Victorian Institute of Forensic Medicine

Residential Aged Care Communiqué

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CONTENTS

EDITORIAL

Welcome to the third edition of the year. This edition examines the plight of young people who live in residential aged care services (RACS). No, that statement is not an oxymoron. There is a significant number of young people, defined as those under the age of 65 years, who rely on RACS for accommodation and care. The appropriateness of this existing arrangement and the availability of realistic alternative options are hotly debated.

The two cases highlight the common clinical issues confronting staff of RACS in the provision of care for younger residents, which can be quite different to older residents. The lessons learned from the cases around formulating and adhering to care plans as well as ensuring the staff have the necessary education and training also apply more generally to RACS.

We have two commentaries from experts in the field, one from Maggie Whitmore, who is the Acting Systemic Review Manager with the Disability Services Commissioner of Victoria. Maggie is part of the team conducting an analysis of the deaths reported to the Disability Services Commissioner. This report is being tabled in Parliament later this year.

The other commentary is written by David Murphy, the Director of Rehabilitation at St Vincent's Hospital and chair of the Victoria and Tasmania Branch of the Australasian Faculty of Rehabilitation Medicine. David examines the role of the rehabilitation team for young people in RACS.

We also highlight the findings from our team's research into the subject as part of their Bachelor of Science Global Challenges Honours year. These short reports were written by Josh Zail, Alex Hopkins and Anna Cartwright, and are well worth a read.

On a final note, the ten recommendations from Monash University's Health Law and Ageing Research Unit relating to this topic are available in their report, *"Recommendations for prevention of injury-related deaths of young people in residential aged care services"*. The full recommendations are available at: http://vifmcommuniques.org/wp-content/uploads/2018/08/YPiRACS-Recommendations-Ebook-FINAL.pdf

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Next issue: November 2018

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Case: Don’t bother me while I eat

Case No: QLD 2015/3395
Précis author: Carmel Young; Research Nurse, Monash University

Clinical Summary

Mr M was a 53-year-old male requiring high-level care at a Residential Aged Care Service (RACS) located in a large regional town. Past medical history included Huntington’s disease (diagnosed six years previously), depression, gastro-oesophageal reflux disease and asthma.

Mr M had entered another RACS two years earlier in 2013, when his care needs became such that they could not be met in the community. Mr M had several behavioural issues including agitation and aggression towards co-residents and staff, which prompted an admission to an acute hospital in 2014. During this admission, it was deemed not possible for Mr M to return to the first RACS as it could not provide the necessary care. And so, he was relocated to another RACS and transferred directly there from the acute hospital.

The acute hospital discharge letter documented that Mr M was independent with eating food if the meal was set up and; that he liked being independent, often becoming upset if staff stepped in to help without seeking his permission first. On occasion, Mr M was physically abusive towards staff. The discharge letter also provided advice about effective strategies to manage Mr M’s behaviour and suggested that his symptoms were manageable by adherence to standard principles of care for people with dementia and more specifically Huntington’s disease patients.

This particular winter morning, care staff served Mr M breakfast, partly consisting of two pieces of bread cut into triangles with butter and jam. A staff member left Mr M in bed and closed the door to the room, as Mr M did not like to be disturbed when eating.

When the care staff returned approximately two hours later, they found Mr M lying in the bed on his right side with his left hand raised to his face. There was a piece of bread in his mouth and bread on the bed underneath his face. The police were called and the case was referred to the coroner.

Pathology

A forensic pathologist completed an autopsy to establish the cause of death. An internal examination found a large food bolus extending from the base of the tongue, through the pharynx and into the upper oesophagus. There was further food bolus in the trachea extending to both the left and right main bronchi. The cause of death was given as: 1(a)—Choking, 1(b)—food bolus in pharynx and, 2—Huntington’s disease; coronary atherosclerosis.

Investigation

By coincidence, approximately six months after Mr M’s death, a report into the deaths of persons with a disability over a five-year period was published by Public Advocate. The report identified systemic factors leading to death from choking. These included a lack of compliance by support staff with mealtime management plans and periods of non-supervision. On this basis, the coroner directed that further investigation was required and the case proceeded to inquest. Statements were received from the RACS provider, manager and care staff, the Public Advocate, and an independent expert.

The nursing care manager acknowledged receiving the discharge letter and stated that even though the speech pathologist recommended that Mr M was to have a minced, moist diet, he was sometimes determined to eat what he wanted. He would occasionally take food from others and would at times refuse to eat anything at all. On those days, Mr M was given sandwiches as a last resort, in an effort to have him eat something. The sandwiches comprised of bread that was very soft and moist with the crust removed.

Staff said that he had eaten the soft sandwiches on multiple previous occasions without coughing or any other signs of choking.

The staff explained the challenges of balancing Mr M’s strong preferences for being independent, choosing what he wanted to eat even if this was sometimes contrary to speech pathology advice, his wide range of difficult behaviours, and being able to provide the support he needed. The behaviour management strategy plan was to allow him to feed himself, once the meal had been set up for him, as the major concerns were around spillage of food causing a slipping hazard rather than choking.

> The coroner concluded that the care provided for Mr M to manage the risk of choking was not in accordance with the care plans.

The expert who had qualifications in social work and nursing, reviewed the appropriateness of care and reported that the provision of assessed care needs was complicated by Mr M’s behaviours and wishes; and that the RACS staff appeared to have made every effort to provide care consistent with assessment and care plans. Although it was difficult to know if the outcome would have been different, the expert considered there was a lack of compliance with Mr M’s care plan and an unacceptable period of non-supervision.

Coroner’s Comments and Findings

The coroner concluded that the care provided for Mr M to manage the risk of choking was not in accordance with the care plans. Specifically, the recommended food/fluid intake was not strictly adhered to by staff and he had been left unsupervised in a closed room.

The coroner made four recommendations. The first was that *“choking deaths of persons in care with a disability be specifically acknowledged as a systemic issue, and strategies to manage, monitor, review and report on this particular issue should be built in to the NDIS [National Disability Insurance Scheme] quality assurance and reporting framework”*. The other three recommendations addressed the need for staff handover of any material change to a resident’s care plan prior to the commencement of their next shift; residents’ care plans are to be reviewed every three months or sooner if circumstances change and; residents with conditions that affect their ability to swallow should undergo regular medical examinations to identify and treat aspiration pneumonia.

Case: One plan is better than two

Case No: NSW 2015/00118871
Précis author: Joseph Ibrahim and Carmel Young; Monash University

Clinical Summary

CC was a 28-year-old female resident at a community-based group home requiring a high level of care. CC was a good natured person, with a wonderful sense of humour and a love for music who enjoyed dancing in her chair. CC's past medical history was very complicated, as she was born six weeks prematurely with a cerebral haemorrhage causing brain damage. By the time CC was 14 months old, the list of medical conditions included cerebral palsy, hydrocephalus, left hemiparesis, dislocated hips and poor vision. At the age of five years, CC had a clonic-tonic seizure leading to the diagnosis of epilepsy. At the age of ten years CC was requiring full time care and so entered a group home.

Eighteen years later, very early in the morning, a group home staff member was doing a final check on the residents and heard CC breathing heavily with her body rigid and shaking. The staff member left the room to get CC's Epilepsy Management Plan and rang a colleague for advice. The colleague suggested calling the manager, CC's mother and the paramedics. The seizure terminated shortly after. The staff member handed over to the morning shift staff and mentioned that estimated length of CC's seizure was of several minutes duration.

A short time later that morning, CC appeared to be in her usual post-seizure state. When the morning shift carer returned after 30 minutes, CC was lying face down and her face was blue. Cardiopulmonary resuscitation was commenced and emergency services called. When the paramedics arrived, CC was in cardiac arrest. The paramedics continued resuscitation efforts for 30 minutes before CC was pronounced dead.

Pathology

Following an autopsy, the pathologist determined the cause of death as being 'unascertained'.

Investigation

The coroner directed that further investigation was required because the cause of death was "unascertained" and the circumstances raised issues about her care. Specifically, how was CC's epilepsy managed, and had staff adhered to CC's Epilepsy management plan? An inquest was held and statements were received from the group home executive and staff, several pathologists and a neurologist.

> The RACS staff stated that an ambulance was not called because the seizure had lasted only four minutes. Further, they had never been trained on how to measure the duration of a seizure or how to administer midazolam.

The investigation revealed CC's epilepsy management involved her neurologist, general practitioner, team leader and staff at the group home, and her mother. The coroner noted that there were a number of documents that contained inconsistencies. For example, the first plan based on a protocol developed by the neurologist involved the administration of buccal midazolam for "emergency treatment of seizures", followed by a call to the ambulance service if the seizure duration exceeded five minutes. Another document dated three years later stipulated that midazolam should be used if the seizure duration was more than three minutes.

The inquest also revealed that CC had not attend a scheduled review with the neurologist a few months prior to this event. The RACS staff stated that an ambulance was not called because the seizure had lasted only four minutes. Further, they had never been trained on how to measure the duration of a seizure or how to administer midazolam.

Coroner's Comments and Findings

The case was closed following an inquest. The coroner concluded that: CC died from complications of epilepsy; staff did not follow the documented emergency epilepsy management plan; the training of staff was less than optimal and this led to potentially unsafe care practices.

> The coroner highlighted the need for all services to learn from the identified shortcomings in the supported living services provided to CC

The coroner stated that there was not any conclusive evidence to suggest that a different response would have altered the outcome. The group home had made changes to improve care prior to the inquest. This included education and training of staff in the use and administration of midazolam; that staff fully understand the individual needs of their clients; and that casual staff are included in all staff communications.

The coroner directed recommendations to the Chief Executive Officer of the National Disability Insurance Agency and the Managing Director of the group home.

The coroner highlighted the need for all services to learn from the identified shortcomings in the supported living services provided to CC, and recommended *"the adoption of a multidisciplinary team approach to the drafting and implementation of appropriate Epilepsy Management Plans"*.

Commentary: Avoidable deaths: what we can be doing better

Maggie Whitmore
Acting Systemic Review Manager,
Disability Services Commissioner

A person with a disability residing in a RACS may experience multiple challenges. They may have health conditions that can result in them becoming critically ill within a short period of time, as well as difficulties in their communication, mobility, cognition, eating and/or swallowing.

In Victoria, it is essential that anyone working with an individual with disability understands the *Charter of Human Rights and Responsibilities Act 2006*. The Charter imposes an obligation on Victorian public authorities to act in a way that is compatible with human rights, or give proper consideration to relevant human rights when making decisions. The Charter articulates that every person has the right to freedom of expression, which includes the freedom to seek, receive and impart information and ideas of all kinds; whether orally, in writing, in print, by way of art or in another medium chosen by the person.

The combination of a lack of functional communication and associated 'behaviours of concern' can make it difficult to identify potential health issues, sometimes resulting in late diagnosis of pathology and resultant potentially serious implications for the person's health.

A person with disability who has limited communication may use 'behaviours of concern' as a means to communicate when they are unhappy, sad, frustrated, uncomfortable or in pain. Unfortunately, it is commonplace for an individual to be labelled as 'difficult' or 'problematic' without an understanding of what might be behind such behaviours.

The combination of a lack of functional communication and associated 'behaviours of concern' can make it difficult to identify potential health issues, sometimes resulting in late diagnosis of pathology and resultant potentially serious implications for the person's health. Given this, it incumbent upon service providers, both legally and morally, to be supporting a person's ability to communicate to the best of their ability through the development and implementation formalised communication plans.

Good plans are only effective if they are followed up with training for everybody involved in the person's care.

Further, all too often people with disability are living in circumstances that they have not chosen, without a say on who is caring for them or who else lives in their home. It is vital that people with disability are supported by appropriately skilled staff and receive services that promote their safety and wellbeing. The ability to identify that certain behaviours or presentations are unusual for an individual can be reliant on the degree to which a staff member knows that individual. It is essential to have consistency in staffing to ensure staff members are familiar with an individual's needs.

The importance of having clear and up-to-date support plans cannot be over emphasised. These plans need to contain the key information required to support the individual. In circumstances where there are multiple plans (e.g. support plans, health plans, mealtime assistance plans, dental plans, behavioural support plans) it is essential that these plans are consistent, kept up to date as the person's needs or circumstances change, and do not provide contradictory information. When multiple support plans exist, they need to be centrally located to ensure staff have access to all relevant information.

Good plans are only effective if they are followed up with training for everybody involved in the person's care.

For example, to reduce the risk of choking and associated respiratory infection, support staff should have ready access to the relevant plans and also receive training around safe mealtime practices including following prescribed meal plans, ensuring optimal environmental conditions, preparation of food to recommended textures, monitoring of the eating process, and recognition at an early stage, of signs that an airway may be compromised.

Aspiration pneumonia is a life-threatening infection caused by inhaling food, fluid, saliva or vomit into the lungs. Aspiration pneumonia is often avoidable if, in the event of inhaling foreign matter, timely medical treatment is provided. Preventative measures include eating and swallowing assessments along with awareness of vulnerability to infections and respiratory conditions.

> Training directed on best practice methods of care is required for staff supporting people with disability who have epilepsy, in order to reduce the incidence of sudden, unexpected death.

Such preventative measures have been emphasised in the literature and through death reviews across multiple jurisdictions.

Literature pertaining to mortality and disability indicates that sudden unexpected death in epilepsy (SUDEP) is a growing trend. In SUDEP cases, a complication of epilepsy has resulted in sudden and unexpected death however the cause of death is generally unascertained. Training directed on best practice methods of care is required for staff supporting people with disability who have epilepsy, in order to reduce the incidence of sudden, unexpected death.

Given the often-complex needs of people with disability, it is critical that services have clear policies and procedures to guide and support staff to provide high standards of care in areas such as safe mealtime assistance, epilepsy management and communication plans. Services must also take the necessary steps to ensure that care is delivered as directed. Advanced training on topics of health and wellbeing will enhance staff competence in identifying symptoms early and seeking the relevant course of action, improving outcomes for the people in their care.

It is fundamental that organisations working with people with disability ensure their practices are person-centred and rights-based. Staff need to be provided with access to ongoing learning and development and be trained in the specific needs of each individual. Support plans need to contain essential information to ensure that the person is supported in a manner that upholds their rights and maintains their dignity.

References

1. Victoria's Charter of Human Rights and Responsibilities at: https://www.humanrightscommission.vic.gov.au/human-rights/the-charter.

2. Heslop P et al. 2013, op. cit.; MENCAP 2007, *Death by indifference: following up* the Treat me right! *report*, https://www.mencap.org.uk/sites/default/files/2016-06/DBIreport.pdf, accessed 4 July 2018; New South Wales Ombudsman 2013, op. cit.

3. Trollor J, Srasuebkul P, Xu H and Howlett S 2017, 'Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data', BMJ Open, vol. 7, no. 2, e013489, doi: 10.1136/bmjopen-2016-013489.

4. *Upholding the right to life and health: a review of the deaths in care of people with disability in Queensland – a systemic advocacy report*, State Government of Queensland, Brisbane

5. New South Wales Ombudsman 2013, *Report of reviewable deaths in 2010 and 2011: volume 2 – deaths of people with disabilities in care*, State Government of New South Wales, Sydney;

Commentary: Young People in RACS: the role of the Rehabilitation Team

Dr David Murphy MBBS, FAFRM
Director of Rehabilitation, St Vincent's Hospital and St Vincent's Private Hospital Melbourne
Chair: Australasian Faculty of Rehabilitation Medicine (RACP) Vic/Tas Branch
Chair: Rehabilitation Medicine Society of Australia and New Zealand
Vic/Tas Branch

We are fortunate in Australia to have well-developed support systems that enable many young people with significant disability to be able to live in a supported environment in the community. The introduction of the National Disability Insurance Scheme (NDIS) will enhance these supports such that our country will be a world leader in the provision of resources that assist young people with disability to achieve their optimal and desired level of participation in life.

The introduction of the NDIS is one of the most significant social changes that have occurred in my lifetime, along with the introduction of Medicare, access to tertiary education and marriage equality. Despite the considerable resources of NDIS, there will still be a need for young people to reside in RACS, which may be by choice as is the case for some of my patients who live happily in such facilities, or by necessity due to the complexity of their medical, physical and psychosocial circumstances.

The cases in this RAC Communiqué provide two quite common examples of the difficulties faced by young people with complex neurological conditions. Children with cerebral palsy are usually managed by very well-resourced paediatric services which are a "one stop shop" where, as in the case example, the child and family can access the Epileptologist, Neurosurgery, Orthopaedic, Gastrointestinal, Ophthalmological and other medical and allied health services which are centralised and case-managed by the service.

The transition to adult health services may be very difficult as the young adult is expected to be able to negotiate the confusing world of public and private health services and the case co-ordination falls onto their busy and often under-resourced general practitioner (GP).

> Providing clinical leadership and coordination of services to meet the needs of the young person is another important role.

This complex process and nature of transition has been recognised, but only quite recently. In Victoria, this has led to the establishment of a "Young Adults with Complex Disability Services YACD" in metropolitan and regional centres to assist with transition. These services are staffed by experienced rehabilitation professionals headed by a Rehabilitation Physician. As the Director of Rehabilitation where one of the YACD operates, I am acutely aware that the pool of clinicians with the skills to work in such services, whether they are hospital, community-based, public or private, is limited and we must do more to expand this pool.

A key role of these rehabilitation clinicians should be to provide education and support to the rapidly expanding disability support workforce. There are many areas in which the clinicians have valuable knowledge and expertise.

> Rehabilitation physicians, nurses and allied health professionals can and should be an integral part of the network that supports young people in RACS as well as in the community.

These include management of medical issues such as pain, seizures, spasticity, continence, musculoskeletal and gastrointestinal conditions. The rehabilitation clinicians also have an important role in managing physical conditions such as nutrition, swallowing, mobility and seating and, cognitive and behaviour management.

Providing clinical leadership and coordination of services to meet the needs of the young person is another important role.

The two cases demonstrate the importance of training and education of staff caring for young people with disabilities. These cases also highlight the absolute necessity of careful planning and consistent management of this very vulnerable group of people.

Rehabilitation physicians, nurses and allied health professionals can and should be an integral part of the network that supports young people in RACS as well as in the community. They must themselves have access to training and support to acquire and maintain the high level of skills that is required to work in this field.

Research into Young people in RACS in Australia

As part of their Bachelor of Science Global Challenges Honours year, Josh Zail, Alex Hopkins and Anna Cartwright completed three inter-related research projects on young people in Residential Aged Care (RAC). These three students conducted a geospatial analysis, an epidemiological analysis, and consultation with an expert panel to identify injury prevention recommendations. The aim of this research is to contribute to the knowledge, policy and practice base for improving the quality of care for young people in RACS. Their findings are summarised below.

Geospatial analysis

Josh Zail, Honours student, BSc(Advanced) - Global Challenges
Faculty of Science, Monash University, Clayton VIC 3800, Australia

Across Australia, there are approximately 6000 young people (under 65 years) living in RACS. Little is known about the geographical distribution of this population. I set out to determine the feasibility of mapping the geographical distribution of young people living in RAC in Australia, by generating and describing a wide range of maps of pertinent characteristics of young people in RAC.

I obtained Aged Care Funding Instrument (ACFI) data from the Australian Institute of Health and Welfare and combined it with population statistics using Geographic Information System software. The result was a set of 13 choropleth maps - which use colour and shading to represent data, and reveal geographical trends.

These maps show that regional areas, particularly in Victoria, are over-represented in terms of young people in RAC. Although the number of young people in RAC has decreased nationally since 2009, the distribution has changed, with many areas experiencing increases in numbers, especially in regional Victoria and southern NSW.

The demographic maps show high proportions of young people in RAC under 50 years of age in the 'Outback' areas in Australia's north and west, and reveal that young people in RAC gender proportions vary significantly between areas. The distribution of young people in RAC with Intellectual or Developmental Disorders is somewhat correlated with the prevalence rate of young people in RAC.

I also assessed the care needs of young people in RAC across the three ACFI domains, but I could not establish a clear geographical pattern, although certain areas of Melbourne, Sydney and Brisbane show relatively high needs, whilst certain areas in regional NSW and Queensland show relatively low needs.

These findings show that mapping is indeed feasible, and has the potential to be a valuable tool for researchers, planners and policy makers.

Epidemiological analysis of deaths

Alex Hopkins Honours student, BSc(Advanced) - Global Challenges
Faculty of Science, Monash University, Clayton VIC 3800, Australia

Young people continue to die in RAC and there are concerns about whether some of these deaths are potentially avoidable. Natural causes of death usually follow an expected pattern. In contrast, unexpected deaths are more likely to be due to unnatural and potentially preventable incidents, which may reflect suboptimal practice.

Analysing the causes of death and comparing these with the young person's illness or injury that was the reason for admission, gave insight into this area. National Coronial Information System (NCIS) full text documents were examined for circumstantial data of events that occurred between entry into a RAC, and their death.

Of the 119 deaths studied of Australian RAC residents under 50 years whose deaths were reported to the coroner between 2000 and 2013, it was found that the majority of young people who entered RAC died of causes directly related to their clinical reason for entry. Naturally occurring clinical conditions were the most common reason for entry (n=56), and the cause of death was deemed natural for a similar number (n=59). Interestingly, exactly half who entered RACS for a naturally occurring condition (e.g. multiple sclerosis) also died of what was classified as natural causes (n=28). Moreover, over half of the causes of death were deemed to have a less than 50% chance of being prevented. This is the first study to examine the relationship between reason for entry and cause of death. That severe and progressive disease feature in both the reason for entry and death was expected. Nonetheless, there were clear opportunities for improving care.

Injury Prevention

Anna Cartwright, Honours student, BSc(Advanced) - Global Challenges
Faculty of Science, Monash University, Clayton VIC 3800, Australia

The third part of this research program focused on injury prevention for young people in RAC. This involved two expert/stakeholder panels employing a modified nominal group technique to produce a list of prioritised recommendations for injury prevention specific for young people in RAC.

The experts/stakeholders comprised of a passionate, articulate group of individuals representing government, advocacy, aged care, research, and healthcare sectors.
Ten recommendations were developed encompassing the themes of: improving quality of care, developing collaborative approaches, increasing choices, and reviewing and reporting. Many of the recommendations focused on system level reforms which may have stemmed from the participants' sense of urgency around the issue of young people in RAC.

Each of the recommendations were evaluated in terms of implementation. The respondents chose aged care providers as the most common group for implementation, indicating that whilst the reforms may need to be system wide, the implementation of the changes need to be at an individual service level. When asked to evaluate the timeframe for implementation, the experts/stakeholders selected a short time frame (1-3 years) most often.

Save the date

Seminar "Young people in RACS: Time to act"

Friday 31st August 2018

The seminar explores why this situation continues, what initiatives are in place to change the status quo, and what can be done to better enable young people in RACS to have a better quality of life. Presented by Monash University and the Victorian Institute of Forensic Medicine, this educational seminar will be run by experienced leaders in the fields of disability, aged care, law and policy. This seminar is designed for aged care workers, nurses, managers, and healthcare professionals who want to know more about policy, practice and what the future may hold.

Centrally located at the Alfred Medical Research and Education Precinct (AMREP) lecture theatre, 75 Commercial Road, The Alfred Melbourne Victoria.

Online payment and registration are to be made via the following link:

https://shop.monash.edu/young-people-in-residential-aged-care-services-seminar.html

List of Resources

1. "Recommendations for prevention of injury-related deaths in residential aged care services" from the Health Law and Ageing Research Unit, Monash University 2017. This has information about reducing harm from choking. Available at: www.vifmcommuniques.org/?p=5194.
2. Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland, 2016. The Office of the Public Advocate (Qld).
3. RAC Communiqué Volume 2 Issue 2 May 2007. Choking.
4. RAC Communiqué Volume 5 Issue 3 August 2010. Unmet needs.
5. RAC Communiqué Volume 6 Issue 3 September 2011. Dignity of Risk.
6. National Disability Insurance Agency (NDIS) https://www.ndis.gov.au/index.html.
7. NDIS Quality and Safeguards Commission https://www.ndiscommission.gov.au/.
8. Summer Foundation, includes resources for the aged care sector to improve outcomes for NDIS participants. https://www.summerfoundation.org.au/project/aged-care-capacity-building/
9. Younger People in Nursing Home National Alliance, https://www.ypinh.org.au/.
10. National Disability Services, for disability service providers https://www.nds.org.au/.

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FEEDBACK

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

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All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed.

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National tour screening and discussing “Dignity of Risk”

Professor Joseph Ibrahim (Monash University) or 'Prof Joe' is touring across Australia with the film "Dignity of Risk" in 2018 and 2019. The film won "Best Narrative Film Category" at the 2017 Global Impact Film Festival and was an official selection with laurels for six other international festivals including the Awareness Festival (Los Angeles 2017), Atlantic City Festival (New Jersey 2017), United Nations Association Film Festival (San Francisco 2017), American Association Public Health (Atlanta Nov 2017). Rendezvous with Madness Film Festival, (Toronto Canada 2017) invited a special screening and in Australia the film received a laurel at the Fifth Setting Sun Film Festival, (Yarraville, Melbourne 2018). This week we received exciting news that the film is selected for screening at the 7th Annual Social Justice Film Festival (Seattle USA Oct 2018).

Each event on the tour will commence with a screening of the film, "Dignity of Risk” and will be followed by an informal lecture with opportunity for questions from the audience to explore the notion of dignity of risk for older people, how living with the impact of dementia is constructed, the role of aged care facilities, and the complex interplay between individual, family and organisational requirements to manage risk.

The total event duration is approximately 90 minutes comprising 15 minutes for screening the film and 45 minutes for presentation, discussion and questions.

To register your expression of interest please go to this link: [https://goo.gl/forms/foexsKXjbGdFqqCP2.](https://goo.gl/forms/foexsKXjbGdFqqCP2)