

# Residential Aged Care

# Communiqué

VOLUME 10. ISSUE 4.  
November 2015 Edition  
ISSN 1834-318X

## EDITORIAL

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**Next issue: February 2016**



A Victorian  
Government  
initiative



Welcome to the final issue for 2015 in which we consolidate the lessons from the case reports we published over the past year. This issue examines 'reporting' in Residential Aged Care (RAC), something we all find challenging.

Over the past 12 months we published cases where: residents had died prematurely due to a nurse deliberately setting fire to a RACS; a premature death was 'covered up' as it was initially not reported to the Coroners Court; and a death occurred due to the actions of another resident. Many of these events received media attention bringing a new and heightened level of scrutiny about the policies, practice and professionalism of staff in RACS.

It would be foolish to dismiss these events as tragic 'one-off' cases. It is too easy to 'write-off' these situations as being due to naiveté, ineptness, careless, thoughtless or criminal behaviour of a single person. A sensible approach is to examine what happened, and to contemplate how the same events may occur on our shift. Typically, we look for reasons why we think it would not occur, rather than why it may. That's just human nature.

To help us reflect on what happened in these cases and to be better prepared we have sought two clinical experts to provide commentaries and we include a brief precis of two research projects. We examine the nature of 'reporting' delving into what is mandatory or voluntary; why requirements exist, what our responsibilities are as an individual, professional and employee and finally reporting from the point of view of the resident, regulatory authorities and community. The latter form of reporting is more commonly seen as accreditation and quality indicator programs.

We wish our subscribers and readers all the best for the New Year and look forward to 2016 which is our 10 year anniversary. We are hoping to mark the occasion with a special event.

## Cases Revisited

Please note these summaries do not provide all the details or context of each case, we have sought to highlight one aspect of each for the expert commentary.

### RACC Feb-2015: Failure to report a death to the Coroners Court

Ms M was a 76 years old female with a past medical history of severe vascular dementia. She had a tendency to wander and was residing in a dementia specific RACS. One afternoon, Ms M went for a walk in the courtyard. Staff searched for her when they realized she was missing and found her, deceased, lying at the fountain. Ms M had tripped over a garden light and fallen headfirst into the pond. The cause of death was “*Immersion (with underlying cause undetermined in circumstances of a fall into a courtyard water feature)*”. The death was not initially reported to the Coroners Court. The Coroner stated; “The death of Ms M was complicated by breaches of policy and procedure at [RACS]. Indeed the actions of some staff amounted to little more than a cover-up” as neither the General Practitioner nor the family were told of the circumstances of death.

### RACC May 2015: Resident on resident aggression

Ms K was walking in the hallway of a RACS, when she stopped to talk to another resident Ms X. During this conversation Ms X pushed Ms K who fell fracturing a hip. Despite surgery Ms K died within a week from a myocardial event. Ms X was a 70 year old female resident with a medical history of dementia with paranoid episodes. At the time of this incident, she was on a range of medications to treat the Behavioural and Psychological Symptoms of Dementia (BPSD), which included two antipsychotic agents. Ms K's family reported the incident to police on the day it occurred. Recommendations made included, “*residents who are assessed as a danger to other residents should be given priority to receive timely intervention, including admission to a behavioural unit as appropriate*” and that RACS staff should contact their local health services for assistance.

### RACC Aug 2015: Arson

A fire was deliberately lit in the RACS by a recently employed member of nursing staff causing, or contributing, to the deaths of 14 residents. This was done by the individual in an attempt to cover up his theft of Schedule 8 medications from the RACS. The RN had been subject to past employment disciplinary action and disputes but these were not disclosed nor revealed by the RACS scrutiny of employment records and checking of credentials. Also, staff had noticed his behaviour was unsettled but had not reported this to management.

## Commentary: Making a report

### Ruth Vine

*Ruth is the Executive Director of NorthWestern Mental Health and a practicing psychiatrist for over 20 years. Ruth previously worked in forensic psychiatry and in the Department of Health (Human Services) in a number of roles including Director, Mental Health and Chief Psychiatrist.*

Being part of the care team for persons living with dementia should be experienced as a safe and satisfying role. However, some of the persons cared for are likely to show behavioural and psychological symptoms associated with Dementia (BPSD) and pose difficult challenges for staff in how to provide a caring, therapeutic and safe environment.

Getting the right mix of residents is important, as is having staff who are experienced, skilled in managing difficult behaviours, and well engaged with residents and their family. I have always been very impressed by the care and skill of staff in the RACS I visit. Residents of these facilities are among the most vulnerable in our community and deserve to be cared for in a way that preserves their dignity and ensures safety for all residents and staff.

If there are allegations or suspicions of assaults, these should be reported under the provisions of the Aged Care Act 1997 VIC (Sect 63.1AA). Reporting is required to be made to the Australian Department of Social Services, and to the police. There is an element of discretion to this – where the resident involved is affected by assessed cognitive or mental impairments and if there are subsequent reports of a similar nature. But, it is always best to err on the side of caution and staff should ensure that there has been documentation of the level and nature of impairment by the treating General Practitioner (GP), and that all persons involved have been reviewed, and that if there has been a serious injury a report is made. Staff reporting such incidents are protected. Most important is good documentation, as close to the incident as possible – dated and signed.

Often staff feel a little intimidated or unsure when making a report to the Department of Social Services and Police. It is useful to be able to explain the Act, and to make sure you are familiar with all the details of the resident, the facts of the assault and can be confident in what you are describing. It is important that all services have in place a system of review and provide opportunity at relevant meetings for such incidents to be discussed.

There should be a Register of reportable assaults, and a system for ensuring that relevant family members or a guardian have been informed.

Staff in RACS are able to access information, advice and support in the management of persons who do have behavioural and psychological problems associated with dementia. Such support can be provided by the State funded aged care services through the Aged Psychiatry Assessment and Treatment Teams (APATT). Contact and referral details should be readily available in all units.

## Commentary: Clinical Forensic Medicine role in investigating physical and sexual assault

### David Wells

*David Wells is a consultant at the Victorian Institute of Forensic Medicine (VIFM) and was previously head of Forensic Medicine at VIFM for almost 20 years, he is an Associate Professor in the Departments of Paediatrics and Forensic Medicine at Monash University and co-ordinator of the international post-graduate program in Forensic Medicine at Monash. David is currently contributing to a global project for the WHO, aimed at assisting victims of sexual violence occurring during periods of armed conflict and identifying perpetrators of those crimes.*

### What should you do if you think a resident might have been physically or sexually assaulted?

This might occur if your patient (or their family member) complains of an assault or if there are unexplained injuries or if there is change in their behaviour. You are likely to be the best person to notice changes in their physical or mental state. Unless you are very confident that there is no substance to the concerns (e.g. injuries explained by a witnessed fall), then the next step is to inform your senior/supervisor. This should result in a notification to the next of kin (unless there is any suggestion of their involvement) and then a report to the local police. Ideally these steps should occur within 1-2 hours.

Police will then take responsibility for the investigation. This will include preserving the scene, collecting physical evidence and speaking to the parties (witnesses, staff, family).

In Victoria, police will also contact the Victorian Institute of Forensic Medicine (VIFM) to get advice on the medical management and the investigation. VIFM staff will advise police and nursing staff about the examination and what is required before this occurs; accessing consent, preserving clothing and not washing the patient or treating injuries unless there is an urgent need to do so.

In most cases, the examination can be done at the facility and would occur within a few hours. Ideally a facility staff member who knows the patient well would be present. After the examination is completed, VIFM staff would speak to family, nursing staff and the patient's GP about the findings and the patient's management. Police will advise the parties about statements, investigations and any court matters.

### **What is clinical forensic medicine?**

Forensic medicine is a small area of practice at the interface of medicine and the law. Clinical forensic medicine deals largely with the living whilst forensic pathology focuses on the deceased. Other fields of forensic practice include forensic psychology and psychiatry, odontology and a range of specialist practices under the heading of the forensic sciences. In Victoria, clinical forensic medicine and forensic pathology services are provided through the Victorian Institute of Forensic Medicine which is co-located with the Coroners Court in Southbank. The Institute also functions as Monash University's Department of Forensic Medicine.

Clinical forensic medicine encompasses a diverse range of activities. These include:

- Interpersonal violence - in particular, allegations of sexual assault in both adults and children. This will include clinical management of the patient (alone or with the assistance of other health practitioners), documentation of history and examination findings, collection of specimens, acute management and advice on follow-up.
- Traffic medicine - the effect of alcohol and other drugs and medical conditions on driving, fitness to drive or to hold a licence;
- Custodial medicine - fitness for detention or interview;
- Biological specimens - collection of specimens that may assist a criminal investigation

Arising from these activities, there is a significant amount of report writing and provision of evidence in court cases.

A range of skills is utilised in the delivery of these medico-legal components; injury interpretation, clinical toxicology, risk assessment etc. Teaching and research round off these clinical activities.

Staff of the service includes full-time and part-time medical practitioners and nurses located in Melbourne and a number of regional centres providing a 24-hour statewide service. The majority of clinical services are provided at public hospitals and the forensic assessment is often conducted in parallel with the health management undertaken by hospital staff.

Whilst members of the public can utilise the service, access to the service is usually through police, lawyers, hospitals, government organisations (e.g. Vic Roads) and professional organisations (e.g. AHPRA). The service is accessible at any time of the day or night to respond to enquiries, offer advice or participate in the delivery of a clinical service. In forensic cases, early interventions are often vitally important; before trace evidence is lost or health interventions change the presenting findings.

It is important to acknowledge that there are many challenges in the delivery of medico-legal services. These include ethical issues (in particular, confidentiality and disclosure), legal obligations (reporting), risks (to staff, family or the general public), documentation (hospital notes and legal reports) and court attendance. Every case is different and brings with it a range of complexities often not envisaged at the early stages. Inexperience, the unique nature of the case, specific issues of the workplace and differing opinions of colleagues can make evaluations difficult. Decisions on these and other matters are best made after accessing advice from specialist services and experienced practitioners.

### **Editor's comments**

We are very grateful for David's contribution, which was written whilst in a conflict zone overseas. To give you a sense of the situation David's email opened with the sentence "Slipping into bed with helmet, flak jacket, radio and evacuation plan on the bedside table".

Note: each jurisdiction will have different services available to support the investigation of criminal matters in each State and Territory of Australia. It is important to know your local services.

In Victoria, Australia, the VIFM forensic medical or nursing advice can be readily accessed by phone: (03) 9684 4480 or email: [cfm@vifm.org](mailto:cfm@vifm.org). The service is free of charge and confidential.

## **Policy into real world practice**

### **Joseph Ibrahim**

Any policy that stipulates 'compulsory' or 'mandatory' is difficult to enforce and in the end is reliant on an individual's action. Individual's beliefs, interpretation of complex situations varies and so; what one person may report another may not. This does not remove an obligation to report. The law recognizes the complexity of the situation by making provisions to protect the person making a report. The Act stipulates that if you "have reasonable grounds to suspect that a reportable assault has occurred; and the disclosure is made in good faith" you are protected from civil or criminal liability.

To eliminate assault from RACS requires understanding: how often these circumstances arise; to investigate the causes and to develop methods that improve care. The first step is recognizing and reporting these events. If you are ever in doubt about what to do, ask someone senior or discuss with DSS or police.

A noteworthy aspect in RACS is that the onus for mandatory reporting is on the RACS provider - not the individual staff member to report assault. The expectation is the provider has systems in place that encourages staff members to notify them of any concerns so that they can fulfil their statutory obligations. The information below is taken from the DSS website and worthy of discussion with your peers and the executive of your RACS.

*"Residents of aged care homes, their families and advocates, visiting medical practitioners, other allied health professionals, volunteers and visitors are not required under the Act to compulsorily report assault and therefore are not afforded statutory protection under the legislation.*

*However, these people are strongly encouraged to report incidents of abuse or neglect of an aged care resident to the Department's Aged Care Complaints Scheme. The person providing information may do so openly, anonymously, or may ask the Scheme to keep their identity confidential.*

*Further, these people also have access to existing protections from defamation action through common law. As such persons are often well placed to identify if an assault of a resident is reasonably likely to have occurred, an approved provider should consider establishing visitor policies and protocols encouraging reporting where it is in the best interests of the residents."*



# A different form of reporting quality indicators and accreditation

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## Quality Indicators

This study consisted of interviews with 56 senior clinical, executive and front-line staff across 20 public sector residential aged care services (RACS) in Victoria (Australia). The aims of the study were to (1) identify the benefits and limitations of using quality indicators (QIs) for improving care, and (2) to determine any enablers or barriers to the implementation of a QI program.

Most study participants reported positive benefits to using QIs within RACS. Two of the major benefits included (1) an improvement of quality culture in staff and within the organisation, such as practice change and promotion of self-evaluation and (2) improvements in the quality of care for the resident (such as improved risk assessment).

Limitations for implementing a QI program largely centred on increased workload, need for additional resources and duplication of effort between the QI program and other accreditation requirements.

The main barriers identified by study participants included concerns about the credibility of the QIs, such as interpretation of definitions and inconsistent checking across RACS of QI data. The most important enabler for implementing a QI program included education and training of all staff with an explanation of the rationale, purpose and use of the QI data identified as the most important objective of education.

Overall, the use of QIs led to substantive benefits for resident care and contributed to a culture of quality in RACS.

If you want to read the full article the reference is: *Senior staff perspectives of a quality indicator program in public sector residential aged care services: a qualitative cross-sectional study in Victoria, Australia.* Chadwick, L.M., MacPhail, A., Ibrahim, J. E., McAuliffe, L., Koch, S., & Wells. Y. *Australian Health Review.* 2015 Jul 13. doi: 10.1071/AH14197.

## Accreditation in Canada

This study was conducted on 587 long-term care (LTC) homes in Ontario (Canada) that provide services to individuals requiring high levels of assistance with personal care, 24-hour nursing care and supervision in a secure environment. Accreditation of LTC homes in Ontario is not a compulsory process. To encourage participation, incentives including higher reimbursement rate (per bed day) are provided by the regional Ministry of Health and Long-Term Care. The aim of this study was to compare accredited and non-accredited LTC homes to examine whether: (1) voluntary accreditation is associated with more favourable safety; and (2) whether organizational characteristics are predictors of LTC home accreditation.

Accredited homes had fall rates that were 8% lower than non-accredited homes but the same in four other areas measured. The study also found that accredited LTC homes were more likely to be owned by a for-profit corporation, to belong to a chain and to be located in an urban area. Municipal and non-profit LTC homes were six times less likely to be accredited.

The authors proposed that studies on accreditation should be region specific due the differences in accreditation programs between regions and countries.

*If you want to read the full article the reference is: Accreditation and Resident Safety in Ontario Long-Term Care Homes. McDonald, S. M., Wagner, L. M., & Gruneir, A. (2015). Healthcare Quarterly, 18(1):54-9.*

## RACC Resources

### 1. Previous editions of RAC-Communiqué

- RAC-Communiqué Volume 10 Issue 1: Information and culture of reporting
- RAC-Communiqué Volume 10 Issue 2: Resident and resident aggression
- RAC-Communiqué Volume 10 Issue 3: Arson

### 2. Department of Social Services, Compulsory Reporting Guidelines for Approved Providers of Residential Aged Care.

This provides guidance about identifying, reporting and responding to allegations of assault in residential aged care in Australia. Available at <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/programs-services/aged-care-complaints-scheme/compulsory-reporting-guidelines-for-approved-providers-of-residential-aged-care>.

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## ACKNOWLEDGEMENTS

This initiative has been made possible by collaboration with the Victorian Institute of Forensic Medicine and funding from the Ageing and Aged Care Branch, Department of Health and Human Services of Victoria.

## FEEDBACK

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

## DISCLAIMER

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

We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health, Victorian Institute of Forensic Medicine or Monash University.

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