

# Residential Aged Care

# Communiqué

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## EDITORIAL

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Welcome to the third issue of 2017. This issue will depart from our usual format in that we focus on the current landscape of how RACS are providing safe and high quality level of care to its residents. This edition presents a brief history of aged care safety and quality issues by revisiting cases previously published in the RAC Communiqué. We look at these with a view to identifying characteristics of a high performing RACS. We also highlight findings from our research, list work we recently had published in academic journals, and draw on an expert's commentary.

All of these provide different types of evidence that preventable harm and premature deaths are occurring. Our collective challenge is getting the key stakeholders including residents, families, health professionals, governments, health and aged care departments, providers and regulators working together to develop strategies for reducing harm by improving practice.

Eilon Caspi is an international expert on resident-resident aggression and has written the commentary in this issue. In it he explains the importance of having a register and data gathering about significant incidents that harm residents. Eilon is based in the United States and has published extensively on behavior management and the need to understand and eliminate resident-resident aggression. He makes a compelling case for the development and implementation of new codes or tags to identify all cases of resident-resident aggression. Similar reasons and benefits have been described previously for clinical registries. The ideas presented are applicable across all the categories of injury that cause serious harm or death, and address one of the key items for the current Senate inquiry into examining the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents.

We are in the midst of multiple inquiries. It is disappointing to be in this situation as a sector given the overall healthcare improvements that have been made in the last 20 years. What I think has happened is that although there has been a general improvement, the gap between what is possible and, what we actually do is widening. Alongside this, are significant societal changes to respecting rights, and challenging the standards, norms and behaviours that were once acceptable. The Aged Care sector is part of this, evident in the increasing expectations of residents and the community who are no longer accepting of the status quo. While this is challenging, we should be optimistic that the level of interest and scrutiny will ultimately contribute to making the aged care system better and more prepared for the future demands.

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**Next issue: November 2017**



## National study into premature deaths

Ibrahim, J. E., Bugeja, L., Willoughby, M., Bevan, M., Kipsaina, C., Young, C., Pham, T., & Ranson, D, Premature and potentially preventable deaths among nursing home residents in Australia: a medico-legal examination, *Medical Journal of Australia* 206/10, 2017, 442-447.

This is the first national comprehensive study in Australian RACS looking into premature and potentially preventable deaths of residents. We identified deaths – from falls, choking, suicide and homicide – which accounted for almost 3,300 deaths of residents. The study used coronial data to review the deaths by external (also known as injury-related) causes of all residents between 2000 and 2013.

The study found that of the 21,672 deaths of nursing home residents reported to the Coroners' Court during the 13 year period, 3,289, or 15.2 per cent, were from external or preventable causes, almost all unintentional.

Unintentional Deaths: Four out of five of those who died from external causes died from falls (81.5 per cent) while one in 12 died of choking (7.9 per cent). Somewhat surprising was the small number who died from complications of clinical care (1.2 per cent) which we expected would be much higher. Intentional Deaths: Almost one in 18 people who died from preventable causes in aged care facilities were either from suicide (4.4 per cent) and resident-to-resident assault (1.0 per cent).

Our research team consider this figure is probably an underestimate. It is likely that some deaths are being misclassified as "natural" due to the tendency for health professionals and society to downplay the significance of the injury-related factors in older people. Most people assume that old age and any underlying illnesses are the explanation for deaths.

This study is the first step to improving the quality of care for residents but we need more information to better understand the how, why, where and when residents die.

*This was published in Australia's leading peer-reviewed general medical journal, the Medical Journal of Australia. It was the lead article and featured in the editorial of the journal. The research drew wide spread media attention reaching over 5.7 million people through: National public television 'The 7.30 Report on the ABC' and 'The Project' on Channel 10; national online and print media (The Conversation, The Age and The Herald Sun); and various national and regional radio programs.*

## Opportunity to comment on injury prevention:

### "Recommendations for prevention of injury-related deaths in residential aged care services".

Following on from our national study into premature deaths of residents, the team at the Health Law & Ageing Research Unit, Monash University have produced a draft report titled *"Recommendations for prevention of injury-related deaths in residential aged care services."*

This report is the culmination of a three-year study examining the scientific literature and epidemiology of injury deaths among residents of Australian RACS investigated by coroners. With the assistance and input of expert practitioners in the fields of gerontology and injury prevention, 104 recommendations have been formulated on strategies to prevent future similar deaths. The report focuses on the following causes of deaths: choking, medication events, physical restraint, an unexplained absence, 'while in respite care', suicide and, resident-resident aggression.

Before we finalise this report and publish it for a wider audience, we welcome any feedback that would improve its application to aged care policy and practice.

The report is available at the following link:

<http://www.vifmcommuniques.org/wp-content/uploads/2017/08/RACS-Field-Guide-18-August-2017.pdf>

## RAC Communiqué Seminar: Lost and Found

Unexplained absences of residential aged care residents, often referred to as absconding, eloping, wandering, or leave without notification, is one of the most challenging issues related to the care of older people.

The issue of "to lock or not" poses challenges for the care provider when trying to balance safety with independence. Understanding how to manage leave without notification of residential aged care residents will become more a more pressing issue as the population ages. Which is worse, the psychological impact of being locked in, or the physical dangers of leaving?

Presented by Monash University and the Victorian Institute of Forensic Medicine, this educational seminar will be run by experienced leaders in the field of aged care practice, law and policy; as well as search and rescue.

Places are limited, so register soon or you will miss out.

The full program and registration is available at the following link:

<https://shop.monash.edu/lost-and-found-rac-communique-seminar.html>

## Case Studies: Lessons from the past for a high performing RACS

Professor Joseph Ibrahim  
Department of Forensic Medicine,  
Monash University

There is enormous interest and many sources of advice for residents and their families about what to consider in choosing a safe and high quality RACS. We examine the question of 'what are features of a high performing RACS?' to see what we can learn from the cases presented in the RAC-Communiqué and from two other events that are prominent in the minds of anyone interested in the quality of RACS.

### **Kerosene to treat scabies**

We open the discussion with the incident at Riverside in the year 2000, where fifty-seven (57) residents had kerosene added to baths to control an outbreak of scabies with some suffering second-degree burns and blisters. A review audit conducted by the Aged Care Standards and Accreditation Agency concluded there was evidence of 'severe risk' to residents and the RACS' license to operate was revoked. The facility closed and the residents were relocated.

Commentary: "One of the fundamental issues in this situation was the failure of the RACS to apply a contemporary evidence base to aged care practice."

### **Physical restraint death**

#### **[RACC-Oct 2006]**

A 68-year-old female with a medical history of Huntington's chorea and dementia died due to postural asphyxia from wearing a therapeutic restraint. The medical practitioner 'rubber stamped' nursing staff recommendations by providing a general authority for restraint rather than exercising medical judgment about relevant matters. The most common rationale provided by staff was that restraint was 'to protect residents from falling and from injury'.

Commentary: "Our duty of care is to the person. This includes their 'soul' not just their femur!"

### **Choking death**

#### **[RACC-Jun 2007]**

Mr R was an 84-year-old male with a past history including dementia who was on a 'patient special drink list' due to swallowing difficulties. He was given a sandwich and a drink of Milo by the night duty nurse and later died due to aspiration of food bolus. The coroner recommended a review of the induction, training and supervision of nursing staff with an emphasis on the procedures for notifying changes in diet.

Commentary: "A multidisciplinary approach is essential in the management of elderly people with dysphagia."

### **Thermal injury**

#### **[RACC-Jun 2010]**

Ms K was an 82-year-old female resident requiring high-level care with a past medical history that included aortic stenosis, ischaemic heart disease, osteoporosis with fractures, and chronic back pain.

Ms K often used hot water bottles to ease the back pain. However on this occasion the hot water bottle split open causing burns to 9% of her body. The cause of death following an inspection and report was multi-organ failure from burns on a background of aortic stenosis and ischaemic heart disease.

Commentary: "In a vulnerable group, with many co-morbidities such as the aged (and especially those over 80, as in this case), there is no place for complacency."

### **Dignity of risk**

#### **[RACC-Sep 2011]**

Ms H was a 78-year-old female resident requiring high-level care with a past medical history that included dementia and smoking up to thirty cigarettes a day. Over the past few years Ms H's mobility and manual dexterity had declined to a level where she was wheelchair-bound and required full assistance with transfers. Two carers took Ms H outside, lit a cigarette and left her alone to smoke. Minutes later, Ms H was found ablaze by staff. The cause of death was severe burns. The coroner's recommendations included the need for risk assessments to be made of all residents permitted to smoke on premises.

Commentary: "The risk of harm in such circumstances raises ethical issues for carers at three broad levels – the promotion and protection of residents' best interests, respect for residents' autonomous decisions, and justice in the allocation of scarce resources (such as staff resources)."

### **Resident-on-resident aggression (RRA)**

#### **[RACC-May 2015]**

Ms LL was a 97 year old female resident in a secure dementia section with a past medical history that included advanced dementia, hypothyroidism, diverticulosis, rheumatoid arthritis, diabetes mellitus, depression and a left leg ulcer. One day Ms LL was entering the dining room using her walker and a male resident approached her from behind, they exchanged a few words before he pushed Ms LL's shoulder causing her to fall to the ground. The cause of death following an autopsy was pneumonia as a consequence of fractured humerus and fractured patella, as a result of a fall.

Commentary: "Appropriate, frequent and practical training is required for residential care staff to improve competencies in recognition, prevention and de-escalation of RRA, which needs to be fully supported by management."

### **Respite and public holiday staffing**

#### **[RACC-May 2016]**

Ms N was an 83-year-old female with a past medical history that included osteoporosis with vertebral crush fractures and pulmonary fibrosis. On Christmas Eve, Ms N was admitted to the RACS for urgent respite care. Ms N was unsettled, disorientated, and walking about looking for her husband. She had several falls and appeared distressed for many, many hours. A medical review could not be obtained. The staff eventually noted her hip was shortened and externally rotated and called an ambulance. Ms N died from complications following fracture and surgical repair of the left hip with underlying chronic lung disease and valvular heart disease. The coroner noted the staff "were caring and well-intentioned" but went on to say that an appropriate standard of care was not provided.

Commentary: "People take holidays, but diabetes and dementia don't."



## **Infectious disease outbreak**

### **[RACC-Jun 2013]**

In April 2007, there was an outbreak of gastroenteritis at a metropolitan RACS involving 22 of the 30 residents, of which six deaths were reported to the coroner. Four of the deaths were considered connected to the outbreak. The coroner made comment about the confusion and misunderstanding surrounding the roles and responsibilities of the medical practitioners and the Department of Health in an infectious outbreak. Communication between the nurses, management of RACS and the attending general practitioners (GPs) was suboptimal. The GPs were not aware there were 17 symptomatic patients in the RACS and three residents had died.

## **Arson and homicide**

### **[RACC-Aug 2015]**

A recently employed registered nurse admitted to deliberately lighting a fire that killed 14 people. The RN had obtained another staff member's cigarette lighter, and set alight a sheet on a bed in an unoccupied room. The motive was to cover up his theft of Schedule 8 medications. The RN had been subject to disciplinary action and disputes at a previous place of employment.

Other issues the case raised were around preparedness and management of fire safety in the RACS; recognition and assistance of impaired health professionals; and credentialing and scrutiny of an employee's qualifications and credentials.

The coroner made a number of recommendations to address aspects of the emergency, fire and rescue services and the RACS response to the fire: the need for clear fire exits, staff training and evacuation of residents; the scrutiny of employment records and checking of staff credentials; identifying impaired health practitioners and understanding the obligation around mandatory reporting to AHPRA; the management of Schedule 8 medications in RACS; and education of staff about many of these matters.

## **Failure to report and culture**

### **[RACC-Feb 2015]**

A resident was found dead, lying head first in the outdoor water feature of the RACS. The staff failed to report the death to the coroner and failed to disclose the circumstances of death to family and to the general practitioner.

The coroner was particularly concerned with how a range of staff were able to participate in the 'cover-up' and how staff from culturally and linguistically diverse (CALD) communities could be more susceptible to manipulation and exploitation unless strong organisational moral values are actively upheld by employers.

## **Neglect of residents with challenging behaviours**

We close with Oakden in 2017. A review was undertaken of the wards at Oakden in South Australia (a facility that provided statewide specialist mental health and geriatric residential care for its residents). It was intended to manage challenging behaviours that may have prevented residents from living in mainstream aged care facilities. The review came about because of concerns about the clinical care being delivered.

Significant deficits were identified including: the model of care; the staffing model; the quality and safety of care; the organisation's culture and; inappropriate use of restrictive practices.

Although a little simplistic, we argue that a high performing RACS would have systems in place to deliver and evaluate their service removing any possibility of an adverse occurrence. It is worth discussing these points with colleagues and peers.

Do you agree that a high performing RACS would:

- apply the contemporary evidence base to aged care practice.
- consider the resident as a person.
- use a multidisciplinary approach with exceptional teamwork.
- be proactive in preparing staff to manage frail persons who are vulnerable because minor trauma can lead to dramatic or life-threatening consequences.
- promote and protect the residents' best interests, respecting residents' autonomous decisions.
- have appropriate, frequent and practical training for staff to improve competencies in practice.
- operate as a 24/7 service because that is what residents need.
- clarify roles and responsibilities of the medical practitioners and the Department of Health in an infectious outbreak.
- engage and communicate with their partners in delivery of care such as general practitioners (GPs).
- be prepared and flexible enough to manage surge in service demands that arise from known risks that arise in communal residential settings such as infectious outbreaks.
- actively identify and manage staff performance, competence and credentials.
- have a robust organisational culture, with contemporary social values that are actively upheld by employers.
- promote transparency and learn from adverse events.
- have a model of care appropriate for residents that was matched with appropriate staffing levels and capability.

What is missing? Perhaps review our back catalogue of cases and see what you can add.

There is a general trend for frameworks describing quality and safe care to incorporate and give prominence to organisational leadership, culture and learning. The challenge as always is how a RACS balances economics, workload and safety while providing residents an opportunity to thrive and enjoy their life.

## A selected list of inquiries relevant to Residential Aged Care Services

The following inquiries have either recently been completed, or are underway, and will impact on how RACS operate in the near future.

### **Senate Community Affairs References Committee: Future of Australia's aged care workforce**

Released in June 2017, the report made 19 recommendations and the government committed resources to support the establishment of an industry-led taskforce to develop a national aged care workforce strategy.

More details available at:

[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/AgedCareWorkforce45/Report](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report)

### **Aged Care Legislated Review**

The independent review of the impact and effectiveness of the changes made by the Aged Care (Living Longer Living Better) Act 2013 was provided to the Australian Government in July 2017. The final report is expected to be tabled in Parliament by mid-September.

More details available at:

<https://agedcare.health.gov.au/reform/aged-care-legislated-review>

### **Australian Law Reform Commission Report into Elder Abuse - A National Legal Response**

The final report was released in June 2017. Fourteen recommendations were made about improving the provision of aged care for both residential and home-based settings. Recommendations 4.1 and 4.2 describe the need for a new serious incident response scheme to report and monitor the outcomes with an independent oversight body. Recommendation 4.7 addresses the perennial issue about quality of care and staffing in residential aged care services.

More details available at:

<https://www.alrc.gov.au/publications/elder-abuse-report>

### **Review of National Aged Care Quality Regulatory Process**

This was established by the Australian Government in response to the Oakden Review and will review aged care quality processes including accreditation, complaints investigation and compliance monitoring. The report is due to be delivered Aged Care Minister, Ken Wyatt by 29 September 2017.

More details available at:

<https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes>

### **Senate Community Affairs Reference Committee Inquiry and Report**

This is examining the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. The report is due on the 18 February 2018.

More details available at:

[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/AgedCareQuality](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality)

### **Cost of Care Report**

This was completed by the University of Wollongong and released in February 2017.

Their key finding was "The ACFI [Aged Care Funding Instrument] is no longer fit for purpose. It does not adequately focus on what drives the need for care among this frail population and it no longer satisfactorily discriminates between residents based on their care needs." The report provides several options for funding.

More details available at:

<https://agedcare.govcms.gov.au/reform/residential-aged-care-reform/alternative-aged-care-assessment-classification-system-and-funding-models-final-report>

## List of research publications

The following is a list of the academic journal articles that the team at the RAC Communiqué and Health Law and Ageing Research Unit have published about residential aged care services. HLARU is a multi-disciplinary team with expertise in public health, aged care, health care and medico-legal death investigation led by Professor Joseph Ibrahim and is based at the Department of Forensic Medicine, Monash University.

We will continue to update our readers about future publications that are part of doctoral research programs into intentional deaths of RACS residents; unexplained absences and the application of dignity of risk in the RACS setting; choking deaths among Australian RACS residents and medication-related deaths.

A list of recent publications is available on the website at:

<http://www.vifmcommuniques.org/?p=5077>

# Commentary - A national register of events causing serious resident harm

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It is of vital importance to have a register that identifies, reports and gathers data about significant incidents that harm residents. I have argued for the development and implementation of new codes or tags to identify all cases of resident-resident aggression.

There are 20 reasons, under the following four domains: (a) basic knowledge; (b) quality improvement initiatives; (c) analysis and research opportunities; and (d) consumers' right to know. The key principles are that:

## Basic knowledge

Tracking, summarizing, and publicly reporting in a structured manner will allow the identification of care-related conditions, causes, contributing factors, situational triggers, and risk and protective factors for these incidents.

## Quality improvement

Comparison between organisations and jurisdictions: Compiling these incidents will allow analyses to be conducted with the aim of identifying variations within and across jurisdictions in the quality and practices used by state surveyors in filling out these reports.

Data collection allows much needed large-scale research studies to examine systemic barriers for change, risk, and protective factors and consequences (such as impacts on residents' health, function, well-being, and safety). These insights could inform policies and practices for prevention. Identifying all incidents will enable an in-depth examination into staffing levels, staff training and allow appropriate classification of the underlying causes. For example, some deaths may be incorrectly labelled as due to natural cause (e.g. pneumonia rather than choking) or falls-related rather than to excessive use of an antipsychotic.

## Consumers' right to know

Greater transparency becomes possible by introducing a specific data system to report. The benefits of transparency are an increase in the accountability among individual nursing homes, providers and the sector as a whole. This should translate into improvements in the quality of care. An important property of public reporting is to have information that is user-friendly and easily accessible to consumers, care advocacy organizations, policy makers, legislators, and the media. This shared knowledge increases the likelihood for well-coordinated policy and preventive interventions. This also encourages adherence to the laws and regulations relevant to the incidents.

I am learning over the years of studying this phenomenon, that it is also the regulatory and oversight agencies (in the U.S. it is the Centers for Medicare and Medicaid Services' and the 50 state survey agencies) that need to become more transparent and accountable to the public, consumers, and long term care providers.

## Editors comment

The time for a similar system in Australia has already been foreshadowed in the recommendations of the Australian Law Reform Commission's Report into Elder Abuse. It would be sensible to develop a national system that would include other serious events leading to resident harm or premature death.

The citation for the full article is: Caspi E. A federal survey deficiency citation is needed for resident-to-resident aggression in U.S. nursing homes. *Journal of Elder Abuse & Neglect* <https://doi.org/10.1080/08946566.2017.1333939>.

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## FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:  
[racc@vifmcommuniques.org](mailto:racc@vifmcommuniques.org)

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