Department of Human Services

Secretary

50 Lonsdale Street
Melbourne
Victoria 3000
GPO Box 4057
Melbourne
Victoria 3001
Telephone: 1300 650 172
Facsimile: (03) 9096 9220
www.dhs.vic.gov.au
DX210081

29 AUG 2013

e3184288

Ms Briley Miller
Registrar
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Miller

Thank you for your letter of 16 June 2013 regarding the Coroner's recommendations delivered on the 5 June 2013 arising from the investigation into the death of Mr Stephen Summers on 17 February 2006. I have considered the recommendations and provide the Department of Human Services (the department) response and action for each recommendation.

Recommendation a: Provide direct care workers in community residential units with education and experience in identifying, preventing or managing pressure sores in disability clients.

Significant efforts have been made to provide staff with information to enhance their knowledge and understanding in identifying, preventing and managing pressure sores in disability residential services since the death of Mr Summers. While the department considers the development of a care plan on the management of pressure sores as primarily within the role of a qualified medical practitioner, the department has undertaken a number of actions to ensure direct care workers have the necessary knowledge and skills in identifying, preventing and managing pressure sores for residents. The department has:

- developed and released the first edition Residential Services Practice Manual in 2007 (RSPM) that sets out the roles and responsibilities of direct care staff and practice requirements for department-managed residential services. The RSPM is also published on the department's website and is made available to community service organisations delivering residential services. The RSPM was subsequently updated in 2009 and 2012
- provided a practice instruction on *'Managing pressure sores'* in the 2009 version of RSPM, including the identification of changes in a resident's skin integrity, such as skin discolouration and seeking medical attention if necessary and assistance with pressure care management from the Royal District Nursing Service
- published two articles on management of pressure sores in the Disability Accommodation Services Practice Update (a bi-monthly newsletter sent to staff working in department-managed residential services) in January 2009 and April 2012.

State Government Victoria

Recommendation b: Create a pool of allied health service providers with experience in managing disability clients and ensure that they are available to direct care workers for consultation and review of referrals for equipment like air mattresses.

Recommendation e: Arrange for appropriate provision of community medical and allied health services to clients with profound disabilities who are referred by their carers.

Since Mr Summers's death, the department has undertaken significant work to assist clients with a disability access appropriate mainstream allied health services. The department:

- provided a practice instruction on '*Managing pressure sores*' in the 2009 version of RSPM (Part 5.4) and about how to support clients to access mainstream allied health services
- mandated the use of the Comprehensive Health Assessment Program (CHAP) – a clinically valid tool to support annual health reviews of people with an intellectual disability with their general practitioner (GP) (including a check of residents' skin) in the department-managed residential services in 2007. The use of CHAP was made available and recommended for use in community service organisation managed residential services in 2010
- since 2008, provided funding to General Practice Victoria to conduct annual 'master-classes' for GPs and practice nurses on annual health reviews of people with an intellectual disability
- provided funding to the Centre for Developmental Disability Health Victoria to provide education and clinical services, online resources for health professionals and a telephone advice service for health professionals.

Recommendation c: Undertake systematic reviews of the management and other factors contributing to the death of residential clients with severe disabilities.

In 2009, the department developed and implemented policy and procedures for the management and review of adverse events, including client death, within department or community service organisations managed disability services. The *Promoting better outcomes – systemic improvement policy: managing and reviewing adverse events* outlines practice and reporting requirements for service providers and staff in the reporting, and effective management of, all adverse events during service delivery. The department or a community service organisation can initiate a practice review using a root cause analysis methodology to identify contributing factors to an adverse event and to recommend on system changes to prevent reoccurrence of similar incidents or events in future.

The policy was subsequently revised in 2011 and 2012 with minor amendments to enhance its useability.

Recommendation d: Require direct care workers in community residential units to verbally report to the house manager any observations they make of deteriorating health of disability clients as well as writing their observations in the communication book and the clients record.

Since the release of the RSPM in 2007, direct care staff have been provided with practice instructions to:

- seek medical assistance from the resident's GP, or from Nurse-On-Call if the resident's GP is unavailable, when a resident's health deteriorates. Staff have been instructed not to wait until they have contacted their line manager during business and after hours (through an on-call arrangement) or rely on their line manager who is not medically qualified before seeking medical assistance
- provide a written incident report of any unplanned hospital admission of a resident following the sudden and unexpected onset of an illness or rapid deterioration of health (for example, a pressure sore is identified and the resident is admitted to hospital) to their line managers within one working day and in accordance with the department incident reporting procedures
- report health issues or concerns about residents to their supervisors, document any deterioration in a resident's health in shift reports, communication books and the non-

critical client event log and ensure other staff are informed of the incident and of any actions to be implemented.

Recommendation f: Routinely audit all the community services provided to clients with profound disabilities to ensure they remain relevant to the clients' changing specialist needs and available when they are required.

A range of audit functions were in place prior to Mr Summer's death and these have been strengthened following the death of Mr Summers.

The Promoting Better Practice Program commenced in July 2007 and ensures audits and reviews are conducted of the department-managed group homes and residential services chosen by both random sampling and targeted selection every year. Under the program, audits/reviews for over 40 group homes are scheduled throughout the year. Two audit trained reviewers conduct two-day on-site reviews and assess compliance with the practice instructions outlined in the RSPM.

On 1 July 2012, the *Department of Human Services' Standards* (Standards) replaced the *Standards for Disability Services in Victoria*. Through the Standards, the department mandates service providers have acceptable levels of management, administration and service delivery in place and promote a culture of continuous quality improvement.

Key guiding principles of the Standards are that clients should be at the centre of service delivery with their rights promoted and upheld, and that standard review processes play an important role in ensuring an organisation's policies, processes and systems uphold client rights and needs. The Standards include indicators for service delivery pertaining to client empowerment, access and engagement, wellbeing and participation.

From 1 July 2012, all disability services providers are required to:

- undertake an independent review against the department's Standards by an endorsed independent review body every three years
- achieve and maintain accreditation against the department's Standards, including governance and management standards of a department endorsed independent review body.

If you require further information on any of the above actions, please contact Mr Shane Beaumont, Manager, Complex Support and Systemic Improvement, on 9096 2523 or at shane.beaumont@dhs.vic.gov.au

Yours sincerely

Katy Haire
Acting Secretary