ECW ELDER CARE WATCH

NEWSLETTER
January 2017 Edition 60

## Mary MacKillop Care St Catherine's *Berri, SA* sanctions imposed

***"insufficient staffing has resulted in repeated failure to attend to residents' toileting needs...."***

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## Law Reform Commission recommends

**compulsory reportable incidents scheme**

**national employment screening process**

**code of conduct for aged care workers**

**placing legal limits on restraint of residents**

**referral power for community visitors**

**official visitors scheme to monitor care**

**but *déjà vu* - leaves the critical staffing issues of numbers, skill mix and qualifications to other reviews!**

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## Disturbing evidence from Coroner's inquest

***St Basil's Aegean Village Christie Downs, SA***

*see page 7*

## RN sentenced to 36 years jail

***"conduct almost too awful to contemplate"***

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# Mary MacKillop Care, St Catherine's
## *RACS ID 6840, Berri, SA*
## *sanctions imposed*
## *the curious reversal on continence management*

**Review audit**

A Quality Agency review audit in August 2016 at Mary MacKillop Care revealed failure of five standards:

*comments & complaints*
*human resource management*
*medication management*
*regulatory compliance*
*privacy and dignity*

One standard that was written up as totally satisfactory was *continence management.*

***Odd reversal of fortune***

Curiously, less than 2 weeks later, an *assessment contact* ('mini -audit') by the Quality Agency found the home failed ***continence management*** and that there was a "*serious risk"* to residents in relation to this and also to *human resource management,* and *privacy and dignity.*

www.aacqa.gov.au Audit Report, Mary MacKillop Care, August 2016

***Continence management***

In imposing sanctions on 10 September, the Health Department described a systemic failure of *continence management* which posed an *"immediate and severe risk"* to resident health and welfare (www.health.gov.au –current sanctions).

What the Quality Agency report said about *continence management* the second time around is not known as *assessment contact* reports are not released to the public.

***Elder Care Watch is in contact with the Quality Agency at the time of going to press and will provide information on the Agency response in the next edition (Editor).***

**Comments & complaints**

***"Not all care recipients and representatives feel they can raise complaints without fear of retribution..... Staff are not satisfied their complaints ...are actioned appropriately"***

**Human resource management**

[Those interviewed] ***are not always satisfied with the responsiveness and availability of staff and as a result the adequacy of care. Management do not ensure that sufficient staff numbers are provided..."***

**Medication management**

[Those interviewed] ***are not satisfied that their medications are administered safely or correctly. ..... Staff who administer medication have not all completed current medication competencies"***

Audit Report, August 2016: 10,11 &15.

# Law Reform Commission Discussion Paper *(December 2016)* reportable incidents scheme

## *recommends shining a compulsory light on all forms of abuse but leaves staffing numbers and skill levels to others*

### Compulsory reportable incidents scheme

The Law Reform Commission (ALRC) advocates a compulsory *'reportable incidents'* scheme to replace the present narrow *'reportable assaults'* law.

***A broad definition***
Incidents to be broadly defined; provider must report them to the Aged Care Commissioner within 30 days. No exemption for resident-on-resident incidents.

***Powers of Commissioner***
The Commissioner to oversee the provider's investigation and response to the incident but have no enforcement powers, only a power to make recommendations and to publicly report on particular incidents or providers.

***'reportable incident' should mean:***

***(a) a sexual offence, sexual misconduct, assault, fraud/financial abuse, ill-treatment or neglect committed by a staff member on or toward a care recipient***

***(b) a sexual offence, an incident causing serious injury, an incident involving the use of a weapon, or an incident that is part of a pattern of abuse when committed by a care recipient toward another care recipient; or***

***(c) an incident resulting in an unexplained serious injury to a care recipient***

ALRC, Elder Abuse, Discussion Paper 83, December 2016:200

***Co-exist with current Complaints Scheme***
The Scheme would sit alongside the existing Complaints Scheme. There is no proposal to strengthen the powers of the Commissioner under the current Complaints Scheme.

***Reporting to police***
ALRC says it is critical that serious incidents be reported to police but has no firm view on whether this should be a legal requirement.

Currently, *'reportable assaults'* must be reported to police within 24 hours but there is no legal requirement for the provider to take any action!

**Staffing is for others to recommend**
The Commission has decided to leave the vital issues of staffing numbers and skill levels to other reviews *(see page 6)*

# Law Reform Commission recommends

## *centralised screening agency to collect information on aged care workers and issue clearances to work*

**Screening agency**
A national screening agency would share information about employees working in aged care.

Employees to apply to the agency for a clearance to work.

Continuous monitoring of the police database and of notifications under the proposed *reportable incidents* scheme.

Would apply to all those currently required to have a police certificate. A process similar to 'working with children' checks.

Nursing home managers could check the register on outcomes and status of clearances when employing staff.

The agency should not be a substitute for managers conducting reference checks with previous employers when employing staff.

ALRC, Discussion Paper 83:228,231

***The proposed screening process would assess:***

***(a) a person's criminal history***

***(b) relevant reportable incidents under the proposed reportable incidents scheme***

***(c) relevant disciplinary proceedings or complaints***

***A national database would record the outcome and status of employment clearances.***

ALRC, Discussion Paper 83, December 2016:222.

**Comments sought**

The Commission is seeking comments on:

**the types of reportable incidents that, in the event of an adverse finding, should result in a refusal of a work clearance;*

**how long a work clearance should last.*

Note that the closing date for submissions on the recommendations in the Discussion Paper is 27 February 2017.

## Remember Quakers Hill
### *a disastrous failure of personnel management*

In 2011, a registered nurse deliberately lit a fire which led to the deaths of 14 residents. He had a (written) record of drug affected behaviour at work. His previous record was apparently not checked and a medical screen protocol for new employees was not followed. Competent and thorough personnel management would have been enough in this case.

# Law Reform Commission recommends

## *legislate at State level to apply National Code of Conduct for Health Care Workers and include personal carers in the Code*

A National Code was adopted by the Australian Health Ministers' Advisory Council in April 2015. To become the law in a State it has to be passed by that State parliament. So far only Queensland has this law.

**Legislate to apply the *Code of Conduct***

Personal carers and assistants in nursing should be subject to State laws giving effect to the *National Code of Conduct for Health Care Workers* adopted by all Health Ministers at the Council of Australian Governments' (COAG) Health Council in 2015.

***The political response***

If aged care workers are included in a legislated code of conduct for health care workers this will be the political response to the long-standing argument that personal carers should be registered, just as nurses are.

For nurses, registration means a set of practice standards. It also means complaints can be made by the public about the practice of an individual nurse.

Under the Commission's proposal, personal carers and nursing assistants would be defined as 'health care workers' and any person would be able to make a complaint about a breach of the code by them to the health complaints body in their State. The Code has to be part of State legislation of course.

***Content of the Code***

In relation to clinical practice, the Code says that health care workers are to "*provide services in a safe and ethical manner"* but much of what follows is written with a sole practitioner in mind and certainly does not recognise the fact that in residential care, personal carers work under the supervision of registered nurses.

COAG Health Council, Final Report: A National Code of Conduct for health care workers, April 2015, Appendix 1.

[the Code] ***will set national standards against which disciplinary action can be taken and, if necessary, a prohibition order issued, in circumstances where a health care worker's continued practice presents a serious risk to public health and safety"***

ALRC, Discussion Paper, 83:234

# Law Reform Commission recommends

## *legislate (Aged Care Act) to limit restraint of residents establish official visitors scheme*

**Restrictive practices**
The Commission uses the term *'restrictive practices'* to mean any restriction on the rights or freedom of movement of a person with a disability.

It includes physical, chemical and mechanical restraints, seclusion and detention. In nursing homes, chemical sedation and inappropriate use of drugs is claimed to be the most common form of restraint.

The Commission advocates new provisions in the *Aged Care Act* to limit and carefully regulate such restrictive practices.

***"..... the use of restrictive practices can amount to abuse. Concerns have been expressed about the use of restrictions as a 'means of coercion, discipline, convenience or retaliation by staff or others providing support, when aged care facilities are understaffed'"***

Extract from NSW Parliament Elder Abuse in NSW (2016) cited in Discussion Paper 83:239

**Official visitors scheme**
Official visitors would have right of access to inquire into and report on whether residents' rights are being upheld; the adequacy of information regarding their rights and concerns about abuse and neglect.

Official visitors would have the power to confer alone with residents and staff and to make complaints and reports about suspected abuse or neglect (Discussion Paper 83:246).

The existing Community Visitors Scheme should retain its emphasis on companionship but these visitors should be able in future to refer residents to advocacy services and complaints mechanisms.

Discussion Paper 83:245.

### Staffing left to others

***"The Aged Care Legislated Review is required to consider workforce strategies .. and is better positioned to make recommendations relating to these issues"***

**The issues cited by the Commission include: adequacy of numbers and mix of staff; appropriate qualifications; quality of training; pay and conditions.**

***"The Senate Standing Committee on Community Affairs is also conducting an inquiry into .. Australia's aged care sector workforce".***

Discussion Paper 83:235 and note 227

# Disturbing evidence from Coroner's case
## *St Basil's Aegean Village, Christie Downs, SA*

### *failure to protect residents from clear and present threat to safety*
### *failure to follow protocol for checking on residents*

The disturbing evidence emerged during a Coroner's inquest in November 2016, held some four and a half years after the death of a resident, Dorothy Baum, from injuries allegedly inflicted by another resident Rozalia Setalo.

**29 May 2012**

***Alleged assault***

At 0200 hours a cognitively impaired resident lashes out with walking frame and plastic covered metal chain. Resident detained by police and taken to hospital. Subsequently investigated for alleged aggravated assault of two residents and a carer.

***Return to open wing***

Resident discharged from hospital and although deemed a risk to residents is returned to the unsecured wing.

**30 May 2012**

In the early hours, a resident is bludgeoned with the same chain sustaining severe injuries.

**31 May 2012**

***Resident dies in hospital***

The resident who was attacked dies in Flinders Medical Centre.

***Police investigation***

The police and the public prosecutor took over 3 years to drop the case concluding there was insufficient evidence. The alleged attacker died in July 2016.

**November 2016**

***Inquest evidence***

The Court heard Mrs Baum had been left dying in her bed for up to 3 hours before she was found in a pool of blood.

***RN on night duty***

The RN on night duty, Ute Latz, admitted to procedural errors relating to the violent outburst on 29 May and the discovery of Mrs Baum on 30 May.

She failed to follow the protocol for frequency of checking on patients.

She also failed to confine the violent resident and move other residents and staff away from her. She said: *"There wasn't anywhere I could have confined her safely"*.

A. Hough, 'Attacked in bed - left to die', The Advertiser, 24 November 2016:10; E. Henson, 'Nurse grilled over patient's violent death', The Advertiser, 25 November 2016:37.

***continued on page 8***

*continued from page 7*

## Coroner's case disturbing evidence

After discovering the injured resident, Ms Latz chose the option of an ambulance arriving within one hour when given the choice by paramedics of arrival within 15 minutes or one hour.

***Quality Agency called***

The Coroner, Mark Johns, has asked for a representative from the Aged Care Quality Agency to appear before the inquest to answer questions about its audits of St Basil's Aegean Village.

E. Henson, 'Inquest extended over 'disturbing' evidence', The Advertiser, 26 November 2016:40.

Ute Latz was registered as an RN in Australia in November 2010.

The Quality Agency website shows that St Basil's met all 44 standards in an announced accreditation audit in July 2015. There is no information about any unannounced visits as these are not available to the public.

www.aacqa.gov,au

## Murders at Ballina nursing home

***RN sentenced to 36 years' jail with non-parole period of 27 years***

On Friday 16 December 2016, Justice Garling in the NSW Supreme Court sentenced Megan Haines to a maximum of 36 years' jail with a non-parole period of 27 years for the murders of two female residents at St Andrew's Village in Ballina, NSW in 2014.

The judge said Haines' actions amounted to "***conduct almost too awful to contemplate"*** and ***"cannot be tolerated".***

J. Dye, 'Megan Haines jailed for 27 years for murdering patients at Ballina nursing home', Sydney Morning Herald, 16 December, 2016.

At the time Megan Haines was subject to conditional registration as a nurse due to her past misconduct *(see Elder Care Watch, November 2016).*

***"Conditions***
***Ms Megan Haines must provide to AHPRA satisfactory professional performance reports every six months for 18 months from the commencement of her employment. These professional performance reports must be provided by a Director of Nursing or equivalent"***

www.ahpra.gov.au

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