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11 March 2014

Mr Lachlan Broadribb
Coroners Registrar
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 300

Your ref: COR2011/2017
Office: Melbourne
Email:
Lachlan.Broadribb@coronerscourt.vic.gov.au

Our ref: John Moore

Inquest into the death of Caterina Montalto

I refer to your email dated 18 December 2013 attaching a copy of Coroner Spooner's finding into the death of Caterina Montalto. The findings included three recommendations relevant to Arcare Pty Ltd (Arcare).

Please find below, Arcare's response to the recommendations.

1. *Review the Verification of Death Assessment Form to include a tick box or information regarding the requirement to report a death that was or may have been associated with a fall, to the Coroner.*

   (a) Arcare has amended its Verification of Death Assessment form to remind staff that a reportable death includes a death that was or may have been associated with a fall. A copy of the updated form is attached.

   (b) Arcare has updated its Employee Information Guide to include reference to a death associated with a fall in the example section of what constitutes a reportable death to the Coroner. A copy of Arcare's Deceased Resident Reporting process map contained within its Employee Information Guide is attached.

   (c) Following the Coroner's finding and recommendations, Arcare implemented a monthly audit of the circumstances of the deaths of a sample of residents who have died and not been identified as constituting a reportable death. Arcare will continue to conduct such an audit until it is satisfied that the new reporting system is effective in capturing all reported deaths.

   (d) Furthermore, Arcare has introduced automatic notifications via our electronic care planning system so that facility, regional and state managers are notified of a death as soon as the incident form is completed online. The process will become part of Arcare's standard practice throughout all of its facilities once the electronic care system is fully implemented by the end of June 2014.

2. *The Department of Health checklist regarding dementia-friendly environments recommends that outdoor spaces may contain a safe water feature without a hazardous pond or stones. Due to the proximity of the non-operational stone laden fountain to the courtyards' path, removal of the fountain from this location, as well as any other similarly positioned and dimensioned objects in the courtyard that would be a potential risk to the residents of the Jasmine Unit at Arcare Hampstead.*

   (a) As the Coroner is aware, following Mrs Montalto's death in 2011, the water feature at Arcare Hampstead was drained and filled with decorative rocks. Following the Coroner's finding, the courtyard in the Jasmine Unit has been re-landscaped and the water feature removed entirely. We attach photographic evidence of the removal of the fountain.

   (b) In addition to this, in March 2014, an extension of the lounge room adjoining the courtyard has been scheduled in order to enhance the visibility of the courtyard and provide an outdoor connection for the benefit of residents who remain inside the Jasmine Unit.

   (c) Further, Arcare has reviewed the design, build and location of their courtyards and gardens in regular consultation with Alzheimer's Australia and other individual experts in the field.

3. *The Australian Government Department of Health and Ageing Aged Care Complaints Scheme undertake an investigation into Arcare once the activities undertaken by registered and unregistered staff regarding Mrs Montalto's death were known. The investigation should include whether referral to the appropriate agencies to review individual professional registration(s) is a reasonable expectation within the Aged Care Act 1997 and certified provider receiving subsidies by the Australian Government.*

   (a) By letter dated 19 February 2014, Mr Michael Culhane, branch manager of Aged Care Complaints, wrote to Arcare requesting information on the actions taken by Arcare as expressed in the Coroner's recommendation. A response was provided to the department on 28 February 2014 including copies of Arcare's notifications to AHPRA.

4. *Other considerations.*

   (a) The Coroner has made reference to the need for cultural change amongst the staff at Arcare. Arcare is happy to advise the Coroner that its culture has significantly developed since 2011 both at the Hampstead facility and across the organisation as a whole. This cultural change has been aided by the implementation of the following three strategies:

      (i) Arcare Hampstead has undergone a significant review and now has revised management and team structures;

(ii) Arcare is in the process of implementing a Dedicated Staffing Model across the entire organisation to ensure best practice methodology, particularly throughout our dementia units. This process includes the use of an assessment tool to determine the aptitude and suitability of care staff within dementia units, review of rosters and working arrangements to ensure residents are exposed to the same staff members regularly and the establishment of care relationships between residents, families and our care staff;

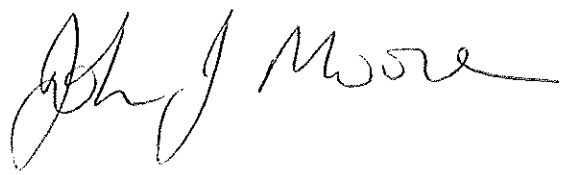
(iii) In order to ensure the development of a healthy culture that is well understood and accepted by all staff, Arcare has rolled out a "Values Roadshow" project. The project includes a workshop with residents, family members and staff to develop and determine the values of the company which form the foundations of Arcare, the production of a "Values Roadshow Movie" to demonstrate to staff examples of key behaviours which are underpinned by Arcare's values and a presentation to every staff member by the Dementia, Strategy and Innovation Manager and the National Human Resources Manager in order to assist the moulding of the culture at Arcare

(b) In addition to the above, Arcare's Clinical Governance Committee meet regularly to review and audit the company in order to oversee the clinical governance of Arcare and identify emerging trends.

We are confident that Arcare has implemented all of the Coroner's recommendations and that processes are in place to ensure that Arcare maintains a healthy staff culture and best practice care for its residents.

Should you require further information in relation to this matter, please do not hesitate to contact myself directly (03) 9559 9102.

Yours sincerely



John Moore

State Operations Manager - Victoria

Arcare Pty Ltd

Enc: 1. Updated Verification of Death Assessment Form.

2. Updated Deceased Resident Reporting process map identifying examples of reportable deaths to the Corner.

3. Photographic evidence of removal of fountain from courtyard of Arcare Hampstead dated 17 February 2014.

Arcare

VERIFICATION OF DEATH ASSESSMENT - VIC ONLY

COMPLETED IN PERSON BY REGISTERED NURSE – OR – PARAMEDIC

**OPT OUT OPTION – VERIFYING DEATH IS A VOLUNTARY ACT AND NOT MANDATED FOR EITHER PROFESSION (RN OR PARAMEDIC). IF YOU WISH TO OPT OUT – CONTACT LOCUM/MEDICAL OFFICER TO ATTEND – RECORD ACTIONS IN PROGRESS NOTES.*

RESIDENT SURNAME:	RESIDENT GIVEN NAME(S):	DATE OF BIRTH: ☐ MALE ☐ FEMALE

REPORTABLE TO THE STATE CORONERS OFFICE

REPORTABLE DEATHS (EXCERPT FROM GUIDELINES) :

A REPORTABLE DEATH IS A DEATH THAT APPEARS TO HAVE BEEN:
UNEXPECTED, UNNATURAL, VIOLENT OR TO HAVE RESULTED (DIRECTLY OR INDIRECTLY) FROM ACCIDENT OR INJURY – INCLUDING POST-FALL.

IF YOU BELIEVE THE RESIDENTS DEATH MEETS THIS CRITERIA – CONTACT THE POLICE, ARCARE MANAGEMENT AND THE STATE CORONER'S OFFICE IMMEDIATELY (9684 4380).

☐ RESIDENTS DEATH IS NOT REPORTABLE TO CORONER (USING CRITERIA ABOVE)

CHECK MARK INDICATES CLINICAL ASSESSMENT COMPLETED	CLINICAL ASSESSMENT TO VERIFY DEATH *MINIMUM GUIDELINES FOR THE CLINICAL ASSESSMENT NECESSARY TO ESTABLISH DEATH HAS OCCURRED (VERIFY DEATH). PROFESSIONAL CLINICAL JUDGEMENT IS REQUIRED TO MAKE THIS DETERMINATION AND UNIQUE CIRCUMSTANCES MAY WARRANT ADDITIONAL CHECKS OVER AND ABOVE THE MINIMUM GUIDELINES BELOW:*
	NO PALPABLE CAROTID PULSE AND
	NO HEART SOUNDS HEARD FOR 2 MINUTES AND
	NO BREATH SUDS HEARD FOR 2 MINUTES AND
	FIXED (NON RESPONSIVE TO LIGHT) AND DILATED PUPILS AND
	NO RESPONSE TO CENTRALISED STIMULUS (E.G. TRAPEZIUS MUSCLE SQUEEZE; SUPRAORBITAL PRESSURE; MANDIBULAR PRESSURE OR THE COMMON STERNAL RUB) AND
	NO MOTOR (WITHDRAWAL) RESPONSE OR FACIAL GRIMACE IN RESPONSE TO PAINFUL STIMULUS (E.G. PINCHING INNER ASPECT OF ELBOW
>	OPTIONAL – ECG STRIP SHOWS NO RHYTHM

LOCATION OF EXAMINATION	DATE:	TIME:

☐ COMPLETING THE MINIMUM GUIDELINES ABOVE FOR VERIFICATION OF DEATH, I VERIFY THE DEATH OF

(RESIDENTS NAME):_____

NAME OF PERSON COMPLETING FORM (PRINT):_____

SIGNATURE:_____

DESIGNATION:
☐ RN ☐ PARAMEDIC

NOTIFICATION OF VERIFICATION OF DEATH

CHECK PRE-ADMISSION ASSESSMENT AND/OR ADMISSION INFORMATION AND INTERIM CARE PLAN FUNERAL DIRECTOR DETAILS (IF RESIDENT/REPRESENTATIVE SUPPLIED)

TIME	DATE	NOTIFIED	INITIAL
		RESIDENTS NEXT OF KIN (NAME)	
		FUNERAL DIRECTOR (NAME)	
		MEDICAL OFFICER (NAME)	

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Arcare Incident Management Flow Chart:

Resident Incidents: Resident Death; Injury; Fall; Medication Error; Resident Absconds and is found by staff (police not contacted);

Process Explained:

Person in Charge of Shift will ensure:

- Ensure instructions on the **Incident Report - Resident** are followed;
- Management of the Post-Fall Flow Chart is followed (page 3 of this procedure)
- Ensure the Incident Report is completed fully prior to Facility Manager/Regional Manager receiving the document;
- Determine if there is a need for Doctor/Locum to visit the resident/facility;
- **Contact Senior Arcare Management as directed by the Incident form (example: all resident deaths are reportable to Senior Management; and follow any directives provided by Senior Management).**
- If required, transfer resident to hospital;
- Document all care provided in progress notes.

eCase automatically processes when staff complete a Progress Note for Death of Resident – screen shot below (page 2) is of Test3 Resident and shows how to choose the Progress Note filter (tag/subject of note).

Please see body of the (test) Progress Note for more information.

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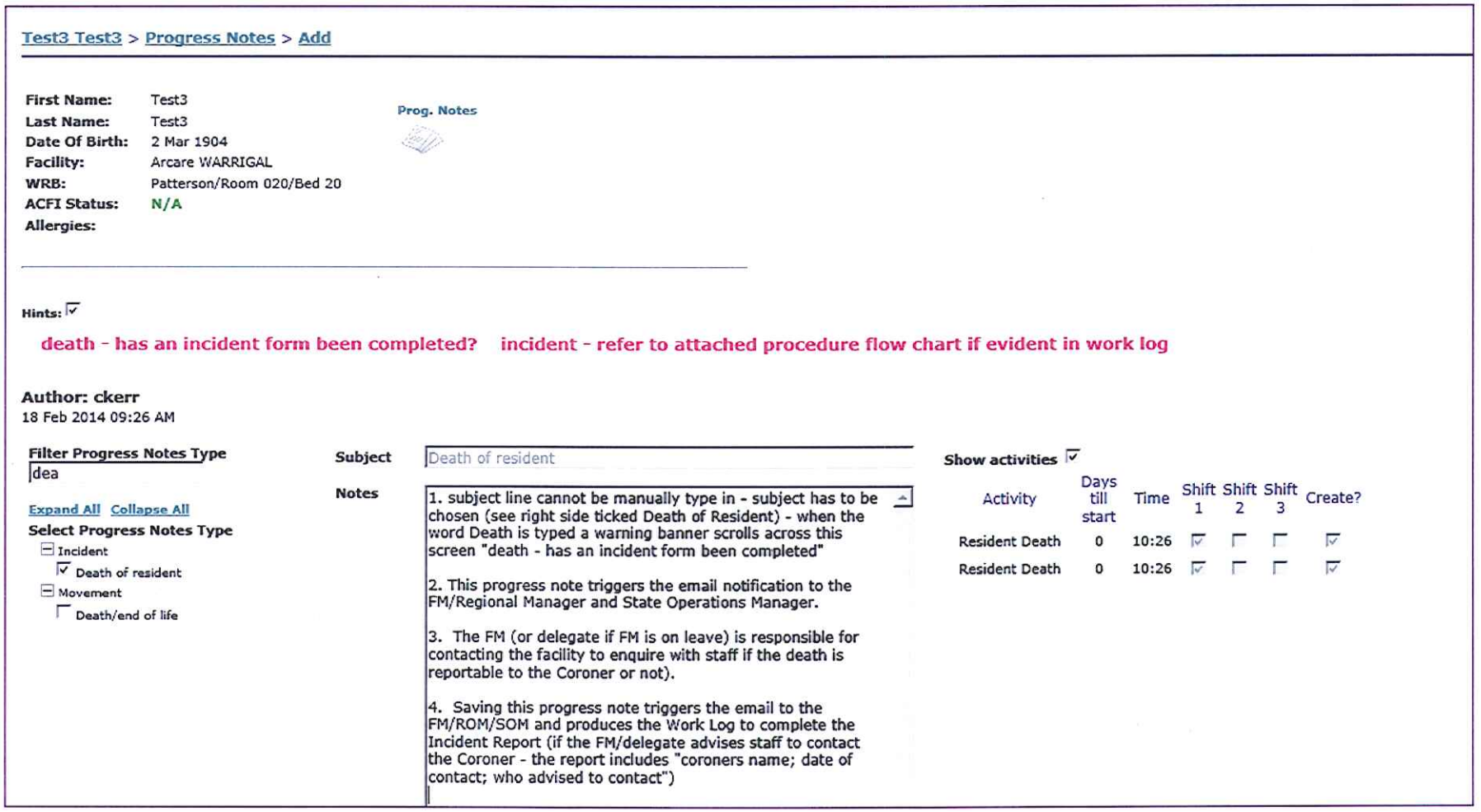
Example of eCase Death Notification:



Test3 Test3 > Progress Notes > Add

First Name: Test3
Last Name: Test3
Date Of Birth: 2 Mar 1904
Facility: Arcare WARRIGAL
WRB: Patterson/Room 020/Bed 20
ACFI Status: N/A
Allergies:

Prog. Notes

Hints:

death - has an incident form been completed? incident - refer to attached procedure flow chart if evident in work log

Author: ckerr
18 Feb 2014 09:26 AM

Filter Progress Notes Type
dea

Expand All Collapse All

Select Progress Notes Type
- Incident
  - Death of resident
- Movement
  - Death/end of life

Subject Death of resident

Notes

1. subject line cannot be manually type in - subject has to be chosen (see right side ticked Death of Resident) - when the word Death is typed a warning banner scrolls across this screen "death - has an incident form been completed"

2. This progress note triggers the email notification to the FM/Regional Manager and State Operations Manager.

3. The FM (or delegate if FM is on leave) is responsible for contacting the facility to enquire with staff if the death is reportable to the Coroner or not).

4. Saving this progress note triggers the email to the FM/ROM/SOM and produces the Work Log to complete the Incident Report (if the FM/delegate advises staff to contact the Coroner - the report includes "coroners name; date of contact; who advised to contact")

Show activities

Activity	Days till start	Time	Shift 1	Shift 2	Shift 3	Create?
Resident Death	0	10:26	☑	☐	☐	☑
Resident Death	0	10:26	☑	☐	☐	☑

Coroners Findings – Mrs Caterina Monalto

The Coroner recommends that:

Arcare should remove the fountain and other similar objects from the courtyard that may pose a risk to the residents of Hampstead.

✓ Completed, following Coroners Recommendation.

Date of photo: 17/2/14

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