COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Effectiveness of the quality assessment and accreditation framework in protecting residents of aged-care facilities

(Public)

TUESDAY, 21 NOVEMBER 2017

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Tuesday, 21 November 2017

Members in attendance: Senators Dastyari, Fawcett, Patrick, Polley, Siewert, Smith.

Terms of Reference for the Inquiry:

To inquire into and report on:

a. the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;

b. the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;

c. concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;

d. the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;

e. the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;

f. the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and

g. any related matters.

WITNESSES

HANSON, Ms Jackie, Chief Executive Officer, Northern Adelaide Local Health Network, SA Health

STUBBS, Dr Thomas, Chair, Oakden Response Oversight Committee

Committee met at 08:40

CHAIR (Senator Siewert): I declare open this public hearing of the Senate Community Affairs References Committee, and welcome everyone here today. We acknowledge the traditional owners of the land on which we meet and pay our respects to elders past, present and emerging. This is the first public hearing of the committee's inquiry into the effectiveness of the aged-care quality assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. I thank everybody who has made a submission to the inquiry.

This is a public hearing and a Hansard transcript of the proceedings is being made. The audio of this public hearing is being broadcast via the internet. Before the committee starts taking evidence, I remind all present here today that, in giving evidence to the committee, witnesses are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee, and such action may be treated as contempt by the Senate. It is contempt to give false and misleading evidence to the committee. The committee prefers all evidence to be given in public, but, under the Senate's resolutions, witnesses have the right to request to be heard in private session. It is important that witnesses give the committee notice if they intend to ask to give evidence in private. If you are a witness today and you do want to give evidence in private, could you please let us know as soon as possible. Finally, please check your mobile phones to make sure they are rendered silent or in fact turned off.

As you see, we have media present here today. If any witnesses do not want the media here when they are giving evidence, please let us know. I will check with our current witnesses: are you okay for the media to be present for your evidence?

Dr Stubbs: I am.

CHAIR: If you are a member of the audience and you don't want to be filmed, could you please let us know. And to the media: there are certain restrictions on the media in terms of where you can go. You are not to go anywhere behind us or film our documents. Also, you are not to film members of the audience if they request not to be filmed. So far I haven't had that request, but, if any one of you change your mind, please let us know.

I welcome representatives from the Oaken Response Oversight Committee and also SA Health. I want to double-check: has information on parliamentary privilege and the protection of witnesses been given to you?

Ms Hanson: Yes.

Dr Stubbs: Yes.

CHAIR: I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policy or factual questions about how and when policies were adopted.

We have your submissions. Thank you. I invite each of you to make an opening statement, if you wish to do so, and then we will ask you some questions.

Ms Hanson: I appreciate the opportunity to present to you this morning on the effectiveness of the current aged-care accreditation framework in the context of the Oakden Older Person's Mental Health Service facility review and the subsequent actions taken by Northern Adelaide Local Health Network, following events which assessed these facilities as failing critical standards of care.

The Oakden facility consisted of three units: the Makk and McLeay wards had 55 Commonwealth funded beds, and there were 24 state licensed beds at Clements House. NALHN has learnt significant lessons and is committed to ensuring improvements in all aspects of its older person's mental health service provision.

By early December 2016, after meeting with the family of a previous resident at Oakden, I formed the view that there may be serious issues relating to residents' care at the facility. I commissioned the then South Australian Chief Psychiatrist, Dr Aaron Groves, to undertake a review into the Older Persons Mental Health Service. This review commenced in January 2016. Concurrent to the review, I placed a nurse adviser into the Oakden campus to begin assessing the appropriateness of care. It became evident at this time that there were immediate changes required to improve the health and wellbeing of the residents. I therefore imposed a moratorium on accepting new residents, and that moratorium remains in place today.

NALHN took immediate steps to ensure the ongoing safe treatment of care recipients and to ensure the quality of care provider at Makk and McLeay was of the highest standard. This included employing a new acting clinical practice coordinator with extensive experience in aged care; to increase the hours of our consultant psychiatrists; engaging after-hours senior nurses so there was 24/7 senior nursing cover; the employment of a part-time social worker, occupational therapist, and care consultant; the employment of a nurse adviser to provide high-level regulatory independent advice to management; and the employment of a senior clinical pharmacist.

The review was completed in April 2017. The South Australian government accepted all six recommendations from Dr Groves's report. The SA Health Oakden Response Plan Oversight Committee, which is chaired by Dr Tom Stubbs, was established in May 2017 to oversee and guide South Australia in the implementation of the recommendations outlined in the Chief Psychiatrist's report. Six expert working groups have been convened to address each of these recommendations, with a focus on achieving services that are customer-centric, contemporary and best practice.

Clinical services closed at Clements House on 22 September 2017, with the last two clients relocating to Northgate House on that day. This followed the June closure of the Makk and McLeay wards, when the residents transitioned to Northgate House and to other aged-care providers. On 22 September that closed the Oakden facility.

A specialised contemporary model of care is in its final stages of development and a scoping study is underway to determine the site and design for a new $14.7 million neurocognitive behavioural unit. NALHN will continue to follow through on the recommendations made by the Chief Psychiatrist in order to ensure older of Australians living with dementia and/or enduring mental illness get the care, dignity and respect they deserve.

In regard to the accreditation at Oakden, despite what is now recognised as failings occurring at Oakden over a long period of time, NALHN received full accreditation from the Commonwealth aged-care department in 2010 and at every subsequent accreditation a three-year accreditation cycle was granted. In fact, as recently as February 2016, Makk and McLeay passed all 44 expected outcomes under the Commonwealth Accreditation Standards and received a three-year accreditation period. Makk and McLeay also received an unannounced visit from the Commonwealth auditors in October 2016, and passed that assessment as well. At no time were concerns raised with NALHN in relation to systems and processes on any of these occasions until the audit conducted between 6 March 2017 and 17 March 2017, following the announcement of the Chief Psychiatrist's Oakden review. The results of the audit were taken very seriously by NALHN. We were sanctioned at that time. Given the potential impact on the health and wellbeing of residents, a comprehensive continuous quality plan was developed and implemented. The governance structure that was put in place immediately to improve accountability and implementation of actions to address the implementation plan was activated.

NALHN undertook numerous positive actions in response to the findings in the report, including the appointment of an external nursing adviser, and the training of staff, as recommended by the aged-care quality standards. A new residential-aged-care-specific medication management system to support the response to several areas of the Commonwealth's compliance requirements was implemented. Weekly meetings were scheduled between the Commonwealth and SA Health and daily visits by ACQA to review the implementation of actions to address the concerns were undertaken.

A clinical review of all residents and their medication orders was undertaken at that time. Staff trained in medication safety and administration and competencies. The changes incorporated and lead to a range of improvements, including a significant reduction in medication errors, with ongoing improvements to ensure the safety and appropriate care provision for residents was achieved.

The continuous improvement plan developed by NALHN as a result of the ACQA accreditation continues to be used to progress actions in line with accreditation standards for the care provided at Northgate House. While these clients are not currently receiving Commonwealth-subsidised residential aged care, NALHN is committed to running Northgate House consistent with the Commonwealth accreditation requirements. The South Australian government has always maintained a strong and positive working relationship with the Commonwealth. I thank the committee for its time this morning and welcome your questions.

CHAIR: Dr Stubbs, did you want to make an opening statement?

Dr Stubbs: Thanks for the opportunity. I don't have a formal statement, but I thought it might be useful for the committee if I outlined how the oversight committee has been formed and works. It was formed in June, as Ms Hanson said. It consists of a fairly large number of members—representatives from the operational services of psychiatrists, geriatricians, nurses; and a number of important external members: the chief executive of the Health Consumers Alliance, the chief executive of the Aged Rights Advocacy Service; the chief executive of COTA; the

Office of the Public Advocate herself; and the Principal Community Visitor, Maurice Corcoran, who you will be hearing from later.

The committee met every two weeks for the initial five or six meetings and now meets every month while the expert working groups are doing their work. There are six expert working groups. In the terms of reference for the Oakden review there were five terms of reference. The first related to models of care. The second related to staffing. The third related to clinical governance, the fourth to culture and the fifth to restrictive practices. That emerged in the review as six sets of recommendations, because under the model of care there was both the model of care but also an infrastructure component for the built environment component. So, we have formed six expert working groups. Those working groups, again, contain a mixture of external people and internal people, experts in the particular field and in particular a lot of people with lived experience. They might be consumers, past consumers, carers for consumers or family members.

The other thing we did with the expert working groups was to invite the three major unions to nominate people to each of those working groups. The nursing and midwifery union, the medical officers union and the public service union. Some of them took up all those opportunities and some of them just nominated people to particular groups.

Those working groups therefore are at various stages of their work. The model of care working group has made an initial report to the department, which will then go to the minister. That will then have further work to do. The second group, the infrastructure group, is looking at where a facility or facilities might be built in the future, according to a set of principles, such as care close to home, proximity to public transport, proximity to other health services and the like. The third working group, which is staffing, is obviously critical, because one of the issues that arose in the review was around the mix of staffing, the qualifications, the training and aspects like that. So, staffing is a critical group. But I would say that we should not forget that despite all the horrors of Oakden there are a lot of very dedicated and very good staff who did a great job. That needs to be remembered in all of this.

The fourth working group was the one around clinical governance and safety and quality. That is taking expert advice from people from interstate, including David McGrath from New South Wales. In fact, in all of these working groups we are taking advice from interstate and best practice and looking at the evidence. The fifth working group is around culture. That's chaired by Ms Hanson. Again, that has extensive involvement with consumers, because culture is clearly one of the very important things to deal with.

The final working group is the restricted practices working group, because one of the worst aspects of Oakden was the amount of physical restraint that occurred. That working group, again, is well advanced in terms of the action plan that the recommendations said would be developed. That's the way the group is functioning. There are different time frames for reporting, but our expectation is that most of the work will be completed by about February next year. That's probably all I want to say as an opening remark.

CHAIR: Thank you. Senator Patrick, given that it was your team that referred this matter and you're a local, I will go to your first. But I think we all have questions, so I will allocate some initial timings to make sure everyone gets some questions and then we'll share it out again if we have some extra time.

Senator PATRICK: Ms Hanson, how long have you been the chair of the Northern Adelaide Local Health Network?

Ms Hanson: The chief executive officer—I commenced in January 2015.

Senator PATRICK: How many people sit between you and the nursing manager at Oakden?

Ms Hanson: There are a number of levels of governance between my position. Without having an organisational chart in front of me, I would say four to five.

Senator PATRICK: The picture painted by the chief psychiatrist wasn't a good picture, was it?

Ms Hanson: It was not.

Senator PATRICK: There was no model of care or approved model of care for Oakden. How do you get into a situation whereby there wouldn't be a model of care that was approved for such an important facility?

Ms Hanson: The units were operated as three discrete mental health units that had a non-contemporary model of care.

Senator PATRICK: I understand that, but obviously the model is key—getting the right care, the right timing for the care, the right team for the care. From a governance perspective, it seems to me inexcusable that you wouldn't have a model of care in place for any facility.

Ms Hanson: The model of care was a mental health driven model of care operated by psychiatrists and nursing staff with mental health qualifications. That was the model of care.

Senator PATRICK: The chief psychologist basically said that there was no model, or in fact there was a draft model but it had no connection between the model and any reality because there was no funding that could have implemented the model of care.

Ms Hanson: The model of care pre-existing the report was that of managing the areas as mental health units. They were funded to do that. What the chief psychiatrist reported was that these people actually had BPSD or severe behavioural disorders, and that was a part of the model of care that hadn't been recognised and was absent.

Senator PATRICK: Staffing inadequacies: the chief psychiatrist said that basically, perhaps on a worst count, to be fair, a shortfall of 44 staff out of 100 would have been required.

Ms Hanson: Unfortunately, page 61 of the Oakden report is inaccurate in terms of the staffing profile, and that's been put on record. The information that the chief psychiatrist received was a previous iteration of the staffing profile at Oakden. The nursing profile had been approved through a business rule review in 2015 with the ANMF and signed off as appropriate.

Senator PATRICK: So you don't accept that there was a staffing shortfall, even though after the event, as in your opening statement, you committed a whole bunch—

Ms Hanson: Retrospectively, I would accept, with the contemporary model we now have, that the nursing hours per patient day that were negotiated and approved by the ANMF don't deliver the model of care that we now have in place, which is that of dealing with older people with severe behavioural disorders and/or enduring mental illness.

Senator PATRICK: I guess where I'm coming from is that, as a result of what's happened at Oakton, you've had 12 staff suspended, three staff terminated, two staff resign, nine matters referred to SAPOL and 34 staff reported to AHPRA. But it seems to me like a lot of these issues, such as the lack of a model of care, the ageing state of the building, the staffing inadequacies and the lack of surety among staff say that a whole bunch of blame is clearly being directed at some of the individual staff. These seem like management issues to me.

Ms Hanson: There were long-term managers in place at Oakden across many disciplines. In fact, for almost a 10-year period it was the same management team.

Senator PATRICK: I am talking about the team that sits above them—people who are signing off on the expenditure of money to try and make sure people receive the proper level of care. In those four levels, between perhaps the nurse manager and you, has anyone been in any way counselled, reprimanded or moved on?

Ms Hanson: The matters that are currently under human resource investigation, I am unable to comment on.

Senator PATRICK: I am not asking you to identify any particular person. I am just asking: are you looking at the management that sits above the Oakden staff and manages on the ground at Oakden?

Ms Hanson: You noted a few moments ago that there have been terminations, there have been suspensions and there have been reports to AHPRA and to ICAC on a range of staff. What I can state is that the current management structure that sits between the position of the chief executive officer and Northgate House is a new management team.

Senator PATRICK: Moving across to the remedy: Dr Stubbs, you have clearly got a reasonable sized team working on what to do as a result of the failure that occurred at Oakden. Have you had a commitment from the state government as to the funding of whatever you end up determining as the best course of action?

Dr Stubbs: As an opening comment, I would say the commitment from government has been extremely high at this stage, in general, from both bureaucratic and political sides. I have been invited to talk to the chief executive of the department at any time I want to. Ms Hanson and her staff have been very responsive. The minister met with me, I think, on his second day in office, and the Premier's office has offered their support at any time. In terms of your specific question about funding, the government immediately announced some $14.7 million of funding. A small component of that was for the operations of the committees and working groups, and the bulk of it was for a built facility. My expectation is that there will be more funds allocated but it will depend on the work of the working groups—for example, in the recommendations, the restrictive practices working group had to come up with an action plan. With the various elements of those action plans, some will have resourcing implications and some won't. So, as those become completed, the government will be presented with recommendations and associated resource requirements, and then of course it is up to the government as to what level of commitment it wants to make. But it has made an immediate commitment, and I expect there will be more to follow there.

Senator PATRICK: Is there anything in the forward estimates?

Dr Stubbs: Yes, there is. That money is in the forward estimates.

Senator PATRICK: That is $14 million?

Dr Stubbs: I think it was $14.7 million in total, but I think $1.3 million of that was for the support of the project and working groups. So there is something like $13-plus million in the forward estimates at the moment. Whether that is sufficient will depend on the advice of the infrastructure working group, which is looking at sites and facilities or a facility, and the requirements, the size and the nature of that building.

Senator FAWCETT: Dealing with patients that clearly have troubling behavioural issues as well as dealing with drugs that have serious consequences if misadministered or maladministered, there is obviously a risk profile attached to a facility like this, compared to perhaps other facilities where there are lower risks. Ms Hanson, can you talk to me about the legacy risk assessment system and how that linked to your degree of oversight and practices. Dr Stubbs, can you talk to me about what is changing as you look to move forward to make sure that we identify risk and have the appropriate amount of scrutiny and supervision.

Ms Hanson: The legacy system that's used to report any incident in SA Health is called SALS. It's a safety learning system. It's an electronic system and reports—

Senator FAWCETT: I'm not talking about a reactive scheme where something has occurred; I'm talking about the fact that, as you plan and manage the oversight of facilities, clearly some have a far higher degree of risk, both to patients and to staff, in terms of safety, and for patients in terms of the administration of medication. At the planning and governance level there should be an assessment of risk. I'd like to know what your current system is for assessing risk.

Ms Hanson: There's no pre-emptive assessment risk for medication management, as an example. Every registered nurse that is employed has to undergo medication competency assessments and is unable to provide medication without that. We have clinical pharmacists that regularly review medication charts and meet with the clinicians or the prescribers and have discussions around things such as the risk of the medications that have been ordered and whether or not that is appropriate. We now have a clinical pharmacist. We employed a clinical pharmacist in mental health in October 2016.

Senator FAWCETT: What about behavioural issues? Do you have a system to assess the risk to staff and patients due to the behavioural issues?

Ms Hanson: There are many assessments used. There are various scores and scales. There is the Abbey pain scale. With people with behavioural disorders, their symptoms can quite frequently be related to pain rather than other behavioural disorders. So there are specific tools that are used to assess.

Senator FAWCETT: Sure, but that's at an individual level. I'm talking about a governance level as you look at the running of a facility. What I'm hearing is that you had no pre-emptive system to assess the fact that this facility had a higher risk to both staff and patients than a facility that was dealing with ageing people, for example, without mental health issues or severe dementia and behavioural issues, or indeed a facility that looked after people with mental health problems that weren't also ageing. I'm hearing that there was no differentiation of risk in terms of your governance.

Ms Hanson: No. The SLS system and the reporting of any incident, whether it was a behavioural incident, a medication or a fall, was all reported through SLS, and the trending and activities that were put in place were as a result of what was recorded in SLS.

Senator FAWCETT: Dr Stubbs, I'm not a great believer in waiting till things go wrong to understand the risk. Having been a professional test pilot before this job, I'd have been making a lot of use of parachutes if I did. Can you tell me, moving forward, what you're doing to put in place a system that will identify and appropriately compensate for risk to both staff and patients?

Dr Stubbs: I think there are a very large number of elements to that and they do cover both the proactive and the reactive that you referred to before. In terms of proactive, clearly you want staff to be adequately trained; you want them to have appropriate qualifications, which hasn't been the case in the past; you want the right mix; and you want a multidisciplinary team as opposed to someone that's used to dealing with, I guess, the less complex patients. One of the important factors that the evidence shows is the whole environment in which these people live. Even going from the Oakden site to the Northgate site—I don't know if any of the committee members have seen the two sites—the Oakden site was very restrictive and oppressive; the Northgate site has a lot of open areas where patients can walk without running into barriers. One of the things that happens with patients with BPSD—behavioural and psychological symptoms of dementia—is that, if they're in close proximity to other patients or to staff, they tend to be more dangerous or more agitated. So the environment does play a big part in it, which is why the facility, if we have a specific facility, will need to be very carefully designed.

In terms of proactive: again, the governance group or the safety and quality group will have to put in place a set of arrangements so that there will be much more accountability and responsibility than there was under the old arrangements. We are getting external advice on that particular feature, because that is critical. The culture working group will contribute to this, because if you have a culture which is oppressive as opposed to open and transparent then people will not report incidents. They will be scared to report incidents or they won't be encouraged to report incidents. So we want openness and transparency. Sometimes it is better to have more reports of incidents than what looks like a good low report of incidents, because often when you get low reporting it means that people just aren't reporting them, and the incidents are still there. All of those things are proactive.

I guess the other one is restrictive practices. One of the remarkable things that has happened already under the initial response from northern Adelaide has been that restrictive practice incidents or restraint of patients has gone from probably the highest level in the country to virtually nothing. That is a mixture of training and awareness. Also, there is obviously a real focus on this at the moment. The issue that I am concerned about is that whatever we put in place is sustainable. So we need to make sure that it is not just something which will work for six months but will then revert to something like the previous environment, which will then go forward. I don't know if that answers your question sufficiently.

Senator FAWCETT: I am conscious that the chair will wind me up in a minute. To come back to restrictive practices: we have seen in places like Don Dale and other places where there are problematic behaviours that the practices sometimes start for good reasons or good purposes but then the culture over time can take them to a point where they are deemed to be unacceptable. There has been a lot of discussion in your submission about the models and broad frameworks coming right down to that best practice for individual staff dealing with an individual patient around how to prevent the patient doing harm to themselves or harm to the staff. Where are you going to look for best practice in that? And how are you seeking in your reforms to make sure that once implemented those best practices remain within the parameters as staff change over or as perhaps staff remain there for a longer period and that we see a continuation within a range of practice that is good for both the patient and the staff?

Dr Stubbs: People have to realise that these are very difficult patients to manage. So staff often have a fear factor, which makes it easier to do restraining as opposed to other forms of management. I think one of the key things going forward, which has been missing in the previous environment, is much greater involvement of family and carers. Often these people are isolated. They don't get visits. They don't have anyone there who has any sort of empathy for their condition. So we are trying to involve right from the outset families and carers and to take much more notice of what they say and what they know, because I think that will make a huge difference.

There has also been in the past what I would call 'hidden' forms of restraint. You can put someone into a lounge chair, and the fact is that they can't get out of the there. They might not look as though they are restrained but they can't get out of there. So there is a huge education role in this. As you have said—and I couldn't disagree—the real challenge is to make sure that this is sustainable. I think part of that is adequate or good recruitment of staff and much more continuity of staff. I suppose the people that come in aren't used to the environment and overreact to particular incidents, and then it becomes habit forming.

Senator FAWCETT: The first part of that question was: where are you going and who are you seeking that best practice information from? And the corollary to that is: moving forward, do you have any plans to essentially have peer-to-peer organisation interactions so that groups who are working with like cohorts of patients can compare and work collaboratively around how to revolve that best practice?

Dr Stubbs: I think the answer to that is that we are looking both externally, interstate, and internally. Sometimes you can forget that there are actually good practices within the states. There are some aspects of southern Adelaide which have really good practice—for example, a rapid access team.

That rapid access team has been used to go to standard so-called nursing home facilities to top up at those facilities the expertise the team has, and that has worked really well. It enables patients or consumers who might otherwise be at an Oakden type facility to be in a much more standard environment, but with extra work done for them with allied health or whatever might be appropriate.

We are looking at excellence in our own state; we're also looking at facilities—I don't want to name too many, but if you take HammondCare in Victoria, that's seen as a leader in these sorts of practices. We're getting advice from them; we're bringing people over and we're talking to them. I don't think we're restricting our view in any way, and, in the feedback on the models of care, we sent that far and wide to get people's comments on had we got it right or did they have better ways of doing things.

Senator POLLEY: Thank you both for coming to give evidence to us today. Obviously we have to give credit to the state government for the action that it's taken, but we still haven't got to the core issue: how did this happen? The oversight of the Australian Aged Care Quality Agency has failed. There have been a number of reports, and if you look at all of the evidence that's been provided, fundamentally it comes down to the fact that there was a tick and flick attitude. There is no other way that this could have happened over such a long period of time without sanctions. What confidence can Australians—not just South Australians, but all Australians—have in the accreditation of aged-care homes in this country?

Ms Hanson: I think the chief psychiatrist's report very clearly cautions us about using quantitative data only to assess appropriateness of care. Looking back over the last 10 years of accreditation under that scheme, although there were 44 standards and there was quite a lot of rigour on the surface around those standards, the process itself did not deep dive into individual care. Take Oakden as an example: the residents of Oakden had little or no capacity themselves to speak to people who came for assessments. I don't believe that the carers or the families of the people who lived at Oakden were given an opportunity to share their perceptions with the accreditors. Certainly the past residents' families that I met with subsequent to the report being released, they all, without exception, reported observing the same issues, the same behaviours, the same treatment over many, many years. If they had been involved in the accreditation process, because the residents had no capacity, we would have seen a different outcome.

Senator POLLEY: Dr Stubbs, do you have anything to add?

Dr Stubbs: No, I think that's a fair comment.

Senator POLLEY: Some of the most vulnerable South Australian residents have been treated less than most people would treat their pets at home. This has continued for a long time. We spoke about the changes in the procedures around medication. How could it go on for so long that medication was mixed in the same pestle time and time again, without any cleaning and no sterilisation, and causing cross-contamination of other residents' medication? How could that happen? How could no-one report that?

Ms Hanson: That's a very difficult question for me or anybody else to answer, because I simply do not understand it. It is clear that over many, many years—I will preface my next statement by saying the staff that worked at Oakden, by and large, had been working there for 30 years. They had come from places like Glenside and Hillcrest. There were constant staff who clearly behaved in a fairly consistent manner. The staff themselves under-reported; the managers didn't report. It was a very closed environment. The wards were locked wards, and the clinical view, from the staff working there, was that it wasn't really a safe or appropriate place for too many visitors to enter, because it stimulated the residents to a point that they would get very upset. My personal opinion of that, in my reflection of what I now know and what I've heard from meeting with staff and families, is that the closed environment was a very toxic environment. The people who worked there didn't recognise what they were doing, or walked past it.

Senator POLLEY: We know that we are going to be confronted, going forward, with enormous numbers when it comes to Australians who will have dementia in this country, so the best practices that are currently in place—those that were in place here were not enough, quite clearly. Apart from the fact that you've had the overview and you've got the reforms in place, do you have any confidence in the accreditation agency?

Ms Hanson: We are undertaking a gap analysis this Thursday with the ACHS rather than the aged-care accreditation agency, in preparation to go through an assessment with that particular agency.

Senator POLLEY: You didn't answer the question, but I think you did without saying so. With the process that we have now, where auditors go into an aged-care home, there seems to me to be a fundamental problem: if you have the same auditors going into the same residential homes, it builds up a rapport that can dilute the professional nature of those audits. Would that be a fair assessment that that happened in this case?

Ms Hanson: Yes.

Senator POLLEY: It is extraordinary that we have, under the oversight of the Commonwealth government, auditors who become so familiar with the aged-care providers, whether it is part of a state government run organisation or whether it's in the greater sector of aged care, that this happens. That's outrageous; it's unacceptable, is it not?

Ms Hanson: Yes. The ACHS process is that there are many trained assessors who are health professionals, and the teams that are formed to undertake ACHS assessments are never the same teams.

Senator POLLEY: Would you like to see a recommendation—I don't want to put words in your mouth, but it's something that I've been thinking about for some time; I believe I raised it in Senate estimates a couple of weeks ago with the agency—that there needs to be more transparency, that there needs to be a rotation of auditors that are trained and skilled, but move between states so that they don't build up that familiarity with the providers?

Ms Hanson: Yes.

Senator POLLEY: There have been a lot of comments in relation to the age of the facility. I don't take that as an excuse because I've visited numerous very old facilities around this country—facilities that still have four people in a ward, or two people in a ward—and their care has been second to none. The use of restraints in 2017, to think that that was still happening last year and up until March this year—I don't think anyone can step away from some of the blame for that sort of care. People who are the most vulnerable in our communities, people with dementia or mental health issues, deserve the same care. Taking up from a question that was asked in relation to this: where does the buck stop?

Ms Hanson: The buck stops with my position, with the CEO. I'm on record saying that.

Senator POLLEY: In terms of trying to attract the best possible people to care for these most vulnerable people in our community, whether or not the people in care are difficult to manage or not is irrelevant; they deserve the same respect, dignity and care. How are you attracting people now to work in this sector?

Ms Hanson: We've undertaken a recent recruitment process because many staff have left. We undertook a values-based recruitment process. The selection was really about asking people questions about why they were choosing to work with people with dementia and/or enduring mental illness. I'm very happy with the selection. We've had those people onboard between six months and two months ago, which was the most recent.

The onboarding for those staff was very different from the historical method of recruitment for all staff at Oakden. That included me providing a presentation from one of the past residents, Mr Bevan. His sister had written a poem, on behalf of Phil, and we showed photos of Phil's time, his journey through Oakden, which was a very moving story. There is values based selection, the use of family stories in the orientation process and things like mandatory training. MAPA manages actual or potential aggressive behaviours. We've had Nightingale Nurses, from Alzheimer's Australia, on the floor mentoring their staff, one on one. We've also had Professor Jenny Abbey, who's now retired. She wrote the Abbey pain scale, which is how you assess people with dementia and their pain. Jenny spent a number of months at Northgate with the staff.

I said in my opening statement that I put a moratorium on new residents to that service, in January, and I have not lifted that. We're only caring for 11 residents now and we will not reopen that service until we're confident that everything that's required to be in place, to provide contemporary best-practice care to people who are vulnerable, is ready to go. Our executive team all adopted an existing resident. In addition to the principal community visitor, the Office of the Chief Psychiatrist, we make unannounced visits at Northgate, to visit our adopted resident, as another mechanism to ensure that the care is appropriate. In the last three months we have probably had only six resident-on-resident interactions that have not been appropriate. We have only one resident who's had an episode of restraint, and that was at the request of his wife, and permission was sought from the Office of the Chief Psychiatrist. We are confident that the people who are residing in Northgate House are getting very appropriate care, and we are confident that we will not open up the service again until we have all the processes that are required to be in place to deliver that care.

Senator POLLEY: In response to the stain that's been left on the sector, in South Australia, the good thing coming out of that is there's been a lot of focus, so I have no doubt that things will improve. But there is still an issue around unannounced visits. I just want to gauge from you, firstly, whether you believe that all visits should be unannounced and, secondly, if we need—I know what my view is—stronger response for complaints so that the complaints commissioner, at a Commonwealth level, has far more teeth to take some action. That's one of the big downfalls. As you said, most of the residents weren't able to verbalise what was happening to them but you can tell when they cringe, when a certain staff member comes along, that there's been an issue. How do we strengthen the complaints area and do we need all visits to be unannounced?

Ms Hanson: My view on unannounced visits is that the formal accreditation process—it probably needs to be announced, but in between that cycle every visit should be unannounced and should be more than a couple of hours. I firmly believe that whether the visits are announced or unannounced, for services that are caring for people with dementia and/or enduring mental illness, there should be a standard for the auditors that they have to interview a certain number of family members to really understand. For me, it was my meeting with the Spriggs family. It wasn't just Barb's account of Bob's treatment, it was her observation of the entire service, because she spent a lot of time there, and she was articulate. It was immediately after that meeting that I had concerns.

In relation to the complaints commissioner, the families I met didn't know each other and they span—I met with families who had a resident in 2007, 2011 and 2014. I asked them why they didn't complain. They complained internally, to the management team. I'm not speculating when I say they were intimidated, in relation to using any of the external agencies to make further complaints. It's part of what we are now doing. The family or guardian is involved at least fortnightly with a multidisciplinary meeting about what's happening to their loved one. At those meetings the families are encouraged to provide any type of feedback. We've also provided every family member with information on how to contact the Aged Rights Advocacy Service, promoting their ability for people to make complaints. It is my view that people who could have complained were intimidated.

CHAIR: How did this facility pass an unannounced visit?

Ms Hanson: I do not know.

CHAIR: If this facility could have passed an unannounced visit, just announced visits are not going to do the job, are they?

Ms Hanson: Speak to the families, if not the residents. If the residents have capacity, then we should be speaking to them; it's their home; it's their life. If they don't have capacity, I believe we absolutely have to be connecting with the families. They will tell the truth.

CHAIR: Later on today we're going to be hearing from Flinders University, who have their CCI 3D user guide, which talks about how you involve residents and, for people with severe illness, their families. Have you had a look at that, and is that the sort of approach you're talking about?

Ms Hanson: I haven't had a look at it, no.

CHAIR: Would you mind taking on notice having a look at that submission and giving us—I can't ask for opinions—some thoughts on that policy?

Ms Hanson: Yes, I'll do that.

CHAIR: I go now to this issue of training. You articulated earlier that some of the staff had been there for 30 years. Both Senator Polley and I—and I'm sure others have too—have visited a number of aged-care residences. A couple had a very strong approach to moving away from restraints and moving away from medications, to the point where they've reduced the use of medications by over 80 per cent. There are some really good results. A lot of that involved dedication from the management and having a really strong staff who were continually trained. For example, they were getting training in understanding cognitive behaviour.

Was there no effort here for the staff to ensure that they have had training to bring them up to date with the way you manage people with significant psychiatric orders or severe behaviour issues?

Ms Hanson: There was baseline training offered. In particular, Makk and McLeay, which were the two units for the people with severe BPSD, were predominantly staffed by mental health trained nurses—not aged-care trained nurses but mental health trained nurses—from 1970 onwards. It is my view now that that type of care was in place for a number of years.

CHAIR: So the processes here were deficient in terms of requiring ongoing—

Ms Hanson: They undertook training to de-escalate aggressive behaviour and they did some cognitive behavioural training, but it was baseline training.

CHAIR: Modern training now has moved away from that form of training.

Ms Hanson: Absolutely. In the last 12 months, we've undertaken trauma-informed care training. There is a whole range of training, and that framework will be in place, moving forward, for when we are comfortable that we can re-establish a full-blown service—absolutely. But your question was about the past, and I need to tell you it was baseline training; it was not contemporary.

CHAIR: Yes. So, from your understanding, there was no contemporary training for staff? Whether they were aged-care support workers or whether they were mental health workers, there was none in either sphere?

Ms Hanson: Only baseline training.

CHAIR: That also, for me, goes back to the accreditation process. Why was this not picked up? Why was it not picked up that staff in both spheres of care were not—

Ms Hanson: It was part of the assessment—the human resource element; it goes across all of the 44 standards—and evidence was produced. Clearly, the baseline training that was produced as evidence was determined to be sufficient.

CHAIR: Thank you. Dr Stubbs, I've got a couple of questions for you, going back to this issue of contemporary training, particularly around severe behaviours and cognitive impairments. When you talk about looking at best practice, are those the areas you're focusing on?

Dr Stubbs: Absolutely. I think often in health services we put people into situations where they're not adequately trained, and some of them adapt appropriately. But, when you're dealing with the most complex and the most difficult of clients, you can't manage without the proper training. The health system functions very well for the standard sorts of issues and for people with one issue. But what we have to remember about these clients—we class them as BPSD or as enduring mental illness—is that they're actually, in many cases, old people with multiple comorbidities. In fact, one of the issues for general nursing homes but also for these sorts of facilities is that they don't have enough access to geriatricians or even to GPs. I chaired the board of ECH, one of the aged-care providers here, and it was extremely difficult to get those facilities enough medical expertise in the form of general practitioners or geriatricians. So we need to make sure that, when we're looking at these clients, we recognise the totality of their needs and treat them as people who deserve the best possible life, and that's when we need highly trained but also a really good mix of staff.

CHAIR: One more question, and that is on the issue that Ms Hanson raised, and which has been raised in submissions to us, around resident interviews and family interviews in terms of the assessment process. Are you looking at that through your processes?

Dr Stubbs: Yes, we are. It was very interesting, the discussion about why accreditation has failed, and one reaction to that is to say, 'It's not valuable.' I think it is extremely valuable to have external accreditation. I chair a number of risk and audit committees, and one of the dilemmas is how you get close enough to the organisation you're auditing or whose risk you're assessing if you're external. It's a bit like Senate estimates committees: how does the opposition get close enough to the real facts? That's where the dilemma arises with the issue that Senator Polley was talking about: do you have a change of staff all the time or people coming in? I think the dilemma there is that the danger is that you get captured—that's the issue that was talked about before—but the other side of it is that you sometimes need to understand the organisation to know where to ask the right questions and who to ask. The more you understand it, the more you're able to ask probing questions. So I think there's a balance there between making sure someone's not captured by the organisation—and therefore it's almost a sweetheart agreement—and having someone who understands the organisation and understands where to go for the real answers. But certainly part of the real answers in these situations is the consumers themselves and their families and carers.

CHAIR: Thank you. Are there any last-minute questions?

Senator PATRICK: Yes. It's clear that there were systemic problems at Oakton prior to when the chief psychiatrist made his report. In terms of oversight, one would hope that you knew about at least some of those problems. With a finite health budget, how affected have you been by the overspend on the new RAH, $600 million? That must come from somewhere. Were you under extreme financial pressure?

Ms Hanson: The Northern Adelaide annual budget has had growth in it year on year for each and every year that I've been the chief executive officer there, so it has had ability to invest and grow.

Senator PATRICK: In that sense, you're suggesting that it was simply a lack of knowledge about what was going on there?

Ms Hanson: Correct.

Senator POLLEY: I have one short question on notice: would you both be able to turn your minds to the sorts of amendments or strengthening of the accreditation process that you think will help to alleviate another repeat of the Oakden situation? Would you be able to take that on notice and provide it to the committee?

Ms Hanson: Yes.

CHAIR: Thank you very much for your evidence today. The secretariat will be in contact on timelines for return of answers to questions on notice.

BOLGER, Ms Christina, Executive Director, Regulatory Policy and Performance, Australian Aged Care Quality Agency

RYAN, Mr Nick, Chief Executive Officer, Australian Aged Care Quality Agency

WUNSCH, Ms Ann, Executive Director, Operations, Australian Aged Care Quality Agency

[09:43]

CHAIR: Welcome. While you're settling in, I'll just double-check you've been given information on parliamentary privilege and the protection of witnesses and evidence. Thank you. I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. We have your submission. I invite you to make an opening statement, and then we'll ask you some questions.

Mr Ryan: Thank you for the opportunity to make a statement. On behalf of the Australian Aged Care Quality Agency, we appreciate the opportunity to appear before the hearing. I would like to begin by making a short statement about the quality agency and our role in the aged-care sector. I would like to touch on the Nous report, which I commissioned earlier this year, and also on the Carnell-Paterson review, the recommendations of which followed the quality agency's March 2017 review audit of Makk and McLeay ward within the Oakden Older Persons Mental Health Service.

The quality agency's primary purpose is to deliver a quality monitoring and compliance framework for Australian government funded aged-care services based on the regulatory framework which came into existence in 2013. The agency is responsible for the oversight of 2,678 residential aged-care services and for holding them accountable against the accreditation standards as well as the home care standards for home care services. Under the 2013 regulatory framework, our role was fundamentally one of accrediting and monitoring the systems that aged-care providers have in place.

The quality agency is continually improving the way we assess against the standards, including identifying and addressing any instances where desired outcomes have not been met. At present, the vast majority of Australia's 2,678 aged-care services are meeting the accreditation standards and are providing quality care. Today, over 97 per cent of Australian aged-care homes have been found to be compliant with the standards at their last re-accreditation and this compares to only 60 per cent in the year 2000. The quality agency's assessment of individual homes together with the tens of thousands of residents and families we talk to every year tell us that most operators and their staff are committed to providing quality care. Unfortunately, no accreditation or compliance monitoring system can fully safeguard against individual instances of abuse or neglect.

The quality agency is a part of a network which also includes the Commonwealth department of health, the Aged Care Complaints Commissioner, aged-care providers, staff, family members and visiting professionals. There is no doubt that the April 2017 Oakden report by South Australia's then chief psychiatrist, Dr Aaron Groves, and his colleagues presents a number of disturbing findings. Dr Groves's report corroborates the failures of care that my agency found in our review audit at the Makk and McLeay units in March 2017. We found the service to be non-compliant with 15 out of 44 expected outcomes of the residential aged-care accreditation standards. A finding of serious risk under our principles to the safety, health and wellbeing of aged-care recipients was made by the quality agency and was referred to the department of health at that time. However, there is no doubt that the quality agency has some significant learnings to take away from the failures at Oakden.

Following our review audit and the following month the release of the Oakden report, I appointed an external reviewer—that's the Nous group—to advise me on any shortcomings in internal processing and the way that our systems can be improved. Nous provided external independent advice regarding the need and opportunity to improve accreditation practices in the light of the concerns arising from Makk and McLeay. The Nous report identifies opportunities for the quality agency to improve its processes, particularly when assessing more complex aged-care facilities and identifying serious risk. The Nous report made four key recommendations and also 24 actions following those recommendations on improvements that we can make. I have accepted all of the recommendations of the Nous report and we are well underway in implementing the necessary changes identified in that report. Both the Nous report and the quality agency response in the form of an action plan are on our website. Minister Wyatt formally released the report resulting from the broader Carnell-Paterson Review of National Aged Care Quality Regulatory Processes on 25 October. The report provides advice to government and makes 10 recommendations for the government's consideration.

At this stage, the government has made a commitment to move to unannounced re-accreditation visits for residential nursing homes as soon as possible. This commitment is referenced under recommendation 8 of the Carnell-Paterson report. The move to unannounced visits presents an opportunity for the agency to strengthen our risk based approach, and we are working quickly to determine how to best implement this change.

We are currently looking closely at the Quality Agency Principles—our major guide and rule book for how we do accreditation—and working with the Department of Health to understand what changes need to be put in place to implement this commitment. Members of my team have joined a cross-government working group to explore to implication of the review's recommendation before the government formalises the response to the review.

You'd also be aware that the government is consulting with the sector on moving away from the current accreditation standards under which providers are assessed in favour of a single set of aged-care quality standards. The new standards will focus on quality outcomes for consumers rather than just provider processes and make it easier for consumers, their families, carers and representatives to understand what they can expect from a service. Subject to government agreement and changes to aged-care legislation, the new standards will take effect some time following 1 July 2018, but that is subject to final government decisions and announcements.

We are committed to protecting vulnerable people and ensuring quality care for older Australians. The quality agency is also committed to continuously improving our own processes as well as working with government and other stakeholders to enhance the aged-care regulatory framework. Thank you for the chance to make this statement. Obviously, we're pleased to provide any answers to questions.

Senator POLLEY: Thank you very much for appearing before us. Can we just start with an easy one. Can you explain to the committee what processes were in place for your auditors to allow accreditation for the Oakden facility for so long when there were obviously a lot of issues. Can you talk us through the process that your assessors went through when they did an audit and how we could end up where we did in February and March this year?

Mr Ryan: As you'd be aware, the fundamental benchmark for aged-care accreditation is a re-accreditation audit where comprehensive information of four standards and 44 outcomes and our staff go on-site and gather information about how an aged-care provider meets those outcomes. We always start with interviewing a minimum of 10 per cent of the residents or their representatives—

Senator POLLEY: Can I just ask again: how did you interview people who obviously had mental health issues and were suffering from illnesses like dementia? How was that conducted?

Mr Ryan: We interviewed a minimum of 10 per cent in this case of resident representatives—normally, family members or loved ones. We conducted that in February of last year and at each reaccreditation audit.

Senator POLLEY: Can you table the accreditation audit that was conducted for the last six years.

Mr Ryan: I believe that information was tabled earlier in the Senate, but we can table that again, Senator.

Senator POLLEY: What training do your auditors undertake?

Mr Ryan: We undertake an initial training where they're brought up to date on our approach to accreditation and how to use the tools around accreditation. They undertake an exam at the end of that period. They're then under a minimum of six months professional supervision. They're subject to a minimum amount—15 hours. We exceed the 15 hours in the last few years of CPD every year. You will note that more than 50 per cent of our surveyors, as we call them now, hold a nursing qualification or have been qualified in nursing in the past. We have a broad cross-section of other health professionals involved. We have physiotherapists. We have people with law degrees.. We have people with experience in other regulatory systems, so we have a broad cross-section of skilled individuals and—

Ms Wunsch: I might add that the training that is provided to our assessors and surveyors is an ISQua-accredited surveyor training program and it is aligned with the VET auditing competencies.

Senator POLLEY: How long is that training for?

Ms Wunsch: The face-to-face component of that training is 10 days, but there are also online and other aspects of that training.

Senator POLLEY: Can you then explain, with your skilled surveyors, how the accreditation of Oakden was ticked off for 44 of the recommendations that they had to pass. How did that happen?

Mr Ryan: Are you speaking about a specific audit?

Senator POLLEY: 2010, 2016—

Mr Ryan: And 2013, in fact—yes, all three.

Senator POLLEY: Knowing what we know now from the evidence that has been given to us in submissions, how was it possible that they passed accreditation? Is that a failure of your system?

Mr Ryan: We think there were significant learnings that we could take from our re-accreditation. What was obvious and what was apparent to Dr Groves—and, in fact, what was obvious and apparent to us the month before Dr Groves and his colleagues reported—did not come to light in our February 2016 audit. Based on my own visit to the home in April of this year, I determined to ask and answer those questions. I wanted to find out how it was possible that a home that had such failures, as identified by Dr Groves, but, as mentioned, as we had identified—

Senator POLLEY: So how did it happen?

Mr Ryan: We think there were opportunities for improvement around the way that we schedule—

Senator POLLEY: Sorry. Mr Ryan—

Mr Ryan: Sorry, Senator. If you're asking a question, I'm happy to answer it.

Senator POLLEY: You've had a lot of time to reflect on what happened. Surely, you can express to us in very clear terms what happened and why this failure was let go for so long.

Mr Ryan: I think that there are some significant issues around the Oakden facility, especially the two Makk and McLeay wings. Firstly, it was a really complex environment. It had multiple levels of governance—and you've already taken evidence this morning. It had a history of non-compliance 10 years ago. We think that the learnings from 2007, 2008 and 2009 were not adequately drawn through in the 2010, 2013 and 2016 audits. We think that there were strengthened opportunities around the way that we identify risk. We had already done a lot of work around risk in the last two years, but we think there are opportunities to strengthen around how we identify risk and how, especially in a complex service such as Makk and McLeay, we can identify risks and make sure that those specific risks are drawn through, are ticked off or are addressed clearly when we undertake an audit. We also think that for the role that decision-makers take and the availability of information to decision-makers who are never on site during the audit—there's a review step built into our processes—there is strengthened opportunity for how they make decisions on the information that they may have available.

Senator POLLEY: Can I stop you there. You're covering the same ground. Do you not accept any responsibility that your agency failed these vulnerable people here in South Australia that were residing at Oakden?

Mr Ryan: It is clear that there are failures involved in Makk and McLeay. The fundamental failure rests with the provider. The fundamental—

Senator POLLEY: So you see no responsibility that your surveyor has failed their job?

Mr Ryan: I'm still answering the question, Senator.

CHAIR: Senator Polley, let the witness finish.

Mr Ryan: Clearly, the fundamental responsibility rests with the provider. It's that case under the Aged Care Act; that's the law. We certainly think that we ought to have picked up in 2016—and we have looked for ways and committed to ways, and already commenced the reforms to better pick up risks and vulnerabilities in highly complex service such as Makk and McLeay. I'm committed, along with my team and along with the government, to learning the lessons. What happened at Oakden is absolutely unacceptable. Everyone involved in the Oakden facility—and that includes me, as the CEO of the agency, and my team—will look for every opportunity and is already taking active steps to ensure that a facility such as Oakden is picked up next time and the abuse uncovered.

If I may, I might quote Dr Groves himself on radio here in Adelaide in April this year. He said that he visited the home for half a day in June of last year. That is four months after our re-accreditation audit. The quote was, 'There was nothing to see then.' The fact that he found nothing and that we did not find it in February of last year doesn't mean that it wasn't there. It did take Dr Groves, another psychiatrist, a chief psychiatric nurse and a health researcher who visited the facility for 10 straight weeks to uncover the rate of abuse going on. There was complicit compliance going on in that facility. There was a culture of cover-up in that facility. We're determined to take the steps—we're already undertaking the steps—so that we will be much more alert systemically as well as with the training and available resources and times to pick that up were that to occur again.

Senator POLLEY: So you take no responsibility. It was a very long answer but still avoiding taking any—

Mr Ryan: I think this important information—

Senator POLLEY: I'm sorry; I'm still speaking.

Mr Ryan: I beg your pardon.

Senator POLLEY: You're still taking no responsibility whatsoever for your agency and the audits that took place at that time. What confidence, then, do Australians and older Australians have—and we know there's going to be a huge increase in people suffering from dementia as we go forward—that there's not going to be another incident because of the tick-and-flick attitude of your surveyors?

Mr Ryan: Firstly, the beginning of your question was the assumption that I don't take responsibility. I have taken responsibility. I personally visited the facility as soon as I read the Groves report. I commissioned the Nous report. I took on board four recommendations. We've already commenced implementing it. We actively participated in the Carnell-Paterson review. We are absolutely committed. We accept that we had a role to play and that the public can expect and ought expect us to be vigilant in the way that we undertake accreditation. We are part of a regulatory framework where the key responsibility lies with the provider, but I accept responsibility that our system needed improvement and I've taken the active steps to deliver that.

Senator POLLEY: What else then? Do we need a review of your agency to give you more power to intervene in these circumstances? I find it hard to understand why there's so much evidence from family members over an extended period of time that there needs to be a much stronger complaint mechanism to resolve these issues. Many of the residents were unable to verbalise what was happening to them, but it was pretty obvious that, if somebody had been rough with them, they were going to be hesitant and would react around those people. The thing I read in the evidence that was so alarming was that many of these staff believed that whatever they said and did to these people who had mental health issues or dementia did not matter, because they'd forget about it. The reality is we all know the evidence proves that people still have reactions to people who have been abusive of them. So do we need to look at strengthening the agency's capacity to ensure this doesn't happen again?

Mr Ryan: I think you'll find that the government commissioned Carnell-Paterson as well as my own commissioning of the Nous review—

Senator POLLEY: That's only one recommendation. There are nine others. Do you support those?

Mr Ryan: Clearly I'm supportive of the broad range of the recommendations coming out of Carnell-Paterson, and it's crucial to note that the Australian government is taking on board all of that information and will make decisions and announcements in due course.

Senator POLLEY: They've accepted one recommendation, and that is unannounced visits for accreditation. That surely is not going to resolve the issues that we've seen at Oakden and we're experiencing around the country with other issues relating to the poor care of some of the most vulnerable people in this country.

Ms Wunsch: I think there is significant value in having an unannounced re-accreditation audit, which would be over a period of days where the team is able to observe care in a way that is not filtered by a set of arrangements where staff are brought in to provide information so that we will have better access to what is actually happening on the ground. We also would be looking to have self-assessment information provided by the provider at a different time so it doesn't impede our access to people and the care that's being delivered and we are spending more time making observations and engaging with families and are recipients during the audit. So I think it will make a significant difference. I know that providers are already coming to an understanding of what this will be like for them, because the effort that has perhaps gone into the preplanning and arranging of a piece for accreditation will no longer be there.

Senator POLLEY: Have you ever visited an aged-care home where they're preparing for that accreditation visit, where they roster on more staff; where they run around madly, making sure all their paperwork is up to date; where they ensure that the troublesome residents who may speak about some of the issues that they're not happy with are being bussed out on a day trip? Have you visited and observed those processes being in place? I have.

Mr Ryan: We certainly are aware that providers get ready for re-accreditation audits under the announced system. I think it's important to note because we hear this from time to time. When we go on site, as well as conducting interviews of a minimum of 10 per cent, the notion that they roster up for the visit may be the case; however, we look at historical staffing rosters going back months. We're interested in looking at the available food, the range of services, the range of supports available for months and months before that. So we're not just interested in observing. Whilst we do observe what occurs on the day, we're obviously aware of and interested in seeing the long-term conduct of the home. That includes diet, staffing, medication and a whole range of matters, not just the notion of seeing what we do on the day.

Senator POLLEY: In relation to the Carnell report, which is one of many that are sitting o the minister's desk, how can older Australians and their families feel that they're going to be protected when, as I said, it's unfortunately fairly common that people are living with dementia? How are they going to be reassured with the breakdown in the system that has now eventuated? You were talking about looking at rosters over many months and looking at food. Why then have we got evidence here—pages of it—where family members have made complaints about the fact that their loved one has lost a significant amount of wait after having gone in that wouldn't have been picked up. And there are issues around restraints. So there are family members who've made complaints.

Mr Ryan: Certainly. One of the things that we require under expected outcome 1.4 is that there's an adequate complaints and comments process. You're obviously aware that the Australian government has strengthened the role of the complaints scheme and brought it out of the department. Rae Lamb is an independent statutory officer and she's the Aged Care Complaints Commissioner.

Senator POLLEY: Yes, she's even sat at estimates.

Mr Ryan: I would certainly reassure you that we have a very close MOU and working relationship. There would not be a week that goes past where Ann Wunsch or Christina Bolger doesn't receive advice and referrals. We have a protocol for the sharing of data with the complaints commissioner. If they send us a level 3—that's their highest-level referral—we are normally in that facility within 12 hours. It's very rare that it's longer than 48 hours later. What is important to note is that the public can be reassured that there are opportunities within the home to raise complaints. The new draft standards, which are fairly close to being decided by government, have a much stronger and strengthened role around the role of consumers speaking up, not just having the opportunity to raise complaints but being actively involved in the design, delivery and evaluation of care. We encourage everyone involved, be they family members, residents, staff members or others, if they've got any concern, to speak to the provider. If they're not satisfied with those outcomes, speak with the complaints commissioner. If they uncover issues of concern, they're vigilant in going in to address those. If they're concerned that they're systemic, they refer that to us, and we work very quickly to uncover any concerns that we have. We would often conduct an unannounced visit, and where be have concerns we do a full review audit. That can be up to 10 days on site. So I think the public can be reassured that there is a vigilant safety and compliance framework for aged care in Australia.

Senator FAWCETT: In your submission you make the comment that medication management is one of the top five areas of noncompliance. You mentioned in your verbal evidence that you have a risk based approach. I am struggling to understand why, if you have a risk based approach and you have identified that as an area of noncompliance, that was not picked up at this facility in your 2016 inspection, because that is the time frame your submission says you were focused on this area?

Mr Ryan: To review a home's performance under medication management, we do review medication charts. We do review a range of information. We do interview, not the residents in this case, but we interview at least 10 per cent of the residents' representatives—normally family members. We do undertake what we call—it is not specific to medication—SOFI, which is the structured observational framework. We sit and observe interactions. But, in the case of medication management, we review the medication charts and the system that the home had for medication. We found they were compliant at that time.

Senator FAWCETT: In March 2017 then, your conclusion was that the service did not have effective systems in place. Compliance with a system might be one thing, and that goes to staff training and culture et cetera, but the actual system itself does not suddenly change in 12 months. So, you have a focus area, you went and you said it was compliant, and yet less than 12 months later you are saying that they did not actually have effective systems in place. That either says that you have changed your standard of assessment, once all the scrutiny has come on, or that your initial standard of scrutiny of their system was inadequate, given that you have actually identified that this was an area of weakness across the whole sector.

Mr Ryan: There are a few points in your question. Clearly, we had information in January of this year of a medication error at Oakden, at the Makk and McLeay wings of Oakden. We conducted an unannounced visit and a full review audit. Then, we did find failure against medication management as an outcome. The performance of a home can change in 12 months, by the way. The performance of homes can change over three months. But I was not satisfied that all of what ought to have been found in February 2016 was found, and that is why I commissioned Nous as a matter of urgency. That is why we have taken on board all of the recommendations from Nous and commenced implementation by early August of this year. Clearly, there were concerns around medication this year, and that is why I was determined to find out.

Reading the report of Dr Groves and his colleagues, I think you will find that there was a culture at Oakden of not being forthright. There is a difference between hospital accreditations, where they are required to disclose any other negative findings from any other scrutiny. We currently don't have that in aged care accreditation, whereas they do in hospital accreditation. Had we had access to the information available in the Clements wing, which is the hospital wing, not the residential aged care wing, we may have been better focused. It is true, though, that there were lessons to be learnt from the every 2016 re-accreditation audit. I have already explained the steps we have taken.

Senator FAWCETT: You have talked about the risk based approach and you heard my questions to the government witnesses earlier.

Mr Ryan: I didn't hear all of that.

Senator FAWCETT: In terms of your assessment of facilities—risk is a combination of probability plus consequence of failure—do you look at a facility like this, where you have a combination of both mental health issues and the frail and ageing, and apply more resources and more in-depth assessment than you would do to a facility that has a more generic population of people who are ageing, but without the co-morbidities?

Mr Ryan: We certainly would have approached Oakden in a different means. Oakden is not a unique facility in Australia, but they are a very small percentage of facilities. Certainly, in commissioning the Nous advice we have taken a much closer look at how we understand risk. It is important to note that we have a case management approach every month. There are weekly meetings at the state level and a national meeting every month. We have a list of homes that will be of concern to us. They could be due to our own concerns, based on our own observations. It could be due to information received from the complaints commissioner or the department or from other sources of regulatory intelligence.

For any home where we have outstanding concerns, whether or not they have varied accreditation, we take a specific look. We target the way that we undertake unannounced visits. Whilst we make one unannounced visit every year, where we have a home of concern we will conduct multiple unannounced visits. If we have concerns around compliance we will conduct a full review audit. So, it is based on available information. One of the things we have done is that we have strengthened our information systems, we have strengthened our risk based approach, and we have taken significant steps to improve our findings of serious risk, which is a statutory finding that we make. We have done that over the last two years. So, our risk approach looks at available information but we certainly think there are areas for strengthening that.

Senator FAWCETT: Can I come to the issue of staff competence. I rate competence as a combination of qualifications plus experience. Ms Wunsch, I think I heard you say before that around 50 per cent of your assessors have a nursing background. Does that imply that 50 per cent have no specific background in a medical or care type facility?

Mr Ryan: No. If I can refer you to my former answer, we have a number of other people who have medical backgrounds in paramedical fields, such as physiotherapy, occupational therapy and so forth. We have people who have legal training—law degrees. We have people who have experience in other regulatory systems. What is important is what we call the team, which is how we roster our staff on. We look at the specific needs of the home and we will put the right combination of surveys together that meets the risk profile of that home. In the vast majority of cases, if not in every case, standard 2, which is around medication and personal care, would be assessed by someone with a nursing background.

Senator FAWCETT: We—not this particular committee but parliamentarians generally—have heard from aged care facilities over many years that, increasingly, they are spending time filling out paperwork as opposed to delivering care to the residents. As the focus of public attention comes onto an issue like this, how are you working with the sector to ensure that the priority for those staff is delivering the quality care we expect whilst having transparency around their practices so that they are not spending the majority of their time filling out paperwork?

Mr Ryan: That is a very good point. One of the things we are committed to doing is to be a best practice regulator. Being a best practice regulator means that we take the active steps needed to make sure that participating in our processes is simpler and our approaches are more transparent. The adoption of the CAAT, the computer assisted audit tool, makes findings of compliance and noncompliance far more transparent, and providers have access to that information. Our aim is to not have unnecessary regulatory overhead or regulatory burdens placed upon providers. However, where we have concerns, any concerns, around the quality and safety of care and services, we are vigilant in pursuing that. But, as I said earlier in my statement, the vast majority of aged care providers in Australia do meet the standards. We want to ensure that we are open and supportive in terms of their intent, going forward, but we are vigilant in holding account. What we look for and what we seek is feedback. We conduct an exit survey every time we visit a home, and they provide us with feedback around whether we were timely, whether we were adequately transparent, and whether we had an unnecessary impact upon their business as usual.

As an accreditation system, there is a full and thorough re-accreditation audit normally every three years. In South Australia there are 49 homes that gets up to 5 years, because of the hub.

That, combined with an annual unannounced visit, broadly speaking, is not a heavy regulatory burden. However, the responsibility to provide adequate care and services sits with the provider each and every day. And I would put it to providers that it's not so much a regulatory burden with us; it's that they can satisfy themselves that they provide adequate care to their residents.

Senator FAWCETT: Do you formally benchmark your practices and outcomes against oversight bodies in similar areas—for example health—or, indeed, with oversight bodies for aged care in like nations, such as Canada, the UK et cetera?

Ms Wunsch: The Australian Aged Care Quality Agency is an active member of the International Society for Quality in Health Care, ISQua. A number of us are surveyors in that space, and we are involved in surveying accreditation programs and standards and surveyor programs internationally. The majority of that work is done as a desk exercise in Australia, but we're also involved in international teams. Our organisation is accredited and our surveyor training program is accredited, and we are in constant contact with our international colleagues to understand best practice accreditation and regulation in the aged-care space and social care space and health care internationally.

The issue raised by Nick Ryan earlier about the other scheme that operates healthcare accreditation having open disclosure as a fundamental principle in accreditation is one that you will see replicated across the world, and we are very keen to see that as a fundamental principle of the way that we conduct accreditation in aged care going forward. So new standards and unannounced accreditation audits, where we are auditing at the point where care is delivered, are critical as is also having an opportunity to know what has occurred in a facility and the onus not being on us to discover, because that, I believe, has been an impediment in the process that we've been undertaking. We are seeking to be best practice in accreditation in regulation and we are doing that in the context of what is occurring internationally.

Mr Ryan: I would just add that we did undergo a re-accreditation audit with ISQua and received 91 per cent mid-year. It is vital for us to benchmark our activity against international systems, because that's one of the ways that we learn. We did a joined-up approach with the Australian Council on Healthcare Standards in looking at a co-accreditation sample in Victoria last year where you have bush hospitals that are both a hospital and a residential aged-care facility. So we are interested in understanding how hospital accreditation and aged-care accreditation can better work together.

Senator PATRICK: How long have you been at the helm of AACQA?

Mr Ryan: Since April 2014.

Senator PATRICK: In looking at the My Aged Care website—and perhaps my data might be a little old, so I would appreciate if you could confirm this—it appears that you have something like 26 facilities where there are notices of noncompliance and nine that are under sanction at this point in time. Is that correct?

Mr Ryan: I will just check the data on that.

Senator PATRICK: Is that about the right order of magnitude?

Mr Ryan: We will just get the precise data for you, Senator.

Ms Bolger: From our re-accreditation audits for last financial year, there were 12 instances where new expected outcomes weren't met, of noncompliance. From our review audits, there were 22. From our unannounced assessment contacts, which is our compliance monitoring activity, there were eight new instances of noncompliance and, from our unannounced assessment contacts, 38. That's the profile for the last financial year.

Senator PATRICK: Okay, but are we seeing an increase? I've got some data that was provided to me that suggests that in the past we weren't getting those sorts of numbers.

Mr Ryan: I think it's fair to say that about two years ago we had a thorough look at the finding of serious risk, which is under section 2.63 of the principles. We did have a very deep dive into identifying the relationship between failure against the standard by a provider—noncompliance against one of the outcomes—and the possibility of serious risk to the health, safety and wellbeing of residents. We amended our approach so that, every time we find noncompliance, we test and assure ourselves one way or another whether it placed one or more identifiable residents at serious risk.

Senator PATRICK: But, if I went back 12 months, would some of the facilities that you're looking at now for noncompliance and sanctions have been compliant?

Mr Ryan: The findings of serious risk have increased as we've improved and sharpened our focus on the relationship between failure against an outcome and identifiable risk. So not only are we satisfied that we're better placed to pick up regulatory failure where we find it; we test in a far more forensic sense the impact upon residents that is in any way linked to that failure.

Senator PATRICK: So in some sense you're agreeing with the idea mentioned at the table here that maybe a year or two ago it was very much 'tick and flick' that was occurring?

Mr Ryan: No. In fact, we've never had a tick-and-flick approach. We've found noncompliance throughout the history of the scheme. We are just sharper on the relationship now between noncompliance and whether it has placed one or more residents at serious risk.

Ms Bolger: Senator, I think that it's important also to understand the balance of activity between the reaccreditation audit, which is a cyclical, programmatic activity, and our compliance monitoring activity, which is driven much more by regulatory intelligence and information. It's that latter category that we have strengthened over the last 18 months through better relationships with the department and the Aged Care Complaints Commissioner; and increased referrals, which have led to escalations to review audits. It's true to say that we are finding more noncompliance in those review audits, but I think that's a positive story out of strengthening some of our information leading to compliance activity.

Senator PATRICK: Sure. Since Oakden, in terms of staff resignations, have you had an increase in assessors resigning or any change in profile in terms of resignations?

Mr Ryan: I would have to take that on notice. Certainly, I'm not aware of any particular spike. It's the Australian Public Service, so there is a rate of turnover, but there's nothing specific terms of staff resigning—at least, not in a way that appears to be a reaction or anything. I'm not aware of anything like that.

Senator PATRICK: Okay. Moving now to the specifics of Oakden, we had a facility that had no approved model of care, it clearly had some staff shortages and the facility was in decline. I wonder whether or not those factors are considered as part of the 44 standards that you're looking at—things like a model of care. I wonder how you ever passed an audit when you don't have a signed-off model of care for a facility.

Ms Wunsch: The model-of-care issue is a really important one that we have reflected on in relation to Makk and McLeay. We believe that the new draft standards are far more focused on understanding the relationship between care and individuals, and support a much more detailed assessment against this particular issue. We note that the standards that we're currently working with were developed in the 1990s, and that we're looking forward to an opportunity to work with these new standards in the context of unannounced reaccreditation audits to produce what we believe will be a far better engagement with consumers and families at the point where care is delivered, to really understand the performance of that service against aged-care standards.

Senator PATRICK: In the situation where, to me, it appears as though there were systemic problems and that many of these things could not reasonably be attributed to any single staff member or even a collective of staff members at the coalface, do you have scope and powers to examine what happens above the organisation, or is there a comity issue in the context of the state government versus the federal government?

Mr Ryan: I think there are a few points there. Certainly we look at the overall administration. Standard 1 looks at the administrative system. Clearly the question around stronger corporate governance is something that we look at. As based on your question, on the notion of individual staff members, it was difficult to identify which individual staff members were responsible for Oakden. I think you'll find that the provider has referred a number of them to AHPRA. There has been a significant change in staff. I think it's important to note that frontline staff members are responsible, but the ultimate responsibility rests with the provider, and that includes not just the clinical governance but the cultural governance of the organisation. That's something we look at very closely as part of our accreditation, but, again, following on from what Ms Wunsch has said, the draft standards out for consultation at present are due to come in sometime in the latter half of next year, and there is a much stronger focus on corporate governance, not just clinical governance.

Senator PATRICK: From looking at some of the compliance case notes, they make reference to the complexity of governance, particularly in relation to government. If that's identified, is there anything you can do about that, looking into the state government and trying to make it less complex?

Mr Ryan: There's always a complexity, as you'd be aware, in relationships between state and federal governments. What we seek to do is to work very closely with the state and territory departments of health. That's really important for us around infection control, for example, with flu seasons and so forth. We think there are opportunities and we think that's really a matter best answered in the COAG space.

Senator PATRICK: That's problematic if it's in the COAG space.

Senator SMITH: I want to return to some of the responses you gave Senator Fawcett. In some remarks you've mentioned that, in this particular circumstance, you've been operating in a complex environment with multi levels of governance. So of the 2,600 or 2,700 aged-care homes in Australia, how many of them would have characteristics similar to those you described in regard to this circumstance?

Mr Ryan: Every facility is unique, but if you're talking about psychogeriatric facilities conducted by the state government, we have a number for that. Let's take that on notice. We certainly think it's a small subsection of aged-care homes and it's one we've been particularly vigilant in looking at, as you can imagine, in the last six months. So there is a risk profile with psychogeriatric facilities with complex governance environments, yes.

Senator SMITH: About seven per cent of aged-care homes in Australia fall into that state government category. Is this a subset of that seven per cent?

Mr Ryan: I think the psychogeriatric facility that Makk and McLeay was—as you know it's gone; it's closed—is a smaller subset. As you may be aware, the Victorian government is a fairly large provider of residential aged care, so that would make up a fair proportion of that seven per cent. But complex psychogeriatric facilities would be a much smaller number than seven per cent of the 2,678.

Ms Wunsch: I just want to add that it is also important for us to understand that not all elderly Australians with psychogeriatric issues are located in government facilities and that we are using our risk profiling to understand where those people are being cared for. There are some that are in other facility types outside of government.

Senator SMITH: Given this circumstance, can you just elaborate for us what you have done in response, specifically around these types of—as you describe them—complex multiple levels of governance type homes?

Mr Ryan: As you'd appreciate, Senator, we moved very quickly after the Oakden report, and after our own findings around the review audit in March of this year, to undertake unannounced visits across those homes. We have a specific interest in understanding—I think what you'll find with Oakden is that what made it unique was not just the psychogeriatric; it was a fairly complex governance environment even within the South Australian government. There was NALHN, the department of health et cetera. We've had a particularly close look at any home with a profile such as that, since what was uncovered at Makk and McLeay, and they remain the homes for which we always take a very close watching brief. One of the things that we did learn from Oakden and one of the things that I can advise the committee is that a home with historic noncompliance such as Makk and McLeay will never fall off our watchlist again.

Senator SMITH: If a home has noncompliance, going forward it will stay on a watchlist?

Mr Ryan: It will certainly stay on a watchlist, especially the rate of noncompliance on or around 10 years ago—such a home would always stay on a very, very close watchlist going forward. That doesn't mean that they can't return to full compliance, but we will watch them very, very closely, because that was one of the key learnings—that was one of my questions going forward, in April of this year: it's not just 'How do we re-accredit them with 44 out of 44 in 2016?' It was 2013 and 2010. I think it is important to note that, at that time, Makk and McLeay did undertake a significant amount of work to improve their service. They did go to a trusted and well-regarded provider to bring in advisers to help them come back to compliance. There is no doubt that that occurred. When I visited the home, there was evidence of significant effort to build a sensory garden in the courtyard with a bus stop and so forth. Unfortunately that had fallen into disrepair. There was physical evidence of improvement, but that had gone into decline; there was no doubt.

Senator SMITH: In your previous comments, when Senator Fawcett asked you about our international benchmarking around our accreditation regime compared to others—and I'm paraphrasing, so excuse me if I don't paraphrase it perfectly—you talked about moving away from a discovery function. I'm curious about that. If there is a culture of cover-up—Mr Ryan, they were your words—

Mr Ryan: Yes.

Senator SMITH: If there is a culture of cover-up, or cultures of cover-up, and you're moving away from a discovery function, how can you then be confident that cultures of cover-up are not being allowed to fester, to grow?

Mr Ryan: We think that there are opportunities, going forward, for providers to self-disclose, not just to us as the regulator but to consumers, more and more. We would see real opportunities for improvements in aged-care accreditation, looking at self-disclosure, as would be the case in a lot of health environments, not just aged care, going forward. It's not just the regulator who wants to know that; existing and potential consumers want to know what's actually going on in this home. In hospital accreditation, there is a requirement under their accreditation: 'Are you subject to any other type of oversight and what do they find?' We don't currently have that. We don't want to move away from discovery. We're going to remain vigilant in discovery. But we also need to recalibrate so that significant matters, sentinel events—and you'll find some of that in Carnell-Paterson in terms of what providers; there are recommendations around a SIRS, a serious incident reporting scheme, and so forth. We think the move towards providers being ever more open about what's going on—good and bad—is important for regulatory oversight and consumer confidence.

Senator SMITH: What's the incentive, in this particular case, for someone to have self-disclosed?

Mr Ryan: There might not be an incentive but, if there's an obligation under the regulatory system to disclose, that makes it easier and more transparent, and it might help us focus where we might look next.

Senator SMITH: Finally, I'm curious about the average number of residents per aged-care home in Australia.

Mr Ryan: We'll take that on notice. It's about 70 to 100, but we'll take that on notice so that we're precise for you.

Senator SMITH: There'll be a minimum requirement that you interview 10 per cent of residents, so, in an aged-care home of 70 people, you'll be interviewing seven as a minimum.

Ms Wunsch: Our current average interviewing is around 16 to 17 per cent. We're looking to move towards 20 per cent, and our consumer experience report structured interview is engaging with more and more care recipients and families. So we are increasing our engagement under our current system, but we look to increase that further in the future.

Senator SMITH: Going back to Ms Hanson's point—I don't know if you heard it earlier in this morning's evidence—my interpretation of her evidence was that there is a requirement for much more qualitative information. So I was curious: why would it be 10 per cent and not 20 per cent? You've allayed my concerns. Again, why wouldn't it be 25 per cent? If you are interviewing more residents, you're going to get more of a cross-section of experiences.

Mr Ryan: When we developed the consumer experience report with La Trobe University, it was around the area of statistical confidence: how confident can we be that this particular subsection is a fair representation of the overall performance of the home? As we get close to 15 per cent, it's statistically significant and it can be used not just to understand the home but to understand two homes in a fully comparative sense. We think that the move towards consumer experience reports asks them to provide answers around 10 standardised questions plus two open-ended questions: 'What do you like best?' and 'Where does it need to be improved?' That is qualitative in its nature, and we publish all of that information now on our website as to what we've found. We're about 13 to 14 per cent on trend at the moment with the number of residents being interviewed.

Senator SMITH: Okay. What's the target range? Is it 20 per cent?

Mr Ryan: That's a recommendation in Carnell-Paterson.

Senator SMITH: Is it a decision for government still?

Mr Ryan: Yes, that's a decision for government.

CHAIR: I want to follow up that particular issue. In the process that you're going to use, have you looked at the CCI 3D process that Flinders has done quite a lot of work around and has provided us with quite a substantial submission about? Have you looked at that process?

Mr Ryan: No, I haven't. I'm sorry.

CHAIR: Could you take on notice having a look at that and giving some response.

Mr Ryan: We'll do that. Thank you.

CHAIR: I want to go to the specific 10 per cent process that was used for Oakden. What basis did you use for asking residents? How did you pick them, or how were they selected? What were the questions that were asked? Do you need to take that on notice?

Mr Ryan: No, I'd be happy to answer that briefly if I can. If you're talking about the re-accreditation audit, with any re-accreditation audit up to June of this year, we would interview a minimum of 10 per cent. Some of those would be self selected. There's a requirement that the provider inform family members that we're coming to do a re-accreditation audit and that people can self-select to come and say, 'We've got a concern,' or, 'We're quite happy.' If that didn't make up our 10 per cent, we would then randomly sample residents and/or their representatives and ask them questions. We didn't have a standardised set of questions. In terms of benchmarking, not only did CAAT enable us to benchmark evidence from a provider but the consumer experience report enables us to benchmark it under consumer experience reports now. It's random.

CHAIR: You didn't have it then.

Mr Ryan: We didn't have it then. It's a randomised sample. We will still identify; we still interview people who turn up, who want to give us feedback. But the consumer experience report is a randomised 10 to 15 per cent.

CHAIR: I want to get to what happened at Oakden and particularly, for example, during the unannounced visit, and whether the residents were asked questions then and what the feedback was then, given that they passed.

Ms Bolger: All the unannounced visits that we undertake involve consumer interviews. Prior to May this year we didn't have a structured format for those interviews; it would pursue lines of inquiry in relation to compliance with the standards. So, the assessors would follow their nose, be seeking to understand what the consumer's experience of care was, but that wasn't done in a way that delivered a structured or standardised way of comparing homes.

CHAIR: And during that process what happened actually for that last unannounced visit that did not show any problem, that they passed?

Ms Bolger: Obviously with the unannounced visit the unannounced nature of it means that care recipients' representatives aren't given prior notice of us coming. So, the assessors will interview care recipients on the day. They may have a particular interest in an area of compliance that they will seek out care recipients to respond to questions in relation to that, and I understand that is the process that was applied through those—

CHAIR: On notice perhaps you could provide further details of—how many? Whether 10 per cent were in fact interviewed—

Ms Bolger: Yes, we have—

CHAIR: and how they were selected.

Mr Ryan: We can do that.

CHAIR: And the questions that they were asked, please.

Ms Bolger: It may not be possible to provide the questions that were asked, but we should have their responses in the audit reports.

CHAIR: Thank you. Under the new process, what process will you be using to choose the 20 per cent—that process that you've just articulated?

Mr Ryan: That's a randomised sample. One of the things we did in the development of the consumer experience reports was that in order for it to be a valid cohort or a subsection it needed to be randomised, because if people self-selected to be part of that cohort it can skewer the outcomes. That doesn't mean that if a family member wants to be interviewed—of course we'll interview them, and we'll take on board anything and everything they have to say, but we won't include them in the sample for the consumer experience reports. So, we go through it and if we're going to interview, say, 15 residents, we'll start rarely at No. 1; we'll go to 2 or 3 and then we'll go every 15, down the list.

CHAIR: Could you also take on notice: I presume, because it was an unannounced visit and the response that you gave, Ms Bolger, was that family members weren't interviewed—that would automatically take out—is that a correct assumption?

Ms Bolger: If there are family members there on the day when we usually would seek them out, yes.

CHAIR: Could you take that on notice? That would then, in a number of circumstances, preclude finding out what's going on with the people who had very significant, severe behaviours. We've already talked a bit about that—that they sometimes can't be interviewed. That meant that you were missing that very cohort of people who have been subject to some of the worst treatment.

Mr Ryan: As mentioned earlier, we adopt the structured observational framework tool. That means looking at the interactions between care providers and care recipients. So, we do have ways of gathering and understanding that, but clearly the move to consumer experience reports standardises that type of data.

CHAIR: I understand where you're going in terms of telling us about the new approach. I'm interested in particular, in this inquiry, in what happened. So, could you also take on notice how many of those observations that you undertook.

Mr Ryan: We will.

CHAIR: And I want to go back to the Nous report. I thought I heard you say that you're implementing four. Is that what you said?

Mr Ryan: That's right: four out of four recommendations.

CHAIR: Can we just be clear that we're talking about the same thing? Under the Nous report there are a whole lot of subrecommendations.

Mr Ryan: Correct.

CHAIR: So, are you saying that you are implementing all the recommendations, including all the subrecommendations? Under each of them there's many.

Mr Ryan: That's correct, yes.

CHAIR: Do you have anything on that in writing?

Mr Ryan: All of that information has been integrated into our corporate and specifically in our operational plan. We'd be happy to table that, on notice.

CHAIR: That would be appreciated. Thank you. I want to go very quickly to this issue of training. I think you were here by the time—I did see you come in at the back; I can't remember exactly at what point you came in—I was asking questions of Ms Hanson. She made reference to the fact that some of the staff had been there for over 30 years. It's obvious that they hadn't been given training, from what she said, on contemporary practice.

Mr Ryan: Her staff, or our staff?

CHAIR: I beg your pardon: the staff at Oakden. The staff at Oakden had been there from the seventies and would have had training in the seventies, and they hadn't been trained consistent with contemporary practice. How did that get missed? I understand that you look at training . How did that get missed—the fact that some of the staff there had not had training in what is regarded as contemporary best practice in terms of particularly caring for and supporting people with severe psychosocial and cognitive impairments?

Mr Ryan: We assess under expected outcome 1.6, which is human resource management, and there are common standards across all four standards that do require effective staff education and staff development. So, the home at the reaccreditation audit in 2016 would have provided sufficient information. Whether or not that was a reflection of everything that happened in that home has obviously been subject to much more rigor since. But they were able to provide information that showed that in their recruitment and in their training of staff there was ongoing training of staff. If the CEO of NALHN has considered that it was insufficient, we note that with interest. That was not the information the provider gave to us in February 2016.

CHAIR: We'll provide you obviously with the *Hansard* of the responses we got to the questions that I was asking, and perhaps you could take on notice to compare it with what you got from the audit. That would be very helpful.

Mr Ryan: We can do that, yes.

CHAIR: Yes. I've run us over time, but I considered that your evidence was extremely important for this inquiry. Thank you very much for your time today. We'll be in contact about the response time for our questions on notice.

Mr Ryan: We will do that as quickly as we can.

CHAIR: Thank you very much.

Proceedings suspended from 10:52 to 11:04

CORCORAN, Mr Maurice, Principal Community Visitor, Community Visitor Scheme, South Australia

CHAIR: I welcome the representative of the Community Visitor Scheme. For the *Hansard* record, could I double-check that you've been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Corcoran: Yes, I have.

CHAIR: Thank you for coming. I invite you to make an opening statement and then we will ask you some questions.

Mr Corcoran: The Community Visitor Scheme commenced operations in July 2011 and it gets its powers under the South Australian Mental Health Act, sections 50 to 54, which describe the roles, functions and powers of community visitors but also of the Principal Community Visitor. In short, the role and function is to visit and inspect acute mental health units. Initially when the scheme commenced, it was specific only to acute mental health units throughout South Australia. It includes the Oakden facility—Makk, McLeay and Clements. All gazetted treatment centres were required to be visited every month. The process of doing visits is that two community visitors are required to do each visit and following that visit to provide a written report back to myself as the Principal Community Visitor. Once the reports are received from each of the visits, they are presented to our mental health coordinator and, in turn, to me to read through and acknowledge whether there are any particular issues.

Our community visitors are volunteers but they're recruited. Particularly targeted are people who are semiretired or retired and professional people. We have a range of people who have been career-long social workers or who have worked in the human services areas as well as ex-police officers—people from a range of backgrounds. They are required to provide a written application, a curriculum vitae and three referees, and then they are invited to an interview. If they think they've got the necessary skills, there are no prerequisites, but the main skills we are looking for are that they have good observation skills, good interviewing skills and have a deep interest in protecting the rights of people with disabilities. If we are happy that they seem to have those skills, they're invited to a two-day intensive training workshop, where they are observed. It's a participatory workshop and they are assessed during that process. We have expert trainers come in to talk around mental health conditions and how someone might present if they are unwell, or if they have a particular psychiatric condition or experience some psychosis. There is also a lot of focus on interviewing techniques and preparing reports and observations.

We say to all our visitors when we're preparing and going through our training that when they're visiting and inspecting units that they run the mum test over it, which is basically that if they are going to look at the facility, the key part of it is a human service. So it is looking at the observations between staff, patients and family members, and how they're being cared for and being treated, but also to look deeply into such things as individual care and treatment plans.

Once the reports come back, if there are any issues or concerns they are put into what is called an 'issues tracking document' and we collate reports for particular areas such as the reports that go from Oakden and for services that NALHN are responsible for. We forward copies of those reports, but also extract significant issues that are within the reports, on to the senior executive mental health directors et cetera who are responsible for those services and seek responses for those. We have an issues register as well which has systemic or long-term issues of concern that we track and monitor. We present those to an advisory committee, which meets on a two-monthly basis, and that includes a range of statutory officers, the chief psychiatrist, a senior practitioner in disability, representatives of both public and private mental health services as well as consumer and carer representatives and community visitors. Ultimately, I provide an annual report, through the minister, to parliament and that is predominantly where we can highlight our systemic issues or issues of concern.

There are two areas that I really want to focus on today. The first is our monthly reports and extracts from some of those reports, which I have tabled in confidence to the senators. Also, I want to highlight the complaints issues and the complaints process through the example of us meeting with and supporting Mrs Barbara Spriggs and Clive and Kerry Spriggs. I want to acknowledge Mrs Spriggs and her family for their resilience, integrity and patience as we tried to get answers to the complaints and issues they raised. Right from when we first started visiting Oakden, in July 2011, it was made clear by some of the senior staff that there was a degree of uncertainty. Staff had been advised that the staff had been streamlined and trimmed down in readiness for a possible tendering out to the non-government sector and that it would no longer be a government service, that it would be either a privatised service or an NGO run service. That was made clear to us in the very early days. That had an impact on staff and the uncertainty for staff. And that affected the number of agency staff that were brought in on a regular basis to work at Oakden. That is very relevant. That placed enormous pressure on a number of other staff we met with—regular and permanent staff—who were responsible for a lot of the data entry and the recording of incidence and issues on their Safety and Learning System.

I would like to touch on some of the extracts—a summary of issues from our visit reports. At the outset, I would highlight that it was reported that important allied health services staff such as social workers and OTs were quite often vacant when people were moved to other positions. That placed enormous stress and pressure on existing staff who were very committed to doing the work that they did there. The social workers are in contact with other agencies and aged-care facilities and trying to move people through—and psychologists and OTs, obviously. We see a multidisciplinary approach and very thorough individual care and treatment plans that are reviewed on a regular basis. There is also a very high level of service.

A lot of these people have come from repat ward 18, an aged-care facility which has very tight processes and means for all patients having individual support plans. The patients themselves and their family are involved in the development of those individual plans. All staff are required to be familiar with them on a daily basis and update them wherever necessary. Families and individuals are interviewed near the end of their stay to determine how involved they were and how much say they had in the individual plans and the support for their loved ones. For example, Bob Spriggs was a patient at the repat hospital. He went from there out to Oakden. It was a shock for the family to go there from quite a nice facility which has lots of space and a multidisciplinary approach and a really thorough individual process. Going out to Oakden was quite a shock for the Spriggs family—and for the many others who go through that.

I would like to touch on some of the extracts from the reports that I have tabled with you in confidence today. In 2012, in the 7 to 8 August report, a senior staff member at Clements raises concerns about the changes in management of the Oakden campus to NGOs as part of the overall governance strategy. Of greatest concern were workforce matters and whether there would be a transfer of staff from the government system to NGOs. The lack of a transfer date was also of concern. That is something that was relayed in one of our reports.

In 2012, in the 28 September report, there was recognition that there had been a major refurbishment, refit and paint-over of the unit and that the new rooms had changed from four beds back to two beds. It was made to feel a lot more homely. It was noted that many consumers had personal photographs and images in their rooms to make it a lot more personal.

In 2013 it was commented that there seemed to be a lot fewer staff and most of those staff did not have the time to engage with patients, apart from offering cups of tea and plates of watermelon. We were told that there were shortages of mental health nurses and some were on WorkCover due to injuries. Several nurses commented on the staffing level, which had not been restored to the original level. They were still operating with one nurse fewer than prior to reduction, when the number pf patients dropped to 16. In Clements House, there were 21 patients and five nurses. It became a problem when two staff members were on a meal break because that sometimes left only two nurses to manage lunch. They tried to avoid toileting patients if some staff were at meetings or meal breaks or not available to help. When patients are unsettled and need to be segregated into another ward, two nurses go into that area, leaving the other three in another area. So we were regularly picking up that there were pressures on existing staff.

In 2013—and I guess this is something, on reflection, going back over visitor reports—four consumers had passed away since the last visit. These were three gentlemen from Makk and one who had come from Lyell McEwin Hospital in August 2 who had frontal lobe dementia and got an infection. That person had been taken to Lyell McEwin for treatment. Within the three months afterwards, a doctor at the unit stressed the need for a visiting geriatrician for complex medical conditions. Hampstead and Lyell McEwin have a geriatrician but the doctor at Oakden often has to phone someone else to get advice and to answer questions. The doctor had put in a special request but said they were not getting much of a response.

In terms of allied health staff, in 2014 there were concerns that there was not a psychologist at the facility. Again, in May 2014, the report said that the CEO was planning to talk with staff about the process of privatisation of the facility, which was complicated by McLeay and Makk coming under federal purview and Clements coming under the South Australian government's jurisdiction. And staff were somewhat unnerved by the impending changes.

In July 2014, it was mentioned that the accreditation was going to be occurring on 16 July and that the National Safety and Quality Health Service Standards were up on display around the unit. Some of the staff were a bit concerned about that aspect of it. That same report highlighted that another three of the residents had died due to pneumonia within the facility. Staff said it was not uncommon for patients who were frail and suffering from dementia and Alzheimer's to get pneumonia in that colder weather. Again, this is forensically looking back at some of the reports and the impact on this. In that same report, comments were made by staff that all use of restraints were to be put into the incident reports through the Safety and Learning System online. But staff said this was very time consuming, especially when patients need restraints to ensure that they don't fall from chairs et cetera—in terms of the argument around safety. Of course, evidence that was highlighted in the review by the Chief Psychiatrist highlighted the fact that it is more likely that people were going to have more falls et cetera if they are consistently restrained.

In 2015, in the 25 August report, the social worker who was in that facility, who had been doing a really good job, was not having his contract renewed and was worried about where to go next. He was considering going elsewhere—simply because of the uncertainty of the contract for that social worker. In 2015, staff expressed dismay at the discontinuation of funding for a social worker at the facility. It was at this time that we intervened and wrote to the then Executive Director Of Mental Health around that position—and about other allied health staff at various times. In 2016, the September report highlighted that there was no OT or social worker available on site—only a physio from Lyell McEwin who attends once a week. Again, the staff reported those issues or concerns directly to us.

As you can see, there are a range of things that were picked up around the pressures on staff within those units. Ms Hanson questioned the issue around complaints today. I have spoken to Mrs Spriggs and the family and sought their permission to talk about their complaint and what happened to Bob Spriggs. I want to acknowledge that this continues to be draining and places enormous pressure on that family. From the outset, from when they came to speak to us on 1 June 2016, it was always about not wanting any other family to go through the experience they had gone through. They really just wanted answers to what went wrong, how it went wrong and how we can make sure it doesn't happen in the future. In summary, the family learned that on three separate occasions Mr Spriggs was given 10 times the prescribed amount of antipsychotic medication. That was soon after he was moved out to Oakden. His first admission was on 13 January 2016.

Not only that but there were other experiences at the time. When Clive had gone out to see his father, he received a comment from the staff: 'Your dad seems to have gone off his food and drink.' Clive went in and there was a drink and a meal in the bedroom but, at that stage, Mr Spriggs had deteriorated so quickly that he couldn't give himself a drink. Clive offered him a drink and about three or four drinks more. He was famished, very thirsty, and Clive had to through the process again to assist with the meal.

There was another example where Kerry went out, found her dad lying on the floor and questioned why he was lying on the floor. The staff said, 'Oh, he just does that.' There was no offer of assistance to actually help Kerry lift her dad up. The extreme bruising that was found on his thigh, the family discovered that initially. Kerry mentioned the extreme bruising on his thigh to Barbara and she raised that with staff. It has since been agreed it would have been from a restraint to hold him into a chair or in some position. When Mrs Spriggs brought it to attention, it was soon after that he was taken to the Royal Adelaide Hospital where, again, it was found that he not only had this bruising but he had a chest infection and was very dehydrated. The thing I was really concerned about was that, after going through all of this experience and after all the efforts that were made by the transfer on two separate occasions by the staff at the repat hospital to do a detailed handover to the staff at Oakden, it didn't seem to be implemented in the way that it was intended.

The ultimate insult, I guess, was that, after the last days at Oakden, Mrs Spriggs asked Kerry, her daughter, to finalise payment that was due for his care while he was there, an amount owing of $400. She attempted to pay that with her credit card and they said they couldn't to that; it needed to be paid in cash. So Barbara ultimately had to go out herself and pay that money in cash. Weeks after that, she was given two bags of Bob's clothing that were meant to be returned and only two items were actually Bob's; the rest were not.

The family had every right to be angry, frustrated and annoyed. They came to us on 1 June. I have given a chronology of that complaint, which we detailed and then forwarded on 7 June. We forwarded the detail of that complaint to the director of nursing at Oakden older persons services. We had a phone call directly after to talk through the serious issues that were raised in the complaint. From that, they agreed to have the consumer liaison officer carry out an investigation. The consumer liaison officer is a staff member who was given the responsibility to examine complaints within the service. But it is a difficult task doing those sorts of investigations when they are located alongside fellow staff members. We informed the chief psychiatrist on 9 June, so within two days, as well about this and asked him to also look into this matter.

On 20 July we followed up with NALHN to try and find out what was happening with the investigation, and we were told that it was still in process. This went on right through to 25 July, when we were advised that the report and the investigation would be with us within days. Then we were told on 30 August that the investigation report and response were with the office of the chief executive at NALHN. On 2 September, we again emailed the director of mental health services, trying to follow up on where the investigation report and response were. We also copied in the Chief Psychiatrist to all this correspondence. Ultimately, on 30 September, I detailed the length of time it was taking to get a response to our complaint on behalf of the Spriggs family. I wrote to the minister on 14 October, formally asking for a review of Oakden services and also to meet with the Spriggs family about their experience. Sorry, I'll stop it there.

CHAIR: You don't need to be sorry. There's lots of information there, thank you.

Senator FAWCETT: Chair, can we refer to this letter that's been tabled?

CHAIR: Is it okay if we ask you questions from it?

Mr Corcoran: Yes.

Senator FAWCETT: I want to go to your comment that people had been transferred to the facility from acute wards in other facilities, and yet Oakden was classified as subacute, which had an impact on staffing levels. Can you explain a bit more to the committee about whether that concern had been raised previously and whether you ever got any response from the minister about that.

Mr Corcoran: We'd certainly raised it with the Chief Psychiatrist. This was one of the things that I certainly didn't understand. They were getting some of the most complex and challenging clients from acute wards, which have staffing ratios higher than what Oakden had as a subacute ward, yet it was expected to cope with and manage and support people with some of the most challenging behaviours of all. It was classified as a subacute model of care, a longer term subacute model of care. It was something that, again, I failed to understand why it was so when we were dealing with some of the most challenging clients. It was certainly something we tried to seek answers to.

CHAIR: Were you ever given answers to that?

Mr Corcoran: Not in real terms as to understand, no. It was just the model of care for a longer term facility as opposed to a short-term stay in an acute unit. It was meant to be a longer term aged-care facility. So, no, we didn't.

Senator FAWCETT: You may have heard some of my questions to previous witnesses around a proactive attempt to understand what is the risk, both to staff and residents, of a facility where there's a compound nature of need. As we look now, we've seen people transferred from Oakden to other facilities. Do you have any confidence that issues around staffing ratios, for example, have been adequately addressed at the new facilities that they've been sent to?

Mr Corcoran: We've been out and visited the new Northgate facility. They've got a full contingent of multidisciplinary staff. They've got all the staffing levels that they need to run the facility as they should do. Again, a full staff contingent and a whole-team approach, and individual planning and clinical care and governance is all being implemented now. It's great to see the change. We've had some of our visitors who've been visiting Oakden for a number of years and have then gone on to see them in their new facility, and to see the improvement and the change in that with the number of patients.

Senator FAWCETT: Is there any precedent for your letter to the minister? Have you ever felt the need to write to the minister about a facility in the past?

Mr Corcoran: I have in other areas, yes, around forensic care, and with other ministers et cetera. Certainly, it was not only our concerns and calling for a review of the services around this subacute model and the model of care, but also the indignity of not giving a response to the details of the Spriggs family's complaints. It really brought to my attention the grave concern about how it was just—I was embarrassed. Although we had multiple email exchanges and phone calls, trying to get responses back from them, it didn't happen. Really that's where it forced me to place that into my annual report, which was tabled in parliament. I forwarded it to the minister on 30 September. So two weeks prior to that letter, I detailed these issues and called for a review of Oakden in my annual report, knowing that that would be tabled in parliament.

Senator FAWCETT: Sure. You said previously that there was at least one other incident where you've had to write to the minister about a facility. Was the response time similar, so around two months, or was there a quicker response?

Mr Corcoran: No. Usually there is an acknowledgement letter: 'We've received your letter. We've got your letter and we're dealing with that.' There is usually an acknowledgement that the minister is preparing a response.

Senator FAWCETT: You and your team obviously cover a range of facilities in South Australia. This one, for a range of reasons, had obviously got to a place where the staffing levels, and hence whatever was causal—that will come out, I guess—and the care were unacceptable. Do you have concerns that there are any other facilities that have not yet had this kind of a spotlight shone on them that should be similarly raising flags?

Mr Corcoran: There are some units that I have concerns about—they're not necessarily in the aged-care area, older persons, but certainly we have concerns about other units—but not to the extent where a range of allied health staff or a range of positions have been vacant for long periods of time, placing enormous pressure on other staff. And I'd just like to acknowledge that there were some incredibly committed and hard-working staff in the facility at Oakden who were very open with us around the pressures placed on them in trying to get positions filled.

Senator FAWCETT: If there are other units that do raise some concerns—I won't ask you to name them unless you wish to—then are you satisfied that you have been able to raise or flag those concerns with the appropriate authorities and that the appropriate action is being taken to address those concerns?

Mr Corcoran: We're certainly making a lot more progress now. On reflection, what's come out of Oakden is that there is a little bit more attention on our reports that are being forwarded to various people responsible for services.

Senator PATRICK: Mr Corcoran, from the material that you tendered and from your testimony, is it fair to say you were frustrated?

Mr Corcoran: Yes, frustrated is a good description, certainly. Frustrated not only for us as an independent statutory officers not getting a response to a complaint on behalf of the Spriggs family, but also frustrated about the lack of recognition of what they'd been through. I though that not giving attention to their grievance or giving them an answer to what actually happened was very insulting.

Senator PATRICK: You said that you've visited Oakden on numerous occasions. You said the staff were very cooperative during your visits. Did you have access to other reports that were perhaps going to ACQA or to the department?

Mr Corcoran: No. One of the things I've highlighted that I'd like to finish off with is the suggestion in some of our reports about the accreditation process, the use of them, and being able to meet with community visitors. No, I haven't seen their reports.

Senator PATRICK: Does the act under which you operate give you a power to ask for those sorts of documents and reports?

Mr Corcoran: Yes. We have the same powers as a health inspector to request documents and information related to the care and treatment of patients; we can request anything that we think is relevant to the care and treatment of patients in facilities.

Senator PATRICK: So it's not so much a problem that you weren't given access; you simply didn't ask or exercise those powers.

Mr Corcoran: Correct.

Senator PATRICK: You came to conclusions, and you've basically consistently cited problems. What's your avenue of raising alarm? Is it simply to the minister? Is it to the facility? Is it to the CEO? Or is it to all of them?

Mr Corcoran: We have the power to refer matters and issues of concern; it particularly names the chief psychiatrist where it's around clinical care and treatment and medication errors. It's certainly the purview of the chief psychiatrist, which is why we raised and provided copies of the complaint of the Spriggs family within two days of providing it to the facility, and copied him into all of the correspondence between ourselves and the Oakden services in trying to get responses over a five-month or six-month period.

Senator PATRICK: Did you ever seek to have a meeting with the chief psychiatrist or the CEO or the minister?

Mr Corcoran: I met regularly with the chief psychiatrist on these sorts of issues. Certainly we had attempted to meet with the executive, the director of mental health services at the time.

Senator PATRICK: Was there a response when you requested those meetings?

Mr Corcoran: We had to follow up a number of times on email requests trying to get answers about the investigation report, which we knew had been completed by late July. We were trying to obtain that, and it was very difficult to try to get that. It was hard to get a response.

Senator PATRICK: Can you take on notice the times or dates that you sought to get answers, or in fact raised concerns and sought to get responses?

Mr Corcoran: The meeting that we sought from the letter of 14 October—we met with the chief executive of NALHN with the Spriggs family on 19 December.

Senator PATRICK: In your own words you said you were trying to get answers. You weren't getting answers, and you were trying to find out what was happening. Do you have any ability to blow the whistle, so to speak, if you're not getting responses? Can you go to the Premier? Can you go to the media? What are the restrictions on you?

Mr Corcoran: Good question. I guess our ultimate tool is highlighting it within our annual report and writing to the minister. Highlighting it in our annual report, which is tabled in parliament—I know there's usually interest, particularly at around this time, in when my annual report is going to be tabled in parliament. When it was tabled on 7 December, there were reporters who got in contact with me to discuss the issues that were contained within that report. It becomes a public document; it enables others within parliament to ask certain questions and to follow up on issues that we've raised.

Senator POLLEY: Thank you for appearing before us. I think at the very least the Spriggs family, and all the other families who have been impacted by the outrageous neglect of residents in this home, deserve an apology. Can you explain to the committee how the audit process needs to be strengthened or can be strengthened?

Mr Corcoran: I was interested to see in the report that they're now going to have unannounced visits. I just think there are probably benefits in the accreditation process also of having communications or regular communications with other statutory bodies that are going into the facilities, such as a Community Visitors Scheme, but also the Office of the Public Advocate, who have a number of clients in Oakden and in these facilities, and the Aged Rights Advocacy Service, who, again, may be contacted around individual complaints. I wonder—and I have to plead my ignorance here—whether the accreditation process examines the proportion of agency staff versus permanent staff that are working in the facility. It's something that I'm unsure of, but I think that was certainly an indicator that there were challenges for us. But also there are the number of positions, such as allied health positions, that are vacant or not filled at the time that they're doing their accreditation process. If that isn't taken into consideration, I think it's something that maybe should be.

Senator POLLEY: Have you seen, or been given a copy of, the Carnell review?

Mr Corcoran: I have had only a brief look at it, not a detailed look. I've looked at the executive summary.

Senator POLLEY: There were 10 recommendations relating to Oakden. The federal government has adopted one of those at this point in time. Would you support all of those recommendations and support that they should be implemented immediately?

Mr Corcoran: I think anything that improves the diligence and the process of assessing whether an agency is doing what it should be doing in meeting the standards of care—any sort of improvement I would support in any way.

Senator POLLEY: The Aged Care Complaints Commissioner has given evidence—and I've had some conversations over a period of time with her—that there does need to be more teeth given to that position. In as far as complaints are made—and it was very evident from the evidence that we have got in our submissions, and I have no doubt that it will be confirmed this afternoon—it is courageous of families to make complaints about a facility like Oakden and to have that taken seriously, let alone responded to. Have you got any recommendations, or would you like to take it on notice, how we can strengthen the complaints process to ensure that families and individuals are actually heard?

Mr Corcoran: It's one of the things that I've been critical of. The way that complaints are raised at facilities—say at NALHN at the moment—are investigated is by a consumer liaison officer, which is a member of staff who sits among staff that they're investigating. So it puts them in a very difficult situation. Again, I think it's really important to have a level of independence of anyone investigating any of these complaints and it's important that they have the skill sets—the investigative interviewing skills—and a background in enquiry and in making objective independent assessments. They need to have good investigative interviewing skills.

Senator POLLEY: With you're experience and your organisation having access to Oakden, understanding the complaints process and understanding the aged-care quality assessment audits that have been conducted over a number of years that have failed to detect these issues, do you have any confidence in the Australian quality assessment agency?

Mr Corcoran: I heard the previous discussions around the improvements that were to be made. What we recognised and saw was there was a lot of emphasis and a lot of focused work that went into preparing for the accreditation process. I also heard Dr Stubbs saying earlier on that it was important to check on all the process and reporting, et cetera. I think accreditation and detailed forensic analysis of whether services are compliant—it will always be important to have someone external coming in.

Senator POLLEY: We've heard evidence today—and it's regularly raised with me—about the red tape and the paperwork and how we need to find a balance between meeting accreditation and the output of good care that's based on respect and dignity. How do we achieve that when we have surveyors that go in regularly to the same nursing homes?

Would you support a process whereby random surveyors were visiting sites across the country? Your position that you have is unique to South Australia, where you have this organisation and oversight that has obviously aided the exposure of what was happening at Oakden. What more could we do?

Mr Corcoran : For your information, there are community visitor schemes in all the states and territories. Victoria operates under the Office of the Public Advocate. To your earlier question about how onerous it is for the reporting, detailing, preparing individual care and treatment plants, reporting on incidents and then getting teams to reflect on where there are incidents or errors that are made, we visit, like I said earlier on, units that do that extraordinarily well. We talk about the fact that there are great benefits in developing individual care and treatment plans and reviewing those and the team do that as a team. It is usually as a result of leadership and having good thorough clinical practice in hand. The units that do manage and to comply with the standards and do that exceptionally well and provide a lot of engagement of their patients and their families achieve that. They don't talk about that same problem of having to report. They do it, they comply and they provide a much better service.

Senator POLLEY: If you can do it in early childhood education, where there is a daily plan in consultation with the child, the parents and the teachers, why shouldn't we be able to do it with older Australians?

Mr Corcoran : I agree.

CHAIR: Thank you very much for your time today. I think there were some questions that you took on notice to follow up in relation to any changes to the framework of accreditation.

Senator DASTYARI: Do we have a date for the return to the questions on notice yet?

CHAIR: No. We will be contact about that. Thank you very much for your time today. It is very much appreciated.

DYER, Dr Suzanne, Senior Research Fellow, Department of Rehabilitation, Aged and Extended Care, Flinders University

IBRAHIM, Professor Joseph Elias, Head, Health Law and Ageing Research Unit, Monash University

WHITEHEAD, Professor Craig, Clinical Director, Rehabilitation, Aged Care and Palliative Care, Flinders University

[11:53]

CHAIR: Have you been provided with information on parliamentary privilege and the protection of witnesses?

Dr Dyer: Yes.

CHAIR: We have your submissions. Thank you very much. I invite both organisations to make an opening statement and then we will ask you lots of questions.

Prof. Ibrahim: I am really pleased that people are looking into aged care. I think we have dropped the ball as a country on that for a long time—and that goes to parliament, not specific governments. My greatest concern, listening to the evidence today, is that you are focusing on a single episode rather than on the system as a whole. The research we've done indicates that bad things happen every year in every state that are potentially preventable. So what we have is a systems-wide issue in the same way that we had with patient safety in hospitals back in the nineties which we have tried to address.

The reason, I think, that people don't pay attention is that there's general apathy towards ageing. The example is that people don't even care about their superannuation, which affects them, let alone worry about anything else. We're in a state of denial about ageing disability and don't believe that any of us are going to get there, so we don't think about residential aged care. There's an absence of voice. Aged care is the only institution where the person who goes in dies—that is almost guaranteed—so there are no repercussions for society about how they've been treated. If you have a bad education system, a bad prison system or a bad hospital system, there are repercussions for society when those people leave those institutions. That's not the case in aged care.

The question is: is the system broken? I'd then ask you: how bad does it need to be for us to act? Overall, the system's really quite good. When we resort to saying it's quite good, we forget about getting that last 20 or 30 per cent in the system that we're capable of achieving now. We did that for health; we're choosing not to do that in aged care. So we're not delivering the standard of care that we can deliver now. It's a fallacy to focus on the agency and say that strengthening regulation is going to dramatically change what happens on the ground with the resident and the PCAs and the overseeing nurse. There's an issue related to the culture and leadership in residential aged care. As a society, we haven't defined what residential care is. We wax and wane depending on what suits us. We will say, 'It is your home,' when we want to ask people to pay more money, and we'll call it a 'hospital' when care isn't delivered. So the people delivering are caught between those two issues. We as a community accept it as being 'God's waiting room'. We've not made the statement that you should go into aged care and thrive before you die. I'm not dead when I go into a nursing home. Yes, I might die in six months or I might die in two years, but I still have a life to live. The work that we've done trying to focus on injury prevention was done deliberately to focus on premature deaths, because people don't believe harm occurs in residential aged care, or, if it does, it's acceptable because you're 90 and you only had a couple of weeks to live.

So my question to each of you is: would you give me a week of your life for no reason? That's what we're asking older people to do. I could only access data on deaths because of our legal system—not because of our health system and not because of our aged-care system but because our laws allow us to obtain data from courts. I can't get information on severe injuries or hospitalisations. I can't get any information from corporates or any other organisation about their serious events and their less serious events. So, when we present data on 28 people dying from resident-to-resident aggression over a decade, people say, 'It's only two people a year; that's not very many for the 200,000 residents.' The health department has reports of at least 1,000 episodes a year of resident-to-resident aggression. The next question is: what's in that information and what's below that? Remember the road toll. We look at fatalities; we look at serious injuries; we look at crashes. The only aged-care data that is publicly accessible to researchers or anyone is the fatalities. We don't have data on serious injuries or serious events that do not lead to harm but are high risk.

I should stop there. I have a whole bunch of recommendations and a book to leave with you.

Prof. Whitehead: First of all, as a clinician who's worked with frail older people for 20-plus years as well as researched recently, I would like to acknowledge the residents and families of Oakden. As a practitioner in the South Australian community, it's entirely possible that some of my patients could have ended up there, and we never really knew what was going on outside of that system. So I think it's important that we acknowledge what they've gone through as we go through this today.

Dr Dyer and I represent an NHMRC funded partnership centre that was a collaboration between Sydney university, Flinders University, the University of Queensland and three large aged-care partners: HammondCare in New South Wales, Helping Hand here in South Australia and Brightwater in Western Australia. We are involved in a range of research. I have also been on the board of an aged care organisation, which is in fact Helping Hand.

We recognise and acknowledge a number of things—similar to, and completely unprepared, we kind of agree with our colleague down the road. One of the things that struck us is that the idea of quality or clinical governance in an aged care institution is very much in its infancy. Some aged care organisations are starting to look at risk and quality and managing adverse events, but, by and large, it is not mandated. I think the policy dilemma that the government has is whether this is your home or a place of health care intervention, when in fact it is clearly both. Governments—because it is independent of parties and has been a perennial problem for as long as I have worked in geriatric medicine in aged care—can't decide what we want.

If you look at high-performing health care organisations, they have robust quality systems. That includes incident monitoring and independent review of adverse or high-risk events, where there is a culture of learning and reflecting on those things. There is also—and this is what we bring specifically to our submission—an increasing trend, which is in its relative infancy in health care institutions, called patient experience in health care. That is where you measure what your consumers think about your service, in a routine fashion. It is an amazing idea, I know! The reason it is in its relative infancy in health care is that I think there has been a demographic shift in terms of recognising that the patient is actually at the centre of care in hospitals, which may not come as a surprise to any of you, but perhaps will to some of my more senior, grey-haired colleagues in hospitals. That is changing.

Speaking as someone on the board of an aged care institution, when you are at board meetings you have a lot of financial metrics but what you don't have is to know whether you are actually delivering good care. When we started our research project looking at different models of aged care, looking at health economic evaluation, when you do a health economic evaluation, if you like a cost-benefit analysis, you can measure cost and resource utilisation but first thing we encounter is to ask what the outcome is. What is the thing we need to know, that you are buying better-quality aged care? In fact, no such measure really existed for that. As part of that project we took a step to develop the instrument that we bring today, which is a patient experience measure. It can be measured, and it is scientifically well-validated. We can tell you how we did that if you want to know. Essentially, it allows us to get a very simple questionnaire that a carer complete, a resident with even moderate cognitive impairment can complete. We have weightings for all the measures to allow the scores between carer and resident to be comparable. We know that this instrument does correlate with quality of life, using more standard measures that are used, particularly, in populations that have a large number of people in them with dementia.

By way of explaining how we reach the instrument items, that involved an extensive process of going to residents and carers in aged care facilities and asking them what they value about the aged care experience. The comments my colleague made about the fact that many people who go into residential aged care are of an advanced age and have advanced frailty and they are in the last phase of life. Most quality of life measures focus on whether you can walk, walk and do more walking. We are dealing with a population were that probably is not going to change a lot. But, in fact, as we found and measured, being able to go outside actually might be something that you highly value. We started off with residents and carers and asked them what they valued. We took that to our consumer groups, our aged care experts, to validate those measures.

We also undertook a process whereby we conducted a discrete choice experiment, in which we forced people to choose between the measures. That allows us to create a weighting so that we know that people value X more than Y. They are very unpleasant questionnaires to complete, having done a few myself, because they force you into uncomfortable decisions, like how you would rate going outside versus having more involvement in your care. You have lots of different scenarios and that forces you to choose. That is a health economic technique—it is actually an economic technique that has been used outside of health, but in South Australia we have been using it in the health care arena for the first time. We then end up with a questionnaire that is validated and that allows you to put different weights on different items, depending whether you are a carer or resident. That is what we present as one of the possible suite of things you could add in.

I would emphasise the other point my colleague made, which is about a policeman—an external accreditation of aged care facilities. You have to have them but they are not the solution. You have to develop a culture of quality management and probably clinical governance within aged care facilities so that they start to self-reflect and look at their own data and information about where they are doing well and where they are not doing well. The learnings you can take from high-quality health care organisations could be applied to aged care—that is, that they need to have a strong quality agenda. I am sure that from an aged-care provider point of view they would argue that they need to be funded to do that, but to be honest that is probably not a huge expense, I suspect, in terms of the total expense.

CHAIR: Dr Dyer, did you have an opening statement?

Dr Dyer: No, I am happy to support what Craig has said.

CHAIR: I asked the agency this morning about their questions to residents. They said they have come up with a list and they are developing a new list and process as part of the new standards. Have you been involved in any discussions over that? Have you seen them?

Prof. Whitehead: No, we haven't. In fairness, we have only just finished the completed research on this. To put my scientific hat on, the reality is that to develop robust questions that really mean something is an elaborate process. This took us two or three years.

Dr Dyer: We started the whole research project in early 2014. This is only a component.

Prof. Whitehead: It does take time to do properly. Traditionally, in this area people just make up a questionnaire, but there is actually a science behind it.

CHAIR: That is what I took very strongly from your submission, as well, which is why I was following it up this morning with the agency.

Prof. Whitehead: We certainly would welcome discussions with the Commonwealth quality agencies about this. I personally believe this instrument, because of its ease of use and the ability for carers to complete it, has great capacity to be widely used in aged care. It has the potential for a carer to complete it without it necessarily having to be involved with the facility. I'm not sure that I necessarily completely agree with that, but it has the capacity to do that. Because it is so simple, it also has the capacity to be entered online. So, you could create, and this is where health is moving, an online cloud database of aged care facilities so that you could start to produce reports. We know that in some parts of health, particularly in, say, rehabilitation settings, there is national benchmarking on the basis of standardised measures that every facility produces. Given its simplicity, this would have the capacity for every facility to contribute this to a national database. Then you could compare between like and like facilities. An example is the Australian rehabilitation outcomes database, which has been enormous at driving clinical practice in rehabilitation settings. Potentially, you could use an instrument like this, without massive infrastructure, to develop that, because it is such a simple questionnaire.

CHAIR: Somewhere in your document you talk about it being able to be applied, as you just said, to carers as well, and also to people with mild cognitive impairments or mild complexity.

Prof. Whitehead: Yes.

CHAIR: In regard to assisting people with even some more significant cognitive impairments, for example, have you looked at a supported decision-making approach so that we can try as hard as we can to ensure that as many residents as possible can participate personally rather than relying on a carer to interpret? I am not having a go at carers, but we want to go to supported decision-making as much as possible.

Prof. Whitehead: Absolutely. I will get Sue to comment in a minute. In the studies we did we used interviewers. We had part of a funded research program. All of those are the complexities you would need to develop if you wanted to include this as a quality measure, if you like, for aged care in Australia. But, yes, it can be supported. Part of the ACFI assessment uses the PAS-Cog, which is a measure of cognitive impairment that is used to help drive the funding instrument. We use that as a surrogate marker of cognitive impairment, and we had people who had a PAS-Cog of 11, which is a moderate level, who were able to complete it. Did you want to comment, Sue?

Dr Dyer: We have used this model on 500 residents and their families across residential aged care facilities in Australia. There was self-completion up to about a PAS cog of 11. And around that threshold, there really was an approach of trying to encourage the residents to self-complete, where they could, and then going to families or carers where they couldn't, and in more severe cases of cognitive impairment their carer would complete it. On an individual basis, around mild to moderate, it was seeing where it was possible for residents to complete it themselves.

Senator PATRICK: Professor Ibrahim, just to turn this around, your research, as you've indicated, is data driven and that leads to some sort of research outcome. If we took what you're doing and put it into the planning side of things, what effect would that have—for example, if you had a direct involvement in planning?

Prof. Ibrahim: The focus of our research was primarily on injury. We were restricted to understanding the causes of why people have died from choking deaths, suicide and resident aggression. There are lessons there, in terms of a public health model, about how you identify risk, how you address a situation as it occurs and what you do to follow up after that episode. In our experience, having reviewed the literature internationally over the last five years, one of the things that is clear is that we do not have the workforce in aged care that is able to drive the change. Of the 20 medical schools and 30 nursing schools there is not a gerontics training course. You do not need to be qualified in aged care to work in aged care.

The thought here about, 'We will strengthen regulation and action will occur,' is unrealistic. Using the health model that we tend to fall back to, for 30 residents you'll have one RN and five PCAs. For 30 patients in a ward you'll have at least five RNs, you'll have three to five doctors, including senior specialists, you'll have a pharmacist and occupational therapist, a physiotherapist, visitors coming through and people asking questions: 'Are you doing the right thing,' 'Are you doing what is current,' and 'Why do you practise this way?' That does not happen in aged care with five PCAs working with one RN. We haven't equipped the aged-care sector to deliver what we want. That's not their fault, that's our collective fault.

Our recommendations will take a step towards doing that but it really needs a five- to 10-year plan, in the same way that we addressed the issue in 1995 when the research came out to say one in 10 patients was being harmed by the care they were given. We set up the council, then the commission, then strengthened regulations and we pumped money into research to say, 'How should you practise?' and 'How do you implement?' There is virtually no research in Australia specific to how you would practise in Australia.

Senator PATRICK: Thank you, but I guess I'm trying to focus on, if you had an input, if you were involved with the Department of Health in some of the planning, does that happen, and would there be a benefit if you were invited in?

Prof. Ibrahim: The judgement about whether I bring value or not to someone else, I'd be delighted to be involved. Trying to become involved is always a challenge.

Senator PATRICK: What's the challenge—non-acceptance?

Prof. Ibrahim: All I can do is say I offer, and if it's not accepted I don't know why it's not accepted.

Senator PATRICK: In terms of your research you've talked about the need for data input and that it's very difficult to get. What changes could occur to allow you to get data? I presume you're mostly targeting APRA when you're after data.

Ms O'Bryan: No, it's getting data from ACFI. It cost us $25,000 to purchase ACFI data, which had to be siloed. So we can't look at the data; we have to hire a different group to do the analysis to link it to the deaths. I can't get access to the aged-care commissioner's complaints data because of the regulations or legislation. Information from the accreditation agency would help. The linking data from hospitals with data from the health department about residents, which would be—if I could link ACFI to hospital admissions I would know residents who had gone to hospital and what their outcome had been, linking it to the court data. There is a large volume of existing data that you can't get hold of because of the rules around confidentiality. The Office of the Public Advocate is another source that has got caseloads about what they have been able to do, but I can't readily get hold of that because it has not been done before—the rules around it just don't exist—so people follow the existing laws. That is the existing data. We do not continually analyse the data coming out of the coroner's office so, when our work stopped in June, it stopped. No-one is following that up. In Canada, they have a geriatrics committee that looks at deaths related to aged care. They keep it in real time which means they get better information about what happens at the time.

Senator PATRICK: My understanding is in Canada, as they do in Sweden, they have much greater transparency overall, which drives improvement.

Prof. Ibrahim: I think transparency is a driver. As I said, the only transparency we currently have is through the Coroners Court. We've been working with that information now for over 10 years and every quarter we produce an educational newsletter about another death that has occurred that was potentially preventable.

Senator PATRICK: Could you take on notice what your wish list of data would be and where the inhibitor is. That might be helpful to the committee as it looks at regulation.

Prof. Whitehead: I would make a comment about data, sorry to interrupt. The Premier's Research and Industry Fund in South Australia has just funded a new registry of older South Australians which I am involved in setting up. In South Australia, the ACATs are still currently auspiced under SA Health so we have a working relationship with them. We are going through the process of consenting everyone at the ACAT stage to allow their data to be linked. That does answer some of the questions. It is a really logical time because they all see a clinician, they are all being given stuff at the time and it potentially that allows us to link that to hospital data, death data, MBS, PBS, ambulance service and allows us to follow people progressively. That has only just started, but I believe the Commonwealth Department of Health and Ageing has been talking about linking these data sets. But really, if you want to understand the aged care system, you need to start at the point of ACAT assessment and give people a choice to opt out but allow their data to be linked from that.

One of the challenges that the Commonwealth has created with the new My Aged Care system is that the data they are going to pull out of that new aged-care system may be a dog—pardon the expression. We don't know whether we're going to have any useful data out of that, which is an absolute tragedy, but it is something we have been working with South Australian SAHMRI just down the road. We've been establishing this data because we have data linkage skills here in South Australia. In fairness, it could be done anywhere but we just happened to get some money to do that.

Senator PATRICK: Had you had input into the way the data was structured, may that have been helpful?

Prof. Whitehead: Absolutely. One of the great challenges in both health and aged care is the disconnect between academics, scientists and practitioners. That is the problem that bedevils health and aged care across the globe. The evidence-practice gap is partly what we are dealing with. The reality is academics and scientists need to be able to work much more closely with partners on the ground, which not only teaches them but teaches us. We have been lucky in South Australia to have been able to do a couple of projects. But Professor Ibrahim is quite right: if you had that sort of data base available, what cures a problem like Oakden is transparency, information available that you can bring to light. It is very hard to create good quality information out of our current aged care system. There is a massive amount of data collected at the time of ACAT. There is data produced by it but it is all siloed, and no-one has ever linked it together. It is technically feasible to do it but it requires a will, a degree of independence and some surety for the people who are going through that process that their information is not going to be used and abused.

Senator PATRICK: For your tool that you are developing—I might state that I used to be in charge of developing software—how mature is your software? Often at the academic level, it is not quite as mature as what might otherwise be required by a customer.

Prof. Whitehead: An excellent question. I will just say we've only just published the actual tool. Looking at it—and I fully take your point—there is a piece of work to operationalise it, and that's something that would have to be done. I think, to be honest, a six-item questionnaire that can be self-completed is the ideal thing to operationalise. As to whether it's on an information software platform, certainly we're seeing in the health setting the use of these Cloud based systems to collect a variety of consumer metrics. We just had one demonstrated to us in my own local health network last week. There is no software developed for it. I guess what I was saying is that obviously we're big supporters of the tool, but it would be something that could be pushed in that direction very easily, we think, and could become a platform for widespread quality data for all of aged care in Australia.

Senator PATRICK: Have you identified a pathway to make it go from—

Prof. Whitehead: As I said, we've only just published it, but I think, if you look at it, it's an obvious next step to take. The tool isn't copyrighted, I think, so it is in the public domain. Obviously we'd want to participate in the collection and creation of data, and we'd obviously want to work with a partner, but, no, that partnership has not been developed, and that may be something that government should consider.

I would emphasise that this is one instrument. You need a range of measures. You need the global data that Professor Ibrahim was talking about. You need a range of data sources. If you look at any organisation in health and in aged care, you should have a balanced scorecard, basically. You should collect a range of things, from staff attitudes to outcomes of patients, consumer experience measures, mortality, falls, finance—you need to look at the whole lot. As I said, one of the challenges—and interestingly it's raised more by the non-clinical members of the board that I'm on—is that they say: 'Well, how do we know we're doing a good job? We know where the money's going, but how do we know we're doing a good job?' I'm sure that conversation is replicated across aged-care boards across Australia.

Senator PATRICK: Again on notice, perhaps you could collectively provide a further submission that just focuses on what data you think would be essential and what the inhibitors are, and maybe one of the things that could come from this committee is a recommendation that sought to make your life a bit easier.

Prof. Whitehead: Okay, we can do that.

Senator PATRICK: Thank you.

CHAIR: This committee does have a reputation for being very focused on data, so I think you're continuing the tradition there, Senator Patrick.

Senator POLLEY: Thank you for appearing before us and for all the evidence that's been presented. The easy question I'll ask first: how do we change society's view on ageing, because, unless we accept as a society that ageing is part of the whole process of living and actually give some real attention to ageing, we're not going to really have the outcomes in aged care that we all want?

Prof. Ibrahim: One of the simplest steps that is possible with parliament is to have in every government a senior minister that's dedicated to aged care. If you go through the history over the last 20 years, there sometimes hasn't been a specific minister, and typically the minister's a junior in that role, so, as a government or parliament, we do not send the message to the community that it's important. I think that's the first step.

The second would be to value the staff who are actually working in aged care and be clear that they need to be specifically trained and recognised. There is no recognition for being additionally trained in aged care. There would be if you were doing paediatrics or adolescent health or women's health or any other form of specialty. It would be recognised. Aged care is not recognised as the specialty that it is.

I think they're some of the basic steps. Increasing transparency and actually having some sort of statement that says, 'Residential care is a complex environment, and we're not looking for a simple solution for a complicated problem,' would take us part of the way there.

Making residential aged care part of the community is probably the biggest step. At the moment people are parked in aged care. No-one visits. It's offsite, out of sight, and there is much relief when someone dies. We have not incorporated that as part of our community.

Senator POLLEY: Can I follow up from that. It's no secret that obviously my side of politics believes there should be a minister sitting at the cabinet table who can make decisions, not just when the issue comes out about aged care. There needs to be someone there to give that focus. It is, after all, a growing part of the federal budget that has to be met.

I understand the criticism in relation to our focus on how we stop this from happening again, the oversight of the agency and whether or not their processes of audit have teeth and are professional and the right questions are asked. But, when we're talking about Oakden, we have to ask these questions.

When you talk about the My Aged Care website, the portal into what's supposed to be the avenue—I consider it to be the maze—into this sector, a lot of money has been put into that. It's failing miserably. To access the data from that for your purposes I think would be quite limiting and unreliable.

Prof. Whitehead: In answer to your first question: it's a massive question. If I can make a personal observation about when I heard about Oakden and everyone was looking for someone to blame, I know this sounds trite, but actually society is to blame. There would been hundreds and hundreds of people who could have been exposed to that who could have done something about it. You're talking about a prolonged period of time, multiple ministers, multiple government officials. I think it's because, to be honest, people don't value the frail and cognitively impaired of our society. That is a broader social issue that we need to tackle.

In fact, one of the reasons why dementia is such a feared diagnosis is that, once you receive that label, you're perceived as, 'Well, you're now a burden,' whereas in fact I think—and perhaps this was illustrated when I was giving some talks in Tasmania, where I was given a piece of art created by a person who had dementia, which was actually a very nice piece of art, and we're going to hang it in our dementia ward at Noarlunga Hospital, which we just opened—it's that idea that across the life span people can still contribute. How they can contribute is different, and I think we need to get our heads around that as a society. We need to see how all people across the age spectrum can contribute. At the moment, we say that older people are a burden. I read it in the headlines all the time. They are 'bed blockers'; they're 'a burden', as opposed to being people who have given to society and still give to society, still bring joy to their families, still have something to give.

I guess ultimately governments have a role to play in that. I have to agree that ageing as a portfolio is kind of tucked away in various different parts of government, and I think that's not done it any favours as an issue.

In terms of the data, I think My Aged Care is a significant problem. If we want an example about how older people are not valued, when My Aged Care first appeared—I know this is a bit off topic—we had a patient offered services in Queensland who lived in South Australia. If that had been a 15-year-old boy with a disability, it would have been on the front page of the newspaper. It didn't even rate. The most I saw was two column inches on page 12 after three months of complete buggerising around, if you'll pardon my expression.

I think that's the real problem with the My Aged Care system: we tolerate, and older people tolerate, enormously inadequate services. I think the reality is that that group of people—and, to be honest, people my age who are the children of parents who are going through it—are not going to tolerate that for much longer. I think that is also part of the issue.

As a geriatrician—we are very half-glass-full people—I am optimistic that we will get some data out of My Aged Care, but I think it's a very big risk. My ACAT assessors spend about an hour with every patient collecting an enormous amount of information which, if we could access it, we could design better services with, if we could link it with various things. But I don't have huge faith that we'll get great data out of it. I think we'll get some, and certainly the Australian Institute of Health and Welfare, who we're working with, believe they're going to get some data out of it.

Again, we need to create the possibility of dialogue between researchers who are interested in this space and the Commonwealth to allow us to progress this. That's certainly something we would love to see happen. That's part of the reason why I think in South Australia being able to do this under the auspices of SAHMRI is quite important, because it may not be a big deal outside South Australia, but it is a big research organisation within South Australia. We're keen to work with the Commonwealth on our registry, on the work we're doing, and I'm sure there are a lot of other researchers in Australia who would be in the same boat.

Senator POLLEY: There's a lot of good work that's been undertaken by some of the big providers with various universities around the country, which is very reassuring, because ageing isn't just about getting care when you're in a residential home; it's about GPs; it's about ambos; it's about firemen—it's about everyone actually being educated on how we should be respecting and caring for older people. But, in terms of ageing well, there are some really good residential homes that actually do have that ethos that you're going in there to age well, and that's a good thing.

But it goes beyond what happened in Oakden and residential homes, because now all governments, of every colour, want to ensure that people who have the ability to age at home have the support that they want. That's another Pandora's box that's going to open up in relation to how people age well in their own home.

Prof. Whitehead: Absolutely. In fact you'll find that one of the perverse consequences of the Commonwealth reforms, in my opinion, is that it's probably driving people into residential aged care. In my local health network, we would find accommodation for about 50 to 60 people a month in residential aged care out of our 300 or 400 hospital beds. A common scenario is someone struggling at home for a long period of time, not being able to access services, coming against this maze, with sandwich generation children who are looking after kids and parents, who say, 'This is all too hard; mum just needs a home.' The older person, who is often demoralised, says, 'You're right; I need a home,' and, 'Where can we go?' other than look for that.

One of the reasons why we need much better data is so that we can explore these relationships between community care, residential care, hospital and home, and it would allow us to have a much greater understanding of the whole aged-care and healthcare system, because the two interact incredibly. The commonest pathway to go into aged care is from hospital, and they are high consumers of hospital services. We need to understand and know much better what is going on in order to allow us to understand what's a unique system in the world, because really no-one else does it the same way we do it in Australia.

Senator POLLEY: When we look at ageing well and ensuring that we're ready to cope as a society, all tiers of government are going to have to deal with the increasing demand for care for people with dementia as that continues to grow, because there is no magic pill anytime soon that we can see. When you look at the evidence that was provided around Oakden—and I have to say that I fear that this is lacking in a lot of aged-care homes—there was no therapy around music, around art, about engaging people. I walked into a fantastic dementia ward in Western Australia very recently, and, when you looked around that big lounge room, there's no way anyone would walk in there and understand that that was a dementia ward, because there were staff engaged and those residents were engaged in music, art, games, listening to music or just talking and listening to each other. How can we progress this so that there is a huge change and we don't repeat Oakden elsewhere?

Prof. Whitehead: That's a $64,000 question.

Senator POLLEY: But you're a professor; I'm not!

Prof. Whitehead: I'll try and answer it as briefly as I can. This clinical consortium also helped to endorse and develop the first national guidelines for dementia care for Australia, so I've had the opportunity to look at a lot of this evidence as part of that group that developed that. We certainly recognise that there are a number of nondrug interventions that are very much underdone. The overall benefits and impacts of music therapy and some of these things, and certainly occupational therapy, are small but effective, and they need to be part of that.

The challenge is about how you take an aged-care group that has been set up as a housing group and move it to develop some slight but definite healthcare credentials. I will just go from the model of health care that works well. You have academic healthcare institutions that have teaching, research, quality and service. If you have all four of those, you develop good outcomes. The perception that research in a hospital is wasteful is foolish because in fact it drives us to deliver better care, because we work in that environment. The same probably needs to apply to aged care. As you've said, there are some big aged-care organisations that have recognised that and developed links with the research organisations because they're trying to get that triumvirate.

I think that, at a policy level, we need to be promoting those sorts of good quality and clinical governance and recognise that aged-care providers need to be delivering good clinical care. This is housing for people with a complex illness, dementia, and to pretend that it's purely housing is a fantasy, in my view, and has been ever since I've worked in the industry. I think that at some stage governments—and it's both sides of politics, and it's every one I've seen—need to recognise that this is specific accommodation for people with a specific illness.

There are ways of delivering this. Obviously you need to work through to make it cost-effective and all of that sort of stuff, because we don't have a limitless amount of money—we recognise that—but I think we could do much better. At the very least, we need to be getting the average aged-care provider—that bottom 20 to 30 per cent, as Professor Ibrahim mentioned—starting to look at their quality and being encouraged to look at their quality and look at the incidents and look at their adverse events. That is how you develop a quality culture in an organisation.

Prof. Ibrahim: What we've had is a top-down approach—directives leading to how you want people to behave. There is no bottom-up. There is not the workforce with the experience and the knowledge to drive that change. The power differential between the managers and the workers is substantive and much greater than you'd ever see in a hospital. There is no intermediate group. If we really want to change things, then we need to get better engagement and better preparation of people who are delivering the care, to be asking those questions with support. It's not going to happen otherwise. We'll just keep going the way we are, giving instructions to people who don't know how to implement them.

Dr Dyer: When we're talking about offering meaningful activities to people living in residential aged care with dementia, it's recognised that there are benefits in terms of behavioural and psychological symptoms of dementia, but what's particularly important is that the activities are individualised. Not everyone wants to go and do art. Not everyone wants to go and do some craft. It comes back to having a consumer rated measure of quality of care. The tour we have actually has a specific item which came from consumers saying that this is important. One of the items is: are they offered individualised meaningful activities? Again, if you have a consumer view of the quality of care that's feeding back, that will be captured in that, in a tool that's addressing those. That will reflect in the level of the quality of care and should provide feedback to providers and others about whether they're meeting those needs.

Senator FAWCETT: I want to go to the discussion about the nonpartisan leadership group as well as your access to data. You've talked a little bit in your verbal evidence about the concept of a register. You mentioned in your submission the council in Canada that provides a non-competitive, collaborative approach to thought leadership. Could you discuss a little bit more as to what you see that looking like in the Australian context?

Prof. Ibrahim: I've been involved in aged care since the early 1990s, as a practitioner, in policy and in public health. I've sat on a number of state and federal committees. There is enormous consultation that goes on in the aged-care sector, absolutely enormous. Sometimes that means that things get frozen with the amount of consultation. If you're trying to get the providers, you have to get the public; the not-for-profit, faith-based; the not-for-profit, not-faith-based; the privates; and whichever groups they've worked in to just get the representation from that group. Then you end up having to get every single discipline that has anything to do with aged care, and you end up with about 50 people in a room trying to sort out what to do next, which generally isn't very productive. I would have thought that a small group—I've based a lot of this on my experiences with the patient safety movement. I was doing my PhD when that started and saw that progress over the last 20 years. They had a group of roughly 15 people not representing any organisation but with the responsibility to shift care from where it was to what it ought to be. We don't have that type of leadership in Australia. The competition between providers means that the only time they cooperate is when they come to the Commonwealth to ask for more money. Other than that, I've not seen a high level of cooperation. Then you have a whole lot of different interest groups about what is needed for each respective group rather than: 'The purpose of providing the service is to look after older Australians, and are we doing that?'

I think we always end up losing sight of the person that is occupying that bed, because each individual discipline, craft group, stakeholder or peak body has a view. I would see, really, a group of about 15 people that are selected based on their skills, with a directive or a goal that says, 'Your job is to improve the care and the lives of older people.' All models are up for discussion. All approaches are up for discussion. Rethink how we've actually geared up aged care.

We're still working on a doctor, nurse and PCA model from probably the 1970s, and in reality what we actually need are people that understand how to look after older people and give them their freedom, which no-one's been trained in. To reform aged care, we have to reform the tertiary education sector and reform how people are paid in aged care, because why would you work there? It's a tough job and, if they can make the same amount of money as a PCA somewhere else that's cheaper selling goods, that's what people will do. So I think we don't have that.

You need bipartisan support. You're going to need states and territories to cooperate, because they generally don't. And then you've got to look at the cost shifting and how substitution of service occurs, because in residential care you've got the federal money, and what do you do in terms of getting GPs engaged and shifting some of the rules, particularly around the model of aged care with GPs being able to elect in and elect out? You've got no ability to govern the GPs or any other service provider coming in.

Senator FAWCETT: The last question any of you might want to answer. I go to the circumstances of Oakden in particular. Most of your discussion has been aged care more broadly. We're looking here at a model of care for people who have mental health or behavioural issues around dementia. Is there any research or international best practice that would point towards how we should be moving forward in this space? Is having dedicated facilities with highly trained and appropriately staffed facilities the appropriate way? Should we look to disperse this population amongst existing homes? What is best practice?

Prof. Whitehead: I can make some comments if you'd like. Personally, this is not an issue where you've got large-scale, randomised control trials. The evidence base is not great. We did look at some of that with the UK National Institute of Clinical Excellence guidelines, which are the guidelines we based our Australian guidelines, and we didn't really find a lot around that. It's not really been well researched. My personal view is that, because it's such a small proportion of the entire population of people with dementia, to achieve something that is cost effective and is a large enough size that you can deliver quality care, particularly in a state like South Australia, where the population is very urbanised and it's all around Adelaide, I think you would have one site for South Australia. That's my personal view; not everyone else shares that. I just know, having run healthcare services, that it probably needs to be one site.

I think you need to have it with a proper healthcare governance model, and, to be honest, for the group of people who are in Oakden, you need to split out the people with enduring mental illness from the people with dementia—they are separate clinical groups—and you need to have a specific dementia focus. You may be familiar with the Brodaty triangle, which I'm sure may have come up at some stage. So you're talking a tier 7 group. Once their behaviour settles—because for many residents it does settle over time—you then need to be able to step them down to a lower-level facility, which probably would then be done in partnership with an aged-care provider, because ultimately what you don't want is a custodial model of care that people never leave. If people improve, you need to be able to move them through. That has been experimented on or tried in New South Wales. HammondCare do or have run what I think they call a psychogeriatric unit, which takes some very difficult tier 7 type residents, and they were having people stay on average three months but sometimes up to a year in that facility. Again, it's not randomised, control trial evidence, but they certainly have done that for a relatively small number of residents.

I was involved in a psychogeriatric expert reference group as a representative for the geriatric society of Australia-New Zealand. That was auspiced by COAG a number of years ago. That did produce a report that actually recommended a model of care that's very similar to what's being proposed as the potential replacement to Oakden, but I don't know if that committee at a Commonwealth level ever progressed. That was endorsed by all levels of government.

The reality is dementia is a growing problem. That top one per cent who have severe behavioural disturbance and potential for very high levels of aggression need a specific service, and my personal view is you cannot fund it as an aged-care institution. I think it needs to be something different.

Senator SMITH: To follow on from your evidence: Professor Whitehead, how would you rate Australia's aged-care system compared to other regimes internationally?

Prof. Whitehead: It is not something we looked at in the guidelines. My personal view is that in fact the Australian aged-care system is not bad. To an extent I'm not sure of the value of the question, because in fact you really want a system that actually tries to improve itself. I would say that the aged-care system in Australia is not designed to improve itself. I do really have to echo Professor Ibrahim's comments about the quality and the training of our staff and the challenge we have at undergraduate nursing, medical and allied health level, where in fact teaching and training around dementia care is really absent.

From personal experience, my daughter just completed her nursing degree and she covered nothing. She only learnt about it because she's worked as a carer in a nursing home and, to be honest, that turned her off actually working with these people, because she never got the more positive side of it, which is that there are specific skills you can acquire as a nurse to care for these people well.

Conversely, I've had experiences where we've taken groups of nursing staff who ran a general medical ward. We changed the focus of the ward to caring for people with dementia, and now those staff would never leave. They've learnt—and, again, it's in a hospital environment; it's a different staffing structure. So I think there are ways we can improve it, but I think the challenge is that we need to take a look at aged care as an institution. We need to recognise that it needs to have a quality focus. It needs to be self-reflective and aimed at improving, and that will need to be resourced. And it needs to acknowledge that it's actually got a clinical responsibility for the residents in its care. On complexities about general practice I absolutely support Professor Ibrahim. That is incredibly difficult.

Prof. Ibrahim: We're ranked in the top 20 internationally. The question I'd ask is: the ranking doesn't matter; it's what you value and what you could actually achieve. Would we be comfortable being ranked 17th if it was the health service, because our health service is usually ranked in the top 10 or better? Why do we accept lower ranking? If it's your football team, are you happy being ranked 17th out of 18? To me the greatest frustration is that we have the knowledge and the ability to improve the care substantially and yet we sit comfortable because it's okay. And mostly it's okay. I will go to work tomorrow and recommend residential aged care to some of my patients without any qualms, because the system is okay. Like any health or human service, there are problems. We're just not doing the best that we can and we've shifted all the responsibility back to the people who are working in aged care. We would be in deep trouble if they ever chose to move, because people aren't flocking to it.

CHAIR: We've had a whole inquiry about that.

Senator SMITH: You did allude to my second question, Professor Whitehead. What is the capacity in the Australian system to do that exact evolution, embrace of change and focus on constant improvement—or is there an element of complacency in the system?

Prof. Whitehead: I think it's very variable between organisations. I think high-performing aged-care organisations—and, in our research collaborative, clearly the people who put themselves forward to be involved are high-performing aged-care organisations. HammondCare is well known in Australia, as is Brightwater and, I think, as is Helping Hand. The reality is they are moving in that direction. But your issue isn't the high performers; it's the average performers. I think it's about bringing everyone up to a minimum standard. I don't think you can do it for free. It's got to be a multipronged approach. I think there is an issue about government setting a standard and being willing to fund a particular standard. There is the issue about education and training and about ensuring that you should have some basic requirements to have a qualification in dementia care. There is a very good Bachelor of Dementia Care run through the University of Tasmania. It's possible to take advantage of that. There are lots of things in Australia that we could build on. Nothing we're talking about is rocket science, but the reality is that there has to be an acknowledgement. I'd want to underpin it with a measurement system. Where we've made leaps and bounds in our own services, we measure what we do. I think that's pretty well a mantra in healthcare quality and I can't see any reason why that wouldn't be in aged care quality. It needs to be a judicious measurement. You want to get measurements that are going to help. Obviously, we're fans of the measurement we've created, but, at the end of the day, you need something that you can hang your hat on and, ideally, something that you can benchmark against other providers so you can say, 'So-and-so, who is part of our organisation, is performing at this level. The national average for that sort of service is this. What's going on?' That's the sort of thing you need to be able to do. That's what a good quality framework is. Certainly, from our own experience of using the rehab outcomes database in our rehab service, we benchmark very well, but it's been a progressive improvement over the years. So we know things have changed—and we've driven that change—because we have had a measurement system to support us. To my mind, that's pretty basic.

Again, you'd have to tailor it specifically to aged care. Prof Ibrahim's comments about the staffing structures are very apropos. Part of the problem is, in my experience, that a good facility is only different from a bad facility on the basis of one or two staff members. They're very vulnerable to having a poorly performing senior RN. Thank God that there are some out there who actually care about older people and want to look after them properly. But, they are, potentially, a dying breed, because I'm not sure that our current undergraduate system is creating graduates—judging from my personal experience—who are going to want to care for this group of people.

CHAIR: We've certainly had quite a bit of evidence in past inquiries on exactly that point, which is in line with what you just said. We've gone over time, but all our evidence has been interesting and valuable, so thank you very much for your time today. Did any of you have to take onboard homework?

Prof. Whitehead: I think we had to provide something about measurement.

CHAIR: That's what I thought. Could I ask you to look at—we'll provide the *Hansard*—what the agency said about the questionnaire for residents. Your feedback on that would be appreciated.

Prof. Whitehead: We'd be happy to do so.

CHAIR: Thank you very much for your time today.

Proceedings suspended from 12:52 to 13:37

BARON, Mrs Carla, Partner (Retired), N & C Baron & Associates

BARON, Mr Neil, Partner (Retired), N & C Baron & Associates

OLSSON, Ms Sharon, Private capacity

CHAIR: Welcome. For the *Hansard* record, can I double-check that you've all been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Baron: Yes.

Ms Olsson: Yes.

Mrs Baron: We have, thank you.

CHAIR: Would you like to add anything about the capacity in which you appear?

Ms Olsson: I previously worked for the department as a senior administrator and I now work for Flinders University teaching in mental health.

CHAIR: We have your submission. I invite any or all of you to make an opening statement.

Mrs Baron: I think all three of us have things to say, but I will kick off. I will say first of all that I think Neil, Sharon and I are the only people you have here with a long history of what really happened at Makk and McLeay. Neal and I were the appointed advisers, initially, in 2008 when Makk and McLeay was sanctioned.

From the point of view of N & C Baron & Associates, we applauded the introduction of accreditation 20 years ago. It had a very positive effect that moved the industry forward really well. Twenty years on, it's in need of some reform. The system itself could still be effective but for some obvious flaws. The first is poorly worded standards that fail to provide clear guidelines and expectations to all concerned. I think that's been discussed and is being addressed. The second is inadequate agency assessor and management training to recognise and address bias. I think we need to recognise that we all hold biases. This morning when we were sitting here the bias we heard is that the big organisations do a great job. And that's true, but many small organisations, too. When you're an assessor for the accreditation agency, if you have the bias that the big organisations do a good job but the small organisations not so good, then when you go into a small organisation you're possibly not doing them the best service.

I should also say right now that I was an external assessor with the agency and have done accreditation audits. In any case, this lack of identifying and recognising bias resulted in inconsistencies at all levels and that I believe resulted in significant failures that have not only threatened the usefulness of the system but also put residents second to the system so far, and that was the result of what happened at Oakden. Neil and I have a history of successfully managing sanctions and have assisted over a dozen organisations to meet requirements both before and after our experience at Makk and McLeay nursing home in Oakden. The difference is that that was the only place we ever attended where there was a concerted effort by all concerned—staff and management at Oakden, the Department of Health and Ageing and the Aged Care Standards and Accreditation Agency—to maintain the status quo: keep it as it was; don't rock the boat.

Mr Baron: If we look quite seriously at Makk and McLeay, or Oakden, it was a dumping ground for other aged-care facilities, if you had a resident who was a problem. All aged-care facilities have security of tenure. As a resident you have security of tenure. How do you get rid of somebody who doesn't fit in? You can send them to the hospital and the hospital sends them back. Makk and McLeay was one place you could send them to. They went to Howard House, and from there they went to Makk and McLeay. Once they got to Makk and McLeay the families were told: 'Well, this is sort of the end of the line. Nobody really wants to take you, but we will, and we'll look after you, and you really don't have any options.' That is what families were told. We spent a lot of time talking to families. They went through gut-wrenching experiences, and, I must say, I used to walk out of that place, walk to the parking lot, and just about cry for the situation—not so much for relatives; most of them were out of it and didn't understand. But the families were torn apart, and the staff could not have cared less.

I'm trying to summarise very quickly for you where I went. I started looking at Cs, and the first C I put down was for competence. There was no competence there. There was no competence at the senior level. The first time we asked for a meeting with senior executives we had 14 people roll up—everybody from a psychologist to all sorts of people. They all had fancy names, but nobody had a basic understanding of aged care or why they were there. And really, what were they doing? They were saying, 'Let's just patch this up, let's just cover it up, let's just move on.' Another C was for culture. There was a toxic culture in that place. The staff could not have cared less. The ones who could were trampled on, and if they weren't trampled on they moved on. A lot of the agency staff who came in—and we knew agency staff, because we worked in a lot of different facilities—would say, 'I'm not coming back here', and they wouldn't come back. So, what was left there was a toxic environment. I asked one staff member, 'How do you manage some of these residents?' He said, 'We use an old mental health trick: you stand on their feet, and that slows them down.' They had residents wandering around in an open paddock in 35- and 40-degree heat, not doing anything, just wandering around. It was an absolute farce.

Another one is complacency. Complacency was all over the place. You can talk about the physical environment of the building, and that was less than ideal, but the toxicity was throughout the whole facility. And culpability: yes, there were people who were culpable, as Carla indicated. Mental Health was culpable. As I said, there were a lot of people there with big titles, but they weren't doing anything. I have to wonder how the agency let stuff slip through there. We have to look at certification. Certification was for every aged-care facility—how they allowed stuff to happen. We walked in there, and places that were supposed to be toilets were used as storage areas, and they weren't even nice; they were just thrown in there. You can't imagine what the place was like.

And conflict of interest: was there a conflict of interest? Yes, there was. We looked at the situation. We were there. We went to the Commonwealth delegate for the minister to a meeting, arranged with him and senior executives from Mental Health. At that meeting he looked at them and said, 'We all have a minister that we have to answer to.' The looks on those people's faces were incredible. They went from frowning and being worried to having big smiles. That's when we said, 'We're leaving this place; we cannot achieve anything.'

We left the place. And we were asked by ACH Group, because they were going to move in there, for a backgrounder. We provided ACH with a backgrounder. We told them some of the problems, and they said: 'Don't worry. We know what we're doing. We can fix the problem.' We took them at their word. They were there for three years. Now, we were there in 2007. This is 2017. The situation didn't change. And I guess I as an individual really want to know what they did in those three years. Did they do anything? Did they build up that culture? Did they fix the problem, and then it slid back again? Or did they paper over the cracks? I think that's a question that hasn't been asked, and I think it does need to be answered.

The conflict of interest: the CEO of ACH was on the board of CNAHS, the approved provider for the organisation. Now, is that just coincidence that they got the go-ahead to run the place and co-manage? There are different titles there. Some people call it co-managing; some say that they were in a partnership agreement. But there was some arrangement. And there was a press release saying that they weren't able to function so they had to bring in a manager. What does that say about this place? This was being opened then. Craig Whitehead this morning said that everybody's to blame, because people could have replied and they could have responded to this and they could have complained. They couldn't complain. There was no ICAC at that time. There was nobody to complain to. If you complained it fell on deaf ears. It was that whole idea of, 'Leave the place alone; it's a necessary evil.'

Was there collusion? Of course there was collusion. How else could the agency, the department and ACH, all working together, come up with these solutions? If it was another facility they would have been nailed. They would have been gone. But, as I said, this was a convenient dumping spot for somebody, so they were getting special treatment. I don't know how. I can't answer that question. But to me it smells. It smelt back in 2007 and 2008 and it smells today. And unfortunately I think what's going to happen is that it's going to go away. It will go away. The people who were in charge at that time have all dissipated; they've gone to other jobs, they've got other careers. There's nobody there to take any responsibility for it.

And corruption: is there corruption on this? I believe there was. I believe this whole situation was a stinking mess of corruption. But what are we going to do about it? What is the government going to do about it? Obviously nothing. The state government's not going to do anything about it. I don't think the Commonwealth government's going to do anything about it, and I think we're just going to shuffle this off, put it away, say, 'Oh, that was Oakden, but everything is good now, everything is happy now.' I don't believe it is. We know that ICAC is looking at it, and hopefully maybe there'll be something good there. I'm sorry, but I think if it looks like a duck and quacks like a duck it probably is a duck. Thank you.

Ms Olsson: I'd just like to make a statement about my submission. My submission was in confidence but I think, owing to the gravity of the situation, I'm happy to have that made public. There are names mentioned in the statement, and I'm happy to have those redacted. I have a background in nursing, administration and tertiary education, and I've worked in clinical practice. I've been involved in change in different cultures over many years, and over the course of my nursing career I'd assumed leadership roles in adult mental health services and aged care. These roles have included leading nursing practice standards, improvement and culture change in services that have failed standards monitoring. That was in Queensland. My commitment to service development and improvement have been rewarded throughout my career with various awards, and it was for this reason that I was asked—this is what I was told by the executive director—to go out to Oakden in 2008, after the 2007 review, to fix things, and I encountered nothing but blocks, demoralisation. I was thwarted at every turn.

The committee has my statement, but I will just talk briefly about the problems that we encountered, which were serious problems that I couldn't get support on. They were things like having no identified documented model of care. That was talked about this morning. When that was raised with the executive, the response was: 'The model of care is that it's a mental health facility. Ergo, you have your model of care. You've just come from Glenside.'

There was a clear lack of nursing leadership and clinical supervision. No senior nurses were in the clinical area, from what I saw, at any time, unless you basically shamed them into being there. There were inappropriate resident-nurse interactions. They were handled. I couldn't even say they were fed and hydrated, because they weren't. So many of the meals went back to the kitchen because nurses couldn't be bothered to take the time that it took to feed some people. I don't know if you're aware, but people who have dementia and mental health problems often have difficulties during feeding and eating.

There was an unsafe nursing environment with things everywhere. Things were broken. The chairs were all peeling apart. These were what the residents were expected to sit in. There were outdated and incompetent nursing practices. I noticed in the first few weeks that there were a lot of emaciated-looking residents, and that concerned me, so I went to look at their weight charts. What I found was that most of the residents—something like 65 to 67 per cent; I can't remember the exact figure—had lost at least 10 per cent of their body weight within six months of admission to the facility. When I talked to the nursing staff about this, the lack of education and knowledge was extremely clear, because I was told: 'These are people with dementia. Don't you know people with dementia lose weight? They don't eat properly and they lose weight.' I think that just reflects the lack of understanding and nursing ability.

There was incompetent medication preparation and administration. That was mentioned earlier this morning, I note, but what I witnessed was nurses actually mixing one lot of medication in a mortar and pestle, giving it to one resident, and then mixing another lot of medication in the same mortar and pestle without washing or rinsing it, so the cross-contamination of medication was unbelievable.

There was behavioural mismanagement, with high rates of restraint. That was of particular interest to me because there was a federally funded national project for reducing restraint across Australian mental health facilities, and I had done extremely well in that at Glenside, having closed down a restraint room and opened up a chill-out room. So I was very keen to see that restraint was addressed. However, that was a very difficult thing to do, because every time you said to the staff, 'Why don't you take this person for a walk?' the response was, 'No, they're aggressive, and if you're going to make us do things like that we're going to the union.' So it was very difficult. Then, if you enlisted the support of the service director or the executive director, you were told, 'Well, you're there to fix the problems that the Commonwealth have identified.' I said, 'Yes, that's what I'm trying to do.' 'Well, not if you're threatening staff.' I hadn't threatened anyone. So it became a very difficult situation, because, as Carla said, the environment was very toxic. There was a culture of cover-up, but I'd say that the cover-up was more at senior level than at base level.

There were inappropriate rostering practices, where favours were done for mates and a whole lot of overseas general trained nurses were brought in. A lot of these people came from Asian cultures that had absolutely no background in looking after aged care. As one of them said to me, 'We don't have this facility in my country; I do the best I can.'

The other thing that was particularly difficult to bear was that nurses were often sent to Oakden as punishment. If they hadn't performed or they got on the wrong side of someone or there was a personality clash at Glenside, then it was easy just to ship that nurse out to Oakden. There was minimal staff development for hands-on staff. The level 3s and above were sent on what I considered to be junkets. The real education was needed at the coalface. You had to do basic life support, because that's one of the legal requirements under the nurses act, and anything that was mandatory, that had been mandated by the Commonwealth, for example, and that's the physical handling aggression program. Those kinds of things were the only things that were really programmed. There was a very disenfranchised nursing and care division. I'm happy to take questions and ask for any further detail on that.

CHAIR: If you could wind up when you can, because we want to ask lots of questions.

Ms Olsson: Okay. Suffice to say by the end of the first week the Commonwealth advisers, the nurse and Neil and I, developed a very good, collegial and constructive working relationship, as did the educator and the charge nurse I brought out there, and a nurse manager. We all had a very good working relationship. As I say, we were thwarted at what seemed to be every turn. It was so demoralising. We weren't sleeping and our health was being affected. We did try and see the Commonwealth department of ageing, and that just got us nowhere. There were commiserations with the ED, because they had a minister to report to. After that, Neil and Carla left, so I said, 'We're not going to go anywhere. Let's go to the health rights commissioner,' and that was Leena Sudano at the time. We went to see Leena Sudano but were told that she didn't have the resources to help us, that we weren't really going to get anywhere and we should look after our own careers. So, with that, feeling totally demoralised, having failed at making the changes that I was to make—and I've never had this situation before—I left. I went back to my substantive position, because I knew I couldn't cope with it any longer.

CHAIR: How do you think they got back to meeting the accreditation process?

Ms Olsson: I have absolutely no idea—no, that's probably not true, because there were a lot of friends. With respect, I'm a Queenslander, but I have to say the health system in this state is the most nepotistic department that I've ever worked in. I've worked in three states in health departments, and its jobs for the boys and the girls; it's not qualifications. The person who was put in charge of the purse strings when I was sent out there to fix this was a service director who had one nursing certificate done at a hospital base and had never held senior management positions like that before. However, she was a very close friend of the ED and the CEO socially as well as professionally.

Mrs Baron: If I may, with regard to the accreditation agency, with Sharon speaking about internal South Australia, I think this is where problems arose with some of the way the accreditation agency operated. As I said, Neil and I went to many places that were sanctioned, and often staff were making efforts and you were trying to help them and say, 'Good job, good job.' Sharon, Neil and I were saying, 'You've got to clean up your act,' and the agency come in and go, 'You're doing a great job here—we can already see improvements.' So we'd talk to them and they'd go: 'Buzz off. The agency says we're doing a good job.'

This is where I also want to talk about that bias. ACH know what they're doing. I have no qualms in saying that. I think ACH went in and put their systems in place. The agency said—we even have documentary evidence:

> Extensive non-compliance was identified at the review audit. However following the audit, ACH Group, which has extensive experience in aged care, has entered into a partnership with the approved provider in relation to the management of the home.
>
> … … …
>
> ACH is implementing new management systems to improve care for residents and to address noncompliance identified at the review audit.

So for that reason the decision to revoke was removed. ACH took over. They said, 'ACH know what they're doing; all will be well.'

The process then followed, as does. ACH got them compliant in 44 out of 44 expected outcomes and they received one-year accreditation. ACH stayed. They maintained that compliance. They got them three-year accreditation. ACH left. Now this is where I am somewhat puzzled. We do not know what happened during that time, but standard practice is that when there's a change of key executives or management—the term 'key personnel' is used in the act—the agency monitors very carefully. I have no idea what monitoring they did. I am puzzled how in 2016 they received 44 out of 44 with ACH gone.

One of the questions I need to ask, even when ACH was there, is how they came to pass some of the expected outcomes. I talked earlier about the poorly worded outcomes, and they do pose a problem. There is an item there where you can say, 'It's a judgement call and you see what you see.' But then you look at expected outcome 4.4, Living environment. We have pictures of the place when we were there in 2008. We took pictures because we intended to use them with the staff to say: 'This is what's wrong. You can't have a wheelchair in front of a fire hydrant. This is a problem.' We took lots of pictures. In being interviewed for another body, we took those pictures along. That person had been through the place the week before and he said: 'It hasn't changed any. These pictures could've been taken last week.' So how did it pass 'Living environment' during all those years? Whatever ACH did or didn't do, the building was not a safe and comfortable environment. It never was.

So I do have questions about how those decisions were made. And I do question why, after 2008, Mike Rungie went on to be on the board of the agency. It is very difficult for an assessor to find noncompliance in an organisation when they know the CEO of that organisation is a board member of the agency.

Mr Baron: I guess we can look at accreditation as like selling your house. If you want to sell your house, you try to present it the best way possible. You move furniture out. You have the coffee smell and all the rest of it. Accreditation was the same situation. Furniture was moved in and out; staff were moved in and out. One place we knew put their disruptive residents on a bus for the day. They took them out on a trip so that they weren't around to talk to the assessors. Can you do a bodgie and fudge an accreditation? Of course you can. And if you know how to play the game, you know how to deal with assessors, you can get through. It really depends on the goodwill of the organisation to show whether or not they're dinkum. That's the situation: yes, you can do a bodgie and get away with it, and it has been done.

Mrs Baron: The other issue, as I said in the beginning, is that the agency has turnover of staff too. You get a new assessor, they walk in and they've been told: 'This place has been fixed up, so you're probably going to be okay with it. Don't worry about it.' They go in and they don't necessarily see or look for the right things. You usually have two assessors: a senior assessor, who sets the tone, and the other assessor. They might say, 'I'm a bit concerned. But then it's: 'Oh, it's okay. It passed last time, so it must be okay.' So I do believe there are flaws in the agency. Normally in an organisation those little things might not have been big. But in this case it actually supported institutionalised elder abuse. And that's what Makk and McLeay were, make no mistake.

Sharon talked about restraint management. We saw a gentleman who would be a good six feet tall tied to a chair with wheels. The chair was like a kiddie style chair. He was trying to move up and down the hallway and he was crying out. I went up to speak to him and the staff said, 'Don't go near him; he's aggressive.' I thought, 'Bloody hell, I'd be aggressive too if you treated me like that!'

This place should have been closed in 2008. The fact that Barb Spriggs' husband, and others, had to go through that 10 years later is a failure and an indictment on both the state government and the Commonwealth government. I disagree with Craig that it's everybody's fault. No. There were opportunities and they were picked up. Am I passionate about that? Yes. Like Sharon, we haven't suffered a lot of failures. But I don't feel a failure because I think we didn't do our job properly; I feel a failure because residents and families suffered far more than they needed to because the system did not work.

Senator POLLEY: Thank you very much for your submission. It is quite obvious that you are very passionate about this. Unfortunately, we can't go back and change the event. But what we can do is change the system so that we don't see a recurrence of that—and it was so bad we think it would be impossible for it to happen in this country in the first place. What steps do we need? You heard the oversight agency today. Frankly, he didn't take the responsibility that I think he should take for this. What's the next step to ensure that all older Australians—in South Australia, Tasmania, Western Australia or wherever they are in this country—don't succumb to the lack of care and consideration of dignity and respect for these older Australians?

Mr Baron: First of all, the accreditation system was good. When it was first implemented, in 1997, it was good. It was a necessary step and it was good. But it is aged now and it is a very subjective process. What do I mean by that? What if I said to you that you have to drive on a road and it is signposted at 60 k's an hour. You and I and everybody knows it is 60 k's an hour. That's great. If you go faster than that, and there happens to be a police officer there, you could get pinged. But what if I said you must drive at a reasonable rate of speed? What does that mean? It means something different to me than it means to you. This is the problem with the accreditation system. It has motherhood statements that are open to interpretation.

The bulk of staff working in aged care are very dedicated people; but, let's face it, a lot of them are under-educated and under-resourced. There are a lot of carers there. Some of them are coming in from other countries. They are limited in what they can do. They will comply. But if you want them to comply make it easy for them to comply. Don't load them down with all sorts of paperwork. Look at good quality systems. Take McDonald's. McDonald's has a quality system. They may not make the best hamburgers in the world, but they can get 14-year-old kids to comply. We should be doing the same thing in aged care.

Most people do want to comply, they do want to do the right thing and they do care about residents. Get rid of the ones that don't, and really encourage the rest to do that sort of thing. Free up people so they can do it. And, as was suggested this morning, we need specialised gerontic training for people going into aged care. But we also need specialist training for the assessors. Quite often these assessors come from one organisation. They walk into your place and say: 'Your doing that wrong. I've been at this place for 10 years and we've never done it that way, so you're doing it wrong.' That is their frame of reference. We need to widen this and broaden it. We need to look at who is involved, who the key players are. I'm not talking about the upper level, the CEO level; I'm talking about the coalface. How can we start there and work so that it's going to work? As I said, most of these carers work damn hard.

Mrs Baron: I would really like to support what Neil's saying about the agency assessors, too. When this all started in 2001, there was a determination to try to use a number of external assessors, to have more of a peer review type of situation, and that that would be good. As was mentioned this morning, though, it has become a very competitive industry, and people don't always take kindly to having a director of nursing from another organisation assessing their organisation—'Oh, they're going to steal all my good ideas!' If we get back to—'We're here for the residents, for heaven's sake!' Nevertheless, there has been an attempt to bring in, if you like, specialists from other areas, but that can get back to that bias. I've worked with some excellent assessors, but, again, we all have our biases. I worked with one who was an assessor in food hygiene. She was really good doing the kitchen, but she wasn't very practical or knowledgeable about some of the other things.

Senator POLLEY: Are you now suggesting that assessment would be better if you had people for certain areas and that they transfer across the country, or just one?

Mrs Baron: I think that's what they were trying to do to get more people in. There are good and bad points to every system. I believe the agency made a huge mistake when, a number of years ago, they decided to take over their own training of assessors. It used to be an external group that trained assessors, and they trained quality assessors in all different industries. They trained about, 'What is quality, what is management, what are your biases?' I know my bias. My bias is pain management. When I go do stuff, I go: 'I can't spend all my time looking at pain management, and I can't be doing this. I've got to get my head around,' and, 'I don't like that, so I'd better go do it.' It had that wider focus.

The agency has isolated itself bit by bit. It took over its own training. Yes, there's a culture, but then that culture, if it's the bad bits, gets passed down as well. They isolated themselves in other ways. They became more insular. Where I was talking, again, about external assessors, I see merit in going to other states because, particularly in a small state like South Australia, I always had to put my hand up—and more so as an educator, because I don't think there were very many aged-care facilities in South Australia that I didn't do education in. I'd have to put my hand up, saying, 'I can't do this one, because I've actually given them some consultation.' But they agreed that if I did education I could go do it. I walked in the door and people knew me, so there's a conflict there. But it also showed me something. I would walk in the door and they'd go: 'Oh, Carla!—oh, you're here from the agency.' Their whole demeanour changed. It was not open, it was fearful; it has become a punitive exercise.

Senator POLLEY: Ms Olsson, in relation to medication and your evidence in your submission, did you report to senior management that there was no sterilisation of that mortar and that this was obviously something that was quite common?

Ms Olsson: Yes, I did.

Senator POLLEY: What was the action that they took?

Ms Olsson: They didn't take any action. They, once again, kept referring me back to the 44 standards. I said, 'But medication is one of the standards.' I said, 'We need to remove the mortar and pestles.' The other thing that concerned me was that medications were going into things like jams and marshmallows. Putting something in marshmallows in a residential care facility's not a good look, with a lot of the choking situations that you have.' I went to speak to the GP about those things, because we had a GP. I'd also noticed that there hadn't been medication reviews for the residents, particularly the ones who'd lost weight and who were on psychotropic medications. I couldn't get him to see the residents or to do the reviews, so I reported this to the psychiatrist, thinking, 'Well, he'd obviously report to the psychiatrist.' The psychiatrist just said, 'You'll have to get him to do the reviews because it's up to him to do the reviews and I don't see residents unless there's something wrong, and I don't see residents' relatives.'

My belief was if they wanted to give medication, say, in jam there needed to be a good clinical reason for that, and it needed to be discussed with the resident's family and for them to be aware of this. As I said, nothing happened. When I said to the staff that I was going to get rid of the mortar and pestle, they reported it to the service director, who told me it wasn't my place to remove the tools from the clinic; it was my place to focus on the 44 standards.

Mrs Baron: May I also remind you, Sharon, that you told the agency, because medication management they found was compliant. Sharon went to the acting agency assessor, who was the manager of the agency at that time, and said, 'You've got to make this noncompliant,' which blew her mind! People don't generally say that to them. They just said, 'No, we can't change that.' This is, again, where we couldn't get the staff. They said, 'Why are you bugging us about that? That's compliant. Even the agency says it's compliant.' Sharon made every effort she could. We made every effort. We all tried from different angles. And this is why I say 'being complicit'. Everyone was complicit in saying, 'No, we can't go there.'

Ms Olsson: It's important, too, to talk about the education. I brought an educator out from the education centre to look at the standards, to meet with us and develop an annual planner, with a focus in the first three months on trying to get some of the basic nursing things up to standard. I received absolutely no support with this. In fact, the service director started having friends of hers come in and doing sessions that weren't on the planner, that weren't part of the priority we had. He just said to me one day, 'Look, I want to go back to the learning centre. I'm losing credibility with the staff because every time I say I'm going to do something somebody else comes in and does something else. I'm not staying.' It really didn't matter what you did, because it was thwarted in some way.

Mrs Baron: If I may, those are things we reported to the delegate before we had the meeting with them. We met with him, prior to that meeting, to say, 'These are the problems we're having. We need you to put the hard word on them.'

Senator SMITH: Mr Baron, in your evidence you said that you were in a meeting with Commonwealth and state officials. Someone, perhaps the delegate, made a remark and then there were smiles or a sense of relief on the look of some officials' faces, when the discussion fell to ministerial responsibilities and accountabilities. Could you expand on that experience a little bit further?

Mr Baron: Like I said, the people from mental health were really concerned about this meeting. They were very uptight, and we had talked about it beforehand. As soon as the delegate had said that, it was a nudge-nudge wink-wink thing. We both have ministers that we have to answer to. The relief was noticeable. They thought, 'We don't have a problem anymore.' We had said to them, effectively, 'They can shut you down. This is the situation. You guys have to make sure that you toe the line, because they can shut you down.' As soon as they heard that it was, nudge-nudge wink-wink it's all over; there's not going to be a problem, and their whole demeanour changed.

Senator SMITH: As if to say, 'We're not going get shut down.' At that level, it's fine.

Mr Baron: That's right.

Senator SMITH: Ms Olsson, you reflected on the interrelationships that lots of people seem to have with each other, here in South Australia; it's the smallest state et cetera. I was curious about some nurses being sent to Oakden from Glenside as a form of punishment. Could you explain that a little bit further?

Ms Olsson: For example, in one of the units on Glenside, somebody complained about the rostering, how they weren't getting a fair—people were always getting the weekends off, and they weren't having any say in the rostering. So they went and they talked to the nurse manager and the nurse manager said: 'Well, the rostering is as it is. If you want to make any changes, you can actually apply for a change of the roster.' 'Yeah, but you won't give me that, will you?' 'Well, I might or I might not. It just depends.' So they then went to the nursing director, who was me at the time. I went to talk to the nurse manager, and the nurse manager said: 'Well, this is really bullying, because I'm an autonomous practitioner and I do the rostering. And unless I have things in writing then I don't do anything about that.' So I asked the staff member to put something in writing to me, to cc it to the nurse manager, and then I would take that up with the don. But that didn't actually happen: I didn't receive anything, and then I found out two weeks later, when I went to actually look for the nurse, she was out at Oakden. And when I contacted her, I was told that: 'Look, I don't want to make any more troubles, it's bad enough; I just want to finish my work now and get my super. I've only got another 18 months to go.' That kind of thing. Because they had created—about the nepotism of the rosters—basically, they were sent out to Oakden.

Senator SMITH: I'm an outsider; I'm not from South Australia, but it sounds like for a long time a protection racket has been allowed to develop.

Ms Olsson: Good word.

Senator SMITH: It's clear that the residents aren't being protected. It's clear that the families aren't being protected. Again, my words—but who is the protection racket protecting?

Ms Olsson: Staff.

Mr Baron: We had one RN that used to scream and holler at everybody. And we thought, this is just totally unacceptable. So we said, she has to go off that unit. And we had a lot of resistance there, we actually went to the ANMF to discuss with them about the whole situation. They'd moved her off-site but they were continually coming back and saying: 'No, no; this person needs to come back on site.' And then we were also told by staff—it was sort of, 'You guys really did the wrong thing by even mentioning her because, you know, she is a good person, and why did you have to bring that up? So it was—it was intimidation by them, to us, for even mentioning it.

Mrs Baron: The whole place was staff-centric. At one point we said: 'The parking lot—maybe you could leave the first row of parking for families, because the wives and husbands are elderly themselves, and it's a long walk.' And they said: 'What? Those are our parking places, we deserve them, they can walk.' And that was the attitude. Everything was about, 'don't upset the staff, we have to look after the staff.'

Ms Olsson: I guess another very quick example of that is the fridge, and I know this sounds petty. But in the review it was noted that relatives wanted to bring things in and put things in the fridge for the residents. It was all broken off, and it wasn't sealing properly, and food was going off, and so another fridge was ordered. At the same time, the service director—who held the purse strings—ordered a bar fridge for her office. It was quite a big bar fridge. The bar fridge came, but the other one didn't. And when I said: 'Oh, the fridge is here'—I thought it was the residents' fridge—it wasn't, it was the bar fridge for her office! And when I said: 'When is the one coming for the residents?' 'Well, we don't know if we're going to go ahead and buy that, because you know we're going to be selling Oakden and we don't know how long we're going to be here, so we don't really—we can put it in the fridge in the kitchen, if you have to.'

Senator SMITH: Where was the Australian Nursing & Midwifery Federation during all of this?

Mrs Baron: They were protecting their members. I did have a word with them, because we were close. Again, this one who the relatives said bullied them and screamed at them, and the ANMF were pushing for her to come back, and I did say to the acting secretary at that time: 'If you push this, we will go back to the Commonwealth. I'll tell you, these residents will not have this woman back, and we'll just go on a merry-go-round—she cannot come back.' These relatives were already demoralised and in tears. They were in terrible shape and to be bullied by her and then have her protected by the ANMF was another slap in the face. They did their job: they protected their members.

Senator FAWCETT: Ms Olsson, we had some evidence earlier today from people who highlighted that some residents had come to Oakden from acute-care facilities but Oakden was considered to subacute and they questioned why that was the case because it directly affected things like staffing ratios. Given that you worked in Glenside, I think, you said, you are clearly familiar with acute type facilities. Could you offer the committee a comment on whether you think that categorisation of Oakden as a subacute facility was wrong? If facilities like this continue on, should they be regarded as acute facilities?

Ms Olsson: They shouldn't be regarded as acute facilities; they weren't acute facilities. I think, Neil used the words 'dumping ground' and that really grates because I'm a nurse and I don't like to think of any facility in that way. It was accepted that if somebody was admitted to Makk and McLeay it was because no other facility would take them due to behavioural issues. Therein lies part of the problem. Staff had this view that the relatives should be grateful that we had them because nobody else wanted them. In fact, I actually hauled a nurse in for saying words similar to that to a relative. Ward 18 at repat is a fantastic residential care facility. But there is a lot of education; there's a different kind of culture there, and it was acute. But once people went there and they were acute, if they couldn't be then sent home because of behavioural problems or to another facility, then they came to us to Oakden. It certainly was not subacute. I would not consider it subacute.

I would also make the point that I agree with what has been said here today in that there is a difference between dementia and mental health in the aged-care population. It's like mixing young adolescents in a penal system with people who are well-versed in their art, for example. The nursing care that's needed in that situation is very different. There was no education given to these nurses. They had no idea. If people had dementia, yes, they lost weight. If they didn't want to eat, yes, they got sick. Of course they got urinary tract infections because they don't get up. The staff need to get people up. They need to engage with people.

They were actually sent there and it became God's waiting room. We didn't have an OT. When I first went there was no OT, there was no psychologist, there was nobody to give any specialised care and allow us to have individual care plans under a reasonable model of care.

Senator FAWCETT: Can I clarify: you started off by saying it shouldn't have been acute. At the end I think you said it definitely wasn't subacute. In terms of future facilities and staffing ratios, should it be treated as something that is more complex than a standard mental health or a standard aged-care home?

Ms Olsson: Yes, it should be.

Senator PATRICK: Just to clarify, Ms Olsson has asked if her submission can be made public. Is that a decision we can make now?

CHAIR: Yes, we can't make it public now because it will require some redaction. People have been asking about it, so I think that's okay so long as we aren't using names.

Ms Olsson: Yes.

CHAIR: When we release it, we'll redact the names.

Senator PATRICK: Just stepping through what you said in your submission—and I'm mindful that the chair will be ruthless on time with me—you were called in to assist. It appeared to me from your submission that you negotiated both freedom and authority, and that was the condition under which you went there.

Ms Olsson: Yes.

Senator PATRICK: It appears as though you gathered further information and did a dietitian's report and other reports.

Ms Olsson: Yes, there's a dietitian's report. Nobody seems to know where it is. I had a specialist dietitian come in. I had full bloods taken of all the residents who had lost 10 per cent or more of weight within the first six months of their admission, and all the results were then discussed with the dietitian, and she did specialist diet meals for those residents. They were to have specialist meals. There was a report from the dietitian to the organisation about that.

Senator PATRICK: Maybe we can ask for it. The South Australian health department, I presume, would have that.

Ms Olsson: Yes.

Senator PATRICK: So the bottom line was that you identified a bunch of problems and you revealed some of those, and then you identified the solutions to those problems.

Ms Olsson: Yes.

Senator PATRICK: Here is my line of questioning, to get to the crux of the question I'd like to ask. It sounds to me as if, having coming up with a set of solutions, you sought to implement them. I think, Mr Baron, you said there was a protection racket. It seemed like someone was standing in your way. You were stymied in some way. Can you just take me through that. Who was doing that?

Ms Olsson: The directorate management team, which was made up of the CEO, the executive director and the head of safety and quality.

Senator PATRICK: Why didn't they want it fixed? Was it a money issue? Was it an expensive solution?

Ms Olsson: That was part of it. I tried to put the CNCs, who are the equivalent of charge nurses, back in the wards, and I said, 'You can't monitor standards from over in another building.' 'Well, we can't go there, because we've got no data points for the computers.' I spent all the time I was there trying to get data points put in, but I was told, 'Well, that's going to cost a lot of money, and we're really not going to be keeping the facility.' What I gleaned from all this was that, when I asked for anything that related to money or to holding the doctors or nursing staff accountable, which would have meant SASMOA or ANF involvement, it was, 'No, no, no; just go through the motions.' Basically, the impression I got was: 'Put a bandaid on it. Let's get the accreditation.'

Senator PATRICK: So, between the three of you, you had an opportunity to turn this around?

Mr Baron: Yes, we could have.

Mrs Baron: We could have, but it stopped the day the delegate said, 'We're answerable to our ministers,' in which she was saying: 'We're not going to shut you down; they stopped the tap of the money and said: "We're all going to be okay. Put the bandaid in place for the agency and move on."'

Senator PATRICK: That was back in 2007-08?

Mrs Baron: In 2008.

Senator PATRICK: You're presuming the same thing was happening beyond that?

Mrs Baron: We have to question that. We're going on the basis of our experience.

Mr Baron: I just note that I said to the person that they nominated to be, I guess, the equivalent of the director of nursing, 'How much aged care do you have?' and she said, 'I don't have it.' I said, 'Well, how come you got the job?' and she said, 'I've got a mortgage to pay.' So that was her criterion for getting the job, and she was there for quite some time. That was the situation. It wasn't overt, but there was all this sort of stuff that was just there: 'Just leave everything alone. It'll die down and it'll go away. Don't rock the boat.'

Senator SMITH: Excuse me, Ms Olsson. You used an acronym, SASMOA. What does that stand for?

Mrs Baron: The South Australian Salaried Medical Officers Association.

Senator DASTYARI: This is something you could take on notice and consider whether there is something you want to add. If there isn't anything to add then don't feel the need to do so. It seems this inquiry has two objectives. One objective is to highlight and expose what has happened. The second is to bring up some ideas and recommendations to make sure that it does not happen again. It is to do with both things. Victims and those involved have a right to have their stories told, but, also, we need to learn from that so that the mistakes aren't made in the future.

I am fascinated by this idea of whether or not you think the changes to the aged care accreditation process alone are enough to ensure the safety and wellbeing of residents, or will we have to look at going beyond simply making recommendations for the accreditation process—whether it is a more of a holistic failure or a specific accreditation failure. I will leave that with you to think about whether there is something you would like to put on the record. Would you take the question on notice? If there is nothing to add to that, then don't feel the need to do so.

Mrs Baron: I will just say one thing. In preparing our submission I looked back at the Senate inquiry of 2005. Many of the recommendations there have not been fulfilled or have been poorly fulfilled. So, when you ask me if we need to go further than making recommendations, yes, you need to see somehow that those recommendations are followed up and somebody needs to evaluate the effectiveness of the action that's taken. So I guess you need an accreditation agency or a quality agency to oversee the accreditation agency!

Ms Olsson: One thing I was able to do in changing culture and bringing in transparency in the intensive care unit at Glenside was to actually open it up. By opening it up one of the things I did was have a relative and a consumer on the quality improvement committee. Maybe the health standards monitoring people need to look at incorporating some consumer people, as well, as part of the review.

CHAIR: Thank you for your submissions and your evidence. We will be in contact with you about the rest of the question on notice that Senator Dastyari was just asking and a time line for when we would like it back.

Mrs Baron: We have documentation and photos of the place. If you want access to those, let us know.

CHAIR: There will be a lot of interest in that. So, yes, if you could start getting it ready for us as part of the question you took on notice. That would be appreciated.

BARKLA, Ms Carol Anne, Chief Executive Officer, Aged Rights Advocacy Service Inc.

[14:39]

CHAIR: Welcome. Can I check that you have been given information on parliamentary privilege and the protection of witnesses and evidence?

Ms Barkla: I have.

CHAIR: We have your submission, which we have numbered as submission 60. I invite you to make an opening statement, after which will ask you some questions.

Ms Barkla: I acknowledge the lands that we meet on today are the lands of the Kuarna people and I acknowledge their deep spiritual connection to the land and pay my respects to elders, both past and present. I wish to also acknowledge all older people and their representatives who are raising awareness and contributing to having the voices of older people being heard, in particular the most vulnerable, who seldom speak out without support. I also wish to acknowledge that there are many good service providers and aged care staff supporting older people. However, we are here today as a community seeking to learn how this has happened. It is critical that the lessons be learnt and that future systems be informed by those lessons and developed in true partnership with older people and their loved ones. I thank you for the opportunity to give evidence today.

ARAS is a state-wide, not-for-profit independent community based organisation that has provided advocacy support for older people across South Australia for more than 27 years. Older people who use community or residential care services, people who live in retirement villages and older people who are experiencing or are at risk of abuse from family and friends can request an ARAS advocate to assist them to address their concerns. ARAS is supported by an experienced, committed board and a full-time-equivalent staff of 14, who provide information and education about aged care and broader human rights, and representation to resolve issues and ensure the voice of the older person is heard.

ARAS's vision is a society in which all older people are recognised as valued, active and contributing participants, and where aged-care services are responsive to the rights and needs of all consumers. ARAS's mission is to increase the person's control over goods and services, quality of life, and to develop a sense of empowerment and of being valued as individuals and citizens of Australia, through an advocacy process. It is important to acknowledge that ARAS does not have any statutory powers, except for the right to visit a resident at their request. Generally, we rely on the goodwill of service providers to facilitate resident representative education and to encourage staff education sessions.

ARAS welcomes the opportunity to provide evidence to the Senate Standing Committee on Community Affairs about the inquiry into the effectiveness of the Aged Care Quality Assessment and Accreditation Framework for protecting residents from abuse and poor practices and ensuring proper clinical and medical care standards are maintained and practised. ARAS has previously provided a submission to the committee. Additionally, ARAS has provided a number of submissions in the last 12 months, including to the Australian Law Reform Commission issues and discussion papers into elder abuse. *ALRC report 131* makes a number of recommendations that ARAS generally supports. ARAS is also a member of the Older Persons Advocacy Network, and supports OPAN's submission. ARAS is also generally supportive of the *Review of national aged care quality regulatory processes* report, completed by Ms Carnell and Professor Ron Paterson, released in October 2017.

ARAS's advocacy model is based on human rights principles. If focuses on supporting the independence of the older person by providing information to support informed decision making and self-advocacy, and representations based on the will and preferences of the older person. This work is conducted by phone and/or face-to-face, depending on the circumstances and the needs of the older person. Community education and aged care staff education is conducted with the aim of raising awareness of the rights of older people. During 2016-17 ARAS provided advocacy support to 1,756 older people, as well as providing 725 older people with information to support older people to exercise their rights, to obtain entitlements or to take steps to address elder abuse. Additionally, ARAS undertook 344 education sessions and attended 66 networking events. Overall, ARAS supported over 12½ thousand South Australians to understand their rights and entitlements, have their rights respected, have their dignity and choice upheld, receive the expected standard of care and support, raise their concerns with a service provider or administering regulatory body and consider options to prevent or overcome abuse by family and friends.

I understand that the focus of this inquiry is on residential aged care. The team of three residential advocates provided advocacy support to aged-care residents and their representatives in a total of 474 cases during the last financial year. The residential team provided education to over 1,900 residents and representatives throughout 85 aged-care facilities across the state. Additionally, ARAS received a substantial number of requests from providers in respect of staff education on elder abuse prevention in residential aged care. In total, 66 staff sessions to approximately 1,300 staff were undertaken.

The sanctioning of Makk and McLeay and the subsequent Oakden report, authored by Chief Psychiatrist Dr Aaron Groves, caused a number of inquiries and commissions but also led to the community outcry about the terrible abuse and poor clinical care that the residents experienced. As noted by the Hon. Ken Wyatt AM, MP, the community expects the Commonwealth regulation of aged care to be able to assure it that people in residential aged care facilities are safe and well cared for and have a good quality of life. As advised in our submission, ARAS attended the sanctions meeting held at Makk and McLeay at the invitation of the older persons mental health services executive. In attendance were the Commonwealth Department of Health, the aged-care complaints commission, the Australian Aged Care Quality Agency, ARAS, the executive of the older persons mental health unit and executives from the Northern Adelaide Local Health Network. A special telephone number was set up for residents' representatives as well as former representatives to raise their concerns. A consumer advocate from the older persons mental health service was also present. A clinical nurse adviser was also present. Our flyers were made available and also left at the service. It was clear from our observations that SA Health were pulling out all stops to address issues. After such a shocking report, ARAS also reflected internally to see if there were any cases that we had had in the last five years from Makk and McLeay, noting that people can also seek anonymous information from us. We were unable to identify any such cases. The last education request was in 2011. We were also not approached by any residents or representatives to raise issues on their behalf. After the sanctions meeting, we were also invited to attend family representative meetings, which we did when we were able to do so. ARAS also offered to provide education sessions on residents' rights to staff, and we conducted seven sessions post the sanctions.

Noting that Makk and McLeay also were subsequently removed from the aged-care accreditation sanctions process to facilitate getting the facility back to accreditation status, ARAS essentially didn't have a remit to be involved, as our scope is based on Commonwealth funded aged-care facilities. However, we were prepared to support older people or their representatives if they approached us. ARAS has also participated in the South Australian Health Oakden Response Plan Oversight Committee in an advisory capacity. We understood that the principal community visitor, Mental Health, was continuing to provide support as well. Subsequently, ARAS has also been called upon to attend further sanction meetings at other residential aged-care facilities in South Australia that have failed to meet accreditation standards.

Such a sentinel event as Oakden provides an awful opportunity to reflect on the regulatory system supporting aged care. When considering and writing my opening statement, I felt like I was commencing to write a thesis so I decided to break down many of the recommendations into three broad themes designed to support change. These are specific comments about the regulation of aged care generally.

First off, I would suggest leadership at a government level and the need for reform to continue to support older people to participate in all decisions that affect them and to live a life free from abuse by staff, other residents, family and friends. The proposed establishment of an independent aged care quality and safety commission incorporating a care quality commissioner, a complaints commissioner and, importantly, a consumer commissioner and a chief clinical adviser as set out in the Carnell-Paterson report is welcome. Also the proposed implementation of a rating system and meaningful data is welcome, including participation in clinical indicators.

ARAS has concerns about the current compulsory reporting scheme and is generally supportive of a serious incident scheme, as proposed by the Australian Law Reform Commission. However, we would like to ensure that the older person is able to be supported during this process under a vulnerable witnesses scheme and also made aware that they can seek support from an advocate. Outcomes and barriers should be transparent and used to inform change.

I note the rise of organisational advocates and am supportive generally of any role that supports consumers to be able to exercise their rights. However, I am concerned that older people need to be made aware that they can access an independent advocacy service and that they are free and accessible. Leadership from both state and federal governments is needed to ensure that there is transparent information sharing, and a no-wrong-door approach needs to be developed between agencies at both the state and federal level. Leadership at a governance level of organisations, in particular clinical governance, is required. My observations are that financial governance is generally reasonably undertaken. However, clinical governance requires more attention.

The second theme is culture. A rights based culture is central to older people having quality of life and not just quality of care. The understanding of fundamental principles such as the right to make decisions and informed consent needs to be reinforced. ARAS is supportive of the need for greater understanding of the charter of rights, which really reflects the expectations of the community in how any human being should be able to live their life.

ARAS is also supportive of the recommendation by Ms Carnell and Professor Paterson that all approved providers must ensure all staff undertake regular OPAN education on consumer rights. Consideration will need to be made to ensure that OPAN has adequate resources to ensure this happens.

ARAS is also supportive of a deeper dive into the culture of an organisation. As identified in the Oakden report by Dr Aaron Groves, it took about 17 days for the true culture of the Oakden to emerge. ARAS is supportive of unannounced visits but is concerned that the notice requirement currently may mean, if it is removed, that families' views may not be able to be reflected during a visit. In order to address that issue, ARAS would support that there be independent staff surveys, also resident and family surveys. These surveys should be undertaken regularly but also on exit of the service. Additionally, ARAS supports the right of an older person or their representative to consider the ethical use of cameras.

My third theme is about communication. On a systemic level, the need for open disclosure and increased powers of the Aged Care Complaints Commissioner are supported. However, it is also essential that older people are made aware that they can be supported by an advocate when raising a complaint with both the service provider and the complaints commissioner.

Independent sources of communication is fundamentally critical for a lot of older people because they don't necessarily trust government. This is particularly the case with special needs groups. ARAS supports a significant number of CALD clients. In particular, we have a specialist Aboriginal advocacy program. The feedback from special needs groups is they feel fearful of coming forward to government entities. So there needs to be an independent service that is available to support them to speak up.

In conclusion, I would urge the senators to consider the recommendations by the Australian Law Reform Commission and the Carnell and Paterson report, and involve older people and their advocates in the changes. Just because you are old does not mean you don't have rights. Just because you are frail or have a mental illness, or a cognitive impairment, doesn't mean you don't have rights. It does mean, however, that at times it is difficult to exercise your rights. It is the responsibility of a civil society to ensure that older people who are at their most vulnerable can be supported to exercise their rights and also live a life free from abuse and exploitation. Thank you.

Senator PATRICK: You're clearly funded by some donations. Do you receive any state or federal funding?

Ms Barkla: We do receive both state and federal funding.

Senator PATRICK: What magnitude in terms of your overall income?

Ms Barkla: The majority of our funding would come from the federal government and is funded for us to provide advocacy support in terms of home support and people living in residential aged care.

Senator PATRICK: You said that you had a team of three looking after—

Ms Barkla: For residential care.

Senator PATRICK: 474 cases. What's your interaction with the Community Visitors Scheme?

Ms Barkla: We provide education to the Community Visitors Scheme in terms of the Community Visitors Scheme mental health or the Community Visitors Scheme aged care.

Senator PATRICK: The authority—the statutory body.

Ms Barkla: Okay. That's the Community Visitors Scheme mental health. Since Oakden, I've certainly met with Maurice Corcoran. We have discussed having an MOU in place. We have talked about referrals.

Senator PATRICK: I'm just wondering: in any of the cases that you've dealt with—because they basically said that they had identified a number of area of concerns and had gone to various authorities, and had difficulty getting responses. Is that your experience?

Ms Barkla: It's very difficult. Are we talking about Oakden in the last five years?

Senator PATRICK: You actually said you hadn't had much to do with Oakden. So, just in general, when you're dealing with people who have an issue in an aged-care facility, do you have difficulties getting access and responses from government?

Ms Barkla: The way ARAS works is we take direction from the older persons. So, essentially, the first way we would assist the older person is to understand their rights and give them a range of options. They then choose to decide where they want to take those options. They may want to self-advocate to a service provider. They may wish to make a direct complaint to the Aged Care Complaints Commissioner. We can support them by representation, as well. If your question is around if we have issues in raising issues with service providers on behalf of the 437 cases that we've done, generally not. If we did, we would then take them to the Aged Care Complaints Commissioner. So we have a clear way of working. Oakden itself is quite different in terms that it is not a usual place for ARAS to spend a lot of time in. The overlap is, quite clearly, being a mental health service in an aged-care facility.

Senator FAWCETT: I understand from your submission that you were quite involved in Oakden 10 years or so ago, after that first large focus on their accreditation, but, in the intervening period, until the 2017 inquiry, it sounds as though it has been quite a gap. I understand that you can only be involved when either residents or their family have requested that, but my question is: for your kind of service, once you finished that intense involvement in 2008, did you follow up with the families at all or did you have some avenue of making sure that current residents and their families knew of the existence of your service? How would someone with a concern about Oakden know that you exist or how to reach out to you?

Ms Barkla: In terms of 2008, I would have to take that as a question on notice and go back and look at the case files. We are not a case management service. We are there to support the older person, or their family, to speak up. If their family want further support, they can come back to us many times and get that. We premise our work on advocacy. In terms of the actual casework, I would have to go and find it out of the systems.

Senator FAWCETT: I'm not looking so much at the casework as at the broader principle. People can only access you if they know that you exist. I'm interested to understand, once you were involved with that resolution, is it part of your remit to make sure that the implementation of the reforms has been effective? Do you proactively stay in touch with families to check that's the case?

Ms Barkla: No. We don't have the ability to proactively stay in touch with all of the casework that we would have done over the 20 or 30 years that we've been in operation. The fundamental principles for us are around empowering people to speak up and giving them information. They are more than welcome to come back to us many times and ask for further support as required. We base that on human rights principles of independence. In terms of systemic advocacy, my understanding is that we provide brochures and supply any organisation if they request further information. My understanding is that there should be a clear complaints process in the residential care agreements that should identify advocacy. That should really be available to anyone who has signed a residential care agreement. They should be aware of those avenues.

CHAIR: What if they've got a cognitive impairment?

Ms Barkla: Once again, if someone's got a cognitive impairment I would understand that someone else would have had to have signed that agreement on their behalf.

CHAIR: And they would then get the material?

Ms Barkla: Yes. I would be expecting to see that information. It's in the charter of residents' rights that people are entitled to access advocacy services. I would be looking at the accreditation reports to see what material was made available to residents.

Senator FAWCETT: Do you send brochures to aged-care facilities, including Oakden, each year to make sure they're available for residents?

Ms Barkla: We do send brochures, at the request of the organisation.

Senator FAWCETT: Only at the request of the organisation?

Ms Barkla: Generally, because we have to print multiple bits of information. There is also information on our website.

Senator FAWCETT: Do you have an annual or biannual schedule where you visit an organisation to reacquaint yourself with the staff and make sure they are still handing out your brochures?

Ms Barkla: As part of a reflection of this process, this year, as part of our KPIs, we will be virtually visiting every organisation in the state, in terms of residential aged care. In terms of resourcing, I think there are about 270 facilities alone in South Australia. We try and turn over about 85 or 90 every year, because we do the casework and we also do the education within that team of—it's actually 2.8.

Senator PATRICK: Just following on from that, I wonder if, as a point of help, you might consider making sure that parliamentarians' offices know, because we often get people calling up saying, 'I need some help.'

Ms Barkla: Yes. We are certainly more than willing to do that. We are reasonably well-known in the aged-care industry. I suppose mental health is a different and new area for us, and we certainly reflect on that, like anyone: how do we better provide services across all of the facilities as well in a team of 2.8?

Senator POLLEY: Because you are funded by the Commonwealth government and the state government, how can you give an independent assessment of issues that are happening within the sector?

Ms Barkla: I'm not sure what you mean.

Senator POLLEY: You're not really independent. If you're funded by the Commonwealth government and the state government, a fair assessment by most people would be that you're not really independent of government and, therefore, biased in making any assessment because your funding might be in danger if you're too critical.

Ms Barkla: I understand your question. We are currently funded from this financial year through OPAN. The funding goes to OPAN and ARAS is a member of OPAN. As part of our contract, if I'm correct and I would like to check that, we are allowed to speak out on advocacy issues.

Senator POLLEY: Your submission touches on peer-to-peer violence and that there's no record kept. Could you elaborate on that for the benefit of the committee.

Ms Barkla: We do have some concerns around the number of reports that are made. We do have some concerns about exception to reporting based on resident-to-resident aggression. The reason we have concerns around that exception is because there is no record of the outcomes, no national register, no record of what is occurring. So we don't know what has occurred within that facility.

Senator POLLEY: That really is the reason that we are here today: to talk about what happened there but also to find a way forward so that it's not repeated anywhere else. Would you be supportive of a register for carers and those people working in the aged-care sector so that staff don't move from one facility to another?

Ms Barkla: Absolutely.

Senator POLLEY: What recommendations would you have in terms of accreditation? Do you have concerns about the surveyors who go from home to home making assessments about whether or not the homes meet the accreditation standard? Do you have anything to add in relation to the evidence that has already been provided about their independence and whether there is too much familiarity with the homes they're assessing and whether there should be a team of assessors that go into other jurisdictions—for instance, South Australians doing the assessments in Tasmania and Queensland doing it in Western Australia et cetera? Do you have any comments?

Ms Barkla: Only that I think diversity through experience is a good way to manage teams that only work in one particular area.

Senator POLLEY: For somebody who is an advocate for older people, what's your reaction to the fact that the lack of care and support at Oakden was able to continue on for more than a decade? The problem is that the people in Oakden at that time had no voice because of mental health issues or deterioration through dementia. It made it very hard for them to verbalise the treatment that they were experiencing.

Ms Barkla: Absolutely. It's devastating and it gives us great concern. We would suggest that as changes occur in aged care and there's a higher level of acuity in residential aged care we need to make sure there is access to advocacy services and support.

Senator POLLEY: We want to ensure the safety and respect for older residents but I'm concerned that you would be seeking some consideration of having cameras utilised as part of protection. That's, very much, an invasion of privacy. Whether you have a camera there or not, abuse or mistreatment or neglect can happen outside of wherever a camera might be. Isn't that, really, an invasion of the individual's rights?

Ms Barkla: We thought long and hard, and I'm more than happy to provide a copy of our ethical position on cameras. Our position isn't that cameras are a blanket, one size fits all. The issue with cameras is that there is the ability for someone to ask for a camera if they feel unsafe or concerned for their safety. The way I couched this is I asked my mum, who's 85. I said, 'Mum, if you were living in an aged-care facility, would you like to have a camera in your room?' She said, 'Absolutely not.' She's very fit. She's independent. My next question to her was, 'Mum, if I were worried about your treatment and you had dementia and I was concerned that you were being abused, would you like a camera?' Her response was, 'Absolutely.' So it depends on the question you ask people and it depends on the vulnerability you may well be experiencing.

From our perspective, we developed our position statement because there was a lot of discussion around blanket cameras. Of course, as a rights based organisation we need to respect people's privacy but we also need to weigh up their safety. I take the situation where we supported Clarence and Noleen Hausler to raise issues about cameras. If there wasn't that footage, I'm not convinced that there would have been a conviction.

Senator POLLEY: A lot of older vulnerable Australians already feel that they lose their dignity through the circumstances, being bedridden or whatever the circumstances are. Would we be better to focus our attention on training and additional staff? If you want to use an example, we have cameras in department stores and shops everywhere but it hasn't stopped shoplifting, because people always find a way around it. Whether you have a camera in somebody's room or not—in the bathroom?—I don't think that's the answer. I would have thought training and public awareness might have been a better option. And when you're talking about people's rights, how does somebody who has dementia ensure that their rights are being heard if they don't have family members coming regularly to visit them, because they no longer have the capacity to verbalise what's happening to them?

Ms Barkla: I understand your point. Cameras in isolation are not the answer. When we released our media release, we were very clear that we expected mandatory education of staff as well. The focus should be on understanding people's rights and understanding the nuances around identifying that elder abuse may be occurring, and how it occurs. I get concerned that we will pick certain bits out of recommendations when we actually need a holistic suite of recommendations. That's why ARAS is very supportive of the Australian Law Reform Commission. They looked at the whole suite of issues, in terms of elder abuse, not just aged care. Other issues that need to be addressed are ageism, age discrimination and a whole range of issues like service-delivery, support and education. We can change the law but we also need to put behind it the support services to make that happen.

Senator POLLEY: How much contact did you or your organisation have with Oakden over that period from 2007 through to March this year?

Ms Barkla: I would have to double-check the figures. I went back five years, thinking of looking at the remit. We try and go to organisations about every three, four or five years with education sessions. Can I take that on notice?

Senator POLLEY: That'd be great. It would be good to have that information around the training your organisation provided.

CHAIR: Thank you for your answers today. We'll be in contact about time lines for the questions you took on notice.

Proceedings suspended from 15:15 to 15:30

BLAKELEY, Ms Christine, Private capacity

COLE, Mrs Patrina, Private capacity

COSTA, Ms Maria, Private capacity

GLOWIK, Mrs Natasha, Private capacity

JOHNSTON, Mr Stewart, Private capacity

KRECU, Mrs Alma, Private capacity

MARTIN, Mr Mark, Private capacity

SPRIGGS, Mr Clive, Private capacity

SPRIGGS, Mrs Barbara, Private capacity

STOJANOVIC, Ms Deanna, Private capacity

CHAIR: Welcome. After your statements we'll ask you questions and get into a little bit of discussion. Rather than speaking in solid blocks I think it's probably better if we have some interaction and are able to ask you questions.

I also want to talk about your submissions. Some people have asked for their submissions to be confidential and have been marked confidential, respecting that. Because we have to go through a process, we have accepted them as confidential submissions. If you name family members, for example, or other people we have to go through an adverse comment process, and we generally redact those names. We also redact family names. What we have been getting a lot of recently is people coming back to us—in some instances, literally five or six years down the road—saying, 'We're really sorry we made that submission public; can you take it off the website?' and we can't. As you all know, once it's on the web it stays on the web. Even with the best will in the world we can't erase it. We also like to give people plenty of time to think about that. I've heard people say they want to make their submissions public. I've got an alternative for you: if you decide you really want it public, send us something else with your family names withdrawn and we can handle it very effectively and it can go up on the website. That's the same for the next group—those of you that are here. If that's okay and you do want it to go public, send us another version with the names withdrawn.

I need to check with you all that you've been given information on parliamentary privilege and the protection of witnesses and evidence. Thank you. This committee, by its very nature, takes evidence that's quite sensitive and emotional, so we understand if you want to take a break or if you need to stop for a while, and we'll come back. We're in your hands in that respect. Once you've all given your evidence—your five-minute statement—we'll get into some questions and answers. Mr Johnston, I think you're first.

Mr Johnston: My official capacity, I guess, is the son of a former Oakden resident, Helen Johnston, who is now deceased. I have an opening statement and I thank you for allowing me to read it. Can I first take this opportunity to thank you all for the opportunity to speak with you directly and have our evidence and our family's stories heard and treated seriously and with the consideration they all deserve. This has been a horrendous period in my life, as it was and is for us all. It would be an understatement to suggest it wasn't any better, as one could possibly expect closure, than for me in 2008, the time period of mum's actual abuse. As you know from my submission, it had a detrimental effect on mum's mental health and that of myself and the rest of the family. An overwhelming distrust of any hospital or medical facility engulfed us and seriously affected the medical care needed for mum in the future.

The past seven months since the Oakden report dropped in April have certainly been a roller-coaster ride for me, personally, to find out some nine years later that my beautiful mum wasn't the only one horrifically mistreated and abused. It was unexplainably difficult to accept. My grief came flooding back, with an overwhelming sense of almost self-hatred that I allowed myself to be fobbed off as I was back then. If only I had fought back, all these poor families and their loved ones who suffered after 2008—to suddenly realise too you had been deceived and lied cut very deep to me.

Working full-time, a single dad of two and principal carer, essentially, of two critically unwell aged parents at the time, I was easily and naively allowed to be fobbed off and dismissed. I had no reason to object and disbelieve the constant referral to mum's abuse as being a one-off by Oakden staff. Nothing will make up for what mum and others went through, but our expectation is accountability, and the evidence, with exposed time lines and reported failings have been uncovered thus far throughout many inquiries, shows without doubt that there were identifiable and culpable people who either in the past or still currently do via the position they held or hold either actively sought to cover up, encourage or, at the very least, fail to execute their duties. This facilitated and allowed a systematic abuse of procedure and through inaction and maladministration actively and successfully created and continued to develop a culture of bullying, intimidation and corruption with outright, blatant criminality. This also allowed blame shifting and zero accountability to become the norm at all levels of SA Health and other industry overseers. These individual people, including ministers of government, CEOs and senior bureaucracy within departments, whether in a past appointment or tenure or a current one, were and are responsible through the position they held, and it is already unequivocally clear where and with whom the chain of command started and finished.

Oakden has been the tip of an iceberg. The level of media scrutiny, which we are all very grateful for, has allowed aged-care abuse to finally be exposed as a national issue. I have been approached by and responded to over 65 individual families, either via social media or general media, who have come forward since the Oakden report in April. As we well know, even after April—and even at Oakden after April—there was further abuse. The majority of the Australian public has their eyes open now. There was always a guarded apprehension about nursing homes—generally nice places on the outside but concern existed when no-one was looking. Now that fear has been confirmed. The aged-care sector, unfortunately, essentially is made up of nine for-profit conglomerates that report to the stock exchange and shareholders, and their level of care and expenditure is in reality, but should not be, consciously decided on a budget aimed at maximising profit and margin to shareholders. Suitable funding but also, importantly, correct disbursement of that funding into staffing levels and care models is paramount. There is now public expectation of open, transparent accountability.

As with the child abuse royal commission and the abhorrent events of the fifties, sixties, seventies and eighties, the level and frequency of abuse in aged care has shocked this nation. Glaringly, the following points are of extreme importance if we are ever to change: (1) an absolute shake up, from the ground up, of the accreditation system; (2) federal and state responsibility buck passing and blame shifting is counterproductive and must stop; and (3) training requirements, and the fact that the aged-care industry is described as a future growth industry, at its entry level are of paramount concern. Cert. III personal-care-attendant course applicants are accepted with minimal or zero basic levels of education or life skills. After completing a basic police clearance three to four weeks classroom training and then a three-week placement in a facility, the job they are given, for 98 per cent, pays $21.60 an hour, on average. A Coles cash register operator rate is $26.30. Further, in many cases they almost immediately begin working on the front line in dementia wards, directly responsible for the care of the most challenging and vulnerable. There is more scrutiny in selection considerations and personality profiling done in the recruitment process of a major supermarket or fast-food restaurant than there is in aged care.

Overwhelmingly, the consistent theme for all people who have come forward to me in the conversations I've had is the confusion experienced about where to lodge a complaint, how to lodge a complaint and whether it's safe to lodge a complaint. And after lodging a complaint via the many channels, there are no clear avenues of independence and responsibility to follow up communication.

My belief from day from is serious consideration of something similar to the 1800RESPECT line or Crime Stoppers reporting line, with primary capture by an independent audit firm, who would take the calls from a family member of a loved one or whistleblower workers. Similar to Crime Stoppers, it could be independently investigated at arm's length from every current watchdog, player, provider and vested interest. This can be the only way we can truly, as concerned family and members of the public, be assured that a complaint, firstly, is safe to make and, secondly, will be listened to without prejudice and independently investigated, and that will ensure that this doesn't get repeated.

We've seen firsthand the blatant ignorance from those in charge of monitoring the sector, feigned bewilderment and sorrow and, yes, at times, from some a genuine surprise that something like Oakden was occurring and had occurred blatantly, in hindsight, with all these so-called checks and balances and levels of competency. No longer will it be or should it even have been an acceptable defence of senior ministers and bureaucracy that they were never told, and no longer must it be acceptable that we'll always have a percentage of our elderly being abused, and we must just accept that.

These people aren't just a waste figure on a budget line or an achievable or measurable KPI on a business trading report. One person assaulted in a nursing home is one too many. Zero tolerance is the favoured buzzword of those in charge after the event or once in receipt of yet another report or after another inquiry. The only way to truly implement zero tolerance after an event is by having in place a completely overhauled framework, complete with a zero-excuses focus, 100 per cent accountability and independence and probable delivery outcomes. The harsh reality of business is that, when there are vast sums of money to be made, maladministration, vested interests and blatant corruption are always bubbling under the surface.

Inquiries and investigations ordered politically as a result of adverse events being exposed are legendary. So are the resulting actions in administering and implementing findings. Why? Generally those at the top commission the very same negligent framework of people and personalities to implement the findings, or be seen to, with a large implementation window of years.

As I said, I was contacted by up to 45 to 60 other individuals around Australia to tell their loved ones' stories. In attempting to tell their story and to champion change since Oakden, I've been met with unsolicited private calls on my mobile suggesting that I shut up, that it is in my best interests to shut up or that people have friends in high places and I need to be careful. This has not deterred me. I was told by a senior state government adviser that, with my decision to inform the public during one particular radio interview here in Adelaide of reports of in-house carers being found to have questions to answer regarding abuse, I had made every elderly person scared to be in the home. When I pushed her for evidence of an elderly uprising during my interview, she conceded that in fact the state government had been contacted during my interview by many numerous private providers, telling them to basically shut me up, and, 'Who the hell is he?'

Let it be known to those who need to be educated: this time it's different. Millions of eyes are watching this saga. Millions of pairs of legs will walk away from any political party wishing to play old-school politics 101 with this result. And millions of collected voices will be heard.

I'd like to finish with a quote which I believe sums up perfectly the underlying issues and highlights an almost-too-perfect-to-be-true example of a *Yes Minister* type spin and an insight into how each lobby group or level of bureaucracy is full of vested interests and, at the very least, could be described as so far removed from the general public expectation and point of view. In a very thorough article written by Michael Bachelard and published by Fairfax Media in the publication *The Examiner* on 22 September 2015, and in relation to the article highlighting an abhorrent mistreatment and abuse and also at Oakden, Cameron O'Reilly, the Chief Executive of the Aged Care Guild, which represents the nine biggest for-profit providers, says:

> … a few hundred thousand people being cared for … sometimes there will be incidents of quality failures that are regrettable …
>
> … I don't believe that, relative to the past, there's been any deterioration in quality, but there is more opportunity now with residents and consumers to expose where there have been failings.

My translation of what he actually says is: 'We know the abuse has always been happening. There's no real increase. All that's changed is that people are now aware and are reporting it, so we can't keep it quiet anymore.'

We will happily remain the Oakden families, if for one reason only, and that is to allow the state and country to never forget that their old way of treating our elderly is over. We will forever hold them to account and see a complete overhaul of the care received and expected. I thank you for your time.

CHAIR: Thank you.

Mrs Cole: I'm the daughter of Pietro De Cicco. He died in McLeay house on 14 November 2014, so it's been three years this month. There are a lot of unanswered questions that I have surrounding the day of his death. I have raised those concerns through a police statement that I made and have also written to the coroner directly. Neither party has contacted me about those. I also raised concerns when we went there when he had just passed away through what had happened. I had no significant answer given to me. Unfortunately, receiving that phone call in the morning did not give me all the information about what had happened to him, and then a few hours later he had passed away.

In general, the care regarding his malnutrition, his rapid weight loss, neglect—my mum and we as a family had constantly been talking to the doctors there, who rotated every few months. Each time a new doctor would come on, they would not be familiar with his file, so we—me mainly—would have to get that doctor up to speed with his condition et cetera. He'd suffered a stroke quite some time before he ended up at Oakden, and through that he was a complete mute, so communication with him was to look at him. If you asked if he wanted a drink or something, he would nod his head or shake his head, and that was all. There was no speech. So, where things went on, there was no way for him to communicate to us if there were issues going on there in regard to his care. There were a whole range of issues with food, his clothes going missing, teeth being broken—he'd received a cut lip from one of the other patients—and other patients picking on him, which again comes into question on the day of his death: what actually really did happen?

I strongly believe that, if there had been CCTV in the common areas, I wouldn't be sitting here today, three years on, still wondering what happened to him. I'm quite surprised I haven't heard back from the coroner—I'm sure he's quite a busy person—or regarding my police statement about all the concerns that I had raised in regard to the overall care there but also his death.

In regard to the level of care, I think all of us as families have suffered similar paths of guilt. There was nowhere else for him to go. He was shuffled between different institutions because of the overmedication, which would then make his aggressiveness worse, so then that institution would say, 'I'm sorry; we can't have him here anymore.' He would then go back to the RAH and stay there for quite a number of weeks to be reviewed again, but he wasn't put in a mental health section at the RAH; he was just put in a normal ward where others had just had an operation. They could sit and feed themselves, toilet et cetera, and he was strapped to a bed, in one instance for seven weeks. So I would go in every morning and try and feed him breakfast, and my mum would go in every lunchtime.

It got to a point where, when he got to Oakden, he was in quite a normal weight range for his condition, and he was there for almost a year and lost, roughly, nearly 20 kilos. Unfortunately, there was no care in regard to trying to help keep him at a substantial weight so that it could help him. He would still be alive today, I believe, if it wasn't for him being at Oakden. His heart was fine. He just couldn't talk to you. Yes, he had mental health issues, but still I believe that he would still be here today.

Unfortunately, I'm disheartened to feel that we're in a community and a nation where, for aged mental health but also just mental health in general—there's an early onset of dementia and Alzheimer's—we are not providing that level of care, and there's a culture of staff that aren't trained. There are staff that were sent to Oakden because they were bad eggs at other institutions. There was an incident that occurred in front of my mother between a doctor and a staff member. You have to raise these issues in your brain to think, 'Well, how could a place like that, which is supposed to be the central hub for mental health, be run in that way, where our taxpayer money is paying for this facility to operate, and yet the staff are not trained in mental health?' The level of care was not there, and then my dad withered away to nothing. I don't want to see that happen to other families.

By the time we went through all the rigmarole of him going to the RAH initially and being assessed for care, even that was just a whole hurdle of jumps and forms et cetera that my poor mum had to go through just to get him in some sort of care. There was no private facility that would take dementia in his condition. He wasn't bad at the beginning. By the time of his stay at Oakden, unfortunately, it became a lot worse.

My concern is: in this state, why don't we have facilities for this kind of condition? They're not 'all just old people', and they're not there just to die as such. That's where, as a culture, everyone just seems to think: 'Oh, they've got mental health issues, so dose them up, overmedicate them'—which they did for my father—'and just leave them to be. Strap them in a chair for the daylight hours and then just put them to bed at night.'

CHAIR: Thank you. For everybody, I know it takes a great deal to sit here and tell us your personal experiences, but it helps us learn what's been going on. Thank you.

Ms Blakeley: I'm the daughter of Mr Phillip Blakeley, who was there in 2010. He went there in February, and he died in June, but within that small amount of time he lost weight. He would sit in a chair, and his eyes would just be rolled back. We couldn't communicate with him at all. But, when he went into Clements, we could talk to him. He knew us all. He suffered dementia, and he got pretty aggravated at times. All they did was sit him in a chair. It's horrible. It is horrible. He would cry. He had black eyes. He had bruised arms with fingermarks. He had bruised legs. He had butterfly bandaids. And, when we kept asking what was going on, they said: 'Well, this is how it is. He's intruding on other people's space.' I mean, seriously? Where were the carers then? It shouldn't have happened to him.

Then one day I took him out to an area outside where you could watch TV. It had a lounge. I got him out of his wheelchair because he couldn't walk, and he walked in there. He fell asleep, and I just gave him a little, 'Dad,' and he jumped, covered his face and said, 'No, please don't.' Now, what happened there? I brought that to their attention, and she said, 'Oh, he was having a dream.' I don't think so. I really don't.

And then, in late May, I rang Oakden to say we were coming out and, 'How was Dad?' and she said, 'Oh, we've been trying to ring you'—not true. She said: 'We've just put your father in an ambulance. He stopped breathing.' So they took him to the Lyell McEwin Hospital. We got there probably about an hour later, because I lived up at Sturt, near the Marion shopping centre. What had actually happened to him was that he had Weet-Bix all stuck down his throat, so they weren't giving him a chance to swallow his food, and that was the end of Dad. He just deteriorated more and more, and he passed away on 1 June 2010.

I wrote a letter of my concerns on 19 June 2010 to Christine Egan, from the commission. We went and had a meeting with them in 2011 and gave her our concerns. There was a panel of people. I walked out of there not knowing any more than I did when I walked in. It was, 'Oh yes, we're going to change this,' and, 'The girl that you're talking about is no longer working with us,' and, 'They're going to be able to go into the rooms now'—because before you had to push a button and wait and wait, then someone would come out, or, on the intercom, you'd say who you wanted to see, and then you'd still wait while they went and got him and brought him out. We couldn't go in there, and I want to know: why couldn't we do that?

Then one day I finished work about a quarter past six, and I went out to see Dad. All the girls were sitting there. There was a little outdoor area as you walked in, and all the girls working—well, maybe not all of them, but some of them—were out smoking. I did the code, got into the first area, looked through the glass—they were all in wheelchairs, sitting in front of their doors. I pushed the button and pushed the button. It took 20 minutes. I had to go outside and call out to one of the girls that were sitting outside to see if they could get my father for me. So why were they sitting in front of their doors—and they were out smoking? I could go on and on. Seriously, I could go on and on. It's absolutely disgusting.

My father was a good person. He paid his tax, he worked hard, and this is how he got treated at the end of it. It's very upsetting. My mother has suffered depression ever since, even more so now. She's on medication. She just can't deal with it anymore. It's very sad that there are people in this room that have been through the same thing. Those girls, those carers—how would they have felt if that was their mother or their father in that nursing home receiving that treatment? It's just not on.

I think and I hope that this makes sure that people, the elderly, are respected and looked after. I hope this never ever happens again, because it could happen to all of us—we could all get dementia. We don't know that. We would like to be treated well, wouldn't we? Thank you.

CHAIR: Do you want me to me to come back?

Mrs Krecu: I'll be fine. Sorry.

CHAIR: No—please, no-one feel that you have to apologise.

Mrs Krecu: My father, Ermanno Serpo, was a resident at Oakden from 2013 to 2016. He was there just short of three years. In December 2012 we went on a family cruise for Christmas, and dad deteriorated very quickly. He was fine. He was 79 at the time. There were some behavioural issues, but we unfortunately put it down to, 'He's getting old.' It was just a joke between the family. In April 2013 my dad deteriorated very quickly, to the point where we had a person not requiring any care whatsoever to requiring 24-hour care.

My dad unfortunately had to go through the system of being admitted to the Modbury Hospital. He was diagnosed at the Modbury Hospital with Lewy body dementia. With that, dad was very aggressive. After two weeks he was in the GEM unit there and we were told that they could not handle him anymore. We sat down in a room and they told us exactly what was going to happen to Dad: 'Basically, your dad will deteriorate. He will aspirate and he will die.' That's what we were told in this meeting with the doctor at the Modbury Hospital. From there, we were then transferred to the Lyell McEwin Hospital, 1H, and for eight weeks, where my dad was restrained day and night for eight weeks in a princess chair with a pelvic restraint. He was no longer eating, he was no longer talking and he was medicated—to the point where we could then transfer him.

We were then told that there was no way that we could take dad home and that he needed to go to Oakden, because that was the best place for his care. So, as we had done on the occasion prior—my mother and I—we would go and look at the facility. So we walked into Oakden before my dad was transferred there, and to say 'distressed' doesn't even describe it, but I suppose at the time we were just so overwhelmed with what was going on in four short months; we had no idea. We were just thrown through the system and we just went through. Unfortunately, we accepted that that's where Dad had to go for the level of care that he required. For me, it wasn't obviously ecstatically pleasing, but I thought, 'As long as the care is okay, it's just bricks and mortar—it doesn't matter.' My dad then transferred to Oakden in July of 2013. The minute we arrived there it was one little incident after the other—just little things in terms of dad wearing someone else's clothes, other people wearing my dad's clothes. My dad was no longer talking, so it wasn't that my dad felt anything. But as a family going in, seeing your loved one wearing someone else's clothes, or vice versa: it's disturbing.

He was no longer eating, because the quality of food was just disgraceful; in fact, we challenged the clinicians at the time to sit in front of us and eat the food. We asked them if they felt that frozen nuggets and frozen vegetables was acceptable and provided the nutrition, and we challenged them to eat it in front of us—which they blatantly refused, quite obviously. In that short period of time, my dad lost 20 kilos. He was not eating the food, and so my mum would come day and night. My mum—that became her second home. She was there 18 out of the 24 hours a day. Mum would travel up and down—we lived around the corner, fortunately for us, but my mum was travelling up and down. In fact, a friend of mine described my mum's life as a living widow, because that was what it was basically like. Dad, the way we knew him, had gone, but he was, obviously, still alive. So she was just back and forth, but there was no communication with my dad.

On 17 December 2013, my father was assaulted there by an agency carer. My mum went out to warm up dad's food, because there was no microwave facilities—food would only come out three times a day: you had your breakfast, lunch and dinner; drinks weren't available readily for anybody, you could only have drinks at that certain time. Like, if a resident was thirsty, there was just nothing available, It was always locked away. It was dinnertime but, because my dad wasn't eating the food, my mum went down to the main foyer to warm up my dad's food. And when she was coming back in—my dad was a resident of Makk—she could hear screaming, and she didn't know what was going on. As she walked in, there was a registered nurse that was employed by Oakden, standing at his medication trolley getting ready to distribute the medication to the patients, and my mum could still hear this screaming. So she just actually stood behind the registered nurse to see what was going on, and what she saw was a carer screaming at my father.

My dad was holding a paper plate of sandwiches, we're just talking a little plate of sandwiches, and the carer was pointing his finger at my dad and saying to my dad: 'I've told you many times that you're not to touch other residents' food.' Now my dad hadn't spoken for 6 months at this time, and he turned around to the carer and he said to the carer: 'Oh, I'm sorry.' My mum was—well, she felt some hope there, because dad actually spoke for the first time. So my dad put the paper plate down on the trolley, but this carer continued to scream at my dad. Now both the carer and the registered nurse were unaware that my mum was there. With that, my dad must have felt threatened in some way—because the carer was right up in my dad's face, pointing his finger at my dad—so my dad showed his fist to the carer. He didn't touch him, but, with that, the carer then proceeded to drag my father by the scruff of his collar, drag him along the dining room and, as my dad was starting to lose balance, my mum jumped in and said: 'What do you think you're doing?' So at this point, the carer does now know that my mum is there, but he still continues to drag my father along and throws him into a chair.

With this, the RN did not interfere at all and so my mum basically said to him: 'What do you think you're doing? And he turned around and he said: 'Well, I'm not here to be attacked'—the carer said. My mum said, 'Look, they're all here because they're sick.' The carer continued to still scream at my father so, with that, my father tried to kick him—still didn't touch him—and the carer went right up to him again and said: 'If you touch me, watch out—or else!' So my mum said: 'Or else what? What are you going to do?' Anyway, this carer was then told to go into the office. The police were called; however, no charges were ever laid against this carer, because the registered nurse that was on duty downplayed the incident and said that my father had actually provoked the attack. I don't know how a patient with Lewy body dementia—and yes, my father was aggressive, but at that point his medication was stable enough that he wasn't. So nothing ever happened to that carer or to the registered nurse that witnessed the whole thing and did nothing to intervene.

My submission goes on for a little bit, and I don't want to go on but I suppose I really want to make comment about the last five days before my dad passed away. In the week leading up to dad passing away, he had five unwitnessed falls at Oakden. My mother, as I said, was there a very good portion of the day. However, these falls always happened when my mother left. They were always unwitnessed. There's a few pictures that have been out in the media of my dad, and there's quite a large knock to the front of his head, and one to the side. They were always unwitnessed falls, and they could never tell us what happened.

On 19 April we had another family meeting and were told that my father was probably ready to go to a mainstream nursing home, and on 20 November dad was taken to the Mulberry hospital and then passed away at the Mulberry hospital on 24 November.

As I said, there are lots of other things in my submission. But, as everyone has pointed out—and as I pointed out earlier—we're in Australia and it's 2017 and I just cannot accept that we need to be here today having this discussion about elderly abuse.

Mrs Spriggs: My name is Barbara Spriggs, and, if it is okay, Clive and I will share this submission. My husband, Bob Spriggs, was 66 years of age. For four months, he was in the acute ward, ward 18, of the Repatriation General Hospital, where he was very well cared for. After he had been in there for four months it was decided that it wasn't safe for me to have him at home to care for, and so he had inpatient orders put on him while he was in ward 18. They got him to a point where they thought he would be fine in a secure area in private residential care. On Christmas Eve we were able to move him to private residential care in South Australia. He was escorted down there by two staff from the Repatriation Hospital and had a good changeover period.

Unfortunately, he only lasted there until the evening of Christmas Eve. He went in at around 10 o'clock or 11 o'clock in the morning and we settled him in as a family. I left late in the afternoon and, at 10 o'clock that evening, I had a phone call to say that there had been an incident and that he had lashed out at some of the carers in the residential care so they had sedated him and taken him to the Noarlunga Hospital. I was told to not go down there because he was sedated and was told to ring back the next day and they would work out what they were going to do. So on Christmas Day I went down to the Noarlunga Hospital and was told that they couldn't keep him there because it wasn't a good environment for him to be in when you have mental health issues. I said, 'I would really like him to go back to the Repat,' and they said, 'We've tried to get him back in there but they're fully booked.' Luckily one of the doctors there felt very strongly that another move wouldn't be good for him, so she tried her hardest to get him back into the Repat, which did happen. So on Christmas Day in the afternoon he was transferred back to the Repat.

I went down to see him the day after Christmas and was told by the psychologist or psychiatrist—I am not sure which she was—that because of what had happened down at Aldinga, he would no longer be able to go into private residential care and he would have to go out to Oakden. I knew nothing about Oakden. I didn't know what the facility was or anything about it, but I was told, 'People are looked after well there. It's not the best looking place but, if you don't look at the facade of the building, the care is good.' We had to wait for maybe a couple of weeks before a place came up for Bob out at Oakden. He went out to Oakden and staff from the Repat went out with him with a written plan of how to take care of him.

As a family, we were out there to greet him when he came. It didn't feel good right from the word go. We didn't appreciate the way that we were treated when we got there. We didn't appreciate the fact that they were asking us so many questions about Bob's care and what he needed, because we knew that there had been a good handover from the Repat. But, that aside, we just tried to embrace the fact that Bob had to be there, because we were told at the first meeting how we were very fortunate to get Bob in there, because it was the only place in South Australia that would take somebody like him, so we should feel very lucky that he was able to get a place there. They said, 'You have to tick lots of boxes to get in here, and you've ticked all the boxes,' so we thought, 'Well, we're probably lucky that he's in here.' But we didn't feel good about it.

We went out every day to visit him, because we wanted to make sure that he was being well looked after and was in a good place. After he'd only been out there exactly one week, I went out there one day—I think it was on the sixth or seventh day after he was admitted out there—and was told that the psychiatrist wanted to have a meeting with me. So he came in while I was there visiting Bob and said: 'Look, we're going to see if we can get Bob to go back to the Repat, because things aren't working out here. It's a bit hard to handle him. We've had lots of code blacks, and he needs a lot more care. He will probably end up back out here, but for the time being we feel he needs to go back to the Repat.'

I was devastated, because I was told that this was the place for him to go, and I was told at the Repat that he couldn't stay there because it's not a nursing home but an acute ward. I thought, 'It's out of my hands.' The next day, I had a phone call to say, 'He's in an ambulance and is on his way back to the Repat,' so I went back to the Repat, to ward 18, the acute ward. I was told: 'He will have to go back out to Oakden, because there is nowhere else. He won't be accepted in residential care, because of what had gone wrong down at Aldinga, and he's now got a black mark against his name, so if we try to get him into residential care the alarm bells will go and people will be asking, "How come he's been in an acute ward for so long?" So he will have to go back out there.' They thought maybe they didn't do their handover well enough; maybe they could improve on their handover. So we had family meetings and worked out how we could make things better for him to go out a second time. So he stayed back at the Repat for a few weeks, and then we gave another chance to go back out to Oakden.

As a family, we bent over backwards to make this work the second time. It was heart wrenching to think, 'We've had one failure, and now you're sending him back out there again.' I can't give the Repat high enough marks as to how hard they worked to put together a package for him to go out there with lots of backup. They assured me that they would ring every day and offer help. They stayed out there the whole day the first day that Bob went out there. There were two staff members that went out with them. I saw them putting information into the computer. I saw them talking to the whole staff about how to look after him. They would ring me nearly every day to ask how things were going, and I could see there were a few things wrong. They said: 'Well, we've rung up and we've asked, "Can we help you?" but no; they're okay. They were managing.'

During that time, I went in there one day and he was lying on the floor, and I was told as I walked in, 'Oh, Barbara, Bob's just put himself on the floor.' I thought: 'Oh, that's okay. What's the problem?' I went to Bob, and he was lying on the floor quivering because he couldn't speak to tell me what the problem was. I've probably lost it a bit here somewhere. When I read Dr Aaron Groves's report, I realised that they'd put him on the floor because that was floor time when patients were too hard to handle, as Bob was. He was 66 years of age. He had plenty of go in him. He would be walking around organising people. In his eyes, he was there as supervisor, because he was in the building trade, and he was giving directions to all the staff. My interpretation was that, because they didn't like that, they put him on the floor, with a nurse on either side to stand on him if he tried to get up.

We had lots of things like that, which we had to deal with. Every time we went in, one of the nurses seemed to delight in telling us, 'We had three code blacks last night!' and all of this stuff. And I'm thinking, where's all this coming from? We didn't have this kind of thing going on at the repat. So, we put up with all of that, and then after he had been there for—I'm going to say five days—I went in one day and again put the code in to get in to see Bob, and I was told that he was asleep, so I said, 'That's fine; I'll go and sit with him'—thinking he was asleep in a chair, because on the whole they weren't in their bedrooms. The nurse said, 'No, he's not in a chair; he's in his bedroom', so I said, 'Okay, that's fine; I'll go and talk to him in his bedroom.' And she said: 'Well, there's actually been an incident. I think I'd better get the doctor to come and speak to you.'

So, I went in to see Bob, and I couldn't believe it: he was just in another world, out of it, in bed and not able to talk or anything. And the doctor came in and said, 'There's been an incident where we have given Bob the wrong medication.' I can't remember exactly—I wouldn't like to swear on it—but I think she did say to me, 'I had written up 50 milligrams of Seroquel but it was interpreted by the nursing staff as 500, so we need to monitor his water intake.' It went over my head, to be honest, and my heart went out to the doctor, because we all make mistakes. Looking back, I should have really jumped up and down, but I just said, 'Okay, well, mistakes happen.' And they said that they would monitor him and get things back on track. We went out again the next day and I think maybe a couple of days later Clive went out there, and he was up but not able to really feed himself—

Mr Spriggs: No, he went from being able to walk into the facility to, after the overdose, really not being able to communicate. He was really dehydrated. He couldn't walk. He pretty well lost use of his hands. When he went in he could talk and communicate. It didn't always make sense, but he could communicate in certain ways. He could move around. He wasn't always stable on his feet, but it went to the point where we went in one day and he was chairbound, basically. He couldn't get up or feed himself or anything. One of the nurses said to us that he wasn't having any water, he wasn't eating or anything like that. So my wife and I sat with him and in the space of about 10 minutes I reckon my wife would have given him five glasses of water, straight up, and you could just see how dehydrated and undernourished he was, just in that amount of time. That's when I think they ended up calling a meeting.

Mrs Spriggs: We had a family meeting that day and we were told that we were going to have to send him back to the repat because it was not working out. Again, at that point I kind of lost it a little bit and said, 'You told us this was the only place. You told us you could look after him, and now you're telling us that you can't, so do you want me to take him home? And I was told politely: 'No, you can't take him home. This is our problem and we'll sort it out with the repat.' And they asked whether we had any questions. We had a few questions that we wanted to ask. My daughter asked about a bruise she'd noticed on her dad the night before when she was there. He kept trying to pull down his tracksuit pants. She didn't realise at the time what he was doing and she pulled them up, but she could see that there was a bruise at the top of his leg, so she asked me to bring that up, and we brought it up when we had this family meeting, when they told us that he would go back to the repat. And the look on the doctor's and the staff's face was kind of like: 'Oh my gosh. What bruise?' or 'Oh my gosh. They've found out.'

When we left—sorry, I haven't got enough time to get it all out—they said that they would sort out the transfer for him to go back to the Repat. I went to the car to see my two children off because they had to go back to work. I thought, 'I'm going to go back and see Bob,' because I didn't really have time to see him that day. When I went back in I put my code in to get in and no head nurse came out of the little office so I walked through the ward. Not one staff member was on that floor, but all the patients were sitting in their chairs. Note that to this day I don't think anybody knew that I walked through the facility. I went down to the end of the corridor where Bob's room was and all the doctors and nurses were around Bob in his room. I kind of thought, 'Well, I'm not supposed to be here; I'm going to go home and come back later.' So I left the building and nobody knew that I had been in or out.

When I got halfway home I pulled into a shopping centre and put my phone back on and I had all these missed phone calls from Oakden. I rang Oakden and they said, 'We just wanted to ring you to let you know'—they were all very jittery—'we've just put Bob in an ambulance and he's on his way to the Royal Adelaide Hospital.' I asked, 'Why is he going there?' They said, 'We think he might have broken his hip'—they're all very jittery—'and we want to get a few things checked out so he needs to go there and have an X-ray.' I went to the Royal Adelaide Hospital and that's when I found out he'd been over-medicated, he was dehydrated and he had pneumonia.

After he'd been in the Royal Adelaide Hospital for five days the nurses and doctors came out one morning when I went in—a Friday. That doctor said to me, 'Barb, I think we're getting him back on track and I think by Monday we'll be able to send him back to Oakden.' I went, 'You have to be joking.' They said, 'That's where he needs to go.' I went, 'I don't want him going back out there; things have gone wrong twice.' But we had no choice. That's where he needed to go. I could go on, but I think I've probably well and truly gone over my time.

CHAIR: Thank you. It's given us a pretty clear idea about the sort of treatment that he received. Has anybody got short questions? We don't have a lot of time. We've got about 10 minutes.

Senator SMITH: We've heard a lot of positive things said about the Repat ward. Did anyone at the Repat ward raise any questions with you or did you get a sense that they might be familiar with the deficiencies in the care at Oakden?

Mrs Spriggs: No. The only impressions that they gave me were that it was a very tired-looking place but that the staff should be able to take good care of him.

Senator SMITH: And no-one at Royal Adelaide Hospital raised any queries or questions with you about the deficiencies of care at Oakden?

Mr Spriggs: What we find really strange is that if mum had taken dad to the Royal Adelaide in the condition he was in—if she'd taken him herself—the police would've been called and mum would've been questioned as to his condition. Yet he was transferred from another medical facility and no-one questioned what had gone on. He was over-medicated, he was dehydrated and he had mass bruising and bruises around his body, yet nothing has been reported—not to our knowledge, anyway. Certainly no-one came forward and said.

Mrs Spriggs: To this day, I would like to know if Royal Adelaide Hospital reported to anybody the state that he was in when he came from a government-run facility. I have a fair question.

Mr Spriggs: And if they didn't, why didn't they?

Senator SMITH: Would anyone else like to make a comment on those two questions that I've asked?

Mrs Krecu: As I said earlier, my dad went from Modbury and he also considered the Royal Adelaide that week before he passed away. Like the Spriggses have said, there was no documentation and nothing was ever told to us. There was no indication of how bad Oakden was going to be. It was the only place for your father or your husband to go. There was certainly no indication. When dad arrived at the Royal Adelaide a week before he died he had been completely unresponsive at Oakden for 12 hours. It took them 12 hours to call an ambulance. At the Royal Adelaide, one of the nursing staff from Oakden went to give a handover to the Royal Adelaide emergency department, and they were giving a handover for a completely different patient to the nursing staff. When I intervened and said: 'I don't know what you're talking about; my father has actually never been a patient of Royal Adelaide ever before,' I was told, 'You must be talking about the wrong patient.' I said, 'You clearly are.' The nursing staff then told that nurse that she could go back to Oakden and they could get a clearer handover from the resident's family as opposed to the nursing staff.

They also did some blood tests. We actually told Royal Adelaide that we felt that dad was being overmedicated—we know for sure he was being overmedicated. They agreed with that and they told us that they were going to write a letter to Oakden because they questioned all the medication. My dad was still on antipsychotic drugs three years later, and they wanted to know why he was on such high dosages of all those drugs. We had that family meeting two days later and were reprimanded, because we overreacted when we walked in and saw my dad completely unresponsive and we scared the nursing staff at Oakden. We were reprimanded on that first up, and in the next breath we were told that dad was ready to go to mainstream—all after Royal Adelaide, supposedly, and I don't know if they ever did, send a letter about my father's medication.

Senator SMITH: It would be interesting to know how many Oakden residents were admitted to Royal Adelaide over what time period and what action, if any, was followed up.

Mr Johnston: In the case of my mother, she was referred to Oakden via the Royal Adelaide and the Queen Elizabeth in order to receive her electroconvulsive therapy. That was why she was there. Hearing these stories constantly of RAH and the other mainstream hospitals not picking up when the role is reversed and the patient is coming from Oakden to them does make you wonder whether there was an insulated view. The QEH and the RAH had no issue referring my mum. We are talking 2008, though, in my case. Still, as we know, the Barons had already done the accreditation and Oakden was failing miserably, even more so back then.

We were referred there and were given an older person's aged-care case manager after mum's abuse at Oakden, and we were ushered through the QEH within a couple of weeks of me getting her out of there after the abuse. But we were closed down at every level: that this shouldn't have happened to mum and that she was the only one that ever suffered abuse and that Oakden was a five-star resort. Like hell it was.

Mrs Spriggs: When Bob went back to the repat the second time, the staff were absolutely gobsmacked when the ambulance brought him in. One of the nurses said to me: 'Barb, I cannot believe this is the same person that we sent out to Oakden two weeks ago. I hope you're going to do something about this. I hope you're going to report it because we will.'

Senator POLLEY: I know I speak on behalf of the committee in thanking you for giving evidence here today and we acknowledge that you have to live through the experience again. In visiting a lot of aged-care homes who care, sometimes loosely, for people with dementia, people with dementia lose the ability to verbalise what is happening to them. An issue raised in other inquiries is the lack of people caring for people with dementia who have a second language. For instance, if your first language is German, as the dementia progresses they revert back to their native tongue. There is a real issue around trying to express and verbalise that they have other pain. Was that obvious at Oakden that they had no tolerance or understanding of the lack of ability to verbalise or reverting to their first language?

Unidentified speaker: Absolutely.

Senator POLLEY: Mrs Spriggs, when you said that the Adelaide Hospital asked you if you were going to report this because we are—

Mrs Spriggs: Sorry, there maybe a misunderstanding. The Royal Adelaide Hospital didn't ask me to report it. When Bob went back to the acute ward at the repat after he'd been in the Royal Adelaide for one week, the staff there said to me, 'I hope you're going to report this because it's disgusting.'

Senator POLLEY: Do you know if they themselves reported the condition?

Mrs Spriggs: They said that they would but I never questioned it and I didn't report it straight away because I had a lot to deal with getting Bob back to himself a little bit. It was a few months after that I finally reported it.

Senator POLLEY: Unfortunately we can't change what happened but we need to be able to ensure that this never happens anywhere else at all. If there was one thing each of you wanted to see changed, could you quickly verbalise what you would like to see changed to prevent this from happening.

Mr Johnston: Independence. The establishment of a hotline and the ability for people to come forward anonymously and report, including staff members in facilities. We have got a great way with the now unannounced visits, which should have always been a fact. We have got to inject some KPMG or something that is completely external from every government and every player to oversee every facet of this sector so that we can genuinely know that things are being done correctly.

Mrs Cole: I strongly believe there is not enough funding not only in aged care health but mental health as such because it affects a younger generation now, as we are seeing. Also the culture needs to change among the staff at that facility. They are not just there because they have mental health issues and are worthless, because at the end of the day they could be their mother or father or spouse there. Us as a community need to broaden our knowledge and understanding that that could be one of us one day. So it is about funding, culture and training. You can be trained in looking after people in aged care facilities but it doesn't make you fully trained in mental health. This is like talking chalk and cheese. If we're going to make a new facility, we could just make a building and make it all looks swank and fantastic inside; that's great but it it's what goes on inside that counts. Those families need to feel comfortable that when their loved one goes there they will be okay. It is not like it is going to be their home but at least they will be okay and won't be abused.

Ms Blakeley: My thoughts are the same as Patrina's. People have to be educated and learn how to treat the patients. It is all in how you treat a dementia person. If you speak kindly to them, you get a better reaction back. If you yell and scream and give them a hard time, of course they are going to get aggressive. I found that when Dad was in ward 18 at the Repat. There was one gentleman who must have been a farmer. He wanted the horses put away. He was getting really upset, and they didn't know what was wrong with him. I went up to him and asked him, 'What's wrong?' He kept saying, 'The horses.' I said, 'Do you want them put away?' And he did. So I made out to put them away. I went away and came back and said, 'They are all in their stables.' He was happy then but they were ready to restrain him because he was getting aggressive. So it is training, definitely training.

CHAIR: I don't know if you heard this morning when Ms Bolger was telling us the training a lot of the staff had was from back in the seventies so they didn't understand anything about contemporary training around cognitive impairment and the way that you would address a gentleman who wanted his horses put away.

Ms Blakeley: When I used to go there, we used to play cards or have meetings. We would all sit around the table. Someone would be the secretary. My dad would always be the Treasurer—he always had to have the money. We would all talk and they would give us their ideas. One of the nurses said to me, 'We need you here every day.' Because if you kept them active with quoits and things like that, they were okay.

Mrs Krecu: For me, it is about families having more choices here in South Australia. Clearly, this has blown up, Oakden has closed and we only have Northgate at this point with 17 beds. I know the government wants to build this brand-new facility but it is about having more choices. Everyone that works in this industry needs to remember they are human beings that we are talking about here.

Mrs Spriggs: We need a better educated staff and more time put into employing the right people, not just they've got a piece of paper with all the right words on it but that they have also got a good heart to be doing it. You don't have to always have the certificate to say that you can do the job; you need the heart, too.

Senator PATRICK: The last answer was very, very helpful. You would have had a view immediately after your experience as to where the problem lay at Oakden. I presume you've all read the chief psychiatrist report, a very, very blunt, honest report. Has that changed your view on where the problems were?

Mr Johnston: I didn't realise it was as extensive as the report alluded to. It horrified me, actually, right down to the environment, the people and the procedure. The culture from top to bottom, there was possibly, I would suggest—in most facilities, I'd say there are five per cent bad eggs and 95 per cent good, but I'd suggest that in Oakden it was the other way around. There was vested interest in covering up every facet of what they were doing. I found, once I read the report, that my eyes became open looking back. That's right, I didn't recognise that. I didn't see that. It compounded my view.

Mr Spriggs: Even since the report has come out, the more stuff that people have said, and even just sitting here today listening to people's stories again—and I'm sure it'll be the same later—it just keeps unravelling. It just goes deeper and deeper. The problems are horrendous. It's horrendous that we've got to sit here today and go through this.

Mrs Cole: They could write a book on it.

Senator FAWCETT: One of the common themes that I've picked up is that people felt helpless or at the mercy of the system, and that there was an element of trust despite the discomfort. It struck me that none of you had anyone that you could go to and say: 'I'm feeling uncomfortable about this. Am I just being silly and emotional or is this legitimate?' Another field of endeavour: the federal government's recently brought in what we're calling Health Care Homes, which is where, for someone who has a complex need, their GP is kind of a central point of contact to coordinate care. I'm not necessarily suggesting that your GP is the appropriate person for this kind of situation, but if there were someone that your GP who you know and trust could refer you to, whether it's an ombudsman type person or a point of reference, would that have assisted in your journey?

Mrs Krecu: Absolutely. As I said: for my family it was very quick. In December 2012 we were on a cruise; April, my dad's in hospital never to come home again. You are just overwhelmed with everything that is going on. I'm sorry, the person that was giving evidence before we came on—what would be great is if you were given information. To be quite honest, I'm not even sure if we did get any information when we arrived at Oakden about who to go to if you've got any concerns, because I don't really remember. What would be nice is if you actually had a person that comes and sees you a month or even a week or so later to say: 'Hey, I know your loved one has just arrived here. I just want to go through some things. If you've got these concerns, these are the people you need to speak to.' Not immediately when you arrive, because you are overwhelmed with everything that's going on, but just to have somebody that can come and speak to you. We went to a consumer liaison person in the northern area. I was on a first-name basis with a gentleman, and he helped where he could, but I just felt that nothing happened. You went and you voiced your concerns, but my dad was still there three years later and still had his falls and everything. But if you have just that one person that will come and see you that's independent to the facility—no-one from the facility; independent.

Mrs Spriggs: That's made very public so that you know that that person is there, too.

Mrs Krecu: Absolutely.

CHAIR: We're going to have to wind up because we've got another group. Thank you very much. It is really your lived experience that gives us the critical information that we need. I'm sorry if you've had to relive things and it's brought out emotions. We really value it.

COSTA, Ms Maria, Private capacity

GLOWIK, Mrs Natasha, Private capacity

MARTIN, Mr Mark, Private capacity

STOJANOVIC, Ms Deanna, Private capacity

[16:39]

CHAIR: Thank you for coming. As you're settling in, could I just double-check that you've had information on parliamentary privilege and the protection of witnesses and evidence? Yes? Okay. Thank you. We'll do the same as we've just done—that is, I'll ask each of you to speak for around five minutes and then we'll ask you some questions. Does anyone want to go first?

Ms Costa: My mother will be with me but I'll be doing the talking. She's not very good at speaking in English. But we're doing it together.

CHAIR: Okay. If there's anything she'd like to chip in, that's fine.

Ms Costa: I'm not a good speaker, so I will just read from what I have here. Firstly, I would like to say: 'Thank you, someone, for listening. Thank you.' My name is Maria and this is my mother, Philomena. My father was Mario Costa, who entered Oakden in February 2014 and was there till November 2015. On behalf of my mother, Philomena Costa, and the rest of my family I also wish to express my dissatisfaction with the level of care Mario received while a resident at the older persons aged-care home at Oakden. I also would like to say that I have just relived a lot of memories from what everyone else was saying.

From early on in my father's stay, my mother, because she was there most of the time, noticed there were minor issues with his clothing. They were minor at the time. She visited several times a week and would notice that the clothes he wore were never the same and weren't his clothes. We were told to send his clothes somewhere to get labelled—it was a service we paid for at the home—and we did that. He continued to wear other residents' clothes or old, stained clothes, and my mother continued to buy him new clothes. Even his shoes weren't his, and more often than not he had no socks on. He was inadequately dressed in winter time. I remember several times when I visited seeing him hovering in a position and I knew that he was cold. His hands and feet especially were icy to touch. It was not hard for someone to tell, if they cared enough to look, that they needed to go into his room and get another jumper or socks or whatever he needed. I did that or my mother did that to make him more comfortable.

My mother would continually buy him new clothes and they'd go missing. It got to the stage where I bought a black clothes marker and wrote his name, in large writing, across his tops. That helped a lot of the time. We brought this up with management and staff many times. They were responsible for dressing him every day. The facility was responsible for sending clothing to the laundry and putting it back in the resident's room. Mario, at the time of going into the home, could not talk or look after himself in any way. He was high care, a hundred per cent. From what I saw, most residents were in a room on their own. When my mother asked the staff why Mario was not wearing his clothes, they would often say, 'Other staff dressed him this morning.' Most of the time they would blame each other. Anyway, that became minor, as we gave up.

As Mario continued to stay in that home, other more serious concerns started arising. As I said, my mother would visit several times a week and she would always feed Mario when she was able to. She was concerned and distressed quite often, as she noticed he was not eating well. Many times he was heavily oversedated. Even tapping his face and calling his name did not wake him up. Every time my mother went there she would ask the staff, 'Did Mario eat breakfast today?' The reply on many days was, 'I don't know; I was not here this morning,' or, 'No, because he fell asleep again.' It was due to them not getting the medication right and him being oversedated. Obviously, it was too hard for them to look at their notes, which they should have been keeping.

At one point, there was an agency staff member—earlier on, when we entered into the home—who saw us feeding him and actually told us off for feeding him, because 'he has to learn to feed himself'. Well, there was no way he was going to feed himself. So alarm bells started going off back then as well. When my mother was trying to feed him, a lot of the times he'd have always have his eyes closed. He looked to be heavily sedated. She tried to get him to chew but, when he did, he was not chewing properly, which could have caused choking. She would often ask Rina Serpo, who was there a lot of the times every day, to please feed Mario and look out for him, because she was able to be there every day. My mother didn't drive, so she could only go there several times a week. Rina was kind enough to help. My mother did not drive, as I said. She only took taxis or buses to get there. She would always be in a worried state when she could not go, due to worrying about the care of my father. I remember there were a few occasions when my mother would come home content, knowing that two particular female staff who were not rostered on the same day were working that particular day and they actually cared about and communicated with the residents in a caring manner. This is while my mother was visiting. I don't know what went on when she wasn't there.

My other point is that the staff was insufficient. My mother and I witnessed on numerous occasions the residents soiled for lengthy times and not enough staff to assist with care duties. A lot of the time she would have to ask them to change my father, because he was always wet—or whenever she got there he'd be wet and he'd be like that for quite some time. There were never enough staff in that particular area where my father was. The whole time that he was in the home, I saw mostly agency staff come and go. The weekends were the worst. There would only be one to two staff to about 15 residents, and, when they went for their break, there was only one or none. There was just no-one around. The place was bare.

The first incident happened in 2014, around May. My father entered the home in February. Around May, we suspected something was wrong—a bit of abuse—so we complained. What happened was that one of the agency staff asked my mother how my father got a bruise on his chest. He was bruised on his chest and he had other bruising. How could my mother know? She wasn't there. We made a complaint to the aged care. They just put it off as: 'There weren't enough staff and we don't know what happened,' or he fell. I can't remember. We've got a letter from them, but I can't remember exactly the content of the letter. But that's what they were saying. We strongly now feel that he was abused. It just looked to us like a punch to the chest and therefore him losing his balance and hitting his head when he fell. That's how we see it. After we had contacted the appropriate authorities of health, ageing and complaints regarding this incident, we did receive a letter back from them and we decided not to complain anymore in case my father continued to be mistreated. We realised, from what they had replied in the letter, that they cover each others' backs.

Then in June 2015 my father had a fall and broke his hip. When I asked the staff at Oakden how this had happened, of course I knew what the answer was going to be: 'We don't know.' No-one was around. I asked to see some recording, but they didn't have any, so no-one knew anything. Had there been enough staff per number of residents, maybe someone could have seen something or been there or done something and it could have been prevented, because Mario was walking prior to this fall—and that's all he could do, walk, because he could not talk at all.

After he was operated on, on the hip, which went well, he was sent back to Oakden. The doctor had told them what they needed to do. They needed to get a physio there to get him up and walking on a daily basis. That was supposed to be done several times a week. Well, the physio treated my dad maybe once or twice for the remainder of his stay at Oakden, because he was never awake to be treated. He was always asleep. He was always sedated. He was heavily sedated most of the time. In my opinion, he should have been lifted out of the princess chair on a daily basis to get some kind of movement. We don't think that ever happened—(a) because there were not enough staff to take time to attend to this, and probably no-one could lift him up. If they had a lifting machine, they didn't use it, so he was stuck in that chair day in, day out. A lot of the times when I had gone to see him, I could see him trying to move. It's like being in a cavity and screaming because you can't speak. He obviously needed movement. Can you imagine being stuck in that chair day in, day out and only being lifted out when you have to get changed or when you have to go to bed? It's a nightmare. I feel claustrophobic thinking about it. It's just not fair. Someone should have been lifting him. I'm sure they had the machine there to lift him up and move his legs or something like that.

Anyway, I tried to lift him myself, but obviously I couldn't; I'm not strong enough, or I would have taken him outside to get some sunshine. We were all upset watching him trying to wriggle his body, trying to move et cetera. We saw how uncomfortable he was the whole time that he was in that chair. He wanted to get up. A lot of the time he tried to move his legs, but he needed help, and no-one could help him. Even when they were soiled, they left him there. They left him there longer. He had to wait his turn. They had to change everybody else, because there were fewer staff. So my mother had to call the staff on numerous occasions to change him. Again, if there'd been more staff, this would have been attended to more quickly. Not long after the operation, we were called in by the psychiatrist and were told to find a nursing home for him, as he no longer needed to be there, so they got rid of him.

CHAIR: Sorry to interrupt, but can I ask you to finish up.

Ms Costa: Can I just say that I really believe what someone else was saying before about the training of the staff. You actually need people who have lived with these people for a long time, not just someone who's going to work every day. These people need to be people like us, people that have had family members that have had a really serious illness like this, because until then you don't know how to treat these people. I can't explain it. You have to go to every little detail to understand. You have to understand how these people need to be treated. It's not just that you go to work and get a pay packet. It's not like that at all. So I would like to see that kind of thing—people with that kind of qualification to be in this field.

CHAIR: Training has come up a lot as an issue, as you know.

Ms Stojanovic: I am the daughter of the late Eveline Ethel Damms. My mum was a patient at Oakden for 2½ years. She was admitted on 3 February 2015, when she was no longer able to be placed into a mainstream nursing home. She'd been refused at three nursing homes due to her dementia and behaviour issues. She walked around when she got tired. Slowly, in my mum's time at Oakden, she lost use of her legs. Nobody offered her physio. They just placed her in a princess chair, where she remained until the doors closed at Oakden this year. She used to have what they would call sleepy days, where she would sleep all day. I used to visit her every single day after work. When I'd ask how she was, they'd say, 'Oh, she was just having a sleepy day again.' Never could they give me a reason for why these sleepy days were happening. I constantly asked and asked and asked, and all I kept getting was, 'Oh, she refuses to cooperate.' My mum couldn't talk. She talked only confused talk. Many times I'd go in there. She'd have bruising on her face. When I asked how she got the bruising on her face, I would get told, 'Oh, she punched herself.' I don't know how she punched herself or why she punched herself. Why didn't she do that when I was there?

I complained regularly about my mum's care and hygiene and her clothing not being placed on her and her being dressed like a hobo—I'm sorry to say that—and being cared for as if she didn't matter. My mum was a clinical nurse, and I know for a fact my mum never treated any of her patients the way they treated my mum. I used to ask why they didn't put her clothes on: 'How would you feel not wearing your own clothes? That's all they have.' And they used to say to me, 'It doesn't matter; they don't know what they're wearing anyway. It doesn't matter if it doesn't match. They don't care.' To me, that's so disrespectful to these people.

My mum was in the male catheter incident that was in the Oakden review. It was performed by two clinical staff who were told right up to the procedure to ring me to get permission to do this procedure. My mum had a urine infection for a week, and they needed to get a urine sample. In the end, it was said that they needed to do an in-and-out catheter to get this urine sample. I'd been spoken to about that, and I said, 'That's going to be too hard. She's not going to allow you to do that.' They said, 'No, no, we'll get it done. We'll get a urine sample,' and that was all I heard. Then I heard she was on antibiotics. I was never, ever told anything. I had power of attorney for my mother. I was everything. I was [inaudible]. I wanted to be spoken to, I wanted answers: why?

After the procedure, I was told by somebody that the ward manager had walked in and said to the two people performing the procedure with the catheter on my mum—after her screaming for two hours, just screaming out, 'No, no, no,' that she went through. The ward manager said that she had to ring me to get permission to actually have done that. So I got a phone call at work, and I left work, and as I got to Oakden, to the back door—because I used to go through the back door because I was always there after hours—the male staff member that opened the door just looked at me and he said, 'I'm so sorry, Deanna. I had to tell them to stop. She was screaming. She was screaming in pain.'

When I walked into my mum's room, she was sitting there on a towel, naked from the waist down, with a towel across her. Her eyes rolled up to the ceiling and she was just lifeless and pale, and I just said to her, 'Mum, are you okay?' and I was touching the side of her face. And the clinical nurse that came in said to me, 'She was being uncooperative.' That was not what I wanted to hear. I didn't want to hear that. I'll move on from that.

Another thing was that she choked and they had to suction my mother—because she had a choking issue. They had to suction her. I said, 'How did she choke?' They said, 'She was sleeping, but we had to feed her lunch.' Oh, okay. I wouldn't try feeding a person if they were asleep. If they were sleeping and having a sleepy day and hardly even opening their eyes, why would you try? At the times that she was a bit alert, offer her food; don't try while she's asleep. She choked, on this particular occasion, and they had to put her on the floor and suction her, and it was quite—I can't even tell you what it was 'quite', because I wasn't there, and they didn't talk to me about it. All they did was give me another phone call. I said, 'I will be there within 40 minutes'—I work in Glenelg and they're at Oakden. I said, 'Yes, I'll be there.'

When I got there, the same nurse that had done the catheter incident was standing there arguing with an ambulance officer—because my mum's throat had swollen up so much that she was having trouble breathing. She was standing there arguing, and the ambo officer turned to me and said, 'Who are you?' I said, 'I'm Eveline's daughter,' and he said, 'What hospital do you want us to take her to, because none of these morons here can tell me.' I was like, 'Just take her to the closest one. I don't care. Just get her there.' As they were wheeling her out, I then had the ward manager go, 'Oh, I've never actually met you. I'm so-and-so.' I just looked at her and said, 'I don't care who the eff you are. I really don't. Just get away from me.' As I followed my mum, she was again choking. The sirens went on the ambulance. They got her to the Lyell Mac. They did get her to be okay, which was reassuring: my mum was still alive. Within the night she was then transferred back to Oakden.

As Mum was there till the closing days, I looked at it: 'Do I worry so much? I know the care there is atrocious,' but like all the other families I was told, 'This is the best place for your mum; this is the only place they can look after your mum.' Now, my mum was in a princess chair and weighed 47 kilos. She wasn't a big lady. She never hit out. She never hurt anybody. She sat there in her confused way, and she would smile when I walked in and call me her sister's name or her brother's name—but she called me something. My 12-year-old daughter wouldn't go to the facility, as she was scared they were hurting her nanna. My partner wanted to really, really hurt people; he didn't want anything to do with the facility. So it was solely me there.

I witnessed so much bad culture in the place that was absolutely disgusting. It was disgusting. I would often think, 'Animals are treated better than these poor people.' I would go in and be the only one sitting there between the hours of six o'clock and nine o'clock. Some nights I would make them leave my mum up because I knew that then a certain staff member, who I trusted, would come on and then put her to bed. It was just reassurance for me. I was promised that my mum would go to Northgate, but then she was miraculously assessed as being able to go to a mainstream nursing home. I was quite happy for her to go Northgate, because they knew my mum. They knew her swallowing problems. They knew that she had these sleepy days.

But, three days before Oakden closed, I was pulled aside by Duncan McKellar, who was running the place, and he said that he had miscalculated his numbers and that my mum would be placed into the men's wing at Northgate. I looked at him and laughed and said, 'You're placing my mum, who sleeps in a princess chair, stays there 24 hours a day and cannot move, in with some really quite big men,' and he said yes. He said, 'She'll be fine.' I said: 'What? You can't do it.' I was promised five times by him that she would go to Northgate. He knew that I would say no to that.

So then it was a big rush to get my mum into a mainstream nursing home. She was eventually placed in Helping Hand at Ingle Farm, where nobody knew her. She was known as 'the Oakden resident' that everybody felt sorry for. SA Health did give her so many hours of one-on-one nursing, but it was Helping Hand's nurses, who knew nothing of my mum. They did the same and, coincidentally, my mum was there for seven weeks and passed away by aspirating and pneumonia, which I don't think is fair, because my mum was only 70 years old. She didn't deserve to be treated like that. She didn't deserve to be treated like nobody. I just want to see change. It needs to change. These people never deserved any of this—never. Thank you.

CHAIR: Thank you.

Mrs Glowik: I represent my mother, who was a resident at Oakden from 1998 to 2007. It's a considerable period of time and, rather than just go through a whole series of her situation, I'd be interested in knowing what exactly it is that you want to know. As an overriding statement, I would say that Oakden was a perfect marriage of chaos and maladministration. And then I ask you what it is that you actually want to know.

CHAIR: We're trying to understand what the major issues were. Obviously we never, ever want to see this happen again.

Mrs Glowik: I concur with everything that people have said. I could add my experiences there.

CHAIR: That is helpful for us to understand the nature of the things that happen.

Mrs Glowik: From the level of staffing to the care to the medical aspects as well, it is a very complex psychogeriatric illness. It takes great understanding and staff that can cope with this, and there are staff who would, quite frankly, be dangerous cutting your lawn. They are unexperienced and short of patience, and I would say most of them would never, ever be employed anywhere else. It became a dumping ground. It was quite obvious. For those who were experienced, excellent. You could leave your rellie and have wings on your heels because you knew they were going to treat your relative just as if it was their own. The rest? No way, Jose. It was absolutely appalling. What else would I say?

Senator FAWCETT: We're also looking at a number of systemic factors that we as governments and organisations can do. One of the things that you can tell us is how we could have empowered you to have expressed your concerns more effectively and fully.

Mrs Glowik: That's a very good question. When asking head staff of complaints: 'We don't want to know about complaints. We are Oakden. We are government run. There is nowhere else to place this type of patient. You're kidding if you think we'll ever be closed. And, as for complaints, go away.'

CHAIR: It sounds to me from what you've been saying that you did try to raise these concerns with staff.

Mrs Glowik: As you know from my submission, there were a broad range of issues where I even got to the point of Crown Law, who were appalled at the clothing situation and did in fact ultimately give compensation. It is absolutely chaotic from the clothes point of view. You use the pensioner money to buy clothes, but what do you get back? Congealed messes. Other people's clothing. Loss of clothing. It's appalling. Nobody is responsible.

CHAIR: In terms of the sorts of things you've heard us discussing today, what's your response?

Mrs Glowik: In essence, I concur with all the complaints, yes. How can a government-run establishment continue like this? How possibly can this ever have occurred? There are so many things you see over a nine-year period. You range from sobbing to wishing you had a baseball bat.

CHAIR: There is a sense of powerlessness?

Mrs Glowik: Yes, absolutely. The only inspirational thing was when the late Margaret Tobin arrived. She had great passion and understanding and a vision for this type of establishment, but she was later murdered. Yes, it was an awesome experience—a very sad one. For instance, she's 95 years old, one of the gracious old ladies in the facility. I walk in, and she says, 'Darling, I'm so thirsty; can you give me a drink?' I went to the nurses station. There were a trio of nurses there. Two of them were tending to the hair of the third one, seated. She had a meeting with her paramour in the evening. When I explained the situation, I was told, 'She's always asking for a drink.' My next question was, 'Has anyone done a recent blood sugar level?' 'Oh, go away. We'll tend to that when the time comes.'

Medication at five pm is being dispensed. If you or I are in touch with our mobile phone when we're driving, that's a serious breach of law. Here we have a table with the medication spread out and a mobile phone tucked under the ear. It is a long social call filled with much hilarity. When I raised a complaint, I was told, 'No, there will be no complaint, but I will sort of disseminate this among the staff, and peer pressure will probably stop such activity.' I reckon I would have ripped strips off this person, because they freely admit, 'Yes, we do make medication error here.'

There are lots and lots of things. I don't know which is the stronger, the maladministration or the chaos. I do not know, but it was evident. A government-run facility, and they had such superiority.

Senator SMITH: For my part, I don't understand why you have agency nursing staff. You have people being admitted into Royal Adelaide Hospital, people being taken back to ward 18 at the repat. You have ambulance attendances. You have Commonwealth agencies receiving complaints. And this is not something that has happened for one month or three months but for years upon years. It's hard for anyone in our country, let alone in South Australia, to have a degree of confidence in the system at all if no-one is ringing the alarm bells, if people aren't speaking.

Mrs Glowik: I think in our age we're well aware of alarm bells. When my mother was admitted to the RAH, the first question was, 'I bet you're from a nursing home and I bet we know which one.'

Senator SMITH: What year was that?

Mrs Glowik: 199—I don't know. It's in the notes—whenever she had the *Pseudomonas aeruginosa* infection. They were onto it. They asked, 'Indeed, is this scalding?' I said, 'No, it's an infective process.' 'You're joking. Topical cream on this?' They were well aware, I think.

Senator SIEWERT: If it's okay with you, we'll go to Mr Martin. There will be more questions when we go to questions.

Mrs Glowik: Okay.

Mr Martin: My wife's name was Cheryl Martin. She was at Oakden from 2007 to when she died in 28 October 2008. But my story is going to be a little bit different. My wife was very sick with mental illness, and I went on the carers pension to look after her in 1988. First she had postnatal depression. Then she had depression. She'd get better for a couple of years and drive a car, go shopping—do all these things—and then she'd get sick again. Eventually , the doctors struggled for a diagnosis so they changed it again to schizoaffective disorder.

She got sicker and sicker and sicker, so they did a PET scan and a SPECT scan at the Queen Elizabeth Hospital, and the neurologist worked out that what she had was frontotemporal lobar degeneration brain disease. She was only 41—my wife—she was 43 when she died.

They changed her medication and everything around to suit dementia. What happened was about four weeks later she ended up at Lyell McEwen Hospital, just like this other lady's father and husband did, and she was shackled to a bed—arms and legs—for eight weeks. She had bed sores all over her. They weren't walking her. The only time she was able to be walked was if I was there and I begged them to walk her, and a security guard had to walk with me.

When that didn't work, they decided to change her medicine again and they said, 'Look, there's no way you can take her back home.' I said, 'I'm bringing her back home and I'm going to look after her.' They arranged for Helping Hand to help me. I had four nurses or carers who would come in from seven o'clock in the morning until three o'clock.

I was coping quite fine. I brought up two kids as well mostly on my own. Everything was going okay, and then they decided to pull the pin. Because Cheryl had a neurological disease and she was getting sick, I wanted to put her into 1G at the Lyell McEwen but they refused. They said, 'No, we can't take her, because it's neurological, not psychological.' So they cut me out of getting help, and Helping Hand gave up because it was neurological as well.

So she went back to the Lyell McEwen Hospital again, restrained, waiting for placement. They said the only placement they could find that would possibly suit Cheryl was Oakden. That was the last thing I wanted, so I bought her home again, but it didn't work. We ended up back at the Lyell McEwen, and so she had to go to Oakden. I had no choice. My wife couldn't feed herself. She couldn't drink properly. She didn't know when she was going to go to the toilet. She had to have continence pads on. She had to be showered. She had to be bathed. You had to do everything, because she fully needed help.

She ended up in Oakden. Again, they started messing around with her medication. I didn't know about it but what they did was try to reduce her sodium valproate, which is a mood stabiliser or for seizures and things. Then I got a phone call and they said, 'Look, she's being rushed off to the Modbury Hospital right now. She's just had three massive seizures.' I also found out later that they had to resuscitate her twice in the ambulance, because she had stopped breathing, to get her there. Once they got her there, she got transferred to the Royal Adelaide and she had to be in an induced coma for a week or so before they brought her out of it.

Then she went back to Oakden. She was in a wheelchair for about eight weeks—slurred mouth, couldn't talk. When she started getting a bit better, no-one would take her for walks unless we took her for walks. She was always, as the others said, dirty, always unclean. I used to have a little bag that I'd leave in the car in the car park. I'd bring Cheryl out. I'd sit her down in the back. She used get facial hair. Because she couldn't do it herself, I'd have to pluck it out. Sometimes it would be that long. It was ridiculous, so I'd fix that. She used to have wax in her ears. I'd have to wax her ears. I'd check in her hair as she used to have all these scabs in there. I used have to wet it and then rub it off. She always had other people's clothes on. She never had her clothes on.

I used to go in there and I'd complain all the time—complain, complain, complain. In the end, behind my back, the Oakden staff, or administrators, got her sister to take me to the Guardianship Board to try to wrestle control off me because I had full power of attorney. The Oakden people were all on one side with my wife's sister, and I was on the other side. They asked all these questions, and I won. They lost there, so that stuck it up them. Then she was back there again and, like I said, everything was a mess, filthy and dirty. She had a fall. I found out. They rang me up and they said Cheryl had had a fall. They got her X-rayed and they X-rayed her from her wrist to her elbow, that was all, at radiology. They came back and said, 'No broken bones; nothing wrong.' Two and a half days later, she was all black and blue on her shoulder. They discovered, and it's all on record, that her shoulder was five centimetres from where it should have been. So for 2½ days her arm would have been dangling like this—and they would have been dressing her and moving her arm and everything. She had to go into hospital and she was operated on to get it fixed. They had to re-operate a couple of weeks later just to fix it a little. Then she had her arm in a sling. A couple of weeks later, I went to visit my wife and they brought her out of her room and a nurse was holding her just on the side for balance. I looked at her and saw in her eyes, and I said to them: 'There's something wrong with my wife. She's not right. I can tell.' They said, 'No, no, no, she's fine.' I said, 'I want someone to see her.'

Anyway, I went home and they gave me a call and said that the local doctor had looked at her and said that she is quite fine. Two days later, I got a phone call and they said, 'Cheryl's being rushed to Modbury Hospital with suspected bronchial pneumonia.' I knew. They should have listened to me but they didn't. She went in and five days later she died. I wrote a letter to the coroner and asked him to investigate it, and he did but he said he didn't really find anything wrong. But after all these years, my daughter reminded me: 'Dad, a month before mum died, she had those operations. That's probably when she got the pneumonia, after she had the operations and that led to her death.' To this day, we think that if they had listened to me and my family, my wife would still be alive. That's it in a nutshell.

CHAIR: Thank you. This committee has held a number of inquiries on disability and aged care, and the issue around guardianship has come up when people complain. It has come up quite a bit where parents or the person themselves or the guardian—

Mr Martin: [inaudible] that's why they did that.

CHAIR: This committee has heard on a number of occasions where a provider or an institution has sought to change guardianship because somebody complained about the service. Sometimes they have been successful and sometimes they haven't.

Mr Martin: My wife was only 43 years old. She shouldn't have even been in an aged-care home. Their diagnosis was wrong as well. When they put her on the medicine for dementia, she got worse. They had to put her back onto her depression and manic depression pills to make her a bit better.

Senator POLLEY: It's hard to know where to begin as there are so many questions. Really, the questions need to be asked of the oversight agency and governments, both the Commonwealth and state. They are the ones that really need to have the questions asked about. I want to place on record how much we appreciate you giving your evidence. It was very difficult to sit here and hear it, let alone how hard it must be for you having to recount what your family has been through.

This morning, I mentioned a dementia unit I visited in WA. That aged-care home does something quite unique. They have members of the family on the interview panel for when they appoint people to that facility. So through the whole interviewing process, there are family members who are actively involved in that. Their record is about 98 per cent success with the people who are appointed. I think we can learn something from them. You've all given very moving accounts of the difficulties your families went through. Is there's one thing, it doesn't matter if it's been said before—we've raised issues about education, about training, about transparency—you want us to record in this report that you believe will change the situation? We want to do everything humanly possible to make sure this doesn't happen again.

Mr Martin: The staff certainly need more training. Silly me, I thought I might be able to bring my wife home at one time, so when she was at Oakden I went and did an aged care certificate III. I passed that. St John's come in and get you to practice if someone is sick. I'm not being mean, but the training that I and the others got was ridiculous. If someone fell down, for me to try and pump their heart after doing it on a plastic doll for just half an hour—and I passed as qualified—in a nursing home, what a joke. No wonder so many people don't know what they're doing in there, because they haven't been trained properly.

Mrs Glowik: It's a very serious pathology. You can have other things wrong with you, beside dementia. How many cancers have been missed simply because the overview has always been, 'Oh, it's dementia'? That is very, very dangerous.

Senator POLLEY: The level of pain.

Mrs Glowik: Yes.

Ms Stojanovic: I would like the people to be respected and be treated like human beings, treated as you would your own parent or somebody that you love dearly, and not to be treated like dirt and like a nobody. They are somebody. I said to one of the RNs at the place one time, 'You're new.' And she commented: 'Yes. I've got a job here because my husband doesn't talk to me at home.' My mother always told me: 'Be passionate about your job. Be passionate. Don't go to work every day hating going to work. Be passionate about what you're working for.' I've always got that in my head, and when I heard her say that, I thought: 'My God, are you serious? Because your husband doesn't talk to you? That's disgusting to me that it's not because you want to care for these people, but that he doesn't speak to you.' To me, that was outrageous. I just want to see change, so it never happens again to anybody. That's what my mum would want.

Mrs Glowik: I've heard that also: 'I'm only here because my husband wants a spa bath.' There's dedication for you, isn't it.

CHAIR: They come to work to earn money for a spa bath!

Mrs Glowik: There you go.

Ms Costa: I agree with what everyone has said. I still firmly believe that the people who are working in these institutions should be people who care about people, who have a high level of care and who have had real-life experiences. They shouldn't just be anybody. I really believe that. I've looked after my father for a long time. I know that if you have that real-life experience, only then will you understand what these people need to be cared for, how they need to be cared for. That's what I believe.

Senator PATRICK: Mr Martin, you said that you complained and you complained and you complained. Were they internal complaints, or did you end up going outside of the facility?

Mr Martin: No, not really. When I'd go there, I'd tell them that she's not dressed well, she's not even in her own clothes, she's not cleaned properly—things like that. I'd tell the guy who was running the staff.

Senator PATRICK: Were you aware of any external complaint mechanisms?

Mr Martin: At that time not really. I wouldn't say I was thinking about that, no.

Senator PATRICK: Anyone else?

Ms Stojanovic: I made complaints to the managers. I also wrote letters to the managers stating that I didn't want certain nurses working with my mum, because every time they did she ended up with bruising and I'd get told that she'd punched herself or scratched herself and things like that. She had many unexplained bruises around her cheeks, where I got told 'lifters'. I complained and, when the Oakden review came through, my paperwork had gone missing.

Senator PATRICK: Did you complain externally at any point?

Ms Stojanovic: No.

Senator PATRICK: Okay. Thank you.

Ms Stojanovic: I didn't know who to.

Senator SMITH: So, when the Oakden review took place, you were told that your paperwork had gone missing.

Ms Stojanovic: Yes, and I actually sat with—I don't even know what his title was there; I only met him once before in the actual Oakden facility. I'd sat with him and said that these were my concerns with this particular person working with my mum, and he just said, 'Oh, I think she's just trying to be a little bit overpowerful in her position, and she's competing with the other one.' And I said, 'Well, that's nothing to me. I don't care how powerful she thinks she is, I don't want her near my mum.' They then did move her, but, as with the other Oakden families, we later found out that they placed the other nurse onto the side where my mum was, which was McLeay, because he'd had complaints about him. So what they used to do was just swap and change. But if you've had major complaints about one certain male staff member, who was quite a big person, and you're putting them with people that are already very vulnerable, why would you do that? Why? Why wouldn't you deal with the problem?

I remember at the end of the Oakden review this male nurse was there and he said to me, 'I'm just waiting to get a payout. I'm just waiting, and I don't care.' This is what I mean by you have to be passionate about your job. If you lose that passion, what's the point of even being there, because you're not caring? You didn't care that my mum was dressed as a homeless person, basically, in clothes that weren't even her own. My mum was an immaculate woman. When she dressed, she dressed immaculately. She had her hair done. My mum went to a dental appointment at the dentist with shit in her hair—shit—and in her hand and on a chair that was falling apart. And this was representing Oakden, the only facility that could look after her. It was disgusting. It was absolutely disgusting.

And it hurts. It hurts that my mum's now passed and they didn't care. They didn't care at all, and it hurts a lot; it really does. And that's why, for my mum's sake, just change. Just try to make change, because all it's going to be is better. It can only be better; it can't get worse.

I put the abuse signs all over the mainstream nursing home, but people were taking them down. Every time they took them down I put them back up: 'Report elderly abuse'. And I said to them, to every nurse that looked after my mum, 'You make a step wrong and I will report you. I'm not scared to report you.' 'Oh, yeah, well, your mum's been through a lot, hasn't she?' 'Yes. Yes, she has, yet she still sits there and shakes herself and smiles at me and talks to me in her confused talk and doesn't remember a thing about that trauma that she went through, and it is just unexplainable that people allowed it to happen.'

CHAIR: Thank you for all sharing your experiences with us. It helps us to understand, and I'm really, really sorry that it re-upset you. It makes us all the more determined to make sure that this—

Ms Stojanovic: I think it's just that mum's passing is very recent. So, yes, it just hurts.

CHAIR: We're very hopeful that, between the reports that have been done and this report, we can drive some change. Thank you.

Ms Stojanovic: Thank you very much.

CHAIR: We'll adjourn this hearing. I thank all our witnesses, particularly the families of the people who have suffered at this institution. Thank you for your submissions and thank you for your evidence today. Thank you also to broadcasting and the secretariat.

Committee adjourned at 17:35