

Residential Aged Care

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Next issue: August 2019

 **MONASH** University



EDITORIAL

Welcome to our 50th edition of the RAC Communiqué. It is a golden landmark we are very proud to have achieved. It is a double bumper issue being almost three times the length of our usual production, so there is enough material here for the next six months!

This issue revisits eight of our 49 past editions, in part to remind our readers of the value looking back and, in part to encourage using the case studies for education and training. In most part it is to highlight the value of these cases. We have selected content pertinent to the new Aged Care Quality Commission standards. We have matched a past issue and case precis with each of the eight new standards. This should help ease the challenge the sector is facing with the implementation of these new standards.

We also wanted to reinforce the use of the RAC Communiqué as an educational tool and learning aid. To that end we have invited commentaries from a broad range of experts about how this could be achieved.

Penelope Eden, a partner with MinterEllison, examines the role of coronial findings in improving the quality and safety in residential aged care. Basia Diug from the Medical Education Research and Quality Unit, School of Public Health and Preventive Medicine, Monash University explains the need for gaining research literacy knowledge and skills. That is, the ability to identify the difference between facts and an opinion, an essential part of practice these days.

Kerrie Shiell, a practising Clinical Neuropsychologist at Ballarat Health Services looks at how to effectively build knowledge recognising that each staff member will learn in different ways. Margaret Winbolt, a Director with Dementia Training Australia and Senior Research Fellow at the Australian Centre for Evidence Based Aged Care gives valuable insights into the role of case studies in the education of nurses and care workers. While Tamsin Santos, a practising medical specialist in geriatric medicine provides a 'how to guide' for use of case studies in education of medical, allied health and nursing staff. We finish with a personal reflection from our own staff, Carmel Young, about the challenges in providing our readers with the case precis.

Our objective is to assist our readers as the cases and the associate commentaries in each issue of the RAC Communiqué are invaluable teaching and clinical governance resource.

The experts were asked to comment on how to use the past 49 issues for education and to answer the question 'What advice you would give to the senior staff in RACS about selecting and using the RAC Communiqué cases?'

- How and why people learn?
- How do we introduce a topic?
- How do we set learning goals?
- How do we select a relevant case?
- What are the differences in teaching between presenting positive situations (ie right way to do things) or traumatic situations (ie when things go bad)?
- How does fear impact learning?
- An approach to reinforce learning?
- What are some ways to encourage staff to read and discuss the case studies?

Coronial Findings: The role of coronial findings in improving the quality and safety in residential aged care

Penelope Eden LLB Partner, MinterEllison Brisbane QLD

The practice of medicine (and any part of healthcare) is underpinned by evidence. Evidence drives all that we do and importantly, sharpens our focus on continuous improvement in the delivery of safe, high quality aged care services.

It is generally accepted that there is underreporting of death in the residential aged care context. The cause of underreporting is multi-factorial and may be related to factors such as concerns around litigation, criminal prosecution or simply a lack of knowledge on the part of staff about when to report.

An important role of the Coroner is to make recommendations or comments (depending upon which jurisdiction you are in) to prevent recurrence. The Coroner does not make findings of guilt or liability but rather, focuses on injury and death prevention. Whilst often seen as one of the most influential parts of the Coroner's findings (particularly in the health context) the research suggests that recommendations are rarely implemented. In fact, there is no legal requirement to respond to or implement coronial recommendations.

The challenge in this new era of aged care is to move beyond compliance and to examine our thinking about our current organisational practices and approach to provision of aged care services.

At a time when the sector is subject to increasing community and government scrutiny, coronial reports and recommendations are a powerful education tool that give organisations a good steer on where to focus their efforts.

As a health and aged care lawyer with over 20 years' experience (and a clinical background as a registered nurse) I am often dismayed to see the same themes arising in coronial investigations that go to inquest. Further, once the inquest is over and we go back to 'business as usual', there is often an apathy on really engaging around coronial recommendations. I see this as a lost opportunity for organisations.

Whilst reasonable minds may differ about what might be regarded as contemporary industry practice, or criticisms might be made about whether coronial recommendations are sufficiently informed by appropriate peer opinion, we can always find a reason not to do something. The challenge in this new era of aged care is to move beyond compliance and to examine our thinking about our current organisational practices and approach to provision of aged care services.

Creating systemic change, requires the engagement of the whole team.

A clinical governance framework has always underpinned the delivery of safe care within aged care facilities. However, the implementation of the new Single Quality Framework will raise the bar on accountability for governing bodies of aged care organisations. Standard 8 is stated to require the governing body to 'drive and monitor improvements to make sure the organisation is committed to quality care and services and the best interests of consumers'. Coronial reports and recommendations provide us with crucial data about preventable harm and can be used (in conjunction with data on other quality indicators) to inform the content of clinical policies and guidelines.

We all like to believe 'it won't happen to us' – that the way in which the 'Swiss cheese holes' have lined up simply cannot happen in our organisation. Creating systemic change, requires the engagement of the whole team. First, give them the raw data. Show them the facts, use the case studies, and examine the recommendations.

Then, engage your team in a way that allows them to see the 'lived experience', something the Royal Commission into Aged Care Quality and Safety is keenly focused on in the evidence to date. This is what will drive engagement around operationalising change within your organisation.

An effective prevention strategy requires an understanding of what went wrong - this is the real power in coronial findings.

Creating a culture that is prepared to honestly look at and examine incidents in delivery of care and services within residential aged care is critical to embedding a quality and safety culture within an organisation.

The literature suggests that leadership and organisational culture is at the heart of improving quality and safety outcomes for residents.

Most organisations will have committees to monitor compliance and improvement activities and to enable them to measure and report on performance. But these are just supporting structures. The quality of the consumer experience hinges on its people. This, at its heart, is about organisational culture. A key recommendation of the Hayne Royal Commission was that organisations must be in what amounts to an 'always-on cycle' to monitor culture. This involves a robust (and regular) assessment of culture and governance, confronting and addressing problems as they arise and assessing whether changes have been effective. According to Hayne, this takes 'intellectual drive, honesty and rigour'. He endorses the mantra that tone is set from the top. But it must be echoed from the bottom and reinforced at every level of management. Creating a culture that is prepared to honestly look at and examine incidents in delivery of care and services within residential aged care is critical to embedding a quality and safety culture within an organisation. Coronial data is one tool an organisation can use to examine whether your clinical governance framework remains 'fit for purpose'.

As we move to a more transparent, accountable and measurable star rated system, the use of data will help providers communicate 'what good looks like' in aged care. Whilst the UK experience reveals that a ratings system is unlikely to be a significant pull factor for consumer behaviour, it has been established that it does drive provider quality. Now is the time for providers to adopt some of these practices and to get ahead of the curve in order to meet the changing and increasing expectations of the consumers and community we serve.

Penelope Eden's Biography

Penny has over 20 years' experience working exclusively in the area of health, ageing and human services, utilising her understanding and experience of having worked in the clinical area as a registered nurse to provide practical, timely and outcome focussed solutions to legal problems.

Her broad experience in aged care, health and disability extends to the provision of advice on a range of industry specific issues including risk and reputational management following major clinical events, health service investigations, governance and regulatory advice.

Penny is widely regarded as a leading advisor to the aged care industry. She provides a broad range of regulatory and commercial aged care advice to a range of private and not-for-profit operators and regularly advises on compliance with the *Aged Care Act 1997* (Cth).

Penny is currently acting for a number of private and not-for-profit aged care operators in the RCAC, which enables her to have key insights into the issues confronting the industry and oversight of common risks areas.

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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:

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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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Promoting research literacy: separating fact from fiction

Author: Associate Prof Basia Diug PhD Head, Undergraduate Courses and Head (Quality and Innovation), Medical Education Research and Quality (MERQ) Unit, Department of Epidemiology and Preventive Medicine School of Public Health and Preventive Medicine, Monash University

There have been numerous changes to our teaching and learning over the past few years. The landscape of our universities is changing as we replace didactic lecture theatres with interactive workshops and embrace active learning strategies in contemporary, technology embedded teaching spaces.

'Learning management systems' are used to deliver a 'flipped' approach to teaching. In plain language, this is where students are given both the pre- and post-learning materials to prepared for tutorials. The tutorials now require application of acquired knowledge, critical thinking and problem solving rather than simple clarification of content from lectures. Also, some education units are taught partially or completely online allowing for long distance and flexible learning.

The ability to identify between fact and an opinion is essential.

This change in teaching mode and delivery has created challenges in what and how we teach our students. A benefit is that allows us the opportunity to teach both knowledge and key skills that apply in daily life and the workplace. Some of these core skills include cultural competence, good communication skills both verbally and online, working with others in a team, the foundations of professionalism, the ability to both give and take on board feedback as well as critical thinking skills.

These skills, in conjunction with specialised knowledge, are fundamental to being a proficient work ready graduates in health and aged care.

Working in teams, problem-solving, using best practice and communicating well is a requisite part of the job and it is in this space that having key critical thinking skills is necessary.

The ability to identify between fact and an opinion is essential. This requires a set of skills called research literacy and equips our students to navigate the ever-growing clinical science literature and to make evidence-based decisions. Gaining research literacy knowledge and skills requires the learner to; ask and structure a research question, be able to effectively search the literature, critically appraise, interpret and synthesise the information found and then, apply these findings to a clinical setting.

The need for the continued development of research literacy among our students is the greatest it has ever been.

Research literacy requires the learner to identify different types of bias, understand the research methodology from study design to data analysis. Fundamentally, it requires the student to learn research methods to a level that they are able to pick up a medical, nursing or allied health journal article and confidently engage with the content and judge the merit of the research. These skills are a core part of evidence-based medicine which itself is an important part of our health care approach.

The need for the continued development of research literacy among our students is the greatest it has ever been. Undergraduate degrees are transitioning to include more research skill development through the form of scholarly intensives programs whilst the Master of Public Health postgraduate degrees have increased in their popularity. This has come about because of the realisation that learning of how to assess clinical research cannot be acquire through osmosis and/or whilst practising as a clinician.

Instead it requires structured training with a focus on research methodology to ensure our health professionals are workforce ready and well equipped to apply the evidence-based paradigm as part of their patient and resident care.

Patient and resident care is why research literacy competency is so important and so its accomplishment should be a goal for all of our health professional graduates. It is the key to improving population health through accelerating translation of research to patient care a priority aim of the National Health and Medical Research Council.

Research literacy competency is the tool that allows clinicians to cut through the medical research, discriminate between high quality and low-quality studies and identify the evidence that is clinically relevant and meaningful. It also provides the means to have a dialogue with your patient or, resident about information they have found online, heard from a friend or on television. It is this use of evidence to inform practice that strengthens the quality of care and tailors it to the needs of the person. This is why research literacy is core part health professional training programs and should remain so into the future.

Making the most of the RAC Communiqué

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Milestone occasions give us a chance to reflect upon all that has been written and learnt since the inception of the RAC Communiqué in October 2006. In the twelve plus years since that first edition, the RAC Communiqué has provided an opportunity for discussion and growth within the Aged Care sector.

So why do I think it has been so effective, and how does it help us to build our knowledge?

Ongoing case précis' in the RAC Communiqué have enabled clinicians to reflect on their own practice and the practice of their teams. Research involving learning and memory has shown that we are well-placed to learn from these opportunities, as we are building upon our pre-established knowledge within aged care. This foundational knowledge only helps to improve our retention of new information, as we consolidate and integrate new material with our longstanding skills and experience.

Unfortunately, all too often carer burnout, fatigue, and fear impact upon our ability to adapt our thinking and deviate from old routines.

To optimise the potential benefits of the RAC Communiqué, we must also recognise that each staff member will learn in different ways. Given that this publication is presented in a visual format (e.g., a written educational material), it will be important to ensure staff have an opportunity to discuss the cases in more detail (e.g., verbal learning strategy). Research has demonstrated that although we may have strengths in either the visual or verbal domain, the greater the level of interaction with the material, the more deeply we process and retain the information.

Whilst awareness of the issues presented in the RAC Communiqué is an important first step, using this information to improve practice is crucial. Unfortunately, all too often carer burnout, fatigue, and fear impact upon our ability to adapt our thinking and deviate from old routines. The learnings presented in the RAC Communiqué will be more readily incorporated into daily practice in facilities that provide staff with an opportunity to address carer fatigue through structured discussion and fostered innovation.

The RAC Communiqué has sought to challenge, confront and educate us about the often difficult realities of working in the residential aged care sector.

When our thinking is governed by fear and risk mitigation, rather than 'dignity of risk', our residents' suffer. It is not possible for staff to adapt their approach when their minds are distracted by fears of reprisal. No one can think logically when their bodies are overwhelmed by primitive 'fight-or-flight' responses. Therefore, it is critical for senior staff to reflect on the learning of the RAC Communiqué and then create a resilient and secure environment for both the staff and residents to flourish.

The RAC Communiqué has sought to challenge, confront and educate us about the often difficult realities of working in the residential aged care sector. With stories of terrible resident outcomes, it is difficult not to become overwhelmed by the task of caring. However, it is important to recognise that these stories, whilst emotive, are always thought provoking and provide an important springboard for learning. It requires a degree of courage to examine our own practice (and it is often easier to look at the folly of others), however the RAC Communiqué highlights the needs for us all to reflect on our efforts in order to address the ever-changing needs of our residents.

The coroner recommended adoption of "a register of resident-to-resident aggression in the aged care sector to be supported by a system of mandatory reporting of such incidents, and that it apply regardless of the residents' cognitive status." And "that the Minister for Health raise with his counterparts the proposition that such registers should be duplicated across the other States and Territories, or better still that there be the adoption of a national register at the Commonwealth Government level."

Role of case studies in education: Using the RAC Communiqué for education of nurses and care workers

Author: Dr Margaret Winbolt RN; PhD
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It is hard to believe that this is the 50th edition of the Residential Aged Care Communiqué. Since its inception in 2006 this clinical education newsletter has provided an excellent teaching resource for use in the education of aged care staff. As a nurse involved in dementia education, I am acutely aware of the valuable role case studies play in the education of nurses and care workers. The use of case studies take teaching beyond the didactic transfer of knowledge to actively engage the learner in a 'real-world' situation thereby promoting problem-solving and critical thinking skills as well as the ability to relate knowledge to their own practice and work situation. The case studies described in the Communiqué also serve to humanise teaching content; they are about real people in real situations.

In my experience it is important that case studies used in teaching are realistic enough to be relevant to the individual learner and workplace setting because, for case studies to be effective, the story must resonate with the learner. I have noticed that the impact and learning outcomes are particularly profound if learners are able to imagine themselves being in the same scenario. For these reasons the case studies in the Communiqué are especially useful to aged care educators as they present actual cases from the residential aged care setting.

The now substantial collection of case studies compiled by the Communiqué means an educator can readily select an edition with a case study which covers a topic that will meet the staff group's desired learning outcomes. These learning outcomes may be prompted by identified gaps in staff knowledge or in response to a workplace situation.

There are a variety of ways in which case studies can be used in teaching and each approach can be adapted to meet the knowledge, skill and role expectations of the learner group. For example, care workers would not be expected to analyse the same aspects of a case study as Registered and Enrolled Nurses. Alternatively, different case studies with the same learning outcomes can be used for different groups of staff.

As well as being an excellent teaching resource the case studies provided by the RAC Communiqué are also a valuable resource for an organisation or individual to review current practices, policies and procedures to minimise the risk of the same event occurring to it or to them.

At its simplest case study teaching can involve an individual or group being asked questions about the story. These questions can be as simple as "What would you have done in this situation?" Another strategy is to ask learners to work in groups to identify key points in the story where something could or should have been done differently, what could or should have been done and how changing the scenario at these points could have change the outcome.

Depending on the staff involved the educator may want to delve deeper and ask learners why the characters in the scenario might have made the decisions they did, including what might have influenced their decision making. Learners can also be asked how, within the scope of their role, they would be able to influence what happened. A more elaborate approach is to use role play where learners adopt the role of the characters in the scenario and enact what they would have done in the same circumstances. This approach gives learners insight into the characters' actions and enables them to understand these from the characters' perspective.

As well as being an excellent teaching resource the case studies provided by the RAC Communiqué are also a valuable resource for an organisation or individual to review current practices, policies and procedures to minimise the risk of the same event occurring to it or to them. This could be achieved by an organisation reviewing each case study and working with key personnel to determine what, if any, aspects of the organisation could lead to the same scenario occurring within its aged care facilities.

Using case studies: a how to guide for people wanting to use case studies in teaching

Author: Dr Tamsin Santos BSc, MBBS, GradDipClinED, FRACP

Continuing medical education is a requirement of all medical, allied health and nursing staff. In our daily practice there are a plethora of events that occur that can help us improve our practice. We can ask; was there a case of exemplary care? Or were any needs missed in care? Are these due to gaps in knowledge or skill? Inspiration for learning can also come from the experience of others and published cases.

In geriatric medicine community practice, we work in a multidisciplinary team of medical, allied health and nursing staff to help the patient achieve their best health outcomes. Provision and coordination of multidisciplinary care can afford a lot of good intra and inter disciplinary learning opportunities.

When choosing the case, it is best for it to align with the proposed learning objectives of the topic. As the cases demonstrated a lack of protocol, learning objectives for the above topic could be; 'where do you find the protocol?' and 'what is the protocol?'

When I am asked to teach/present a topic in geriatrics the first step for me is to highlight and identify the learning needs of the attendees. This can be assessed from the perspective of learning requirements set by their employer/role description or student/course requirements. Another way is to perform a learning needs analysis and ask the attendees. This can be via survey or questionnaire prior to the presentation. Lastly, the presenter will bring their ideas for learning objectives as well. These combined learning objectives are then used to drive the content and help form the outline of the presentation.

I like to base any presentation on a case or scenario to introduce a topic and demonstrate gold standard practice or to highlight a gap in practice which leads the learners to identify better practice. For example, if we look at the topic "how to management hypoglycaemia in aged care facilities", we can turn to the cases of diabetes mellitus management in the RAC Communiqué Volume 3, Issue 4, September 2008. The cases highlight gaps in practice.

When choosing the case, it is best for it to align with the proposed learning objectives of the topic. As the cases demonstrated a lack of protocol, learning objectives for the above topic could be; 'where do you find the protocol?' and 'what is the protocol?'

Learning objectives also need to be demonstrated on completion of the presentation. For example, 'where do you find the protocol?' and 'what is the protocol?' would require a verbal description whereas 'be able to administer glucagon' would require a simulation/run through of glucagon administration.

The case can be read alone or with comparison to current practice. It can also be used to ask staff to highlight whether it demonstrated expected practice and protocols. Further knowledge and skill can be ascertained by questions around "What could be done?" "Why is it recommended?" "What are the outcomes we want?"

I find short sessions (30-45 minutes) that are more frequent can be useful in engaging teams. This means the session can be rotated to cover multiple staff over multiple shifts.

I like to end the session with a feedback questionnaire that helps the attendees think about the learning they have undertaken and what their next step will be; to drive ongoing learning. My three questions are;

1. "What have you learnt today?" (knowledge gain)
 2. "What will you do differently?" (behaviour change)
 3. "What else do you want to know about?" (next step)
-

Reflection: my personal experiences writing case précis' for the RAC Communiqué

Author: Carmel Young RN CritCare, Research Nurse, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University,

I am often asked about “What’s it like to write the cases for the Residential Aged Care Communiqué?” Hopefully, this reflective piece answers that question.

It is an honour and a privilege to be involved with RAC Communiqué from the production of the first issue in October 2006. Over the past 49 issues we have covered so different practice issues from physical restraints to infectious outbreaks and these highlight many themes around how we provide care to residents.

My intention has always been to relate the findings of the case from the coroner’s investigation to the staff working on the floor. I am hopeful that the cases we select are ones that are actively discussed with all levels of staff and, not just sitting in a folder somewhere.

Reading the coroners findings have highlighted to me the vital role families play in raising concerns or a suspicion of something being not quite right. The family often state that they tried to alert staff that there was a problem but felt they were ignored.

I have become acutely aware of the importance of making notes, as the coroner and the court staff and the experts called to evaluate what happened do read every word.

I am very aware that it is often up to nursing staff to recognise and manage a sick resident. The onus is on nursing staff to ‘make the call’ if a resident’s condition has changed and requires attention. As nurses, we must persist and escalate if we are not happy with the response from our colleagues or medical practitioners.

Remember to document who has been contacted, when, why and the nature of the response.

Documentation is vitally important. I know what it is like when its busy. I also know that the documentation becomes the last thing to do before going home at the end of a busy shift. But reading the coroners findings I have become acutely aware of the importance of making notes, as the coroner and the court staff and the experts called to evaluate what happened do read every word.

What I do is to paint a scene illustrating what I think it was like. It’s up to the reader to surmise what it was really like.

It is sometimes frustrating when there is a limited amount of information given in the final report of the coroner’s findings. I am often tempted to add my little bit of what I think happened or how I think the nurse reacted in a particular situation. But if it’s not written in the report then it cannot be included in our summary. The coroner’s report is the official, legal description. It is important we respect that and remain consistent—our role is not to reinvestigate or re-interpret. What I do is to paint a scene illustrating what I think it was like. It’s up to the reader to surmise what it was really like.

When I first read the case, it seems that it’s always a very few missed opportunities for action in care that have led to the person’s death. It makes me realise how important it is to step back. To take stock of what is really happening and the bigger picture, to step away from the bedside and look at what or how were the set of circumstances created that led to the death. I look for ‘red flags’ or early warning signs and take note of these to highlight for our readers.

Sometimes, with a very long written coroners finding of 50 or 60 pages I find being restricted to our short word limit is frustrating. I’m always afraid that by leaving things out of the précis I will lose the thread of what the coroner is saying. The challenge is finding a balance in each case so it is clear enough to engage our readers and to highlight an aspect of care that we should improve.

Quality Standards Overview: The Aged Care Quality Commission's new standards and a relevant past issue of the RAC Communiqué.

The following sections describe an aspect of each of the new standards from the Aged Care Quality Commission. All eight standards are included. We begin with a short summary of the standard and then provide a case précis from a relevant RAC Communiqué issue.

This should serve as a basis for discussion and education of the board, executive, staff, residents and families. If you want more detail on the topic, then re-examining the whole RAC Communiqué issue will provide the additional expert commentaries on the topic.

Apply the questions presented by our expert commentators to the case study.

Ask learners to work in groups to identify key points in the case précis where something could or should have been done differently and, how do the new standards assist with implementing structures and processes to protect against adverse outcomes.

'What would you have done in this situation?'

'What would you have done or recommended to the board to prevent this situation occurring?'

'How does this case relate to the new standard?'

Standard 1 Consumer dignity and choice

This standard addresses seven important concepts one of which is Dignity of Risk. The Aged Care Quality Commission describes *'Dignity of risk is about the right of consumers to make their own decisions about their care and services, as well as their right to take risks.'* As part of Standard 1 Requirement (3d) Each consumer is supported to take risks to enable them to live the best life they can.

RACC Sep-11 Vol 6 (3) Smoking Dignity and Risk

Mrs H was a 78 year old female with a past medical history included dementia and a heavy smoker of up to thirty cigarettes a day. She would smoke by leaning forward to meet the cigarette or holding it in her mouth for long periods of time.

On this particular day, Mrs H rang the communication bell shortly before the evening meal. Two carers attended and took Mrs H outside, lit a cigarette and left her alone to smoke. Minutes later, Mrs H was found ablaze by staff. She was transported by ambulance to hospital, assessed to have non-survivable injuries and died that evening.

The coroner found that Mrs H suffered fatal burns when her clothing accidentally caught alight while smoking in a designated outdoor area, and that the lack of supervision was a clear contributing factor in her death.

The coroner recommended that the formulation of a Care Plan and the details of any changes that are made, as well as any procedures and practices maintained by a facility regarding a resident's smoking habit, must be properly documented and communicated to all staff and family members.

Standard 2 Ongoing assessment and planning with consumers

The Aged Care Quality Commission describes Standard 2 Requirement 3b as *'Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.'*

RACC Dec-14 Vol 9 (4) End of Life

Ms E was admitted to a regional acute hospital after a fall at home and was diagnosed with a urinary tract infection and a small subdural haematoma. Past medical history included: Alzheimer's disease, atrial fibrillation, hypertension, ischemic heart disease, osteoarthritis and chronic kidney disease. After being in hospital for about seven weeks it was clear Ms E had not recovered sufficiently to return home and was transferred to a RACS.

At that time Ms E required full assistance with personal care and had a MMSE score of 13/30. A standard form for *'goals of care'* was completed on admission to the RACS indicating Ms E was for "transfer to acute care for treatment but not for intensive care or cardiopulmonary resuscitation."

Ms E was transferred to acute care several times over the next two years for: surgery on a hip fracture; sepsis and deep vein thrombosis; chest infection and dehydration; bradycardia and lethargy due to medication toxicity. The goals of care were re-examined each time.

On this last occasion (February), a new directive was completed and signed by her son (power of attorney) and the medical practitioner, indicating Ms E was for full cardiopulmonary resuscitation.

Six months later (July), Ms E's developed a productive cough and was transferred to an acute care hospital, the son told the ambulance officers that Ms E was for full resuscitation. Ms E was diagnosed with myocardial infarction and aspiration pneumonia. The family requested continued adherence to the full resuscitation status.

As Ms E's condition continued to decline, the family held discussions with the clinical team and continued to ask that in the event of deterioration the intensive care team should be called. At this point the medical practitioner requested an ethics consultant to support the family in their decision-making.

This led to a change in the goals of care to *'do not resuscitate'* and Ms E died three days later.

The coroner reminded that RACS staff and health care providers that the process of consent for goals of care and advance directives must be well documented including the documentation of provision of appropriate information to substitute decision makers to allow for meaningful decision making.

Standard 3 Personal care and clinical care

The Aged Care Quality Commission describes 'Standard 3 Requirement 3b Effective management of high-impact or high-prevalence risks associated with the care of each consumer.' Some of the clinical issues mentioned which have been addressed in past editions of RAC Communiqué including: managing risks of choking, managing medications safely and, preventing and managing pressure injuries.

RAC CC Mar-09 Vol 4 (1) Pneumonia

Ms P was a 78 years old female with chronic obstructive airways disease who died from an atypical pneumonia consistent with having been caused by a virus such as influenza.

This case is an example of primary viral pneumonia.

We often forget how serious the "flu" can be, especially for older persons and those with multiple health conditions. Each year the questions to ask include whether immunization with the influenza vaccine has been offered? Accepted? Administered?

Standard 4 Services and supports for daily living

The Aged Care Quality Commission describes 'Standard 4 Requirement (3g) Where equipment is provided, it is safe, suitable, clean and well maintained.'

RACC May-11 Vol 6 (2) Mobility Aids

Mr TD was an 88-year-old male with a past medical history including seizures and who required a wheelchair for mobilisation for over five years after major hip surgery.

It was late morning when staff went into Mr TD's room to transport him to the dining room for lunch. When staff entered the room his wheelchair was found empty and facing the bathroom. Mr TD was on the floor with his head lodged between the bed and armchair.

Over the next three weeks in hospital, Mr TD's condition deteriorated and he died.

The cause of death was: "Aspiration pneumonia, complicating a right frontal brain contusion which he sustained in a fall".

An independent examination of the wheelchair reported to the coroner 'the frame was damaged' and 'the chair shows a definite lack of maintenance. Apart from the chair having bald tyres and ineffective brakes, it was filthy dirty'.

The coroner was unable to ascertain if the wheelchair was "a factor which contributed directly to his death", and stated that "everything that can be done is done by those in a position of providing care to make sure that such equipment is appropriately maintained to ensure that the safety of the person is not in any way diminished."

Standard 5 Organisation's service environment

The Aged Care Quality Commission describes 'Standard 5 Requirement 3b (ii) The service environment enables consumers to move freely, both indoors and outdoors. And later on for Requirement (3c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.'

RACC Feb-18 Vol 13 (1) Falls and cervical fracture

Mr Dd was a 91 year old male with a past medical history included Alzheimer's disease, atrial fibrillation, hypertension, angina, and osteoporosis. Mr Dd had a high risk of falls and 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 found Mr Dd still sitting but with his neck flexed forward in the chair, which was now resting on an angle against a brick wall.

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 and he died in hospital four days after the incident.

The coroner concluded that the use of lightweight plastic chairs was not optimal, especially when used in outdoor areas; that some formal procedure be in place to provide ongoing monitoring of residents in outdoor areas. 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.

Standard 6 Feedback and complaints

The Aged Care Quality Commission describes 'Standard 6 Requirement (3c) *Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*'

RACC Feb-15 Vol 10 (1) Failure to Report

Ms M was a 76 year-old female living at a metropolitan located Residential Aged Care Service. Past medical history included severe vascular dementia and this was complicated by coexisting medical conditions including hypertension, ischaemic heart disease, and atrial fibrillation. On this particular autumn day, in the afternoon, Ms M went for a walk outside and sometime later, was found dead in the courtyard lying at the fountain.

A tub chair was used to help transfer Ms M from the fountain to her room, whereupon another carer dried and re-clothed her in preparation for the family.

The general practitioner was contacted and informed that Ms M had been found dead in the courtyard. The family members were informed that Ms M had died from a heart attack.

A staff member who had seen Ms M in the courtyard and had observed her lying face down in the pond independently contacted the coroner, via the nurses union concerned as the death had not been reported.

An autopsy was conducted and the cause of death determined by the Coroner was '*Immersion (with underlying cause undetermined in circumstances of a fall into a courtyard water feature)*'.

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 organizational moral values were actively upheld by employers.

Standard 7 Human resources

The Aged Care Quality Commission describes "Standard 7 Requirement (3c) *The workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles*"; and later on "requirement (3e) *Regular assessment, monitoring and review of the performance of each member of the workforce.*"

RACC Aug-15 Vol 10 (3) Arson

In September 2011 a registered nurse (RN) approached an accredited RACS that provided high-level care for residents requesting to work night shifts. The RN provided a resume describing his most recent nursing position as working at an acute public hospital four years earlier and the referee was a person he worked with in the year 2000.

In mid-November on the night shift, the assistants-in-nursing noticed that the RN had spent a lot of time in the treatment room where the drugs of addiction or schedule 8 drugs were stored. Subsequently, the RN discovered an investigation was underway into missing medications. That night an extensive fire consumed the RACS with multiple fatalities.

The subsequent police investigation discovered the RN had been subject to past employment disciplinary action and disputes.

The Coroner made a number of recommendations including the need for: scrutiny of employment records and checking of staff credentials; identifying impaired health practitioners and; the secure management of Schedule 8 medications; and education of staff about many of these matters.

Standard 8 Organisational governance

The Aged Care Quality Commission describes 'Standard 8 Requirement (3b) *The organisation's governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery;*' and later on Requirement (3d) *Effective risk management systems and practices.*

RACC Mar-13 Vol 8 (1) RCA Governance

Ms IC was a 91-year-old female with a medical history of a recent stroke and multiple falls entered a RACS. On arrival Ms IC was met by the duty RN, given a given a cup of tea and initial observations taken. An hour later she was found by staff semi-conscious on the floor near the bed. Ms IC died the following day.

The cause of death following an inquest was "traumatic subarachnoid haemorrhage and an acute and chronic subdural haematoma as a result of a fall."

The coroner directed further investigation was required to determine (a) whether the care provided was in accordance to professional standards; and (b) what had been done to prevent a recurrence. The approved provider had not completed any internal review of this event. The only response over the next eighteen months was two lines written on an "Accident Report" made on the day, by the RACS manager.

The coroner recommended the Commonwealth Department of Health and Aging requires all RACS to undertake a Root Cause Analysis of all deaths and hospitalisations that occur following a traumatic event.

Royal Commission: An update of our contribution from Health Law and Ageing Research Unit

Our team presented on Day 7 (Thursday 16 May 2019) of the third series hearings of the Royal Commission into Aged Care Quality and Safety.

The transcript of evidence and a webcast of our evidence are available at the following links.

<https://agedcare.royalcommission.gov.au/hearings/Documents/transcripts-2019/transcript-16-may-2019.pdf>

<https://webstreaming.lawinorder.com.au/acrc>

Podcast with MJA: Residential Aged Care in Australia

Prof Joseph Ibrahim also participated in a podcast see *MJA Podcasts 2019 Episode 19: Aged care in Australia*, where we talk about the state of Australia's residential aged care system and how it can be fixed. With MJA news and online editor Cate Swannell. 29m 33s

<https://www.mja.com.au/podcast/210/9/mja-podcasts-2019-episode-19-aged-care-australia-prof-joseph-ibrahim>