofessional

- Work occurs when a range of professional practitioners work in parallel. Each discipline has clear role definitions and specified tasks and there are hierarchical lines of authority and high levels of professional autonomy within the team.
- Multiprofessional, as a term, may not imply optimal levels of collaboration.
- Practitioners consult individually with service users and use their own goals and treatment plans to deliver services.[13]

Collaboration

- Is ‘an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of providers to synergistically influence the ways patient/patient care and broader community health services are provided’.[14]

Do we need to focus on interprofessional collaborative practice – don't professionals already work interprofessionally?

Interprofessional practice is a way of practicing that is based on collaboration. Nurses, doctors and other health professionals have, for a long time, worked closely together and have developed successful long-term partnerships. However, as has been stated:

> We cannot assume that health professionals have either the skills or attributes required for interprofessional practice. They may need to learn how to collaborate. Developing interprofessional practice requires a commitment to engage in shared learning and dialogue. Dialogue has the potential to encourage collegial learning, change thinking, support new working relationships, and improve patient care.[15]

Although health professionals receive extensive professional development, most training emphasises specific disease processes, technology and treatment and has largely undervalued human factors. Human factors training is necessary to help individuals learn how to improve working relationships with colleagues and those from other disciplines.[15]

The end goal of interprofessional education is to create a health workforce with improved levels of teamwork, collaboration, knowledge-sharing and problem-solving, eventually leading to better patient and patient outcomes in health settings.[16] The WHO has recognised the importance of interprofessional education and collaborative practice in developing a health workforce that is able to meet the complex health challenges facing the world and assist in the achievement of the health-related Millennium Development Goals.[7]

ACTIVITY ONE

What would you expect to notice as indicators of interprofessional practice?

What range of factors might be different in an interprofessional practice environment?

ACTIVITY ONE: ANSWER AID

Anecdotes from clinicians with an increasing awareness of interprofessional thinking and behaviour in the clinical environment:

“I went to a placement and something clicked. It gelled and I suddenly got it…it’s more than an awareness of others – you realise you are not an island and it’s up to others as well. You can recognise opportunities for patients and refer them to other disciplines”.

“I used to get frustrated at them not seeing through my discipline lens but then I saw how difficult it was for me to learn about their discipline”.

“You begin to realise you are part of a bigger picture and because of that you need to be able to communicate with people in a way they understand… I was listening to nurses with all the jargon they use and it made me become more aware of the amount of jargon I use – I thought I was practising interprofessionally but didn’t realise I was using so much jargon”.

Section Two: Competency framework for interprofessional education

Although a range of competencies have been identified, there is no one overarching framework that provides a definitive set of interprofessional competencies. Initial findings from an Australian national audit of pre-registration interprofessional education in health identified five IPE domains to support the development of a national curriculum framework. The identified domains were:

- Teamwork;
- Understanding roles and respecting other professions;
- Role clarification;
- Understanding of IPE; and
- Reflection.[5]

Patients will increasingly demand physicians, nurses and other health professionals to communicate and work together effectively

Teamwork

The identified domain 'teamwork' included the elements: communication, leadership, attitudes, team relationships and conflict resolution. We know that effective teamwork plays a key role in improving quality and safety in health care, and the need for increased collaboration and teamwork across the health professions is necessary in order to care for an ageing population with multiple chronic illnesses.[17] Patients will increasingly demand physicians, nurses and other health professionals to communicate and work together effectively. Teams bring their collective knowledge and experience to provide a more robust foundation for decision making than any single clinician can offer.[17]

Team functioning and collaboration is thought to be enhanced when individuals:

- Participate in team activities;
- Foster positive team relationships;
- Appreciate differing personalities within teams; and
- Demonstrate respect.[17]

Lack of focus on human factors

The elements that make up teamwork are regarded as 'human factors' and are the non-technical factors that impact on patient care. Human factors can be defined as the interaction of equipment and individuals and the variables that can affect the outcome.[18,19] Bromily and Reid quote Catchpole in their article,[20] stating that more broadly the term clinical human factors can also encompass interactions with the environment that include an 'understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities, and the application of that knowledge in clinical settings'.

The contemporary focus of human factors in health care reportedly had its genesis in the work of James Reason in 1995 when he stated that, 'human rather than technical failures now represent the greatest threat to complex and potentially hazardous systems'.[18] More recent research highlights that rather than poor technical skill, human factors such as suboptimal communication and organisational system and culture inadequacies were implicated in up to 87% of the errors, adverse events and near misses that occur.[21-24]

Historically, health care has regarded technical skills and competence as key to patient safety. Technical excellence in, for example, nursing and medicine is important because health care professionals need to know what they are doing to maintain high standards of care and quality outcomes for patients. However, other safety-critical industries (such as defence and aviation) have learnt that even the most technically qualified and expert individuals can encounter difficulties when under stress. Such non-technical abilities – sometimes referred to as 'soft skills' – need to be valued equally.[25] Humans, when under pressure, have a capacity to become overly focused or fixated on technical problems.[26] Focus on human factors to improve the way teams work is important because:

- Opportunities to optimise the way teams work is becoming progressively more difficult with an increasing number of part-time workers, increasing patient loads and decreased staffing;
- The attitudes and behaviours of those who make up `teams' can be problematic at times and a lack of congruence in how teamwork itself is interpreted exacerbates underlying resentments, undermines professional esteem, and in some cases, creates outright conflict; and
- Working in teams, at times, can be fraught with difficulties and the `ideal' of effective team – working as defined in the prescriptive literature, is apparently rarely realised.[27]

ACTIVITY TWO

Think about your team (past or present) and how your team functions…what are the issues that make it challenging to focus on improving team performance?

What strategies have you found to be effective in improving team performance?

What do you feel could be done to improve team performance?

Communication

Appropriate interprofessional communication:

- Maintains patient confidentiality;
- Provides and delivers feedback;
- Promotes the role of other disciplines to patient/carers;
- Communicates in a clear and concise manner;
- Validates the knowledge of other disciplines; and
- Explains discipline-specific terminology.

Interprofessional practice also places an increased focus on the needs of service users and carers. Although communication among and between professionals is critical, to ensure the interests of service users and carers remains at the centre of learning and practice, strategies to enhance communication practices with service users and carers are essential. Patient-centred care:

- Places the service users and carers at the centre of practice;
- Establishes patient-centred goals;
- Facilitates decision-making with patient/family; and
- Recognises and responds to the patient's changing needs.[28]

The mnemonic LIPSERVICE will help ensure that you consider the many aspects of successful communication with clients and patients and will be utilised later in the resource.

L is for Language	• Does your patient speak English? • How well do they speak it? • Do you need to consider getting an interpreter to assist? • What is the person's education level and understanding – will you need to modify the language you use in order to help them understand what you are asking or telling them?
I is for Introduction	• Make sure you introduce yourself to the person, and give them your role – especially if what you do is something that is not commonly known. While most patients will understand the role of a 'doctor', they may not be familiar with what an 'occupational therapist' does. If in doubt, you should explain your role.
P is for Privacy, Dignity and Cultural issues	• Is this a person who is going to be embarrassed by being examined by someone of the opposite gender? • Should you ask before you address them by their first name? Many more elderly patients are of a generation who value the respect that being called 'Mr' or 'Mrs' gives them. Be aware of different cultural expectations that you may encounter.

S is for Subjective Questioning	• This is where you take the person's history. • A thorough history will be invaluable in helping to make a diagnosis. • Be aware of the power of 'leading questions' though. • Ask open-ended rather than closed questions to obtain your answers.
E is for Examination	• Some considerations here include talking the person through what it is that you are doing, especially if this is an invasive or unusual procedure for them. • Knowing what is happening and why, as well as what to expect, can help alleviate the person's concern about what it is you are doing to them.
R is for Review	• Talk through what you have done as part of the examination – and what it added to your knowledge of their condition. • For example, 'You were talking about how you get short of breath, and I could hear from listening to your chest that your lungs are quite congested.'
V is for Verdict	• The diagnosis. • What their history and your examination have led you to think is causing their symptoms and signs.
I is for Information	• What does the diagnosis mean for the person? • Having a diagnosis of a lump in the breast can mean many things. • The person needs to know about these.
C is to remind you to Check Understanding	• This is where you determine if what you have said has made sense to the person. • People may only hear the diagnosis and then go into a state of shock – which means they don't process what you tell them next.
E is for End or Exit	• What's going to happen next for the person? • What about follow up? • Referrals to other professionals?

Understanding roles and respecting other professions / role clarification

The need to address complex health and illness problems, in the context of complex care delivery systems and community factors, calls for recognising the limits of professional expertise and the need for cooperation, coordination and collaboration across the professions in order to promote health and treat illness. However, effective coordination and collaboration can occur only when each profession knows and uses the other's expertise and capabilities in a patient-centred way.[29]

The WHO report in 2005 argued that health care providers must work interdependently, demonstrating mutual respect, trust, support and appreciation of each discipline's unique contribution. Although it is changing, the traditional way in which health professional students are educated is uni-professional, and occurs within discipline- and profession-specific groups.[30] Within uni-professional environments students develop a solid grounding in the specific knowledge of their own profession, although many, if not most, students leave educational environments with a cursory understanding of other disciplines' roles and responsibilities.

Interprofessional practice is about developing professionals who are confident in their own core skills and expertise and who are also fully aware and confident in the skills and expertise of fellow health and care professionals.

One educational approach which is thought to assist professionals to develop greater `team awareness' is to understand other professional perspectives through 'shared learning'.[27] Shared learning has the potential to deepen understanding of how professional roles and responsibilities complement each other[29] and engender a greater appreciation of 'common' or overlapping competencies.[31] An enhanced understanding of other professionals' roles and responsibilities possible through shared learning can alleviate some of the potential tensions that exist in relation to overlapping competencies between health practitioners.

Interprofessional practice is about developing professionals who are confident in their own core skills and expertise and who are also fully aware and confident in the skills and expertise of fellow health and care professionals.[32]

ACTIVITY THREE

Within your own discipline, how easy/ difficult would it be to verbalise your concerns about a colleague's knowledge, skills or competencies?

Thinking outside your own discipline, how would you know what knowledge, skills and competencies other disciplines need/ should have? Pick a discipline you have contact with and explain what it is they do, as if you were explaining it to a patient.

Would it be more or less difficult to flag concerns about a colleague from another discipline, than a colleague from your own discipline and why?

ACTIVITY THREE (continued)

Over your career, how have you learnt about other professionals' roles?

Given that optimal interprofessional practice requires you to have a deeper understanding of other professions' roles and responsibilities, identify two professions you would like (or need) to know more about and list strategies you could implement to attain a greater in-depth understanding of that profession's roles and responsibilities.

ACTIVITY THREE: ANSWER AID

Each profession's roles and responsibilities vary within legal boundaries; actual roles and responsibilities change depending on the specific care situation. Professionals may find it challenging to communicate their own role and responsibilities to others. For example, Lamb et al.[34] discovered that staff nurses had no language to describe the key care coordination activities they performed in hospitals. Being able to explain what other professionals' roles and responsibilities are and how they complement one's own is more difficult when individual roles cannot be clearly articulated. Safe and effective care demands crisply defined roles and responsibilities.

Specific Roles/Responsibilities Competencies:

RR1. Communicate one's roles and responsibilities clearly to patients, families, and other professionals.

RR2. Recognise one's limitations in skills, knowledge, and abilities.

RR3. Engage diverse health care professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.

RR4. Explain the roles and responsibilities of other care providers and how the team works together to provide care.

RR5. Use the full scope of knowledge, skills, and abilities of available health professionals and health care workers to provide care that is safe, timely, efficient, effective, and equitable.

ACTIVITY THREE: ANSWER AID (continued)

RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.

RR7. Forge interdependent relationships with other professions to improve care and advance learning.

RR8. Engage in continuous professional and interprofessional development to enhance team performance.

RR9. Use unique and complementary abilities of all members of the team to optimize patient care.

(Interprofessional Education Collaborative, 2011)

Reflection

The importance of personal reflection in interprofessional practice was highlighted in a national study designed to inform the further development of IPL in Australian health professional education and workforce development. The report identified the importance of reflection as interprofessional learning centred on:

> …the relational aspects of practice or practising, with a learning and reflective focus on the team, as well as the individual, and is responsive to a body of knowledge and ethical orientation that engages with teams and team functioning as well as individuals and individual functioning. [5]

Processes that facilitate both individual and team reflection are critical to increase awareness and understanding of intra and inter personal relationships. One such tool to assist in the process of personal or team-based reflection to generate well-considered steps to problem solving with team members, patients and clients, is the mnemonic ASPIRIN.

A	Acknowledge the problem	Basically, is there something that needs to be addressed?
S	Situational analysis	What is the cause of the situation? How did it come about and who is involved? What is likely to happen if you don't act? What are the risks if you do act?
P	Provide some solutions.	There is almost always more than one approach that could be used to try and solve this situation. Decide on which is the most suitable.
I	Implement	Your preferred solution.
R	Review the outcome	How did it help? Do you need to try something else?
I	Inform stakeholders	Let people know – communication is very important.
N	Next steps	Is this a temporary fix? Do you need to look at a different long term solution? Will the problem occur again and again unless steps are taken to resolve it in the longer term?

ACTIVITY FOUR

Consider a problem (past or present) and utilise ASPIRIN to assist you to generate new ways of thinking about that situation.

Reflect on how you consider interprofessional practice has the potential to impact upon patient outcomes.

Reflect on what you have covered in this resource thus far and consider what changes you need to make to ensure your own practice is interprofessionally focussed.

Duty of care

The ageing population in Australia creates the potential for complex situations that can complicate the discharge planning process. The goal of discharge plans is to create a safe environment that protects the patient from danger and fosters his or her recuperation.[33] Health care practitioners' duty of care to patients and their carers has both legal and ethical implications for discharge planning. The 'Code of conduct for registered health practitioners in Australia' states that: 'Practitioners have a duty to make the care of patients or clients their first concern and to practice safely and effectively'. The Code further details these duties in the context of providing good care, effective communication, coordinating care with other practitioners, health advocacy and minimising risk, all of which comprise elements of effective discharge planning.[34] Key points in relation to duty of care follow:

- Duty of care is an ethical principle and a legal concept, both of which have implications for practice.
- Ethics can be discussed in terms of the four principles approach:
    1. **Autonomy**: 'deliberate self-rule'. Two conditions are essential to autonomy: agency and liberty;
    2. **Justice**: the fair and equitable distribution of benefits, burdens, and duties among members of society;
    3. **Beneficence**: 'to do good'. In the context of health care, this means that one should always do what is best for the patient; and
    4. **Nonmaleficence**: 'above all, do no harm'. This principle encompasses due care or duty of care.
- There are five rules supported by **nonmaleficence**:
    1. Do not kill;
    2. Do not cause pain or suffering;
    3. Do not incapacitate;
    4. Do not cause offense; and
    5. Do not deprive others of the goods of life.[35]

Points to consider

- There are situations in health care whereby an action may have both a harmful and beneficial effect: this is called the **principle of double-effect**.
- Nonmaleficence means not inflicting harms, and also not imposing *risks* of harm.
- Because the exact consequences of actions may be difficult to predict, nonmaleficence often means weighing probable benefits against potential risks of harm.
- Avoiding 'actual' harm and also the 'risk' of harm means a violation of the principle of nonmaleficence can occur as a result of what is done (commission) as well as what is not done (omission).
- A person can harm or place another person at risk without harmful intent.
- Duty of care, or due care, is taking sufficient and appropriate care to avoid causing harm, as the circumstances demand of a reasonable and sensible person.
- In legal terms, **negligence is the absence of due care**.
- Negligence is a tort, or civil wrong.

There are **four elements** that constitute a negligence action:

1. **There was a duty of care**
    - Due to patients' dependence upon health carers for physical and mental care, the law has established that health carers owe a duty of care to patients.
    - This reflects the neighbour principle.
    - Under Australian law there are certain categories outside of work where no liability for negligence will arise.
    - In a professional capacity, the common-law principle is that a health professional who owes a duty of care to a patient or client is required to exercise the skill and care that, objectively, would be expected of the ordinary reasonable skilled health professional (of a given discipline) in the particular situation under consideration.
    - The standard of care required by health professionals in law has been established in civil liability legislation; however this varies in each State and Territory in Australia.
    - The neighbour principle means that duty of care is owed not only to patients but to others whose wellbeing and property may be harmed by failure to take responsible care of a patient (i.e. third parties).

2. **The act or failure to act (omission) fell below the expected standard**
    - If what the defendant did or failed to do fell below the standard of care expected, the defendant is in breach of his or her duty of care.
    - When delegating, the individual who takes on the job becomes personally liable for their own professional actions.
    - Generally, the law will give no special consideration to beginners and learners.

3. **The act or failure to act was the direct cause of damage**
    - The plaintiff must have suffered damage.
    - There must be a direct causal relationship between the damage and the negligent act.

4. **This damage was reasonably foreseeable**
    - The defendant should have to compensate the plaintiff only for such damage that can be said to be a reasonably foreseeable consequence of the defendant's negligence.
    - Defences to an action in negligence include contributory negligence and vicarious liability.

Duty of care in the context of discharge planning has become increasingly complex, particularly when planning care for elderly patients/clients and their carers'. Court rulings (in the USA) have raised questions around how far duty of care extends, who is responsible and the foreseeability of harm to patients and third parties. Interprofessional teamwork and effective communication optimise the success of discharge planning coordination of home care.[36] This is likely due to an increase in diffusion of responsibility, as represented by Reason's Swiss Cheese Model. This model suggests that holes in the cheese slices represent individual weaknesses in individual parts of the system, and are continually varying in size and position in all slices. The system as a whole produces failures when all of the holes in each of the slices momentarily align, permitting 'a trajectory of accident opportunity', so that a hazard passes through all of the holes in all of the defences, leading to a failure.[37]

A more complete literature review about duty of care is available in Section Four.

Resource activities in relation to duty of care follow in Section Three.

The scenario in Section Three highlights the importance of duty of care and its implications for interprofessional collaborative practice.

Section Three: Scenario – It's just a fracture!

Scenario

Mary Jones is brought to the Emergency Department (ED) after a fall resulting in a Colles' fracture and fractured collar bone. During the fall she has also broken her glasses. Mary has a range of chronic health problems. Mary is brought to the ED by her son Simon, who seems agitated and eager to leave as soon as possible.

List of characters

- Mary Jones
- Simon Jones
- Emergency Department doctor
- Emergency Department nurse
- Occupational therapist

What to do next

Section Three of the resource requires that you:

1. Watch each scene of the associated resource 'It's just a fracture!':
    - Scene One – Emergency Department
    - Scene Two – Emergency Department cubicle
    - Scene Three – Nurses' station
    - Scene Four – Interview with occupational therapist
    - Scene Five – Nurses' station
2. After you have watched a scene, complete the activity questions relevant to that footage.
3. If necessary, refer to the answer aid boxes after the activity questions for hints relating to duty of care.

Scene One: Emergency Department

Please watch It’s just a fracture!: Scene One

Notes:

ACTIVITY FIVE

What are some of the challenges facing the interprofessional team in this scenario?

Describe the positive and negative impact patient flow initiatives, like the Four Hour Rule, have on effective teamwork using the aims of IPP:

- Communication;
- Role boundaries;
- Understanding roles and respecting other professions;
- Patient-centred care;
- Role clarification.

ACTIVITY FIVE (continued)

What human factors do you think may be influencing the interaction between the nurse and registrar at the end of the scene?

What might be some of the cues you would observe if a colleague was experiencing diminished situational awareness?

ACTIVITY FIVE: ANSWER AID

Four Hour Rule:

In 2011, WA signed the National Partnership Agreement on Improving Public Hospital Services. The agreement includes the National Emergency Access Target (NEAT), which will drive improvements in access to emergency care for patients. The NEAT requires that by 2015, 90% of all patients presenting to a public hospital ED will be admitted, transferred or discharged within four hours. Between now and 2015 each State is required to meet annual interim targets which increase progressively until 2015. Performance is calculated as an average of all participating hospitals over the calendar year.

(Source: Government of Western Australia)
http://www.health.wa.gov.au/emergencyaccessreform/home/

Situational Awareness (SA):

Level 1 SA – perception of information and cues from the environment. No interpretation or integration of data occurs at this stage. *"What are the current facts relevant to this case?"*

Level 2 SA – comprehension of the situation and the way the individual combines, interprets, stores and retains information. *"What is going on?"*

Level 3 SA – the ability to forecast future events and dynamics and is the highest level of understanding of the situation. *"What is most likely to happen if?"*

Level 4 SA – Resolution: awareness of the best available path to follow from several available paths to achieve the needed outcome in the situation. *"What exactly shall I do?"*

(Source: Singh et al. 2006)[38]

Scene Two: Emergency Department cubicle

Please watch It's just a fracture!: Scene Two

Notes:

ACTIVITY SIX

If you were writing the script for this scene, what attitudes and behaviours would you change in regard to the:

- Registrar;
- Mrs Jones;
- Son?

The son seems agitated and is potentially causing some disruption. How might the ED staff address this for both his and others' safety?

Identify which other health disciplines could be included in this scenario and how they may contribute to the overall care.

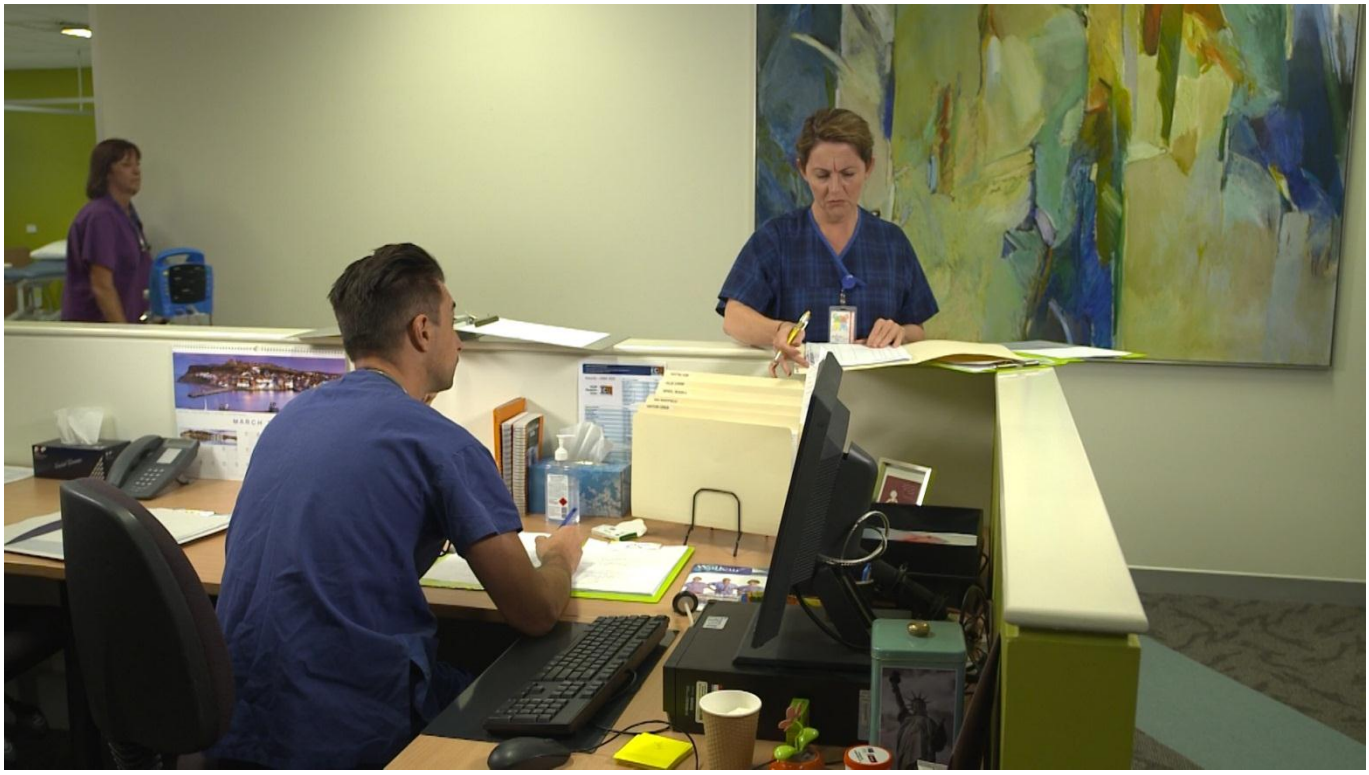
ACTIVITY SIX: ANSWER AID

The son seems agitated and is potentially causing some disruption. How might the ED staff address this for both his and others' safety?

- It is foreseeable that Mary's son will not be capable of adequately caring for her while she recuperates.
- Failure to act (omission) constitutes an infringement of duty of care.
- Consider duty of care to third parties.

Scene Three: Nurses' station

Please watch It's just a fracture!: Scene Three



Notes:

ACTIVITY SEVEN

What factors might make one member of the team more aware of a patient's needs than another?

How would you improve the communication between the registrar and the nurse?

Is it the patient's responsibility to speak up about her home situation, or is it the health professional's responsibility to explore this?

ACTIVITY SEVEN (continued)

Why would you, as a health professional, explore the home situation? What would keep you from doing this?

What would an interprofessional care plan for a patient with multiple co-morbidities and inadequate home support look like?

ACTIVITY SEVEN: ANSWER AID

Is it the patient's responsibility to speak up about her home situation, or is it the health professional's responsibility to explore this?

- There is possible conflict between the ethical principles of respect for autonomy and nonmaleficence.
- Autonomy underpins privacy, confidentiality, veracity and consent, and assumes that the individual has the capacity for deliberation.
- When ethical principles are in conflict, nonmaleficence is usually the more stringent duty.
- Obligations of nonmaleficence are not only obligations of not inflicting harms but also include obligations of not imposing *risks* of harm.

Scene Four: Interview with occupational therapist

Please watch It's just a fracture!: Scene Four

Notes:

ACTIVITY EIGHT

What would a team-based approach to patient-centred care look like?

In this situation, what role could team members have played that would result in more effective team work?

How can the patient best be supported as an active participant in the health care team?

ACTIVITY EIGHT: ANSWER AID

How can the patient best be supported as an active participant in the health care team?

As a patient, being an active participant in the health care team includes:

- Taking an active role in disease management;
- Taking responsibility (helping make decisions about treatment, setting treatment goals, collaborating with others);
- Gathering evidence/research;
- Being aware of medical errors;
- Advocacy – self and others; and
- Being confident in own decisions.

Engagement, information and community support facilitate patient autonomy and empowerment.

Scene Five: Nurses' station

Please complete Activity Nine *before* watching It's just a fracture!: Scene Five, and then complete Activity Ten.

Notes:

ACTIVITY NINE

What would you identify as gaps in Mrs Jones' and her son's care and support in this situation?

If you were discussing this case with a colleague, what duty of care issues would you raise to include referrals for Mrs Jones' son as part of her management plan?

ACTIVITY NINE (continued)

What services and professionals might assist Mrs Jones' son and what do you understand they would contribute to his wellbeing? How will you verify your understanding?

In the next scene, consider whether all the stages of iSoBAR are completed.

ACTIVITY NINE: ANSWER AID

If you were discussing this case with a colleague, what duty of care issues would you raise to include referrals for Mrs Jones' son as part of her management plan?

- It is foreseeable that leaving Mrs Jones (and her demented husband) in the care of the son could constitute an unsafe environment.
- As Mrs Jones is her husband's carer, the duty of care to Mrs Jones extends to her husband (third party).
- Both Mrs Jones and her husband are at risk if Simon is unable to adequately care for them and facilitate Mrs Jones' recuperation.

In the next scene, consider whether all the stages of iSoBAR are completed.

iSoBAR: a handover "how to"

i **IDENTIFY** – Introduce yourself and your patient.

S **SITUATION** – Why are you calling? Briefly state the problem.

o **OBSERVATIONS** – Recent vital signs and clinical assessment.

B **BACKGROUND** – Pertinent information related to the patient.

A **AGREED PLAN** – What needs to happen? Assessment of the situation.

R **READ BACK** – Clarify and check for shared understanding. Who is responsible for what and by when?

(Source: Porteous et al. 2009)[39]

ACTIVITY TEN

What evidence did you find in this scene that demonstrated patient-centred care?

What changes will you make in your personal (future) practice as a result of what you've learnt in this scenario?

ACTIVITY ELEVEN

Watch Scenes One to Five again and complete LIPSERVICE (below) to determine how focused the individual characters were on the needs of service users and carers.

First letter	LIPSERVICE Questions	Your notes
L is for Language	• Does your patient speak English? • How well do they speak it? • Do you need to consider getting an interpreter to assist? • What is the person's education level and understanding – will you need to modify the language you use in order to help them understand what you are asking or telling them?	
I is for Introduction	• Make sure you introduce yourself to the person, and give them your role – especially if what you do is something that is not commonly known. While most patients will understand the role of a 'doctor', they may not be familiar with what an 'occupational therapist' does. If in doubt, you should explain your role.	
P is for Privacy, Dignity and Cultural issues	• Is this a person who is going to be embarrassed by being examined by someone of the opposite gender? • Should you ask before you address them by their first name (many more elderly patients are of a generation who value the respect that being called 'Mr' or 'Mrs' gives them). • Be aware of different cultural expectations that you may encounter.	
S is for Subjective Questioning	• This is where you take the person's history. • A thorough history will be invaluable in helping to make a diagnosis. • Be aware of the power of 'leading questions' though. • Ask open-ended rather than closed questions to obtain your answers.	

E is for Examination	• Some considerations here include talking the person through what it is that you are doing, especially if this is an invasive or unusual procedure for them. • Knowing what is happening and why, as well as what to expect, can help alleviate the person's concern about what it is you are doing to them.
R is for Review	• Talk through what you have done as part of the examination – and what it added to your knowledge of their condition. • For example, 'You were talking about how you get short of breath, and I could hear from listening to your chest that your lungs are quite congested.'
V is for Verdict	• The diagnosis. • What their history and your examination have led you to think is causing their symptoms and signs.
I is for Information	• What does the diagnosis mean for the person? • Having a diagnosis of a lump in the breast can mean many things. • The person needs to know about these.
C is to remind you to Check Understanding	• This is where you determine if what you have said has made sense to the person. • People may only hear the diagnosis and then go into a state of shock – which means they don't process what you tell them next.
E is for End or Exit	• What's going to happen next for the person? • What about follow up? • Referrals to other professionals?

Section Four: Literature review – Duty of Care

The ageing population in Australia creates the potential for complex situations that can complicate the discharge planning process. The goal of discharge plans is to create a safe environment that protects the patient from danger and fosters his or her recuperation.[33] Health care practitioners' duty of care to patients and their carers has both legal and ethical implications for discharge planning. The 'Code of conduct for registered health practitioners in Australia' states that: 'Practitioners have a duty to make the care of patients or patients their first concern and to practise safely and effectively'.[34] The Code further details these duties in the context of providing good care, effective communication, coordinating care with other practitioners, health advocacy and minimising risk, all of which comprise elements of effective discharge planning. Duty of care will therefore be discussed in relation to both the ethical principles and legal concepts, and implications for practice.

Ethical principles and implications

Ethics can be discussed in terms of the **four principles approach**, which aims to develop a practical bridge between ethical theories and common morality that can be used in making decisions in health care.[40] To contextualise the concept of duty of care in an ethical sense, the four principles will be briefly discussed.

Autonomy

'Autonomy, described as 'deliberate self-rule', recognises the right of a person to have an opinion, make choices, and take actions based on personal values and beliefs'.[40] Beauchamp and Childress[41] asserted that two conditions are essential to autonomy: agency and liberty. To meet the condition of agency, a patient must possess the capacity for both understanding and intention. The condition of liberty requires that a patient have access to information about his or her condition and options and freedom from coercion.[33] Autonomy underpins privacy, confidentiality, veracity and consent, and assumes that the individual has the capacity for deliberation.[40]

In health care areas, different kinds of professional behaviour prompt bioethical concerns because they violate patients' authority. Such behaviour includes treating patients without their consent or without giving them all the relevant information necessary for making an informed and intelligent choice; lying to patients or withholding information; forcing information upon

patients when they have expressed a wish not to receive it; and forcing health care staff to act against their consciences.[42]

There are five components of informed consent:

1. Competence;
2. Disclosure;
3. Understanding;
4. Voluntariness; and
5. Consent.

Some writers present these elements as the building blocks for a definition of *informed consent*: One gives an informed consent to an intervention if (and perhaps only if) one is competent to act, receives thorough disclosure, comprehends the disclosure, acts voluntarily, and consents to the intervention.[35]

Standards of competence feature mental skills or capacities closely connected to the attributes of autonomous persons, such as cognitive skills and independence of judgment. In medical contexts, a person is usually considered competent if able to understand a therapeutic or research procedure, to deliberate regarding its major risks and benefits, and to make a decision in light of this deliberation.[35]

The principle of autonomy is supported by the 'Code of conduct for registered health practitioners', which states that providing good care includes 'recognising and respecting the rights of patients or clients to make their own decisions' and that good practice involves 'practising patient/client-centred care, including encouraging patients or patients to take an interest in, and responsibility for the management of their health and supporting them in this'.[34]

Ethical dilemmas can arise in health care when what is in the patient's best interests conflicts with their customs, values and spiritual beliefs. Consider, for example, the case of an adult Jehovah's Witness patient who refuses a blood transfusion, or a patient with chronic obstructive pulmonary disease (COPD) who refuses to stop smoking cigarettes.[43]

Justice

Justice, in an ethical sense, refers to the fair and equitable distribution of benefits, burdens, and duties among members of society. There are four ways to conceive what is fair and equitable among people.[40]

Justice as fairness

The concept of justice as fairness was first expressed by the English philosopher John Rawls. Justice as fairness concerns human equality and, applied to the health care area, focuses on the provision of equal treatment regardless of social attributes such as gender, religion, age and birthplace.[44] To be clear, equality does not mean that everyone should receive the same treatment, but rather that they receive appropriate treatment in relation to their illness, regardless of their social attributes.[42]

> Virtually all accounts of justice in health care hold that delivery programs and services designed to assist persons of a certain class, such as the poor or the elderly, should be made available to all members of *that class*. To deny benefits to some when others in the same class receive benefits is unjust. But is it also unjust to deny access to equally needy persons outside of the delineated class (e.g. workers with no health insurance)?[35]

In current health service delivery there are many examples of people gaining preferential treatment and of others being denied access to needed services.[40]

Comparative justice

Comparative justice in the health area holds that our response to any one person's health needs can only be determined by comparing them and weighing them up alongside the competing needs of others.[42] In other words, the best way to achieve the best outcomes for the greatest number of people is to prioritise them so that the greatest needs receive the greatest resources.

A practical example of comparative justice is in the emergency situation triage system, whereby decisions regarding who should receive treatment first are based on who has the greatest need. While triage could be seen as unfair to some, it is a process that results in the likelihood of the greatest number of people surviving.[40]

The health care system has far greater demand for services than resources available. Making choices about who should receive services first (e.g. waiting lists) are common realities for health professionals.[40]

Distributive justice

Issues surrounding allocation of resources in the health care area are often related to notions of justice. Comparative justice is often discussed in the context of 'micro allocation' of resources,

whereas distributive justice is related to macro allocation of health care resources, characterised by questions such as:

- What proportion of total resources should be allocated to health care?
- How do you allocate resources so as to maximise the level of health care for the greatest number of people?
- Is it better for most members of society to receive low cost, basic health care or for a smaller proportion to receive expensive, high standard care?
- Which is the better approach to providing health care – preventative medicine or curative medicine?
- How should resources be allocated to the particular sub-areas of medicine (such as heart transplants, mass screening programs for cancer or IVF units)?[42]

Widely-held values are applied to decide who is best able to make use of the benefits and most able to shoulder the burdens so that society can function well. Some societal norms that are used to distribute benefits and burdens are: giving each person an equal share, or giving to each person according to their need, effort contribution or merit, according to free-market exchange.[35]

Philosophers and others have proposed each of the following principles as a valid material principle of distributive justice:

1. To each person an equal share;
2. To each person according to need;
3. To each person according to effort;
4. To each person according to contribution;
5. To each person according to merit; and
6. To each person according to free-market exchanges.[35]

There are some properties that are morally indefensible norms in the determination of justice, such as gender, race, intelligence, social standing, nationality, age or sexual preference. These properties are not acceptable because they are attributes afforded a person through either natural or social lotteries, not through personal effort or action.[40]

> The **fair opportunity rule** says that no person should receive social benefits on the basis of undeserved advantageous properties (because no persons are responsible for having these properties) and that no persons should be denied social benefits on the basis of undeserved disadvantageous properties (because they are not responsible for these properties). Properties distributed by the lotteries of social and biological life do not provide grounds for morally acceptable discrimination between people in social allocations if they are not properties that people have a fair chance to acquire or overcome.[35]

The fair opportunity rule underpins non-discrimination and equal opportunity law and policies to ensure that benefits are distributed on merit alone and burdens are shared equitably.[40]

Compensatory justice

Compensatory justice suggests that people experiencing problems such as discrimination should receive some form of compensation or be given added resources to redress the balance, even though there is no particular person or organisation that can be blamed for the situation. The principle of affirmative action proposes to redress past discrimination against women and minority groups (e.g. Aboriginal people) through measures to improve their economic and educational opportunities.

Affirmative action, in the form of special services and programs aimed at improving health and educational outcomes of Aboriginal people, is funded through government grants. These resources are taken away from general services and, as such, have been criticised as a waste of money and being discriminatory against other Australians.[40]

Beneficence

The principle of beneficence, in simple terms, means ‘to do good’. In the context of health care, this means that one should always do what is best for the patient, and that the good of the patient should be put before one’s own needs.[43] This principle entails not only preventing harm, but also actively promoting the health and welfare of the patient. Beneficence is integral to the development of discharge plans, because the goal of such plans is to create a safe environment that protects the patient from danger and fosters his or her recuperation.[33]

Examples of the rules of beneficence, in their most general forms, are:

1. Protect and defend the rights of others;
2. Prevent harm from occurring to others;

3. Remove conditions that will cause harm to others;
4. Help persons with disabilities; and
5. Rescue persons in danger.[35]

An example of beneficence in practice is the 'slow code', or delayed cardiopulmonary resuscitation (CPR), whereby efforts to save a terminally ill patient are delayed to the point of inefficacy. This act may be seen as beneficent, as it assures the patient's family that 'everything' is being done, while providing the patient with 'a means to a successful exit from their devastating illness'.[45]

In relation to the principle of beneficence, the crucial questions are: *Who decides what is in the patient/client's best interests, and on what basis?* Two of the principal constraints against or criticisms of beneficence are that (1) it implies paternalism, and (2) it may conflict with the principle of justice.[43]

In a health context, paternalism has come to mean behaving in a way that does not respect a person's autonomy, for that person's supposed good. This carries overtones of immorality or, at least, of conflict between the principles of autonomy and beneficence.[40] Throughout the history of health care, the professional's obligations and virtues have been interpreted as commitments of beneficence. Hippocrates wrote '*As to disease, make a habit of two things – to help, or at least to do no harm'.*[35] In the past, there has been an assumption that health professionals, particularly doctors, 'know best' and have been justified in making decisions on a patient's behalf if it is deemed to be in that patient's best interests. As assertions of patient autonomy have increased, the problem of paternalism has loomed larger.[35]

The obligation of beneficence is further complicated by the principle of justice. That is, the duty to do good is a duty to do good to all patients equally. Herein lies the dilemma. Is it always possible to do good for one person, without doing less good for another? When dealing with more than one patient's needs, it may be necessary to not do all that any one individual might deserve or need, but what will result in the most good for all.[43]

Nonmaleficence

The principle of nonmaleficence can be summarised as an obligation to 'above all, do no harm' and has been described as the cornerstone of health care on which practices and legislation relating to duty of care, negligence and malpractice are based.[40] The principles of beneficence

and nonmaleficence are intrinsically entwined. Some ethicists argue that the duty of nonmaleficence is more stringent than the duty of beneficence.

A frequently cited illustration of this is:

> Our duty to not push someone who cannot swim into deep water seems stronger than our duty to rescue someone who has accidentally strayed into deep water.[41]

To distinguish between beneficence and nonmaleficence, Beauchamp & Childress[35] have grouped the principles into an arrangement of four norms:

Nonmaleficence

1. One ought not to inflict evil or harm;

Beneficence

2. One ought to prevent evil or harm;
3. One ought to remove evil or harm; and
4. One ought to do or promote good.

The principle of nonmaleficence focuses on actions which either permit or cause, or intend to permit or cause, harm or risk of harm. The principle is not absolute, in that most health interventions inflict some harm.[40]

According to Beauchamp & Childress,[35] there are five rules supported by nonmaleficence:

1. Do not kill;
2. Do not cause pain or suffering;
3. Do not incapacitate;
4. Do not cause offense; and
5. Do not deprive others of the goods of life.

There are situations in health care whereby an action may have both a harmful and beneficial effect. For example, vaccination programs seek to do good by preventing the spread of infectious diseases however the injection administered to the individual patient causes pain (harm) and in some cases side-effects that may be harmful. This is called the **principle of double-effect**. To apply the principle ‘above all, do no harm’ in the case of giving vaccinations

is illogical, as it would mean not vaccinating anyone and that would have obvious harmful effects.[43] When weighing up whether an act is more harmful than beneficial, the following criteria should be met:

1. The act itself must be morally good, or at least neutral;
2. The purpose must be to achieve the good consequence, the bad consequence being only a side-effect;
3. The good effect must not be achieved by way of the bad, both must result from the same act; and
4. The bad result must not be so serious as to outweigh the advantages of a good result.[43]

Nonmaleficence and Duty of Care

Obligations of nonmaleficence are not only obligations of not inflicting harms but also include obligations of not imposing *risk*s of harm.[35] Because the exact consequences of actions are often undiscernible, nonmaleficence frequently entails weighing probable benefits against potential risks of harm. Difficulties arise when professionals, patients and family members disagree as to what constitutes a benefit or harm. In discharge planning, the health professional's responsibility is to consider the impact of post-hospitalisation plans on the physical and psychosocial wellbeing of the patient.[33]

Avoiding 'actual' harm and also the 'risk' of harm means a violation of the principle of nonmaleficence can occur as a result of what is done (commission) as well as what is not done (omission). Both types of violation are evident in the more common ways duty of care is infringed. This is evident in Table 1 below.

The line between due care and care that falls below or exceeds what is due is often difficult to draw. This presents difficulties for determining the scope of obligations of nonmaleficence. Several guidelines have been developed in religious traditions, philosophical discourse, professional codes, and the law to specify requirements of nonmaleficence in health care, particularly with regard to treatment and non-treatment decisions. These guidelines often draw on the following distinctions:

1. Withholding or withdrawing life-sustaining treatment;
2. Extraordinary (or heroic) and ordinary treatment;
3. Artificial feeding and life-sustaining medical technologies; and

4. Intended effects and merely foreseen effects.[35]

A person can harm or place another person at risk without malicious or harmful intent, and the agent of harm may not be morally or legally responsible for the harms. In some cases, agents are causally responsible for a harm when they do not intend or are unaware of the harm being caused. Duty of care, or due care, is taking sufficient and appropriate care to avoid causing harm, as the circumstances demand of a reasonable and prudent person.[35]

Table 1: Common infringements of the duty of care

Acts of commission	Acts of omission	Acts of commission and omission
	Failure to refer	Departure from normal approved practice
	Failure to adopt recognised precautions	Providing incorrect diagnosis
	Failure to attend or examine	Error in the nature of provision of treatment
	Failure to diagnose	Poor delegation
	Failure of communication	Negligent use of certificates
	Failure to warn or explain	Negligent advice
	Failure to inform when something goes wrong	
	Failure to control a patient adequately	
	Failure to keep abreast of the current state of knowledge	

Source: Lewins, 1996[42]

Legal concepts

Negligence

Negligence is the absence of due care. Negligence is a tort (civil wrong) that has grown over the last century. Negligence has evolved from 'an action to achieve adjustment of losses based on recognising liability if fault could be proved to an expanded, and still growing, concept that also recognises damage caused by omissions, that is, failure to act'.[46]

This area of the law permits patients, or relatives of patients, to bring claims against hospitals, health authorities, medical practitioners, nurses and other health professionals seeking financial compensation as a result of an alleged negligent act that has caused personal pain, damage and financial loss, both present and future.[47]

The relevant legislation in each State and Territory of Australia is set out in Table 2.

Table 2: Legislation relevant to a claim alleging professional negligence

State or Territory	Legislation
New South Wales	*Civil Liability Act 2002*
Victoria	*Wrongs Act 1958*
Queensland	*Civil Liability Act 2003*
South Australia	*Civil Liability Act 1936*
Western Australia	*Civil Liability Act 2002*
Tasmania	*Civil Liability Act 2002*
Northern Territory	*Personal Injuries (Liabilities and Damages) Act 2003*
Australian Capital Territory	*Civil Law (Wrongs) Act 2002*

Source: Staunton and Chiarella, 2008[47]

Elements of negligence

There are four elements that constitute a negligence action:

1. There was a duty of care;
2. The act or failure to act (omission) fell below the expected standard;

3. The act or failure to act was the direct cause of damage; and
4. This damage was reasonably foreseeable.[46]

Principle One – Duty of care

Due to the dependence upon the health carer for the physical and mental care, and wellbeing of the patient, the law has established that the health carer owes what is called a 'duty of care' to the patient. This is based on the principle that a person must take reasonable care to avoid acts or omissions which would be likely to harm any person they ought reasonably foresee as being so harmed (their legal 'neighbour').[48]

The neighbour principle arose from the findings of *Donoghue v Stevenson* (1932) AC 562 (House of Lords, England). This became known as the 'snail in the ginger beer bottle' case and many of the principles that govern negligence issues today arose from the findings of that case:

> A woman's companion bought her a bottle of ginger beer and poured it out for her. The ginger beer contained what appeared to be the decomposing remains of a snail, which caused the woman both physical and mental harm, severe enough for her to sue the manufacturer of the drink.[48]

This was a landmark case in establishing the modern definition of duty of care. Prior to this, one only had a legal duty of care to those with whom one shared a special relationship (e.g. parent and child). The manufacturer of the ginger beer had a duty of care only to the retailer to whom he supplied, not to the consumer of the goods. Many in the legal profession felt it was time this changed, as consumers of faulty goods had no redress under the law. It is therefore believed that members of the legal profession financed the woman's case to the House of Lords, where Lord Aitkin subsequently made his landmark ruling in her favour.[48]

Arising from Lord Aitkin's judgment is what is known as the '**neighbour test**':

> You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be – persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.[48]

So a neighbour is someone who can be reasonably foreseen as being affected by your actions, and therefore does not need to be in immediate, direct, physical proximity. Duty of care therefore captures those who delegate, those who have responsibility over their staff, students,

volunteers and contractors: anyone whose actions could reasonably affect others by those actions.[46]

Duty of care outside work

Outside work, there are certain categories where no liability will arise (under Australian law). The first category includes activities that may be considered socially valuable:

- Public authorities, particularly those who provide or manage services for the general benefit of the community;
- 'Good Samaritans' who provide assistance in emergencies; and
- Volunteers involved in carrying out work in community organisations.

The second category is where the plaintiff should bear the risks associated with a particular activity:

- Activities that involve inherent and/or obvious risks;
- Certain recreational activities;
- Consumption of alcohol, or other drugs; and
- Criminal activity, including where the defendant acts in self-defence.[47]

Duty of care in a professional capacity – Standard of care

In a professional capacity, the common-law principle is that a health professional who owes a duty of care to a patient or client, is required to exercise the skill and care that, objectively, would be expected of the ordinary reasonable skilled health professional (of a given discipline) in the particular situation under consideration. It is not possible to give a list of predetermined guidelines as to what is or what is not reasonable in every conceivable incident that may arise. What is or is not reasonable depends on the facts and circumstances of each individual case.[47]

The standard of care required by health professionals in law has been established in civil liability legislation; however this varies in each State and Territory in Australia (see Table 2).

Suggested considerations in identifying a reasonable standard of care include:

- Is this the way I've been taught to proceed in these circumstances?
- Is this situation covered by hospital/health care facility policies/procedures?

- Is this the way freely available textbooks or journals tell me to proceed?
- Is advice and/or assistance reasonably available and should I seek it?
- What do my colleagues and superiors say should be done in this sort of situation?

Factors determining 'reasonable' care include:

- The circumstances (e.g. urgency, resources);
- Practice established by the profession;
- The condition of the patient; and
- The magnitude of the probable harm.[48]

Determining the standard of care expected in a given situation requires gathering evidence from the following sources:

- Professional peers;
- Statutory provisions;
- Departmental guidelines and/or employer policy and procedure directives;
- Professional standards of practice; and
- Academic texts and publications.[47]

The ***Bolam*** test originates from the United Kingdom decision of *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582:

> Mr Bolam was admitted to hospital as a voluntary patient to undergo electroconvulsive therapy (ECT) for depression. In accordance with his usual practice at the time, the treating doctor administered ECT unmodified; that is, no relaxant drug was given before the treatment and no manual restraint was applied other than holding Mr Bolam's chin and nurses being present at either side of the couch in case he fell off. During the treatment, Mr Bolam sustained bilateral fractures of the pelvis caused by the head of femur being driven through the acetabulum. Mr Bolam sued the hospital, alleging the doctor was negligent on three grounds:
>
> - Failing to administer any relaxant drugs prior to the ECT;

- Failing to provide some form of manual control or restraint; and
- Failing to warn Mr Bolam of the risks involved in treatment.

> The *Bolam* principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes a duty of care: but the standard of care is another matter of medical judgment.[47]

In Australia, the High Court declined to follow the *Bolam* test in relation to the principle to be applied in determining the standard of care for medical practitioners (it would also apply to other health professionals). This case illustrates the obligation to provide sufficient evidence about a proposed treatment and associated risks as part of the duty of care:

> In this case an ophthalmologist (Rogers) did not explain that a very rare complication was possible as a result of proposed surgery. Postoperatively, Mrs Whitaker suffered this complication, resulting in total blindness.[46]

In the case of *Rogers v Whitaker* (1992) 109 ALR 625 the High Court rejected the *Bolam* test and determined that a decision as to whether the standard of care had been met in relation to the examination, diagnosis, information, advice and treatment given to a patient was a matter for the court to determine on all the evidence and not by reliance on professional practice.[47]

Duty of care to third persons

The neighbour principle means that duty of care is owed not only to patients but to others whose wellbeing and property may be harmed by failure to take responsible care of a patient. Thus, for example, potentially dangerous individuals must be properly supervised and cared for to prevent them from harming others, and not carelessly allowed to leave an institution if they show a tendency to violence (*Holgate v Lancashire Mental Hospital Board* (1937) 4 All ER 19).

In this case, the defendants allowed the release on ‘holiday licence’ of a compulsorily detained man with a propensity for violence without making any checks in relation to his supervision while out. He attacked the claimant, who succeeded before a jury. The report sets out the judge’s direction to the jury, which appears to have been on the basis that a duty of care existed. In this case, the hospital made no proper inquiry as to the circumstances after discharge of the patient.[48]

In the case of *BY v Oei* (1999) NSWSC 1082:

> A man was the patient of a medical practitioner. He suffered Hepatitis B yet was not (the court found) advised by the medical practitioner to undergo an HIV test. Later the man formed a relationship with a woman who was not a patient of the medical practitioner. She acquired HIV by transmission from the man, and succeeded in a claim against the medical practitioner who was held to owe a duty to the male patient's later sexual partners.[48]

Principle Two – The act or failure to act (omission) fell below the expected standard

If what the defendant did or failed to do fell below the standard of care expected, the defendant is in breach of his or her duty of care. This means, that on the balance of probabilities, it has been established:

- A duty of care exists;
- The standard of care expected as part of that duty; and
- That the defendant failed to achieve the standard of care expected in the circumstances under review.

If that is so, then:

- The defendant is in breach of his or her duty of care to the plaintiff.[47]

Delegation

It is not unusual to hear qualified health professionals claim that they will be liable for the actions of students or junior colleagues, so they feel they cannot delegate or they feel responsible for every action taken by these staff. This is incorrect. When delegating duties it is imperative that the qualified health professional assess the situation and establish the level of competence of the other staff. Then that individual who takes on the job becomes personally liable for their own professional actions. If they fail to admit they do not know what they are doing, if they do not identify that the duty is outside of their competence and they proceed to work outside best practice guidelines then they will be personally and professionally liable for their own actions.[46]

Learners and the inexperienced

Generally, the law will give no special consideration to beginners and learners. The beginner who takes on a particular health care role is just as responsible for providing a reasonable standard of care as those who are more experienced in that role. Thus, a person taking on the role of a senior health professional should act as a reasonable senior health professional, a junior as reasonable junior, and so on. Health care facilities, or those supervising students, are expected to provide an adequate standard of care to patients and to prevent harm from negligence, and this involves adequate supervision and training of students. The student is also responsible for ensuring that he or she does not undertake care for which he or she is not prepared.[48]

Principle Three – The act or failure to act was the direct cause of damage

Two factors need to be established:

1. That the plaintiff suffered damage – if the plaintiff suffered no damage, no compensation can be awarded; and
2. The damage being complained about is a consequence of the defendant's negligent act – that is, there must be a direct or causal relationship between the damage and the negligent act.

There are many examples where, because of what a health professional does or fails to do, he/she would be in breach of his or her duty of care to a patient (e.g. medication errors), but the patient suffers no damage. If there is no damage there can be no action, because it is for the damage caused that the plaintiff is compensated in a negligence action.[47]

The case of *Hotson v East Berkshire Area Health Authority* (1987) 2 All ER 909 (House of Lords, England) illustrates the importance of establishing causation:

> As a result of a fall, Stephen Hotson developed avascular necrosis, but the employees of the health authority did not diagnose this for five days. Mr Hotson sued the Authority, stating that a failure to diagnose was the cause of the necrosis.[48]

After consideration of all of the evidence, particularly on the point of causation, the judge decided that even if the Health Authority had correctly diagnosed and treated Mr Hotson on the day of the injury, there was a 75% chance that the injury would have followed the same course. However, the Health Authority had breached its duty of care in the conduct of the examination immediately following the injury. This delay in diagnosis denied Mr Hotson the 25% chance that,

given immediate treatment, avascular necrosis (which resulted in permanent disability) would not have developed. If avascular necrosis had not developed, Mr Hotson would have made very nearly a full recovery. The judge proceeded to award Mr Hotson 25% of the total damages sum determined.[47]

Principle Four – This damage was reasonably foreseeable

The general proposition here is that the defendant should have to compensate the plaintiff only for such damage that can be said to be a reasonably foreseeable consequence of the defendant's negligence. In other words, there are some types of damage that the law will acknowledge the defendant should not have to pay for, because the damage is too remote a consequence of the defendant's negligent act – that is, it was not reasonably foreseeable.[47]

Adequate follow-up on discharge

There is a difference between a person leaving a health care facility of their own volition and the formal discharge of a patient from the facility. The former is done at the person's own behest, whether or not they are considered fit to leave, and the latter is done with the warrant of the facility that the person is in a suitable condition to leave. The case of *Niles v City of San Rafael,* 42 Cal App 3d 230 (1974) (CA California, United States) illustrates this point:

> A child who suffered a blow to the head was examined, and after a time allowed to leave. The hospital failed to admit the child, or to give the father a card they had listing symptoms which would indicate that he should return. The child already had five of the seven symptoms listed on the card. The hospital was found negligent as the staff had not properly considered the next step in the treatment program.[48]

Considerations when patients leave care

- Where are they going?
- What support or care will they need?
- Can this be given where they are going?
- Do they (or those they will be with) know how to care for them(selves)?
- Do they know what symptoms indicate the need for further medical attention?
- Do they know how to seek further attention?
- Do they know what other complications can occur?

- Do they know how to deal with any that do?
- Are they physically and mentally able to deal with any complications?[48]

Defences to an action in negligence

The most common form of defence is denial or rebuttal of one of the four elements that establish an action in negligence. Other principles in defence include contributory negligence and vicarious liability.

Contributory negligence

As an employee you work within a number of regulations and contractual obligations. There is legislation in most States which directs the court when making an award for compensation to reduce the amount of compensation if the plaintiff (employee) contributed to their own injury.

For example, the *Queensland Work Cover Act 1996* specifies that contributory negligence can be found if the injured employee:

- Failed to comply with the employer's workplace health and safety instructions;
- Failed to use protective clothing and equipment provided;
- Failed to use anything provided to reduce the risk of injury;
- Interfered with or misused something provided to reduce the risk of injury;
- Was adversely affected by the intentional consumption of a substance that induces impairment; and
- Failed, without reasonable excuse, to attend any relevant safety training organised by the employer during work hours.[46]

The partial defence of contributory negligence may have some relevance to hospitals and health centres if it can be established that, in a negligence action brought by a patient, what the patient did or failed to do was also negligent and accordingly contributed to the damage the patient is complaining about.[47]

Vicarious liability

This doctrine shifts the responsibility for financial compensation from a negligent employee to the institution. Hospitals and other services have a responsibility to their patients. This is referred to as a non-delegable duty of care.[46]

Vicarious liability is based on the principle that you are responsible for the actions of those you engage to do your work for you. This means that despite the utmost efforts on the part of the employer to ensure that the best care is given to its patients, and even the lack of knowledge on the part of the employer of the negligent activity, so long as the employee is carrying out activities which are part of the employer's enterprise, the employer is responsible for the patient's welfare.[48]

Table 3: Respective responsibilities of employers and employees

Carer's duty to patient	To provide reasonable care
Carer's duty to employer	To further the objectives of the employer by providing reasonable competent health care to patients. This would include discussion of his or her experience and competencies, so that he or she can be appropriately placed to provide services to patients.
Employer's duty to patient	To provide reasonable services, including adequate and competent staff.
Employer's duty to carer	To provide adequate and safe facilities, staff training and support so that he or she can provide reasonable care to the patient.

Source: McIlwraith and Madden, 2009[48]

Implications for practice

For health care professionals, common law tort principles regarding negligence dictate that a duty of care is owed to their patients/clients because of the special relationship that exists between the two parties.[36]

Litigation for clinical negligence is on the rise. While the aim of negligence rulings is often to keep health care professionals 'on their toes', the requirement to be answerable to both patients and the law should not come at the expense of innovative practice and patient-centred care, and the ethical obligation to do good (beneficence).[49]

The following advice (distilled from case law analysis and the consideration of the findings of recent public enquiries) is suggested, to guide health care practice whenever possible.

Practitioners should:

1. Always make accurate and contemporaneous notes and records;
2. Ensure that care and treatment is evidence-based;
3. Always show their 'working-out' in terms of clinical decision-making;
4. Observe colleagues (and students) closely and notice how they do things;
5. Endeavour to attend training events and engage in clinical supervision;
6. Not become complacent;
7. Update their knowledge and skill regularly;
8. Take note of policy changes, clinical guidelines and be aware of new procedures;
9. Document anything unusual and report it to their line manager;
10. Be both self-aware and self-critical monitoring their own effectiveness;
11. Work closely and consult with colleagues in the multi-disciplinary team;
12. Be willing to appraise colleagues in a measured and professional manner; and
13. Strive towards best practice and balance the interests of patients, against the need to protect the public and maintain professional requirements.[49]

Duty of care in the context of discharge planning has become increasingly complex. Court rulings (in the USA) have raised questions around how far duty of care extends (i.e. at the time of discharge, when leaving the health care facility's premises, the patient's own home); who is responsible (e.g. nurses increasingly are being found to owe a duty of care to their patients that is independent of any relationship the nurses have to the patient's treating doctor); and the foreseeability of harm to patients and third parties.[36,50]

Although there is growing awareness and understanding of the complexities involved in discharge planning, particularly in the older population, little has been written to guide health professionals in the handling of common ethical dilemmas. Cummings & Cockerham[33] propose a five-step model to assist in analysing problems in discharge planning and arriving at ethically based decisions:

1. The identification of background facts pertinent to the dilemma – the patient, the family situation and the context of the situation must be assessed;
2. Identification of central decision-making elements – who is involved in the decision-making and what are their abilities?;
3. Alternative courses of action should be identified and considered – the consequences (costs and benefits) of each option must be weighed;
4. The value system of each party must be considered – identifying the ethical systems and principles being applied by the patient, family and staff helps clarify the perspective from which each party is operating and avoids miscommunication and conflict; and
5. Involves taking action and monitoring the consequences – while recognising no optimal solution may exist.

Ethical considerations in discharge planning also include the impact on hospital resources (the principle of justice). One study in the USA found that unplanned readmission of elderly patients accounted for 25% of all hospital admissions. These readmissions were often due to poor discharge planning and inadequate assessment of the abilities of the patient and their carers'. The authors suggest that interprofessional teamwork and effective communication optimise the success of discharge planning coordination of home care.[51]

Procter et al. suggest:

> Problem resolution requires a fundamental change in focus from disease management as a central measure of health and success in hospital discharge, to a focus on communicative action within a framework of ethical decision making designed to promote quality of life for all people involved in the discharge process.[52]

Conclusion

Health care practitioners' duty of care encompasses both ethical principles (nonmaleficence) and legal concepts (the tort of negligence). Duty of care in the context of discharge planning is a complex issue, particularly when planning care for elderly patients/clients and their carers'. Ethical dilemmas may arise when health care practitioners are presented with conflicting obligations, for example autonomy and confidentiality versus nonmaleficence or beneficence. The legal implications of duty of care require health care practitioners to mitigate foreseeable risk to both the patient/client and third parties. The 'Code of conduct for registered health practitioners'[34] states that 'good practice in relation to risk management involves taking all reasonable steps to address the (risk management) issue if there is reason to think the safety of patients or clients may be compromised' and that 'providing good care includes formulating and implementing a suitable management plan' as well as 'facilitating coordination and continuity of care'.[34] These professional requirements can be applied to discharge planning and its goal of protecting the patient/client and facilitating optimal recovery.

Acronyms

AHPRA	Australian Health Practitioner Regulation Agency
AIPPEN	Australasian Interprofessional Practice and Education Network
ASPIRIN	Acknowledge the problem; Situational analysis; Provide some solutions; Implement; Review the outcome; Inform stakeholders; Next steps
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardiopulmonary resuscitation
ED	Emergency Department
HIV	Human Immunodeficiency Virus
IPE	Interprofessional education
IPL	Interprofessional learning
IPP	Interprofessional practice
LIPSERVICE	Language; Introduction; Privacy dignity and cultural issues; Subjective questioning; Examination; Review; Verdict; Information; Check understanding; End or exit
WHO	World Health Organization

Glossary

Beneficence	A group of norms for providing benefits and balancing benefits against risks and costs.[35]
Colles' fracture	A fracture of the distal radius with displacement and/or angulation of the distal fragment dorsally.[53]
Comparative justice	Suggests the best way to generate the best possible outcomes for the greatest number of people is to compare the different needs and prioritise them so that the greatest needs receive the greatest resources.[40]
Compensatory justice	Suggests that people experiencing problems such as discrimination should receive some form of compensation to redress the balance.[40]
Contributory negligence	Whether a reasonable person in the plaintiff's position would have taken precautions against the risk of harm, having regard to what the plaintiff knew or ought reasonably to have known.[46]
Distributive justice	A way of allocating resources where widely held values are applied to decide who is best able to make use of the benefits and most able to shoulder the burdens so that society can function well.[40]
Duty of care	Where a health care provider has undertaken to provide care, supervision or control of a patient/patient or where it has assumed responsibility for the management of the patient/client's safety.[46]
Informed consent	An individual's autonomous authorisation of a medical intervention or participation in research.[35]
Interprofessional education	Occasions when two or more professions learn from, with and about each other to improve collaboration and the quality of care.[8]
Interprofessional learning	Learning arising from interaction between members (or students) of two professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings.[8]
Interprofessional practice	Two or more professions working together as a team with a common purpose, commitment and mutual respect.[8]
Liability	Holding the defendant responsible for their actions.[46]
Mnemonic	Any learning technique that aids information retention, e.g. acronyms and memorable phrases.
Negligence	Behaviour that results in unintended harm.[46]

Nonmaleficence	An obligation not to inflict harm on others.[35]
Paternalism	Literally means ‘behaving like a father’.[40]
Simulated learning environment	A technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion.[1]
Tort	Civil wrong. Not necessarily an illegal act but an act which causes harm.
Vicarious liability	This doctrine shifts the responsibility for financial compensation from a negligent employee to the institution (e.g. hospital).[46]

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