Victorian Institute of Forensic Medicine

Residential Aged Care Communiqué

VOLUME 13. ISSUE 2.
MAY 2018 Edition
ISSN 1834-318X

CONTENTS

FREE SUBSCRIPTION

The Department of Forensic Medicine, Monash University will publish the RESIDENTIAL AGED CARE COMMUNIQUÉ on a quarterly basis. Subscription is free of charge and the Communiqué is sent to your preferred email address.
If you would like to subscribe to the RESIDENTIAL AGED CARE COMMUNIQUÉ, please sign-up on our website at http://vifmcommuniques.org/subscribe/

Next issue: AUGUST 2018

EDITORIAL

Welcome to the second edition of the year, one that features a new editor and a single RACC theme that despite its existence, is one that is seldom talked about. Our guest editor is Briony Jain (nee Murphy) who recently completed her PhD on suicide in residential aged care services. In this edition, we draw on two coronial cases - one from Australia and another from Canada, that highlight this complex and troubling theme.

We debated long and hard about whether we should cover this topic, and whether or not to include case reports, as we understand the subject matter is extremely sad and potentially traumatic to readers. We have chosen to publish this issue because if we do not confront the reality of what happens, then how will we know what to change to improve the circumstances? “Due to the nature of the content of this issue, the case studies and commentaries have been edited to contain minimal detail. This aligns our publication with the Mindframe guidelines on reporting suicide and mental illness, to minimise risk to vulnerable persons. Evidence has shown that explicit descriptions of method used for suicide have been linked to increased rates of suicide.

We have two commentaries from experts in the field - Professor Brian Draper who is the Clinical Leader, Academic Department for Old Age Psychiatry at the Prince of Wales Hospital and Heather Miller from the suicide prevention team at *beyondblue*. Both provide unique insights on the theme, and are encouraging about the actions we can take to reduce harm from suicide and improve care for residents with depression.

We know you often share your thoughts with colleagues and discuss the content of each RACC issue. It is important to continue talking and sharing, especially with this issue. In this way, we will improve our understanding of the causes and warning signs, and promote the actions needed to prevent resident death from suicide.

It was positive to see that the recently released Commonwealth Budget included initiatives designed to provide better access to treatment and management of mental health conditions for aged care residents. This initiative will provide access to selected services such as psychiatrists, psychologists, trained social workers and occupational therapists, funded by the Medicare Benefits Scheme. This included $102.5 million for mental health services for older Australians of which over $82 million is for older Australians in residential aged care.

On a final note, we have provided an Excel spreadsheet that contains all the 104 recommendations from Monash University’s Health Law & Ageing Research Unit report, "Recommendations for prevention of injury-related deaths in residential aged care services". The spreadsheet is designed to assist each RACS to determine what action they need to take. You will find the eleven recommendations to prevent suicide located in section six. Please feedback to us any suggestions you have on how the spreadsheet that can better serve your needs.

MONASH University

VICTORIA State Government

Guest Editorial

By Briony Jain

This edition draws on much of my PhD research on suicide among older people living in residential aged care services (RACS) in Australia. As the guest editor, I would like to take readers on the journey from what we knew about this issue when I commenced my research in 2014, to what we know now.

The following is an extract from a reflective piece I wrote for the Medical Journal of Australia on my experience reviewing 141 coroners' files on RACS residents who had died by suicide between 2000 and 2013 in Australia.

"I sat alone in a windowless room for a week at a time... There were times when I had to clock off early for the day because I was emotionally drained and I wanted to preserve my own sanity. There were times when a seemingly minor feature of someone's story made me stop and shake my head in disbelief, and even brought me to tears. Some of the stories were tragic. Some were relatable, even understandable. Some were political statements, others a statement of the deficiencies of our aged care and mental health systems."

I wanted to reflect on this experience because it was just that, an experience, and one that I shared with very few other people in the world. My PhD research aimed to examine the epidemiology and prevention of intentional deaths from suicide and resident-to-resident aggression among RACS residents in Australia through the use of existing medico-legal death investigation information. This is the first time in Australia that these types of deaths have been collated and analysed for their implications for public health and injury prevention at a national level, as opposed to being considered on a case-by case basis by individual coroners. This is also the largest study of its kind in the world.

It took three and a half years, employing a mixed methods approach comprising three key phases to complete the research project. This included: a systematic review of the existing international literature; a quantitative analysis of routinely collected information on intentional deaths from suicide and resident-to-resident aggression among a national cohort of RACS residents in Australia; and qualitative studies to determine major issues and develop recommendations for prevention, and improvement through stakeholder consultation.

Phase 1: The first phase of the research on suicide indicated that very little is known about this issue in Australia and internationally. There were just eight research studies reporting a total of 113 deaths from suicide among RACS identified in systematic review conducted by myself and colleagues at the Health Law and Ageing Research Unit, Monash University. The review found that residents at greatest risk of dying by suicide were those living with depression, in their first 12 months of residence, and experiencing declining physical health, but that more large-scale research was required to confirm these findings, particularly in an Australian context, and to examine other incident and organizational factors relevant to prevention.

Phase 2: Our follow up landmark study, recently published in the International Journal of Geriatric Psychiatry, found 141 nursing home residents had died by suicide in Australia over a 13-year period since 2000. This alarming news received national media attention with a coinciding article in "The Conversation" which was read by over 35,000 people in one month. The detailed findings of the research showed that the majority of residents who died from suicide were male (n=97, 68.8%); had a diagnosis of depression (n=93, 66.0%); and had resided in the RACS for less than 12 months (n=71, 50.3%). Major life stressors identified in suicide cases included: health deterioration (n=112, 79.4%); isolation and loneliness (n=60, 42.6%); and maladjustment to life in a RACS (n=42, 29.8%).

Phase 3: The final qualitative stage of the research involved the presentation of initial results from the above study to a forum of experts in geriatric medicine and suicide prevention, and stakeholders in the aged care sector, to develop recommendations for improved practice and prevention of suicide in nursing home settings. Among the 11 recommendations put forth by this group, the three identified as most important for implementation included:

- expanding state and national suicide prevention frameworks to include older adults and those residing in institutional settings as priority groups;
- aligning life in a RACS with community living to make aged care homes a place where most people would be happy to live; and
- improving residents' access to mental health services.

These recommendations are included in the HLARU report available here: www.vifmcommuniques.org/?p=5194

Overall this research has provided a foundation for understanding how and why older adults living in RACS may take their own lives, and importantly what can be done to prevent such tragic deaths in the future. This work has generated much needed discussion of the complex issues surrounding suicide among older adults in general, and the state of our aged care system. However, there is still much work to be done in redirecting community attitudes toward recognising this as a public health and injury prevention problem rather than, the overly simplified and erroneous notion that it is solved merely by the introduction of voluntary euthanasia laws.

Case #1: Nothing seemed out of the ordinary

Case No: (6/2015 (1365/2012) SA)

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

Clinical Summary

Ms CX was a 72-year-old woman who usually resided at home with her husband, son and daughter-in-law. She had a past medical history of spinal cord compression, chronic back pain, osteoarthritis, osteoporosis, right total hip replacement, bilateral carpal tunnel syndrome, hypertension, high cholesterol, hypothyroidism, asthma and depression. Ms CX was a qualified medical practitioner in her homeland but had not practiced medicine after arriving in Australia with her husband. Her primary spoken language was Mandarin—and she was unable to communicate in English, resorting mainly to gestures and 'yes' or 'no' responses.

As a result of her multiple chronic conditions, Ms CX lived in considerable daily pain, with reduced mobility, and was reliant on her husband for day-to-day care. Ms CX underwent two spinal decompression operations (in 2003 and 2007) but neither resulted in any significant improvement in her symptoms. Four months after the second spinal operation, Ms CX attempted suicide by taking an overdose of sleeping tablets.

In 2009, Ms CX was reviewed at home for the purposes of an Aged Care Assessment. A Mandarin speaking clinician performed the assessment and approved low level permanent residential and respite care, and a community aged care package. Ms CX declined referrals to council services at that time.

> Ms CX's husband noted that his wife was frequently tearful throughout the day and that she was taking an antidepressant.

In January 2010 Ms CX self-referred to the Aged Care Assessment Service asking for a review of her eligibility for a community package. The same Mandarin-speaking clinician saw Ms CX at home and noted her increasing care needs. Ms CX was now requiring assistance with personal care from her husband.

Ms CX was 'mostly independent' in her transfers and ambulating with a gait aid indoors. Mobility outdoors required her husband to push her in a wheelchair. Ms CX's husband noted that his wife was frequently tearful throughout the day and that she was taking an antidepressant. Ms CX was waitlisted as a high priority for a community package.

In May 2010, Ms CX underwent a third spinal operation, which like the first two, did not relieve her symptoms. She was left with complications of neuralgia, muscle spasm and weakness, as well as pressure sores. She returned home with her husband and received a Community Aged Care Package in June 2010.

> Whilst in respite, Ms CX preferred to spend most of her time in her room, eating in her room and not participating in the daily activities of the residential aged care facility (RACF).

In late 2010, Ms CX's family planned to travel overseas and made arrangements for her to be cared for in residential respite care during that period. Ms CX entered the aged care facility with a plan for approximately two months of respite. A Mandarin-speaking nurse assisted Ms CX and her family through the admission process and her husband provided a list of medications. The medications were not administered until a medical practitioner filled out the medication chart the following day.

Whilst in respite, Ms CX preferred to spend most of her time in her room, eating in her room and not participating in the daily activities of the residential aged care facility (RACF). Her daughter-in-law visited daily.

On day 12 of her admission she complained of dizziness on waking. She ate her breakfast and midday meals in her room alone. In the early afternoon, she was found by care staff on the floor in the bathroom. Ms CX was unresponsive and a short time later, emergency services confirmed that Ms CX was deceased.

Pathology

Post mortem examination revealed neck abrasions, consistent with the ligature found at the scene. Death was attributed to hanging. Toxicology results found therapeutic levels of medicines- buprenorphine, metoclopramide and carbamazepine (and metabolites).

Investigation

The investigation focused on Ms CX's suitability for 'low level' respite care, the clinical management provided by her general practitioner (GP) and the adequacy of overall care provided to Ms CX by the RACF during the respite period.

At inquest, the aged care facility's executive director conceded that facilities are heavily reliant on the evaluation of aged care assessors. The ACAS clinician who had twice assessed Ms CX observed that she was heavily 'mentally dependent' on her husband. Whilst no formal mental state examination was undertaken, the clinician did specifically enquire about Ms CX's mental state and noted that she denied suicidal ideation. The clinician regarded Ms CX to be suitable for 'low level care'.

> There was considerable lack of clarity regarding the prescription of amitriptyline for Ms CX's mood and pain.

Ms CX's GP (also a Mandarin speaking clinician) had been seeing her twice monthly for at least 12 months prior to her death. The GP was unaware of her previous suicide attempt and acknowledged that depression had not been an active clinical concern. However, her clinical records included descriptions of Ms CX's mental state as 'really upset', 'really frustrated' or 'depressed'. There was considerable lack of clarity regarding the prescription of amitriptyline for Ms CX's mood and pain. Ms CX had seemingly self-ceased amitriptyline at some point in the months leading up to her death and her medications were not reviewed subsequently. During the coronial investigation, it was difficult to clarify Ms CX's actual medication records, with numerous discrepancies found between the general practice, residential respite and, the handwritten medication lists. Despite the discrepancies, the coroner found that all regular medications were charted and administered during Ms CX's respite period. Further, the delay in obtaining a medication chart did not adversely impact Ms CX as her husband administered the medications in the interim.

Ms CX's family noted that she had complained to them about deficiencies in care during her time in RACF. These concerns related to prolonged call bell waiting times and infrequent assistance with showering (every 4-5 days). Ms CX asked her family not to trouble the staff with her complaints.

Ms CX was also overheard telling a visitor that she 'would rather die than live in this nursing home'.

> Had the GP had an appreciation of Ms CX's previous suicide attempt and previous treatment for depression her mental state may have been more directly assessed and proactively managed.

No formal mental state examinations were performed during the respite admission. Ms CX was attended by both Mandarin-speaking and non-Mandarin speaking staff throughout the respite period. The RACF executive director gave evidence that the policy was to find a member of staff to assist with communication for non-English speaking residents, especially if there was a recognised complex or medical issue. Staff had noted Ms CX had been anxious about her blood pressure but no other concerns about her mental state were observed.

Coroner's Comments and Findings

The coroner concluded that the Aged Care Assessments on both occasions were thorough and that Ms CX was a suitable candidate for low level respite care. Had the GP had an appreciation of Ms CX's previous suicide attempt and previous treatment for depression her mental state may have been more directly assessed and proactively managed. The clinical management did not, however, contribute to Ms CX's death.

It was also deemed that the RACF took reasonable steps to overcome the linguistic barriers and that Ms CX's dissatisfaction with the level of care provided was not brought to their attention. There was no evidence that the care provided by the RACF was unreasonable or inadequate.

The coroner noted that this case highlights the challenges involved in providing care to linguistically diverse populations, in order to meet their fundamental needs for communication and social engagement. The coroner also commended the RACF on the subsequent introduction of a psychogeriatric depression scale tool to be applied on admission to all new residents to identify and address any issues.

Risk Register: recommendations to prevent harm from injury

The Health Law and Ageing Research Unit, Monash University have developed this tool to assist RACS in the implementation of the recommendations arising from adverse events resulting in death or serious injury. The register covers the topics from our recent review with the 104 recommendations for Choking, Medications, Physical Restraint, Respite, Resident-on-Resident Aggression, Suicide and Unexplained Absences.

We thank Marrianne Beatty and Jane Boag for their contributions in developing this tool.

The findings of our research, and the resultant recommendations are listed under seven (7) main headings, which can be located as 'tabs' on the bottom of the screen. These tabs contain all the recommendations from the enquiry in relation to that heading on the page or "tab".

It is available here: http://vifmcommuniques.org/hlaru-recommendations-spreadsheet/

Case #2: A pain in the back

Case No: GLTCRC 2016-23

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

Clinical Summary

Mr Z was a 95-year-old male admitted to a long term facility (LTF) in June 2013. Past medical history included hyperlipidemia, hypertension, angina, atherosclerotic heart disease, atrial fibrillation, heart failure, glaucoma, cataracts, a previous fracture of the neck of his femur, osteoporosis, and benign neoplasm of the anus.

In November 2015, he went on an outing and on his return injured his back when he twisted to get out of the car. The back pain was initially treated with 'Panadol' and two days later this was changed to the stronger analgesic 'Panadeine'. As the pain was not improving, a portable X-Ray of the lumbar spine was organised and the images indicated a compression fracture of L1.

In December, the analgesia was adjusted to Oxycodone 5mg three times a day and then to hydromorphine 0.5 mg three times a day along with dimenhydrinate (antiemetic) 25mg. A few days later Mr Z developed urinary retention and required a urinary catheter. An acute hospital review followed, which confirmed the diagnosis of compression fracture at L1 and he was prescribed an increased dose of hydromorphine.

> He requested "pills and poison" and stated that he just wanted to die.

Around this time his daughter became concerned that her father was increasingly sedated, with nausea and decreased appetite. As his power-of-attorney, she requested the analgesia be withheld. This led to the pain returning, which became so severe he was screaming.

Two days later he had a fall, sustaining a haematoma to the right side of his face. He requested "pills and poison" and stated that he just wanted to die. Staff contacted his daughter and placed him on "suicide watch" that required observations every 15 minutes.

One hour later he was found dead lying on his bed with his head towards the wall.

Pathology

Autopsy gave the cause of death as Plastic Bag Asphyxia. The possibility of intracranial pathology due to the fall was excluded.

> That inadequate management of pain often results in sleep abnormalities and may lead to depression.

Investigation

The coronial investigation revealed Mr Z had no mental health diagnoses and no cognitive impairment. The investigation found a number of gaps in the care provided. These included: his care plan was not reviewed and, it was not revised after he complained of sudden back pain or when he developed urinary retention; that the pain assessment instrument was not used; that his medical practitioner was not informed the pain medications were withheld.

Comments and Findings

The impression was that Mr Z had become depressed and lost the will to live due to the circumstances. That inadequate management of pain often results in sleep abnormalities and may lead to depression. The Geriatric and Long Term Care Review Committee in Canada made a number of recommendations, including the following:

1. Ensure treatment plans are developed and implemented in consultation with all members of the clinical team and that any changes are communicated and discussed with other team members.
2. All medical, nursing and care staff should receive appropriate training and education on the principles of recognition of pain, as well as, the complications associated with poorly managed pain.

Get Help

If you or anyone you know needs help these telephone support services are available to individuals:

- Lifeline Australia telephone counselling at 131 114 (24 hours)
- Suicide Call Back Service on 1300 659 467 (24 hours)
- SANE Helpline - Talk to a mental health professional at 1800 187 263 (10am-10pm AEST)
- Guide to staying alive: https://www.sane.org/mental-health-and-illness/facts-and-guides/guide-to-staying-alive
- *beyondblue* on 1300 22 46 36
- Perinatal Anxiety & Depression Australia on 1300 726 306
- Kids Helpline on 1800 551 800
- MensLine Australia on 1300 789 978
- Headspace on 1800 650 890
- Resources for discussing suicide: http://www.conversationsmatter.com.au/

Commentary: Suicidal Behaviour in Residential Aged Care

Professor Brian Draper MBBS MD FRANZCP
Professor (Conjoint), School of Psychiatry
University of NSW, Sydney, Australia
and
Clinical Lead, Academic Department for Old Age Psychiatry
Prince of Wales Hospital, Randwick

Suicidal behaviour is quite common in residential aged care; it includes suicidal thoughts and plans, direct self-harm (e.g., self-cutting), indirect self-harm (e.g., refusal to eat) and infrequently, suicide. Indeed, suicide should be regarded as the tip of the iceberg because the other behaviours are much more common as well as being indicators of high suicide risk. The two cases illustrate key issues related to suicidal behaviour to be aware of in the care of older residents.

The process of admission to residential aged care is a stressful life event associated with suicidal behaviour. For some it is the fear of having to move into an aged care home that leads to self-harm in the community; in others, it is the subsequent reality of the event. Few older people want to live in residential care and so this is frequently a difficult emotional adjustment that may last months. Staff and family have a critical role in providing emotional support while keeping a look out for more severe depressive reactions and thoughts of self-harm.

Depression might already be present on admission. The use of a depression screening tool such as the self-report Geriatric Depression Scale or a staff-administered scale (e.g., Psychogeriatric Assessment Scales Depression Scale) in the admission process can improve detection. As these are not diagnostic instruments, screen positive scores should alert staff of the need for a more detailed assessment and management plan. Screen negative scores do not always exclude clinical depression and so if you have other reasons to be concerned, also do a more detailed assessment.

Of course, admission into residential aged care implies that the older person has quite significant health problems that are unable to be safely managed at home. Many older people notice the mounting adversities in their life and this can lead to the sense that 'enough is enough', that life no longer has a purpose and that their ageing body is letting them down.

As one 93-year-old man who was exhibited indirect self-harm behaviours' in a nursing home told us in our research,

"Getting older I'm getting more illness and pain and that's not very good. If everything's good of course you want to live a long life, but when it's happening you don't want to live that long."

While these emotional reactions are understandable, they are not untreatable.

> In a vulnerable older person, unrelieved acute severe pain may be sufficient in itself to result in impulsive self-harm.

Staff should allow the older person to express their feelings by listening in an empathic fashion and not allow the sometimes overwhelming sense of hopelessness pervade the care provided. Usually it is possible to identify ways to minimise suffering such as through meaningful interpersonal, spiritual and social interactions. In older frail residents, the means used for self-harm may include indirect methods, such as refusal to eat; direct methods include asphyxiation with a plastic bag, so ensure that plastic bags have small holes or are removed from the bedside.

Pain is a factor in around 20% of older people who die by suicide. While in most cases it is chronic pain, in some it is the acute pain associated with an injury or other acute medical concern. In a vulnerable older person, unrelieved acute severe pain may be sufficient in itself to result in impulsive self-harm. As one 83-year-old who was self-harming told us,

"Yes, it was just too much for me. I couldn't control myself .... because of the pain; just too much. Very tight."

An accurate assessment is often enhanced with a pain tool such as the Abbey Pain Scale. While opioid analgesics might be required for some residents, in many, less potent analgesia will suffice. With acute pain, an urgent management plan involving the doctor, resident and family is essential. If strong analgesia is required, the plan needs to include a process for managing any adverse effects including sedation, confusion and falls risk.

Communication is essential and this is often amplified in residents from non-English speaking backgrounds who can easily feel isolated and lonely in a facility where few staff or residents speak their primary language. Another 82-year-old man who was self-harming believed that,

"They [nursing home staff] were teasing me. I can't speak English. I could understand some of the words, some I couldn't understand."

Indeed, it was unlikely that the staff were teasing him – but that was his belief, fuelled by his inability to speak English.

> There is no single factor that leads to suicidal behaviour in residential aged care but the common theme is that of a person who is suffering and the challenge for staff is to establish ways to provide relief.

It is critical for staff to establish processes for communicating with residents that do not speak English including the use of Communication Cards, telephone interpreters, family members and where possible, staff. Other residents who speak a common language are obviously important for socialisation, which of course is important for all residents.

There is no single factor that leads to suicidal behaviour in residential aged care but the common theme is that of a person who is suffering and the challenge for staff is to establish ways to provide relief.

Commentary: Suicide Prevention

Heather Miller

Suicide Prevention Team

beyondblue

As you walk into an aged care facility you are surrounded by people with different life experiences, beliefs, values and expectations; living together as part of a new community. Some will have chosen this as their new home, while others might feel the decision was made for them. What connects them all is the hope that they can continue to live a life with dignity, respect and meaning.

Ageing brings with it many challenges, but people can continue to experience joy, hope, satisfaction, and meaning; everything that is essential for wellbeing. Supporting people to adjust, cope and feel positive about their life in their new home is an important first step. We all know the time it can take to adjust to major change, and new residents in aged care are no different. New residents are often grappling with their changed level of independence and mobility, changes in social interactions, changes in routine, grief related to leaving their long-term home, and for many, the decision-making process about living in care may have been a stressful one for themselves and their families.

> While death is a regular part of life in aged care, suicide and the associated trauma and grief, is something that we have a responsibility to try to prevent.

Depression and anxiety are not an inevitable part of getting older, however, there are a significant number of people in aged care who experience mental health issues. We also know that tragically, people in aged care are ending their lives in significant numbers. While death is a regular part of life in aged care, suicide and the associated trauma and grief, is something that we have a responsibility to try to prevent.

Suicide prevention in aged care means ensuring providers:

- Offer holistic care; involving family in care planning and program planning
- Commit to increasing staff knowledge and confidence in being able to recognise and respond to mental health issues
- Promote wellbeing, including social connectedness and meaningful engagement in social, cultural and spiritual activities
- Engage in open and regular conversations about wellbeing; asking about suicide risk when concerns are raised
- Create and maintain a safe physical environment
- Advocate for system change
- Provide support and training to staff to ensure their wellbeing.

Many aged care providers endeavour to create an environment that is caring, supportive and homely, but it is the personal touches of staff that help people feel settled, reassured, comfortable and valued. So what else can we be doing?

The first twelve months in aged care is the highest risk time for suicide. Knowing this, we need to ensure that new residents are encouraged and supported to get involved with community life; build new friendships and take part in meaningful activities. It would also be beneficial to support residents through a formalised model of peer support, offered by longer-term residents of the aged care setting. Aged care staff can then work to ensure residents' individualised care plans include the necessary medical, psychosocial and emotional interventions required to support their emotional wellbeing.

Staff also need to keep doing what they do best, which is to communicate. By having regular and clear discussions about mental health and suicide, staff can work with new residents on their mental health needs. Staff can talk with residents about how they are feeling, and how their mood is affecting their engagement with family, friends and their daily activities. They can support and validate how residents are feeling, sit with them and work through their range of emotions, and reassure them that they are not alone. Talking directly and compassionately about suicide also provides people with an opportunity to talk safely, and without judgement, about their thoughts of suicide, and to have an opportunity to discuss what support and care is available to them.

No matter what their age, people have the right to grow older with a sense of hope, purpose and connectedness. Residential Aged Care providers and staff have a unique and very personal role to play in supporting people to live a meaningful life and to decrease the incidence of suicide in aged care settings.

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

ACKNOWLEDGEMENTS

This initiative has been made possible by collaboration with the Victorian Institute of Forensic Medicine and funding from the Department of Health and Human Services (Victoria).

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

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.

List of Resources

The Victorian Department of Health and Human Services website

i. Standard care processes, including information for residential aged care staff on the identification and response to residents with depression and pain at: https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes (ie revised and newly published)

ii. Consumer information sheets, including information on depression for residents, families and carers available in 8 community languages at: https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/participating-with-consumers

Other resources

Communication Cards can be found at the Centre for Cultural Diversity in Ageing

http://www.culturaldiversity.com.au/service-providers/multilingual-resources/communication-cards

Various tools to measure behaviour, depression (Geriatric Depression Scale, Cornell Scale for Depression in Dementia), cognition and quality of life in people with dementia are available from the Dementia Outcomes Measurement Suite, an Australian Government initiative.

http://dementiakt.com.au/doms/

The Abbey Pain Scale is available from the Department of Health website

http://www.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-abbey

The Psychogeriatric Assessment Scale User Guides are available on the Department of Health, Ageing and Aged Care website

https://agedcare.health.gov.au/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/psychogeriatric-assessment-scales-pas-user-guide

Articles about depression in residential aged care

i. Aged Care Guide

https://www.agedcareguide.com.au/talking-aged-care/reducing-depression-in-nursing-homes-requires-more-than-just-antidepressants

ii. Australian Institute of Health & Welfare Report

https://www.aihw.gov.au/reports/aged-care/depression-in-residential-aged-care-2008-2012/contents/summary

Resources applicable to general population

i. R U OK? Day - Thursday 13 September 2018 with further information at: https://www.ruok.org.au/join-r-u-ok-day

ii. beyondblue also has a range of information and resources to help staff and families talk about mental health issues and suicide:

https://www.beyondblue.org.au/who-does-it-affect/older-people

https://www.beyondblue.org.au/health-professionals/working-with-older-people

https://www.beyondblue.org.au/get-support/have-the-conversation

https://www.beyondblue.org.au/the-facts/suicide-prevention

iii. Mindframe: provides access to up-to-date, evidence-based information to support the reporting, portrayal and communication about suicide and mental illness.

Visit: www.everymind.org.au

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 expert speakers from such diverse and specialised fields is rare to find in a one day seminar, and includes 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. It is well worth the cost of registration.

More details available at: http://vifmcommuniques.org/wp-content/uploads/2018/04/RACC-Conference-Flyer.pdf