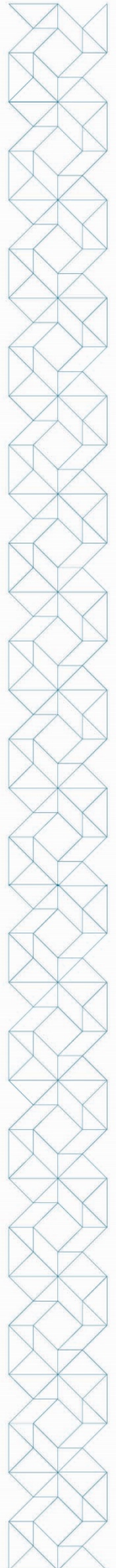# RECOMMENDATIONS FOR PREVENTION OF INJURY-RELATED DEATHS IN RESIDENTIAL AGED CARE SERVICES

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The author has no conflicts to declare.

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Glossary

ACSAA	Aged Care Standards and Accreditation Agency
APINCH	Anti-infectives, Potassium and concentrated electrolytes, Insulin, Narcotics and sedatives, Chemotherapy agents and Heparin and other anticoagulants
AIN	assisted-in-nursing
AACQA	Australian Aged Care Quality Agency
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
BPSD	Behavioural And Psychological Symptoms of Dementia
CQR	Clinical Quality Registries
ENs	Enrolled Nurses
GUSS	Gugging Swallowing Screen
ICD-10	International Classification of Diseases
IDDSI	International Dysphagia Diet Standardization Initiative
ISRAD	International Search and Rescue Incident Database
NCIS	National Coronial Information System
NHMRC	National Health and Medical Research Council
PCA	Personal Care Attendants
RN	Registered Nurses
RACS	Residential Aged Care Services
RMMRs	residential medication management reviews
RRA	Resident-to-Resident Aggression
SSA	Standardized Swallowing Assessment
WHO	World Health Organization

Contents

Executive Summary

Australia's ageing population could be better served by improved aged care, health care, regulatory mechanisms and legal systems. These systems are complex, fragmented and risk averse with divergent, discordant or contradictory approaches. This contributes to significant gaps in care, especially in Residential Aged Care Services (RACS) (commonly referred to as nursing homes).

Improving the quality of care for older people living in (RACS) in Australia requires a better understanding of how, why, where and when residents die. This information contributes to reducing the risk of injury deaths in RACS by developing evidence-based information essential to prevention strategies and the allocation of adequate financial and human resources. Substantive changes are required to improve aged care in Australia. A major aspect of this should be to address the barriers contributing to failure to respect older persons' autonomy, rights, choices and freedom. The initiatives that would assist include:

- Foster community understanding about the need for, nature of, and resource investment required for reform that improves quality of life and reduces harm from injury or death.

- Building national leadership and skills in law, clinical and risk management to enhance regulation, monitoring and translation of knowledge into practice.

- Engage in an active participatory approach between aged care, health and legal sectors for a common goal of improving health and wellbeing of older people living in RACSs.

- Implement a comprehensive process that will identify lessons and the translation into practice of the strategies for health and well-being improvement of vulnerable older people.

This report is the culmination of an in-depth analysis of injury-related deaths of residents living in accredited Australian RACS. The seven topics of focus comprised: choking; medication; physical restraint; resident-to-resident aggression (RRA); respite; suicide; and unexplained absence.

Three methods were applied to develop the evidence for this report: 1) a series of systematic literature reviews; 2) a retrospective case series study of deaths among residents of RACS reported to Australian coroners; and 3) expert consultation forums and follow up survey. The Victorian Institute of Forensic Medicine Research Advisory Committee and the Department of Justice Human Research Ethics Committee for access to coronial information via the NCIS approved this program of research.

From this analysis 104 recommendations to reduce the risk of future similar deaths have been formulated for consideration by government, RACS providers and other agencies and professionals with a mandate or interest in the health and safety of nursing home residents. These recommendations were provided to over 300 agencies and individuals with an interest or mandate for the health and safety of RACS residents.

We were grateful to received feedback about addressing the overall system rather than discrete areas, matters about level and need for regulation, methodological debate about how the research into premature deaths was conducted, as well as the groupings and individual recommendations. We have sought to acknowledge and / or address this feedback so as to provide a balanced and evidence-based appraisal of this issue to assist the government and the sector to enhance RACS for the future.

In addition to our 104 recommendations generated through expert panels for reducing injury, our research team proposes an additional eight recommendations that apply broadly to the whole of the aged care sector.

These eight recommendations arose from the research team's key reflections and observations are that older persons in RACSs suffer preventable harm and that the workforces

in the community, law, health and aged care sector are ill-equipped to address the issue. Systemic factors and not individuals that are the underlying cause compounded by knowledge gaps to inform evidence-based policy and practice in aged care. The lack of academic discourse and absence of leadership for improving quality of care in RACS means the status quo is not being challenged.

Australia requires a *Program for Improving Quality of Care and Safety for Residents and Staff*. This program would promote organisational leadership, a respectful, transparent, resident-centred culture and continuous learning, the use of a standard nationally gathered empirical data; together these elements will provide residents an opportunity to thrive and enjoy their lives.

We hope this report leads to a collaborative effort where every RACS in Australia is considered to be a high performing organisation with systems in place to deliver and evaluate their service, thereby reducing the possibility of any residents' suffering a preventable adverse event (e.g. fall, choking). There is a tremendous opportunity for Australia to become an international leader in aged care. Implementing our research-based recommendations should contribute to a fundamental shift in attitudes and practice.

System reform recommendations

A1.   Consider each of the 104 recommendations for prevention of premature death

A2.   Expanding the research to the areas of premature death not studied

A3.   Redefine Residential Aged Care Services as a 'place to thrive before we die'

A4.   National study to investigate the standard and quality of care within RACSs

A5.   Improve access to existing data

A6.   Improve data capture of essential information with a RACS quality of care registry

A7.   Continue and expand the lessons from national study into medico-legal death investigations

A8.   Establish a non-partisan leadership group

Specific injury type recommendations

Choking Recommendations

1   That residential aged care setting (RACS) policies, procedures and practices reflect the need for specific and detailed care plans of residents who have swallowing difficulties/dysphagia or a prior history of choking and that this is evaluated 6-monthly or after any change in the person's health care to ensure the needs of residents are met.

2   That RACS providers enable appropriate supervision of residents with appropriately skilled staff who have swallowing difficulties/dysphagia or a prior history of choking when eating and that this is reviewed on a regular basis to ensure the supervision needs of residents are met.

3   Residents who are at risk of choking as a result of impulsive or other behaviours should be referred to a multidisciplinary team (medical, mental health, nursing, speech pathology, dietetics) for a formal assessment and behavior management care planning.

4   That RACS facilitate referrals to provide clinical expertise to assess and manage a resident who is identified by staff, family members or reports swallowing difficulties.

5   That valid and reliable screening tools for identifying RACS residents with dysphagia are developed and implemented in Australian RACS.

6   All residents should be screened at admission to RACS and annually as a minimum or when their condition changes to determine whether a choking risk exists and if so, this should prompt a referral to their General Practitioner and/or an allied health professional as appropriate.

7   That all care staff receive training in the identification and reporting of swallowing difficulties in older adults using a validated screening tool.

8   That RACS providers ensure that their facility is resourced to follow the instructions provided by the speech pathologist or dietitian following an assessment of a resident at high risk of choking.

9   That there are comprehensive communication and checking systems in place to ensure that all staff involved in the preparation, serving, feeding and supervision of residents at meal times are aware of individual resident's choking risks.

10   That RACS providers and staff design and monitor the meal supply systems to ensure that the appropriate food is served to the correct resident.

11   That transfer of information about residents' risks of choking and eating plans are promptly and reliably shared between health and aged care providers (hospital, general practitioner, RACS).

12   That the aged care sector as a whole, providers and funders, review their existing model of care to ensure the allocated resources enable and promote the provision of speech pathology, other allied health and dental services to meet the needs of residents who have swallowing difficulties/dysphagia or a prior history of choking.

13   That the aged care sector review how the existing models of care deploy the RACS workforce to determine whether these are consistently meeting the needs of residents who have swallowing difficulties/dysphagia or a prior history of choking.

14   That the aged care sector consider the development of the Allied Health Assistant workforce for screening of swallowing and monitoring.

15   That RACS implement clear, evidence-based procedures and training where simulated choking incidents are part of the medical emergency response.

16   That RACS schedule annual practices or drills for staff around responding to a choking incident and that these should be carried out as part of First Aid response training.

17   That all care staff are trained to safely provide assistance to residents with eating at meal times which includes how to manage the safe delivery of modified texture diets. This includes positioning, particularly important for people who are dependent on assistance to eat.

18   That there is an evaluation of the effectiveness of different safe feeding training formats

        e.g. online training in comparison to traditional 'face-to-face' forms of training delivery

        in this context.

19   That a national data collection system about choking incidents including deaths in RACS

        residents in public and private facilities is developed to better understand the problem

        and guide improved practice by standardized reporting and investigation.

20   That a suitably qualified Australian National Steering Committee develop guidelines for

        provision of residents with the modified texture diet that are specifically designed to be

        implemented in Australian RACS to align with the International Dysphagia Diet

        Standardization Initiative (IDDSI).

Medications Recommendations

21.   That a centralised electronic medication management system accessible to residential

        aged care (RAC) staff and relevant health practitioners (medical, pharmacy and nursing)

        should be developed to ensure availability to up-to-date residents' clinical and

        medication information at the time of prescribing.

22.   That policy makers should consider the use of electronic medication management

        systems as a mandatory requirement for accreditation of residential aged care services

        (RACS).

23.   That clinical colleges or organisations for medicine, pharmacy and nursing along with

        key aged care sector stakeholders should form an interdisciplinary group of clinical

        experts to develop evidence-based prescribing guidelines specific to the needs of older

        persons who live in RACS.

24.   That RACS providers should ensure that evidence-based prescribing guidelines, in hard

        and/or soft copy, are readily available to medical practitioners and aged care staff at the

        point of care.

25. That RACS providers, medical practitioners and information technology groups should consider the feasibility of integrating evidence-based prescribing guidelines into open source medical prescribing software.

26. That disciplines of medical, nursing and pharmacy should place a greater focus on de-prescribing by instituting policies and practices that will support the identification of residents, in consultation with their families, who may benefit from this initiative.

27. That policy makers and disciplines of medicine and nursing should explore the feasibility and impact of a pharmacist-led medication review service with a focus on medication simplification and de-prescribing.

28. That RACS and health providers (hospital, community) should develop a standardised approach to communication and information transfer pertinent to quality and safer use of medication on transitions of care. This may include a standardised template for verbal and electronic transfer of information between health providers (hospital and community) and RACS.

29. That RACS should regularly review their medication administration procedures to identify opportunities for increased support, education and training for RAC staff. Procedures to review may include the choice of dose administration aids and measures to minimise errors during administration of high-risk medications.

30. That RACS and pharmacy should explore the utilisation of technology (e.g. barcode medication administration systems, provision of medication charts/lists with pill images) to reduce medication errors during medication administration.

31. That policy makers, funders and providers should review new and existing models of medical care, including general practice, in Australia and internationally to identify the optimal model of care that enhance medication safety for residents in RACS.

32. That RACS providers, in consultation with medical practitioners, should develop policies and procedures detailing expectations and requirements (e.g. frequency of visits and

additional education) for medical practitioners who provide care to their residents to optimise medication safety.

33.   That RACS and health practitioners (medical and pharmacy) should ensure there is a clear process in place for the identification and minimisation of harm associated with the use of high-risk medications by RAC staff, medical practitioners and pharmacy. This process should include guidelines and procedures for harm minimisation and clearly defined roles and responsibilities of all relevant parties.

34.   That RACS and health practitioners (medical practitioners and pharmacists) should develop specific guidelines for the therapeutic monitoring of high-risk medications in RACS.

35.   That RACS should ensure there is a clear process for the early identification and reporting of clinical deterioration associated with medication toxicity by RAC staff.

36.   That a national program should be designed to educate and empower residents and their families to recognise and report changes to medical and RAC staff when their clinical status is adversely impacted by medication use.

37.   That policy makers should develop standardised procedures for RACS to ensure timely and collaborative pharmacist-led residential medication management reviews are performed with consideration for medication simplification and residents' goals of care.

38.   That policy makers and regulators of the aged care sector should consider establishing standards alongside education and training modules for RACS staff and health practitioners to ensure competency in the monitoring and review of high-risk medications.

39.   That a national mortality and morbidity surveillance system of medication errors that occur in RACS with a standardised approach to information collection and reporting should be established to examine trends over time.

40. That RACS and the relevant professional organisations for general practice, nursing and pharmacy should promote a just culture of reporting and learning system to encourage reporting of medication errors and incidents.

41. That RACS should ensure a comprehensive and systematic approach is taken to improve the information provided by RACS staff and medical practitioners when reporting a potential medication-related death to the Coroner's Court. The incident report should include each of the key steps in the medication process (e.g. prescribing to administration).

Physical Restraint Recommendations

42. That there is a single definition of physical restraint that is legislated so it is used universally to ensure a common understanding between aged care, health care professionals and providers about when physical restraint policy and protocols should apply.

43. That residential aged care services (RACS) should focus on and be supported in, sustaining a person-centered care approach that respects the human rights of each resident.

44. That policies and practice reflect that any behavioural symptoms exhibited by residents with dementia should act as a trigger for direct care staff to assess and consider whether there are any unmet needs of the resident.

45. That the construction of new RACS adhere to specific building guidelines about structural design to promote a dementia-enabling environment; and that any refurbishment of existing homes also adhere to such guidelines.

46. That any clinical handover between health and aged care providers follow a standardized approach to ensure optimal communication that enables an effective multidisciplinary approach to manage residents with dementia.

47.   That the residential aged care (RAC) staff profile and competencies are appropriate to meet the increasingly complex needs of residents with dementia and obviate the need to apply physical restraint.

48.   That the application of physical restraint should only occur in extremely limited circumstances. The process should involve at least two health professionals and requires clearly documenting the reasons for use, duration of use, outcome of restraint and any adverse events that occur.

49.   That all RACS should have a physical restraint policy that promotes alternative approaches and if restraint must be used, it is defined within the parameters of this policy.

50.   That informed consent is obtained from the resident and/or their appointed substitute decision-maker prior to any physical restraint application, and that this is documented.

51.   That use of physical restraint acts as a trigger for mandatory referral to a specialist aged care team to review the resident's care plan and identify strategies that eliminate or reduce the use of physical restraint.

52.   That physical restraint is instituted and monitored only by staff who have received formal training and been assessed to demonstrate competency in this intervention.

53.   That a national, systematic and coordinated approach be taken to improve identification, investigation, analysis and reporting of adverse events involving physical restraints among RAC residents.

54.   That at the time consent is obtained, residents and family members should be provided with education about how and where to lodge any concerns and complaints related to the use of physical restraint.

55.   That a national standardized and, co-ordinated approach to the investigation of all deaths of a RAC resident while in a physical restraint is required.

56. That if a resident dies within seven days of being in any form of physical restraint that this is reported and triggers an investigation into the cause of death.

Respite Recommendations

57. That mandatory use of a central electronic system, that stores medical records and information from health and aged care providers (e-health records), is required as part of residential aged care services (RACS) accreditation to reduce adverse handover incidents.

58. That a planned preventative care model of respite is adopted to maintain the caring relationship and reduce adverse events related to emergent admissions.

59. That facilities specialising in residential respite be developed to manage the care of respite residents with complex needs.

60. That a simplified procedure, involving identifying five vital care needs of the respite resident, is implemented to mitigate adverse events through a standardised handover procedure.

61. That there is flexibility in when respite residents are admitted and the length of their stay to improve access and use of respite care by carers.

62. That information gathered on respite residents is optimised to identify how and why respite is used and to provide opportunities to prevent adverse events through enhanced national data collection on respite residents.

63. That respite residents are able to bring in personal and familiar items to respite care to create a familiar environment, thereby reducing adverse events.

64. That clinicians assess respite residents on admission to determine the presence of conditions that may impact the care and health of the respite resident.

65. That a national, systematic and coordinated approach be taken to improve identification, reporting, investigation and analyses of adverse events involving residential respite residents.

66. That a standard and comprehensive procedure for admission, handover and discharge from respite care is implemented so that the family, general practitioner and community services are aware of the needs of the resident during and immediately after respite care.

67. That a national standardised and coordinated approach to the investigation of all deaths of respite residents while in, or within seven days after discharge from respite care is implemented.

Resident-to-Resident Aggression Recommendations

68. That government, health department, regulators, providers and health professional bodies develop national standards describing the skills mix and staffing levels required to manage the needs of residents to prevent RRA.

69. That all relevant data on incidents of aggression and assault in residential aged care services (RACS) be centrally collected in a national database and reported publically each year.

70. That current mandatory reporting requirements be extended to include all types of aggressive incidents in residential aged care (RAC), regardless of the cognitive status of residents involved.

71. That mandatory training for RAC staff be extended to include training on the fundamentals of dementia and RRA.

72. That aged care providers introduce zero tolerance policies in RACS for violence against staff, residents and visitors.

73. That the physical environment of the RACS be designed and used in a way that enables, rather than disables, residents with cognitive impairment.

74. That clear, user-friendly definitions of the spectrum of aggressive behaviours be included in mandatory reporting legislation, policy and protocol documents.

75. That RAC staff adopt a person-centred care approach to new and existing residents.

76. That government agencies, advocacy groups and aged care providers develop and implement a community awareness campaign to increase the general public's understanding of dementia, its Behavioural and Psychological Symptoms, and knowledge about the preventability of aggressive incidents among older adults.

77. That RACS providers introduce policies aimed at supporting families to feel part of a comprehensive care team.

Suicide Recommendations

78. That a coordinated and multifaceted approach is taken to align residential aged care (RAC) life with community living to make the RACS a place where most people would be happy to live.

79. That a systematic, evidence-based approach is taken to increase support for residents to manage physical health issues, which includes addressing community attitudes towards physical health decline.

80. That residents be consulted in regards to their response to and preferences for the physical environment of the RACS.

81. That a greater focus be placed on identifying opportunities for improvements to resident care, safety, and quality of life through the use of technology.

82. That a national initiative be introduced to provide individual orientation and support to older adults entering the residential aged care system and at quarterly intervals during their first 24 months of residency.

83. That existing state and national suicide prevention frameworks are expanded to include priorities for older adults and those residing in institutional settings.

84. That all RAC residents are regularly screened for depression using a standardised valid assessment tool.

85. That RAC staff undergo regular education and training in suicide prevention.

86. That RAC residents have better access to mental health services which includes allied and medical specialists.

87. That a systematic and coordinated approach be taken to improve the identification, investigation, and reporting of suicides among RAC residents.

88. That family members, staff, and other residents receive appropriate support following the suicide of a resident.

Unexplained Absence Recommendations

89. That an agreed definition is formulated of unexplained absence is applied universally.

    (Part 1): That a national human rights and evidence-based approach is developed to integrate technology that supports residents in being able to leave the residential aged care service (RACS) safely.

    (Part 2): That documented informed consent is obtained from the resident or their appointed substitute decision-maker, prior to any external tracking device or method application, irrespective of the resident's capacity, their wishes and preferences are considered.

90. That national guidelines are developed that define accountability and responsibility of enduring power of attorney and guardianship providers.

91. That there is a bi-annual forum for the police, search and rescue teams, and the residential aged care sector (providers, staff and residents) in which information, such as problem areas and emerging trends of unexplained absence, death, and injury are shared and discussed.

92. The construction of new RACS be guided by contemporary research on building design that promotes the perception of freedom and independence, and which may reduce the likelihood of unexplained absence attempts and events.

    (Part 1): That a coordinated and multifaceted approach is taken to align existing aged care training programs with government policy initiatives that support holistic and

person-centered duty of care, and that promote positive values of the older person.

(Part 2): That residents are offered activities that engage and enhance their quality of life and promote the RACS as a place where most people would be happy to live.

93. That an evidence-based approach is taken to the development of a risk assessment tool and risk prevention strategies that identifies residents at-risk of leaving RAC without informing care-givers.

94. That there is a national approach to risk assessments and the development of risk prevention strategies that are agreed with the resident or their appointed power of attorney.

95. That any transfer report between health and aged care providers follows a standardised approach to ensure optimal information is exchanged/shared between providers in regards to any risk of unexplained absence.

96. That within the first 24 hours of a resident's admission, RAC staff conduct an initial assessment to identify residents at-risk of unexplained absence and document the specific strategies to be undertaken. A final review and recommendations should be conducted at 7 days following admission.

97. That any behavioural symptoms leading to an attempt to, or successfully leaving the RACS, without informing caregivers, exhibited by residents should act as a trigger for direct care staff to assess and consider whether there are any unmet needs of the resident, and develop interventions to prevent occurrence or re-occurrence.

98. That there is a national approach to minimum standards for all RACS to have an easily accessible search and rescue plan to support staff and family in responding quickly and systematically to an unexplained absence event.

99. That RAC staff undergo regular training and practice in reporting procedures to ensure they are able to promptly and appropriately respond to an unexplained absence incident.

100. That a simple and easily readable form for providers to complete and give to search and rescue teams and police is developed. The form must be embedded into the resident assessment and care plans, identifying the resident's history and social profile, with addresses where the resident may have likely gone, and information on the unexplained absence event.

101. That federal, state and territory governments establish a national register which is comprehensive, coordinated and requires mandatory reporting of all unexplained absences occurring in RACS.

102. That the national register have a standardised approach to the recording of key individual, organisational, environmental determinants, and search and rescue information, relating to variability of unexplained absence event; and that this information is regularly analysed to identify trends and risk-factors for injury and death. The register is also to include post-rescue information to support the development of prevention strategies.

103. That current approaches to the investigation of all deaths of a RAC resident following an unexplained absence are nationally standardized.

104. That if a resident dies within seven days of being found after an unexplained absence that this is reported to and recorded on a national database such as National Coronial Information System.

Chapter 1 Program for Improving Quality of Care and Safety for Residents and Staff

JOSEPH E IBRAHIM, LYNDAL BUGEJA

Introduction

Improving the quality of care for older people living in Residential Aged Care Services (RACS) (commonly referred to as nursing homes) in Australia requires a better understanding of how, why, where and when residents die. It also requires analyses of the standard of care being provided which is under increasing scrutiny by the community and governments. This report is the culmination and conclusion of our research program.

The empirical research is described elsewhere in academic journals to allow the veracity of our findings to be tested openly and to be peer reviewed. The research comprised three main stages, detailed systematic searches and reviews of the existing national and international literature (over ten were conducted); collation and analysis of deaths that have occurred in nursing homes in Australia reported to the coroner since the year 2000 and; convening of seven different expert panels to develop recommendations.

The recommendations described are seeking to enhance the quality of care and quality of life of residents; preventing injuries and premature deaths of residents. These recommendations are the result of three years of intensive work by our research team and are only possible with the support of the experts, stakeholders and organisations that gave their time and knowledge.

The first step in this research commenced prior to 2000 when the National Coroners Information System was being developed; without this database our research would not have been possible. The second step was in 2006 when we launched the Residential Aged Care Communiqué and began presenting the deaths of residents investigated by coroners as an education resource to help improve care.

The research work of our team over the years has been supported internally through the Department of Forensic Medicine, Department of Health and Human Services (Victoria) and more recently through the Commonwealth's Aged Care Service Improvement and Healthy Ageing Grants Program.

We are grateful for those who took the time and effort to respond to our call for comments. We have addressed any discordance by including a section in the relevant Recommendation outlining concerns or the difference of opinion.

Core objective of these recommendations

The core objective and perhaps the simplest recommendation is that Australia requires *a Program for Improving Quality of Care and Safety for Residents and Staff*. This program would promote organisational leadership, a respectful, transparent, resident-centred culture and continuous learning, the use of a standard nationally gathered empirical data; together these elements will provide residents an opportunity to thrive and enjoy their lives. Many will argue this is already in place, others that the challenges of balancing economics, workload and care delivery hamper any such efforts. A key issue that is being investigated elsewhere is the question of whether there are adequate numbers of qualified staff.

Describing a high performing Residential Aged Care Service

We hope that our research and recommendations lead to supporting a model where every RACS in Australia is considered to be a high performing organisation with systems in place to deliver and evaluate their service, thereby reducing the possibility of any residents' suffering a preventable adverse event (e.g. fall, choking). Some of the features for a high performing RACS include:

- considers the resident as a person with their own set of rights, choices and freedoms

- promotes and protects the residents' best interests, respects residents' autonomous decisions

- applying contemporary evidence to aged care practice

- uses empirical data to drive improvement in practice and discloses this information to the public

- uses a multidisciplinary approach to ensure cohesive teamwork and optimal outcomes for residents

- proactively prepares staff to recognise and manage frail older residents who are vulnerable to dramatic or life-threatening consequences from minor insults or injuries

- has appropriate, regular and practical training programs for staff to improve their competencies in practice

- actively engages and communicates with their partners in delivery of care such as general practitioners (GPs) and allied health professionals

- is prepared and flexible enough to manage surges in service demands that arise from known risks that arise in communal residential settings such as infectious outbreaks

- actively identifies and manages staff performance, competence and credentials

- has a robust organisational culture, with contemporary social values that are actively upheld by management

- promotes transparency, open disclosure, a just culture and learning from adverse events

- implements models of care appropriate for the different needs of residents that are matched with appropriate staffing levels and capability—a fundamental feature for any human service.

Reflections and observations of the research team

Australia's ageing population could be better served by improved aged care, health care, regulatory mechanisms and legal systems. These systems are complex, fragmented and risk averse with divergent, discordant or contradictory approaches. This contributes to significant gaps in care, especially in RACS. The research team's key reflections and observations follow.

1. Older persons in RACSs suffer harm

Older people living in a RACS are at significant risk of harm as a consequence of their physical frailty, cognitive impairment and multiple co-morbidities, complex drug regimens, and poor or inadequate care coordination. Some deaths and injuries can be prevented without reducing residents' quality of life. Preventable deaths include those resulting from falls, suicide, and asphyxia associated with bedrails and restraints, foreign body aspiration, or food obstructing airways.

There is no doubt that some deaths are premature. Any person who dies from an injury does so 'before their time'. When policy-makers, clinicians and academics challenge this internationally accepted definition of *'injury'* they reinforce views that are ageist implying the lives of older people have less value.

2. The workforces in the community, law, health and aged care sector are ill-equipped

A contemporary society must move beyond reliance on informal advocacy from family members or peak bodies by designing legislative protection requiring transparency and reporting of harm including supporting the dignity of risk principle.

The existing regulatory mechanisms are almost 20 years old, being based on the *Aged Care Act 1997* (Cwth). There have been profound changes in the past 20 years about measuring, regulating and investigating quality of care. This, in addition to the changes in the whole aged care sector model of service, staffing, and resident mix, requires substantial changes to match the expectations of our contemporary society.

This must be considered in the context that the personal care attendants, who make up most of the workforce in RACSs are not equipped, able or empowered to fulfil the role as stewards of high quality care. In general, the nursing workforce is not adequately equipped as there is not a single tertiary nursing course on gerontology, let alone specific graduate training for the care of people living in RACSs. Compounding this issue is the potential shortfall in the number of nurses allocated to meet residents' clinical care needs. With such a large gap in the nursing

workforce's knowledge and training it is unreasonable to expect nurses to be able to monitor standards of care, advocate for improved quality of care and challenge the status quo. This is very unlike the situation of health care in public hospitals where there is a large and diverse number of health professions and health professionals that are able to question, challenge, monitor and, support each other to improve patient safety in the organisation.

3. Systemic factors and not individuals

The approach to formulating recommendations took a global or systems-factors approach to identifying factors associated with increased risk of injury. This approach considers how the whole organization operates, that is, the system which includes the environment, workforce, policies, procedures rather than the simplistic approach of seeking to blame a single individual. Some of the key messages that came through in each of the area topics that the experts sought to address were:

- Poor facility design

- Lack of staff training

- Limited access to specialist services (eg. aged care mental health, physiotherapy, speech pathology)

- Lack of contemporary clinical practice guidelines suitable for the Australian context (eg. medications, restraints etc.)

- Lack of a clear medico-legal framework (or sometimes lack of application of existing frameworks)

- Lack of adequate monitoring of preventable harm and injuries across the whole aged care sector

4. Knowledge gaps to inform evidence-based policy and practice in aged care

There is a paucity of empirical research into the regulatory mechanisms and quality of care in RACSs. This is related to a number of factors: a lack of dedicated funding to support research into quality of care in RACSs; the small number of researchers or academics engaged in the

field and; restricted access to, as well as high costs in, obtaining data essential to this type of research.

The complexity of the research and the nature of the study designs do not lend themselves to the standard approaches that are expected to access existing competitive funds through the National Health and Medical Research Council (NHMRC). This requires specific and dedicated PhD scholarship support to recruit higher degree students to improve our knowledge.

Describing the quality of care delivered, let alone any trends, in RACSs in Australia is hampered by a lack of readily available, standardised, objective, national-level measures for quality of care that is accessible to researchers. Our research was only possible because we used information from the Coroner's court and our society adheres to the principle of 'open justice', which requires the courts and their findings are open to the public.

Our team is the only group in Australia with a dedicated, co-ordinated, multidisciplinary approach with technical expertise in aged care, law, health care, public health, injury prevention and public policy focussed on RACSs.

5. Lack of academic discourse

The lack of academic discourse and research in Australia in residential aged care was probably our most profound insight. We conducted over ten systematic searches of the literature screening in excess of 50,000 articles and found very little research originating in Australia. This demonstrates a significant gap in ensuring the safety and quality of care. Empirical research underpins our modern society, it requires gathering objective evidence to determine why things do or do not work, to challenge preconceptions and to test the merits of ideas or practice.

The lack of a robust national academic research program about RACSs is an indictment on state and federal governments, research funding bodies, the universities and the providers of RACS for the past two decades. The growing needs of an ageing population were forecast last century and yet we do not have specialised training for gerontic nursing in our universities nor

sufficient research capability or infrastructure to address the quality and safe care of residents. We estimate that research outputs into this area for the whole nation would only equate to having six full-time professors (so not even one in each State or Territory) and there are 31 schools of nursing in Australia.

6. Leadership for improving quality of care in RACS is too narrow and disparate

The aged care sector is based on a market-driven model that promotes competition and therefore inherently limits collaboration. Innovations become 'commercial-in-confidence' and reporting of adverse events kept 'in-house' at all levels (facility, organisation, department) to protect reputations.

Improving safety and quality of care requires developing partnerships with collaborating organisations to ensure translation of empirical research into practice. This should include engagement of relevant State and Territory departments as well as the Commonwealth Department of Health. Arrangements are required to engage the private and non-government charitable sector. A non-partisan entity with the primary objective to improve residents' quality of care, respect for their freedom and choices while enhancing safety where possible is required.

Substantive changes are required to improve aged care in Australia

Aged, healthcare and legal sectors collaborations are required to improve awareness and address existing gaps which lead to morbidity, premature death. A major aspect of this should be to address the barriers contributing to failure to respect older persons' autonomy, rights, choices and freedom. Initiatives that could assist include:

- Foster community understanding about the need for, nature of, and resource investment required for reform that improves quality of life and reduces harm from injury or death.

- Build national leadership and skills in law, clinical and risk management to enhance regulation, monitoring and translation of knowledge into practice.

- Engage in an active participatory approach between aged care, health and legal sectors for a common goal of improving health and wellbeing of older people living in RACSs.

- Implement a comprehensive process that will identify lessons and the translation into practice of the strategies for health and well-being improvement of vulnerable older people.

Response to Comments

As expected, we also received broad comments about addressing the overall system rather than discrete areas, matters about level and need for regulation, methodological debate about how the research into premature deaths was conducted, as well as the groupings and individual recommendations. These are addressed these below.

Selective in the conditions addressed

The level of funding we received for this research program was modest, equating to less than three full-time researchers for three years. This constrained what was possible for us to do, but we were able to be innovative and flexible enough that we covered seven rather than the initial five areas.

The recommendations address six forms of injury events leading to death (choking, medication errors, physical restraint, suicide, resident-to-resident assault, unexplained absences) and one aspect of residential care programs (respite). Although substantial, examples of other injury topic areas we were not able to address due to resourcing included: deaths from falls; burns, road-trauma and other injuries from the use of mobility devices; pressure-injuries; and infectious outbreaks and clinical-care related deaths. The other aspects or stages in care that warrant examination included: palliative care, end-of-life care, and transition into and out of acute care hospitals and emergency departments. Although we have made a start with the seven areas examined, there is clearly a long way still to go.

Too great an emphasis on regulation in the recommendations

There was some discussion about aged care becoming over-regulated and that our recommendations simply add to that burden. Our response is that the community increasingly wants individual rights clearly articulated and enshrined in law—this is evident in moves towards physician-assisted voluntary euthanasia, marriage equality, and the protection of children and elders from neglect or abuse.

While it is better in any human service to have people perform duties and tasks willingly, rather than through necessity, or worse still, due to mandated or directive instructions. In the current context there is a need for regulation and for enforcement of the regulations in aged care. The role of regulation is far more complex and requires more than a cursory discussion. In this regard, we highlight the following three points.

First, reducing regulation does not automatically create a population of providers or a workforce who are willing to do the 'right thing'. Further defining the 'right thing' or what is considered the 'right thing' changes with time and social values. What was acceptable in health and aged care 20 years ago, is now no longer appropriate. The use of regulations in setting rules, standards and laws help everyone to understand the minimum level of expected behaviours.

Second, simply increasing regulation does not automatically improve care. Knowing what should be done, does not ensure implementation or adherence, as regulations that are in place may have weak enforcement and inconsequential sanctions or fines that cost less than failing to adhere to the regulations. Currently, there are relatively few consequences for providers who fail to provide quality care – unless the failure is extremely serious. Providers need an effective incentive to comply and a sanction or cost to providers who fail to implement strategies for injury and fatality prevention.

Third, creation of consistent, national standards for reporting serious adverse events that harm or kill residents is robust, well-established science. Effective prevention strategies

require gathering the contextual factors in epidemiology, surveillance, and case reporting in each instance in each RACS. Claims that this is a regulatory mechanism are not correct. For example, good public health science requires advocating national standards for reporting residents who experience injury or death from any of the following events: unexplained absences, resident assaults and/or physical restraint. Gathering standardised, comprehensive data helps inform practice and to change resident outcomes.

Too many recommendations

The expert panels generated the recommendations independently of each other so there is so overlap of general principles and themes. We did not consolidate these recommendation as the starting premise of our research was each topic area was considered separately. Prioritisation of the whole set of 104 recommendations was a challenging task. Our goal was to highlight that there are actions possible to reduce harm. The next stage requires broad engagement with policy-makers, providers, funders, aged care consumers and RACSs' staff.

Absence of recommendations

Logistic constraints and limited funding necessitated containing the research to a small number of topics. In retrospect, we required treble the amount of funding to broaden the examination to all aspects of care that contribute to premature deaths. There are gaps and omissions in the recommendations. These are most obvious in the area of fall prevention and addressing chemical restraint, especially given we examined physical restraint. Our silence in these areas should not be construed that there is nothing to be done. As the data examining premature and preventable deaths demonstrated, falls-related events are the most common cause of injury and deaths and require attention. Other areas of neglect and abuse e.g. sexual assault and deprivation of freedom of movement, did not lead to deaths that were reported to the coroners. Therefore, we were not able to examine them.

Emphasis of recommendations

The degree of emphasis in the recommendations was prominent especially around the issue of physical restraint. Some considered the recommendations "a bit weak" – while others "too strict" in their interpretation. This highlights the need for expert groups to work with the recommendations and refine these further. The principle or overall aim should be zero tolerance for restraints that are used outside of very narrow specific situations that are time limited. This requires further work to define those situations in addition to what qualifies as a restraint.

Same key themes in each of the different injury types

Some respondents suggested that conceptualising the same key issues or themes would be more beneficial in demonstrating the core principles. That the individual chapters could have their specific recommendations condensed into the same five key areas of prevention, screening, training, guidelines and monitoring.

There were discordant views about whether we should consolidate the recommendations into the general principles outlined above which would then be universally applicable for all types of injury or premature deaths. Others preferred a specific focus on each individual issue as it helped to direct attention to the core actions for improving care.

Injury mechanism and high risk situation

There is a distinction to be made between the injury mechanism and high-risk situations. Six of the seven chapters examine an injury type, e.g. choking. In contrast, respite care is a situation. The topic of residential respite care is part of a broader issue of 'transitions in care'. These include: new admission to a RACS, transfer to an acute hospital, return from an acute hospital, residential respite care and evacuation due to internal or external disaster. More research is required into these transition periods and they rarely present as a cause of death to the Coroner. Capturing this information requires a specific and dedicated effort.

Recommendations for reform of the aged care sector

The challenge as always is how a RACS balances economics, workload and safety while providing residents an opportunity to thrive and enjoy their lives. In addition to the 104 recommendations generated through expert panels for reducing injury, our research team proposes an additional eight recommendations.

Recommendation A1. Consider each of the 104 recommendations for prevention of premature death

This report is the culmination of three years of research developed with the assistance and input of expert practitioners in the field. We anticipate that government departments, regulators, policy makers, providers, medical and nursing schools as well as RACS staff and the Coroners Court will examine these recommendations. Our hope is this is done in a systematic, proactive national manner. If this does not occur, then the information remains pertinent and will be used on an ad hoc basis or perhaps and case-by-case when the next preventable death is reported to the Coroners.

Recommendation A2. Expanding the research to the areas of premature death not studied

The existing recommendations are limited to seven types of circumstances. Consideration should be given to expanding the work to cover all areas of injury beyond what has been explored. Examples include fall-related deaths, death from thermal injury, mobility aids, transitions of care to and from acute care hospitals.

Recommendation A3. Redefine RACS as a 'place to thrive before we die'

The purpose of a RACS is rarely explicitly stated. Perhaps, it is because the community, professional bodies and policy-makers have a clear sense of their purpose in their minds. The most common perception around the decision for an older person to enter a RACS is a belief that they are no longer safe at home.

Although a RACS is considered a safe option, this move may result in greater harm. Short-term harm examples include through new adverse health events (e.g. falls due to a change in

environment) or an acute deterioration of pre-existing conditions. Long-term harm comes through institutionalisation that disrupts a person's everyday life that may comprise lifelong routines, and the risks of communal living (e.g. infectious outbreaks).

Interestingly, there is not a single international definition or consensus or even a term to describe the purpose of residential aged care. The over-riding view is that RACSs are a place where older people wait to die.

A contemporary definition in a developed country such as Australia would be to stipulate that RACSs should provide the opportunity for their residents to thrive. This is possible in spite of what is commonly understood to be increasing frailty, decreasing functioning as people age. By redefining the purpose, we reframe how the community, staff and regulators perceive a RACS. This empowers our collective ability to improve care as it reshapes expectations.

Recommendation A4. National study to investigate the standard and quality of care within RACSs

Australia does need a national study that uses empirical research to better investigate the standard and quality of care provided within RACSs. The adverse events leading to premature deaths are likely to cause a much greater level of morbidity. This national study should examine a wide range of outcomes including temporary and permanent resident harm, hospitalisation, serious adverse events and premature deaths. For example, instead of deaths from choking we should examine oral and dental care, aspiration pneumonia, malnutrition and sepsis; as well as suicide, examine the levels of under-diagnosed residents with depression and other mental health needs; instead of resident-to-resident aggression, examine the care of residents with dementia.

Recommendation A5. Improve access to existing data

We need greater information and transparency about the quality of care in RACSs.

We should be insisting that access to existing data about quality of care from the Australian Aged Care Quality Agency, the Commonwealth Department of Health, the Aged Care

Complaints Commissioner and that gathered from the Aged Care Funding Instrument, be made available for dispassionate and objective independent analyses.

We should seek commitment from custodians of relevant national datasets to allow access, and the linking and analyses of this information. This requires negotiation with government and regulatory authorities to obtain information about deaths, quality of care, quality indicators, accreditation outcomes, complaints and police reports.

Other key data sources include those available through the Department of Health, Quality Indicators, "reportable Incidents", Coroners Courts/Offices, Police and Prisons information systems as well as those from the Office of the Public Advocate.

Recommendation A6. Improve data capture of essential information with a RACS quality of care registry

There is a need to improve data capture so more information is available about adverse events including complaints. A minimum standard for all RACSs to report to a central agency should be mandated and there should be an annual public disclosure of this performance data.

Federal, State and Territory governments should establish a national register which is comprehensive, coordinated and requires mandatory reporting of a suite of significant adverse events that include, but are not limited to: physical restraint, elder abuse, resident-to-resident aggression, suicide, choking, and unexplained absences that are occurring in RACSs. The national register should have a standardised approach to the recording of key individual, organisational, and environmental determinants, and other information relating to the adverse event. This information should be regularly analysed to identify trends and risk-factors for injury and death.

The strengths of establishing a national register as a form of data collection that can be used to produce reports; identify rates and trends; and the individual, organisational and

environmental risk-factors for death and injury, is well documented in research[1]. It improves (a) the basic knowledge of the event; (b) generates opportunities for quality improvement initiatives; (c) provides for detailed analysis and research enabling an in-depth examination into staffing levels and training and (d) consumers' right to know.

The consumers right to know is the most compelling[2]. Greater transparency becomes possible by introducing a specific data system to report. The benefits of transparency are an increase in the accountability among individual RACSs, providers, and the sector as a whole. This should translate into improvements in the quality of care. An important property of public reporting is to have information that is user-friendly and easily accessible to consumers, aged care advocacy organisations, policy-makers, legislators, and the media. This shared knowledge increases the likelihood of well-coordinated policy and preventive interventions. This also encourages adherence to the laws and regulations relevant to the incidents.

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

Recommendation A7. Continue and expand the lessons from national study into medico-legal death investigations

Our research group have already described the first national comprehensive study in Australian RACSs looking into premature and potentially preventable deaths of residents 2000 to 2013. This work has concluded and the current capacity to continue is constrained by lack of resources.

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

2 Op cit, Caspi E. A federal survey deficiency citation is needed for resident-to-resident aggression in U.S. nursing homes. Journal of Elder Abuse & Neglect.

As we enter the new year of 2018, there is another five years of data in the legal system that should be collated and, analysed to ensure any new or emerging trends are identified early.

Recommendation A8. Establish a non-partisan leadership group

Establish an *International Centre for Geriatric Forensic Medicine and Nursing* to provide the stewardship for improving quality of care in RACSs. This should be a non-partisan group that is able to engage key stakeholders and relevant experts from community, legal, health and aged care sector.

A key role would be establishing a national Geriatric Medicine Consultative Council for premature deaths of vulnerable older people and people with dementia modelled on similar councils that have succeeded in reducing premature deaths (e.g., anaesthetic-related deaths, maternal and neonatal deaths). There is a similar council in Ontario Canada.

Conclusion

There is a tremendous opportunity for Australia to become an international leader in the provision of aged care. Our research-based recommendations are one of a number of inquiries currently available in Australia. What is required is a fundamental shift in attitudes and practice, a change in culture of care and governance.

We should all be working towards an aged care system that improves a resident's quality of life, while reducing preventable harm and respecting an individual resident's rights for Dignity in Care and Dignity of Risk. This needs an empowered and trained workforce operating within the bounds of evidence based clinical care and an agreed legal framework. It is possible to achieve as evidenced by systems in other countries. Improving the quality of Australia's aged care is in our hands and requires action now.

Chapter 2 Background to research program

LYNDAL BUGEJA, JOSEPH E IBRAHIM

Introduction

Injury deaths from choking or suicide among nursing home residents do occur[3] and raises concerns about the quality of care. Recommendations for improving monitoring and the standard of care in nursing homes arise from multiple sources[4] and are highly scrutinised by the media[5] and regulators[6]. To reduce the risk of injury deaths in this setting, evidence-based information is essential to develop prevention strategies and allocate adequate financial and human resources[7]. This information includes empirical research[8], investigation of adverse events[9], and outcomes of the criminal justice or coronial system[10].

Changing healthcare practice is challenging with many obstacles hindering efforts, such as the large size of the sector which makes consensus for change an expensive and time consuming process[11]. Previously successful approaches, such as aged-care industry-wide mandatory

3   Ibrahim JE, Bugeja L, Willoughby M, Bevan M, Kipsaina C, Young C, Pham T, Ranson D. Premature and potentially preventable deaths among nursing home residents in Australia: a medico-legal examination. Med J Australia. 2017;206:442-447.

4   Organisation for Economic Co-operation and Development. Reviews of health care Quality Raising Standards 2015. Australia: OECD, 2015. http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/oecd-reviews-of-health-care-quality-australia-2015_9789264233836-en#page4.

5   Quadagno J, Stahl SM. Challenges in nursing home care: A research agenda. The Gerontologist. 2003;43 (2suppl):S4-S6.

6   Australian Aged Care Quality Agency. Let's talk about quality: Shaping the future: National consultation report December 2015. Australia: Australian Government Canberra, 2015. https://www.aacqa.gov.au/providers/promoting-quality/lets-talk-about-quality-report-1.

7   Aldrich MC., et al. The role of epidemiology in evidence-based policy making: a case study of tobacco use in youth. Annal Epidemiology. 2015;25:360-365.

8   McGovern C, Cusack DA. The case for a cost-effective central coronial database following an analysis of coronial records relating to deaths in nursing homes. J Forensic and Legal Med. 2014;25:21-25.

9   Hogan H., et al. Learning from preventable deaths: exploring case record reviewers' narratives using change analysis. J Royal Soc Med. 2014;107:365-375.

10   Mok E. Harnessing the full potential of coroners' recommendations. Victoria University of Wellington Faculty Journals Rev. 2014;45:321-366.

11   Bosse G, Breuer J, Spies C. The residence to changing guidelines – what are the challenges and how to meet them. Best Practice & Research Clinical Anaesthesiology. 2006;20:379-395.

Recommendations for prevention of injury-related deaths in residential aged care services   45

accreditation[12], require multi-sectorial involvement and time to implement into usual practice[13]. Achieving systemic change requires clarity about what needs to be accomplished and by whom.

This report is the culmination of an in-depth analysis of injury-related deaths of residents living in accredited Australian RACS. From this analysis 104 recommendations to reduce the risk of future similar deaths have been formulated for consideration by government, RACS providers and other agencies and professionals with a mandate or interest in the health and safety of nursing home residents. The seven topics of focus comprised: choking; medication; physical restraint; resident-to-resident aggression (RRA); respite; suicide; and unexplained absence.

Method

Three methods were applied to develop the evidence for this report: 1) a series of systematic literature reviews; 2) a retrospective case series study of deaths among residents of RACS reported to Australian coroners; and 3) expert consultation forums and follow up survey.

Systematic Literature Reviews

A systematic literature review was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses Statement[14] for each of the seven topics[15]. These

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12   Australian Government: Australian Aged Care Quality Agency. Residential Aged Care. Australia: Australian Government Canberra, 2017. https://www.aacqa.gov.au/providers/residential-aged-care (accessed 15 May 2017).

13   **Crawford** L, Pollack J. Hard and soft projects: a framework for analysis. Int J Project Manag. 2004;22:645-653; **Hodges** S, Ferreira K, Israel N. "If We're Going to Change Things, It Has to Be Systemic:" Systems Change in Children's Mental Health. American J Comm Psych. 2012;49:526-537.

14   Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. PLoS Medicine. 2009;6(7) doi:10.1371/journal.pmed1000097.

15   **Abelskamp** G, Bugeja L, Weller C, Kipsaina C, Ibrahim JE. Food Choking in Nursing Home Residents: A Systematic Review. [Under review]; **Ferrah** N, Lovell J, Ibrahim JE. Systematic Review of the Prevalence of Medication Errors Resulting in Hospitalization and Death of Nursing Home Residents. J Am Geriatr Soc. 2017;65:433-442; **Bellenger** E, Ibrahim JE, Lovell J, Bugeja L. The Nature and Extent of Physical Restraint – Related Deaths in Nursing Homes: A Systematic Review. J Aging Health. 2017; doi: 10.1177/0898264317704541; **Ferrah** N, Murphy BJ, Ibrahim JE,

reviews examined all original, peer-reviewed literature published in English. A comprehensive search was preformed across a number of international databases in the disciplines of medicine and nursing (including behavioural sciences, forensic medicine, gerontology, mental health, preventive medicine and public health) including: Ageline; Cochrane library; CINAHL; Embase; Medline; PsycINFO; Scopus; and Web of Science. Key terms were derived to develop a master search strategy, which was piloted in Medline. The final searches were conducted on all selected databases on the same day with results exported to reference management software. Duplicate references were deleted using a standard function in the reference manager and exported to Microsoft Excel for title and abstract review. Two authors independently reviewed the titles and abstract in accordance with a pre-determined inclusion criteria. Conflicts were adjudicated by a third, usually the senior, author. The full text of included articles were reviewed to confirm inclusion and a bibliographic review was conducted to identify any additional relevant articles.

Data of interest from each of the included articles were extracted and recorded into an Excel spreadsheet for analysis. The quality of studies was assessed independently by two authors using a modified Newcastle Ottawa Scale[16] and disagreement was adjudicated by a third author.

Retrospective Case Series Study

The primary data source for the retrospective case series study was information generated for Coroners' investigation of injury-related deaths that occurred in RACS which must be reported to Coroners in accordance with state and territory legislation. From July 2000 (2001 in

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Bugeja LC, Winbolt M, LoGiudice D, et al. Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review. Age Ageing. 2015;44(3):356-64; **Willoughby** M, Ibrahim JE, Ferrah N, Bugeja L. The risk of mortality in residential respite care: where is the evidence. [Under Review]; **Murphy** B, Bugeja L, Pilgrim J, Ibrahim JE. Suicide among nursing home residents in Australia: A national population-based retrospective cohort study. [Under review]; **Woolford** MH, Weller C, Ibrahim JE. Unexplained absences and risk of death and injury among nursing home residents: a systematic review. J Am Med Dir Assoc 2017;18(4):366 e1- e15.

16   Wells GA, Shea B, O'Connell D, et al. The Newcastle-Ottawa Scale (NOS) for assessing the quality of nonrandomised studies in meta-analyses. 2011.

Queensland) information generated for the Coroners' investigation is stored in the National Coronial Information System (NCIS). The NCIS is an electronic data storage and retrieval system that contains coded and free text data fields and four full text documents, including: the police report on the circumstances of the death; the autopsy report; forensic toxicology report; and the Coroners' finding.

With the assistance of NCIS staff, a search strategy was developed to identify deaths where the incident location variable was classified as "home for the elderly/retirement village", "nursing home", "hospice, palliative or respite care", or "residential care facility". A further search identified deaths where age was recorded as 40 years and older and the incident location variable was classified as a place other than those listed above.

Cases were included if the death occurred between 1 July 2000 and 30 June 2013, the coroner's investigation was completed by 31 December 2014, and the death occurred while the deceased person resided in a nursing home accredited by the Aged Care Standards and Accreditation Agency (ACSAA) (determined by comparing the residential, incident or death addresses with a list of accredited nursing homes). Cases were excluded if the incident location could not be established, or if it could not be determined whether the person resided in a nursing home or independent living facility.

Information collected included:

- socio-demographic characteristics;

- the locations (i.e., in or outside the nursing home) of residence, the incident leading to death, and of the death itself;

- the mechanism and cause of death (including the International Classification of Diseases, tenth revision [ICD-10] causes of death coding assigned by the Australian Bureau of Statistics [ABS]);

- the type of care the resident received (permanent or respite resident).

External cause deaths were then disaggregated into subgroups based on the classification of intent, cause and mechanism of injury. A series of descriptive statistical analyses were conducted for each of the seven topics of the causes of death.

Expert Consultation Forums

For each of the seven topic areas, two expert consultation forums were convened using a modified nominal group technique[17] followed by a participant survey using a modified Dillman protocol[18]. Participants were purposively sampled from across Australia and identified through the researcher team's existing network of contacts in aged care, policy, research or clinical practice. Participants did not receive any payment for their attendance.

Each forum was held in central Melbourne or Southbank in Victoria, over a two-hour period with refreshment breaks. Forums included members of the research team and an experienced external forum facilitator who were considered non-participants in the study.

In forum one, findings from the systematic review and case series study was presented to the participants. The facilitator then led the participants through a structured process to generate ideas for interventions to reduce the risk of future similar deaths based on the findings of the systematic review, case series study and their own expertise and experiences in the field. The ideas generated during forum one were developed into draft recommendations. In forum two, the draft recommendations were presented to participants for refinement and validation. A follow-up survey was sent to all forum participants. The survey consisted of three demographic questions about the participant and four standardised items repeated for each of the recommendations and one question asking participant to prioritise the recommendation in order of importance. The majority of questions were closed-ended requiring either a response to multiple choices or grading using a Likert-type 5-point rating scale. Participants were able to add open-ended comments for each recommendation. The

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17   Gallagher M, Hares T, Spencer J, Bradshaw C, Webb I. The nominal group technique: a research tool for general practice? Fam Pract 1993 Mar;10(1):76-81.

18   Dillman DA. The design and administration of mail surveys. Annu Rev Sociol. 1991;17:225-249.

survey was checked for face validity by multiple members of the research team, and took

approximately 20 minutes to complete. Responses were exported from SurveyMonkey into a

Microsoft Excel spreadsheet for analysis.

Ethics Approval

This program of research was approved by the Victorian Institute of Forensic Medicine

Research Advisory Committee and the Department of Justice Human Research Ethics

Committee for access to coronial information via the NCIS.

Chapter 3 Choking

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YOUNG, LYNDAL BUGEJA, CAROLINA WELLER, JOSEPH E IBRAHIM

Background

Acute airway obstruction (or choking) by food in older adults is a global problem and is

defined as the obstruction or occlusion of the airway by food, bones, seed or liquid[19] and may

also result from food obstructing the oesophagus which compresses the airway. 'Dysphagia' is

the medical term for the symptom of difficulty in swallowing. It is frequently misdiagnosed for

other conditions[20] leading to death, hospitalization and emergency department

presentations[21]. Deaths of older adults from choking on food will increase as the global

population ages and the rising prevalence of neurodegenerative conditions that impair

swallowing[22].

In Victoria alone, an analysis of cause of deaths in residential aged care settings (RACS)

reported 89 choking deaths between 2000 and 2012, an average of 7.4 preventable deaths

per year. Adults aged over 85 years accounted for the majority of deaths[23]. This issue presents

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19   World Health Organizaion (WHO). International statistical classification of diseases and related
      health problems 10th revision (ICD-10). 2016; Available from:
      http://www.who.int/classifications/icd/en/.

20   Berzlanovich AM, Muhm M, Sim E, Bauer G. Foreign body asphyxiation--an autopsy study. Am J
      Med 1999;107(4):351-5.

21   **Inamasu** J, Miyatake S, Tomioka H, Shirai T, Ishiyama M, Komagamine J, et al. Cardiac arrest due
      to food asphyxiation in adults: resuscitation profiles and outcomes. Resuscitation
      2010;81(9):1082-6; **Ibrahim** JE, Murphy BJ, Bugeja L, Ranson D. Nature and extent of external-
      cause deaths of nursing home residents in Victoria, Australia. J Am Geriatr Soc. 2015;63(5):954-
      62; **Dolkas** L, Stanley C, Smith AM, Vilke GM. Deaths associated with choking in San Diego county.
      J Forensic Sci 2007;52(1):176-9; **Soroudi** A, Shipp HE, Stepanski BM, Ray LU, Murrin PA, Chan TC,
      et al. Adult foreign body airway obstruction in the prehospital setting. Prehosp Emerg Care
      2007;11(1):25-9; **Mittleman** RE, Wetli CV. The fatal cafe coronary. Foreign-body airway
      obstruction. JAMA 1982;247(9):1285-8.

22   Roy N, Stemple J, Merrill RM, Thomas L. Dysphagia in the elderly: preliminary evidence of
      prevalence, risk factors, and socioemotional effects. Ann Otol Rhinol Laryngol 2007;116(11):858-
      65.

23   Op cit, **Ibrahim** JE, et al, Nature and extent of external-cause deaths 2015; Op cit, **Dolkas** L, et al,
      Deaths associated with choking 2007.

a significant challenge to RACS providers and health professionals who need to make sure residents have nutritious meals in a manner that enhances quality of life while managing the risk of choking.

The recommendations are organised according to chronology, and so are categorised as:

Pre-choking incident: what could be done to prevent a choking incident;

During choking incident: what can be done to reduce the impact of a choking episode; and

Post-choking incident: what can be done to reduce harm after the event and prevent new events.

Summary of recommendations

Pre-choking incident recommendations

These are divided into four categories: care planning, dysphagia screening, communication and model of care.

Care planning

1. That residential aged care setting (RACS) policies, procedures and practices reflect the need for specific and detailed care plans of residents who have swallowing difficulties/dysphagia or a prior history of choking and that this is evaluated 6-monthly or after any change in the person's health care to ensure the needs of residents are met.

2. That RACS providers enable appropriate supervision of residents with appropriately skilled staff who have swallowing difficulties/dysphagia or a prior history of choking when eating and that this is reviewed on a regular basis to ensure the supervision needs of residents are met.

3. Residents who are at risk of choking as a result of impulsive or other behaviours should be referred to a multidisciplinary team (medical, mental health, nursing, speech pathology, dietetics) for a formal assessment and behavior management care planning.

4. That RACS facilitate referrals to provide clinical expertise to assess and manage a resident who is identified by staff, family members or reports swallowing difficulties.

Dysphagia screening

5. That valid and reliable screening tools for identifying RACS residents with dysphagia are developed and implemented in Australian RACS.

6. All residents should be screened at admission to RACS and annually as a minimum or when their condition changes to determine whether a choking risk exists and if so, this should prompt a referral to their General Practitioner and/or an allied health professional as appropriate.

7. That all care staff receive training in the identification and reporting of swallowing difficulties in older adults using a validated screening tool.

8. That RACS providers ensure that their facility is resourced to follow the instructions provided by the speech pathologist or dietitian following an assessment of a resident at high risk of choking.

Communication

9. That there are comprehensive communication and checking systems in place to ensure that all staff involved in the preparation, serving, feeding and supervision of residents at meal times are aware of individual resident's choking risks.

10. That RACS providers and staff design and monitor the meal supply systems to ensure that the appropriate food is served to the correct resident.

11. That transfer of information about residents' risks of choking and eating plans are promptly and reliably shared between health and aged care providers (hospital, general practitioner, RACS).

Model of care

12. That the aged care sector as a whole, providers and funders, review their existing model of care to ensure the allocated resources enable and promote the provision of speech pathology, other allied health and dental services to meet the needs of residents who have swallowing difficulties/dysphagia or a prior history of choking.

13. That the aged care sector review how the existing models of care deploy the RACS workforce to determine whether these are consistently meeting the needs of residents who have swallowing difficulties/dysphagia or a prior history of choking.

14. That the aged care sector consider the development of the Allied Health Assistant workforce for screening of swallowing and monitoring.

During choking incident recommendations

15. That RACS implement clear, evidence-based procedures and training where simulated choking incidents are part of the medical emergency response.

16. That RACS schedule annual practices or drills for staff around responding to a choking incident and that these should be carried out as part of First Aid response training.

17. That all care staff are trained to safely provide assistance to residents with eating at meal times which includes how to manage the safe delivery of modified texture diets. This includes positioning, particularly important for people who are dependent on assistance to eat.

18. That there is an evaluation of the effectiveness of different safe feeding training formats e.g. online training in comparison to traditional 'face-to-face' forms of training delivery in this context.

Post choking incident recommendations

19. That a national data collection system about choking incidents including deaths in RACS residents in public and private facilities is developed to better understand the problem and guide improved practice by standardized reporting and investigation.

20. That a suitably qualified Australian National Steering Committee develop guidelines for provision of residents with the modified texture diet that are specifically designed to be implemented in Australian RACS to align with the International Dysphagia Diet Standardization Initiative (IDDSI).

Detailed overview of recommendations

Pre-choking incident recommendations

Care planning

Recommendation 1:

That residential aged care setting (RACS) policies, procedures and practices reflect the need for specific and detailed care plans of residents who have swallowing difficulties/dysphagia or a prior history of choking and that this is evaluated 6-monthly or after any change in the person's health care to ensure the needs of residents are met[24].

Aim:

To align the resident's care needs to the state of their clinical condition. Reassessment is required as the degree of swallowing difficulties/dysphagia is not constant and changes depending on the underlying cause and when the resident becomes unwell for other reasons.

Rationale:

Previous research has identified that RACS residents who have a swallowing disorder or have previously experienced prior choking episodes have an up to two-fold higher risk of experiencing additional choking incidents[25]. Highlighting this risk on the care plan will help to prompt all care staff are aware of the increased risk of a choking incident and will also increase the ability of RACS providers.

Actions:

This can be achieved by:

- Individual aged care providers and organisations reviewing and adapting their policy, procedures and protocols to address this issue.

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24 Feedback from one organisation in the field stated that they do not support any recommendation in favour of additional regulatory standards that mandate specific approaches and inputs to care in residential aged care settings, specifically Recommendation 1 which suggests revising the accreditation standards and outcomes to mandate detailed care plans for residents with swallowing difficulties and a history of choking.

25 Kikutani T, Tamura F, Tohara T, Takahashi N, Yaegaki K. Tooth loss as risk factor for foreign-body asphyxiation in nursing-home patients. Arch Gerontol Geriatr 2012;54(3):e431-5.

- The age care sector as a whole could adopt a consensus approach with guidelines to meet this recommendation. Alternatively, the legislated national standards and outcomes for accreditation could be revised to incorporate this requirement.

Limitations:

The major limitation is the need for a clinical assessment, often repeated assessments to enable an accurate picture of the resident's needs. This entails staff resource and expertise. The matter of documentation should be relatively straightforward and requires health professionals to review the existing documentation and modify accordingly. This change to existing legislation surrounding accreditation involves multiple complex issues well beyond the care of residents with dysphagia. The national standards are currently being reviewed and this may be an opportunity to introduce and strengthen requirements around management of dysphagia.

Recommendation 2:

That RACS providers enable appropriate supervision of residents with appropriately skilled staff who have swallowing difficulties/dysphagia or a prior history of choking when eating and that this is reviewed on a regular basis to ensure the supervision needs of residents are met.

Aim:

To reinforce the concept that staff supervision of residents with diagnosed dysphagia or swallowing difficulties is important and that this needs to be structure and evaluated.

Rationale:

Acute airway obstruction has the potential to cause brain injury and death due to cardiac arrest unless the obstruction is removed within minutes[26]. The limited available research highlights that successful intervention requires at least one other person if the resident is

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26 Njau SN. Adult sudden death caused by aspiration of chewing gum. Forensic Sci Int 2004;139(2-3):103-6.

unable to dislodge the obstruction by coughing[27], for successful obstruction removal. Cardio pulmonary resuscitation is always required if the obstruction is not rapidly removed[28].

Actions:

This can be achieved by:

- The review of Australian and international standards about the nature and extent of supervision required. This is necessary to identify what expertise the staff requires and where and when they should be deployed for supervising residents.

- A national audit or evaluation of existing programs in RACS for monitoring residents with dysphagia to identify and learn those that are effective.

Limitations:

Potential limitations of this recommendations and barriers to implementation include, there is comparatively little high quality peer-reviewed research that details the impact of supervision on the re-education or prevention of RACS choking deaths. Choking deaths can and do occur in the presence of both trained staff and bystanders. Increased supervision by trained staff will decrease the time delay in providing assistance but may not prevent all choking deaths. Some residents may prefer to eat without supervision and specifying a ratio specifically for residents with dysphagia may create conflict between care staff and residents.

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27   Op cit, **Inamasu** J, et al. Cardiac arrest due to food asphyxiation in adults 2010; Op cit, **Soroudi** A, et al. Adult foreign body airway obstruction in the prehospital setting 2007; Op cit, **Mittleman** RE, Wetli CV. The fatal cafe coronary 1982; **Australian Resuscitation Council**, New Zealand Resuscitation Council. ANZCOR guideline 4 – airway. 2014; Available from: https://resus.org.au/glossary/choking-guideline-4/; **Blain** H, Bonnafous M, Grovalet N, Jonquet O, David M. The table manoeuvre: a procedure used with success in four cases of unconscious choking older subjects. Am J Med 2010;123(12):1150 e7-9.

28   Op cit, Inamasu J, et al. Cardiac arrest due to food asphyxiation in adults 2010.

Recommendation 3 and 4 are considered together.

Recommendation 3:

Residents who are at risk of choking as a result of impulsive or other behaviours should be referred to a multidisciplinary team (medical, mental health, nursing, speech pathology, dietetics) for a formal assessment and behavior management care planning.

Recommendation 4:

That RACS facilitate referrals to provide clinical expertise to assess and manage a resident who is identified by staff, family members or reports swallowing difficulties.

Aim:

To highlight the importance of referral to a multidisciplinary team when there are residents with diagnosed dysphagia or swallowing difficulties. A collaborative approach with multiple clinical disciplines is often required for optimal care of residents in these situations. While referrals are usually the responsibility of a registered nurse or doctor, the argument here is that RACS have an overall responsibility to engage, co-ordinate and facilitate the coming together of key clinical staff.

Rationale:

A variety of neurodegenerative conditions which are common in RACS residents including Parkinson's Disease[29] and dementia[30] can result in impulsive behaviors which may lead to choking. Due to the various etiologies and consequences of dysphagia, effective management may require the input of a multidisciplinary team[31] to increase patient safety[32] including (but

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29   Tjaden K. Speech and Swallowing in Parkinson's Disease. Topics in geriatric rehabilitation 2008;24(2):115-26.

30   Mendez MF, Lauterbach EC, Sampson SM, Research ACo. An evidence-based review of the psychopathology of frontotemporal dementia: a report of the ANPA Committee on Research. J Neuropsychiatry Clin Neurosci 2008;20(2):130-49.

31   Park YH, Bang HL, Han HR, Chang HK. Dysphagia screening measures for use in nursing homes: a systematic review. J Korean Acad Nurs 2015;45(1):1-13.

32   Giammarino C, Adams E, Moriarty C, Cristian A. Safety concerns and multidisciplinary management of the dysphagic patient. Phys Med Rehabil Clin N Am 2012;23(2):335-42.

not limited to) general practitioners, speech pathologists, dentists, dieticians, physiotherapists, nurses, occupational therapists and family members[33].

Actions:

This could be achieved by:

- This is challenging to action, in part because the resources are in place, and it requires collaboration across multiple different health professionals and individuals. Essentially it is about improving teamwork with health providers who are not external to the RACS providers' jurisdiction.

- Individual practitioners, RACS providers and health professional associations could initiate the development of specific teams for each facility to provide this service.

- RACS providers should explore collaborative links with their local health services who have the resources for a multidisciplinary team (e.g. public hospitals).

- Aged care sector and speech pathology Australia could undertake a field study to examine the existing barriers to collaborative teamwork in RACS.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, access to multidisciplinary teams may be challenging for RACS providers, particularly those in regional and remote Australia. Transportation and care of the resident if they have to attend hospitals or off-site clinics for appointments with multi-disciplinary teams can be challenging, particularly if the resident is frail/has limited mobility or has limited access to support.

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33   Sura L, Madhavan A, Carnaby G, Crary MA. Dysphagia in the elderly: management and nutritional considerations. Clin Interv Aging 2012;7:287-98.

Dysphagia screening

Recommendation 5, 6 and 7 are considered together.

Recommendation 5:

That valid and reliable screening tools for identifying RACS residents with dysphagia be developed and implemented in Australian RACS.

Recommendation 6:

All residents should be screened at admission to RACS and annually as a minimum or when their condition changes to determine whether a choking risk exists and if so, this should prompt a referral to their doctor and allied health professionals as appropriate[34].

Recommendation 7:

That all care staff receive training in the identification and reporting of swallowing difficulties in older adults using a validated screening tool.

Aim:

To promote the development and use of a validated dysphagia screening tool among nursing and care staff, particularly during the resident admission process.

Rationale:

The prevalence of dysphagia in RACS ranges from between 9 to 68%[35]. Due to the associated mortality and morbidity burden, identification of new residents with dysphagia is important. A 5-year North American anthropological study of the fluid intake in 39 RAC residents reported that 64% had dysphagia which ranged in severity from mild to severe. However, only five of these residents had been referred for further evaluation.

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34   Feedback from one organisation in the field commented that annual screening of all residents requires further consideration in the context of the evidence base as there would be considerable resource implications for the sector.

35   Op cit, **Sura** L, et al. Dysphagia in the elderly 2012**; van der Maarel-Wierink** CD, Meijers JM, De Visschere LM, de Baat C, Halfens RJ, Schols JM. Subjective dysphagia in older care home residents: a cross-sectional, multi-centre point prevalence measurement. Int J Nurs Stud 2014;51(6):875-81.

Carers appeared to be unaware of resident swallowing difficulties, as evidenced by rapid feeding rates despite resident protests[36]. Two screening tools, the Gugging Swallowing Screen (GUSS) and Standardized Swallowing Assessment (SSA) were identified in a large systematic review[37] as having high sensitivity that could be used by nurses in the RACS context. In addition, the use of a validated screening tool may raise staff awareness of resident swallowing difficulties and increase the reporting of dysphagia for further evaluation. This may enable nursing and care staff to work with the resident earlier minimize choking and aspiration risks. Currently, there is not a single and standardised approach to screening RACS residents for dysphagia in Australia.

Actions:

This can be achieved by:

- Speech Pathology Australia in collaboration with the aged care providers identifying or developing a valid and reliable screening tools for identifying RACS residents with dysphagia.

- Age care providers and the sector as a whole adopt and implement as a standard approach that all residents are screened at admission and at regular intervals.

- Age care providers and their staff develop or modify protocols that would facilitate and prompt a referral to their doctor and allied health professionals as appropriate.

- Collective action by the regulators, providers and health professions to develop, provide and engage staff so they are able to receive the requisite training.

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36   Kayser-Jones J, Schell ES, Porter C, Barbaccia JC, Shaw H. Factors contributing to dehydration in nursing homes: inadequate staffing and lack of professional supervision. J Am Geriatr Soc 1999;47(10):1187-94.

37   Op cit, **Mendez** MF, et al. An evidence-based review of the psychopathology of frontotemporal dementia 2008.

Limitations:

The resource and time required to develop a new, or modify existing valid and reliable

screening tools specifically for Australian RACS and introduce this nationally are potential

limitations and barriers to this recommendation.

Recommendation 8:

That RACS providers ensure that their facility is resourced to follow the instructions provided by the speech pathologist or dietician following an assessment of a resident at high risk of choking.

Aim:

This is to highlight the need for clear communication and collaboration in the care of RACS residents.

Rationale:

The consultations with experts and stakeholders identified a gap between the instructions provided by the speech pathologist or dietician following an assessment of a resident at high risk of choking and their implementation.

The reasons for the gap are multiple and varied with little systematic collected empirical information to identify precise action to rectify.

Actions:

This can be achieved by:

- Age care providers and their staff develop or modify protocols to facilitate clearer communication, documentation and feedback from allied health professionals about their clinical instructions.

- Allied health professional design and communicate their clinical instructions in a manner that meets and assists aged care staff to implement.

- Age care providers and allied health staff jointly review their practice to develop a structured, reliable and standardized approach for communicating information about the resident's clinical needs.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, staff time and resources.

Recommendation 9 and 10 are considered together.

Recommendation 9:

That there are comprehensive communication and checking systems in place to make sure that all staff involved in food preparation, serving, feeding, and supervision of residents at meal times are aware of individual resident's choking risks.

Recommendation 10:

That RACS providers and staff plan and monitor the meal supply systems so that the appropriate food is served to the correct resident.

Aim:

Standardized comprehensive communication and checking systems should be in place so that all staff involved in the preparation, serving, feeding and supervision of residents at meal times are aware of individual resident's choking risks. This would reduce the likelihood of residents choking on food that is of an inappropriate consistency that has been served in error to the wrong resident.

Rationale:

Similar in concept to safe use of medication, examining the 'food chain' from ordering meals to kitchen to the diner may identify gaps that lead to the incorrect meal being delivered to a resident.

Researchers from Switzerland[38] highlights the issue of a RACS resident who fatally choked after being served food that was the incorrect inconsistency. This risk may be minimized if there are comprehensive communication and checking systems in place prior to resident's receiving food. Recent Australian Coroner's findings support this position, with the recommendation that "*Information about the patient's condition together with any risk*

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38   Thali YA, Bolliger SA, Hatch GM, Ampanozi G, Thali MJ, Ruder TD. Death by biscuit--exhumation, post-mortem CT, and revision of the cause of death one year after interment. Leg Med (Tokyo) 2011;13(3):142-4.

minimization measures to be implemented must be communicated to relevant staff in the most appropriate manner prior to any interaction they have with the patient."

Residential aged care relies on "*systems that adequately capture and effectively utilise and communicate…information*"[39]. The challenge is to identify systems that are accurate, user-friendly and time efficient. One system proposed by a US based healthcare group involves the following system to make sure that residents receive the correct meal[40].

- Care staff receive training on how to identify residents and read food/fluid information.

- Both direct care and kitchen staff receive details of the resident's food and fluid requirements (including consistency, preferences and required assistance).

- Both groups of staff are encouraged to seek clarification where required.

Actions:

This can be achieved by:

- Age care providers reviewing their existing systems to determine if there are any gaps and modifying these to reduce the likelihood of the incorrect meals being served.

- Aged care sector could review practice across the sector to identify and learn from those systems that have high reliability.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, resources, willingness to co-operate and a national working group would be required for the aged care sector to review practice across the sector.

39   Gaskin S, Georgiou A, Barton D, Westbrook J. Examining the role of information exchange in residential aged care work practices: a survey of residential aged care facilities. BMC Geriatr 2012;12:40.

40   Johnson M, Sanchez P, Zheng C. Reducing patient clinical management errors using structured content and electronic nursing handover. J Nurs Care Qual 2016;31(3):245-53.

Recommendation 11:

That transfer of information about residents' risks of choking and eating plans are promptly and reliably shared between health and aged care providers (hospital, general practitioner, facility).

Aim:

To promote the prompt and reliable transfer of information about residents' risks of choking and eating plans between health and aged care providers.

Rationale:

The accurate transfer of patient information *"at clinical handover is fundamental to continuity of care and patient safety"*[41]. A number of researchers have reported that poor clinical handover is associated with medication errors, inaccurate or delayed diagnosis[42], and missed actions or misinterpretation[43]. Particularly for residents whose overall function and swallowing may have changed either during or prior to a hospital admission, it is essential that any changes to choking risks or changes in diet consistency are communicated to relevant professionals and care staff. The Australian Medical Association reports that 'good handover is at the heart of an effective healthcare system'[44] and recommends that hospitals or institutions develop their own standardized approaches that are used consistently throughout the institution.

Actions:

This can be achieved by:

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41   Op cit, **Johnson** M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016.

42   Op cit, **Johnson** M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016.

43   Gregory C, Brendan S. Standardizing hand-off processes. AORN J 2006;84(6):1059-61.

44   Australian Medical Association (AMA). Safe handover: safe patients guidance on clinical handover for clinicians and managers. 2006; Available from: https://ama.com.au/sites/default/files/documents/Clinical_Handover_0.pdf

- By reviewing and modifying the existing handover documentation used by the facility and examining the Australian Commission on Safety and Quality in Health Care National Standards for Clinical Handover.

Limitations:

No potential limitations or barriers to implementation have been identified for this recommendation.

Recommendation 12 and 13 are considered together[45].

Recommendation 12:

That the aged care sector as a whole, providers and funders, review their existing model of care to ensure the allocated resources enable and promote the provision of speech pathology, other allied health and dental services to meet the needs of residents who have swallowing difficulties/dysphagia or a prior history of choking[46].

Recommendation 13:

That the aged care sector review how the existing models of care deploy the RACS workforce to determine whether these are consistently meeting the needs of residents who have swallowing difficulties/dysphagia or a prior history of choking.

Aim:

To consider whether the existing model of aged care and the provision of speech pathology, dental services and other allied health services is meeting the contemporary needs and expectations.

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45   Feedback from one organisation in the field commented that consideration needs to be given by funders in relation to additional funding (whether by supplements or other means) to ensure rural, regional and remote providers of aged care services are able to fund access to these services, which historically can be considerably more expensive for them to purchase.

46   Feedback from one organisation in the field stated that while the suggestion of undertaking a whole of sector review is admirable, a recent systematic review exploring oral health in aged care facilities concluded that effective models of care should "thoroughly examine the setting and target group, identify barriers to change and tailor their implementation strategies to these barriers". As such, it is integral that individual facilities are equipped with the skills to target services based on their particular context. Professional oral health care performed on residents by dental hygienists has resulted in significantly lower rates of aspiration pneumonia, lower prevalence of fever, lower relative risk of influenza, lower rates of potent respiratory pathogens and lower rates of upper respiratory tract infections. There are effective models of care that already exist for the provision of dental services in residential aged care facilities. World-leading research here in Australia has demonstrated the effectiveness of a model of care involving dental hygienists providing professional oral care to residents. Further, here are many models of care that have been evaluated overseas, summarised recently in a systematic review.

Rationale:

Access to allied health and dental services for residents of RACS can be challenging. A review of the Australian Allied health workforce in 2013[47] reported that "there is a limited number of allied health practitioners employed in aged care services" and that physiotherapists and diversion therapists are most frequently represented in this context. This lack of access is compounded by the fact that residents of aged care facilities are typically affected by a variety of age-related degenerative conditions and diseases which impact on overall mobility and wellbeing. These include high levels of frailty (up to 90% including prefrailty)[48], dementia (52%) and disorders of the nervous system (44%). Some estimates of the prevalence of dysphagia in residential aged care are as high as 68%[49]. The *Caring for Older Australians* (2011) report noted that "Poor access to medical allied health services affects the capacity of the aged care sector to deliver timely and appropriate care, and can result in unnecessary pressure on other parts of the health system"[50]. Therefore it may be argued that improving access to speech pathology, dental services and other allied health services in RACS may help to identify residents with dysphagia, improve outcomes and ultimately reduce preventable deaths.

Actions:

This can be achieved by:

- The whole aged sector participating in a review of the existing model of care and consider other options. This should involve government, regulators, providers and funders, health professionals and residents. This is only possible if a group took a leadership role to resource and initiate the review.

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47   Australian Government: Australian Institute of Health and Welfare (AIHW). Allied health workforce 2012. 2013; Available from: http://www.aihw.gov.au/publication-detail/?id=60129544591

48   Kojima G. Frailty as a Predictor of Nursing Home Placement Among Community-Dwelling Older Adults: A Systematic Review and Meta-analysis. J Geriatr Phys Ther 2016.

49   Op cit, Sura L, et al. Dysphagia in the elderly 2012.

50   Australian Government: Productivity Commission. Caring for older Australians: report: no. 53, final inquiry report. 2011; Available from: http://www.pc.gov.au/inquiries/completed/aged-care/report/aged-care-overview-booklet.pdf.

Limitations:

This is a large undertaking and requires resourcing and collaboration with all the identified groups. Both the aged care and health sectors have undergone a number of reviews within the past decade and the alternative argument is that there is limited empirical evidence to support additional allied health involvement in aged care.

Recommendation 14:

That the aged care sector consider the development of the Allied Health Assistant workforce for screening of swallowing and monitoring.

Aim:

To open a dialogue between allied health advocacy groups and the aged care sector to determine if it is feasible for allied health assistants to increase their role in aged care facilities to include the screening and monitoring of swallowing.

Rationale:

During the Expert Panel, held as part of this review a number of Aged Care sector representatives commented that Allied Health services (and in particular speech pathology) were expensive and that this was one barrier to utilizing these services. As noted in Recommendation 4.0, there are limited numbers of allied health professionals working in the residential aged care sector. The Expert Panel recommended that the sector consider the development of the Allied Health Assistant workforce to increase the number of people that are able to screen for, and monitor residents with dysphagia. The development of the assistant workforce was also considered by the *Review of Australian Government Health Workforce Programs (2013)* which highlighted some potential issues regarding this deployment. Some professional advocacy groups appeared to not be favour of the increased use of the allied health assistant workforce and the potential for the erosion of professional boundaries.

Actions:

This can be achieved by:

- Further nation-wide consultation between allied health advocacy groups and the aged care sector to determine if there is widespread support for this recommendation.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, resistance from allied health and nursing professional groups due to the potential for role erosion. There is also potential for errors due to a less skilled workforce (Certificate qualified in comparison to Degree qualified workers).

During choking incident recommendations

Choking first aid and meal time assistance training

Recommendation 15 and 16 are considered together.

Recommendation 15:

That RACS implement clear, evidence-based procedures and training where simulated choking incidents are part of the medical emergency response.

Recommendation 16:

That RACS schedule annual practices or drills for staff around responding to a choking incident and that these should be carried out as part of First Aid response training.

Aim:

That RACS providers or an accredited provider conduct annual (as a minimum) First Aid training to all nurses and care staff which includes the recognition, and response to acute airway obstruction due to foreign bodies or food.

Rationale:

Coroner's recommendations that have followed a number of RACS resident choking deaths have emphasized the role of staff awareness of the RACS's emergency procedures and the importance of ongoing staff First Aid training in response to choking incidents.

Actions:

This can be achieved by:

- Strengthen existing programs and introducing the inclusion of First Aid training for all staff in facilities.

- Aged care providers working collaboratively with First aid training service to develop specific programs to address this particular risk and circumstance.

Limitations:

A potential limitation of this recommendation and barrier to implementation is that there is a lack of evidence for efficacy. The Australian Resuscitation Council Guidelines on the *Procedure*

for Choking includes the statement that "there is a lack of any scientific evidence for making strong clinical guideline recommendations" in this area. It notes that "back blows, chest thrusts and abdominal thrusts" may relieve acute airway obstruction caused by a foreign body[51].

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51   Op cit, Australian Resuscitation Council, New Zealand Resuscitation Council. ANZCOR guideline 4 – airway. 2014.

Recommendation 17 and 18 are considered together.

Recommendation 17:

That all care staff are trained to safely provide assistance to residents with eating at meal times which includes how to manage the safe delivery of modified texture diets. This includes positioning, particularly important for people who are dependent on assistance to eat.

Recommendation 18:

That there is an evaluation of the effectiveness of different safe feeding training formats e.g. online training in comparison to traditional 'face-to-face' forms of training delivery in this context.

Aim:

To train care staff on the impact of age and neurodegenerative related changes on swallowing and overall oral intake.

Rationale:

Due to a lack of clear evidence-based or empirical evidence in safe feeding techniques and modified texture diets, this recommendation focuses on care staff training on the impact that age and neurodegenerative changes have on swallowing and overall intake.

The importance of evaluating staff member's assistive feeding techniques was highlighted by one Coroner's recommendation following the choking death of a RACS resident. However, the issue of providing modified texture diets to older adults and the role of positioning continues to be contentious among researchers. There is some evidence to suggest that foods of a slick, pureed consistency should not be given to older adults as traditional First Aid techniques are less effective with this consistency[52]. Therefore, it is difficult to support any recommendations that promote the use of modified texture diets.

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52   Op cit, **Mittleman** RE, Wetli CV. The fatal cafe coronary 1982; Op cit, **Berzlanovich** AM, et al. Foreign body asphyxia 2005.

The role of positioning in the prevention of choking is another area that requires continued research with some researchers emphasizing that video-fluoroscopy is the only method that can demonstrate the efficacy of the techniques including the 'chin tuck' position[53]. Ideally, residents that require assistance with eating should receive this in an upright seated position. This position increases levels of consciousness and opportunities for social interaction.

Actions:

This can be achieved by:

- The inclusion of fact sheets on the impact of age and neuro-degenerative related changes on swallowing and overall oral intake in all new care staff induction packs that are developed by dietician and speech pathology advocacy groups.

- The incorporation of the impact of age and neuro-degenerative changes on swallowing and overall intake into existing staff training programs.

Limitations:

A potential limitation for this recommendation and barrier to implementation is that this is an area that lacks peer-reviewed evidence.

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53   Hoque DM, Kumari V, Ruseckaite R, Romero L, Evans SM. Impact of clinical registries on quality of patient care and health outcomes: protocol for a systematic review. BMJ Open 2016;6(4):e010654.

Post choking incident recommendations

Research

Recommendation 19:

That a national data collection system about choking incidents including deaths in RACS residents in public and private facilities is developed to better understand the problem and guide improved practice by standardized reporting and investigation[54].

Aim:

To develop a national registry of choking incidents and deaths that occur in RACS.

Rationale:

Comprehensive and clinical level data about choking events and outcomes would be invaluable for identifying opportunities for improving care. Registries typically collect data that relates to a limited number of conditions or from specified settings with the overall aim to improve the health outcomes of these specific population groups[55]. There are currently a number of databases that collect choking related data of RACS residents. The National Coronial Information System (NCIS) records the cause of death and demographic detail of all notifiable deaths (deaths that are unnatural and unexpected) in Australia and New Zealand[56]. Ambulance Victoria records all call-outs and serious incidents that occur in aged care facilities are also reported to the Department of Human Services, Victoria. The development of a national registry that includes data from all three sources would enable the consolidation of pre-event, event and post event data and for meaningful analysis to occur. The ultimate aim of the registry would be to prevent choking incidents and deaths.

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54   Feedback from one organisation in the field commented that consideration would need to be given as to the resourcing impact on aged care providers of any new reporting requirements, with a view to streamlining reporting requirements.

55   Op cit, Hoque DM, et al. Impact of clinical registries on quality of patient care and health outcomes 2016.

56   Op cit, Dolkas L, et al, Deaths associated with choking 2007.

Actions:

This can be achieved by:

- The formation of a steering committee to investigate the steps necessary to realize the potential of these existing data sources into a unified register.

- Potential steering committee members could include representatives from the aged care sector, Ambulance Victoria and representatives from other states, Monash University (due to the management of a number of clinical registries) and NCIS.

Limitations:

Potential limitations of this recommendation and barriers to implementation include registries can be both time, labor and cost intensive. Also, registries (by their very nature) collect personal information and therefore the logistics and ethics of collating and then analyzing this data are complex.

Recommendation 20:

That a suitably qualified Australian National Steering Committee develop guidelines for provision of residents with the modified texture diet that are specifically designed to be implemented in Australian RACSs to align with the International Dysphagia Diet Standardization Initiative (IDDSI).

Aim:

To form a National Steering Committee with the purpose of developing guidelines for the provision of residents with modified texture diets that are specifically designed to be implemented in Australian RACSs and hospitals that align with the International Dysphagia Diet Standardization Initiative (IDDSI).

Rationale:

The goal of International Dysphagia Diet Standardization Initiative (IDDSI) was to develop an 'international standardized terminology and descriptors for dysphagia diets' that could be used across all cultures, care settings and throughout the lifespan and avoid the confusion associated with multiple classification systems and standards across settings and jurisdictions[57]. This initiative is supported by Speech Pathology Australia and, the Dieticians Association of Australia. The formation of a national Steering Committee with the purpose of developing guidelines to implement these standards in Australian RACS and hospitals may lead to a coordinated and timely roll-out.

Actions:

This can be achieved by:

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57   International Dysphagia Diet Standardisation Initiative (IDDS). Standardising dysphagia diet terminology to improve safety. 2017; Available from: http://iddsi.org/.

The formation of the Steering Committee. Suggested membership includes: Speech Pathology Australia, the Dieticians Association of Australia, Australian Healthcare and Hospitals Association, the Australian Aged Care Quality Agency and Council of the Aging.

Limitations:

Barriers to implementation of new standards may be met by resistance from both aged care providers and hospitals due to the existence of the Australian Standards for Texture Modified Foods and Fluids. Therefore it could be argued that there is no need for a new system when one already exists. Another limitation and potential barrier to implementation is the time commitments required by the Steering Committee to develop guidelines.

Chapter 4 Medications

NATALI JOKANOVIC, JOSEPH E IBRAHIM

Background

A systematic review of the international literature examined the prevalence of medication errors resulting in hospitalisation and death of residents in residential aged care services (RACS)[58]. The review included 11 studies examining all medication errors (n=5), medication errors resulting on transfer of care (n=5) and potentially inappropriate medications (n=1). Medication errors were reported in 16% to 27% of residents in studies examining all medication errors, 13% to 31% in studies examining medication errors resulting on transfer of care and 75% of residents were prescribed at least one potentially inappropriate medication.

Serious effects resulting from medication errors (e.g. permanent disability or mortality) were found to be low (0-1% of all medication errors). The likelihood of medication errors resulting in serious effects was greater if the medication error was repeated, if the error occurred during transitions of care or during the prescribing stage, if the wrong medication and resident was chosen and if there were increasing numbers of high-risk medications administered.

Medication incident: includes any preventable medication event resulting in inappropriate medication use or patient harm. These incidents may be related to professional practice, and systems and procedures including prescribing, dispensing, administration, monitoring and use[59].[2] Recommendations have been categorised according to processes occurring prior, during and following a medication incident.

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58   Op cit, Ferrah N, et al. Systematic review of the prevalence of medication errors resulting in hospitalization and death of nursing home residents. 2017.

59   Institute for Safe Medication Practices Canada. Definitions of terms 2017 [internet]; Available from: https://www.ismp-canada.org/definitions.htm.

Recommendations have been categorised according to processes occurring prior, during and following a medication incident:

Prior to medication incident: recommendations aimed at processes occurring prior to a medication incident. This includes recommendations targeting models of care and the stages of prescribing, transcription and administration.

During medication incident: recommendations aimed at processes occurring during a medication incident. This includes recommendations targeting monitoring and review of medications.

Following medication incident: recommendations occurring following a medication incident. This includes recommendations targeting the reporting of medication incidents.

Summary of recommendations

Pre-medication incident recommendations

21. That a centralised electronic medication management system accessible to residential aged care (RAC) staff and relevant health practitioners (medical, pharmacy and nursing) should be developed to ensure availability to up-to-date residents' clinical and medication information at the time of prescribing.

22. That policy makers should consider the use of electronic medication management systems as a mandatory requirement for accreditation of residential aged care services (RACS).

23. That clinical colleges or organisations for medicine, pharmacy and nursing along with key aged care sector stakeholders should form an interdisciplinary group of clinical experts to develop evidence-based prescribing guidelines specific to the needs of older persons who live in RACS.

24. That RACS providers should ensure that evidence-based prescribing guidelines, in hard and/or soft copy, are readily available to medical practitioners and aged care staff at the point of care.

25. That RACS providers, medical practitioners and information technology groups should consider the feasibility of integrating evidence-based prescribing guidelines into open source medical prescribing software.

26. That disciplines of medical, nursing and pharmacy should place a greater focus on de-prescribing by instituting policies and practices that will support the identification of residents, in consultation with their families, who may benefit from this initiative.

27. That policy makers and disciplines of medicine and nursing should explore the feasibility and impact of a pharmacist-led medication review service with a focus on medication simplification and de-prescribing.

28. That RACS and health providers (hospital, community) should develop a standardised approach to communication and information transfer pertinent to quality and safer use of medication on transitions of care. This may include a standardised template for verbal and electronic transfer of information between health providers (hospital and community) and RACS.

29. That RACS should regularly review their medication administration procedures to identify opportunities for increased support, education and training for RAC staff. Procedures to review may include the choice of dose administration aids and measures to minimise errors during administration of high-risk medications.

30. That RACS and pharmacy should explore the utilisation of technology (e.g. barcode medication administration systems, provision of medication charts/lists with pill images) to reduce medication errors during medication administration.

31. That policy makers, funders and providers should review new and existing models of medical care, including general practice, in Australia and internationally to identify the optimal model of care that enhance medication safety for residents in RACS.

32. That RACS providers, in consultation with medical practitioners, should develop policies and procedures detailing expectations and requirements (e.g. frequency of visits and additional education) for medical practitioners who provide care to their residents to optimise medication safety.

During medication incident recommendations

33. That RACS and health practitioners (medical and pharmacy) should ensure there is a clear process in place for the identification and minimisation of harm associated with the use of high-risk medications by RAC staff, medical practitioners and pharmacy. This process should include guidelines and procedures for harm minimisation and clearly defined roles and responsibilities of all relevant parties.

34. That RACS and health practitioners (medical practitioners and pharmacists) should develop specific guidelines for the therapeutic monitoring of high-risk medications in RACS.

35. That RACS should ensure there is a clear process for the early identification and reporting of clinical deterioration associated with medication toxicity by RAC staff.

36. That a national program should be designed to educate and empower residents and their families to recognise and report changes to medical and RAC staff when their clinical status is adversely impacted by medication use.

37. That policy makers should develop standardised procedures for RACS to ensure timely and collaborative pharmacist-led residential medication management reviews are performed with consideration for medication simplification and residents' goals of care.

38. That policy makers and regulators of the aged care sector should consider establishing standards alongside education and training modules for RACS staff and health practitioners to ensure competency in the monitoring and review of high-risk medications.

Following medication incident recommendations

39. That a national mortality and morbidity surveillance system of medication errors that occur in RACS with a standardised approach to information collection and reporting should be established to examine trends over time.

40. That RACS and the relevant professional organisations for general practice, nursing and pharmacy should promote a just culture of reporting and learning system to encourage reporting of medication errors and incidents.

41. That RACS should ensure a comprehensive and systematic approach is taken to improve the information provided by RACS staff and medical practitioners when reporting a potential medication-related death to the Coroner's Court. The incident report should include each of the key steps in the medication process (e.g. prescribing to administration).

Detailed overview of recommendations

Pre-medication incident recommendations

Recommendation 21:

That a centralised electronic medication management system accessible to residential aged care (RAC) staff and relevant health practitioners (medical, pharmacy and nursing) should be developed to ensure availability to up-to-date residents' clinical and medication information at the time of prescribing[60].

Aim:

To improve appropriate prescribing by ensuring timely access to up-to-date residents' clinical and medication information at the time of prescribing.

Rationale:

Electronic medication management systems, with or without clinical management software, are currently not utilised by all RACS. Existing software such as iCare® provide electronic medication profiles from which RAC staff can administer and record medications, and the management of resident documentation including progress notes and medical histories[61]. Access to pathology results is not readily available unless scanned into the software program. Shared access with medical practitioners and pharmacy is often limited. Access to up-to-date information at the time of prescribing will improve appropriate prescribing and monitoring, and avoidance of medication interactions.

Actions:

This can be achieved by:

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60   Feedback from one organisation in the field acknowledged that the prescribing of medications is the responsibility of medical practitioners rather than RAC staff. There was agreement with the principle that medical staff who are prescribing medications should have access to relevant and timely information. There is work being attended by the Australian Digital Health Agency and its work in relation to My Health Records generally and more specifically the work of that agency's Medicines Safety Program Steering Group.

61   iCare Health. Medication management [internet]. Available from: http://www.icarehealth.com.au/product/medication-management-software/#/product-features.

- Government, regulatory or professional bodies and RAC providers in consultation with information technology experts developing a centralised electronic medication management system accessible to medical practitioners, nursing, pharmacy and allied health practitioners. This will provide up-to-date clinical and medication information at the time of prescribing.

- Giving consideration to include access to up-to-date pathology results, connectivity to pharmacy software and functionality for medical practitioners to directly prescribe into the software.

- Giving consideration to in-built safety features including drug interaction alerts and alerts for high-risk medications which may require consultation with a pharmacist prior to prescribing, to minimise prescribing errors and potentially inappropriate prescribing.

- RACS providing staff with adequate education and training to utilise electronic medication management systems effectively.

Limitations:

Potential limitations of this recommendation and barrier to implementation include funding, and design and compatibility challenges for RACS, medical practice and pharmacy. Potential changes in workflow for RACS and medical practitioners will need to be explored.

Recommendation 22:

That policy makers should consider the use of electronic medication management systems as a mandatory requirement for accreditation of residential aged care services (RACS)[62].

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62   Feedback from one organisation in the field stated that they supported the introduction of electronic medication systems and acknowledged the advantages these can bring (noting that many providers have introduced these systems to date). However, it does not support the view that it should be mandated as part of accreditation. Electronic systems can be costly to purchase, install and maintain. This may be beyond the means of small, or stand-alone services including those in rural, regional and remote settings. The focus should be on 'safe systems and processes' rather than whether they are electronic or paper based. Feedback from another organisation stated that they do not support any recommendation in favour of additional regulatory standards that mandate specific approaches and inputs to care in residential aged care settings, specifically Recommendation 22 which suggests that electronic medication management systems be considered as a mandatory requirement for accreditation – this does not fit with the role and purpose of accreditation.

Aim:

To ensure timely access to electronic medication management systems across RACS.

Rationale:

There are a number of challenges to timely implementation of electronic medication management systems including cost and compatibility of technology between services. Introducing a mandatory requirement for electronic medication management systems for the accreditation of RACS by a set deadline will encourage discussion and problem solving of these challenges and timely uptake. The accreditation of RACS is managed by the Australian Aged Care Quality Agency (AACQA) who assess each service against the Accreditation Standards[63]. These standards currently do not specify the use of any one particular medication management system to be used across RACS.

Actions:

This can be achieved by:

- Policy makers and regulatory bodies considering the use of electronic medication management systems by RACS as a mandatory requirement for accreditation by a set deadline.

Limitations:

Potential limitations of this recommendation and barriers to implementation, in addition to initial design and compatibility challenges, primarily relate to the high cost to RACS to implement electronic medication management systems and uncertainty in external funding which may be required (e.g. Government).

Recommendations 23:

That clinical colleges or organisations for medicine, pharmacy and nursing along with key aged care sector stakeholders should form an interdisciplinary group of clinical experts to

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63   Australian Government: Australian Aged Care Quality Agency (AACQA). Quality of care principles 2014. 2014; Available from: https://www.aacqa.gov.au/providers/accreditation-standards

develop evidence-based prescribing guidelines specific to the needs of older persons who live in RACS.

Aim:

To improve appropriate prescribing through the development of evidence-based prescribing guidelines for residents in RACS.

Rationale:

Existing clinical guidelines are typically based on clinical trials which often exclude older people. There are currently no specific guidelines for older people in RACS. The Australian 'medical care of older persons in RACS', published in 2006, provides general clinical guidance for residents in aged care, however requires updating[64]. The development of evidence-based prescribing guidelines specific to residents in RACS aims to optimise prescribing practices and minimise potentially inappropriate prescribing.

Actions:

This can be achieved by:

- Professional bodies, including representatives from medicine, pharmacy, nursing and key aged care stakeholders, including consumer bodies, developing evidence-based prescribing guidelines specific to older people in RACS.

Limitations:

Potential limitations of this recommendation and barriers to implementation include limited clinical research studies which have been performed targeting older people. Collaborative development of guidelines with consumer representation and support from regulatory and peak bodies is needed as this level of engagement to encourage uptake of the guidelines.

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64   Royal Australian College of General Practitioners (RACGP). Medical care of older persons in residential aged care facilities (Silver Book). 2006; Available from: http://www.racgp.org.au/guidelines/silverbook.

Recommendation 24:

That RACS providers should ensure that evidence-based prescribing guidelines, in hard and/or soft copy, are readily available to medical practitioners and aged care staff at the point of care.

Aim:

To support appropriate prescribing through improved access to evidence-based prescribing guidelines for medical practitioners and RACS staff.

Rationale:

Access to up-to-date electronic or hard copy evidence-based prescribing guidelines, such as the Therapeutic Guidelines[65] or alternative guidelines specific to residents in RACS, at the point of care aims to support best practice prescribing and reduce inappropriate prescribing.

Actions:

This can be achieved by:

- Aged care providers ensuring medical practitioners and RAC staff are provided with access to up-to-date evidence-based prescribing guidelines, either in hardcopy or electronic format.

- Regulatory bodies considering funding for aged care providers to support initial and ongoing costs of access to prescribing guidelines.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, the initial and ongoing costs of maintaining up-to-date hardcopy or electronic prescribing guideline subscriptions for medical practitioners and RACS. Funding and support from Government may be needed to ensure widespread uptake of this recommendation.

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65   Therapeutic Guidelines Ltd eTG complete. 2017; Available from:
       https://tgldcdp.tg.org.au/etgcomplete.

Recommendation 25:

That RACS providers, medical practitioners and information technology groups should consider the feasibility of integrating evidence-based prescribing guidelines into open source medical prescribing software.

Aim:

To improve appropriate prescribing by providing ready access to evidence-based prescribing guidelines at the time of prescribing.

Rationale:

Integration of evidence-based prescribing guidelines into medical prescribing software aims to increase their accessibility at the point of prescribing and reduce inappropriate prescribing.

Actions:

This can be achieved by:

- Aged care providers and medical practitioners consulting with information technology experts to determine the feasibility of integrating prescribing guidelines within new or existing medical software.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, costs and technology challenges associated with integration of prescribing guidelines into new or existing medical prescribing software.

Recommendation 26:

That disciplines of medical, nursing and pharmacy should place a greater focus on de-prescribing by instituting policies and practices that will support the identification of residents, in consultation with their families, who may benefit from this initiative[66].

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66   Feedback from one organisation in the field stated that they strongly support the practice of multi-disciplinary medication review programs within RACS. They noted that many RACS have in place active Medication Advisory Committees that work in a multi-disciplinary environment (medical practitioners, nurses and pharmacists) to achieve this very aim, and do this successfully.

Aim:

To improve the identification of inappropriate and/or unnecessary medication use among residents in RACS.

Rationale:

The process of de-prescribing involves the reduction or cessation of unnecessary or inappropriate medications with consideration to individual goals of care and life expectancy[67].This includes an assessment of the overall risk of harm versus ongoing benefit of each medication. Potential benefits of de-prescribing include reductions in numbers of medications, adverse drug reactions and improved quality of life[68].

Actions:

This can be achieved by:

- Disciplines of medical, nursing and pharmacy developing and implementing policies and practices that will support the identification of residents who may benefit from de-prescribing.

- Disciplines of medical, nursing and pharmacy developing a targeted education and awareness program for de-prescribing for RACS staff, medical practitioners, and residents and their families.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, the availability of funding, resources and time to develop and implement this initiative. Considerable resources are likely to be required to deliver targeted education and training specific to RACS staff, medical practitioners, and residents and their families.

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67   Scott IA, Hilmer SN, Reeve E, Potter K, Le Couteur D, Rigby D, et al. Reducing inappropriate polypharmacy: the process of deprescribing. JAMA Intern Med. 2015;175(5):827-34.

68   Reeve E, Thompson W, Farrell B. Deprescribing: A narrative review of the evidence and practical recommendations for recognizing opportunities and taking action. Eur J Intern Med. 2017;38:3-11.

Recommendation 27:

That policy makers and disciplines of medicine and nursing should explore the feasibility and impact of a pharmacist-led medication review service with a focus on medication simplification and de-prescribing.

Aim:

To determine the effectiveness and feasibility of a pharmacist-led medication review service for reducing medication-related harm among residents in RACS.

Rationale:

Collaborative residential medication management reviews (RMMRs) are funded for residents every two years or more frequently if clinically necessary[69]. A pharmacist, in collaboration with the local medical practitioner, performs the medication review with the aim to identify, prevent and resolve medication-related problems[70]. The medication review service proposed, aims to focus on medication simplification and de-prescribing to reduce the burden of medications and their potential harms. This service may be an expansion of the existing RMMR service or a new model that could include the co-location of a pharmacist within RACS.

Actions:

This can be achieved by:

- Policy makers and disciplines of medicine and pharmacy exploring the effectiveness and feasibility of a pharmacist-led medication review service, as an expansion of the existing service or a new model, with a focus on medication simplification and de-prescribing.

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69   The Pharmacy Guild of Australia. Residential medication management review programme (RMMR) and quality use of medications programme (QUM): program specific guidelines. 2015; Available from: http://6cpa.com.au/medication-management-programmes/residential-medication-management-review/.

70   Op cit, The Pharmacy Guild of Australia. Residential medication management review programme (RMMR) and quality use of medications programme (QUM): program specific guidelines 2015.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the availability of resources, time and funding to implement this service. The cost to aged care providers to integrate a pharmacist into their services may be high and may require Government support.

Recommendation 28:

That RACS and health providers (hospital, community) should develop a standardised approach to communication and information transfer pertinent to quality and safer use of medication on transitions of care. This may include a standardised template for verbal and electronic transfer of information between health providers (hospital and community) and RACS.

Aim:

To improve the transfer of medication information between health providers on transitions of care.

Rationale:

The incomplete and ineffective transfer of information between health professionals during transitions of care between health providers contributes to medication errors and medication-related harms[71]. Current handover procedures vary between health and aged care providers and may often be incomplete. A standardised approach to information transfer, including both verbal and electronic transfer of information between health providers, is needed to improve the quality of medication information provided.

Actions:

This can be achieved by:

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71   Desai R, Williams CE, Greene SB, Pierson S, Hansen RA. Medication errors during patient transitions into nursing homes: characteristics and association with patient harm. Am J Geriatr Pharmacother. 2011;9(6):413-22.

- RACS and health providers developing a standardised approach to information transfer, including both a verbal and electronic handover, by health practitioners between health providers.

- Development of an electronic handover which should include a minimum data set and be transferred securely to medical practitioners, pharmacy and RACS via encrypted software.

Limitations:

Potential limitations of this recommendation and barriers to implementation include resources, funding and time. A standardised approach to information transfer may result in changes to existing workflow as more time is invested in the process. Resources and funding are required to develop and implement a process for secure electronic handover and delivery to relevant health practitioners.

Recommendation 29:

That RACS should regularly review their medication administration procedures to identify opportunities for increased support, education and training for RAC staff. Procedures to review may include the choice of dose administration aids and measures to minimise errors during administration of high-risk medications.

Aim:

To ensure medication administration procedures at RACs are regularly reviewed and opportunities for improvement are identified and actioned.

Rationale:

A registered nurse, enrolled nurse or personal care worker, in accordance with state or territory legislation, may perform medication administration in RACS. Medications are often administered via a dose administration aid such as a Webster pack (packed by the community pharmacy) or sachets (typically prepared external from the pharmacy using automated packaging technology). Differences in medication administration including dose

administration aids and staffing levels differ between RACS who often have their own policy and procedures.

Actions:

This can be achieved by:

- RACS regularly reviewing existing policies and procedures in medication administration, including the use of dose administration aids (e.g. Webster packs vs sachets), administration of high-risk medications, staffing levels and qualifications, to assist in the identification of targeted strategies to improve administration practices.

- RACS identifying opportunities for increased support, education and training for all RAC staff (including personal care workers) to improve health literacy, medication knowledge and use of dose administration aids where necessary.

- RACS ensuring that medication information resources are available for staff including the Australian Medicines Handbook.

Limitations:

Potential limitations of this recommendation and barriers to implementation include resources and time for RAC management to regularly review their medication administration procedures, and identifying and implementing strategies for improvement. Additional costs to RACS and potential resistance to change existing procedures may also limit this recommendation.

Recommendation 30:

That RACS and pharmacy should explore the utilisation of technology (e.g. barcode medication administration systems, provision of medication charts/lists with pill images) to reduce medication errors during medication administration.

Aim:

To explore the effectiveness and feasibility of technology to assist in the reduction of medication administration errors in RACS.

Rationale:

The utilisation of technology, such as barcode medication administration systems, has been suggested to reduce medication administration errors in RACs. Barcode medication administration systems aim to verify the right medication is given to the right resident. Studies investigating the use of this technology has shown potential in reducing medication errors occurring at administration and transcription [72].

Actions:

This can be achieved by:

- RACS and pharmacy exploring the feasibility of technology (e.g. barcode medication administration systems) to reduce medication errors in RACS.

- Pharmacy to consider providing medication lists with pill images to assist residents in their identification of medicines during administration.

Limitations:

Potential limitations of this recommendation and barriers to implementation include costs, resources and training required for RACS to implement new technology. In addition, changes to medication administration procedures are likely to result in changes in daily workflow.

Recommendation 31:

That policy makers, funders and providers should review new and existing models of medical care, including general practice, in Australia and internationally to identify the optimal model of care that enhance medication safety for residents in RACS.

Aim:

To determine the optimal model of clinical care for RACS for medication safety.

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72   **Szczepura** A, Wild D, Nelson S. Medication administration errors for older people in long-term residential care. BMC Geriatr. 2011;11:82; **Shaw** C, McNamara R, Abrams K, Cannings-John R, Hood K, Longo M, et al. Systematic review of respite care in the frail elderly. Health Technol Assess. 2009;13(20):1-224; **Reed** RL. Models of general practitioner services in residential aged care facilities. Aust Fam Physician. 2015;44(4):176-9.

Rationale:

Numerous models of medical care currently exist including the continuity model (i.e. residents retain their medical practitioner on entry to aged care) and the facility-based model such as the BUPA Integrated Health Care model which sees facilities employing medical practitioners with interests in the aged care setting[73]. It is currently unclear which model of medical care is the most effective for medication safety. Potential new models of care may include incorporating a team approach to care involving medical practitioner(s), a geriatrician and pharmacist who may or may not be directly employed by the RACS, or alternatively a shared medical care model whereby residents receive a new (primary) medical practitioner on admission to a RACS however are able to retain their previous medical practitioner. It is currently unclear which model of medical care is the most effective for medication safety.

Actions:

This can be achieved by:

- Policy makers, funders and providers investigating the effectiveness of new and existing models of medical care to RACS in Australia and internationally.

Limitations:

This recommendation is a substantial endeavour and will require considerable time and resources to identify the optimal model of medical care.

Recommendation 32:

That RACS providers, in consultation with medical practitioners, should develop policies and procedures detailing expectations and requirements (e.g. frequency of visits and additional education) for medical practitioners who provide care to their residents to optimise medication safety.

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73   Op cit, Reed RL. Models of general practitioner services in residential aged care facilities 2015.

Aim:

To ensure clear expectations and requirements for medical practitioners who provide care to RACS.

Rationale:

Policies and procedures outlining expectations and requirements for medical practitioner's aims to introduce transparency and improve collaboration between RACS and medical practitioners. This may include policies outlining frequency of visits to RACS and additional educational requirements specific to aged care.

Actions:

This can be achieved by:

- RACS, in consultation with medical practitioners, developing specific policies and procedures of expectations and requirements (e.g. frequency of visits) for medical practitioners who provide care to residents in RACS.

- RACS and medical practitioners exploring the feasibility of telehealth consults.

- RACS and medical practitioners exploring the feasibility of implementing a mandatory education requirement to provide care to residents in RACS. Expansion of the existing Practice Incentive Program (PIP) for medical practitioners to implement mandatory education modules for aged care to receive payment may be considered.

Limitations:

Potential limitations of this recommendation and barriers to implementation include resistance to change of existing procedures and workflow, and increased time and resources required for medical practitioners to complete additional education requirements or visits to RACS.

During medication incident recommendations

Recommendation 33:

That RACS and health practitioners (medical and pharmacy) should ensure there is a clear process in place for the identification and minimisation of harm associated with the use of

high-risk medications by RAC staff, medical practitioners and pharmacy. This process should include guidelines and procedures for harm minimisation and clearly defined roles and responsibilities of all relevant parties.

Aim:

To improve the identification and minimisation of harm associated with the use of high-risk medications in RACS.

Rationale:

High-risk medications include medications that pose a high risk of causing injury or harm if misused or used in error. The acronym APINCH (Anti-infectives, Potassium and concentrated electrolytes, Insulin, Narcotics and sedatives, Chemotherapy agents and Heparin and other anticoagulants) is often used to classify high-risk medications in a hospital setting[74]. In addition to these medications, there may be high-risk medications specific to individual RACS.

Actions:

This can be achieved by:

- RACS utilising incident report data to identify high-risk medications specific to individual RACS. These may include medications that increase the risk of falls and hospitalisations.

- RACS and health practitioners (medical and pharmacy) working together to develop specific protocols and guidelines, with consideration of clinical context (e.g. renal and cognitive impairment), to assist in the identification and minimisation of harm associated with high-risk medications when used in error.

- RACS providing education and training to RAC staff and health practitioners where necessary.

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74   Australian Commission on Safety and Quality in Health Care (ACSQHC). High risk medicines. 2017; Available from: https://www.safetyandquality.gov.au/our-work/medication-safety/high-risk-medicines/.

- RACS ensuring that there are clearly defined roles and responsibilities for all relevant parties including the medical practitioner, pharmacist, RAC staff and residents and their families.

Limitations:

Potential limitations of this recommendation and barriers to implementation include time and resources to establish protocols and provide targeted education and training to RACS staff and health practitioners.

Recommendation 34:

That RACS and health practitioners (medical practitioners and pharmacists) should develop specific guidelines for the therapeutic monitoring of high-risk medications in RACS.

Aim:

To provide guidance for the therapeutic monitoring of high-risk medications in RACS.

Rationale:

There are currently no specific guidelines for the monitoring of high-risk medications in residents in RACS. Research into cases of medication-related death discovered toxicity relating to supratherapeutic levels of medications such as digoxin and lithium. Education and guidance for medical practitioners and RAC staff to assist in the identification of medication toxicity and monitoring of drug levels (i.e. therapeutic drug monitoring) will assist in the prevention and minimisation of medication-related harm.

Actions:

This can be achieved by:

- RACS and health practitioners (medical and pharmacy) developing specific guidelines for the monitoring of high-risk medications for residents in RACS. These guidelines will be dependent on the identification of high-risk medications which may be specific to each service.

- RACS providing education and training for RAC staff to assist in the identification of residents who are experiencing early symptoms of toxicity.

- Policy makers exploring the feasibility of increased pathology monitoring to be funded.

Limitations:

Potential limitations of this recommendation and barriers to implementation include time and resources required to manage the ongoing therapeutic monitoring of high-risk medications and to provide education and training to RACS staff and health practitioners. Funding for additional pathology costs may be required.

Recommendation 35:

That RACS should ensure there is a clear process for the early identification and reporting of clinical deterioration associated with medication toxicity by RAC staff.

Aim:

To improve the early identification and reporting of clinical deterioration of medication toxicity in RACS.

Rationale:

The early identification and reporting of clinical deterioration in residents is critical to minimise the risk of further medication-related harm and death. It may be difficult to detect changes in clinical status particularly when deterioration is slow or if RAC staff are unfamiliar with the resident. In some cases, clinical deterioration may be incorrectly assumed to be expected, such as in residents with advanced illness.

Actions:

This can be achieved by:

- RACS developing specific protocols and guidelines to assist RAC staff in the early identification and reporting of clinical deterioration.

- RACS providing education and training for RAC staff to assist in the identification and reporting of clinical deterioration.

Limitations:

Potential limitations of this recommendation and barriers to implementation include time and resources required to develop new protocols and guidelines and to provide ongoing education and training to RAC staff. Identification of clinical deterioration due to medication toxicity can be difficult, and efforts will need to be made to improve overall health literacy and medication knowledge of RAC staff.

Recommendation 36:

That a national program should be designed to educate and empower residents and their families to recognise and report changes to medical and RAC staff when their clinical status is adversely impacted by medication use.

Aim:

To educate and empower residents and their families to recognise and report changes in residents' clinical status to medical and RAC staff.

Rationale:

In addition to RAC staff, the family and/or carers of residents play a crucial role in the identification of deterioration in a residents' clinical status. This is particularly the case for residents who are new to a facility and are cared for by RAC staff who are relatively unfamiliar with the resident. By educating and empowering families and/or carers to play an active role.

Actions:

This can be achieved by:

- Aged care providers, together with peak bodies in aged care, developing an awareness package to encourage families of residents to take an active role in their care and to report signs of clinical deterioration to RAC staff. Family members should be encouraged to request regular medication reviews in-line with goals of care.

- Improving overall health literacy in residents and their families. This may include the distribution of medication lists by pharmacy and medication mobile applications that may be used to track medication use.

- RACS to ensure there is regular communication (e.g. email, face-to-face) between family members, RAC staff and the medical practitioner.

Limitations:

Potential limitations of this recommendation and barriers to implementation include ongoing resources, time and costs associated with improving health literacy and engagement with residents' families and carers. Wider support from peak bodies for consumer groups will be needed for effective engagement with families and carers.

Recommendation 37:

That policy makers should develop standardised procedures for RACS to ensure timely and collaborative pharmacist-led residential medication management reviews are performed with consideration for medication simplification and residents' goals of care.

Aim:

To ensure timely and collaborative pharmacist-led residential medication management reviews are performed for residents in RACS.

Rationale:

Residential medication management reviews aim to enhance the quality use of medicines, prevent and address medication-related problems and improve health outcomes[75]. The reviews are performed by an accredited pharmacist in collaboration with the medical practitioner and are currently funded for residents in residential aged care every 24 months. They may be requested more frequently if deemed to be clinically necessary (e.g. following

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75   Op cit, The Pharmacy Guild of Australia. Residential medication management review programme (RMMR) and quality use of medications programme (QUM): program specific guidelines 2015.

hospitalisation or fall) by the medical practitioner[76]. Timely medication management reviews for residents in RACS that consider individual goals of care will improve the appropriate use of medications and reduce medication-related harm.

Actions:

This can be achieved by:

- Policy makers developing standardised procedures for RACS to ensure collaborative pharmacist-led medication reviews are completed for each resident following admission into RACS and following significant changes in the resident's condition or medication regimen. Medication reviews may be performed in line with existing 'resident of the day' initiatives.

- Standardised procedures and checklists of items to be included in medication review reports should be developed to ensure consistency and quality of reporting. Medication reviews should consider residents' goals of care and link in with Advance Care Directives.

Limitations:

Potential limitations of this recommendation and barriers to implementation include access and associated costs for accredited pharmacists to perform timely reviews and ensuring medication reviews are performed in accordance with standardised procedures.

Recommendation 38:

That policy makers and regulators of the aged care sector should consider establishing standards alongside education and training modules for RACS staff and health practitioners to ensure competency in the monitoring and review of high-risk medications.

Aim:

To develop standards for the monitoring and review of high-risk medications in RACS.

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76   Op cit, The Pharmacy Guild of Australia. Residential medication management review programme (RMMR) and quality use of medications programme (QUM): program specific guidelines 2015.

Rationale:

High-risk medications, such as anticoagulants and opioids, are medications with a high potential for harm when used in error or misused[77]. Regular monitoring and review of high-risk medications is essential to ensuring their safe and effective use. Competency standards which address the monitoring and review of high-risk medications aims to ensure RACS staff and health practitioners have the necessary knowledge and skills (provided through education and training) to provide optimal care for residents in RACS.

Actions:

This can be achieved by:

-   Policy makers and aged care regulars establishing standards for the monitoring and review of high-risk medications in RACS.

-   RACS providing education and training programs for RACS staff and health practitioners to ensure staff have the necessary competency to adequately manage high-risk medications.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the resources, time and costs required to provide ongoing education and training for RACS staff and health practitioners. In addition, changes in clinical practice and workflow may be needed to accommodate increased monitoring requirements of high-risk medications.

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77   Op cit, Australian Commission on Safety and Quality in Health Care (ACSQHC). High risk medicines. 2017.

Following a medication incident recommendations

Recommendation 39:

That a national mortality and morbidity surveillance system of medication errors that occur in RACS with a standardised approach to information collection and reporting should be established to examine trends over time.

Aim:

To improve the collection and reporting of information following a medication incident.

Rationale:

The scale of medication incidents associated morbidity and mortality in Australian RACS is currently unknown. Currently RACS have access to incident reporting software to report and manage medication-related incidents within their services. This is separate from adverse drug reactions, which are monitored on a national scale by the Advisory Committee on Medications. Access to high quality data on medication incidents, including medications errors, which contribute to mortality and morbidity on a national scale will assist in the development of targeted interventions to reduce medication-related harm.

Actions:

This can be achieved by:

- Policy makers and regulatory bodies developing standardised policies and procedures for the reporting of medication incidents across RACS.

- Policy makers developing a standardised definition of a medication incident to ensure consistent reporting across RACS.

- Policy makers and regulatory bodies developing a national centralised repository of mortality and morbidity data associated with medication incidents that will allow for the analysis of trends over time.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the resources and costs associated with establishing a national repository of morbidity and mortality data related to medication incidents across RACS. Government support is needed to ensure widespread uptake of this initiative.

Recommendation 40:

That RACS and the relevant professional organisations for general practice, nursing and pharmacy should promote a just culture of reporting and learning system to encourage reporting of medication errors and incidents.

Aim:

To encourage the reporting of medication incidents which occur in RACS but promoting a just culture of reporting and learning system.

Rationale:

Medication incidents, including medication errors, may occur at any change in the medication process from prescribing through to use[78]. The promotion of a non-punitive reporting culture among RAC staff aims to increase the reporting of medication incidents and provide an opportunity for staff to learn from past events.

Actions:

This can be achieved by:

- RACS and relevant professional organisations for general practice, nursing and pharmacy to promote a just culture of medication error reporting.

- RACS holding regular discussions of past medication error incidents and opportunities for practice changes. These discussions may be incorporated into regular Medication Advisory Committee meetings held by RACS.

Limitations:

Potential limitations of this recommendation and barriers to implementation include time and resources required to change cultures within RACS. In addition, cultural change within an organisation is challenging and slow, requiring supportive and strong leadership within RACS.

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78   Op cit, Institute for Safe Medication Practices Canada. Definitions of terms 2017.

Recommendation 41:

That RACS should ensure a comprehensive and systematic approach is taken to improve the information provided by RACS staff and medical practitioners when reporting a potential medication-related death to the Coroners Court. The incident report should include each of the key steps in the medication process (e.g. prescribing to administration).

Aim:

To improve the information provided to the Coroners Court and recommendations made following a medication-related death.

Rationale:

All unexpected and natural deaths are legally required to be notified to the Coroners. Ensuring a comprehensive and standardised approach to the reporting of medication-related deaths to the Coroners Court by RACS and medical practitioners will assist with coronial investigations and ensure that targeted recommendations are provided to prevent medication-related harm in future.

Actions:

This can be achieved by:

- RACS ensuring that a comprehensive and systematic approach is taken to improve the information provided to the Coroner's Court. This includes relevant information provided by RAC staff and Medical practitioners.

- Reports provided to the Coroner's Court including details at each of the key steps in the medication process (e.g. prescribing and administration) to assist with coronial investigations and the development of targeted recommendations to prevent medication-related harm in future.

Limitations:

Potential limitations of this recommendation and barriers to implementation include time and resources for RACS staff and medical practitioners to ensure comprehensive information is provided to the Coroners Court.

Chapter 5 Physical Restraint

EMMA BELLENGER, JOSEPH E IBRAHIM LYNDAL BUGEJA, BRIOHNY KENNEDY

Summary of recommendations

Pre-physical restraint event

42.   That there is a single definition of physical restraint that is legislated so it is used universally to ensure a common understanding between aged care, health care professionals and providers about when physical restraint policy and protocols should apply.

43.   That residential aged care services (RACS) should focus on and be supported in, sustaining a person-centered care approach that respects the human rights of each resident.

44.   That policies and practice reflect that any behavioural symptoms exhibited by residents with dementia should act as a trigger for direct care staff to assess and consider whether there are any unmet needs of the resident.

45.   That the construction of new RACS adhere to specific building guidelines about structural design to promote a dementia-enabling environment; and that any refurbishment of existing homes also adhere to such guidelines.

46.   That any clinical handover between health and aged care providers follow a standardized approach to ensure optimal communication that enables an effective multidisciplinary approach to manage residents with dementia.

47.   That the residential aged care (RAC) staff profile and competencies are appropriate to meet the increasingly complex needs of residents with dementia and obviate the need to apply physical restraint.

During a physical restraint event

48. That the application of physical restraint should only occur in extremely limited

    circumstances. The process should involve at least two health professionals and requires

    clearly documenting the reasons for use, duration of use, outcome of restraint and any

    adverse events that occur.

49. That all RACS should have a physical restraint policy that promotes alternative approaches

    and if restraint must be used, it is defined within the parameters of this policy.

50. That informed consent is obtained from the resident and/or their appointed substitute

    decision-maker prior to any physical restraint application, and that this is documented.

51. That use of physical restraint acts as a trigger for mandatory referral to a specialist aged

    care team to review the resident's care plan and identify strategies that eliminate or

    reduce the use of physical restraint.

52. That physical restraint is instituted and monitored only by staff who have received formal

    training and been assessed to demonstrate competency in this intervention.

Post-physical restraint event and when an adverse event occurs

53. That a national, systematic and coordinated approach be taken to improve identification,

    investigation, analysis and reporting of adverse events involving physical restraints among

    RAC residents.

54. That at the time consent is obtained, residents and family members should be provided

    with education about how and where to lodge any concerns and complaints related to

    the use of physical restraint.

55. That a national standardized and, co-ordinated approach to the investigation of all deaths

    of a RAC resident while in a physical restraint is required.

56. That if a resident dies within seven days of being in any form of physical restraint that this

    is reported and triggers an investigation into the cause of death.

Detailed overview of recommendations

Pre-physical restraint event

Recommendation 42:

That there is a single definition of physical restraint that is legislated so it is used universally to ensure a common understanding between aged care, health care professionals and providers about when physical restraint policy and protocols should apply.

Aim:

To clarify exactly what is, and what is not, considered to be physical restraint so that all health care professionals involved in aged care share a common understanding of where to apply physical restraint protocols.

Rationale:

Currently the understanding of what constitutes a physical restraint is ill-defined[79]. The varied conceptual and operational definition of physical restraint across studies has been reported to be a major factor in the large variance in prevalence rates of physical restraint use across studies[80]. An internationally accepted definition of physical restraint would not only allow RAC staff to more accurately understand when restraint policies should apply, but would also benefit clinical research by facilitating consistent comparisons between studies[81 1,2].

Actions:

This can be achieved by:

- Policy makers collaborating with aged care professionals to define what physical restraint is.

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79 **Bleijlevens** MH, Wagner LM, Capezuti E, Hamers JP. Physical Restraints: Consensus of a Research Definition Using a Modified Delphi Technique. J Am Geriatr Soc. 2016;64(11):2307-2310; **Macilwaine** H, Watson C, McKenzie I. Restraint versus Restraints: defining the concepts for review and measurement. BJFP. 1999;1(3):27-33.

80 Op cit, **Bleijlevens** MH, et al. Physical Restraints 2016.

81 Op cit, **Bleijlevens** MH, et al. Physical Restraints 2016; **Macilwaine** H, et al. Restraint versus Restraints 1999.

- Adopting existing definitions and modifying them according to current ideas and understanding.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, the development of, and agreement on, a single definition of physical restraint use. Legislation of a definition would require the support of the government, legal and regulatory authorities.

Recommendation 43:

That residential aged care services (RACS) should focus on and be supported in, sustaining a person-centered care approach that respects the human rights of each resident.

Aim:

To deliver care that is respectful, humanitarian and acknowledges the personhood of RAC residents in all aspects of care.

Rationale:

Person-centered care involves shared-decision making; tailoring care to the individuals needs; and acknowledging the personhood of individuals[82]. This is particularly pertinent for RAC residents with dementia, as person-centered care provides a decrease in agitation and related behavioural and psychological symptoms of dementia (BPSD) compared to other models of care[83].

Actions:

This can be achieved by:

- Providers ensuring that staff have specific training and implicit knowledge of the person-centered care approach.

- Having a physical restraint policy that supports "restraint use only as a last resort".

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82   Edvardsson D, Winblad B, Sandman P. Person-centred care of people with severe Alzheimer's disease: current status and ways forward. Lancet Neurol. 2008;7(4):362-367.

83   Norman R, Haas M, Chenoweth L, Jeon Y, King M, Brodaty H, et al. Dementia Care Mapping and Patient-Centred Care in Australian residential homes: An economic evaluation of the CARE Study, CHERE Working Paper 2008/4 2008.

Limitations:

Potential limitations of this recommendation and barriers to implementation include having adequate staff resources to provide appropriate person-centered care, and resistance to change in the models of care.

Recommendation 44:

That policies and practice reflect that any behavioural symptoms exhibited by residents with dementia should act as a trigger for direct care staff to assess and consider whether there are any unmet needs of the resident.

Aim:

To emphasise care focused on the person rather than the disease in order to promote comfort and functional autonomy in older adults whose cognitive impairments have progressed.

Rationale:

Residents with significant dementia commonly communicate via non-normative behaviours[84]. Some authors refer to this as 'needs-driven dementia-compromised behavior[85], such as agitation, aggression or wandering behaviours, should prompt staff to consider the whether there are any unmet basic human needs of the resident, including toileting, comfort, hunger or relaxation[86]. Addressing these needs would reduce the need for physical restraint.

Actions:

This can be achieved by:

-    Staff meeting their obligations for attending training and education sessions about dementia care.

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84   Kovach CR, Noonan PE, Schlidt AM, Wells T. A Model of Consequences of Need-Driven, Dementia-Compromised Behavior. J Nurs Scholarsh. 2005;37(2):134-140.

85   Kolanowski AM, Litaker M, Buettner L. Efficacy of theory-based activities for behavioral symptoms of dementia. Nurs Res. 2005;54(4):219-228.

86   Shannon K. The Care of People with Dementia in Rural New South Wales. University of Canberra; 2012.

- Providers offering access to specific dementia care education and training sessions as part of staffs' professional development.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, resourcing for staff training and the effort required to be directed at supporting staff with incentives to attend the training.

Recommendation 45:

That the construction of new RACS adhere to specific building guidelines about structural design to promote a dementia-enabling environment; and that any refurbishment of existing homes also adhere to such guidelines[87].

Aim:

To ensure that building and architectural design of the RACS is compatible with the development of dementia-enabling environments.

Rationale:

The design of the physical environment has been recognised as an important factor in caring for residents with dementia[88]. The environment impacts on the residents' wellbeing and behaviour, including their orientation and safety. Certain architectural factors, such as the acoustic environment, lighting and thermal environment have been reported to benefit the dementia patients by providing safer opportunities for wandering and enhancing spatial orientation[89]. These factors subsequently contribute to a more comfortable, safe and

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87   Feedback from one organisation in the field stated that they supported the development of design guidelines but cautioned against the development of prescriptive design outcome requirements that may have any unintended consequence of making such developments cost prohibitive.

88   Day K, Carreon D, Stump C. The therapeutic design of environments for people with dementia a review of the empirical research. Gerontologist. 2000;40(4):397-416.

89   Marquardt G, Schmieg P. Dementia-friendly architecture: environments that facilitate wayfinding in nursing homes. Am J Alzheimers Dis Other Demen. 2009 Aug-Sep;24(4):333-340.

sustainable RAC environment[90], thus reducing the need for staff to physically restraint residents.

Actions:

This can be achieved by:

- Policy makers implementing specific architectural guidelines to promote dementia friendly structural design.

- Further published research about structural design more conducive to the safety of residents with dementia.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, resourcing for the refurbishment of RACS, relocation of residents while refurbishments, or major changes, take place, and that pre-existing RACS may not be suitable for modification.

Recommendation 46:

That any clinical handover between health and aged care providers follow a standardized approach to ensure optimal communication that enables an effective multidisciplinary approach to manage residents with dementia.

Aim:

To improve resident care and safety through the quick, systematic and efficient sharing of patient notes and documentation between health services.

Rationale:

There is a paucity of research into the clinical handover of a residents' information to RACS. Studies investigating the clinical handover in hospitals have shown that ambiguity and

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90   Wong JK, Skitmore M, Buys L, Wang K. The effects of the indoor environment of residential care homes on dementia suffers in Hong Kong: A critical incident technique approach. Build Environ. 2014;73:32-39.

incomplete transfer of information can increase the risks of adverse events[91]. We speculate

that these findings are generalizable to handovers in RACS, and that an improved culture of

information sharing between healthcare providers would enable appropriate care strategies,

that reduce the use of physical restraint use, to be put into place.

Actions:

This can be achieved by:

- Published research investigating the methods and efficacy of clinical handovers when
  admitting an individual to a RACS.

- Implementation of computer systems that allow easy transfer of patient files between the
  GP and RACS.

- Policy makers engaging with the technology and innovation sector to identify
  opportunities for application to the aged care system.

- Timely discharge summaries and transfer of files from the GP to the RACS.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, time

needed for training of staff around optimal process for handover and the development of a

standardized approach to handover and research to test efficacy.

Recommendation 47:

That the residential aged care (RAC) staff profile and competencies are appropriate to meet

the increasingly complex needs of residents with dementia and obviate the need to apply

physical restraint.

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91   Matic J, Davidson PM, Salamonson Y. Review: bringing patient safety to the forefront through
      structured computerisation during clinical handover. J Clin Nurs. 2011;20(1-2):184-189.

Aim:

To improve RAC staffs' knowledge and education about dementia-specific care, enabling them to implement appropriate restraint-free interventions to manage the complex needs of residents with dementia.

Rationale:

The literature reports that there is a need to improve aged care staffs' knowledge of dementia[92]. Education and training of staff in dementia specific care has been shown to immensely benefit the quality of care of dementia residents by reducing restraint use[93]. In addition, dementia specific training reduces the mental stressors and increase job satisfaction in staff whom receives the training[94].

Actions:

This can be achieved by:

- Staff meeting their obligations for attending training and education sessions on caring for residents with dementia.

- Providers offering access to dementia care education and training sessions as part of the staff members' professional development.

- Policy makers working with Universities and TAFE to develop and implement a national mandatory program incorporating dementia education and training into the aged care qualification curriculum.

- Researchers developing evidence-based training modules specific to the Australian aged care setting.

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92   Jones C, Moyle W, Stockwell-Smith G. Caring for older people with dementia: An exploratory study of staff knowledge and perception of training in three Australian dementia care facilities. Australas J Ageing. 2013;32(1):52-55.

93   Testad I, Aasland A, Aarsland D. The effect of staff training on the use of restraint in dementia: a single-blind randomised controlled trial. Int J Geriatr Psychiatry. 2005;20(6):587-590.

94   Franzmann J, Haberstroh J, Pantel J. Train the trainer in dementia care: A program to foster communication skills in nursing home staff caring for dementia patients. Z Gerontol Geriatre. 2016;49(3):209-215.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, resourcing economic and workforce, and effort needed to be directed at supporting staff with time and incentives to attend the training. This initiative requires investment to implement on a national scale and would required resources such as trainers and educational materials.

During a physical restraint event

Recommendation 48:

That the application of physical restraint should only occur in extremely limited circumstances. The process should involve at least two health professionals and requires clearly documenting the reasons for use, duration of use, outcome of restraint and any adverse events that occur.

Aim:

To ensure the application of physical restraint is only utilised as a last resort, and that this is documented appropriately.

Rationale:

Physical restraints may cause premature death as well as serious physical and psychological consequences[95]. There has been a global push towards restraint free environments over the last decade and physical restraints should only be used as a last resort when there are no viable alternatives[96]. When physical restraints are applied, they should be for the shortest possible time and there should be frequent re-evaluation of their indications, effectives and side effects[97].

Actions:

This can be achieved by:

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95   **Berzlanovich** AM, Schöpfer J, Keil W. Deaths due to physical restraint. Dtsch Arztebl Int. 2012;109(3):27-32; **Gastmans** C, Milisen K. Use of physical restraint in nursing homes: clinical-ethical considerations. J Med Ethics [H.W.Wilson - SSA]. 2006;32(3):148.

96   Flaherty JH. Zero tolerance for physical restraints: difficult but not impossible. J Gerontol A Biol Sci Med Sci. 2004;59(9):M919-M920.

97   Agens JE. Chemical and physical restraint use in the older person restraint. BJMP. 2010;3(1).

- Providers implementing a policy of physical restraint as a last resort only.

- Providers ensuring staff are familiar with the policy and the documentation requirements.

- Staff documenting the use of physical restraint at the time it is applied and not at the end of shift.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, enforcement of the policy and completion of documentation at the time of the restraint. Another limitation is in emergency situations where physical restraint may be utilised as a last resort, gaining access to two health professionals prior to restraint may be difficult.

Recommendation 49:

That all RACS should have a physical restraint policy that promotes alternative approaches and if restraint must be used, it is defined within the parameters of this policy.

Aim:

To ensure that physical restraints are utilized only when indicated by the restraint policy, and when restraints are used that they are done so in a standardized and regulated manner in accordance with the policy.

Rationale:

Despite clinical guidelines that state physical restraint should be an intervention of last resort[98], the lack of mandated restraint policies means that physical restraints continue to be used in an unregulated and potentially fatal manner within aged care facilities[99]. In countries where there are specific policies governing the circumstances under which physical restraint may be applied, the prevalence of restraint use is lower[100].

Actions:

This can be achieved by:

- Policy makers mandating national physical restraint policies that support the push towards restraint-free, humanitarian care.

- Providers implementing specific restraint policies within their RACS.

- Further published research about the efficacious alternatives to physical restraint.

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98   **Gastmans** C, Milisen K. Use of physical restraint in nursing homes: clinical-ethical considerations. J Med Ethics [H.W.Wilson - SSA]. 2006;32(3):148; **Burns** K, Jayasinha R, Tsang R, Brodaty H. Behaviour management a guide to good practice: managing behavioural and psychological symptoms of dementia. The University of New South Wales, Australia: Dementia Collaborative Research Centre-Assessment and Better Care (DCRC-ABC) 2012.

99   Op cit, Berzlanovich AM, et al. Deaths due to physical restraint 2012.

100   Fariña-López E, Estévez-Guerra GJ, Gandoy-Crego M, Polo-Luque LM, Gómez-Cantorna C, Capezuti EA. Perception of Spanish nursing staff on the use of Physical restraints. J Nurs Scholarsh. 2014;46(5):322-330.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, changing staff's perceptions that physical restraints are required and lack of evidence for effective alternatives to physical restraints.

Recommendation 50:

That informed consent is obtained from the resident and/or their appointed substitute decision-maker prior to any physical restraint application, and that this is documented[101].

Aim:

To improve care for residents through promoting a greater emphasis on shared decision-making and respecting the autonomy and wishes of the resident, and/or their appointed decision maker.

Rationale:

It has been argued that the paternalistic use of physical restraint without the resident's consent is morally unjustified and is an unequivocal violation of autonomy[102]. One study also reports that physical restraint use often goes together with a disproportionate infringement of the principle of respect for the autonomy of older persons[103]. This may be attributed to the fact that restraints are often applied in an urgent manner by staff to control a resident's behaviour[104]. Informed consent for the application of physical restraint should be gained when the resident is admitted to the RACS, thus avoiding the potential to violate the residents' autonomy.

Actions:

This can be achieved by:

- Staff consulting with residents and families on admission to gain insight into their wishes regarding interventions, including physical restraint.

- Staff educating residents and families about the risks of physical restraint, and providing them with viable alternatives to restraint.

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101   Feedback from one organisation in the field suggested a clause that allows for the application of a physical restraint in an emergency situation (provided certain conditions are met) without prior consent being gained where this has not been planned for, or anticipated.

102   Cheung PP, Yam B. Patient autonomy in physical restraint. J Clin Nurs. 2005;14(s1):34-40.

103   Op cit, Gastmans C, Milisen K. Use of physical restraint in nursing homes 2006.

104   Moss RJ, Puma J. The ethics of mechanical restraints. Hastings Cent Rep. 1991;21(1):22-25.

-    Visible pamphlets in RACS explaining physical restraint use and the risks associated with it.

-    Regular review of the documented consent to ensure it remains up to date and relevant.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, ensuring the consent documentation is kept in an accessible and visible location in the residents' file that their wishes are known to, and upheld, by staff. Another potential limitation is provider's resistance to incorporate physical restraint consent into the admission process.

Recommendation 51:

That use of physical restraint acts as a trigger for mandatory referral to a specialist aged care team to review the resident's care plan and identify strategies that eliminate or reduce the use of physical restraint[105].

Aim:

To improve quality of care delivered to residents through involvement of specialist aged care teams.

Rationale:

One of the reasons that physical restraints are applied is to manage impulsive behaviours, including behavioural and psychological symptoms of Dementia (BPSD)[106]. BPSD leads to an increase in physical restraint use[107]. Residents exhibiting BPSD should be referred to a specialist aged care team for assessment and subsequent development of management strategies that do not involve the use of physical restraints. Such strategies do exist, with literature reporting that the careful use of antipsychotics, particularly Quetiapine, is appropriate for BPSD management[108], as are non-pharmacological interventions that aim to meet unmet needs of the residents such as boredom, sensory stimulation or relaxation[109].

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105   Feedback from one organisation in the field stated that they supported access to specialist services that may provide guidance or recommendations to those providers who seek such support however, they do not support this being a mandatory requirement.

106   Miles SH, Irvine P. Deaths caused by physical restraints. Gerontologist. 1992;32(6):762.

107   Sullivan-Marx EM, Strumpf NE, Evans LK, Baumgarten M, Maislin G. Predictors of continued physical restraint use in nursing home residents following restraint reduction efforts. J Am Geriatr Soc. 1999;47(3):342-348.

108   **Bishara** D, Taylor D, Howard RJ, Abdel-Tawab R. Expert opinion on the management of behavioural and psychological symptoms of dementia (BPSD) and investigation into prescribing practices in the UK. Int J Geriatr Psychiatry. 2009;24(9):944-954; **Azermai** M, Petrovic M, Elseviers MM, Bourgeois J, Van Bortel LM, Vander Stichele RH. Systematic appraisal of dementia guidelines for the management of behavioural and psychological symptoms. Ageing Res Rev. 2012;11(1):78-86.

109   **Cohen-Mansfield** J. Nonpharmacologic treatment of behavioral disorders in dementia. Curr Treat Options Neurol. 2013;15(6):765-785; **Sung** H, Chang S, Lee W, Lee M. The effects of group music with movement intervention on agitated behaviours of institutionalized elders with dementia in Taiwan. Complement Ther Med. 2006;14(2):113-119.

Actions:

- Policy makers implementing a new policy that mandates that resident's who are physically restrained be referred to specialist aged care teams, or other allied health professionals, for assessment.

- Providers ensuring that staff are familiar with the specialist aged care services available.

- Provider ensuring that procedures are in place to follow up the assessment made by the specialist.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, increased demand on specialist aged care teams, and dependence on individual staff for referrals to be made in the event of restraint use.

Recommendation 52:

That physical restraint is instituted and monitored only by staff who have received formal training and been assessed to demonstrate competency in this intervention[110].

Aim:

To ensure that physical restraints are only used where appropriate, as a last resort, by trained staff with the knowledge to apply them safely and monitor the resident accordingly.

Rationale:

Nurse shortages are a global issue[111] and result in the assistants-in-nursing (AIN) being heavily relied on to staff aged care facilities[112]. In Australia, 68% of the aged-care workforce is made up of AIN[113]. AIN have been reported to consider the use of restraints more important than highly trained registered nurses[114]. This may reflect their lack of specialised training in dementia care and accentuates the importance of having appropriately trained staff utilising physical restraints so that they are not applied unnecessarily.

Actions:

This can be achieved by:

- Providers offering access to education and training sessions about physical restraint use and the risks as part of the staff members' professional development.

- Policy makers working with Universities and TAFE to develop and implement a national mandatory program incorporating physical restraint education and training into the aged care qualification curriculum.

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110   Feedback from one organisation in the field stated that they would encourage an ongoing conversation on what is meant by the terms 'instituted', 'formal training' and 'demonstrated competency'.

111   International Council of Nurses. The Global Nursing Shortage: Priority areas for intervention. 2006.

112   Holmes B. Nursing homes need nurses: losing them would undermine residents' care. The Sydney Morning Herald 2015 May 25.

113   Op cit, Holmes B. Nursing homes need nurses: 2015.

114   Op cit, Fariña-López E, et al. Perception of Spanish nursing staff on the use of Physical restraints 2014.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, effort needed to be directed to supporting staff with time and incentives to attend the training. This initiative requires investment to implement on a national scale, and would require resources such as trainers and educational materials.

Post-physical restraint event

Recommendation 53:

That a national, systematic and coordinated approach be taken to improve identification, investigation, analysis and reporting of adverse events involving physical restraints among RAC residents.

Aim:

To improve understanding about adverse events due to physical restraint so that prevention strategies can be developed.

Rationale:

Physical restraints may cause physical injury such as cognitive decline, falls, nerve injury and incontinence[115]. Literature has given little attention to the injuries sustained as a result of physical restraint. Research is needed to provide clinicians with data on the risk factors and adverse events associated with use of physical restraint in order to develop specific strategies to prevent these from occurring[116]. Systematic reporting of adverse events would help this to be achieved.

Actions:

This can be achieved by:

- Providers ensuring that staff are familiar with the reporting protocols of adverse events.

- Staff documenting adverse events and reporting adverse events to the provider as soon as possible.

- Policy makers implementing national guidelines about the reporting of adverse events, with particular reference to adverse events due to physical restraint.

- Further published research about the injuries caused by physical restraint.

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115   Op cit, Gastmans C, Milisen K. Use of physical restraint in nursing homes 2006.

116   State Government Victoria. Senior Practitioner Physical Restraint Direction Paper: Supporting people to achieve dignity without restraints. 2011.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, resistance to change due to the perceived litigious consequences of reporting adverse events due to physical restraint use. Also, the thorough investigation of physical restraint use and adverse events in this population would require a combination of funding, resources, and time. The recommendation would require the support of Government, legal and regulatory authorities to implement effectively.

Recommendation 54:

That at the time consent is obtained, residents and family members should be provided with education about how and where to lodge any concerns and complaints related to the use of physical restraint.

Aim:

To empower residents and family members to express concerns over perceived poor or inappropriate use of restraint, and to improve quality of care by evaluating complaints lodged.

Rationale:

Complaints are one proxy measure of performance in the RAC setting and potentially represent an additional indicator of quality[117]. It may be challenging for residents to lodge complaints due to cognitive impairment or fear of retaliation from facility staff[118]. However, family members, or any other individual who wishes to do so has the option to lodge a formal complaint with regulators[119][33]. The procedure for lodging a complaint may not be well known to families, thus this information should be disclosed at the time of admission.

Actions:

This can be achieved by:

- Staff consulting with residents and families on admission to give information about the how and where to lodge complaints.

- Visible pamphlets in RACS explaining the process of lodging a complaint.

- Further published research about the content of complaints and the correlations with quality of care.

117   Stevenson DG. Nursing home consumer complaints and quality of care: a national view. Med Care Res Rev. 2006 Jun;63(3):347-368.

118   McGregor MJ, Cohen M, Stocks-Rankin C, Cox MB, Salomons K, McGrail KM, et al. Complaints in for-profit, non-profit and public nursing homes in two Canadian provinces. Open Med. 2011;5(4):183-192.

119   Op cit, McGregor MJ, et al. Complaints in for-profit, non-profit and public nursing homes in two Canadian provinces 2011.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, resistance to change and providing families with information due to fear of criticism or litigation. This initiative requires investment in resources such as trainers and educational materials.

Recommendation 55:

That a national standardized and, co-ordinated approach to the investigation of all deaths of a RAC resident while in a physical restraint is required.

Aim:

To improve the reporting of deaths caused by physical restraint to aid in collecting data about the rates of death and further develop specific strategies for prevention of such deaths.

Rationale:

In Victoria, Australia over 12 years (2000-2012) we estimate approximately 4% of deaths occurring in RACS are reported to the Coroner, accounting for 7% (4027/56,855) of all deaths reported[120]. We speculate that deaths due to physical restraint are significantly under-reported. Under reporting may be due to a reflexive emotional response to conceal the event[121] or failure of providers to provide guidance on reporting requirements[122]. It is also possible that deaths been caused by physical restraint in the RAC resident may be misclassified as being due to natural causes or falls. For this reason it is important that any death occurring whilst physical restraints are applied be thoroughly investigated to ascertain the cause of death.

Actions:

This can be achieved by:

- Providers sustaining a 'blame-free' culture within the RACS.

- Providers providing staff with education about what deaths are reportable and how to report them.

- Staff reporting deaths to the provider or directly to the police as soon as possible.

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120   Op cit, Ibrahim JE, et al, Nature and extent of external-cause deaths 2015.

121   Miles SH. Concealing accidental nursing home deaths. HEC Forum: Springer. 2002;14(3):224-234.

122   Weiss EM, Altimari D, Blint DF, Megan K. Deadly restraint: a Hartford Courant investigative report. Hartford Courant. 1998:11-15.

- Policy makers introducing standardized policies and procedures for the investigation and reporting of deaths due to physical restraint across jurisdictions.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, requirement of support of Government, legal and regulatory authorities to implement effectively. The thorough investigation of physical restraint use and adverse events in this population would require a combination of funding, resources, and time.

Recommendation 56:

That if a resident dies within seven days of being in any form of physical restraint that this is reported and triggers an investigation into the cause of death.

Aim:

To improve the investigation of deaths where physical restraints may have been a contributing factor.

Rationale:

There is no data available about residents who are restrained but do not suffer physical injuries or deaths. Thus there is no denominator to compare the restrained population who dies with the restraint population who does not die. Reporting and investigating deaths occurring in individuals who were restrained within seven days may provide a source of insight into this issue and identify trends among the residents who were restrained but did not die from restraint.

Actions:

This can be achieved by:

- Policy makers introducing standardized policies and procedures for the investigation and reporting of deaths when a resident has been physically restrained in the past week.
- Staff ensuring that the application of physical restraint is documented in the residents file and includes information about adverse events.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, having the resources and funding to thoroughly investigate all deaths where a resident had previously been physically restrained. There may be some resistance to change, due to the perceived litigious consequences of reporting adverse events due to physical restraint use.

Chapter 6 Respite

MELISSA WILLOUGHBY, JOSEPH E IBRAHIM

Background

Internationally, increasing numbers of older people are choosing to reside in their homes

rather than moving into institutional aged care[123]. This has health benefits for the older

person and can reduce government economic spending on institutionalising the rapidly ageing

population. Many older persons living in their homes are cared for by a spouse, who is also

elderly, or other family members. These carers often become fatigued and seek respite care

for their loved one to have a short break from usual care arrangements. Respite care refers to

alternative care arrangements for dependent people living in the community. Formal respite

services are provided for the day or overnight by residential aged care services (RACS) either

as planned bookings or emergency admissions[124].

The demand for respite is high with approximately 80% of older people who require assistance

living in the community cared for by informal carers such as spouses, family members, and

friends[125]. While the need for respite care is clear, its benefits and safety are less clear.

Empirical evidence on the benefits of respite care to carers and dependent older people is

inconclusive[126]. Further, residential respite care involves transitioning an older person from

their usual place of residence to an unfamiliar environment, the residential aged care (RAC)

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123   Wiles JL, Leibing A, Guberman N, Reeve J, Allen RE. The meaning of "aging in place" to older
       people. Gerontologist. 2012;52(3):357-66.

124   Australian Government: Australian Institute of Health and Welfare (AIHW). Aged Care in
       Australia. 2017; Available from: http://www.aihw.gov.au/aged-care/residential-and-community-
       2011-12/aged-care-in-australia/.

125   Op cit, Australian Government: Australian Institute of Health and Welfare (AIHW). Aged Care in
       Australia. 2017.

126   **Neville** C, Beattie E, Fielding E, MacAndrew M. Literature review: use of respite by carers of
       people with dementia. Health Soc Care Community. 2015;23(1):51-3; Op cit, **Shaw** C, et al.
       Systematic review of respite care in the frail elderly 2009.

facility. Transitions in care are known to be fraught with hazards in hospital settings[127]. This is often due to fragmentation in care delivery, communication errors and inadequate definitions of the various clinicians' responsibilities. Transfers to and from residential respite care are likely to be characterised by the similar risk factors and by extension the adverse events, including mortality, as other types of care transition.

The recommendations have been formulated in chronology of the residential respite episode, that is, pre-admission, admission and stay, post-respite stay.

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127 **LaMantia** MA, Scheunemann LP, Viera AJ, Busby-Whitehead J, Hanson LC. Interventions to improve transitional care between nursing homes and hospitals: a systematic review. J Am Geriatr Soc. 2010;58(4):777-82; **Naylor** MD. Transitional care of older adults. Annu Rev Nurs Res. 2002;20:127-47; **Oakes** SL, Gillespie SM, Ye Y, Finley M, Russell M, Patel NK, et al. Transitional care of the long-term care patient. Clin Geriatr Med. 2011;27(2):259-71.

Summary of recommendations

Pre-respite admission

57.   That mandatory use of a central electronic system, that stores medical records and information from health and aged care providers (e-health records), is required as part of residential aged care services (RACS) accreditation to reduce adverse handover incidents.

58.   That a planned preventative care model of respite is adopted to maintain the caring relationship and reduce adverse events related to emergent admissions.

59.   That facilities specialising in residential respite be developed to manage the care of respite residents with complex needs.

60.   That a simplified procedure, involving identifying five vital care needs of the respite resident, is implemented to mitigate adverse events through a standardised handover procedure.

61.   That there is flexibility in when respite residents are admitted and the length of their stay to improve access and use of respite care by carers.

During respite admission

62.   That information gathered on respite residents is optimised to identify how and why respite is used and to provide opportunities to prevent adverse events through enhanced national data collection on respite residents.

63.   That respite residents are able to bring in personal and familiar items to respite care to create a familiar environment, thereby reducing adverse events.

64.   That clinicians assess respite residents on admission to determine the presence of conditions that may impact the care and health of the respite resident.

65.   That a national, systematic and coordinated approach be taken to improve identification, reporting, investigation and analyses of adverse events involving residential respite residents.

66. That a standard and comprehensive procedure for admission, handover and discharge from respite care is implemented so that the family, general practitioner and community services are aware of the needs of the resident during and immediately after respite care.

Post respite stay

67. That a national standardised and coordinated approach to the investigation of all deaths of respite residents while in, or within seven days after discharge from respite care is implemented.

Detailed overview of recommendations

Pre-respite admission

Recommendation 57:

That mandatory use of a central electronic system, that stores medical records and information from health and aged care providers (e-health records), is required as part of residential aged care services (RACS) accreditation to reduce adverse handover incidents[128].

Aim:

To decrease the complexity of admission and reduce errors related to handover.

Rationale:

Traditionally, health information has been collected and stored in paper-based systems, with information about one individual held in a number of disparate locations, such as general practitioners' records, hospital records, and medical specialists' records.

The current direction is to share patients' health information electronically (e-health systems) by connecting up the points of care. *My Health Record* system is the Australian government's digital health record system[129]. It allows patients, their doctors and health professionals, hospitals and other health-care providers to view and share the patient's health information, if the person has given prior consent. This information can include a summary of medications, hospital discharge records, allergies and immunisations.

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128   Feedback from one organisation in the field stated that, they do not support any recommendation in favour of additional regulatory standards that mandate specific approaches and inputs to care in residential aged care settings, specifically Recommendation 57 which suggests mandatory interaction with a central electronic system for storing medical records and information from health and aged care services to obtain accreditation.

129   Australian Government: Department of Health (DoH). Electronic health records and identifiers: legislation discussion paper. 2015; Available from: https://www.oaic.gov.au/engage-with-us/submissions/electronic-health-records-and-healthcare-identifiers-legislation-discussion-paper.

Transfers to and from care have been found to be high risk periods in hospital settings[130] and these risks are likely to apply to respite care. Especially considering older people are particularly vulnerable to morbidity and mortality in transitions of care[131].

There is evidence that digital health record systems can improve the process of care. For example, by reducing the likelihood of mistakes caused by transcribing information and errors that occur when clients are transferred between aged care facilities and health care providers such as hospitals. However, training in the technical aspects of the software is essential[132]. Few Australian nursing homes have implemented *My Health Record* (173 of 263,788 operational aged care places 2013-2014)[133]. Barriers frequently cited include: initial cost of the hardware, especially for smaller facilities; challenges in recording quality data; applicability of recorded data to tasks that staff perform; security of personal data; and liability concerns[134].

Actions:

This can be achieved by:

-   Including the use of *My Health Record* system into Australian Accreditation Standards.

130   Op cit, **Naylor** MD. Transitional care of older adults 2002; Op cit, **Oakes** SL, et al. Transitional care of the long-term care patient 2011; **Forster** AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161-67.

131   Ibrahim JE, Bugeja L, Ranson D. Using existing information from medico-legal death investigations to improve care of older people in residential aged care services. J Law Med. 2013;21(2):255-61.

132   **Raptis** DA, Fernandes C, Chua W, Boulos PB. Electronic software significantly improves quality of handover in a London teaching hospital. Health Informatics J. 2009;15(3):191-8; **Fiander** M, McGowan J, Grad R, Pluye P, Hannes K, Labrecque M, et al. Interventions to increase the use of electronic health information by healthcare practitioners to improve clinical practice and patient outcomes. Cochrane Database Syst Rev. 2015(3):CD004749; **Gagnon** MP, Legare F, Labrecque M, Fremont P, Pluye P, Gagnon J, et al. Interventions for promoting information and communication technologies adoption in healthcare professionals. Cochrane Database Syst Rev. 2009(1):CD006093; **Australian Government**: Australian Digital Agency. My health record statistics – at 30 April 2017. 2017; Available from: https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/news-002.

133   Op cit, Australian Government: Australian Digital Agency. My health record statistics 2017.

134   Op cit, **Gagnon** MP, et al. Interventions for promoting information and communication technologies adoption in healthcare professionals 2009; **World Health Organization** (WHO). Communication during patient handovers. 2007; Available from: http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf?ua=1.

- Further research to determine the specific data to be recorded in the *My Health Record* system that is applicable to the tasks that staff perform for respite clients.

- Training staff to use the electronic system and the related security measures that protect residents' personal information.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, commitment of providers to adopt the electronic system into their operational plan, and unwillingness of respite residents and their families to have their personal data entered into the electronic system due to concerns about the reliability and security of the system. Benefits of this recommendation will be reduced without a number of providers, health agencies and medical professionals implementing the system.

Recommendation 58:

That a planned preventative care model of respite is adopted to maintain the caring relationship and reduce adverse events related to emergent admissions.

Aim:

To support carers by reducing the burden and negative connotations of using respite care through promoting and encouraging respite care to be used at regular planned intervals.

Rationale:

Respite care needs to be considered as a preventative service that carers regularly use to support their health and wellbeing so they are able to continue caring for the recipient. Carers mainly use respite care when they have no other alternatives, are in need of a "break", are no longer physically able to care for the recipient due to decline in their health or the recipient's disease is in the later stages[135]. While emergency, unplanned use of respite care will always be needed and should always be provided, it does not reduce carer burden and "burn out". Respite care needs to be reframed from emergency care to a service that can be used regularly to support carers before they are at risk of burn out.

Published studies report that the demand for respite places outstrips provision, and that the need for respite care will increase as the population grows and ages[136]. While carers who utilise respite care report a high level of satisfaction,[137] there is a high proportion of eligible participants who are not utilising the service. Carers have reported avoiding using respite due

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135   Op cit, **Neville** C, et al. Literature review: use of respite by carers of people with dementia 2015; **Robinson** KM, Buckwalter K, Reed D. Differences between dementia caregivers who are users and nonusers of community services. Public Health Nurs. 2013;30(6):501-10.

136   **Harris** M, Diminic S, Marshall C, Stockings E, Degenhardt L. Estimating service demand for respite care among informal carers of people with psychological disabilities in Australia. Aust N Z J Public Health. 2015;39(3):284-92; **Australian Government**: Productivity Commission. Trends in aged care services: some implications. 2008; Available from: http://www.pc.gov.au/__data/assets/pdf_file/0004/83380/aged-care-trends.pdf.

137   Op cit, **Shaw** C, et al. Systematic review of respite care in the frail elderly 2009; Op cit, **Robinson** KM, et al. Differences between dementia caregivers who are users and nonusers of community services 2013; Op cit, **Harris** M, et al. Estimating service demand for respite care among informal carers of people with psychological disabilities in Australia 2015.

to feelings of guilt from abandoning the recipient or failing to fulfil their family duties[138].

Assessing information is also problematic, specifically information about location of facilities in their community, fees for service, specialists services, sufficient staff to provide and supervise personal care and safety, and registered nursing staff to manage and monitor treatments[139]. Carers are also influenced by the perceived quality of the service based on factors such as[140] staff compassion and knowledge, cleanliness of facilities, dementia programs and food quality[141]. Carers from culturally and linguistically diverse groups, Aboriginal and Torres Strait Islanders, and those from regional areas find assessing respite places and services in their locality particularly difficult[142].

Actions:

This can be achieved by:

- Education program for the public on the necessity for residential respite care beginning early in the caregiving experience.

- Planning research to examine the effectiveness of the planned preventative care model to meet the needs of carers and recipients of care.

- Identifying cost-effective ways, including a physical point of contact, to assist carers navigate the residential respite service system.

- The name "respite care" to be renamed as "short stay care" to reduce the negative connotation of carers using respite care.

138   Op cit, **Neville** C, et al. Literature review: use of respite by carers of people with dementia 2015.

139   Op cit, **Harris** M, et al. Estimating service demand for respite care among informal carers of people with psychological disabilities in Australia 2015; **Stockwell-Smith** G, Kellett U, Moyle W. Why carers of frail older people are not using available respite services: an Australian study. J Clin Nurs. 2010;19(13-14):2057-64; **Alzheimer's Australia**. Submission to the productivity commission: reforms to human service (stage 2) 2017; Available from: https://www.fightdementia.org.au/files/NATIONAL/documents/AA-Submission-to-Productivity-Commission-Human-Services-Inquiry.pdf.

140   Carers Australia. Submission to the Productivity Commission Inquiry on National Disability Insurance Scheme (NDIS) Costs. 2017; Available from: http://www.carersaustralia.com.au/storage/submission-to-pc-inquiry-ndis-costs.pdf.

141   Op cit, **Neville** C, et al. Literature review: use of respite by carers of people with dementia 2015.

142   Op cit, Australian Government: Productivity Commission. Trends in aged care services: some implications 2008.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, cost of a public health program to address the necessity for residential respite care beginning early in the caregiving experience, and commitment by government, funders and providers to increase access to respite in residential facilities.

Recommendation 59:

That facilities specialising in residential respite be developed to manage the care of respite residents with complex needs[143].

Aim:

To improve access to respite care and ensure high quality care.

Rationale:

In Australia, residential respite care is provided in RAC facilities alongside care for permanent RAC residents[144]. Due to this arrangement, respite can be seen as a "secondary" function of RACS with caring for permanent residents as its "primary" function. Facilities that are specifically designed and function to provide respite would be better equipped to care for respite residents with complex needs. There is evidence to suggest that specialist facilities for dementia[145], cancer[146], Hepatitis C[147] do improve care, access to care and quality of life.

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143   Feedback from one organisation in the field challenge this perception, specifically:
- The quality of care and services delivered is dependent on the approach of the facility provider NOT on whether they provide permanent care, respite care or a mix of the two;
- That many respite residents enter permanent care in a facility via having positive exposure to that facility via its respite program;
- When a respite resident has previous experience of a facility (via respite), when they do enter that facility as a permanent resident, they often settle in better, as they will know many of the staff and other residents already;
- That by having facilities spread throughout the broader community that offer a mix of permanent and respite places residents are more likely to be able to remain in their local communities thus keeping an attachment to family, friends, community services (e.g. their local community club), their local GP etc.
- The provision of care and services delivered to respite residents (under the Aged Care Act 1997 and associated Principles) are the same for respite residents as they are for permanent residents. The Australian Aged Care Quality Agency assesses the quality of care and services equally for respite and permanent residents.

144   MYAGEDCARE AG. Short stays in aged care homes. Available from: https://www.myagedcare.gov.au/respite-care/short-stays-aged-care-homes.

145   Kovach C, Weisman G, Chaudhury H, Calkins M. Impacts of a therapeutic environment for dementia care. Am J Alzheimers Dis. 1997;12(3):99-110.

146   Tracey E, Hacker NF, Young J, Armstrong BK. Effects of access to and treatment in specialist facilities on survival from epithelial ovarian cancer in Australian women: a data linkage study. Int J Gynecol Cancer. 2014;24(7):1232-40.

147   Brener L, Gray R, Cama EJ, Treloar C. 'Makes you wanna do treatment': benefits of a hepatitis C specialist clinic to clients in Christchurch, New Zealand. Health Soc Care Community. 2013;21(2):216-23.

Admission to respite care can be an emotional stressful event for both the carer and the respite resident[148]. The quality and design of the RAC environment has been found to influence the health and happiness of the resident. A range of quality elements have been identified for internal spaces, spaces outside the facility, and the urban environment[149]. For example, the type and size of room, opportunities to interact with staff and others, and freedom and choice of movement are important for internal spaces[150]. Specialist facilities would be better equipped to provide these elements as the carer and the care receiver will become familiar with the staff and the type of care provided. Staff will be able to develop a better understanding of the needs of respite residents and will already have a record of their history to ease the admission and handover processes. Specialist facilities will also be able to develop better processes for allied health involvement for respite care.

Actions:

This can be achieved by:

- Government across all sectors collaborating with providers, specialists in respite care, and carers to develop policies and guidelines for the design, construction and implementation of specialist respite facilities and refurbishment of current facilities.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, commitment of all agencies to work together and collaborate with carers to develop designs, policies and guidelines that direct the construction of specialist respite facilities and the

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148   Brownie S, Horstmanshof L, Garbutt R. Factors that impact residents' transition and psychological adjustment to long-term aged care: a systematic literature review. Int J Nurs Stud. 2014;51(12):1654-66.

149   **Alzheimer's Australia**. Dementia friendly communities - white paper September 2015. 2015; Available from: https://www.fightdementia.org.au/files/NATIONAL/documents/Dementia-Friendly-Communities-white-paper.pdf; **O'Connell** B, Hawkins M, Ostaszkiewicz J, Millar L. Carers' perspectives of respite care in Australia: an evaluative study. Contemp Nurse. 2012;41(1):111-9; **Edwards** H, Courtney M, O'Reilly M. Involving older people in research to examine quality of life in residential aged care. QAOA. 2003;4(4):38-44; **Bergland** A, Kirkevold M. Thriving in nursing homes in Norway: contributing aspects described by residents. Int J Nurs Stud. 2006;43(6):681-91.

150   Op cit, Bergland A, Kirkevold M. Thriving in nursing homes in Norway 2006.

refurbishment of existing facilities. Specialist respite centres may restrict the geographic

availability of respite care making it less accessible to some recipients.

Recommendation 60:

That a simplified procedure, involving identifying five vital care needs of the respite resident, is implemented to mitigate adverse events through a standardised handover approach.

Aim:

To reduce hand over errors and enable care staff to quickly familiarise themselves with the respite resident, and their needs including medications.

Rationale:

Clinical handover is the "transfer of professional responsibility and accountability for some or all aspects of care for a patient to another person or professional group"[151]. By definition, handover is a communication event that involves the transfer of resident information between individuals or health care groups. Handover can occur when a resident attends an appointment or test; when staff change at the end of a shift; or when a resident is moved to another ward, transferred to another facility, or returns to the community[152]. The communication may be delivered face-to face, in the patient's presence (bedside), in a common staff area, by letter, or telephone call.

Reported consequences of poor handover include: adverse events, lost information, misinterpretation of information, repeated tests, delayed communication of test results, medication errors, and unnecessary delays in medical diagnosis[153]. The breakdown in the transfer of information during handover is one of the most important contributing factors in serious adverse events and is a major preventable cause of patient harm[154].

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151   Australian Commission on Safety and Quality in Health Care (ACSQHC). Safety and quality improvement guide standard 6: clinical handover 2012; Available from: https://www.safetyandquality.gov.au/.

152   Op cit, Johnson M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016.

153   Op cit, **Johnson** M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016; Op cit, **Gregory** C, Brenda S. Standardizing hand-off processes 2006.

154   Op cit, **Gagnon** MP, et al. Interventions for promoting information and communication technologies adoption in healthcare professionals 2009; Op cit, **Gregory** C, Brenda S. Standardizing hand-off processes 2006.

Research has identified the following problems during handover: lack of a standardised structured format; excessive reliance on memory without reference to written documentation; poor quality medical records; and multiple clinician involvement in a resident's continuity of care[155].

Standardised structured handover requires all participants know the purpose of the handover, the essential information to communicate, and be able to deliver the information according to a structured format. The standardisation of the handover process does not mean that all handovers will be the same in all settings. Rather, they should be designed to fit the local context and the operation plan of the facility[156]. Leadership makes sure the handover keeps the format that has been agreed by making sure that staff are free to attend, attend on time and deliver the relevant information[157].

Involving residents and families in the handover event is recognised as important[158]. TOP 5 is an approach to recognize the carer's knowledge of the resident with dementia. The aim is to reduce resident's anxiety, confusion and disorientation. Staff work with each carer to identify five vital "needs" of the resident and develop strategies to manage these "needs"[159]. These include "things or situations that may cause distress to the respite resident, words or actions that will help settle and calm the resident, set routines to help keep the resident reassured, repetitive questions or recurring issues that may need specific answers, and signs or triggers

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155   **Eggins** S, Slade D. Communication in Clinical Handover: Improving the Safety and Quality of the Patient Experience. J Public Health Res. 2015;4(3):666; **Bomba** DT, Prakash R. A description of handover processes in an Australian public hospital. Aust Health Rev. 2005;29(1):68-79.

156   Op cit, Australian Commission on Safety and Quality in Health Care (ACSQHC). Safety and quality improvement guide standard 6 2012.

157   Op cit, Australian Commission on Safety and Quality in Health Care (ACSQHC). Safety and quality improvement guide standard 6 2012.

158   Op cit, World Health Organization. Communication during patient handovers 2007.

159   Clinical Excellence Commission NSW. TOP 5 research report improving the care of patients with dementia 2013-2013. 2014; Available from:
http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0006/268215/TOP5-Final-Report.pdf.

that indicate a need or a want"[160]. Analysis of the program suggest improvement in patient outcomes, safety, carer experience, and staff satisfaction[161].

Other handover checklists include: SBAR and its modified version iSoBAR[162] and PDSA[163]. The *OSSIE Guide to Clinical Handover Improvement and the Toolkit* provide guidance on implementing standardised processes for handover, tailored to a local context[164].

Actions:

This can be achieved by:

- Providers, senior managers and clinical leaders of a facility selecting, documenting, and implementing a standardised structured handover process that is relevant to the facility.

- Training staff in the process and responsibilities of handover.

- Regular monitoring and evaluation of the agreed handover processes including in collaboration with clinicians, residents and carers.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, commitment of staff to attend training and participate in the handover process, and of providers to invest in a standardised structured handover process as part of the operation plan. Another potential limitation is willingness of carers to disclose personal information relevant to handover.

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160 Op cit, Clinical Excellence Commission NSW. TOP 5 research report improving the care of patients with dementia 2014.

161 Op cit, Clinical Excellence Commission NSW. TOP 5 research report improving the care of patients with dementia 2014.

162 Porteous JM, Stewart-Wynne EG, Connolly M, Crommelin PF. iSoBAR--a concept and handover checklist: the National Clinical Handover Initiative. Med J Aust. 2009;190(11 Suppl):S152-6.

163 St John of God Health Care. Revolving Doors: effective communication in the handover of mental patients to community health practitioner (CHOCYS) 2009; Available from: https://www.safetyandquality.gov.au/wp-content/uploads/2012/03/Public-Report-on-Pilot-Study.-Revolving-Doors-Effective-communication-in-the-handover-of-mental-health-patients-to-community-health-practitioners-CHOCY.pdf.

164 Australian Commission on Safety and Quality in Health Care (ACSQHC). The OSSIE guide to clinical handover improvement 2010; Available from: https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/ossie.pdf.

Recommendation 61:

That there is flexibility in when respite residents are admitted to the facility and the length of their stay to improve access and use of respite care by carers.

Aim:

To improve access to respite care for carers through increased flexibility of services.

Rationale:

In Australia, the use of residential respite care is low in proportion to eligibility[165]. Research has identified a range of complex and interrelated factors that contribute to the use and cessation of use of this service[166]. The most noted being the lack of flexible service provision. Problems of service provision centre on timely access to a facility in the community with appropriate hours of operation that meet the needs of the respite resident including weekends, the holiday period, and time requirements of working carers.

How carers access the service in an interrelating factor. The problem being frustration in navigating multiple government and provider information sources to determine eligibility for the service, identification of service providers, managing long waiting lists, and affordability of the service[167].

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165   Op cit, Stockwell-Smith G, et al. Why carers of frail older people are not using available respite services 2010.

166   Op cit, **Shaw** C, et al. Systematic review of respite care in the frail elderly 2009; Op cit, **O'Connell** B, et al. Carers' perspectives of respite care in Australia 2012; **Phillipson** L, Jones SC, Magee C. A review of the factors associated with the non-use of respite services by carers of people with dementia: implications for policy and practice. Health and Social Care in the Community. 2014;22(1):1-12; **Phillipson** L, Cridland E, Cappetta K, prepared for Alzheimer's Australia for the 'Making Flexible Respite a Practical Reality' project funded by the Department of Social Services. Understanding the factors that contribute to 'flexibility' in the provision of respite for carers of people with dementia: A literature review. 2016; Available from: https://www.fightdementia.org.au/files/NATIONAL/documents/Flexible-Respite%20Brochure-Service-Providors.pdf; **Brownie** S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities: a systematic review. Clin Interv Aging. 2013;8:1-10; **Alzheimer's Australia**. Flexible respite services for people with dementia and their carers; information for service providers. 2016; Available from: https://www.fightdementia.org.au/files/NATIONAL/documents/Flexible-Respite%20Brochure-Service-Providors.pdf.

167   Op cit, **Alzheimer's Australia**. Flexible respite services for people with dementia and their carers; information for service providers 2016; **Shanley** C. Developing more flexible approaches to

Another influencing factor is how the service operates internally. The concern being a lack of consistency in quality of care and permanency of staff; lack of comprehensive assessments to determine respite residents' requirements for specialist services, and activities appropriate to the respite resident's interest, needs and wants; and the exclusion of respite resident's with more severe health problems from certain service providers. Improving access to residential respite care will require action at the government, research, public health and provider levels to overcome the diverse needs and concerns of those seeking residential respite care.

Actions:

This can be achieved by:

- Respite facilities operating in a flexible organisational structure whereby a clinician, such as a registered nurse, assesses the person before admission to identify their needs and determine how the facility's service can meet these needs. This is in opposition to an assessment approach that examines whether the client fits the program criteria.

- Providers increasing flexibility of respite admissions to include all days and lengths of respite stays.

- A trained workforce of sufficient staff to provide high-quality respite care.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, commitment of providers to modify their organisational plan to admit respite residents any day of the week and for any time period. Another potential limitation is that this commitment will increase staff workload or have associated costs of having to employ additional staff to process admissions, conduct assessments and provide care for respite residents.

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respite for people living with dementia and their carers. Am J Alzheimers Dis Other Demen. 2006;21(4):234-41.

During respite admission

Recommendation 62:

That information gathered on respite residents is optimised to identify how and why respite is used and to provide opportunities to prevent adverse events through enhanced national data collection on respite residents.

Aim:

To improve the information collected on respite residents to broaden the understanding on how and why respite is used and how residential respite care can be improved to mitigate adverse events.

Rationale:

Despite rapid technology developments there is limited available data relating to the use of respite care and outcomes of residents. Basic information such as length of respite stay, the type of admission (planned or emergent), the reason for admission, and movement to permanent care is not routinely collected[168]. High quality data collection and analysis is paramount to evaluate services like respite care and measure outcomes[169]. It can also assist in appropriate decision making such as allocating funds, sound, evidence based policies and reduce critical gaps in aging research[170].

Although electronic clinical information systems (databases) are already functioning in some residential facilities, many rely on time consuming paper files for patient records and medication management[171]. There is broad scope within the sector to transfer data to a

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168   Op cit, Australian Government: Productivity Commission. Trends in aged care services: some implications 2008.

169   Chen H, Hailey D, Wang N, Yu P. A review of data quality assessment methods for public health information systems. Int J Environ Res Public Health. 2014;11(5):5170-207.

170   Op cit, Chen H, et al. A review of data quality assessment methods for public health information systems 2014.

171   Op cit, O'Connell B, et al. Carers' perspectives of respite care in Australia 2012.

central registry that complies with Australia's Operating Principles for Clinical Quality[172]. The process of feedback from the central registry to residential facilities is attributed to encouraging changes in clinical practice that are associated with major improvements in health outcomes including fewer errors[173][47,48].

Actions:

This can be achieved by:

- Developing and implementing an electronic database that complies with Australia's Operating Principles for Clinical Quality.

- Training for staff and clinicians to accurate input data into the database.

- Low commitment by clinicians and other members of the care team due to factors such as data entry points not easily accessible, and the use of non-conventional definitions and terminology.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, incentive for providers to implement and maintain an electronic database, and costs associated with training members of the care team and clinicians to input data or to employ staff dedicated to data entry. Another potential lmitation is the commitment by clinicians and members of the care team to enter accurate and timely due to factors such as data entry points not easily accessible, and the use of non-conventional definitions and terminology.

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172 Australian Commission on Safety and Quality in Health Care (ACSQHC). Framework for Australian Clinical Quality Registries. 2014; Available from: https://www.safetyandquality.gov.au/wp-content/uploads/2014/09/Framework-for-Australian-Clinical-Quality-Registries.pdf.

173 **Australian Medical Association** (AMA). AMA Submission to the Department of Health. 2016; Available from: https://ama.com.au/system/tdf/documents/AMA%20Submission%20to%20the%20Department%20of%20Health%20on%20the%20Aged%20Care%20Legislated%20Review%202016-17.pdf?file=1&type=node&id=45458; **Larsson** S, Lawyer P, Garellick G, Lindahl B, Lundstrom M. Use of 13 disease registries in 5 countries demonstrates the potential to use outcome data to improve health care's value. Health Aff (Millwood). 2012;31(1):220-7.

Recommendation 63:

That respite residents are able to bring in personal and familiar items to respite care to create a familiar environment, thereby reducing adverse events.

Aim:

To reduce the potential for adverse events during the respite stay by creating a familiar environment and a sense of "home".

Rationale:

Admission to respite care can be an emotional and stressful event for both the carer and the recipient. Dependent care recipients entering respite care may suffer from stress and anxiety[174]. This may lead to adverse events as older people are particularly vulnerable when there are changes of care. The presence of personal items helps to create a sense of "home" for respite residents. The concept of "home" encapsulates both a physical dwelling and a feeling of belonging. Transition away from home to another dwelling, such as a respite care, can lead to a loss of identity, independence, control and sense of safety[175]. Residents bringing in personal possessions and pets have been linked to, maintaining a sense of identity and belonging, improving mental and physical health, and adjusting to the stay in the respite facility[176].

Actions:

This can be achieved by:

- Encouraging respite residents to bring familiar items, such as photos or cushions to the respite facility.

- Encouraging respite residents to bring pets as animal companionship to the facility.

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174   Op cit, Brownie S, et al. Factors that impact residents' transition and psychological adjustment to long-term aged care 2014.

175   Op cit, Brownie S, et al. Factors that impact residents' transition and psychological adjustment to long-term aged care 2014.

176   **Perkins** J, Bartlett H, Travers C, Rand J. Dog-assisted therapy for older people with dementia: a review. Australas J Ageing. 2008;27(4):177-82; **Kruzich** JM, Clinton JF, Kelber ST. Personal and environmental influences on nursing home satisfaction. Gerontologist. 1992;32(3):342-50.

- Generating a comprehensive list of pet-friendly residential facilities on relevant websites e.g. My Aged Care, National Disability Scheme, Alzheimer's Australia, Carers Australia.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, personal items becoming misplaced, and feasibility and cost of animals in a care facility.

Recommendation 64:

That clinicians assess respite residents on admission to determine the presence of conditions that may impact the care and health of the respite resident.

Aim:

To identify any potential health issues that may impact the care and health of the respite resident.

Rationale:

Unlike permanent residents, respite residents do not receive Health Assessments on admission. The purpose of the Health Assessment is to help identify risk factors exhibited by a respite resident that may require further health management[177]. In addition to assessing a person's health status, the Health Assessment is used to identify a broad range of factors that influence a person's physical, psychological and social functioning.

A medical practitioner must undertake the medical components of the health assessment including a personal attendance with the patient. The medical practitioner is also responsible for making clinical judgements on the matters listed in the requirements for the health assessment and for communicating the outcomes of the assessment and any recommendations to the patient.

The information collection component of the assessment can be undertaken by a suitably qualified third party, such as a practice nurse or Aboriginal and Torres Strait Islander health practitioner, provided the person is acting under the supervision of the medical practitioner and it is done in accordance with accepted medical practice.

Unlike permanent residents, respite residents do not usually see a medical practitioner until they are already sick or in need of a doctor. The number of visits to residential facilities by doctors is declining. The average number of visits per month to residential care facilities is 6.3

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177 Australian Government: Department of Health (DoH). Health assessment for people aged 75 years and older. 2014; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_75 andolder.

visits, a decrease from 8.4 visits per month in 2008[178]. This highlights the need for a

streamlined process to deliver medical care that is appropriate both in timing and in the

nature of the care given.

Actions:

- This can be achieved by:

- Aged care regulators, funders and providers strengthen the need for and completion of a

   Health Assessment, delivered during a first clinical contact timeframe.

- Having in place formal arrangements between NH providers and medical practitioners

   whose role includes administering the Health Assessment.

- Providers having in place a suitably qualified nurse or Aboriginal and Torres Strait Islander

   health practitioner to collect the information component of the Health Assessment, and

   deliver complex clinical treatments that the medical practitioner may prescribe.

- Health Assessment results be recorded on the resident's e-health file, which would be

   accessible to health care teams.

Limitations:

Potential limitations of this recommendation and barriers to implementation include,

additional costs incurred with Health Assessments for respite residents, and availability of

medical practitioners, nurses and ability of providers to put in place arrangements to conduct

Health Assessments, and provide ongoing access to clinical care.

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178   Australian Medical Association (AMA). Aged care survey report 2012; Available from:
        https://ama.com.au/sites/default/files/documents/report_on_the_AMA_aged_care_survey_0.p
        df.

Recommendation 65:

That a national, systematic and coordinated approach be taken to improve the identification, reporting, investigation and analyses of adverse events involving residential respite residents.

Aim:

To inform clinical practice and decision making for continuous quality improvement to improve the identification, reporting, investigation and analyses of adverse events involving respite residents.

Rationale:

Systematic collection and analysis of performance data is essential for monitoring the quality of patient care and identifying areas for improvement in clinical practices. Clinical registries are one mechanism of providing this function[179], of which Clinical Quality Registries (CQRs) are a specific type. They use encrypted longitudinal patient health data collected from institutions such as residential aged care services (RACS) and supplemented with out-of-institution data such as *Registry of Births, Deaths and Marriages*, and *National Coronial Information System* to evaluate quality of care by identifying gaps in best practice and benchmarking performance to generate feedback reports[180]. It is this clinical information outcome feedback loop that is the defining feature of CQRs.

Many instances have been reported where the existence of a CQR was associated with major improvements in health outcomes[181]. These improvements are attributed to encouraging changes in clinical practices that led to improved health outcomes[182]. Therefore, central to the

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179   Op cit, Australian Commission on Safety and Quality in Health Care. Framework for Australian Clinical Quality Registries 2014.

180   Op cit, Australian Commission on Safety and Quality in Health Care. Framework for Australian Clinical Quality Registries 2014.

181   Op cit, Larsson S, et al. Use of 13 disease registries in 5 countries demonstrates the potential to use outcome data to improve health care's value 2012.

182   Op cit, Larsson S, et al. Use of 13 disease registries in 5 countries demonstrates the potential to use outcome data to improve health care's value 2012.

success of CQRs is engaging doctors and other clinical professionals who deliver care, and other stakeholders.

Actions:

This can be achieved by:

-   Implementing a similar system that complies with Australia's operating principles for clinical quality.

Limitations:

Potential limitations of this recommendation and barriers to implementation include cost of developing and maintaining the registry.

Recommendation 66:

That a standard and comprehensive procedure for admission, handover and discharge from respite care is implemented so that the family, general practitioner and community services are aware of the needs of the resident during and immediately after respite care.

Aim:

To reduce adverse events related to admission, handover and discharge to residential respite and to ease transition back to the community setting.

Rationale:

As stated previously, transferring care is a vital but error prone period. During admission, handover and discharge, the care of the respite resident is transferred from the carer to the RACS and back again. Errors in handover procedures can lead to an increased risk of hospitalisation and morbidity[183] and are often due to poor communication[184]. Standardised handover communication strategies and systems processes lead to improved safety and consistency and reduces errors and are recommended by the World Health Organization (WHO)[185].

Actions:

This can be achieved by:

- RACS providers, senior managers and clinical leaders selecting, documenting, and implementing a standardised structured admission, discharge and handover process that is relevant to the facility.

- Training staff in the process and responsibilities of admission, discharge and handover.

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183 Segall N, Bonifacio AS, Schroeder RA, Barbeito A, Rogers D, Thornlow DK, et al. Can we make postoperative patient handovers safer? A systematic review of the literature. Anesth Analg. 2012;115(1):102-15.

184 Op cit, World Health Organization. Communication during patient handovers 2007.

185 Op cit, **World Health Organization**. Communication during patient handovers 2007; **World Health Organization** (WHO). The High 5s Project: Interim Report. 2013; Available from: https://www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/who-high-5s-project-reports/.

- Medical reconciliation, which involves obtaining and verifying a complete and accurate list of each patient's current medicines[186].

- Standardised medication charts[187].

- Respite residents having a standardised care plan[188].

- Developing a minimum dataset for discharge handover.

- Face-to-face communication supported by structured written material such as a checklist or computer-generated pre-populated handover sheet[189]. This could be used in conjunction with e-health records (see Recommendation 1.1).

- RACS to promote and facilitate communication between aged care staff, carers and respite residents[190].

Limitations:

Potential limitations of this recommendation and barriers to implementation include, additional costs for providers related to training staff and implementation of a comprehensive procedure that may need to be tailored according to local circumstances.

186   Op cit, **World Health Organization** (WHO). The High 5s Project 2013; **Roughead** L, Semple S, Rosenfeld E, (ASCQHS). Literature Review: medication safety in Australia 2013; Available from: https://www.safetyandquality.gov.au/our-work/medication-safety.

187   Op cit, **Roughead** L, et al. Literature Review: medication safety in Australia 2013.

188   Op cit, Edwards H, et al. Involving older people in research to examine quality of life in residential aged care 2003.

189   Queensland Government: Queensland Health. Clinical Handover (CH) a strategic options paper consultation draft. 2009; Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0032/428738/consult_draft.pdf

190   Petronio S, Kovach S. Managing privacy boundaries: health provide'rs perceptions of resident carein Scottish nursing homes. J Appl Commun Res 1997;25(2):115-31.

Post respite admission

Recommendation 67:

That a national standardised and coordinated approach to the investigation of all deaths of respite residents while in, or within seven days after discharge from respite care is implemented.

Aim:

To monitor and collect information on deaths to allow for the development of strategies to reduce preventable deaths during or immediately following a respite stay.

Rationale:

There is a dearth of knowledge on the effect, if any, of respite care on preventable mortality. If respite is associated with adverse outcomes, there is a need to determine how to prevent them and which residents are most at risk. Information on deaths during or immediately after a respite stay would support contemporary research, which is critically needed to ascertain the occurrence and extent of harm in respite care[191].

The Coroner investigates the cause and circumstances of deaths and fires and makes recommendations to reduce preventable deaths[192]. Deaths occurring during or within seven days after discharge from respite care should be reported to the Coroner to determine if there are opportunities for prevention.

Actions:

This can be achieved by:

- Recording deaths during or immediately after a respite stay in a morality database.

- Applying the rules and principles of the International Classification of Diseases (ICD) 10 to code the cause and manner of deaths.

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191   Kirk RS, Kagan JK. A research agenda for respite care: deliberations of an expert panel of researchers, advocates and funders. Washington D.C.2015; Available from: http://lx.iriss.org.uk/sites/default/files/arch_respite_research_report_web.pdf.

192   Op cit, Ibrahim JE, et al, Nature and extent of external-cause deaths 2015.

- Amending the relevant Coroners Act in each jurisdiction to make deaths occurring in respite or within seven days after discharge from respite care a reportable death.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, costs associated with implementing and maintaining a mortality database. Making deaths occurring in respite or within seven days after discharge from respite care reportable require changing the Coroners Act in every jurisdiction.

Chapter 7 Resident-to-Resident Aggression

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JOSEPH E IBRAHIM

Background

Resident-to-resident aggression (RRA) in residential aged care services (RACS) is an emergent

public health concern. It is defined as *"negative, aggressive and intrusive verbal, physical,*

sexual, and material interactions between long-term care residents that in a community

setting would likely be unwelcome and potentially cause physical or psychological distress or

harm to the recipient"[193].

RRA commonly occurs between one or more residents with dementia[194]. Due to the ageing

population, the prevalence of dementia has risen considerably in recent years[195]. Currently,

approximately 50% of RACS residents in Australia have a diagnosis of dementia[196]. The

number of people requiring aged care services and specialised dementia care is only likely to

increase with the rapidly ageing population.

Aggression is one of many behavioural and psychological symptoms of dementia (BPSD) which

are largely considered to be expressions of unmet needs[197]. RRA is expected to increase as the

population continues to age and the needs of older people become increasingly complex.

Although research on the topic is limited, a recent prevalence study from the US found nearly

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193 McDonald L, Hitzig SL, Pillemer KA, Lachs MS, Beaulieu M, Brownell P, et al. Developing a research agenda on resident-to-resident aggression: recommendations from a consensus conference. J Elder Abuse Negl. 2015;27(2):146-67.

194 Op cit, Ferrah N, et al. Resident-to-resident physical aggression leading to injury in nursing homes 2015.

195 Australian Government: Australian Institute of Health and Welfare (AIHW). Dementia in Australia 2012; Available from: http://www.aihw.gov.au/publication-detail/?id=10737422958.

196 Australian Government: Australian Institute of Health and Welfare (AIHW). Dementia among aged care residents: first information from the aged care funding instrument: aged care statistics series number 32 2011; Available from: http://www.aihw.gov.au/publication-detail/?id=10737419025.

197 Whall AL, Kolanowski AM. The need-driven dementia-compromised behavior model-- a framework for understanding the behavioral symptoms of dementia. Aging Ment Health. 2004;8(2):106-8.

1 in 5 RACS residents are involved in at least one aggressive encounter with another resident each month[198].

This research aims to develop recommendations for prevention of RRA among RACS residents in Australia through consultations with key experts and stakeholders. The recommendations were developed according to the social determinants of health framework [6] and are arranged in order of priority for implementation as indicated by participants.

Summary of recommendations

68. That government, health department, regulators, providers and health professional bodies develop national standards describing the skills mix and staffing levels required to manage the needs of residents to prevent RRA.

69. That all relevant data on incidents of aggression and assault in residential aged care services (RACS) be centrally collected in a national database and reported publically each year.

70. That current mandatory reporting requirements be extended to include all types of aggressive incidents in residential aged care (RAC), regardless of the cognitive status of residents involved.

71. That mandatory training for RAC staff be extended to include training on the fundamentals of dementia and RRA.

72. That aged care providers introduce zero tolerance policies in RACS for violence against staff, residents and visitors.

73. That the physical environment of the RACS be designed and used in a way that enables, rather than disables, residents with cognitive impairment.

74. That clear, user-friendly definitions of the spectrum of aggressive behaviours be included in mandatory reporting legislation, policy and protocol documents.

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198 World Health Organization (WHO). A conceptual framework for action on the social determinants of health: social determinants of health discussion paper 2. 2010; Available from: http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf.

75. That RAC staff adopt a person-centred care approach to new and existing residents.

76. That government agencies, advocacy groups and aged care providers develop and implement a community awareness campaign to increase the general public's understanding of dementia, its Behavioural and Psychological Symptoms, and knowledge about the preventability of aggressive incidents among older adults.

77. That RACS providers introduce policies aimed at supporting families to feel part of a comprehensive care team.

Detailed overview of recommendations

Recommendation 68:

That government, health department, regulators, providers and health professional bodies develop national standards describing the skills mix and staffing levels required to manage the needs of residents to prevent RRA[199].

Aim:

To increase staff capacity to prevent and appropriately respond to RRA incidents.

Rationale:

Currently, the Commonwealth Government has not mandated minimum staff-to-resident ratios for RACS providers. The Aged Care Act (1997) states that RACS providers must *"maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met"*. Research has found higher levels of skilled staff, such as registered nurses, in RACS is strongly associated with better outcomes for residents[200]. In addition, the Department of Health's 2012 The Aged Care Workforce report found three quarters of residential facilities reported skill shortages among staff[201]. RACS staff need to be adequately qualified and knowledgeable to be able to care for the increasingly complex health needs of RAC residents.

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199   Feedback from one organisation in the field stated that in relation to staffing and skills mix requirements to meet resident needs that additional work was underway and this would need to be incorporated into any future implementation. Specifically, the review undertaken by the University of Wollongong delivered to the sector in April 2017 and a Resource Utilisation Study exploring an alternate 'activities based' funding model. Feedback from another organisation stated that they do not support any recommendation in favour of additional regulatory standards that mandate specific approaches and inputs to care in residential aged care settings, specifically Recommendation 68 which assumes that a best practice staffing model for 'managing' resident-on-resident aggression can be developed by government, regulators and health professional bodies.

200   Horn SD, Buerhaus P, Bergstrom N, Smout RJ. RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care. Am J Nurs 2005;105(11):58-70; quiz 1.

201   Australian Government: Department of Health (DoH). National aged care workforce census and survey – the aged care workforce, 2012 – final report. 2012; Available from: https://agedcare.health.gov.au/ageing-and-aged-care-publications-and-articles-ageing-and-aged-care-reports/2012-national-aged-care-workforce-census-and-survey-the-aged-care-workforce-2012-final-report.

Actions:

This can be achieved by:

- Conducting research to determine optimal staff numbers and skills mix to provide sustainable high-quality care.

- Establishing a national standard describing the staffing levels and qualification requirements for provision of care, this could be through legislation changes, regulatory reforms or by consensus of the aged care sector.

- RACS providers adopting the changes into their policies and procedures.

- The education sector expanding the curriculum for aged care and nursing qualifications to ensure new staff are meeting the needs of the sector.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the lengthy and time-consuming process of reform. In addition, minimum staff ratios have been previously considered by Productivity Commission who found staff ratios are too rigid and will not help to address the complicated and underlying issues related to care and staffing in RACS[202]. They also found staff ratios "*could lessen incentives for providers to invest in innovative models of care […], such as through the application of technology and redesigning work practices*".

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202   Op cit, Australian Government: Department of Health (DoH). National aged care workforce census and survey 2012.

Recommendation 69:

That all relevant data on incidents of aggression and assault in residential aged care services (RACS) be centrally collected in a national database and reported publically each year.

Aim:

To enable tracking of prevalence and trends, benchmarking across the sector and development of targeted prevention strategies.

Rationale:

Currently, basic information pertaining to the circumstances and cause of the aggression incident is not routinely recorded in a centralised, national database[203]. This information is vital to gain a comprehensive understanding to the prevalence and trends of aggression in RACS. Without such information the full extent of problem is invisible. This precludes research into the topic and the development of benchmarking and targeted prevention strategies.

Actions:

This can be achieved by:

- The Commonwealth Government amending the Aged Care Act (1997) to change the reporting framework and to assign a data custodian to record and manage the data.

- Providers accurately and consistently recording and reporting all relevant information on RRA incidents to the data custodian.

- Conducting research using the information recorded in the database to gain a comprehensive understanding of aggression in RACS and to develop prevention strategies.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the lengthy and time-consuming process of legislative reform. There are also costs associated with developing the database, and training and employing staff to collect and manage. Determining

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203   Australian Government: Australian law Reform Commission. Elder abuse-a national legal response. 2017; Available from: https://www.alrc.gov.au/sites/default/files/pdfs/publications/31_may_summary_report_131_0.pdf.

the most appropriate body to act as data custodian may require extensive consultation.

Making the data publicly available may create a moral panic around RRA in RACS as it may be

seen as more dangerous than it is in reality.

Recommendation 70:

That current mandatory reporting requirements be extended to include all types of aggressive incidents in residential aged care (RAC), regardless of the cognitive status of residents involved.

Aim:

To better understand the nature and extent of RRA and develop evidence-based prevention strategies.

Rationale:

Currently under the Aged Care Act 1997 and the associated Accountability Principles 2014, a RAC provider has discretion whether or not to report an RRA incident if the perpetrating resident has been assessed as having a cognitive or mental impairment, and a behaviour management plan has been put in place within 24 hours of the alleged assault. Considering RRA commonly occurs between one or more residents with dementia[204], this use of discretion means the actual incidence of RRA in Australia is currently unknown. As the numbers of RACS residents with dementia rises it is not practical to continue to exclude these cases in reporting. Targeted prevention strategies to reduce RRA require accurate information on the incidences and the residents involved. Any prevention measures developed based on unrepresentative reported cases are likely to be ineffective for the majority of residents.

Actions:

This can be achieved by:

- The Commonwealth Government amending the Aged Care Act (1997) to extend the current reporting framework to include all types of aggressive incidents.

- RACS providers adopting the changes into their policies and procedures now and not waiting for legislative or regulatory reform.

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204   Op cit, Ferrah N, et al. Resident-to-resident physical aggression leading to injury in nursing homes 2015.

- Updating staff training modules to include additional information as required by the extended reporting framework.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the lengthy and time-consuming process of reform. The increased reporting may create an additional burden on the aged care system. Identifying who is the most appropriate body to respond to the reports of RRA; Severe Behaviour Response Team, the police, the Department of Health or WorkSafe, or another agency.

Recommendation 71:

That mandatory training for RAC staff be extended to include training on the fundamentals of dementia and RRA.

Aim:

To improve staff understanding of dementia, its behavioural symptoms and how to identify triggers to prevent RRA.

Rationale:

Currently, there is no standardised national training for RAC staff on the fundamentals of dementia and RRA. The training provided can differ greatly between providers in terms of content and teaching mode. Further, the current training modules in the majority of RACS focus on the legislative reporting requirements for RRA. They do not focus on training staff to understand, prevent and respond to RRA incidences. As the numbers of nursing of residents with dementia increases it is imperative staff understand the fundamentals of dementia and RRA in order to prevent and respond to incidences.

Actions:

This can be achieved by:

-   The Commonwealth Government amending the Aged Care Act (1997), or regulatory reform, or aged sector by consensus to voluntarily extend the current mandatory training for RAC staff to include the fundamentals of dementia and RRA.

-   RAC providers implementing the training without the need for legislative or regulatory reform and providing incentives for staff to attend.

-   Staff training and assessment of their knowledge and skills related to dementia and RRA.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the lengthy and time-consuming process of reform. The costs associated with implementing the training on a national scale and the substantial resources, such as trainers and educational

materials required. Providers may be reluctant as they would need to provide staff with leave

allowances and incentives to the training.

Recommendation 72:

That aged care providers introduce zero tolerance policies in RACS for violence against staff, residents and visitors.

Aim:

To reduce all forms of violence and promote a positive organisational culture of safety and respect.

Rationale:

Freedom from violence is a fundamental human right[205]. Residents should be free to feel safe in their own homes and staff should be able to attend work free from the fear of violence. Being a victim of violence can have dire mental and physical health consequences for residents, staff and visitors. This may include emotional and psychological trauma from being a victim or witnessing violence, physical injuries or even death. Violence at work is also a work health and safety issue. Employers are obligated to provide a safe and healthy work environment for their employees[206]. Violence in the workplace can lead to negative outcomes for the aged care system from staff losses due to injuries or a lack of staff retention.

Actions:

This can be achieved by:

- Providers conducting risk management assessment to identify hazards and risks and possible ways to control or mitigate them.

- Providers introducing and enforcing policies aimed at reducing risks, and encouraging reporting of incidents and a zero tolerance culture.

- Staff reporting all instances of violence against staff members, residents or visitor to encourage a zero tolerance culture.

205   United Nations. The Universal Declaration of Human Rights. 1948.

206   State Government of Victoria: WorkSafe Victoria. A guide for employers: preventing and responding to work-related violence. 2015; Available from: http://www.worksafe.vic.gov.au/pages/forms-and-publications/forms-and-publications/preventing-and-responding-to-work-related-violence

Limitations:

Potential limitations of this recommendation and barriers to implementation include not all risks and hazards leading to violence can be prevented and violence may always occur to some extent. Staff may be reluctant to change as reporting all forms of violence may mean more paper work for already time poor staff. To be effective, zero tolerance policies need to be supported by clear consequences that condemn violent acts. These will be difficult to implement in a RACS setting as it is the resident's home and they cannot be removed or refused service. Further, many residents have cognitive impairments and may not be comprehend the consequences of their actions. However, zero tolerance policies are an important first step towards creating organisational culture and community expectations that consider violence among residents as preventable and not an accepted occurrence in the RACS.

Recommendation 73:

That the physical environment of the RACS be designed and used in a way that enables, rather than disables, residents with cognitive impairment.

Aim:

To reduce agitation and confusion among RAC residents with dementia and prevent RRA incidents.

Rationale:

Triggers for aggression can be related to the physical environment of the RACS. For example, when all hallways and doors are identical, residents with a cognitive impairment may become lost and frustrated. Ten key dementia enabling environment principles have been developed and adopted by Alzheimer's Australia[207]. These principles aim to create a dementia friendly environment that promotes independence safety, security and comfort, allows easy access and finding your way, supports meaningful tasks and participation in daily activities[208].

Actions:

This can be achieved by:

- Providers adopting and implementing the ten dementia enabling environment principles.

- Providing incentives for providers who do implement the ten dementia enabling environment principles or potentially sanctions for those who do not.

- All new RACS that are built adhere to the ten dementia enabling environment principles.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the cost of constructing RACS to comply with the dementia enabling environment principles. Pre-

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207   The Agency for Clinical Innovation (ACI) Aged Health Network. Key principles for improving healthcare environments for people with dementia. 2014; Available from: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/280270/ACI_Key_Principles_fo r_Improving_Healthcare_Environments_for_People_with_Dementia.PDF.
208   Op cit, The Agency for Clinical Innovation (ACI) Aged Health Network. Key principles for improving healthcare environments for people with dementia 2014.

existing RACS may not be consistent with the principles and may need to be renovated which

may be costly.

Recommendation 74:

That clear, user-friendly definitions of the spectrum of aggressive behaviours be included in mandatory reporting legislation and policy and protocol documents.

Aim:

To promote accuracy and consistency in the reporting of and recognition of RRA.

Rationale:

There is not one clear, universally applied definition of RRA. This leads to confusion around what behaviour constitute RRA and therefore, what behaviours need to be reported. RRA can present in many different forms, including physical aggression (pushing another residents), verbal aggression (yelling and shouting), sexual aggression (inappropriate touching) and material aggression (taking other residents property)[209]. A clear definition of RRA needs to ensure all of the above listed forms of aggression are recognised as RRA and reported accurately. Furthermore, under the current reporting requirements, there is potential for misinterpretation of discretion not to report. This may result in incidents not being reported if the victim has a diagnosis of dementia rather than the exhibitor of aggression.

Actions:

This can be achieved by:

- Development of an appropriate definition for use in either the Australian aged care legislation, or regulatory agency standards, or by sector consensus following consultation with researchers, experts and stakeholders.

- The Commonwealth Government amending the Aged Care Act (1997) to include a definition of RRA that includes all the forms of aggression.

- Providers updating their policy documents to ensure they are consistent with the definition of RRA and they will need to educate staff about changes.

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209   Op cit, McDonald L, Hitzig SL, Pillemer KA, Lachs MS, Beaulieu M, Brownell P, et al. Developing a research agenda on resident-to-resident aggression: recommendations from a consensus conference. J Elder Abuse Negl. 2015;27(2):146-67.

Limitations:

Potential limitations of this recommendation and barriers to implementation include the

reforms may become a length and time consuming process.

Recommendation 75:

That RACS staff adopt a person-centred care approach to new and existing residents.

Aim:

To become familiar with the resident and their potential triggers or vulnerabilities for aggressive behaviour.

Rationale:

Person-centred is a service development and delivery approach that involves tailoring the RACS residents' care to their interests, abilities, history and personality[210]. Research proposes person-centred care for people with dementia has four elements: valuing people with dementia, treating people as individuals, considering the world from the perspective of a person with dementia and creating a positive social environment[211]. A randomised control trial has found the use of person-centred care in relation to hygiene resulted in a significantly decline in discomfort, agitation, and aggression among residents and staff being more gentle, verbally supportive and at ease[212]. A person-centred care approach would allow staff to better understand and predict the behaviour of residents and give them the flexibility to adjust care as needed to fit the resident.

Actions:

This can be achieved by:

- Providers adopting a person-centred care policy with practical measures that can be implemented and promoting a culture change in the facility.

- Training for staff enabling them to implement the person-centred care approach.

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210 Kim SK, Park M. Effectiveness of person-centered care on people with dementia: a systematic review and meta-analysis. Clin Interv Aging. 2017;12:381-97.

211 Brooker D. What is person-centred care in dementia? Rev Clin Gerontol. 2003;3(3):215-22.

212 Sloane PD, Hoeffer B, Mitchell CM, McKenzie DA, Barrick AL, Rader J, et al. Effect of person-centered showering and the towel bath on bathing-associated aggression, agitation, and discomfort in nursing home residents with dementia: a randomized, controlled trial. J Am Geriatr Soc. 2004;52(11):1795-804.

Limitations:

A potential limitation of this recommendation and barrier to implementation is the person-centred care approach may require greater resourcing or a greater level of training for staff. The improved documentation through the individualised care plans may be perceived by staff as onerous.

Recommendation 76:

That government agencies, advocacy groups and aged care providers develop and implement a community awareness campaign to increase the general public's understanding of dementia, its Behavioural and Psychological Symptoms, and knowledge about the preventability of aggressive incidents among older adults with dementia.

Aim:

To increase the general public's understanding of dementia and how it can relate to aggression in older people.

Rationale:

Surprisingly, there is a lack of knowledge and research on RRA[213] despite the high frequency of incidents[214]. Dementia is not well understood in the general public. The changes in the brain that occur due to the disease can result in behaviour changes such as aggression, hoarding or repetitive behaviour[215]. These changes can be distressing for family members who may be reluctant to disclose these behaviours to the RACS due to shame or fear the RACS will not admit their loved one. A public awareness campaign is needed to increase awareness that these changes are common and highly manageable.

Actions:

This can be achieved by:

- The Commonwealth Government consulting with advocacy groups and aged care providers to develop and fund a community awareness campaign.

- Advocacy groups and stakeholders promoting the awareness campaign and offering educational events.

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213   Op cit, Ferrah N, et al. Resident-to-resident physical aggression leading to injury in nursing homes 2015.

214   Australian Government: Productivity Commission. Report on Government services 2013. 2013; Available from: http://www.pc.gov.au/research/ongoing/report-on-government-services/2013/2013.

215   Brodaty H, Draper BM, Low LF. Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. Med J Aust. 2003;178(5):231-4.

- Providers communicating the information on dementia and aggression to the families of residents and prospective clients.

Limitations:

A potential limitation of this recommendation and barrier to implementation is the cost associated with running a community awareness campaign. The efficacy of a campaign is also difficult to determine.

Recommendation 77:

That RACS providers introduce policies aimed at supporting families to feel part of a comprehensive care team.

Aim:

To assist RAC staff provide better individualised care and to include families in the care of residents.

Rationale:

Family members are a valuable source of knowledge on the resident's medical and behavioural history[216]. They know the resident best and will be able to advise RAC staff and providers of possible triggers and solutions for aggression. This could assist the RAC providers and staff in developing RRA prevention strategies before the aggression arises. Family members have a vested interest in the quality of care their loved one receives and will be able to provide the RACS with valuable information to form individualised care.

Actions:

This can be achieved by:

- Providers and staff asking family members for information on the residents history and care needs at admission and involving family members in developing care plans.

- Family members ensuring they have accurate records of their loved ones medical and behaviour history.

Limitations:

A potential limitation of this recommendation and barrier to implementation is that some residents may be estranged from their families or their families may be located interstate. Meaning the families will not be able to provide information on the residents' medical and

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216   Gaugler JE. Family involvement in residential long-term care: a synthesis and critical review. Aging Ment Health. 2005;9(2):105-18.

behavioural history. Further, some families may unknowingly give inaccurate information to

the RACS about the care needs of the resident.

Chapter 8 Suicide

BRIONY MURPHY, BRIOHNY KENNEDY, LYNDAL BUGEJA, JOSEPH E IBRAHIM

Background

There are currently more than 3.5 million Australians aged 65 years and older, comprising 15% of the population[217]. This number is expected to reach close to 10 million (approximately 25% of the population) by the year 2060[218].

Approximately 7% of people aged 65 and older are currently residing in aged care. With the ageing population, the number of people with complex physical and mental health conditions requiring residential aged care services (RACS), often referred to as nursing homes, is also likely to increase. Currently, 82% of permanent residents in Australian residential aged care services are assessed as requiring high-level care[219], and over half experience symptoms of depression[220]. In addition to this, adults aged 85 years and older have the highest age-specific suicide rate in Australia (17.7 per 100,000 compared to national suicide rate of 10.9 per 100,000)[221].

The recommendations from the expert and stakeholder consultations are grouped according to the level of prevention where:

Primary prevention refers to recommendations aimed at preventing depression, suicidal ideation and suicidal behaviours before they occur.

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217 Australian Bureau of Statistics [ABS]. 3235.0 - Population by Age and Sex, Regions of Australia. Australian Bureau of Statistics, 2014.

218 Australian Bureau of Statistics [ABS]. 3222.0 - Population Projections, Australia, 2012 (base) to 2101 Australian Bureau of Statistics, 2013.

219 Australian Institute of Health and Welfare [AIHW]. Australia's health 2014. Australia's health series no14 Cat no AUS 178. Canberra: Australian Institute of Health and Welfare, 2014.

220 Australian Institute of Health and Welfare [AIHW]. Depression in residential aged care 2008-2012. Aged care statistics series no 39 Cat no AGE 73 Canberra: Australian Institute of Health and Welfare, 2013.

221 Australian Bureau of Statistics [ABS]. 3303.0 - Causes of Death, Australia. Canberra, 2015.

Secondary prevention refers to recommendations aimed at managing depression, suicidal ideation and suicidal behaviour in individuals at high risk of death from suicide.

Tertiary prevention refers to recommendations aimed at responding to suicide; improving accurate reporting of suicides; and providing care and support to family and friends who are impacted by suicide.

Summary of recommendations

Primary prevention recommendations

78. That a coordinated and multifaceted approach is taken to align residential aged care (RAC) life with community living to make the RACS a place where most people would be happy to live.

79. That a systematic, evidence-based approach is taken to increase support for residents to manage physical health issues, which includes addressing community attitudes towards physical health decline.

80. That residents be consulted in regards to their response to and preferences for the physical environment of the RACS.

81. That a greater focus be placed on identifying opportunities for improvements to resident care, safety, and quality of life through the use of technology.

82. That a national initiative be introduced to provide individual orientation and support to older adults entering the residential aged care system and at quarterly intervals during their first 24 months of residency.

Secondary prevention recommendations

83. That existing state and national suicide prevention frameworks are expanded to include priorities for older adults and those residing in institutional settings.

84. That all RACS residents are regularly screened for depression using a standardised valid assessment tool.

85.   That RACS staff undergo regular education and training in suicide prevention.

86.   That RACS residents have better access to mental health services which includes allied

        and medical specialists.

Tertiary prevention recommendations

87.   That a systematic and coordinated approach be taken to improve the identification,

        investigation, and reporting of suicides among RAC residents.

88.   That family members, staff, and other residents receive appropriate support following

        the suicide of a resident.

Detailed overview of recommendations

Primary prevention recommendations

Recommendation 78:

That a coordinated and multifaceted approach is taken to align residential aged care (RAC) life with community living to make the RACS a place where most people would be happy to live.

Aim:

To improve the quality of RAC life for current residents, improve the perception of RAC life for prospective residents, and increase public confidence in the aged care system.

Rationale:

A key stressor identified among approximately one third (29.8%) of RAC residents who died from suicide was discontentment with RAC life[222]. This is a modifiable risk factor. The aged care system in Australia is moving towards a person-centred approach, placing a greater emphasis on customer service than ever before. By making the RACS a more desirable place to live, and communicating the quality of RAC life to the community, we can improve public confidence in the system; reduce the fear and anxiety that accompanies the transition from independent living to admission to a RACS[223]; and reduce suicidal ideation and suicidal behaviours among residents who may be at risk of suicide[224].

Actions:

This can be achieved by:

- Staff continuing to work one-on-one with individual residents to ensure that the transition from independent living to RAC life is as smooth as possible, and reflects their lifestyle and care quality in the community as much as is possible and/or desired.

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222   Opc cit, Murphy B, et al. Suicide among nursing home residents in Australia: A national population-based retrospective cohort study. [Under review].

223   Loebel JP, Loebel JS, Dager SR, Centerwall BS, Reay DT. Anticipation of nursing home placement may be a precipitant of suicide among the elderly. J Am Geriatr Soc. 1991;39(4):407-408.

224   Mezuk B, Lohman M, Leslie M, Powell V. Suicide Risk in Nursing Homes and Assisted Living Facilities: 2003-2011. Am J Public Health. 2015;105(7):1495-1502.

- Providers ensuring that how they present themselves to the community is an accurate representation of RAC life.

- Policy makers developing a campaign to promote the continuous improvement and high quality of life in Australian residential aged care services to increase public confidence in the system.

Limitations:

Potential limitations of this recommendation and barriers to implementation include funding and public resistance to change. Public awareness campaigns are expensive, and would likely result in significant on-costs to either residents or taxpayers. Furthermore, it may be difficult to change deeply ingrained community attitudes about ageing and aged care.

Recommendation 79:

That a systematic, evidence-based approach be taken to increase support for residents to manage physical health issues, and which includes addressing community attitudes towards physical health decline.

Aim:

To improve resident, family, and community understanding and expectations of physical health decline in old age, and provide access to appropriate support services.

Rationale:

The majority (86.5%) of RACS residents who died from suicide suffered from one or more types of physical health issues, and health deterioration was the most common stressor (79.4%)[225]. RACS residents are likely to suffer from both physical and mental health conditions, and require additional support to effectively manage these conditions and enable them to experience a high quality of life[226]. We often fear ageing, illness and being placed in a RACS because we assume that this automatically equates to a poor quality of life. However, in reality, most health issues are manageable with access to the right services and treatments. Increasing resident access to these services and support for managing physical and mental health issues, and addressing community attitudes towards physical health decline may assist in decreasing suicides associated with health deterioration.

Actions:

This can be achieved by:

- Providers addressing both the resident and their family's expectations of how the resident's health conditions will impact on their day-to-day lives and how this can be appropriately managed to ensure a greater quality of life.

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225   Op cit, Murphy B, et al. Suicide among nursing home residents in Australia 2017.
226   Sartorious N. Comorbidity of mental and physical diseases: a main challenge for medicine of the 21st century. Shanghai Arch Psychiatry. 2013;25(2):68-69.

- Policy makers ensuring adequate services are available to offer emotional and psychological support to residents in regards to their changing health and abilities.

- Policy makers developing a public health campaign to improve understanding of disease progression and health outcomes in old age, and increase awareness of management and treatment options to improve outlooks on declining health.

- Researchers conducting qualitative research to examine resident, family, and community attitudes towards declining health.

Limitations:

Potential limitations of this recommendation and barriers to implementation include funding, resources, and resistance to change. Similar to Recommendation 1.1, this recommendation would require a public awareness campaign resulting in costs to residents and/or taxpayers, and it may prove difficult to change community attitudes about physical health decline and end-of-life care. Furthermore, this would require integration of health professionals (e.g. physiotherapist) into aged care system, which has its own set of potential barriers (see Recommendation. 2.4.).

Recommendation 80:

That residents be consulted in regards to their response to and preferences for the physical environment of the RACS.

Aim:

To improve the overall mood and quality of life of residents through tailoring the physical environment to individual lifestyle and choices, and involving residents in the design process.

Rationale:

The relationship between mood and physical environment is well documented[227]. Considering the majority of residents who died from suicide suffered from a mood disorder (66.0%)[228], it is important to consider how we can improve the physical environment to improve residents' affect and quality of life, and prevent suicides in this setting[229]. By consulting with residents about their response to the physical environment and preferences, this can also make them feel more at home, more valued, and more integrated into the RACS community. This may also have the effect of reducing transition anxiety, and make adjusting to RACS life easier for new residents.

Actions:

This can be achieved by:

- Staff consulting with residents prior to admission or on admission on the layout and design of their own room.

- Providers making modifications to the RACS environment as required/appropriate, including providing opportunities for residents to request changes/upgrades to the environment.

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227 Woo J-M, Postolache TT. The impact of work environment on mood disorders and suicide: Evidence and implicationsint. J Disabil Hum Dev. 2008;7(2):185-200.

228 Op cit, Murphy B, et al. Suicide among nursing home residents in Australia 2017.

229 Reiss NS, Tishler CL. Suicidality in nursing home residents: Part I. Prevalence, risk factors, methods, assessment, and management. Prof Psychol Res Pr. 2008;39(3):264-270.

- Policy makers providing funding and incentives to enable providers to involve residents in the design process.

- Researchers conducting qualitative research in an Australian RACS setting examining residents responses to the physical environment, and the impact of being consulted on the physical design of their own space or communal spaces in the facility.

Limitations:

There are a number of practical barriers to the implementation of this recommendation. Most RACS residents have dementia or cognitive impairment, so it may be difficult for residents to convey their preferences, and difficult for staff to interpret residents responses to the physical environment. Furthermore, the physical environment of the RACS is usually designed in such a way as to maximise resident safety so it may not be advisable to change some aspects.

Recommendation 81:

That a greater focus be placed on identifying opportunities for improvements to resident care, safety, and quality of life through the use of technology.

Aim:

To improve resident care, safety, and quality of life through the utilisation and application of technology.

Rationale:

Technology can increase efficiency in care processes, improve communication across the health network, maintain social connectedness, and assist in day-to-day activities. Isolation and loneliness was identified as a key stressor in over 40% of suicides among RAC residents in Australia[230]. Basic access to technology such as free Wi-Fi has the potential to reduce feelings of loneliness and isolation by providing residents the ability to stay connected to family and friends or even develop new connections.

Actions:

This can be achieved by:

- Providers ensuring access to free Wi-Fi for every resident.

- Community volunteer program connecting young people with RAC residents to learn from one another and teach computer literacy.

- Policy makers engaging with technology and innovation sector to identify opportunities for application to the aged care system.

- Policy makers providing rebates and creating incentives for providers to promote the use of technology in RACS.

Limitations:

Potential limitations of this recommendation and barriers to implementation include funding and practical issues. For example, once opportunities to improve resident care and safety

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230   Op cit, Murphy B, et al. Suicide among nursing home residents in Australia 2017.

through the use of technology are identified, it could be expensive for RAC providers to

purchase the technology for use in their RACS. Some of the practical barriers include that

older adults may find it difficult to learn to use new technology, and may become vulnerable

to cyber-attacks or internet fraud.

Recommendation 82:

That a national initiative be introduced to provide individual orientation and support to older adults entering the residential aged care system and at quarterly intervals during their first 24 months of residency.

Aim:

To provide a mechanism for assisting new residents to adjust to RAC life, and a checkpoint system to monitor resident's health, mood, and satisfaction throughout their residency.

Rationale:

Just over 10% of suicides among RAC residents occurred during their first 30 days of residency, and the incidence of suicide gradually increased from then up to 2 years of residency[231]. Adjustment to RAC life can be difficult, and residents may experiences changes along the way that impact on their quality of life in the RACS. It is important therefore, that not only are residents oriented and given individual support on admission to the RACS, but also that there be regular "checkpoints", where the resident is consulted to see whether they are having any difficulties and how these can be addressed. This would also provide staff an opportunity for early intervention if the resident has experienced a change in their demeanour, and may be experiencing suicidal ideation. This would also reduce transition anxiety and make adjusting to RACS life easier for residents, and may also reduce feelings of isolation and loneliness if they can make a connection with someone early on.

Actions:

This can be achieved by:

- Policy-makers developing and implementing a national program or initiative to support residents on admission and throughout their residency including recruitment campaign, incentives, and training for volunteers.

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231   Op cit, Murphy B, et al. Suicide among nursing home residents in Australia 2017.

- Providing additional support for existing volunteer-based programs to expand the scope of their work.

Limitations:

Potential limitations of this recommendation and barriers to implementation include resources, time, and practical issues. RAC staff are already time-poor and may not be able to provide individual orientation and support to residents in addition to their existing duties. Alternatively, additional resources would be required for volunteers or social workers to provide this service, and to ensure they have the appropriate qualifications. Finally, some residents who view themselves as independent may not want or need these high-levels of support.

Secondary prevention recommendations

Recommendation 83:

That existing state and national suicide prevention frameworks be expanded to include priorities for older adults and those residing in institutional settings.

Aim:

To recognise and address the problem of older adult suicide and its complexities in an aged care residential environment.

Rationale:

Older adults have one of the highest age-specific suicide rates in Australia[232], and are typically more likely to die from suicidal behaviour compared to younger populations who engage in self-harming behaviours[233]. It is important that this age group is acknowledged as a high-risk group and a priority for suicide prevention initiatives. Furthermore, older adults living in residential aged care represent a unique group for suicide prevention initiatives due to their high rate of mental health disorders, reduced physical capabilities, and 24 hour care supervision. Therefore, suicide prevention initiatives should take into account the individual, incident-level, and organisational risk factors identified through this research.

Actions:

This can be achieved by:

- Policy makers (including federal and state government departments) engaging in consultation with researchers and peak bodies in suicide prevention to develop targeting and evidence-based strategies to prevent suicide among RAC residents.

Limitations:

Potential limitations of this recommendation and barriers to implementation include resources and community will. Some may argue the relatively small number of deaths would

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232   Op cit, Australian Bureau of Statistics. Causes of Death, Australia 2015.
233   Conwell Y, Duberstein PR, Cox C, Herrmann J, Forbes N, Caine ED. Age differences in behaviors leading to completed suicide. Am J Geriatr Psychiatry. 1998;6(2):122-126.

make addressing this a low priority. The contrary view is that suicide may be the 'tip of the iceberg' as an indicator of unmet mental health needs. See Recommendation 2.2.

Recommendation 84:

That all RACS residents are regularly screened for depression using a standardised valid assessment tool.

Aim:

To improve identification, treatment, and support for depression among older adults residing in residential aged care.

Rationale:

Although not all people with depression are suicidal or engage in suicidal behaviours, a large proportion of RAC residents who died from suicide had a diagnosed mood disorder, including depression (66.0%)[234]. Furthermore, depression can often go undetected, particularly among older adults who are at high risk of suicide[235]. Regular screening can assist early identification of depression and initiate appropriate actions to manage and treat depression, and reduce the risk of suicide. The standard assessment tool for depression screening is the Cornell scale which has recently been assessed for use among RAC residents[236], and a shorter scale developed[237].

Actions:

This can be achieved by:

- Staff (such as nursing or general practitioners) conducting depression screening of all residents within two weeks of their admission, and again at regular quarterly intervals, or as required.

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234   Op cit, Murphy B, et al. Suicide among nursing home residents in Australia 2017.

235   Fiske A, Wetherell JL, Gatz M. Depression in Older Adults. Annu Rev Clin Psychol. 2009;5: 363-389.

236   Jeon YH, Li Z, Low LF, Chenoweth L, O'Connor D, Beattie E et al. The Clinical Utility of the Cornell Scale for Depression in Dementia as a Routine Assessment in Nursing Homes. Am J Geriatr Psychiatry. 2015;23(8):784-793.

237   Jeon YH, Liu Z, Li Z, Low LF, Chenoweth L, O'Connor D et al. Development and Validation of a Short Version of the Cornell Scale for Depression in Dementia for Screening Residents in Nursing Homes. Am J Geriatr Psychiatry. 2016;24(11):1007-1016.

- Providers ensuring staff are appropriately trained in how to conduct depression screening, and how to interpret results and initiate appropriate follow up responses.

- Providers ensuring that procedures are in place to follow up on the results of depression screening to ensure the resident received appropriate support and treatment and follow up screening.

- Policy makers implementing new depression screening policy and mandating that depression screening occur within two weeks of admission to the RACS, and at regular quarterly intervals, or as required for all residents.

Limitations:

Potential limitations of this recommendation and barriers to implementation include time, resources, and practical issues. Administration of the assessment tool takes time to perform, especially if required for all residents on admission and at follow-up intervals. If depression is detected and diagnosed, resources would be required to provide follow-up treatment and management. Finally, screening every resident for depression on admission may convey a negative message to prospective residents and their families that depression and suicide is expected or understandable in the RAC environment.

Recommendation 85:

That RACS staff undergo regular education and training in suicide prevention.

Aim:

To improve staff awareness of suicide risk factors and behaviours, and ability to implement appropriate prevention strategies.

Rationale:

Over half (52.5%) of RACS residents who died from suicide had expressed written or verbal intent to self-harm prior to the incident[238]. Although these expressions of intent are not always explicit, this does represent a 'red flag' and an opportunity for staff members, or family members to intervene. If staff members are equipped with the information and tools they need, they may be able to better identify residents at-risk of suicide and help to provide them with the appropriate support. Educating staff about suicidal behaviours and suicide prevention strategies specific to older adults residing in aged care services would help to increase awareness of suicide among older adults in general; improve identification of residents at-risk; and improve staff responsiveness to suicide risk[239].

Actions:

This can be achieved by:

- Staff meeting their obligations for attending training and education sessions on suicide prevention.

- Providers offering access to suicide prevention education and training sessions as part of the staff members' professional development.

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238   Op cit, Murphy B, et al. Suicide among nursing home residents in Australia 2017.

239   Chauliac N, Brochard N, Payet C, Duclos A, Terra JL. How does gatekeeper training improve suicide prevention for elderly people in nursing homes? A controlled study in 24 centres. Eur Psychiatry. 2016;37:56-62.

- Policy makers working with Universities and TAFE to develop and implement a national mandatory program incorporating suicide prevention education and training into the aged care qualification curriculum.

- Researchers developing evidence-based training modules specific to the Australian aged care setting.

Limitations:

Potential limitations of this recommendation and barriers to implementation include funding, resources, and time. This initiative requires investment to implement on a national scale, and would require resources such as trainers and educational materials. Effort would need to be directed to supporting staff with leave allowances and incentives to attend the training.

Recommendation 86:

That RACS residents have better access to mental health services which includes allied and medical specialists.

Aim:

To ensure that RAC residents are able to access appropriate services for all physical and mental health issues as required.

Rationale:

The majority of RAC residents who died from suicide suffered from physical (86.5%) or mental illness (75.9%), and health deterioration were identified as key stressors in almost 80% of cases[240]. Improved access to allied and mental health specialists would make the referral process easier and more reliable, reducing pressure on RAC staff; improve identification, diagnosis, and treatment of physical and mental illness; and address underlying causes of depressive symptoms and suicidal ideation.

Actions:

This can be achieved by:

- Policy makers and providers reviewing current availability of allied and mental health services and potential barriers to providers, staff accessing these services on behalf of residents.

- Policy makers creating new service, or implementing new systems that increases access to allied and mental health specialists for RAC residents.

Limitations:

Potential limitations of this recommendation and barriers to implementation include funding, resources, and community will. One of the key issues for implementing such a recommendation is determining how the initiative would be funded. This recommendation would also require the support of industry partners to ensure health professionals are willing

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240   Op cit, Murphy B, et al. Suicide among nursing home residents in Australia 2017.

and able to work in a RAC environment. This would be a substantial endeavour and would

therefore require Government support.

Tertiary prevention recommendations

Recommendation 87:

That a systematic and coordinated approach be taken to improve the identification, investigation, and reporting of suicides among RACS residents.

Aim:

To improve the quality and availability of data on suicides among RAC residents to inform evidence-based prevention strategies.

Rationale:

Suicides in any population may be underreported or misclassified[241] [18]. This is particularly relevant among older adults, who are likely to engage in more passive forms of suicidal behaviour due to physical limitations. It is important to have access to high quality data on suicides to understand the true extent of the problem and ensure targeted prevention strategies are prioritised.

Actions:

This can be achieved by:

- Staff documenting suicidal behaviours and reporting suspected suicides to the provider or directly to health professionals as soon as possible.

- Providers recording details of incidents of self-harm and suicidal behaviour within their facilities, and ensuring suspected suicides are notified to Coroners in accordance with coronial legislation.

- Policy makers consider introducing standardised policies and procedures for the investigation of suicide of older people in aged care setting to gather the data that would inform future prevention strategies.

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241   De Leo D, Dudley MJ, Aebersold CJ, Mendoza JA, Barnes MA, Harrison JE et al. Achieving standardised reporting of suicide in Australia: rationale and program for change. Med J Aust. 2010;192(8):452-456.

Limitations:

Potential limitations of this recommendation and barriers to implementation include finding, resources, time, and resistance to change. Firstly, the recommendation would require the support of Government, legal and regulatory authorities to implement effectively. Secondly, the thorough investigation of suicides in this population would require a combination of funding, resources, and time. Finally, there may be some resistance to change, as the stigma around suicide which affects accurate reporting still remains.

Recommendation 88:

That family members, staff, and other residents receive appropriate support following the suicide of a resident.

Aim:

To provide post-intervention support to individuals exposed to suicide of a RAC resident.

Rationale:

Bereavement from suicide is suggested to be different from any other type of grief[242]. It can be associated with feelings of guilt, anger, betrayal, or understanding and even relief. It is important to remember that in the case of RAC residents; it is not only their family who are impacted by their death, but the staff and other residents as well, who they may have lived with for some time. Research has shown that individuals who have been exposed to suicide are at greater risk of engaging in suicidal behaviour themselves[243]. It is important to ensure that anyone affected by a resident's death by suicide received appropriate support and counselling to work through their feelings and reactions and assist their recovery.

Actions:

This can be achieved by:

- Staff observing other residents, particularly those who were close to the deceased, following their death, to monitor their reactions and make referrals to a grief counsellor where appropriate.

- Staff being self-aware of their own reactions to the death, and recognising the need to seek help.

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242   **Jordan** JR. Is suicide bereavement different? A reassessment of the literature. Suicide Life Threat Behav. 2001;31(1):91-102; **Tal Young** I, Iglewicz A, Glorioso D, Lanouette N, Seay K, Ilapakurti M et al. Suicide bereavement and complicated grief. Dialogues in Clinical Neuroscience. 2012;14(2):177-186.

243   Pitman AL, Osborn DPJ, Rantell K, King MB. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ Open. 2016;6.

- Providers offering the services of a grief counsellor or similar to the deceased's family, and all staff members and residents of the facility.

- Policy-makers providing funding or incentives to ensure that providers can offer appropriate services to family, staff and residents.

Limitations:

Potential limitations of this recommendation and barriers to implementation include resources and time. Suicide is a rare event, and due to the small number of deaths in the RAC environment, the resources required to implement this recommendation may not be readily available for this group. There are established grief and trauma counsellors available – so their roles and responsibilities will need to be considered. There are also practical issues involved in implementing this recommendation, including determining who would provide the counselling, ideally on-site for the residents, and for how long post-suicide it would be offered to family, staff and residents.

Chapter 9 Unexplained Absence

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Background

The term 'unexplained absence' is a specific regulatory term used in Australia to describe an event where a resident of a residential aged care service (RACS) leaves without informing caregivers, and the whereabouts of the resident is unknown. Within the international literature, terms such as 'wandering', 'elopement' or 'absconding' are commonly used to describe this event[244].

Unexplained absence of RACS residents has been described as one of the most challenging issues related to the care of older people[245] especially in residents with dementia[246]. Risk-factors for an unexplained absence include memory and recall deficits, disorientation, poor visuospatial ability and expressive language deficits[247]. However, residents may also purposefully exit the facility to, for example, visit family and friends[248].

Preventing residents' from leaving facility RACS poses challenges for the care provider to be able to balance issues of safety with independence. This issue will become more acute as the population ages[249] with most countries now facing a rapidly aging society. By 2050 the global

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244 Op cit, Woolford MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017;

245 Op cit, **Woolford** MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017; **Rowe** MA, Vandeveer SS, Greenblum CA, List CN, Fernandez RM, Mixson NE, et al. Persons with dementia missing in the community: is it wandering or something unique? BMC Geriatr 2011;11:28.

246 Hodgkinson B, Koch S, Nay R, Lewis M. Managing the wandering behaviour of people living in a residential aged care facility. Int J Evid Based Healthc 2007;5(4):406-36.

247 Boltz M. Wandering and elopement: a comprehensive approach. Assisted Living Consult 2006;17:26.

248 Stefanacci RG, Haimowitz D. Elopement - missing in action. Geriatr Nurs 2013;34(3):235-8.

249 Aud MA. Dangerous wandering: elopements of older adults with dementia from long-term care facilities. Am J Alzheimers Dis Other Demen 2004;19(6):361-8.

population of those 80 years and older will increase five-fold, reaching 379 million[250]. The increase in an ageing population will undoubtedly result in an increase in the number of persons entering RACS.

Estimates of the incidence of unexplained absence in internationally published literature vary with studies suggesting that 11% to 31% of older adults will have an unexplained absence while they are residents of RACS[251]. In the Australian context, the Commonwealth Department of Health received 1,182 notifications of unexplained absences of RACS residents in 2015-2016[252]. This equates to a rate of 0.62% (based on 192,000 operational places in residential aged care in 2015[253]. However, this rate is likely to be an under-estimate because the notifications include only those reported to the police.

Management of unexplained absences poses a challenge for caregivers in RACS in terms of containment which is usually addressed by locking doors and securing the environment with security alarms[254].

Considering the possible risks, both in terms of injury and loss of independence, successful management of unexplained absences takes on an immense importance.

The recommendations are grouped into the following categories:

Pre-admission to RACS

During the persons stay in RACS

250   United Nations: Population Division. World populations ageing: 1950-2050. 2001; Available from: http://www.un.org/esa/population/publications/worldageing19502050/.

251   Op cit, **Boltz** M. Wandering and elopement 2006; **Kopetz** S, Steele CD, Brandt J, Baker A, Kronberg M, Galik E, et al. Characteristics and outcomes of dementia residents in an assisted living facility. Int J Geriatr Psychiatry 2000;15(7):586-93; **Australian Government**: Department of Health (DoH). 2015–16 Report on the operation of the Aged Care Act 1997. Available from: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12_2016/2015-16_report-on-the-operation-of-the-aged-care-act-1997.pdf.

252   Op cit, Australian Government: Department of Health. 2015–16 Report on the operation of the Aged Care Act 1997.

253   Australian Government: Australian Institute of Health and Welfare (AIHW). Aged care services and places. 2017; Available from: http://www.aihw.gov.au/aged-care/residential-and-community-2011-12/services-and-places/

254   Op cit, **Hodgkinson** B, et al. Managing the wandering behaviour of people living in a residential aged care facility 2007; **Matteson** MA, Linton A. Wandering behaviors in institutionalized persons with dementia. J Gerontol Nurs 1996;22(9):39-46.

When there is an unexplained absence event

Post-unexplained absence event

Summary of recommendations

Pre-Admission to Residential Aged Care

89. That an agreed definition is formulated of unexplained absence is applied universally.

     (Part 1): That a national human rights and evidence-based approach is developed to integrate technology that supports residents in being able to leave the residential aged care service (RACS) safely.

     (Part 2): That documented informed consent is obtained from the resident or their appointed substitute decision-maker, prior to any external tracking device or method application, irrespective of the resident's capacity, their wishes and preferences are considered.

90. That national guidelines are developed that define accountability and responsibility of enduring power of attorney and guardianship providers.

91. That there is a bi-annual forum for the police, search and rescue teams, and the residential aged care sector (providers, staff and residents) in which information, such as problem areas and emerging trends of unexplained absence, death, and injury are shared and discussed.

92. The construction of new RACS be guided by contemporary research on building design that promotes the perception of freedom and independence, and which may reduce the likelihood of unexplained absence attempts and events.

     (Part 1): That a coordinated and multifaceted approach is taken to align existing aged care training programs with government policy initiatives that support holistic and person-centered duty of care, and that promote positive values of the older person.

(Part 2): That residents are offered activities that engage and enhance their quality of life and promote the RACS as a place where most people would be happy to live.

During Residential Aged Care Stay

93. That an evidence-based approach is taken to the development of a risk assessment tool and risk prevention strategies that identifies residents at-risk of leaving RAC without informing care-givers.

94. That there is a national approach to risk assessments and the development of risk prevention strategies that are agreed with the resident or their appointed power of attorney.

95. That any transfer report between health and aged care providers follows a standardised approach to ensure optimal information is exchanged/shared between providers in regards to any risk of unexplained absence.

96. That within the first 24 hours of a resident's admission, RAC staff conduct an initial assessment to identify residents at-risk of unexplained absence and document the specific strategies to be undertaken. A final review and recommendations should be conducted at 7 days following admission.

97. That any behavioural symptoms leading to an attempt to, or successfully leaving the RACS, without informing caregivers, exhibited by residents should act as a trigger for direct care staff to assess and consider whether there are any unmet needs of the resident, and develop interventions to prevent occurrence or re-occurrence.

When there is an unexplained absence event

98. That there is a national approach to minimum standards for all RACS to have an easily accessible search and rescue plan to support staff and family in responding quickly and systematically to an unexplained absence event.

99. That RAC staff undergo regular training and practice in reporting procedures to ensure they are able to promptly and appropriately respond to an unexplained absence incident.

100. That a simple and easily readable form for providers to complete and give to search and rescue teams and police is developed. The form must be embedded into the resident assessment and care plans, identifying the resident's history and social profile, with addresses where the resident may have likely gone, and information on the unexplained absence event.

Post-unexplained absence event

101. That federal, state and territory governments establish a national register which is comprehensive, coordinated and requires mandatory reporting of all unexplained absences occurring in RACS.

102. That the national register have a standardised approach to the recording of key individual, organisational, environmental determinants, and search and rescue information, relating to variability of unexplained absence event; and that this information is regularly analysed to identify trends and risk-factors for injury and death. The register is also to include post-rescue information to support the development of prevention strategies.

103. That current approaches to the investigation of all deaths of a RAC resident following an unexplained absence are nationally standardized.

104. That if a resident dies within seven days of being found after an unexplained absence that this is reported to and recorded on a national database such as National Coronial Information System.

Detailed overview of recommendations

Pre-event unexplained absence event

Recommendation 89:

That an agreed definition is formulated of unexplained absence that is applied universally.

Aim:

To decrease the complexity and misinterpretation that arises in the absence of a universal definition; and to support a standardised approach to information collection on unexplained absences.

Rationale:

An operational definition of an 'unexplained absence' that is universally applied in the aged care sector is fundamental. There is no universal definition of an unexplained absence[255], and as such, a number of different terms are used across the aged care sector and the published literature to describe the event. In particular, 'wandering', elopement', 'absconding', and 'missing' are common and interchangeably used terms, each aiming to describe the same but also different event[256].

Problems arise when multiple terms are applied, especially when the terms have various meanings and interpretations. For example, the term 'wandering' is widely used to describe behaviour of cognitively impaired RAC residents who move about inside of the facility aimlessly without a fixed course aim or direction towards a fixed goal[257]. The term is also used to describe RAC residents who go outside of the facility[258], as well as those who are cognitively

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255 Lester P, Garite A, Kohen L. Wandering and elopement in nursing homes. Ann Longterm Care. 2012;20(3):32-6.

256 Op cit, Woolford MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017;

257 Op cit, **Hodgkinson** B, et al. Managing the wandering behaviour of people living in a residential aged care facility 2007.

258 Beattie ER, Song J, LaGore S. A comparison of wandering behavior in nursing homes and assisted living facilities. Res Theory Nurs Pract. 2005;19(2):181-96.

intact, or for purposeful wandering that has positive outcomes such as fulfilling exercise needs and sensory stimulation[259].

Similar confusion arises with the use of the terms elopement and absconding. Both terms are commonly used to describe RAC residents who leave the facility without informing caregivers[260]. However, these terms are also used for any-age patients in psychiatric facilities and hospital settings; and imply that the person 'escapes' or 'runs-away'[261]. The Australian Institute of Health and Welfare[262] defines the Australian aged care system as a place which provides a range of services that support older people with day-to-day tasks or health care support. Therefore, terms such as elopement and absconding are misleading and not appropriate for the RACS population.

It is well reported in the literature that the absence of a consistent definition has impacted our understanding of unexplained absence events[263]. A universal definition will support common understanding, as well as data collection efforts.

Actions:

This can be achieved by:

- Developing a definition, in collaboration with experts from research, public health, search and rescue services and the aged care sector.

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259   Op cit, Boltz M. Wandering and elopement 2006.

260   Op cit, **Hodgkinson** B, et al. Managing the wandering behaviour of people living in a residential aged care facility 2007; Op cit, **Boltz** M. Wandering and elopement 2006; Op cit, Lester P, et al. Wandering and elopement in nursing homes 2012.

261   **Muir-Cochrane** E, Mosel K, Gerace A, Esterman A, Bowers L. The profile of absconding psychiatric inpatients in Australia. J Clin Nurs. 2011;20(5-6):706-13; **Stewart** D, Bowers L. Absconding and locking ward doors: evidence from the literature. J Psychiatr Ment Health Nurs. 2011;18(1):89-93; **Dickens** G, Campbell J. Absconding of patients from an independent UK psychiatric hospital: A 3-year retrospective analysis of events and characteristics of absconders. J of Psychiatr Ment Health Nurs. 2001;8(6):543-50.

262   Australian Government: Australian Institute of Health and Welfare (AIHW). Aged Care in Australia. 2017; Available from: http://www.aihw.gov.au/aged-care/residential-and-community-2011-12/aged-care-in-australia/.

263   Op cit, **Woolford** MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017; Op cit, **Lester** P, et al. Wandering and elopement in nursing homes 2012.

- Local and national government policies and guidelines; and individual services, universally

   applying the term in all relevant documents.

- Making a clear distinction between residents who move (wander) within a facility and

   outside, as these two groups have been identified to differ.

Limitations:

A potential limitation of this recommendation and barrier to implementation includes

collaboration of the government, experts and aged care sector to develop definitions, and

include them in local and national government policies and guidelines, and individual services.

Recommendation 89 Part 1 and 89 Part 2 are considered together.

Recommendation 89 Part 1:

That a national human rights and evidence-based approach is developed to integrate technology that supports residents in being able to leave RACS safely.

Recommendation 89 Part 2:

That documented informed consent is obtained from the resident or their appointed substitute decision-maker, prior to any external tracking device or method application, irrespective of the resident's capacity, their wishes and preferences are considered.

Aim:

To integrate evidence-based technology into the RACS setting to assist in the management of unexplained absences in a way that promotes resident safety and independence.

Rationale:

The decision of whether to allow residents to go outside independently poses substantial problems for caregivers. Fear of the outside environment by caregivers leads to reservations in consenting to an 'open door' policy in which residents freely go outside the boundaries of the RACS. Once outside, care staff fear that the resident may become lost or enter into unsafe areas and be harmed[264]. The level of a resident's physical and cognitive impairment are additional barriers for care providers. This is particularly intensified in residents with dementia whose caregivers are well aware of the possible risks of disorientation and becoming lost[265]. Injury and death may occur following an unexplained absence[266], so this uncertainty about residents' safety strongly influences care providers' decisions on whether to allow residents to go outside independently.

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264 Pot AM, Willemse BM, Horjus S. A pilot study on the use of tracking technology: feasibility, acceptability, and benefits for people in early stages of dementia and their informal caregivers. Aging Ment Health. 2012;16(1):127-34.

265 Op cit, Pot AM, et al. A pilot study on the use of tracking technology 2012.

266 Op cit, Pot AM, et al. A pilot study on the use of tracking technology 2012.

For these reasons the management of unexplained absences largely includes regular and /or permanent supervision; locked and security alarmed doors; restraints, or psychotropic drugs[267]. All of which reduce mobility and independence rather than promote it, and are likely to have negative impacts on a resident's life[268]. In particular, their self-esteem, physical and mental well-being and autonomy are negatively impacted by reduced independence[269]. Technology, such as Global Positioning System [GPS] tracking devices, may offer a solution. Technology may be helpful in supporting residents to go outside independently while at the same time RAC care staff are able monitor the resident's location[270].

Whilst technology can have an important role in the promotion of safety and independence, researchers caution that it should only be used to support the resident, not replace the care provider[271]. Furthermore, electronic tracking devices must be reliable; and their feasibility and acceptability by the resident is paramount. Residents who have the capacity, or where applicable their appointed legal guardian, need to be given the choice of whether to use tracking devices, as some may feel controlled or uncomfortable with its use[272]. Given that each resident has different physical and cognitive impairments, as well as varying beliefs

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267   Op cit, **Pot** AM, et al. A pilot study on the use of tracking technology 2012; **Siders** C, Nelson A, Brown LM, Joseph I, Algase D, Beattie E, et al. Evidence for implementing nonpharmacological interventions for wandering. Rehabil Nurs. 2004;29(6):195-206; **Tilly** J, Reed P. Falls, wandering, and physical restraints: a review of interventions for individuals with dementia in assisted living and nursing homes. Alzheimer's Care Today. 2008;9(1):45-50; **Peisah** C, Skladzien E. The use of restraints and psychotropic medications in people with dementia: a report for Alzheimer's Australia, paper 38. 2014; Available from: [https://www.fightdementia.org.au/files/NATIONAL/documents/Alzheimers-Australia-Numbered-Publication-38.pdf.

268   **Karlin** BE, Visnic S, McGee JS, Teri L. Results from the multisite implementation of STAR-VA: a multicomponent psychosocial intervention for managing challenging dementia-related behaviors of veterans. Psychol Serv. 2014;11(2):200-8; **Wigg** JM. Liberating the wanderers: using technology to unlock doors for those living with dementia. Sociol Health Illn. 2010;32(2):288-303.

269   Woods B. The person in dementia care. Generations. 1999;23(3):35-9.

270   Welsh S. Big brother is watching you - the ethical implications of electronic surveillance measures in the elderly with dementia and in adults with learning difficulties. Aging Ment Health. 2003;7(5):372-5.

271   **Barry** N. Controversial tagging may offer dementia sufferers the freedom to roam. Aberdeen (UK),: The Press and Journal; 2007; **Sturdy** D. Electronic support for 21st century care. Age Ageing. 2005;34(5):421-2.

272   Op cit, Pot AM, et al. A pilot study on the use of tracking technology 2012.

about what will improve their quality of life, identifying and assessing the benefits and risks of technology for each individual person is paramount[273]. Technologies must be understood in context; their use can vary and have differing effects on unexplained absence, depending on an individual's abilities and the broader environment in which they are used.

Actions:

This will be achieved by:

- Researchers conducting a systematic literature review of studies that have investigated technology with feasibility, safety, impact, independence and choice.

- Staff supporting residents with impairment in decision-making capacity to maintain their independence, rather than over protect though limiting choices.

- Staff education on the use of technology and unexplained absences to optimise how these are addressed within the facility.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, commitment of funding bodies to provide grants for research, and of providers and training organisations to provide education and training on the use of technology and unexplained absences.

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273   **Hermans** DG, McShane R. Non-pharmacological interventions for wandering of people with dementia in the domestic setting. Cochrane Database of Syst Rev. 2007;24(CD005994); **Miskelly** F. A novel system of electronic tagging in patients with dementia and wandering. Age Ageing. 2004;33(3):304-6.

Recommendation 90:

That national guidelines are developed that define accountability and responsibility of enduring power of attorney and guardianship providers.

Aim:

To develop clear guidelines on the accountability and responsibility of enduring power of attorney and guardianship providers when decisions are being made about allowing residents to go outside independently.

Rationale:

Whilst this recommendation will unlikely directly contribute to reducing death and injury of RACS residents following an unexplained absence, it does highlight that greater clarity is needed about the powers bestowed, and not bestowed, by powers of attorney and guardianship.

Powers of attorney are legal documents where an individual appoints another person (or people), referred to as 'attorney(s)', to make decisions for them about *all* or *specific* financial and / or personal matters[274]. Powers of attorney can be 'enduring', meaning they continue even if and when the person loses capacity to make their own decisions about matters; or they can be 'supportive' to promote the rights of people with disability to make their own decisions about things that affect them[275].

The person making the enduring powers of attorney may or may not place conditions to limit the scope of authority to specific matters on the power given to the attorney[276]. Even with limitations the impact of powers of attorney are immense[277], making it very important that

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274   Office of the Public Advocate. Powers of attorney. 2017; Available from:
       http://www.publicadvocate.vic.gov.au/power-of-attorney.

275   Op cit, Office of the Public Advocate. Powers of attorney 2017.

276   **Office of the Public Advocate**. Decision making capacity. 2017; Available from:
       http://www.publicadvocate.vic.gov.au/decision-making-capacity; **Wurth** N. Enduring powers of
       attorney: with limited remedies-its time to face the facts! 2013; Available from:
       http://www.austlii.edu.au/au/journals/ElderLawRw/2013/3.html.

277   Op cit, Wurth N. Enduring powers of attorney 2013.

each party involved understands which decisions they have powers to make. For example, having power over financial authority does not extend to decisions about allowing a resident to leave the RACS independently.

Even when the attorney is able to make decisions about all financial and personal matters, the scope of authority the attorney has is limited to acting in the agency capacity[278]. However, what is the resident's capacity and how this is assessed is largely a grey area[279]. Enduring powers of attorney usually occur in the context of a relationship or trust, and family members with enduring powers of attorney may want to over-protect their loved ones to keep them safe indoors, even when the resident is still capable of making their own decisions about going out of the RACS.

A further confusion may arise by the misunderstanding of aged care providers and carers about which decisions they have powers to make. A move to a RACS does not equate to a transfer of decision-making power from the person (resident) to the aged care provider and carers. Carers often have to make a range of decisions that may impact on the personal affairs of the person they are caring for. Many of these decisions can only be made by someone with the legal authority to do so, in particular those who have applied for a power of attorney, guardianship or administration rights[280]. Given that the social construction of unexplained absence is that it is a high-risk activity[281], aged care providers are likely to restrict a resident from going out of the facility out of fear for the resident safety, even when they have no power to issue such instruction.

Actions:

This can be achieved by:

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278   Op cit, Wurth N. Enduring powers of attorney 2013.
279   Op cit, Wurth N. Enduring powers of attorney 2013.
280   Australian Government: My aged care. Legal support for family and carers. 2015; Available from: http://www.myagedcare.gov.au/caring-someone/legal-support-carers-and-family.
281   Op cit, **Woolford** MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017.

- Policy makers developing clear guidelines on the accountability and responsibility of enduring power of attorney and guardianship for when decisions are being made about allowing residents to go outside independently.

- Education for aged care providers and family members about the powers bestowed, and not bestowed, by powers of attorney and guardianship.

- Policy makers developing guidelines that define accountability and responsibility of aged care providers in regards to enduring power of attorney and guardianship providers.

Limitations:

A potential limitation of this recommendation and barrier to implementation is agreement between and cooperation across all Australian jurisdictions on the inclusion of a clause that addresses enduring power of attorney and guardianship for when decisions are being made about allowing residents to go outside independently.

Recommendation 91:

That there is a bi-annual forum for the police, search and rescue teams, and the residential aged care sector (providers, staff and residents) in which information, such as problem areas and emerging trends of unexplained absence, death, and injury are shared and discussed.

Aim:

With the aim of minimising risk and improving practice, provide opportunities for key stakeholders to share information in a bi-annual forum.

Rationale:

A number of different stakeholders are involved in finding the resident following an unexplained absence. This includes RACS staff, family, police, and various search and rescue teams (e.g. State Emergency Services and dog patrol). Following the unexplained absence event, and depending on the outcome; doctors, hospitals, primary health care services, government departments, and coroners become involved. Each stakeholder has a different role to play, and thus a unique perspective on the event and their role within it. In isolation, this valuable information may only be shared with others within the same organisation, or were lost.

Information sharing across stakeholders to minimise risk and promote safety is commonly used in other sectors[282], and has proven to be successful in studies[283 36,37].

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282 **Department of Child Protection Western Australia**. Schedule: guidelines for information sharing across jurisdictions 2017; Available from: https://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Schedule3 GuidelinesforInformationSharingAcrossJurisdictions.pdf; **The Centre for Public Health**: Centre of Excellence for Information Sharing. Information Sharing to Tackle Violence (ISTV). 2014; Available from: http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/documents/isb-1594/amd-31-2012/1594312012guidance.pdf.

283 **Hansagi** H, Olsson M, Hussain A, Ohlen G. Is information sharing between the emergency department and primary care useful to the care of frequent emergency department users? Eur J Emerg Med. 2008;15(1):34-9; **Florence** C, Shepherd J, Brennan I, Simon T. An economic evaluation of anonymisd information sharing in a partnership between health services, police and local government for preventing violence-related injury. Inj Prev. 2014;20:108-14.

Actions:

This can be achieved by:

- Organising bi-annual forums that include all key stakeholders.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, leadership and cost of organising meetings, cost of staff attending and reporting meeting outcomes, and managing workloads during these absences, and finally cost of proposed interventions and addressing members concerns.

Recommendation 92:

The construction of new RACS be guided by contemporary research on building design that promotes the perception of freedom and independence, and which may reduce the likelihood of unexplained absence attempts and events.

Aim:

To design the physical environment of RACS in ways that promote the perception of freedom and independence, and reduce the likelihood of unexplained absence attempts and events.

Rationale:

A RACS is a person's home and therefore, it is not surprising that design of the physical environment is increasingly recognised as an important aid to promote the care of older people[284].

The issue of space and place is particularly important for residents who are vulnerable to overly challenging environments due to declining cognitive abilities that influence their capacity to adapt to change and remain independent[285]. Spatial disorientation is one of the most persistent manifestations of dementia, and influences spatial behaviours such as attempting to leave the RACS[286].

Guidelines for the planning and design of aged care facilities exist for each jurisdiction in Australia. They are largely generic, providing opportunities for refinement so that the building

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284   Op cit, **Tilly** J, Reed P. Falls, wandering, and physical restraint: a review of interventions for individuals with dementia in assisted living and nursing homes 2008; **Mazzei** F, Gilan R, Cloutier D. Exploring the influence on the spatial behaviour of older adults in a purpose built acute care dementia unit. Am J Alzheimers Dis Other Demen. 2014;29(4):311-9; **Day** K, Carreon D, Stump C. The therapeutic design of environments for people with dementia: a review of the empirical research. Gerontologist. 2000;40(4):397-416.

285   Op cit, Mazzei F, et al. Exploring the influence on the spatial behaviour of older adults in a purpose built acute care dementia unit 2014.

286   Op cit, Mazzei F, et al. Exploring the influence on the spatial behaviour of older adults in a purpose built acute care dementia unit 2014.

meets the specific needs and circumstances of each service, whilst at the same time complying with Acts and Regulations[287].

Independence-orientated care is highlighted as a key area within government planning and design guidelines; however, explicit instruction or advice on how this can be achieved is omitted from these guidelines. For example "*The design will maximise the residents abilities, life choices and independence*"[288]. Despite extensive research there is a lack of clear instruction on how residents' abilities and independence can be maximised and achieved, leading to confusion, subjective interpretation and unlikely to lead to sufficient benefits. Environmental factors that have been found to significantly reduce the temptation of persons with dementia leaving include light filled rooms, wandering paths, familiarity, links to the community, provision of space to be alone and with others, and the removal of unnecessary stimulation such as busy entry doors[289].

For all residents, regardless of physical or cognitive impairments, provision for social interaction, visual and physical access to natural settings (such as outside gardens); provide opportunities for residents to be physically active. This may be linked to better outcomes, such as increased wellbeing, improved sleep, better orientation and wayfinding; and quality of life[290 44-46].

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287   Victorian Government: Department of Human Services. Aged care residential services generic brief. 2005; Available from: http://www.priorityhealthcare.com.au/files/Victorian%20Government%20Aged%20Care%20Brief.pdf.

288   Queensland Government: Queensland Health. Queensland residential aged care facilities. 1999; Available from: https://www.health.qld.gov.au/__data/assets/pdf_file/0025/151099/qh-gdl-374-8.pdf.

289   **Fleming** R, Goodenough B, Low L, Chenoweth L, Brodaty H. The relationship between the quality of the built environment and the quality of life of people with dementia in residential care. Dementia. 2016;15(4):663-80; **Dickson** J, McLain-Kark J, Marshall-Baker A. The effects of visual barriers on exiting behavior in a dementia care unit. Gerontologist 1995;35(1):27-130; **Detweiler** MB, Sharma T, Detweiler JG, Murphy PF, Lane S, Carman J, et al. What is the evidence to support the use of therapeutic gardens for the elderly? Psychiatry Investig. 2012;9(2):100-10.

290   Op cit, **Detweiler** MB, et al. What is the evidence to support the use of therapeutic gardens for the elderly? 2012; **Alzheimer's Australia**. Gardens that care: planning outdoor environments for people with dementia. Glenside SA: Alzheimer's Australia SA Inc.; 2010; Available from: http://dbmas.org.au/uploads/resources/101796_ALZA_Garden32pp_LR.pdf; **Anjali** J. Health

Actions:

This can be achieved by:

-   Policy makers developing guidelines on what are optimal building designs that promote the perception of freedom and independence.

-   Construction of new RACS is guided by contemporary research on building design that promote the perception of freedom and independence.

-   Researchers focussing on studies into building design and unexplained absences in residents who are able to function independently.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, commitment by government to collaborate with the aged care sector to develop optimal building designs that promote the perception of freedom and independence. Additionally, commitment by government across all jurisdictions to work with funders of new RACS and the refurbishment of existing facilities to implement guidelines for optimal building design.

promotion by design in long-term care settings. Concord, CA: The Center for Health Design (CFHD); 2006; Available from: https://www.healthdesign.org/chd/research/health-promotion-design-long-term-care-settings.

Recommendation 92 Part 1 and 92 Part 2 are considered together.

Recommendation 92 Part 1:

That a coordinated and multifaceted approach is taken to align existing aged care training programs with government policy initiatives that support holistic and person-centred duty of care, and that promote positive values of the older person.

Recommendation 92 Part 2:

That residents are offered activities that engage and enhance their quality of life and promote the RACS as a place where most people would be happy to live.

Aim:

To align aged care training programs with government policy initiatives so that care is being delivered in a way that is person-centred, rather than positioning person-centred care as something extra to do on top of existing workloads.

Rationale:

Similarly to Recommendation 1.4 (enduring power of attorney and guardianship) this recommendation will unlikely directly contribute to reducing death and injury of RAC residents following an unexplained absence. However, it does highlight concern about the disconnection between aged care training programs and person-centred care policies, and how this effects the care RAC residents receive.

Person-centred practice for older persons is "*treatment and care provided by health services [that] places the person at the centre of their own care*"[291]. The philosophy of person-centred practice aims to replace the traditional focus on physical features of activities of daily living,

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291   Victorian Government: Department of Human Service (DHS). What is person-centred health care? A literature review. 2006.

derived from the biomedical model[292]. Person-centred care underpins many contemporary government policies and guidelines, as well the policies of individual aged care facilities[293].

In 2012 there were 147,000 workers employed in RACS[294]. The occupational composition of direct care employees in RACS vary and mainly consist of registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCA), and allied health professionals and assistants. Overall, PCAs form the largest occupational group (68%), and the one growing at the fastest rate. In contrast, there has been a decrease in the reliance on RNs to provide direct care to residents[295].

Many of the training courses for the varying occupational groups assert that the philosophy of person-centred care underpins their training. Whilst training and education are seen as central activities that deliver changes in practice, research shows that the theoretical ideas of person-centred care do not always translate into day-to-day practice[296]. Training packages have been found to have little or no impact[297].

Person-centred interventions are often difficult to operationalise into practice because they are multi-factorial, comprising of environmental, social, management, staffing, and

292   Op cit, Brownie S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities 2013.

293   Op cit, Brownie S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities 2013.

294   Commonwealth Government: Department of Health and Ageing (DoHA). The aged care workforce 2012-final report. 2012; Available from: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/11_2014/rdp004-nacwcas-report.pdf.

295   Op cit, Commonwealth Government: Department of Health and Ageing. The aged care workforce 2012 2012.

296   Op cit, **Brownie** S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities 2013; **Australian Aged Care Quality Agency**. Study into staff attitudes toward person-centred care. 2014; Available from: https://www.aacqa.gov.au/providers/education/the-standard/2014-issues/quality-standard-october-2014/study-into-staff-attitudes-toward-person-centred-care.

297   Jenkins C, Smythe A, Galant-Miecznikowska M. How can training interventions for nurses promote person-centered dementia care in nursing homes? Ment Health Nurs. 2014;34(5):16-9.

individualised philosophy of care[298]. The difficulty is further enhanced when care is being provided to residents with complex care needs. A limited focus of staff training on person centred-care, a task-focused workforce where safety and physiological needs are met before moving into higher level need are identified barriers[299]. A further barrier is that person-centred care training provided in many of the short courses (such as a 3-month course) can vary in-length, with some being as brief as an hour[300]. Given the complexity of the concept, this is unlikely to be sufficient.

Limited opportunities for training is one barrier, the workload is another. A recent study, in which 61 RAC staff were surveyed about their attitudes toward person-centred care, reported that 64% of staff agreed to some extent that they do not have time to provide person-centred care; and only 26% agreed that they are free to alter work routines based on residents' needs[301].

The ability of residents to leave the RACS and enter the outdoors often relies on a person-centred approach in which staff have the time to support the resident to do so[302]. This is especially the case in persons with dementia[303]. The delivery of person-centred care may be seen by staff as a 'nice extra' to be completed only after all daily tasks and routine matters have been attended to[304].

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298   Op cit, **Brownie** S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities 2013; Op cit, **Australian Aged Care Quality Agency**. Study into staff attitudes toward person-centred care. 2014.

299   Op cit, **Brownie** S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities 2013; Op cit, **Australian Aged Care Quality Agency**. Study into staff attitudes toward person-centred care. 2014.

300   Op cit, **Jenkins** C, et al. How can training interventions for nurses promote person-centered dementia care in nursing homes? 2014.

301   Op cit, **Australian Aged Care Quality Agency**. Study into staff attitudes toward person-centred care 2014.

302   Op cit, Wigg JM. Liberating the wanderers 2010.

303   Op cit, Wigg JM. Liberating the wanderers 2010.

304   Op cit, **Australian Aged Care Quality Agency**. Study into staff attitudes toward person-centred care 2014; Op cit, **Jenkins** C, et al. How can training interventions for nurses promote person-centered dementia care in nursing homes? 2014.

Actions:

This can be achieved by:

- Education and aged care providers constructing training programs that focus on providing concrete examples of ways to deliver routine care in a way that is person-centred, and take into account the organisational context, and take steps to anticipate and address barriers within the residential aged care context.
- Ongoing support from government, organisational managers and leaders for these person-centred care training programs.

Limitations:

Potential limitations of this recommendation and barriers to implementation include, commitment of education providers and government to develop, implement evaluate training courses for aged care staff that emphasise a person-centred care as a day-to-day routine, and of providers to engage and retain staff that have a formal recognised certificate in patient-centred care. There may be lack of action on moving from a task oriented workforce to a model that is expected in a contemporary aged care sector.

During an unexplained absence event

Recommendation 93 and 94 are considered together.

Recommendation 93:

That an evidence-based approach is taken to the development of a risk assessment tool and risk prevention strategies that identifies residents at-risk of leaving RAC without informing care-givers.

Recommendation 94:

That there is a national approach to risk assessment and risk prevention strategies that can be agreed upon by the resident or their appointed power of attorney.

Aim:

To develop a consistent and uniform approach to the assessment and management of risk, specific to unexplained absences.

Rationale:

Risk assessment tools in the management of potential risks in residential aged care are plentiful. There are specific risk assessment forms, such as for falls, pressure injuries, and physiological risk assessments. There are also quality indicator measures and risk matrix to define various levels of risk. The aim of all these measures is to identify the potential sources of risk and facilitate the development of risk management interventions.

Unfortunately, there is an absence of a readily available risk assessment tools for the management of unexplained absences. Decision-making about whether a resident is at-risk of leaving a RACS, and on the potential consequences of taking that risk, is one of the most important and difficult tasks care providers face.

In the absence of a risk-assessment tool, the degree of uncertainty about the management of unexplained absences will vary among care providers[305]. The type of decisions that are made

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305   Fleming A, Slank K. Making a Choice: Self-Other Differences in Decision Making in Risky Situations. N Am J Psychol. 2015;17(3):633-48.

will be influenced by organisational culture, policies and regulation, availability of resources, and the knowledge each care provider has about the management of unexplained absences, as well as the outcomes of those choices.

The consequence of this is that a different solution/decision is made by each carer. More often than not the carer will actively seek to diffuse (control) the potential risk[306]. A structured risk assessment form would support the collection of relevant information and guide aged care providers in the identification and management of risks relating to unexplained absences. Our expert consultation forum participants asserted that risk-assessment forms, and the strategies that follow as a result of the assessment, should involve the resident or their appointed power of attorney.

The adoption of strategies to manage unexplained absences without consultation with the care receiver would lead to a lack of representation of their care needs and preferences in the selection of those management strategies[307]. The most common reason cited for not respecting residents' views is the assumption that residents with cognitive impairments, in particular dementia, are unable to state consistent choices and communicate in a meaningful way[308].

There is however, a growing body of research, spanning over two decades, which suggests that even in the late stages of dementia people retain a sense of self, and are able to report on their situation[309].

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306 **Fleming** A, Slank K. Making a Choice: Self-Other Differences in Decision Making in Risky Situations. N Am J Psychol. 2015;17(3):633-48; **Huber** O, Beutter C, Montoya J, Huber OW. Risk-defusing behaviour: Towards an understanding of risky decision making. Eur J Cogn Psychol. 2001;13(3):409-26; **Entwistle** V, watt IS. Patient involvement in treatment decision-making: The case for a broader conceptual framework. Patient Edu Couns. 2006;63:268-78.

307 Feinberg LF, Whitlatch CJ. Are persons with cognitive impairment able to state consistent choices? Gerontologist. 2001;41(3):374-82.

308 Op cit, Feinberg LF, Whitlatch CJ. Are persons with cognitive impairment able to state consistent choices? 2001.

309 Op cit, **Feinberg** LF, Whitlatch CJ. Are persons with cognitive impairment able to state consistent choices? 2001; **Downs** M. The emergence of the person in dementia research. Ageing Soc. 1997;17(5):597-607; **United Nations**: Department of Economic and Social Affairs: Population

Actions:

This can be achieved by:

- Policy makers developing an evidence based risk-assessment tool(s) and a range of strategies for the management of unexplained absences that can be implemented nationally and across all aged care facilities.
- Providers developing a range of strategies that can be used by care staff to mitigate the risk of unexplained absence, and includes input by the resident or their appointed powers of attorney.

Limitations:

Some of the potential limitations of this recommendation and barriers to implementation include, commitment of government and the aged care sector to engage with developing a risk assessment tool and strategies for the management of unexplained absences. Other limitations are commitment of training organisations to provide training in the use of tools and strategies for the management of unexplained absences, and of staff to implement the risk assessment tool and the identified strategies. Willingness of all aged care providers to adopt the risk management tools into their operational plan may also be a barrier to implementation.

Division. World Population Ageing: 1950 - 2050. 2001 [cited 2016 15 May]; Available from: http://www.un.org/esa/population/publications/worldageing19502050/.

Recommendation 95:

That any transfer report between health and aged care providers follows a standardised approach to ensure optimal information is exchanged/shared between providers in regards to any risk of unexplained absence.

Aim:

To develop a standardised approach to staff handover communication about risk of unexplained absences with the aim of ensuring optimal information sharing.

Rationale:

Handover communication is the transfer of information, responsibility, and authority for a resident's care between carers, and is fundamental to the continuity of care and patient safety[310]. It has been noted that "*The provision of residential aged care is underpinned by information, and is reliant upon systems that adequately capture and effectively utilise and communicate this information*"[311].

Handovers of patient care cut across all care settings and all disciplines, with the World Health Organization listing "communication during patient care handover" as one of its "High 5" patient safety initiatives[312].

Poor handover between care staff has been associated with lost information, misinterpretation, missed direction or actions, medication errors, inaccurate clinical assessment, and diagnosis[313]. The causes of poor handover have centred around two core

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310   Op cit, Johnson M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016.

311   Gaskin S, Georgiou A, Barton D, Westbrook J. Examining the role of information exchange in residential aged care work practices: a survey of residential aged care facilities. BMC Geriatr. 2012;12:40.

312   Op cit, World Health Organization (WHO). The High 5s Project 2013;

313   Op cit, **Johnson** M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016; Op cit, **Gregory** C, Brenda S. Standardizing hand-off processes 2006.

principles: (1) communication, and (2) engagement[314]. This includes: limited opportunities for staff to obtain information, variation in the scope of information conveyed, no written handover, and limited engagement with the patient[315].

Improvement in handover communication in hospital and acute care settings has identified several interventions, including: electronic tools, use of minimum datasets, and structured content[316]. These interventions can lead to reduction in adverse outcomes, enhanced information transfer, improved documentation and resident confidence[317]. However, research and comprehensive guidelines on the handover process in the residential aged care sector is very limited[318]. In regards to unexplained absences, there is a lack of national guidelines/standards on how handover should be conducted between care providers and what information to include.

There are a number of behavioural warnings that have been identified to occur prior to an unexplained absence event, such as agitation, display of more movement, increased involvement in non-social behaviour, announcing intentions to leave, repeatedly looking out

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314   Op cit, Johnson M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016.

315   Op cit, Johnson M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016.

316   Op cit, **Johnson** M, et al. Reducing patient clinical management errors using structured content and electronic nursing handover 2016; **Payne** CE, Stien JM, Leong T, Dressler DD. Avoiding handover fumbles: a controlled trial of a structured handover tool versus traditional handover methods. QMJ Quality Safety. 2012;21(11):925-32; **Advani** R, Stobbs N, killick N, Kumar B. Safe handover saves lives: results from clinical audit. Clin Govern Int J. 2015;20(1):21-32; Yee K, Wong MC, Turner P. Hand me an isobar: a pilot study of an evidence-base approach to improving shift-to-shift handover. MJA. 2009;190(S121-S124):S121.

317   Op cit, Payne CE, et al. Avoiding handover fumbles 2012; **Northway** T, Krahn G, Thibault K, Yarske L, Yuskiv N, Kissoon N, et al. Surgical suite to pediatric intensive care unit handover protocol: implementation process and long-term sustainability. J Nurs Care Qual. 2015;30(2):113-20; **Petersen** LA, Orav EJ, Teich JM, O'Neil AC, Brennan TA. Using a computerized sign-out program to improve continuity of inpatient care and prevent adverse events. Jt Comm J Qual Improv. 1998;24(2):77-87.

318   Lyhne S, Georgiou A, Marks A, Tariq A, Westbrook JI. Towards an understanding of the information dynamics of the handover process in aged care settings--a prerequisite for the safe and effective use of ICT. Int J Med Inform. 2012;81(7):452-60.

of windows and doors, testing locked doors, restlessness and inability to sleep[319]. These must

be communicated during handover.

What is known is that the handover process is both complex yet very important for resident

safety. Unexplained absences in the RACS setting can be difficult to manage, balancing

resident's rights to leave a facility independently with risk of injury[320]. Important health and

behavioural information about residents must be communicated between health and aged

care providers to reduce the risk of adverse events.

Actions:

This can be achieved by:

- Conducting research to develop an in-depth understanding of the handover process that

   occurs between health and aged care providers.

- Providers identifying gaps in information exchange in the handover process and analysing

   implications for resident safety.

- Policy makers developing practical recommendations on how handover processes in the

   aged care sector can be improved and standardised to safeguard optimal information is

   exchanged/shared between providers to enhance resident safety.

Limitations:

Potential limitations of this recommendation and barriers to implementation include,

potential costs to complete a more detailed handover, lack of empirical evidence about the

handover process that occurs between health and aged care providers, and commitment by

the aged care sector and carers to implement a standardised process for handover.

Standardisation of handover process across all states and territories will require

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319   Rowe M, Bennett V. A look at deaths occurring in persons with dementia lost in the community.
      Am J Alzheimers Dis Other Demen. 2003;18(6):343-8; Rowe MA, Glover JC. Antecedents,
      descriptions and consequences of wandering in cognitively-impaired adults and the Safe Return
      (SR) program. Am J Alzheimers Dis Other Demen. 2001;16(6):344-52; Fopma-Loy J. Wandering:
      causes, consequences, and care. J Psychosoc Nurs Ment Health Serv. 1988;26(5):8-11, 5-8.
320   Op cit, Woolford MH, et al. Unexplained absences and risk of death and injury among nursing
      home residents 2017;

Commonwealth government involvement and interest, and collaboration between states and

territories.

Recommendation 96 and 97 are considered together.

Recommendation 96:

That within the first 24 hours of a resident's admission, RACS staff conduct an initial assessment to identify residents at-risk of unexplained absence and document the specific strategies to be undertaken. A final review and recommendations should be conducted at Day-7 following admission.

Recommendation 97:

That any behavioural symptoms leading to an attempt to, or successfully leaving the RACS, without informing caregivers, exhibited by residents should act as a trigger for direct care staff to assess and consider whether there are any unmet needs of the resident, and develop interventions to prevent occurrence or re-occurrence.

Aim:

To identify any potential behavioural cues early in the admission process that indicate the resident is at-risk of unexplained absences.

Rationale:

Many countries, including Australia, are experiencing a societal shift towards an ageing population[321]. Medical advances and improved standards of living have made it possible for an increasing number of persons to reach an age where they become more vulnerable to multiple and more severe physical and mental impairments, and chronic diseases[322]. This increasing complexity has created significant challenges for RAC staff. Persons entering RACS are now having higher care needs compared to past residents[323].

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321 **Brazil** K, Maitland J, Walker M, Curtis A. The character of behavioural symptoms on admission to three Canadian long-term homes. Aging Ment Health. 2013;17(8):1059-66; **Australian Government**: Australian Institute of Health and Welfare (AIHW). Residential aged care in Australia 2010-11: a statistical overview. Canberra2012; Available from: http://www.aihw.gov.au/publication-detail/?id=10737422821.

322 Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

323 Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

The relocation of a community-dwelling older person into a RACS has been associated with stress, confusion and general physical decline[324]. Admission to a RACS can be a high-risk time for individuals in which behavioural symptoms can be intensified[325]. Research has shown that it is often a time when behavioural symptoms, such as wanting to leave the facility, may be exacerbated[326].

Wandering and unexplained absence have been identified as one of the challenges RAC staff face, especially those who are providing care for persons' with dementia[327]; and history of unexplained absences is a commonly-cited reason for placing community-dwelling individuals in a RACS[328].

Early assessment to identify residents at-risk of an unexplained absence holds important practical implications for care planning[329]. The absence of a clearly articulated assessment process at admission to identify and plan for appropriate care has been reported to increase the probability of critical incidents, such as unexplained absences[330]. It also results in a lack of continuity in the management of the admission process, and important resident information may be lost, especially in admissions where multiple staff are involved[331].

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324   Falk H, Wijk H, Persson L. Frail older persons' experiences of interinstitutional relocation. Geriatr Nurs. 2011;32(4):245-56.

325   Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

326   Op cit, Lester P, et al. Wandering and elopement in nursing homes 2012; Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

327   Op cit, **Beattie** ER, et al. A comparison of wandering behavior in nursing homes and assisted living facilities. 2005; **MacAndrew** M, Beattie E, O'Reilly M, Kolanowski A, Windsor C. The Trajectory of Tolerance for Wandering-related Boundary Transgression: An Exploration of Care Staff and Family Perceptions. Gerontologist. 2017;57(3):451-460.

328   Op cit, **Lester** P, et al. Wandering and elopement in nursing homes 2012; Op cit, **Beattie** ER, et al. A comparison of wandering behavior in nursing homes and assisted living facilities. 2005.

329   Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

330   Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

331   Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

Standardised assessments on admission and within 7-days after arrival to a RACS is an important antecedent to appropriate care planning that can avoid critical incidents. Assessments allow for specific needs to be identified and addressed more rapidly than assessments that are completed later on, such as at three or six-months after admission[332]. Early assessments can also support in understanding the reasons behind unexplained absence attempts and how 'risky' the behaviour might be – would the activity result in potentially unsafe consequences, or can the resident safely and independently leave.

Actions:

This can be achieved by:

- A clinician, such as a registered nurse, assessing the older person before admission. The assessment could be recorded on the resident's file and shared to all staff.

- Providers form a multidisciplinary transition care team (involving residents, family, allied health, GPs and key staff) to assist in admission assessments.

Barriers:

Potential limitations of this recommendation and barriers to implementation include, commitment by the aged care sector and carers, costs of additional staff time and staff availability to conduct assessments on residents early on in the admission process, and staff knowledge on the identification of behavioural cues that may lead to an unexplained absence. The development of an assessment form is paramount, cost and who will be responsible for form development will be a significant barrier. Also, time and resources needed to develop interventions to prevent occurrence or re-occurrence for an unexplained absence are notable limitations.

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332   Op cit, **Brazil** K, et al. The character of behavioural symptoms on admission to three Canadian long-term homes 2013.

When there is an unexplained absence event

Recommendation 98 and 99 are considered together.

Recommendation 98:

That there is a national approach to minimum standards for all RACS to have an easily accessible search and rescue plan to support staff and family in responding quickly and systematically to an unexplained absence event.

Recommendation 99:

That RACS staff undergo regular training and practice in reporting procedures to ensure they are able to promptly and appropriately respond to an unexplained absence incident.

Aim:

To support staff in being prepared to respond quickly and efficiently to an unexplained absence event.

Rationale:

Maintaining quality care when a resident is found to be missing from the RACS can be difficult. Aged care staff face multiple and competing challenges, for example - wanting to search for the missing resident as quickly as possible whilst at the same time making sure other residents in the facility are safe and cared for. Where to look, who to call (e.g. management, family, emergency services) can be challenging for staff who have no or very little prior experience in managing an unexplained absence event. It is well reported that carers experience stress when an unexplained absence occurs[333].

The complexities of managing an unexplained absence are intensified when caring for the most vulnerable residents, such as those living in high care and dementia specific units. Furthermore, when a resident leaves the facility during night shift hours, in which one staff

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333 Alzheimer's Foundation of America. Lost and found: A review of available methodologies and technologies to aid law enforcement in locating missing adults with dementia. 2012; Available from: https://www.alzfdn.org/documents/Lost&Found_forweb.pdf.

member is on duty, the responsibility falls onto the one person, placing them under undue pressure to know exactly what to do.

It is vital that all aged care services are well prepared and able to respond to an emergency event that may impact delivery of care [334], as well as the health and safety of the missing resident. Given that an older person's chance of survival increases the sooner they are found[335], launching search and rescue operations quickly and systematically may increase the older person's chance of survival.

The importance of being prepared for emergency situations is well recognised in the Australian Aged Care sector. In Australia, under Accreditation Standards, approved providers are required to have emergency plans and protocols in place to protect the health, safety and wellbeing of care recipients in preparation for fire, security and other emergencies. RACS that do not meet the standards may lose their accreditation, or their period of accreditation might be reduced[336]. State and territory health and emergency management agencies also support aged care providers by publishing additional emergency management planning information that is relevant to each jurisdiction[337]. The ultimate goal is to facilitate a prompt and secure response to an emergency.

Unfortunately, there is very little guidance for aged care providers on how to manage an unexplained absence. Therefore, each response relies on the capacity and understanding of the staff member(s) on duty. This is likely to produce varying levels of responses that may or may not be efficient.

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334 Australian Government: Department of Social Services (DSS). Approved providers of residential care: emergency risk management plans 2014-15. 2014; Available from: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/10_2014/residential_and_fle xible_aged_care_providers.pdf.

335 Koester RJ, Stooksbury DE. The lost Alzheimer's and related disorders subject: New research and perspectives. Response. 1998;98:165-81.

336 Australian Government: Australian Aged Care Quality Agency BCV. Accreditation Standards. 2017; Available from: www.aacqa.gov.au.

337 Aged and Community Services SA & NT. Aged care emergency training. 2017; Available from: http://www.agedcommunity.asn.au/providers/aged-care-emergency-planning/.

A search and rescue plan can guide staff on how to respond quickly and systematically to an unexplained absence event. Direction on the development of an effective and 'user friendly' search and rescue plan, and the required staff training, can take guidance from existing contemporary search and rescue plans. For example, the Commonwealth funded residential aged care facilities First Response notification flowchart[338]; the Australian Government Emergency Management Plan[339], or the Lost Person Behaviour search and rescue guide on where to look.

Actions:

This can be achieved by:

- Policy makers developing detailed written plans and procedures to guide carers in the event of an unexplained absence event, that this could be built into Australian Accreditation standards and Commonwealth, state and territory government policies.

- Regular training of staff on the procedures to follow when an unexplained absence occurs.

- Providers training new employees in emergency; and periodically review the procedures with existing staff.

Barriers:

Potential limitations of this recommendation and barriers to implementation include, cost and responsibility for the development of a search and rescue plan, cost and commitment by age care staff and management to conduct regular training and practice in reporting procedures, and cost of training new staff on facility specific search and rescue procedures.

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338   Op cit, Aged and Community Services SA & NT. Aged care emergency training 2017.

339   Op cit, Australian Government: Department of Social Services (DSS). Approved providers of residential care: emergency risk management plans 2014-15 2014.

Recommendation 100:

That a simple and easily readable form for providers to complete and give to search and rescue teams, and police is developed. The form must be embedded into the resident assessment and care plans, identifying the resident's history and social profile, with addresses where the resident may have likely gone, and information on the unexplained absence event.

Aim:

To ensure a more responsive reporting procedure rather than a reactive approach.

Rationale:

Missing persons with dementia are more likely to be recovered alive if they are found within 24 hours of disappearance[340]. Launching search and rescue operations quickly may therefore increase the older person's chance of survival.

A resident information sheet that summarises the missing resident's social and accommodation history, physical appearance, and cognitive and physical impairments will allow aged care providers to be prepared in the event of an unexplained absence. This should be embedded into the resident's assessments and care plans, updated regularly, and handed over to police when an unexplained absence occurs. This is a powerful tool for police and search and rescue teams who can use the information provided to help determine the search area, and where to look within that area[341].

It is important to know the level of physical and cognitive functioning of the missing person, in particular whether the resident has dementia and its severity. Knowledge that the resident has dementia, can help predict a person's final location[342]. Mild to moderate severity is

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340   Op cit, Koester RJ, Stooksbury DE. The lost Alzheimer's and related disorders subject 1998.

341   Op cit, **Koester** RJ, Stooksbury DE. The lost Alzheimer's and related disorders subject 1998; **Australian Government**: Attorney-General's Department. Emergency management. 2012; Available from: https://www.ag.gov.au/EmergencyManagement/Pages/default.aspx.

342   Koester RJ. Lost person behavior. A search and rescue guide on where to look - for land, air and water. United States: Virginia: dbs Productions LLC; 2008.

associated with more goal-directed traveling whereas more in more severe dementia a person will travel to former residence, favourite places or previous workplace[343].

A further important piece of information is 'intent'. People for whom the possibility of suicide is strong, or who have expressed an intent to suicide, may be more difficult to find. Suicidal behaviour resulting in a search is more complex compared to residents taking generic unexplained absence leave[344]. Despite the complexity, research has shown that two clear patterns emerge. First, persons are often seeking to get out of sight. Second, persons seek out a specific location often scenic or significant in their life history[345].

Collecting information about the resident will therefore allow traditional search and rescue operations to be tailored specifically to the resident whose whereabouts is not known, thereby supporting search and rescue efforts.

Actions:

This can be achieved by:

- Developing an information form, in consultation with the aged care sector, police, and search and rescue teams that can be used in the event of an unexplained absence.

- Development of guidelines on who/when/how the form is completed.

- Provision of training to aged care staff on how to complete the form.

Barriers:

Potential limitations of this recommendation and barriers to implementation include, lack of empirical research on items to be included in the form, commitment and allocation of who will be responsible for form development, cost to develop and implement the form, and staff time to complete the form.

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343   Op cit, Koester RJ. Lost person behavior 2008.
344   Op cit, Koester RJ. Lost person behavior 2008.
345   Op cit, Koester RJ. Lost person behavior 2008.

Post-unexplained absence event

Recommendation 101 and 102 are considered together.

Recommendation 101:

That federal, state and territory governments establish a national register which is comprehensive, coordinated and requires mandatory reporting of all unexplained absences occurring in RACS[346].

102 Recommendation:

That the national register have a standardised approach to the recording of key individual, organisational, environmental determinants, and search and rescue information, relating to variability of unexplained absence event; and that this information is regularly analysed to identify trends and risk-factors for injury and death. The register is also to include post-rescue information to support the development of prevention strategies.

Aim:

To improve the information collected and broaden understating on unexplained absence events and the individual and organisational factors.

Rationale:

There is limited information available on the frequency and consequences of unexplained absences of RAC residents[347]. In particular, there is little understanding of the individual, organizational, environmental profiles for an unexplained absence, and the risk-factors for death and injury[348]. This limits the aged care sectors understanding of the issue and ultimately the development of prevention strategies.

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346 Feedback from one organisation in the field stated that they do not support any recommendation in favour of additional regulatory standards that mandate specific approaches and inputs to care in residential aged care settings, specifically Recommendations 101 and 102 which suggest that mandatory reporting of unexplained absences from residential aged care be built into accreditation.

347 Op cit, Woolford MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017.

348 Op cit, Woolford MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017.

In Australia, compulsory reporting of unexplained absences is the responsibility of an approved provider under the *Aged Care Act 1997*. Aged care providers are required to notify the Department of Health and Human Services [DHHS] about a missing resident only if the provider is approved by the department, the absence is unexplained and has been reported to the police[349]. The DHHS publish the number of cases (frequency) reported to the department in the Age and Ageing yearly report. No further information on the unexplained absence is published.

A combination of the limits placed on reporting of unexplained absences, together with the absence of contextual information means that the aged care sectors understanding of the number and nature of unexplained absences is limited. Further, determining the true rate of death and injury cannot be achieved if reporting on all unexplained absences is not required. Mandatory reporting of all unexplained absences occurring in RACS will enable new and emerging patterns and outcomes of unexplained absences to be monitored and evaluated. This data and information can in-turn be shared to increase understanding and support prevention strategies to reduce adverse outcomes. When the collection of information is comprehensive, standardised and mandatory confidence in the evidence improves, and it's potential to facilitate critical appraisal and translation of evidence into prevention strategies increases.

The strengths of establishing a national register as a form of data collection that can be used to produce reports; identify rates and trends; and the individual, organisational and environmental risk-factors for death and injury, is well documented in research[350]. An increasing amount of health data is available, and is being used in epidemiological research

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349   Australian Government Department of Health: Ageing and Aged Care. Guide for reporting unexplained absences. 2016; Available from: https://agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/guide-for-reporting-unexplained-absences.

350   Thygesen TC, Ersboll AK. When the entire population is the sample: strengths and limitations in register-based epidemiology. Eur J Epidemiol. 2014;29(-):551-8.

more than ever [83]. A strength of databases is not only that large amount of varying data can be collected, but also that data can be available for many years, allowing a long follow-up[351].

The International Search and Rescue Incident database [ISRAD] is a testament of what a database can achieve[352]. The large and detailed data collected on ISRAD is being used to support in the planning of search and rescue operations of lost persons[353].

Action:

This can be achieved by:

- Conduct research on the best approach to data collection, monitoring and management.

- A national aged care data clearing house which would coordinate, store and distribute aged care data and facilitate access for researchers, policy makers and the community.

- Mandatory reporting is built into accreditation to ensure consistent documentation across the services.

Barriers:

Potential limitations of this recommendation and barriers to implementation include, cost and commitment, investment of time and involvement of multiple parties which poses challenged to data collection efforts. There is also an absence of strong empirical evidence on how data from unexplained absences can be collected and managed on a national registry.

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351   Op cit, Thygesen TC, Ersboll AK. When the entire population is the sample 2014.
352   Op cit, Koester RJ. Lost person behavior 2008.
353   Op cit, Koester RJ. Lost person behavior 2008.

Recommendation 103 and 104 are considered together.

Recommendation 103:

That current approaches to the investigation of all deaths of a RAC resident following an unexplained absence are nationally standardized.

Recommendation 104:

That if a resident dies within seven days of being found after an unexplained absence that this is reported to and recorded on a national database such as National Coronial Information System.

Aim:

To collect and monitor information on deaths following an unexplained absence so that a profile of the person, organisation and environment can be better understood for the formulation of prevention strategies.

Rationale:

The social construction of an unexplained absence is that it is a high-risk activity that leads to serious injury and death[354]. Despite this, a recent literature review found that very little is known about death and injury outcomes of RAC residents following an unexplained absence. The National Coronial Information System (NCIS) is a data storage, retrieval, analysis, interpretation, and dissemination system for coronial information. All deaths occurring in Australia and New Zealand that are reported to the coroner are recorded on the system, together with the police, toxicology and autopsy reports, and coroner's finding. In Australia there is no national standard for the reporting of unexplained absences. In circumstances where the death followed an unexplained absence (natural or external), the recording of the unexplained absence on NCIS reports relies on the individual preparing the report. A non-standardised approach poses challenges or creates opportunities for oversight.

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354   Op cit, Woolford MH, et al. Unexplained absences and risk of death and injury among nursing home residents 2017.

Agreements on national standards may be complex and take time, but this recommendation would directly address gaps in knowledge about deaths following an unexplained absence. The NCIS is well established, forming an ideal platform on which the additional data can be collected.

Actions:

This can be achieved by:

- Development of an electronic database to record adverse events that occur following an unexplained event.

- Providers developing incident reporting forms and processes to be followed after an unexplained event occurs.

- Development of a process of review and feedback of incidents from staff to relevant stakeholders.

- Development of processes on how difficulties regarding when a resident has an underlying health condition which will likely be recorded as the cause of death can be overcome.

Barriers:

Potential limitations of this recommendation and barriers to implementation include, staff time and resources, cost of developing an electronic database and/or updating current databases to collect unexplained absence information, cost of conducting specialist investigations, and identifying who will collect and monitor information on deaths following an unexplained absence. There is also difficulty in linking a death to an unexplained absence when multiple non-related sectors, such as RACS, hospitals, police, general practitioners are involved.

Appendix 1

Expert Consultation Forum Participant Organisations

Alfred Health

Allity

Alzheimer's Australia

Alzheimer's Australia, Victoria

Ambulance Victoria

Australian Aged Care Quality Agency

Australian Association of Gerontology

Australian Centre for Evidence Based Aged
Care

Australian College of Nursing

Ballarat Health Services

Blue Cross

Brotherhood of St Lawrence

Caladenia Dementia Care

Carers Victoria

Commonwealth Department of Health

Coroners Court of Victoria

Council on the Ageing

Deakin University

Dementia Training Australia

Department of Health & Human Services,
Victoria

East Wimmera Health Service

Elder Rights Advocacy

Footscray Aged Care

Hammond Care

Justice Connect

Kooweerup Health Service

Latrobe University

Leading Age Service Providers

Lynch's Bridge, Kensington

Lynden Aged Care

Monash Health

Monash University

Office of the Aged Care Complaints
Commissioner

Office of the Chief Psychiatrist

Office of the Public Advocate

Orbost Health Service

Parkinson's Australia

Parkinson's Victoria

Pharmaceutical Society of Australia

Premiumcare Medical Care

Queensland University of Technology

Royal District Nursing Services

Royal Freemasons

Speech Pathology Australia

Society of Hospital Pharmacists of Australia

St Vincents Hospital

Suicide Prevention Australia

Uniting Age Well

University of Melbourne

University of New South Wales

Victoria Police

Victorian Managed Insurance Authority

West Wimmera Health Service

Western Hospital

Wintringham

Appendix 2

Key Publications from Health Law and Ageing Research Unit*

1. Ferrah, N., Ibrahim JE., Ranson DL., Beiles, CB., Overview of surgical death investigations: could a dreaded experience be turned into an opportunity? *ANZ J Surg* (2017) 87:755–756

2. Lovell JJ., MacPhail A., Cunningham N., Winbolt M., Young C., Pham T., Ibrahim JE., Junior doctors and limitation-of-care orders: perspectives, experiences and the challenge of dealing with persons with dementia. *European Journal for Person Centered Healthcare* 2017 Vol 5 Issue 3 pp 373-388

3. Bugeja L., Woolford,MH., Willoughby M., Ranson, D., Ibrahim JE. Frequency and nature of coroners' recommendations from injury-related deaths among nursing home residents: a retrospective national cross-sectional study. *Injury Prevention* 09/2017;, DOI:10.1136/injuryprev-2017-042370

4. Baird C., Lovell J., Johnson M., Shiell K., Ibrahim JE. The impact of cognitive impairment on self-management in chronic obstructive pulmonary disease: A systematic review. DOI:10.1016/ *Respiratory Medicine*. 2017.06.006

5. Ibrahim JE, Bugeja L, Willoughby M, Bevan M, Kipsaina C, Young C, Pham T, Ranson DL: Premature deaths of nursing home residents: an epidemiological analysis. *Medical Journal of Australia*. DOI:10.5694/mja16.00873

6. Cunningham N, Pham T, Kennedy B, Gillard A, Ibrahim J: A cross-sectional survey using electronic distribution of a questionnaire to subscribers of educational material written by clinicians, for clinicians, to evaluate whether practice change resulted from reading the Clinical Communiqué. *BMJ Open* 05/2017; 7(5):e014064., DOI:10.1136/bmjopen-2016-014064

7. Bellenger, EN, Ibrahim JE, Lovell JJ, Bugeja L: The Nature and Extent of Physical Restraint–Related Deaths in Nursing Homes: A Systematic Review. *Journal of Aging and Health* 05/2017; DOI:10.1177/0898264317704541

8. Murphy B, Ibrahim J, Bugeja L, Pilgrim J, Cicuttini F., The use of deceased controls in epidemiological research: A systematic review. *American journal of epidemiology* 04/2017; DOI:10.1093/aje/kwx052

9. Willoughby M, Kipsaina C, Ferrah N, Blau S, Bugeja L, Ranson D, Ibrahim JE: Mortality in Nursing Homes Following Emergency Evacuation: A Systematic Review. *Journal of the American Medical Directors Association* 04/2017, DOI:10.1016/j.jamda.2017.02.005

10. Smith D, Bugeja L, Cunningham N, Ibrahim JE: A Systematic Review of Sexual Assaults in Nursing Homes. *The Gerontologist* 04/2017; DOI:10.1093/geront/gnx022

11. Woolford M.H., Weller C. Ibrahim J.E. Unexplained Absences and Risk of Death and Injury Among Nursing Home Residents: A Systematic Review. *Journal of the American Medical Directors Association* 02/2017;, DOI:10.1016/j.jamda.2017.01.007

12. Smith D, Lovell J, Weller C, Kennedy B, Winbolt M, Young C, Ibrahim J: A systematic review of medication non-adherence in persons with dementia or cognitive impairment. *PLoS ONE* 02/2017; 12(2):):e0170651., DOI:10.1371/journal.pone.0170651

13. Ferrah N, Ibrahim JE, Kipsaina C, Bugeja L: Death Following Recent Admission Into Nursing Home From Community Living: A Systematic Review Into the Transition Process. *Journal of Aging and Health* 02/2017;, DOI:10.1177/0898264316686575

14. Ibrahim JE, Anderson LJ, MacPhail A, Lovell JJ, Davis MC, Winbolt M: Chronic disease self-management support for persons with dementia, in a clinical setting. *Journal of Multidisciplinary Healthcare* 01/2017; Volume 10:49-58, DOI:10.2147/JMDH.S121626

15. Aitken G, Murphy B, Pilgrim J, Bugeja L, Ranson DL, Ibrahim JE. Frequency of forensic toxicological analysis in external cause deaths among nursing home residents: an analysis of trends. *Forensic Science, Medicine, and Pathology* 2017 13(1):1-6. DOI:10.1007/s12024-016-9830-9

16. Bellenger E; Ibrahim JE; Bugeja L; Kennedy B. Physical restraint deaths in a 13-year national cohort of nursing home residents .*Age and Ageing* 2017; doi: 10.1093/ageing/afw246

17. Ferrah N, Lovell JJ, Ibrahim JE: Systematic Review of the Prevalence of Medication Errors Resulting in Hospitalization and Death of Nursing Home Residents. *Journal of the American Geriatrics Society* 11/2016; DOI:10.1111/jgs.14683

18. Yoong J, MacPhail A, Trytel G, Rajendram P, Winbolt M, Ibrahim JE: Completion of Limitation of Medical Treatment forms by junior doctors for patients with dementia: clinical, medicolegal and education

perspectives. *Australian Health Review*:.10/2016; DOI:10.1071/AH16116

19. Hitchen T, Ibrahim JE., Woolford M., Bugeja L., Ranson DL., Premature and preventable deaths in older people: a new perspective. Ageing and Society 2016; 37 (8), 1531-1542 -1. DOI:10.1017/S0144686X16000428

20. Pham T., Ibrahim JE., Kitching F., Bohensky M., Aged care and health care professionals' self-reported impact of printed educational material on clinical practice. Journal of Continuing Education in the Health Professions. 2016 Winter;36(1):38-45. doi: 10.1097/CEH.0000000000000030.

21. Murphy B., Ibrahim JE., Bugeja L., Pilgrim J. "Letter to the editor in response to Caspi" Journal of the American Medical Directors Association. February 2016 [Letter to the Editor in Response to Caspi.]. 02/2016; DOI:10.1016/j.jamda.2016.01.012

22. Bugeja L., Ibrahim JE., Ferrah NM., Murphy B., Willoughby M., Ranson DL., The utility of electronic medico-legal databases for public health research: a systematic review of reports from peer-reviewed publications using the National Coronial Information System. *Health Research Policy and Systems* 2016. 04/2016; 14(1). DOI:10.1186/s12961-016-0096-1

23. Bicknell R, Ibrahim J, Bugeja L and Ranson D. The dangers of dementia: Getting the balance right. *Journal of Law and Medicine*: December 2015 Volume 23 (2), 303-307.

24. Chadwick, L. M., MacPhail, A., Ibrahim, J. E., McAuliffe, L., Koch, S., & Wells, Y. (2015). Senior staff perspectives of a quality indicator program in public sector residential aged care services: *Australian Health Review*, early view. DOI:10.1071/AH14197

25. Ibrahim, J.E., Murphy, B.J., Bugeja, L., Ranson, D. (2015). Nature and Extent of External-Cause Deaths of Nursing Home Residents in Victoria. Australia. *Journal of the American Geriatrics Society*. 05/2015; 63(5). DOI:10.1111/jgs.13377

26. Ibrahim JE, MacPhail A, Winbolt M, Grano P. Limitation of care orders in patients with a diagnosis of dementia. *Resuscitation*: 2016 Jan;98:118-24. doi: 10.1016/j.resuscitation.2015.03.014. Epub 2015 Mar 26.

27. Kitching F, Winbolt M, MacPhail A, Ibrahim JE. Web-based social media for professional medical education: Perspectives of senior stakeholders in the nursing home sector. *Nurse Education Today* 05/2015; DOI:10.1016/j.nedt.2015.05.013

28. Ferrah, N., Murphy, B.J., IBRAHIM, J.E., Bugeja, L.C., Winbolt., M., LoGiudice, D., Flicker, L., & Ranson, D. (2015). Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review. *Age Ageing* 44(3): 356-364.

29. Murphy BJ, Bugeja L, Pilgrim J, Ibrahim JE. Completed suicide among nursing home residents: a systematic review: *International Journal of Geriatric Psychiatry* 05/2015; DOI:10.1002/gps.4299

30. Kennedy B, Ibrahim JE, Bugeja L, Ranson D. Causes of Death Determined in Medicolegal Investigations in Residents of Nursing Homes: A Systematic Review. *Journal of the American Geriatrics Society*: 2014 62 (8), 1513-1526

31. Ibrahim JE., Chadwick L, MacPhail A, McAuliffe L, Koch S, Wells Y. Use of quality indicators in nursing homes in Victoria, Australia: A cross-sectional descriptive survey. 2014 *J Aging Health* 2014; 26:824-840.

32. Ibrahim JE., Bugeja L., Ranson D., Using existing information from medico-legal death investigations for improving care of older people in Residential Aged Care Services. *Journal of Law and Medicine* 2013; 21:255-261.

33. Ibrahim JE and Bandopadhayay P. Social media and medical education: making an animated video for YouTube *Med J Aust* 2013; 199 (9): 627-628.

*There are at least another thirteen manuscripts in draft that will be submitted to academic peer review journals in the next 12-18 months.