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Deaths of people with disability in residential care in NSW: key findings from reviews

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Our role

- Review the death of any person living in, or temporarily absent from, residential care
- Maintain a register of reviewable deaths
- Examine causes and patterns of deaths, and identify ways to prevent or reduce preventable deaths
- Report to the NSW Parliament on our work, our recommendations, and agency actions in response to our previous recommendations

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Snapshot

- Average 100 deaths each year
- Average age at death = 53.7 years
- Main UCOD
  - Respiratory diseases – aspiration pneumonia, pneumonia, COPD
  - Epilepsy
  - Chronic ischaemic heart disease
  - Choking
  - Intestinal obstruction

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Critical issues in preventable deaths

Recognising and responding to critical situations

- Identifying illness and taking timely action
- Providing an effective first aid response
- Escalating significant matters

Critical issues in preventable deaths

Identifying and managing risks

- Breathing, swallowing and choking risks
- Fracture risks
- Bowel management
- Obesity, smoking and other lifestyle risks
- Medication risks

Critical issues in preventable deaths

Support to access health services and treatment

- Support to minimise resistance to health assessments and treatment
- Support in hospital
- Transfer of care
- Decisions based on perceived quality of life
- Access to community-based health programs

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Critical issues in preventable deaths

Incident reporting

- Clear guidance about the matters that need to be reported as incidents, including:
  - 'close calls' or 'near misses'
  - medication incidents
  - significant behaviour or health events, or changes in behaviour/health
  - falls
- Documented, robust and well-understood systems for reviewing and responding to incident reports

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Current work and opportunities

Current recommendations are focused on:

- Access to swallowing assessments
- Access to chronic disease management support
- Diagnosis of fractures in people with cognitive impairment and communication difficulties
- Support to access health services and treatment
- Support in hospital
- Implementation of the Disability Inclusion Action Plan

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Current work and opportunities

- Joint approach to the deaths of people with disability in residential care in NSW
  - NDIS Commission = NDIS providers
  - NSW Ombudsman = NSW service systems (eg: health, justice) + FACS and assisted boarding houses
- Opportunities
  - Data
  - Expansion of ID health teams/ specialised supports
  - Disability-related work in NSW post rollout of NDIS

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