

Residential  
Aged Care

## Communiqué

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Next issue: May 2018



## EDITORIAL

Welcome to 2018 which looks like it will be busier than last year for the whole aged care sector. This first issue of the year focuses on falls and is the third time in 10-years that we have addressed this perennial concern. The risk of falls confronts every older person, in every aged care facility, in every country. Despite some gains in prevention, and better post-fall management, the harm from falls remains a major cause of injury and injury-related deaths in older persons and residents.

It is also important to consider this in the context of the most recent release of the next draft by the Commonwealth Government concerning aged care quality standards. The general expectation is that this will be part of a package of legislative amendments to be tabled in Parliament later this month. Two of the ideas that the RAC-Communiqué and our research staff have long promoted are visible in the proposed standards around the, "Identification and management of high-impact or high-prevalence risks", and, "Organisational systems for clinical governance, continuous improvement, risk management, monitoring abuse and neglect, restraint, etc." (Proposed Standard 8).

This RAC-Communiqué edition addresses the most common cause of resident deaths from injury and illustrates how falls risks are both 'high prevalence' and have a 'high impact' for residents. Other examples of high risks are available to read in past editions of our back catalogue, while a discussion of the issues around clinical governance can be found in our March 2013 edition of the RAC-Communiqué (Volume 8, Issue 1). Once these new standards are ratified, our editorial team will identify how the past RAC-Communiqués assist in focussing residential aged care services on key concepts. It is an exciting time with the new standards strengthening the focus on providers being required to demonstrate systems for the delivery of safe and effective care to residents. The RAC-Communiqué will continue as an important educational resource to help us collectively achieve these goals.

The two cases in this edition highlight the need for robust post-falls management practice, greater awareness of circumstances that lead to falls, and the importance of good communication and documentation. There are three expert commentaries written by clinicians in practice. Craig Edlin is a senior physiotherapist who challenges his peers to be role models and leaders in the provision of care for older people in RACS. Sally Eastwood provides a view from an occupational therapist practicing in a range of hospital, community and RACS settings. Dr Chelsea Baird, a geriatrician, provides our third commentary with useful information about post-falls management.

There are some important dates to look out for this year in the aged care sector. The report of the Senate Community Affairs Reference Committee Inquiry, which 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, is due this month.

Another area in the new standards that is of particular interest to our team is around the concepts of informed choice and the opportunity to take risks, "Where a consumer's choice involves the risk to their health and/or safety, they are informed about the risk, the potential consequences to themselves and others, and how risk can be managed to assist the consumers to live the life they choose" (Proposed Standard 1.3).

We explore this idea in our next seminar, so mark FRIDAY, 15th JUNE, 2018 in your diary to attend the RACC seminar where our team will present on, "Protecting the rights, choices and freedoms of older people living in residential aged care facilities". This will include a screening of 'Dignity of Risk', a short film by Prateek Bando, Jeremy Ley and Joseph E Ibrahim. The film won "Best Narrative Film Category" at the 2017 Global Impact Film Festival (GIDC), a dynamic independent film festival in Washington, DC. USA. The film also won selection laurels at another five festivals including the 20th UNAFF (United Nations Association Film Festival) in California USA.

## Case #1: First impressions

**Case No:** 2012 3130

**Précis author:** Carmel Young  
RNCCM, Department of Forensic  
Medicine, Monash University.

### Clinical Summary

Ms Vv was a 76-year-old female who resided in a RACS located in a seaside town where she required high level care. Her past medical history included dementia, Parkinson's disease, and anxiety. She had declining cognitive function with a hearing impairment and was non-verbal.

One winter's day, Ms Vv had an unwitnessed fall in her room at approximately midday. Upon finding her, the Personal Care Assistant (PCA) sought the help of a second PCA to get Ms Vv back to bed. As no registered nurse or state enrolled nurse (SEN) was on duty at that time, a SEN from another area of the facility was asked to review Ms Vv. The facility's manager was also asked to review Ms Vv some time after the fall. The General Practitioner (GP) was then notified, and it was decided not to transfer Ms Vv to hospital, but to monitor her condition at the nursing home.

Four hours after the fall, Ms Vv's family came to visit, found her in distress, and immediately asked for a reassessment. As a result of that second assessment another phone call was placed to the GP and Ms Vv was transferred via ambulance to the hospital.

Imaging tests revealed a fractured C7 vertebrae, a fractured neck of femur, an acute subdural haematoma and a subarachnoid haemorrhage. After discussions with the family, Ms Vv was provided with comfort care and died five days later.

### Pathology

The cause of death following an external examination by the forensic pathologist was determined to be complications of head and neck injuries sustained in a fall. The contributing factors were Parkinson's disease, dementia and chronic subdural haematoma.

### Investigation

When the family were advised that the coroner intended to close the case as a chambers finding (i.e. without holding an inquest), they raised concerns about the care and management post-incident. The coroner then decided to investigate the matter further and statements were obtained from staff at the RACS. These statements were given to the family to consider whether their concerns had been addressed. These documents included RACS progress notes along with the facility's policy about falls assessment.

The matter was listed as a mention/directions hearing three years after the incident. As no firm conclusion was reached on the matter, the coroner listed the case for an inquest. The inquest was held over two days, four months later, and involved the RACS staff and provider as well as two general practitioners.

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The RACS manager checked the range of movement of Ms Vv's legs and arms, and was told by the SEN that Ms Vv was usually quite stiff. The RACS manager was not aware that Ms V was on aspirin but was told of the possible head strike.

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At the inquest, the first SEN who examined Ms Vv considered that she needed to go to hospital. The SEN was concerned about the 'head strike' and that Ms Vv's pupils were pinpoint. The SEN said that her original notes "went missing", but as she had kept her own notes she was able to make retrospective notes when asked to go into the facility the next day.

The RACS manager who attended noted that Ms. Vv was smiling at her and did not appear to be in pain. She explained that the curtains had been pulled closed in the room to check the pupil reaction and she found the pupils were brisk and reacting to light.

The RACS manager checked the range of movement of Ms Vv's legs and arms, and was told by the SEN that Ms Vv was usually quite stiff. The RACS manager was not aware that Ms V was on aspirin but was told of the possible head strike.

### PUBLICATION TEAM

Editor in Chief: Joseph E Ibrahim  
Consultant Editor: Carmel Young, Nicola Cunningham, Rhonda Nay  
Managing Editor: Alexander Gillard, Samuel Gillard

Address: Department of Forensic  
Medicine, Monash University  
65 Kavanagh St, Southbank  
Telephone: +61 3 9684 4444

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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)

### DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health and Human Services, Victorian Institute of Forensic Medicine or Monash University.

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## Case #1: First impressions (Continued)

The RACS manager also said that she had not made any contemporaneous notes of her examination and assessment, nor of her discussion with the GP.

The coroner noted that observations were undertaken for only one hour after the fall. The nurse who was asked to perform the observations was not told how long to do them for, and so stopped after one hour.

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### The coroner was critical in the absence of a formal post incident review.

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The GP at the inquest stated that if he was told of the fall and head strike he would have asked that Ms Vv be transferred to hospital for further investigation.

#### Coroner's Comments and Findings

The coroner stated that the fall with obvious head strike should have resulted in a thorough examination and assessment being undertaken by, at least a divisional 1 registered nurse, or even more appropriately by a medical practitioner.

The coroner was critical in the absence of a formal post incident review. The coroner stated that it would have been most helpful if the observations/recollections of the staff involved had been sought and documented shortly after the incident. The issue of the adequacy, or more importantly, the inadequacy of documentation in the progress notes would have been obvious at that time.

The coroner recommended the RACS formalize and implement a comprehensive, robust internal review process to examine their approach to this event.

#### Editor's Note

A detailed root cause analysis (RCA) following this type of incident assists in identifying the gaps in care and what improvements need to be made in the future. It is worthwhile looking back to our March 2013 RAC-Communiqué, which explores the utility of RCA and has an interesting commentary on the nature of evidence and recall. These concepts are still applicable today. The past issue also highlights the importance of using information and lessons from other RACS to improve our service.

The need for better documentation and improved responsiveness in RACS are recurring themes familiar to our long-time subscribers. These themes are once again pertinent in this case, and feature in the proposed new aged care standards, specifically, in "Initial and ongoing resident assessment and care planning to inform the delivery of safe and effective care" (Proposed Standard 2.2) and "Deterioration or change of a consumer's function, capacity or condition is recognised and responded to in a timely manner" (Proposed Standard 3.5).

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## Case #2: Keeping warm in the sun

**Case No:** Tas 021/2016

**Précis author:** Carmel Young  
RNCCM, Department of Forensic  
Medicine, Monash University.

### Clinical Summary

Mr Dd was a 91-year-old male who lived independently in his own home until he had a fall that required hospitalisation. After this episode he moved into a medium-sized RACS in a small regional town. His past medical history included Alzheimer's disease, atrial fibrillation, hypertension, angina, arthritis, deep vein thrombosis and osteoporosis.

At the time of entering the RACS, Mr Dd used a four-wheeled walking frame to assist mobility, and required supervision when moving from his chair to his bed or from chair to chair. It was noted that Mr Dd had a high risk of falls and that he enjoyed sitting in the sun in a courtyard outside his room.

On a warm summer day, about six months after entering the RACS, Mr Dd opened the double doors and went outside as he usually did to sit in a chair to enjoy the sunshine.

Sometime later, nursing staff were notified by other residents that Mr Dd had had a fall. Staff found Mr Dd outside, still sitting but with his neck flexed forward in the chair, which was now resting on an angle against a brick wall.

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An ambulance was called and Mr Dd was conveyed to hospital where he was diagnosed with a fractured C7 vertebrae and subluxation at the C6/7 joint in his neck.

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A hoist was required to move him out of the chair and transfer him indoors to his bed.

Mr Dd said that he had a sore shoulder and could not feel his legs.

An ambulance was called and Mr Dd was conveyed to hospital where he was diagnosed with a fractured C7 vertebrae and subluxation at the C6/7 joint in his neck. Surgery was not considered an appropriate option because of Mr Dd's age and frailty. Conservative measures were put in place with the primary purpose of maintaining comfort and symptom control. Mr Dd deteriorated over the next few days and died in hospital four days after the incident.

### Pathology

The cause of death was determined to be hypostatic pneumonia due to a traumatic fracture of C7 vertebrae and subluxation of C6/7, resulting in an unstable cervical joint.

### Beginning Investigation

The coroner completed the investigation without holding an inquest.

The coroner found that when Mr Dd entered the RACS the previous year, there had been an extensive care plan that outlined to staff his mobility limitations and guidance requirements. Mr Dd was judged as being a "high falls risk" and he spent most of each day sitting in a courtyard outside his room.

The investigation identified that access to the courtyard was through an internal door and this was not alarmed. This led out to a small concrete slab and then opened up to a larger grassed area. On the occasion in question, Mr Dd had moved his chair onto the grassed area which was on a slope, rather than continuing his usual practice of sitting on the concrete area. The chair that collapsed under Mr Dd was made of molded plastic and was lightweight.

The investigation also identified that there were not any call buttons for residents to use in the outdoor area. Also, there were no processes for monitoring residents in an outdoor area on a regular basis.

### Coroner's Comments and Findings

The coroner concluded that the use of lightweight plastic chairs was not optimal, especially when used in outdoor areas.

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Another recommendation was that some formal procedure be in place to provide ongoing monitoring of residents in outdoor areas.

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The coroner also recommended that appropriate steps be taken to ensure that residents who use these outdoor chairs are confined to areas where the ground is level and stable.

Another recommendation was that some formal procedure be in place to provide ongoing monitoring of residents in outdoor areas.

The final recommendation was that the RACS carry out an assessment as to whether the most appropriate actions were taken when Mr Dd was found.

### Author's Comments

While it is essential that comprehensive assessment and planning is undertaken to provide the daily living supports to enhance a resident's wellbeing and quality of life, especially for individuals with a history of falls; post-fall assessments are equally important in RACS. This case highlights the importance of an initial post-fall assessment to inform any immediate action taken, such as whether the resident can be transferred safely. In particular, whether moving Mr Dd to a more comfortable place may have increased the risk of injury to the spine as his neck was not stabilised at the time.

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## Commentary: An occupational therapist's view

Sally Eastwood  
Occupational Therapist, Queen Elizabeth Centre, Ballarat Health Services.

There is a fine line when caring for residents, between allowing autonomy and ensuring safety. It can be difficult to respond to the individual needs of the residents, whilst also providing equipment and care to suit the broader group. In relation to the case involving Mr Dd, we have a resident that has a very set daily routine, and therefore appropriate seating could have been provided for him to use individually.

Outdoor areas at RACS should be designed to encourage residents to sit outside. To successfully do this, we need a variety of furniture that would accommodate all residents. An additional factor to consider is sitting these in a way so as to minimise the need for moving furniture (for staff occupational health and safety reasons).

It is important to engage an occupational therapist when reviewing and setting up new outdoor and indoor areas such as these. Occupational therapists are trained to develop safe and engaging areas, working with the staff and management at each facility. They are able to provide knowledge and expertise related to appropriate equipment and furniture to meet the needs of the residents at the facility. Occupational therapists can also be engaged to review areas specific to a resident's needs. This may be required when a new resident is admitted, to ensure they can safely access all areas of the home.

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### When choosing chairs, management should liaise with occupational therapists to ensure they are selecting appropriate options.

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Plastic garden chairs are not appropriate to be used in this setting as identified in the case of Mr Dd. These chairs are unstable especially when used on uneven ground. Another concern is that the material may become brittle, when left outside in the weather for long periods of time, and so the chair may collapse when a person sits down.

When choosing chairs, management should liaise with occupational therapists to ensure they are selecting appropriate options.

The structure, composition and design of the chairs are important.

In Mr Dd's case a recommendation for using metal chairs is reasonable as the material is more stable and more durable than plastic, however an overly ornate 'arty' metal chair which is very low in height or has a narrow base may not be safe. Chairs should be positioned in multiple places, to allow residents to sit under shade or in the sun, based on their preference. This will eliminate the need for residents or staff to move the chairs. The chairs should be a combination of singular and park bench style. This would enable residents to sit alone, together, or with their families as they wish. The single chairs should be positioned individually, and in groups, to allow residents to interact if and when they choose.

In relation to how the outdoor area is set up, there should be multiple areas provided for variety and to increase engagement. For example, have a concrete area which overlooks a garden with pathways that wind around the courtyards and garden areas to encourage mobility, and having seating along the way. This style of courtyard and garden can allow for sensory sections, vegetable patches and raised garden beds for further engagement and meaningful activity. Again, consultation with, and inclusion of occupational therapists during the planning process will ensure a more successful design that optimises safety and engagement in the area.

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### Regular checks by staff will always be an important contributor to safety for residents.

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As these areas can be quite large, having a call button within reach may not always be possible. One way to overcome this hurdle is to have portable call buttons on lanyards hanging by the courtyard doors. Residents would then be encouraged to wear one of these when outside, so they can call for assistance if required. This is not a robust solution, as it relies on the resident to collect the call button, and return it after use. However, for the residents who venture out regularly, this could be incorporated into their routine.

Regular checks by staff will always be an important contributor to safety for residents, however the above suggestions will allow residents to have some autonomy in their day, whilst also maintaining safety.

## Commentary: A Physiotherapist's perspective

Craig Edlin BPhy, MSc  
Physiotherapist, St Vincent's Hospital  
Melbourne.

On initial review of Mr Dd's case there are not many aspects of his death seemingly relevant to a physiotherapist. The most obvious aspects a physiotherapist may have influenced are how he mobilised with the chair prior to falling when he 'should' have been supervised for all mobility, and his initial care after the neck injury when a physiotherapist may have assisted. However, on further thinking there are other interesting subtexts for physiotherapists. These are opportunity-generating behaviours, the leadership role of physiotherapists and person-centred risk management.

The coroner recommended 'some formal procedure be in place to provide ongoing monitoring of residents in outdoor areas'. In other facilities, these have been called 'comfort rounds' or 'care rounds' and involve nurses / personal care attendants walking around the facility on a regular basis, checking on and documenting the safety and wellbeing of residents.

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The culture of the facility plays an important role in viewing risk identification not just as formal processes but also as continuous, implicit and informal behaviours.

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These rounds also generate opportunity to identify and actively manage risks. The quality and frequency of these 'rounds' can be variable and depends on workload, the understanding and training of staff, as well as the culture of the facility. Additional 'form filling' and seemingly pointless care tasks can feel like a burden to staff and residents without tangible benefit.

The culture of the facility plays an important role in viewing risk identification not just as formal processes but also as continuous, implicit and informal behaviours.

These may be as simple as:

- Walking the long way from one place to another and engaging with residents along the way
- Not getting 'stuck in the nurse's station' or other staff areas but being out and interacting with the residents
- Writing notes in resident visible areas
- When a potential risk is identified taking the time to work with the resident and other staff to manage appropriately.

These informal behaviours generate more opportunity to identify risks or other care needs as they arise, although their impact can be difficult to measure. They could also be viewed as time intensive when we all feel 'time poor' with activity/care targets that have to be met. Yet, physiotherapists, who are highly trained team members in RAC facilities, can lead by example. We should be role-modelling behaviour that improves the risk culture of the facility and the experience of residents through regular and any ad hoc interactions.

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Removing the ability to engage in meaningful autonomous activity has been argued as tantamount to a form of restraint (at least philosophically) and increases dependence and institutionalisation.

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These interactions are challenging to generate in a way that balances privacy with observation and freedom with restriction. This requires a framework of risk management that respects the autonomy of an individual's right (even with dementia) to engage in meaningful activity (such as sitting in the sun) and minimises the potential for harm. Removing the ability to engage in meaningful autonomous activity has been argued as tantamount to a form of restraint (at least philosophically) and increases dependence and institutionalisation. In situations like Mr Dd's, risks can rarely be eliminated but it is important to acknowledge risks have positive effects as well as negative ones that are individual to each person. There is no doubt that balancing risk is very challenging and really does require a person-centred context-specific approach with clear communication between residents, relatives, carers and staff.

For Mr Dd, this balancing act may have involved ensuring he could still enjoy sitting in the sun whenever he liked (meaningful and autonomous) while doing it in a safe place, with safe equipment and frequent formal and informal observation/supervision (harm minimisation). The RAC facility physiotherapist has a role as a leader and role model within the multi-disciplinary team to adopt pro-active risk behaviour and work as part of the team to find the best outcomes for residents and staff.

### Resources

Titterton, M. (2005) *Risk and risk taking in health and social welfare*. edn. London: Jessica Kingsley Publishers.

Australian Physiotherapy Association (2017) *Code of Conduct - Our Principles and Values*. Available at: [https://www.physiotherapy.asn.au/DocumentsFolder/Advocacy/AIR31\\_APA\\_CODE\\_OF\\_CONDUCT.pdf](https://www.physiotherapy.asn.au/DocumentsFolder/Advocacy/AIR31_APA_CODE_OF_CONDUCT.pdf)

## Commentary: Cervical-Spine Injuries in the elderly

Dr Chelsea Baird BSc (Med) MBBS (Hons) FRACP Geriatric Medicine, Department of Forensic Medicine, Monash University, and Ballarat Health Service

These cases highlight the tragic consequences of ground level (or lower) falls in older people. It also shows the importance of a thorough initial assessment and reminds us that low impact falls can be a major trauma in this population.

Falls are common in community-dwelling older people and even more common in residential aged care. Falls prevention strategies are often the focus of research, guidelines and policy. However, when a resident falls, the immediate post-fall management may become chaotic. Assessment of older patients following a fall is challenging. The patient and carers may be distressed. There is a desire to rapidly transfer the patient to a bed or chair to provide care and comfort. But in our rush to preserve dignity we may be exposing the patient to significant complications.

Falls from ground level are often mistakenly considered as 'minor trauma' and may therefore be under assessed. A fall from standing height or lower in the elderly can be a mechanism for significant harm, including spinal and traumatic brain injuries. Older patients with ground level falls are less likely to be admitted under a trauma service compared to a younger cohort, indicating that even in our major hospitals the serious nature of these falls is under-recognised and inappropriately triaged [1].

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Assessing for injuries post falls is complex in the older population who may have comorbidities such as underlying cognitive or communication difficulties.

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The older population should be considered unique when it comes to post-fall care. Reduced spinal mobility due to degenerative disease and reduced bone health mean that older patients are less likely to withstand mechanical forces associated with falls [2]. Cervical spine injuries have a poor prognosis in the older population, with a 19% 3-month mortality rate in those over 65 years. This rises to a 30% 3-month mortality rate in those greater than 85 years [3].

Assessing for injuries post falls is complex in the older population who may have comorbidities such as underlying cognitive or communication difficulties. Therefore, in the frailest of our population, the need for a timely and deliberate assessment of injuries post falls is most crucial.

While the response time should be rapid it still needs to be thorough and systematic. The patient should not be moved until completion of the assessment. Enquire about neck pain. Gently examine the cervical spine, looking for tenderness, swelling or a step in spinal structures. A neurologic examination looking for numbness or weakness indicating spinal injury should be undertaken.

In this case, Mr Dd's posture when he was found post fall (forced forward flexion of the neck) suggested a possible mechanism of direct neck injury. No record of an initial assessment was made and it is not possible to determine if the use of a hoist and lack of immediate spinal immobilisation exacerbated the situation.

Evidence-based decision tools exist to assist clinicians when deciding if a cervical injury can be excluded or if further radiological assessment is warranted. The NEXUS criteria mandates imaging if any of these features are present:

- Midline cervical tenderness
- Altered mental status
- Focal neurological deficit
- Evidence of drug or alcohol intoxication
- Presence of other injury considered painful enough to distract from neck pain

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Of course, spinal immobilisation is burdensome. It requires transfer to the emergency department and often a prolonged, uncomfortable period of lying supine in a hard collar.

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In the older population (with a higher proportion of underlying cognitive impairment) altered mental state can be redefined as a change from baseline mental state [4]. This definition relies on having a good knowledge of the patient's usual mental state. NEXUS criteria has been shown to have a lower sensitivity in elderly patients, suggesting that we need to remain vigilant in this group and have a low threshold for imaging [5].

Of course, spinal immobilisation is burdensome. It requires transfer to the emergency department and often a prolonged, uncomfortable period of lying supine in a hard collar. These discomforts should not influence our decision in ensuring the appropriate clinical care. Our hospital systems are beginning to recognise and adapt to the needs of the elderly.

More needs to be done, especially in prioritising radiological assessment before a person suffers complications from immobilisation. In managing the elderly trauma patient, it is always safer to immobilise and complete radiological imaging especially if there is any doubt.

### References

1. Spaniolas K, Cheng J, Gestring M, Sangosanya A, Stassen N, Bankey P. Ground level falls are associated with significant mortality in elderly patients. *J Trauma*. 2010; 69 (4): 821-5.
2. Wang H, Coppola M, Robinson R, Scribner J, Vithalani V, de Moor C et al. Geriatric trauma patients with cervical spine fractures due to a ground level fall: Five years experience in a level one trauma center. *J Clin Med Res*. 2013; 5 (2): 75-83.
3. Harris M, Reichmann W, Bono C, Bouchard K, Corbett K, Warholc N et al. Mortality in elderly patients after cervical spine fractures. *J Bone Joint Surg Am*. 2010; 92: 567-74.
4. Evans D, Vera L, Jeanmonod D, Pester J, Jeanmonod R. Application of national emergency x-ray utilizations study low-risk c-spine criteria in high-risk geriatric falls. *Am J Emerg Med*. 2015; 33: 1184-7.
5. Goode T, Young A, Wilson S, Katzen J, Wolfe L, Duane T. Evaluation of cervical spine fracture in the elderly: Can we trust our physical examination? *Am Surg*. 2014; 80 (2): 182-4.

## List of Resources

- Draft Aged Care Quality Standards, Department of Health, January 2018. Available at: <https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards/draft-aged-care-quality-standards-and-draft-application-of-draft-aged-care-quality-standards-by-service-type>.
- A new “Falls – Standardised Care Process” is shortly to be available at: <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes>.
- Falls – Resident information sheet at: <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/participating-with-consumers>.
- RAC Communiqué Volume 2 Issue 1 March 2007. [Falls](#).
- RAC Communiqué Volume 9 Issue 3 September 2014. [Falls](#).
- RAC Communiqué Volume 8 Issue 1 March 2013. [Root cause analysis](#).

## Save the date

### **“Protecting the rights, choices and freedoms of older people living in residential aged care facilities”**

The RACC team are proud to present our next seminar to be held on the World Elder Abuse Awareness Day, Friday 15th June 2018 at the State Library Victoria in central Melbourne.

This is one day in the year when the world voices its opposition to the abuse and suffering inflicted on older people. This seminar will present a range of information to enhance the aged care sector’s capacity to develop innovative approaches to improving care that is designed to respect and enhance the interest of the older person.

The range of speakers is rare to find in a one day seminar and include Maree McCabe from Dementia Australia, Coroner Jacqui Hawkins, forensic pathologist Linda Iles, Aged Care Commissioner Rae Lamb and Susan Alberti AC who is renowned for her eminent service to the community.

Do not miss out on this unique opportunity. The cost for early bird registration is \$220.

More details available at: <http://www.vifmcommuniques.org/wp-content/uploads/2018/02/RACC-Seminar-15th-June-2018.pdf>

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

A reminder for those who may have missed the report from Monash University’s Health Law & Ageing Research Unit, *“Recommendations for prevention of injury-related deaths in residential aged care services”* published late last year. This contains 104 specific recommendations for seven different circumstances of premature death and another eight recommendations that apply overall to reform of the whole sector. This is free to download and available on our website at: <http://www.vifmcommuniques.org/wp-content/uploads/2017/12/Recommendations-for-Prevention-of-Injury.pdf>