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THE HONOURABLE T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

IN THE MATTER OF THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

CANBERRA

10.02 AM, TUESDAY, 10 DECEMBER 2019

Continued from 9.12.19

DAY 70

MR P.R.D. GRAY QC, counsel assisting, appears with MR R. KNOWLES SC and MS B. HUTCHINS

COMMISSIONER PAGONE: Ms Hutchins.

MS HUTCHINS: Commissioners, the first witness we will call this morning will give evidence regarding the experience of her mother in a residential aged care facility here in the ACT. Her mother's experience highlights issues on the topics being explored in the course of this week's hearings, including access to primary care, hospital transfers between aged care facilities and hospitals and access to rehabilitation by people living in aged care facilities. Commissioners, I call the first witness today, Ms Jennifer Walton.

COMMISSIONER PAGONE: Yes. Thank you.

<JENNIFER MARIE WALTON, AFFIRMED [10.03 am]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Ms Walton, what is your full name?

MS WALTON: Jennifer Marie Walton.

MS HUTCHINS: You've prepared a statement for the Commission.

MS WALTON: I have.

MS HUTCHINS: Operator, please call up the statement which, for the transcript, is WIT.1305.0001.0001. Is this a copy of your statement signed on 26 November 2019?

MS WALTON: It is.

MS HUTCHINS: Do you wish to make an amendments to the statement?

MS WALTON: No.

MS HUTCHINS: Are its contents true and correct to the best of your knowledge and belief?

MS WALTON: Yes, they are.

MS HUTCHINS: I tender that statement.

COMMISSIONER PAGONE: Yes. Thank you. The statement of Jennifer Marie Walton will be exhibit 14-11.

EXHIBIT #14-11 STATEMENT OF JENNIFER MARIE WALTON DATED 26/11/2019 (WIT.1305.0001.0001)

MS HUTCHINS: Operator, please bring up tab 44 of the general tender bundle. Who is this a photo of?

MS WALTON: This is my mum, Avril Marie Walton.

MS HUTCHINS: And she died on 19 May 2019 aged 84.

MS WALTON: Yes.

MS HUTCHINS: What was your mother like when you were growing up?

MS WALTON: Well, my father was away as a marine engineer so Mum raised four of us children basically single-handedly, like Dad could be away for six months at a time, so Mum just basically did everything, so she was basically everything to us.

MS HUTCHINS: And did she live in Melbourne?

MS WALTON: She did, yes.

MS HUTCHINS: And your father died in 2007, and at that time your mother decided to move here to the ACT.

MS WALTON: That's correct, yes.

MS HUTCHINS: And why did she make that choice?

MS WALTON: Well, I have three older brothers, none of whom were living in Melbourne either. And so Mum thought, "Well, if I need some support down the track, it's probably better to place myself somewhere now while I'm still okay". I mean, we had no idea of, you know, how we would end up but, you know, because I was here and in a position to provide support, you know, we thought that was a good idea of hers, so - - -

MS HUTCHINS: And she moved into a retirement village.

MS WALTON: She did, yes.

MS HUTCHINS: Yes. And how was her health while she was living in the retirement village?

MS WALTON: Yes, she was pretty good. She was on very little medication for someone of her age; I think she was just on cholesterol-lowering drugs so, you

know, not – you know, she didn't have any major health issues until, really, she had a hip replacement in 2014. Well, I mean, dementia in 2012 but then - - -

MS HUTCHINS: 2012. And at some point around 2012 your mother asked you to go see her GP with her; is that correct?

MS WALTON: That's correct, yes.

MS HUTCHINS: Why was that?

MS WALTON: Just because she was forgetting stuff and, you know, not feeling confident in what she was doing and, you know, thought probably it was the right time to start to, you know, go in parallel with her to appointments, yes.

MS HUTCHINS: And in 2012 she saw a geriatrician and was diagnosed with dementia.

MS WALTON: Correct, yes.

MS HUTCHINS: And she remained in the retirement village until 2014.

MS WALTON: 2015.

MS HUTCHINS: 2015. Sorry, she had the hip replacement in 2014.

MS WALTON: That's correct.

MS HUTCHINS: Was it after that time that her health was deteriorating?

MS WALTON: Yes, the dementia – so the surgeon actually told us, because Mum had early dementia, that operations that take that length of time under anaesthetic can cause people or can tip people further into dementia. So we were aware of that, but the hip pain was so bad that, you know, you're weighing up do I do it or not do it, so she needed to have the operation but it was after that that it really started to decline. So she didn't really come back to the level that the surgeon sort of thought she probably would.

MS HUTCHINS: And in July 2015 was when your mother first moved into the residential aged care facility?

MS WALTON: That's correct, yes.

MS HUTCHINS: How was her health by the time she was moving into the facility?

MS WALTON: She was – it was – she was still only on the same medication so it was actually okay. I mean, the dementia was increasing all the time, like she was not – not coping at home. I feel awful to say this but I realised she wasn't eating as well

as she could because when she went into the aged care facility and there was three meals a day she put on quite a bit of weight because she clearly wasn't eating properly, so yes.

MS HUTCHINS: What were some of the other symptoms or behaviours that she was displaying as a result of her dementia?

MS WALTON: She would generally be confused about, you know, the day of the week or what she needed to do on the days of the week. So I would actually write her a diary every week as to what was happening, what appointments we were doing and that sort of became her guide. But because she was home on her own for quite a bit of time, I was working full time, you know, like I think I mentioned in my statement that, you know, someone from the Green Loans came around and Mum let them in and they had a cup of tea together and she signed a form that said Green Loans. And I – when I came around to see it I looked at the form and, "My God what is this" sort of thing. It was only an energy audit but Mum had no idea, you know, what she had actually done, so it could have been anything.

MS HUTCHINS: When she moved into the aged care facility she continued to see the GP that she'd been seeing previously in the community?

MS WALTON: Correct.

MS HUTCHINS: How important was that continuation of the relationship to you and your mother.

MS WALTON: It was extremely important because Mum first consulted her in 2007 when she came to Canberra so they had already had that length of relationship by that time, so it provided that continuity of care.

MS HUTCHINS: Did the GP come to see your mother at the facility or would you take her outside to the GPs rooms.

MS WALTON: So I took her to the GPs rooms for a while until it wasn't possible to actually take her out of the facility, you know, in terms of confusion with dementia and being worried about where she was. So the GP then started to visit Mum. So that was a conversation we'd had upfront, "Would you come and visit?" and she said, "Well, as long as you can still bring her, let's do that and then, you know, we will work it out after that".

MS HUTCHINS: Did you ever have any conversations with the GP about why it was her preference that your mother be taken to see her?

MS WALTON: No, but I just assumed, you know, she's a busy GP, and it's easier for her to, you know, for me to be able to bring Mum there, so I just assumed it was that. And I was fine with that knowing that down the track if we needed to, she would come to the facility.

MS HUTCHINS: Yes. And in your statement you note that by 2016 it became too problematic to continue to take your mother out to see the GP. What was it that made it too problematic at that time?

MS WALTON: Well, her mobility wasn't as good by then, so it – you know, difficulty in walking and also with the dementia that Mum had, she took a lot of comfort in the familiarity of places. So taking her out of her environment to take her somewhere else, you know, became quite problematic, you know, a bit panicky and anxiety.

MS HUTCHINS: And when the GP started to visit your mother in the facility would you attend those consultations?

MS WALTON: Usually. Usually, because she would ring me and let me know she was coming or I would have arranged the appointment so I would be there. But if I couldn't do – if I couldn't, you know, leave work for whatever reason at that point she would ring me afterwards and let me know what had happened. But we also had a – we had an email exchange situation so if I was concerned about anything with Mum at the facility, I would email the surgery and I'd give them a call and say "I've just emailed you for the doctor, so can you give a copy of that to the doctor". And that worked quite well because they would then – they would give it to her and she would give me a call or make an appointment or something.

MS HUTCHINS: Yes. And when the GP would visit, where were the consultations held?

MS WALTON: In Mum's room.

MS HUTCHINS: Did she have a private room?

MS WALTON: Yes.

MS HUTCHINS: And were you happy with the consultations being there or do you feel they would have been better off in a special consultation room?

MS WALTON: No. I think – they actually have a consultation room there at the facility but it was better to be in Mum's room because of the familiarity with everything.

MS HUTCHINS: Yes. And was the GP required to bring in particular equipment with her when she was seeing your Mum in her room?

MS WALTON: She just brought a normal doctor's bag of tricks, whatever was in there.

MS HUTCHINS: And when your – when the GP would come to see your mother, were you also accompanied by facility staff?

MS WALTON: Sometimes; not always.

MS HUTCHINS: And did the facility staff have a good understanding of what was occurring during the doctor's consultations.

MS WALTON: Probably sometimes but not always, yes.

MS HUTCHINS: And are you aware how the information would be exchanged between the GP and facility staff in terms of how they would exchange notes or - - -

MS WALTON: Yes.

MS HUTCHINS: - - - any kind of relevant health information.

MS WALTON: So the GP would pick up Mum's file because this facility is not electronic at all, so they would pick up her file and – or she would pick up her file and bring it into the room, and review the medications that she would – once she had finished the consultation she would go and sit at the nurses' station and she would write the notes out in the file and do any prescriptions needed.

MS HUTCHINS: Yes. So during your mother's time at the facility she experienced a number of falls: between November 2016 and August 2017 your mother was transferred to hospital on six occasions following falls. She suffered a pelvic fracture, dislocation of her left prosthetic hip and also a break to her right hip.

MS WALTON: Yes.

MS HUTCHINS: Do you know what was causing these falls?

MS WALTON: No.

MS HUTCHINS: And in your statement, you say that for a person with dementia a 24-hour stay in hospital is awful. Why is that?

MS WALTON: It's just the environment is just not set up for dealing with people with dementia that have some other illness or injury. I mean, going into the emergency department, you know, it's as you would expect, it's loud, it's noisy, it's bright lights, it's, you know, people coming and going, you know, there's people who've drunk too much shouting the odds and, you know, it's just not a calm environment and I'm not expecting it could be but, you know, I've since reflected it would have been good if there was somewhere where we could go that, you know, you could receive treatment that wasn't as agitating in that sense.

So Mum would get upset at what was going on around her and, you know, constantly saying to me, you know, "I want to leave" and, you know, "How do we get out of here?" and what have you.

MS HUTCHINS: And do you think if there was a greater availability of some of the hospital-like services to be provided in residential aged care facilities, that that would have resulted in better care outcomes for your mother?

MS WALTON: I don't know that it would have resulted in better care outcomes, but it certainly would have been less – there would have been less drama for her - - -

MS HUTCHINS: Yes.

MS WALTON: - - - you know, because of the familiarity of environment if, you know, some of the things could have been done - - -

MS HUTCHINS: Yes.

MS WALTON: - - - at the facility.

MS HUTCHINS: So say, for example, in your statement you detail some instances where you thought your mother's transfer to hospital could have been avoided. And I'd like to discuss two of those situations.

MS WALTON: Sure.

MS HUTCHINS: The first one relates to an assessment by your mother – a physiotherapist assessed your mother in January 2017. Could you describe for the Commission what the circumstances were surrounding that physiotherapist assessment.

MS WALTON: Sure. Okay. So mum had had a fall on a particular day and I had actually gone to see her that night, just to check that she was okay. I don't believe the – the facility didn't ring a doctor or an ambulance. And mum was quite calm to me; like, there was no obvious signs of distress. And then the next day I had a phone call from the physiotherapist in an absolute panic. Like, I'm at work and he's going, "Your mother shouldn't be like here," you know, like, "they can't cope with her. She's not suitable to be here. They don't have a sling lift." I'm going, "Crikey, what's going on? I was only there last night", you know, sort of thing.

And that was – I mean, we went to hospital on his say-so and it ended up that the X-ray showed that it was healing, so there was no further issue that needed to be dealt with. But then, you know, that – a trip to hospital and it's – you know, you're waiting probably five hours for patient transport. And that's not a criticism of patient transport; that's how it works. But, you know, we just had all that time in there that was completely unnecessary. And I did complain to the facility that, you know, they should not have allowed that to happen.

MS HUTCHINS: And why do you think that that assessment was made by the physiotherapist?

MS WALTON: I just don't think he understood how mum's dementia presented. I think he had a bit of a panic. He probably, you know, tried to, you know, do something with her and she didn't know who he was and – I mean, I wasn't there to see how he introduced himself to her or what level of understanding she had or whether the staff were in the room. I mean, I'm assuming the staff – I mean, the staff should have been able to explain to him what might happen, but that – I don't believe that happened.

MS HUTCHINS: Yes. Are you aware whether at the facility there was some kind of, you know, care plan or explanation that was provided to staff which would explain to them how your mother's dementia might affect her behaviour and ways that could be implemented to try to avoid any types of reactions in the way that it happened that day?

MS WALTON: I don't believe there was anything like that.

MS HUTCHINS: You also identify in your statement an instance where your mother was transferred to hospital after she had been seen by an after-hours GP. So if your mother required a GP and her usual GP was not available, do you understand what the kind of practice was at the facility?

MS WALTON: Yes. So they would ring an after-hours GP. They'd use, like, CALMS or some service like that and try and get someone to come. But often they couldn't get people to – they either couldn't get them to come or it was a really long wait for them to come.

MS HUTCHINS: And what do you understand to have occurred in the interactions with after-hours GPs which might not have occurred with your mother's regular GP in the way that they would have interacted with your mother?

MS WALTON: Yes. So – I mean, what I'm assuming is that they've come into the room, they're busy, they're, you know, trying – they've probably got cases backed up and they've just done whatever they can quickly to work out what's going on without, you know, understanding what might happen if they, you know, don't approach mum properly, in a sense of introducing themselves and speaking quietly and calmly and, you know, all of the things that – that would have made it better.

I think – like, I have experienced – so when I started to say – when I said to the facility, "If you're going to ring an after-hours GP, I'd like to come and be there at the time", you know, thinking maybe I can calm things down, and I did observe them, after-hours GPs, coming into the room and not really addressing mum, sort of thing, you know. So I would step in and say, "You know, mum has dementia and this is what might happen," and wanted to try and frame it for them.

MS HUTCHINS: Yes. And you note in your statement that after you started attending more of the sessions with after-hours GPs, you found that the hospital transfers weren't necessary?

MS WALTON: That's right.

MS HUTCHINS: Is that right?

MS WALTON: That's right.

MS HUTCHINS: And how many occasions was it that you think your mother might have needed to have been transferred unnecessarily from the facility to the hospital?

MS WALTON: I can't recall specific numbers, but I would imagine at least three or four. Yes.

MS HUTCHINS: And if there had have been the availability of, say, an X-ray service to have come and seen your mum in the facility, do you think that that would have, you know, been a preferable option for her?

MS WALTON: Absolutely. And especially, like – you know, because of the environment, she's still in a similar environment with similar people, the people around her, then she would be left agitated by that. And then, you would think that's a better use of money too, because – especially in a situation where you don't need to go to hospital, because then you don't go.

MS HUTCHINS: Yes. I would like to ask you about your mother's access to rehabilitation during her stay at the residential aged care facility. After your mother's fifth fall that you detail in your statement, which occurred in March 2017, she had dislocated her hip and required surgery in hospital?

MS WALTON: Yes.

MS HUTCHINS: She also had a significant wound on her shin. Were you told how that had occurred?

MS WALTON: Yes. So what happened was because it was actually hip dislocation, in the ED, the doctors get hold of the shin, turn it and put the leg in. But, of course, they had to do it several times because they didn't get it in the first time. And in the process of doing that, basically ripped the skin off all down the shin and caused a major wound that needed to be managed.

MS HUTCHINS: And how long did your mother stay in hospital for on that occasion?

MS WALTON: So she moved from the public hospital to the private hospital and she was actually in there for six weeks. And a geriatrician in the private hospital arranged for the man who did the surgery, the original surgery, because he operates out of that hospital, to come and consult. And he provided the advice on six weeks bed rest.

MS HUTCHINS: Yes. And so was this the first time that your mother had been offered subacute rehabilitation services?

MS WALTON: Yes. Yes.

MS HUTCHINS: And so the other times after the earlier falls, when she had fractured her pelvis and then refractured her pelvis again, were there any rehabilitation services provided to her within the facility?

MS WALTON: There might have been a bit of physio, but it wouldn't have been much.

MS HUTCHINS: Do you know what that physio might have involved?

MS WALTON: No.

MS HUTCHINS: And what was your mother's experience like at that rehabilitation hospital?

MS WALTON: From a perspective of her health getting better it was a good experience, but she was very upset and very agitated a lot of the time. And I know it was very difficult for the staff, because she would call out and want to get out of bed and it was very problematic. So there was no dementia-specific area that provided rehabilitation. So in terms of person-centred care, they were providing care about the hip but not about in the frame of her having dementia.

MS HUTCHINS: Yes. And do you think the staff at the residential aged care facility might have been better equipped to help facilitate that rehabilitation service, given their knowledge of your mother and her dementia symptoms?

MS WALTON: Yes. Yes, probably. Yes.

MS HUTCHINS: And the most recent hospitalisation which occurred, which was following a fall which is detailed in your statement as her sixth fall on 9 August 2017, do you remember the circumstances of that particular hospitalisation?

MS WALTON: Yes.

MS HUTCHINS: And what happened?

MS WALTON: So it was late at night and I – our home phone is down the hallway and it rang, sort of, in the middle of the night. And I didn't make it to the phone before it went to the answering machine, but no answering – no message was left, so I just went back to bed, because I didn't have any sense of what was going on. And, well, I looked at my mobile; there was no message on there either. And then about 1 am my mobile phone rang and it was the hospital saying, "Your mum has had a fall and she's in hospital." So she'd been in hospital a couple of hours before I even

knew that. So I went to the hospital then and she had already had an X-ray that showed that she had broken the right hip, and the surgeon came in to talk to me about her needing surgery.

MS HUTCHINS: Yes. And what kind of state was your mother in when you arrived at hospital?

MS WALTON: A mess. Completely agitated and distressed and – yes.

MS HUTCHINS: And during that hospital visit, she had surgery. And you note in your statement that post-surgery she was placed in a specific area within the orthopaedic ward for people with cognitive problems.

MS WALTON: Yes.

MS HUTCHINS: What was your experience like with that part of the hospital?

MS WALTON: It was really good. It was a four-bed ward. There was a nurse in there the whole time, so 24/7, and they played music in there and it was calm. It was, you know, quite – it was quite different to a busy ward, in a sense. So everybody there had cognitive problems.

MS HUTCHINS: Yes. And did you feel like that was a better environment for your mother to be in than where she had been previously in the hospital?

MS WALTON: Absolutely. Yes.

MS HUTCHINS: Yes. And in your statement you detail that five days post-surgery you received a call from the hospital, advising the transport had been booked.

MS WALTON: Yes.

MS HUTCHINS: Please explain to us a bit more about the circumstances of that call and what you were told.

MS WALTON: Yes. So I was – it was, basically, a call saying, you know, "We're going to discharge your mother." And I'm saying, "But", you know, "she's got a history of falls." And I had seen her the day before only being able to stand and pivot to sit on a chair. And it was incomprehensible to me that she would be ready to be discharged. So I asked to speak to whoever was suggesting that that was okay. So they got the physio therapist to give me a call and it was just – she just talked constantly, was not wanting to actually hear what I had to say.

So I just waited it out until she took a breath and then said, "I just don't believe that situation because that's not what I've observed." She told me that mum was walking to the window – like, her bed was near the door – so mum was walking to the

window and back, and, you know, "would be okay". I was going, "Well, how did that happen?" It's certainly not what I observed.

MS HUTCHINS: Yes. And so what did you do from there?

MS WALTON: So she undertook to re-assess her and I then went into the hospital that afternoon and had a conversation with the nurse unit manager about it. They were insistent that she would be discharged the next day. So this went on for days and I fought it till about day 10 where I just – and the GP got involved. The GP spoke to the specialist and said, "You know, she has private insurance", you know, "let's get her into a private hospital", and we thought that was probably our best option; you know? Happy to get out of the public system. We've got private insurance; let's get in somewhere else.

But that didn't occur and, you know, I – I was actually told by one of the staff that the private hospital wouldn't take her. So when everything settled, like, a few weeks down the track, I contacted the private hospital and I just said in an email, "Look", you know, "this happened. Can you tell me why that would be the case?" only to find out that they were never actually approached by the public hospital to take her. So I don't – I don't know why that occurred. But then – so - - -

MS HUTCHINS: And just to be clear, this is to take her for rehabilitation services - - -

MS WALTON: That's correct. Yes.

MS HUTCHINS: - - - like what she'd received previously?

MS WALTON: That's correct.

MS HUTCHINS: Yes.

MS WALTON: Into that same facility.

MS HUTCHINS: Yes.

MS WALTON: Same place, so - - -

MS HUTCHINS: Yes.

MS WALTON: Yes.

MS HUTCHINS: And so that wasn't available. Or you were told that wasn't available. So what occurred then?

MS WALTON: So she was discharged, but – so this was about day 10 – discharged back to the facility. But as I said in the statement, you know, the conversation I had

with the doctor that morning was, "Okay. You know, if you're going to discharge her, make sure you – can someone give me a call so I can meet the ambulance when it gets to the facility?" And, you know, "Can you ring the facility, to make sure they understand she's coming?" And neither of those things happened, because the facility rang me and said, "Your mum's back. Did you know?" And I said, "But I thought they were going to tell you so you could be prepared".

MS HUTCHINS: Yes. And that was a conversation you had with the doctor from the hospital?

MS WALTON: That's correct, yes.

MS HUTCHINS: Did you have a sense as, you know, across these various transfers you had, you know, to and from hospital with your mother whether there was good information sharing between the residential aged care facility and the hospital about what the condition of your Mum was like when she was going in there, any kind of details they might need to know at the hospital site?

MS WALTON: I feel like – so the hip dislocation when she went to the private hospital back to the facility, I think – and especially because of the wound management required that was better, but with the one in 2017 I don't believe there was much given at all.

MS HUTCHINS: As in much given from the hospital back to the facility?

MS WALTON: Yes.

MS HUTCHINS: Yes. And what about in terms of information from the facility to the hospital? Did the hospital seem to have the information they needed about your mother's current health and - - -

MS WALTON: Yes, so the facility has a process of when they call an ambulance they put a bit of a pack together of information that they send with the ambulance officer to the hospital. I observed that happening.

MS HUTCHINS: Yes. In your statement, you note that your mother had an advance care directive.

MS WALTON: Yes.

MS HUTCHINS: What was the process that you went through when that was first made?

MS WALTON: So, firstly, it was Mum's GP suggested that that should be the case. So we got the template from the website and put that together. But then years down the track we revised it with the palliative care nurse because she had had a look at it

and was concerned that it could in some ways be ambiguous. So it was better to have it clearly set out, plus the template had changed I think.

MS HUTCHINS: In terms of your interactions with the palliative care nurse, was that nurse someone from the facility or an external body?

MS WALTON: She was external but the facility got her in to, I imagine, talk to a range of people. So she spoke to us a few times, yes.

MS HUTCHINS: So that was something that the facility suggested to you that you might benefit from seeing a palliative care nurse.

MS WALTON: Yes, and they arranged it, yes.

MS HUTCHINS: And how was your experience with the palliative care nurse? Do you think that that's advantageous for someone in your position?

MS WALTON: Yes, I found it very positive, yes. She was – I felt like it was a support for me so I understood, you know, sort of what services she could offer, and, you know, towards the end of Mum's life, say, in the last week I actually, she came in a couple of times then, too, and, you know, to understand – enable me to understand what was happening.

MS HUTCHINS: Yes. And you noted earlier that the facility operated a paper-based system so everything was done on files. If residential aged care facilities were encouraged in the future to have electronic files where they might be able to upload information to, say, My Aged Care, is that something that you would have felt comfortable with or uncomfortable with when it came to the treatment of your mother's personal information?

MS WALTON: I would have been completely comfortable with that because it's just ease of information sharing; you know, if you go to hospital you're not having to send a pack of information, that doctors can go back into a computer system and see everything that's recorded. It's just logic in this day and age. I don't know. I mean, they were established in 2015. It's beyond my comprehension why they didn't just have a computer-based system from the start.

MS HUTCHINS: Yes. And is there anything further that you would like to say to the Royal Commission in terms of a message from your experience or areas for improvement that you would like to bring to its attention.

MS WALTON: Sure. I've written myself a few notes so I don't forget. So from our experience, having dementia shouldn't mean that health and aged care systems treat people with any less respect or fail to provide the necessary care to ensure continued wellbeing. That's just – it shouldn't be the case. And on our experience, the hospitals were not equipped to deal with situations where people with dementia present with other issues.

Yet I note the Australian Health Ministers' Advisory Council National Framework for Action on Dementia, which is 2015 to 2019, is being revised now. So it's got a list of outcomes and actions specifically relevant to acute care settings. So, you know, why isn't that happening? And then just finally, continuity of care should be the standard, not the exception and it shouldn't be a fight to get consistent care across aged care and health settings. They should work together and provide wraparound support for people.

MS HUTCHINS: Thank you. There's no further questions, Commissioners.

COMMISSIONER PAGONE: Thank you, Ms Hutchins.

COMMISSIONER BRIGGS: I was very interested to hear, Ms Walton, about the four-bed cognitive area, and would you see that as an option for people presenting – people with dementia presenting at emergency otherwise, a calm room or - - -

MS WALTON: Absolutely, yes. If there was somewhere like that we could shut off what happens in the ED that needs to happen in the ED I think it would have made quite a difference. And especially if you staffed it with, you know, people – nursing staff that understand how people present with dementia, yes.

COMMISSIONER BRIGGS: Yes. Thank you.

COMMISSIONER PAGONE: Ms Walton, thank you for coming to give evidence and thank you for the additional thoughts that you gave us. It's important for us to get the real context in which the broader issues are being looked at. We're very grateful to you. Thank you.

MS WALTON: Thank you.

COMMISSIONER PAGONE: You are formally excused.

MS WALTON: Thank you.

<THE WITNESS WITHDREW [10.36 am]

COMMISSIONER PAGONE: Mr Knowles, I think we might be a bit early.

MR KNOWLES: Yes indeed, Commissioner.

COMMISSIONER PAGONE: If we were to break now, we could start earlier if you're ready to start earlier. Is that convenient?

MR KNOWLES: That is convenient. The witnesses are here in attendance now, so if we break for perhaps 10 to 15 minutes as the Commission pleases.

COMMISSIONER PAGONE: All right. What if we resume then at 10 to?

MR KNOWLES: If it pleases the Commissioner.

ADJOURNED [10.37 am]

RESUMED [10.54 am]

COMMISSIONER PAGONE: Yes, Mr Knowles.

MR KNOWLES: Yes. Commissioners, the next two witnesses are experts in the field of emergency medicine, particularly in relation to geriatric emergency medicine. They are Dr Carolyn Hullick and Dr Ellen Burkett. Among other things, they will give evidence about best practice for transfers between residential aged care facilities and emergency departments, as well as the use of multidisciplinary outreach services. I now seek to have them administered with the oath or affirmation.

COMMISSIONER PAGONE: Yes. Thank you.

<CAROLYN JENNIFER HULLICK, AFFIRMED [10.55 am]

<ELLEN KAREN BURKETT, AFFIRMED [10.55 am]

MR KNOWLES: Dr Hullick, starting with you, can you tell the Royal Commission your full name.

DR HULLICK: Carolyn Jennifer Hullick.

MR KNOWLES: And Dr Burkett, what is your full name?

DR BURKETT: Ellen Karen Burkett.

MR KNOWLES: Yes. Now, you have together prepared a statement dated 29 November 2019.

DR BURKETT: Yes.

DR HULLICK: Yes, that's right.

MR KNOWLES: That bears the witness identification number WIT.1298.0001.0001. You will see the first page of that document on the screen before you.

DR HULLICK: Yes, that's correct.

MR KNOWLES: Yes. Have you read your joint statement lately, each of you?

DR HULLICK: Yes, we have.

DR BURKETT: Yes.

MR KNOWLES: Yes. And save for the specific information that relates to the other person, are you satisfied that the information is true and correct to the best of your knowledge and belief?

DR HULLICK: Yes, I am.

DR BURKETT: Yes.

MR KNOWLES: Yes. And where you've expressed opinions, that they are genuinely held, based on your expertise?

DR HULLICK: Correct, yes.

DR BURKETT: Yes.

MR KNOWLES: Thank you. Commissioners, I seek to tender the joint statement of Dr Carolyn Hullick and Dr Ellen Burkett dated 29 November 2019.

COMMISSIONER PAGONE: Yes, the joint statement will be exhibit 14-12.

EXHIBIT #14-12 JOINT STATEMENT OF DR CAROLYN HULLICK AND DR ELLEN BURKETT DATED 29/11/2019 (WIT.1298.0001.0001)

MR KNOWLES: Thank you, Commissioner. Dr Hullick and Dr Burkett, I'm going to address questions to both of you in light of the nature of the statement that you've given, but I will leave it to you as to which of you starts in giving evidence and if there is one of you that is particularly able to give evidence on it, I will let you determine between yourselves on that. But I note in paragraph 2 of your statement on the first page which remains on the screen, you are giving this statement on behalf of the Australasian College for Emergency Medicine, and this represents the views of the College more broadly; yes.

DR HULLICK: That's correct.

DR BURKETT: Yes.

MR KNOWLES: Thank you. Now, can I ask you a little bit about yourselves. Dr Hullick, you're the chair of the Geriatric Emergency Medicine section of the Australasian College for Emergency Medicine.

DR HULLICK: Yes, that's correct.

MR KNOWLES: Yes. And you're currently enrolled in a PhD at the University of Newcastle studying care of acutely unwell residents in residential aged care facilities.

DR HULLICK: Yes, that's correct.

MR KNOWLES: Your other roles include of that of emergency physician and you're the director of emergency medicine at Belmont Hospital in the Lake Macquarie area.

DR HULLICK: Correct. Yes.

MR KNOWLES: Yes. And you're also the clinical lead of the aged care emergency program for the Hunter New England Local Health District.

DR HULLICK: Yes. That's correct.

MR KNOWLES: Can you tell the Royal Commission just a little bit about what that last role entails.

DR HULLICK: About the program?

MR KNOWLES: Yes, and what your role also as clinical leader of the program entails.

DR HULLICK: I suppose I'm an emergency physician with expertise in caring for older people in the emergency department. And we, in Newcastle, run an extensive service that involves 100 aged care facilities across Hunter New England so from Newcastle to Armidale to Tamworth to Taree, so pretty extensive, small hospitals like Singleton which is a rural hospital within that area as well. It's a nurse-led program where the staff from the aged care facilities can call someone 24 hours a day and get advice over the telephone in relation to care of residents who they're concerned about. It's specifically around being acutely unwell, so not day-to-day kind of concerns but patients that they're thinking about transferring to the emergency department.

And as part of that conversation they also talk about what the goals of care are for the resident if they need to be transferred to hospital because given the complexity of the patient it's actually important that the ED knows what to tackle, and I think we heard about it earlier this morning, you know, the transfer was related to the injury, not

necessarily the other complex medical concerns. And as part of that program we have some algorithms that the nursing staff in the aged care facilities can use in collaboration with the GP and we do training in the facilities in relation to recognition of a deteriorating patient, information that's required in terms of transfer, and the algorithms themselves.

MR KNOWLES: Just those algorithms that you mentioned, can you just briefly outline to the Commissioners how that works; what do they entail?

DR HULLICK: So they've developed over time and I suppose each year when we review them extra ones get added or modified, but they're kind of common reasons why people come to the emergency department. So the commonest reason why residents from aged care facilities come to the emergency department is for falls. So there's ones about falls, head injury, shortness of breath. They're more symptom-related rather than diagnosis-related so that if the care workers within the aged care facility need assistance they can look at those and guide some of the things that they've found, and think about some of the issues that need to be considered in relation to that person. So have you spoken to the family, have you spoken to the GP, what – does the person have an advance care plan; are all kind of central tenets to all of the algorithms but there's also more specific things around observations for head injuries, and things like that.

MR KNOWLES: So I take it then that they are something in the nature of diagnostic and procedural pathways, these algorithms?

DR HULLICK: Yes. They're mostly just one page of – and it's a flow chart, basically, and then maybe the second page might have some detail behind it, then they're referenced and there's some hyperlinks to extra resources if people require them.

MR KNOWLES: Can I turn now to you, Dr Burkett; you're a founding member of the Geriatric Emergency Medicine section of the College as well as being a fellow of that College. You're also the senior staff specialist at the emergency department of Princess Alexandra Hospital in Brisbane.

DR BURKETT: Yes, a, one of many.

MR KNOWLES: Yes. You're also the statewide clinical lead for development and implementation of Residential Aged Care Facility Acute Care Support Services or RaSS, Healthcare Improvement Unit, Clinical Excellence Queensland.

DR BURKETT: Yes.

MR KNOWLES: Yes. That last role, the statewide clinical lead role, can you just explain a bit about that and the actual RaSS service.

DR BURKETT: So in conjunction with a colleague, Dawn Bandiera, myself and Dawn in partnership with consumers and stakeholders across the care continuum developed the CARE-PACT program which was the pilot program for the then development of residential acute care support services. So our experience in developing and implementing the CARE-PACT program, which is a collaborative program that runs across the care continuum with the aim of improving the quality of care of residents across the care continuum as well as providing approved choice of care setting to the residents when they have acute health care needs, that experience and implementation of CARE-PACT is now being utilised to roll out similar programs to other hospital and health services in Queensland, and that's my current role with the Health Care Improvement Unit to lead that body of work.

MR KNOWLES: So that is to expand statewide the program that was otherwise initially commenced with CARE-PACT?

DR BURKETT: Yes. It's not being rolled out to every hospital and health service area but it's being rolled out to hospital and health service areas across, I believe, eight of those hospital and health services in Queensland.

MR KNOWLES: Yes. Can I ask you, perhaps starting with you, Dr Burkett, on that topic, you've said in your statement and this is at page 31 of the statement, if we could bring that up, on the fourth dot point on that page you've called for funding in support in respect of:

> *integrated care models that is support acute health care needs being met in the right place at the right time and in a setting that is concordant with resident choice.*

You've also said, and this is at page 33 of the statement at sub-paragraph (e) there, in the second dot point you've referred to:

> *...inter-jurisdictional integrated models of care to support RACF residents to have improved choice of care setting for acute health care needs.*

And among other things there's a reference there to the RaSS model. Now, do you think having regard to what's occurring in Queensland that there's an unfulfilled need for national coverage of services akin to those that are mentioned in that sub-paragraph there?

DR BURKETT: I think that there's definitively evidence to support the need for integrated models of care to improve the care of this cohort of very frail and vulnerable people across the care continuum. Unfortunately, the current funding structures and the divide between federal and State systems of health care are not conducive to this happening without significant barriers, and I'm very pleased that Queensland Health has taken the initiative to roll out such models of care that aim to integrate care and to develop partnerships with aged care facilities, general practitioners and specialists across the care continuum.

MR KNOWLES: Before I come to the barriers that you've just mentioned, Dr Burkett, can you ask you, Dr Hullick, do you share that view as to an unfulfilled need for national coverage of services of this kind?

DR HULLICK: Yes, I think it's the integration between the aged care system, the State health care acute care system and the federal general practice specialty system that is the kind of key to it, really.

MR KNOWLES: Yes. And how do you see that national coverage being achieved? You've mentioned barriers. Can you just perhaps elaborate on what they are, Dr Burkett, and how they might be surmounted?

DR BURKETT: So I think that there is a need, firstly, for significant funding reform in terms of funding mechanisms that support integrated models of care across the care continuum. I think, secondly, the current funding systems from a health care perspective incentivise activity and don't necessarily bear any relationship to the achievement of outcomes from a resident's point of view. And the funding mechanisms from a residential aged care facility support dependency and incentivise dependency rather than incentivising independence and improved outcomes for residents. So I think that there is a need for significant funding reform in order to facilitate dissolution of the current barriers that exist.

I think that beyond that, even within the context of current funding structures, there is the ability to, through inter-jurisdictional cooperation, to dissolve some of these barriers through formation of partnerships across the care continuum which is the approach that we're taking in Queensland to this problem.

MR KNOWLES: In terms of some of those funding reforms, do you perceive that there is an ability to achieve that within the National Health Reform Agreement framework that presently exists?

DR BURKETT: I think that to a certain extent there certainly would be; there needs to be the will to undertake such extensive change and there certainly needs to be a coherent effort for partnership of not just funding arrangements between federal and State Governments but also there needs to be the willingness to share information and data across the care continuum to allow us to achieve better outcomes and to measure and improve against outcomes of care.

MR KNOWLES: Yes. I will come back to the question of data linkage which you've both referred to in the statement, in due course. But Dr Hullick, can I ask you, what do you see as being necessary to achieve that national coverage that is required, or you see as being required in respect of these particular integrated models of acute health care?

DR HULLICK: So I think you have to actually define what's required, which might sound like a simple thing but it's actually quite complex. And then once you've defined what's required then you – then all the stakeholders involved need to be

around the table. So again for our ACE model, the primary health network is heavily involved. Hunter Primary Care, which is the local primary care organisations involved, the New South Wales Ambulance Service is involved, the aged care facilities are involved, and the hospitals are all involved. And if you actually think about what's required when someone is acutely unwell you actually require meaningful partnerships with all those people in order to be able to achieve what's needed.

MR KNOWLES: How, in that sense, have those meaningful partnerships been facilitated, in your experience?

DR HULLICK: So the way we manage that is we have a governance committee that works at a high level in relation to the relationships and how we all work together. But we also have this community of practice that we also refer to, which is, kind of, at the other end, really, where – at a local level. So there's seven of those across Hunter New England. We have a quarterly meeting and the aged care facilities and then all those stakeholders, to talk about what's working well, what's not working well. But it's also a really good opportunity to connect the hospital system with the aged care system. It's often quite isolated as well.

So, for example, we've – one of the quarterly meetings has been on elder abuse. Another has been on influenza and pandemic planning. Another one of the meetings – the most recent one's been on dementia and behaviour and psychological symptoms of dementia, BPSD. One of the challenges is the Older Persons Mental Health Services are run by the state system, and then Dementia Services Australia is – is run by the federal system. So even within an aged care facility, they're required to, kind of, negotiate between different parties in order to be able to manage those really complex behavioural issues. So by bringing all those parties together, it's much – and get each other to look themselves in the eye, in some ways, it's harder for them to not do what's required.

MR KNOWLES: Yes. Well, just picking up – in terms of what's required or what's to be achieved or sought from these particular programs or services, can I ask you, Dr Burkett – it's often said that they are intended to achieve avoidance of unnecessary hospitalisations. Is that the way that you see these models of care being directed?

DR BURKETT: So I think it's very imperative to undertake the planning of these models of care with the resident and resident choice at the centre. So in my view, the primary aim of these services must be to improve the quality of care of the residents across the care continuum and to improve choice of care setting. The benefits to the health system will flow on, if that is the primary goal. A focus on benefits of the health system as the primary goal, in my view, has a great risk attendant with it from a point of view of the quality of care of residents and may then present a barrier to accessing appropriate health care rather than to improving the care of the resident.

MR KNOWLES: Can I just ask you, when you refer there to benefits to the health system, are you including within that avoidance of unnecessary hospitalisations?

DR BURKETT: Yes. Avoidance of unnecessary hospitalisations, avoidance of unnecessary emergency department presentations.

MR KNOWLES: Yes.

DR BURKETT: And across the care continuum, sustainability of ability to provide health service to all.

MR KNOWLES: Yes. So these are the things that you say are, really, consequences of the model, not necessarily the aims or goals that it sets out to achieve.

DR BURKETT: I think that that's very critical, that the aim of these models of care must primarily be to improve the care of residents across the care continuum. And it's fortuitous in this age group with the frailty and with the complexity of health care that, in general, what's good for the resident, secondarily, will benefit the health system.

MR KNOWLES: Yes. And I think you mentioned earlier that if there is a focus on those benefits to the health system, that will create barriers to access. What do you mean by that?

DR BURKETT: So I think that there is a risk of any service that is established – if the primary goal is to prevent hospitalisation, there is an attendant risk that that becomes the overriding principle of the service, rather than the primary goal of actually improving residents' care and the choice that they have in where they would like that care to be delivered, if it can be delivered safely in a choice of option. So I think it's very important that the primary premise that services are established on is that they're established in a manner that improves the quality of care first.

And then benefits to the system will flow on from improving the quality of care of residents. I think that the other very important factor in establishing such services is to ensure that there is clear clinical governance for the services and that there is not diffusion of responsibility across care providers for the provision of such acute care services.

MR KNOWLES: Well, just on that, who actually comprises that governance structure for these kinds of services? Perhaps if I can start with you, Dr Hullick, in that regard.

DR HULLICK: Well, I think in our health care system – and we talked about it a bit yesterday, the GP is the, kind of, care coordinator, the primary doctor who's responsible for delivery of care to the residents in aged care facilities. And I think that it's actually really important that the systems that we put in place continue to

respect that and support that, rather than not – it's about empowering and supporting the facilities and the families and the residents, not rescuing them. I think it's – and I think that the health care system – we all look at the health care system through our own lens.

So when you're in a busy emergency department and there's patients everywhere and you can't off-load ambulances and, you know, we're not discharging patient within four hours – we're a very heavily scrutinised part of the health system and it's very easy to say, "That's an avoidable presentation. What's that person from that aged care facility doing here?" So I think we have to maintain – but when you talk to the aged care facilities and the families, the story is opposite about the difficulties and the challenges. So I think, ultimately, the GP has to remain as the responsible medical person within our system that continues to be the primary holder of clinical governance.

MR KNOWLES: Yes. What about governance more broadly, Dr Hullick, of these particular services? How is that achieved? Who are the people who are involved in the governance of the service more broadly?

DR HULLICK: Well, as I said, with our service, I think in order to be able to deliver all those systems, we actually need all those – both federal and state systems to be involved.

MR KNOWLES: Yes.

DR HULLICK: And as we talked about earlier, the state government's interest is around avoidable admissions. So sometimes they're the users of that language.

MR KNOWLES: Yes.

DR HULLICK: And the Federal Government is around primary care. So it's always – I think one of the challenges is the blames between the jurisdictions on who's responsible for the patient's care.

MR KNOWLES: Yes. Dr Burkett, do you have something to add to that?

DR BURKETT: I would add that I think there is currently, in a lot of systems across Australia, a diffusion of responsibility and a lack of clarity around who owns the clinical governance for the resident's health journey at any particular point in the care continuum. I think, currently, the aged care facilities are required to report against the aged care standards. However, the aged care standards hold within them, certainly, responsibilities that really lie in the realm of the general practitioner to be able to effect change in. So I think an important step forwards would be consideration of defining the clinical governance to include the general practitioner and the aged care facility together, as a joint entity, to be reporting against the aged care standards.

In terms of the acute services that we then provide from a hospital end to support acute deterioration, either in the aged care facility setting or in the hospital setting, I think it's equally important that there be very clear governance procedures that entail a single point of accountability that then reports into the hospital's safety and quality processes, such that there is the ability to follow up and ensure that there is high quality outcomes for residents, and that – where there are identified issues in that process, that those processes are subject to safety and quality procedures that result in improved quality of care. So I think, across the care continuum, at any juncture in the resident's aged care facility or health care journey, it must be clear where the governance for that particular episode of care lies. And there must be good and clear handover of governance from one party of responsibility to the other, across the transitions of care. And I think currently that's not happening optimally across the country.

MR KNOWLES: Well, having regard to what Dr Hullick just said about the respective responsibilities of different governance, how do you see that being achieved, that clear definition of respective responsibilities, in terms of the clinical governance that exists at a particular point in the care continuum?

DR BURKETT: So I think that there's no doubt that the siloing of funding mechanisms and the siloing of data does make that a larger challenge than what it must be. However, I think even within the current system it is possible to ensure that there's definition and handover of responsibility between the individual silos of care. What supports that is having good transitional care systems and ensuring that there is clear communication of handover between the facility and the hospital, and the facility and GP and the hospital, and the hospital back to the facility. And ensuring that in each of those transitional communications, whichever direction the residents is travelling in, that there is clear handover of governance and clear handover of responsibility for that continuity of care to occur.

COMMISSIONER BRIGGS: Might I follow up on that. Dare I say it, we see bits of this system patched up by various players in it. So we might have, as a result of recent agreements between the Commonwealth and the states, got the bit where GPs get the hospital discharge information. But so what if the aged care facility doesn't; right? So there are some real issues here that we can talk, in theory, but the practice is something that's way lesser than that, isn't it, Dr Burkett?

DR BURKETT: I think that it's very challenging in the current environment with the disparities of data collection systems and clinical information systems across the care continuum. I can certainly say that, from a Queensland Health end, we have opened up the viewer, which is a digital information system that summarises the information from clinical episodes of care – we've opened up the access to the viewer, so the Queensland Health digital clinical system, to general practitioners so that they don't need to wait on a discharge summary, they can see it as it's being approved in the viewer.

They can also check on outpatient appointments, bookings and those sorts of things, up-to-date medication lists. The dependency on that is it still needs to be updated in order for the information to be there. We are also working on the legislative change that is required to allow clinicians that are registered under AHPRA within aged care facilities to have similar access so that there is equity of access between the aged care facility, registered nurses and the general practitioners.

COMMISSIONER BRIGGS: So the availability would go to registered nurses.

DR BURKETT: That is the intent, yes.

COMMISSIONER BRIGGS: Okay. That's helpful. Thank you.

MR KNOWLES: Just picking up on that point, that would occur in real-time, such that the information was available to the residential aged care facility prior to the person actually arriving, perhaps, in an ambulance back from the emergency department or the hospital?

DR BURKETT: So the limitation is it still does have a human element, in that - - -

MR KNOWLES: Yes.

DR BURKETT: - - - the doctors still do need to approve the discharge information. And as that happens, it's uploaded onto the viewer. So it's certainly a marked improvement on the current practice, which, similarly, requires that there is a human element in faxing of the information from a residential aged care support service perspective. And, certainly, from a CARE-PACT perspective, our practice has always been to fax the information to both the general practitioner and the aged care facility, with recognition that that is a partnership that is central to the wellbeing of residents. And provision of continuity of care mandates that both parties have got timely access to discharge information.

MR KNOWLES: That practice you describe, though, exceeds what is actually required by standards, which only require, I think, as Commissioner Briggs just said, that the information go to the GP.

DR BURKETT: So I think that the current health care standards from a hospital perspective don't provide a clear enough level of direction in optimal provision of care for the cognitively impaired person and residents of aged care facilities, and the standards are comprehensive but not sufficiently specific to distinguish what is really, in essence, an inter-facility transfer rather than more akin to a discharge to community. And because there are health professionals that are required to take on the responsibility of the care of these residents at the aged care facility end, it's critical that there is a process that is akin to the same degree of scrutiny that we would apply to an inter-hospital transfer as what we do to a discharge to aged care.

MR KNOWLES: And I take it that you both would – well, correct me if I'm wrong, but you would endorse that information going to the facility prior to the person actually arriving at the facility?

DR HULLICK: Yes.

DR BURKETT: Yes. And I think that – in the ideal setting, I think that not only should there be a written form of inter-facility transfer of information, but I think that, particularly for high risk or complex transitions of care, there is no substitute for a verbal handover to accompany the written handover. Because, in essence, what we're asking the aged care facilities and GPs to do is to take on the ongoing care of that resident and to ensure that that is as optimally achieved as possible, supplementing the written discharge information with a verbal transfer of information. And with a verbal confirmation, that the facility is in a situation where they can encompass the ongoing care needs of that resident. And the GP is able to do that is an important element, in my view.

MR KNOWLES: Does the model that you've described with the viewer, Dr Burkett, provide the capacity to upload photographs, so that there is photographic material that can be provided and accessed by a residential aged care facility?

DR BURKETT: Not at this time. But it is an innovation that I think would be very helpful, particularly in terms of continuity of, firstly, identification of residents. More so, probably, when residents are transferring to hospital where the hospital staff aren't familiar with that resident. Having the ability to share digital images that are up-to-date would improve the ability of assurance that we have that the person in front of us who may not always be able to identify themselves is the person that we believe them to be.

MR KNOWLES: Yes.

DR BURKETT: I think that the – going in the opposite direction, the ability to share clinical images, particularly of wounds, for instance, would be very helpful in assuring that there's a shared understanding of what the wound looked like when the person left hospital and provide a real ability of the providers at the aged care facility end of the care continuum to have an understanding of what it is that they're going to be required to be dealing with on discharge from hospital.

MR KNOWLES: Dr Hullick, are you aware of models of that kind that exist in New South Wales?

DR HULLICK: So we've done some work – and, again, it's very much a pilot around telehealth and discharging patients from our inpatient – we have an inpatient ward at the hospital where I work which is for aged care facility residents going to a new aged care facility. So not a patient coming from an aged care facility but being discharged to a new aged care facility. And it's actually been a successful thing, in that the resident has the opportunity to meet the new staff from the aged care facility.

If the families aren't there, they can telehealth from work or from, you know, a different city into the conversation. But some of the behavioural issues, some of the, like, wound issues that Ellen talked about can all be done by video link when it works.

MR KNOWLES: Yes.

DR HULLICK: But it's a huge amount of work. It's not just turning on a computer. I'm not sure how much you use video technology in the law, but the chances of getting it to be reliable and working at the moment that you have a meeting set up is not always easy.

MR KNOWLES: What are the sorts of things that need to be done to improve that capacity, both at the residential aged care facility and otherwise in hospitals in emergency departments?

DR HULLICK: I think the hospital system is probably getting better at telehealth. And that – we've got – again, in our district – that's a large metro and rural district – you know, there's clinics and there's a lot of telehealth that's actually occurring. But the aged care facilities require all that digital infrastructure in order for it to happen. And I also think there's a staffing requirement in order – if there's a – there has to be someone at either end of the video link that's actually supporting the people in – on either side of the link, in order for that to happen. So it's not just – sometimes our – sometimes people think it's just turning on a computer. And it's a whole lot of change management, infrastructure, training, education that's required in order for that to happen.

MR KNOWLES: Can I return to the question of multi-disciplinary outreach services. Telehealth is one aspect of that that is capable of being employed. What are other elements of those models that you think are essential to their good workings?

DR HULLICK: I think we've gone over a few of those already today, as we've talked about having a clear governance structure.

MR KNOWLES: Yes.

DR HULLICK: Ideally, having a community of practice, being clear on the purpose of the outreach service; I think they're important elements.

MR KNOWLES: Yes. Yes.

DR BURKETT: Could I just add to that, that I think that having a model that spans the care continuum, so I notice that we're talking about outreach but if we want to improve care across the care continuum I think having a model of care that spans the care continuum to improve a shared understanding of what some of the challenges are across the care continuum is very valuable.

From a CARE-PACT point of view, certainly, a lot of the improvements that we saw, not just from a resident perspective but also from a health system perspective were down to the fact that we have emergency department based gerontic nursing staff who undertake a structured gerontic assessment when people arrive to the emergency department, and are also able to advocate for the residents and for their needs and wishes whilst they're in the acute health care sector.

I think that the other elements that I would see as being essential are the ability for any service that undertakes such activity to be aware of and link into other services that have specialists that might practice beyond the scope of the actual service delivering the service. So I think that any service that tries to retain ownership at any point in the care continuum without actually linking into services that are best placed to deliver the care need of that resident are not going to achieve optimal outcomes.

DR HULLICK: So it's the glue in the system in some ways.

MR KNOWLES: How is access to specialists achieved through these services? You've mentioned that there, Dr Burkett; can you just explain how in terms of the RaSS models at least how that is achieved.

DR BURKETT: So I think RaSS models are a little different to a lot of other models of care in that we actually have funded specialists who participate in the model of care and I think that that in itself facilitates access of aged care facility residents to specialists. In general, we advocate for an emergency physician and geriatrician shared model, although our evaluation of our model of care occurred with an acute emergency physician and a small proportion of a subacute geriatrician service. So in my view the optimal model of care would involve both emergency physician and geriatrician access to allow the acute care needs to be met optimally and also to allow the geriatric care needs to be met optimally.

The ability to have access to nurse practitioners, clinical nurse consultants and gerontic specialist nurses is critical across the care continuum and further to that, I think that it's important to form active linkages with other subspecialist groups that are commonly required for this cohort, including psychogeriatricians, wound specialist services, surgical and orthopaedic services.

MR KNOWLES: How have those linkages been established in the models that you've referring to, Dr Burkett?

DR BURKETT: And, sorry, palliative care services. So I think that the formation of linkages in our services has been through largely investment in engagement and co-design with the stakeholders from across the care continuum from the outset. So involvement of the stakeholders on our steering committee from across the care continuum, involvement of consumers so that we are keeping it real and keeping it relevant to what is needed and wished for by consumers, and ensuring that where practical and possible we're driving improvements of care in all of those aspects of the residents' care. So, for instance, in my hospital and health service district with

the establishment of the CARE-PACT service, it became apparent that there were other gaps within the hospital and health service in terms of delivery of care, not just to this cohort but more broadly, and that has then spawned quality improvement activities and funding changes to support better care across the care continuum.

MR KNOWLES: Can I just ask you for my benefit, can you just explain what you mean when you use the expression "the care continuum".

DR BURKETT: So I think that although there are silos of funding and silos of care, really what is relevant to consumers is the whole continuum of care from their place of residence right through to the hospital end, and I think that it's easy for us to fall into the trap of thinking about the silos of care and the care provided in the silos without recognising that, in fact, what's relevant to consumers is the whole continuum of their care and it's really down to health professionals and all parties involved to ensure that we build the bridges to allow that continuum to be a reality for the consumer, rather than them experiencing various silos of care across their journey.

COMMISSIONER BRIGGS: Might I pick up on that issue and I don't mind whichever of you might respond to this. Over the course of the last year we've heard a lot of evidence about inadequate nurse numbers in aged care. So that leads me to ask the question of is there a weakness in the model you suggest caused by a general inadequacy of pure numbers or active working nurses in aged care facilities or working in the community?

DR HULLICK: I think – yes.

DR BURKETT: I think that – that the need for these models of care inherently is because there are weaknesses across the whole system of care. If we had perfect care and a unified care system there may, in fact, not be as much of a need for this sort of system. I think that empowering building of capacity and understanding across all of the silos of care is very important to achieving approved care but I think it's fundamentally important in order to improve the care in a sustainable fashion that there be attention to staffing levels, particularly in aged care facilities and beyond staffing levels the staffing mix so that there are registered nurses.

So one of the approaches that the RaSS model of care has taken is that we have a suite of pathways that are being implemented in a broad sense. Those pathways are not dissimilar from what Carolyn described but we target them specifically at the registered nurses and general practitioners because we believe that the care and the recognition of deterioration is something that requires that partnership to be fundamental in the optimal care delivery for residents. So we target our pathways from the point of illness rather than the point of referral to hospital so that we can try and improve application of early evidence-based approaches to care so that the need for transfer to hospital is reduced but, importantly, outcomes are improved.

DR HULLICK: I also think that if we believe in integrated care, which we do, that we fundamentally need enough skilled nursing staff particularly to be working in aged care facilities and all these models that Dr Burkett and I have both been talking about will work better and do work better in those facilities where you have a very engaged workforce.

DR BURKETT: Could I just add one more comment, just in terms – sorry – just in terms of I think it's important to recognise that there are also needs from a hospital end to improve capacity to look after older persons and particularly persons with cognitive impairment. And I think across the education spectrum, the attention to provision of education to health care professionals, specific to the needs of older people has been under-recognised and there's a critical need from both an undergraduate and a postgraduate perspective to improve education of health care professionals regardless of their professional interest or background in the care needs of older persons.

COMMISSIONER BRIGGS: So Dr Hullick, might I ask you, as I said earlier, we've heard a lot about the inadequacy of these arrangements and nurses spending their time focusing on funding rather than anything else. The training is also important and maintenance of that training, given the high degree of complexity of the requirements. Do you want to talk at all about those kinds of issues and what you see as some of the weaknesses in the current system?

DR HULLICK: I think the expectation that any individual clinician can actually be an expert in the entire needs of a resident from an aged care facility is unreasonable and I think in some ways I think of it in three groups, there's the primary care day-to-day needs of the person that has multiple medical problems and, you know, their medication needs and all those kinds of things. There's the acutely deteriorating patient that Ellen and I are kind of experts in, I suppose, and then there's the end of life care. And in some ways if you break it up into those three sections then you can think about it differently. And I think my work with the aged care facilities is I think that the nursing staff have an amazing love for the work that they do and they actually generally do a very good job, and that they're experts in the residents and they know them well and they know their behaviours, they know their families.

In some ways they know – sometimes they know their goals of care as well and it's – I suppose what they've said to me is that they're asking for assistance when someone is acutely unwell because that's not their area of expertise, and I think the same thing would apply to – they have some expertise in end of life care but sometimes when the needs of the resident extend beyond their ability as a nurse in an aged care facility they need extra specialist support.

COMMISSIONER BRIGGS: And in your joint submission you talk about – correct me if I'm wrong – the reablement, the curative and there's another part of this side. Can you match those to what you were just talking about.

DR HULLICK: Well, I suppose when we all went to medical school a long time ago, the traditional medical model is around curative care, and in reality in 2019 we don't actually do very much in medicine that's curative. So I suppose a good example is a patient with pneumonia who needs antibiotics and oxygen and fluids and they come to hospital and they get management for that and then they go home again and return to their level of function that you would expect if you're a fit and healthy adult. Restorative is returning the patient back to where they were before with the aim of – we've talked about it today.

But the risks of hospitalisation in some ways is related to deterioration in function rather than necessarily – we might cure – we might improve the medical concerns of the patient but it's actually that they're so frail that – lying in bed for six weeks means that they're so frail and so weak that they won't – they're more confused that they – and lots of families talk about their relatives going to aged care facilities and coming to hospital and never returning to the person that they were before.

Palliative care, I think, is around symptom management and most residents, I would suggest, even though I'm not a palliative care specialist, in aged care facilities probably have some palliative care needs related to excellent symptom control and then end of life care is, you know, the last days of life and requirements around that.

COMMISSIONER BRIGGS: Thank you. That's very helpful. I'm sorry I - - -

MR KNOWLES: Not at all. Thank you, Commissioner. Just a couple of extra questions in relation to the outreach services issue. Dr Burkett, you've been involved in trying to expand those sorts of services. Can you just explain to the Commissioners what difficulties you might have confronted in doing so and how they've been surmounted?

DR BURKETT: I think that, firstly, when you refer to outreach services, I'd just like to recognise that that terminology is not universally used in the same manner across Australia, so we utilise the terminology of mobile emergency substitutive care for the mobile components. What we're trying to implement across health services in Queensland is an approach where we focus on care across the care continuum. So we are implementing comprehensive models of care. Those services are based in the emergency departments, follow the resident into the inpatient space, but also offer a telephone triage service and a mobile emergency substitutive care service to support resident choice if their choice is to remain in their own setting.

And in arriving at that decision, we do have a consultant involved in the decision-making in partnership with the aged care facility staff, the resident or their representative, and the GPs. The barriers in implementing these models of care is that, firstly, they are dependent on the building of stakeholder relationships and relationships of trust across the care continuum, recognising that the structures in place across the care continuum do present inherently a barrier to that, in that there is currently no direct data sharing beyond the Queensland Health having implemented the viewer; there is no similar system of direct data sharing from aged care facilities,

and it's still very much dependent on an understanding of individual aged care facility systems and development of relationships at that individual facility level that allow us to improve the transitions of care.

The implementation of the model of care is required to be tailored to a particular hospital and health service's existing resources. So I mentioned earlier that with CARE-PACT we do leverage other services that provide care to aged care facilities and those services are not consistent across the State. So there is a requirement, and I think Carolyn would agree, across Australia that – and I will refer to Carolyn's terminology of - - -

DR HULLICK: Flexible standardisation.

DR BURKETT: That we do need to be flexible in our approaches so that these models of care can be tailored to the particular resources and the particular requirements in certain hospital and health service areas across the State and across Australia. It's also not feasible to deliver exactly the same type of care in exactly the same manner to all areas within our health service areas. So an example would be within our own hospital and health service when we establish CARE-PACT we have got some facilities that for instance one that is on Stradbroke Island where I would love to go and deliver care every day of my working life on Stradbroke Island but that means that my service can't deliver care elsewhere on that particular day because it would take us all day to get there.

So in that circumstance we offer a modified approach where we deliver support via telehealth primarily, and so the types of care that we might be able to provide are delivered with as high quality but in a different fashion. I think, importantly, also the lack of data sharing across the care continuum is a significant barrier to evaluation of quality of care for this cohort and also in outcomes of models of care. So I would emphasise that one of the things that I think is critical to improving the quality of care of residents of aged care facilities across the care continuum is the ability to accurately identify who this cohort is. Current health systems across Australia, and also internationally, do struggle with the ability to reliably and accurately identify residents of aged care facilities.

So I think a primary thing that is required within our health systems is a data linkage that is real time between the My Aged Care system and the hospital systems to allow the accurate identification of aged care facility residents, but beyond aged care facility residents to also identify accurately who from the community is funded for which type of package and who the providers under that package are.

DR HULLICK: Can I say something?

MR KNOWLES: Yes, absolutely. Please do.

DR HULLICK: I think there is some clear evidence in the literature around scaling up health services interventions, and I think the way we've done it within the ACE

program is being really clear on defining the program and what the essential elements are and then having – we've worked really hard on having focus groups with the aged care facilities on what they need and generally what they need is what we can deliver so that – but it's a good way of engaging them. I think, as I talked about earlier, having clear the stakeholders and that everyone's involved and then I think it's coming back to each of the communities and talking about, well, if you haven't got this service in Singleton in a small town how will we deliver that. So that's what the flexible standardisation is about.

It's around – so Port Stephens, some of our smaller communities, they – so Port Stephens is the Stradbroke of Newcastle, I suppose, and it's a very – it's a holiday town with a lot of retirees and previously to the ACE program, the ambulance was being called and the patients were being sent from Port Stephens to Newcastle, so it involved probably 100 kilometres of ambulance time. So by going out to the aged care facilities, negotiating with them, sending them to Tomaree Hospital rather than into Newcastle, but also being able to support the aged care facility we've been able to make a massive impact. Particularly one of the things we haven't talked about today is the impact on shared – on improved ambulance access for the community, too, which is important.

So I think there are – so I think it's defining the – defining the program, having a like a readiness assessment; if you want to engage in this program this is the kind of things you have to agree to. Having a governance program; as I said, having that community of practice that kind of supports it underneath. The other thing we've had to do in Newcastle which is a metro issue not a rural issue is around defining which hospital the patients from the aged care facilities go to. Because if an aged care facility calls 000 in Sydney, Newcastle, there's a multitude of emergency departments across the city that they could go to. So we've actually partnered each of the aged care facilities with a home emergency department and we have aged services so the gerontic nurses in most emergency departments across New South Wales, that role, where their role is to be the advocate, the expert in aged care in emergency departments.

MR KNOWLES: In terms of the flexible standardisation that you refer to, how do we ensure that, given the acknowledged trend in increased acuity of the people who are likely to present from residential aged care facilities?

DR HULLICK: So the – the differences in the model of care, which I suppose is what we're talking about, are different in the different towns rather than for the – should be – it should be around the community rather than the individual, if that makes sense.

MR KNOWLES: Yes.

DR HULLICK: And the flexibility is around us thinking about how are we going to deliver that service in this town that doesn't have access to this problem. So I mentioned Singleton; in some ways – so Singleton is a small emergency department

rural town in the Upper Hunter and the general practitioners are actually desperate to engage with the service because it actually improved their lot as well because the nursing – nurses in the aged care facilities were getting training in communication so if they rang them about a patient it was going to be in a standardised kind of format. And some of the call – we have the 24 hour call line.

So some of the calls would be filtered so like the things that were kind of nursing level could be dealt with by the nursing staff and not necessarily have to involve the general practitioner because the GP in the small town is actually the same person, it's the – they're going to the hospital, they're on call for the aged care facility, they're on call from home. So it doesn't really matter to them where the resident is.

MR KNOWLES: Yes.

DR HULLICK: It's still the same individual.

MR KNOWLES: Yes.

DR HULLICK: And I think – so that's a good example of differences in the model in a small town which is GP-led and run versus a bigger city that has multitudes of subspecialists across the system.

MR KNOWLES: Can I move to the topic of data linkages that you referred to a moment ago, Dr Burkett. Dr Hullick, how might that work in terms of harnessing My Aged Care; what do you see – how do you see that working in practice?

DR HULLICK: Well, I think a fundamental issue for the Royal Commission is going to be around the recommendations and in order for us to be able to monitor and show diligence to the recommendations, we have to understand the data, and at the moment that data is actually very difficult to see in the State health system. So I think at a systems level, an evaluation level, a research level, we need good access to the data.

But on an individual emergency physician basis when I see a patient in the emergency department at 2 o'clock in the morning, I need access to – more so for the people living in the community than in the aged care facility, I need to know who they are, where they've come from, what package they're on, who's their provider, like – so that I can actually make good decisions for that person around what they need.

So I think we need – it needs to be timely, ideally live, that we can access every day, every minute in an emergency department in order to be able to deliver the care that's required.

MR KNOWLES: You say that the information needs to be real time, live.

DR HULLICK: That's my – that's the nirvana.

MR KNOWLES: And in that regard, is there – do you have concerns about the accuracy of the information that does exist that is available to you?

DR HULLICK: I don't have much access to My Aged Care data. There's some linkages in the State health care system. As I mentioned, the asset nurses that I talked about earlier are much better at accessing the aged care system so sometimes I kind of leave it to them to look it up. But the other system that we're kind of alluding to is that also we've got another system called My Health Record as well.

MR KNOWLES: Yes.

DR HULLICK: So we've got the things provided in the community by the Commonwealth Government in My Health Record, we've got the health – hospital health system and we've got the aged care system, and at the moment they're three separate systems that don't necessarily talk to each other. And they – the live aspect is that in order for me to trust the system and make an important clinical decision late at night, when everyone else is not available, is to know that the system in the My Age record and the My Health Record is actually reliable. And at the moment, particularly the My Health Record, I don't know whether the information was uploaded a week ago or a month ago or yesterday. So it's actually quite difficult to – it's good because it helps to guide you in your decisions but it's not something that I can be 100 per cent confident in the accuracy.

MR KNOWLES: Dr Burkett, do you have concerns about what is available in terms of data linkages with records like My Health Record yourself and the accuracy of those – the contents of those databases?

DR BURKETT: I think that the primary issue from an aged care facility resident perspective at the moment is that hospital systems across Australia don't have the ability to accurately identify aged care facility residents. So for hospital sectors to work to improve the care of that particular cohort is currently very challenging. We have established some workarounds in that we do keep a parallel separate system for aged care facilities residents who are seen by a RaSS service, so we can identify the residents that our service has seen.

But, more broadly in a, you know, very robust manner, it is very time and cost intensive for us to accurately identify aged care facility residents. We've done quite a lot of research into this and there is no one hospital identifier that allows us to accurately predict residential aged care facility status. In particular it's often suggested that aged care facility address be used.

However, there is no standardised address entry. An aged care facility might have 50 different ways an address is entered into the hospital systems, and the colocation of independent living units with aged care facilities means that it is not a reliable indicator. Another suggested approach is to have a data item such as a tick box. Those do exist and we've introduced a residential status data item specific to where a person is living, so the type of residence that the person is living in to identify both

aged care facility residents but other vulnerable populations such as itinerant populations or those living in mental health hostels. However, all of those do require a judgment at – of an individual to make an assessment of an environment that is increasingly complex.

So there is no current standardisation of the way in which aged care facilities reporting under the Aged Care Act are required to be named and so you may have an unregulated facility that is providing services to older people but not reporting under the Aged Care Act and they may utilise the terminology of aged living or aged care which is very easy to interpret as being a residential aged care facility when those of us who work directly in that field will know that that is not the case. So I think that the complexity of the environment and the increasing deregulation means that that is likely to get worse with time and that is part of why we really require a live data linkage to My Aged Care.

DR HULLICK: Yes.

DR BURKETT: My Aged Care is a valid record because it is where the record of funding approvals is also kept and so if it's not been funded the person is not living in an aged care facility, that is reported – is reporting under the Aged Care Act.

DR HULLICK: And it's a fundamental issue. We talked about discharge summaries earlier and having an electronic system. If you haven't actually identified the person from an aged care facility in the State health system, how are you going to send them a discharge letter; like you just – you can't do it. So we've, again, got a workaround within our system where the – and, again, not ironically maybe, the State unique identifier for aged care facilities is different to the federal unique identifier of aged care facilities.

But we have a system within our – in our system where the administrative staff can put in which aged care facility that person comes from. It's actually not a huge amount of work in that the residents tend not to move once they're in that aged care facility and in our system we're in the process of using that unique identifier in order to be able to electronically send the discharge summaries out to the aged care facilities.

MR KNOWLES: You mentioned discharge summaries; there are national standards surrounding discharge of people from hospitals.

DR HULLICK: Yes.

MR KNOWLES: Do they sufficiently provide for discharge to residential aged care?

DR HULLICK: I don't think they're – I think the residents of aged care facilities are very frail and vulnerable, as we keep saying.

MR KNOWLES: Yes.

DR HULLICK: They've got very complex health care needs, they're on a significant number of medications so they actually need a bit more information in order – as Ellen talked about earlier, in some ways we're handing over a patient not from an aged care facility to the community; we're handing them over from one health care provider to another. So in – yes. So we actually need that level of detail in order to be able to do it, and again, the way – what we do in Newcastle is we've got envelopes, basically, and they're two-sided envelopes; one's on sending a patient to hospital, and one's on sending the patient home.

And it's a check box, but it is a reminder to the nursing staff: "Have you called the family? Does the GP know? Have you included – was there a resuscitation plan in hospital? What medications were on? When was the last dose of the medications that were given? Has there been any change in medications? Is the discharge summary included?" So I would suggest that the discharge summary is one of those elements but not all of them that's required in order to be able to send a patient home from hospital to an aged care facility and the information that we require in the reverse direction and which we haven't talked about too much today is actually exactly the same.

MR KNOWLES: Yes.

DR HULLICK: But as I mentioned before, we looked through it in our own lens, so the aged care facilities complain the hospital never sends us this information, we don't get the discharge letters, we don't know anything about that, and then the hospitals actually say exactly the same thing. So it's been a really important lesson for me that we all actually need the same information.

MR KNOWLES: Before I come to the flow of information from the aged care facility to the hospital, can I just ask you both about what you see as the best way to incorporate specific standards, if you see them as necessary, in connection with discharge of people into residential aged care. Would it entail a new set of standards or would it be something that would be incorporated within existing standards in some way?

DR HULLICK: It's a big question but I think – I actually think – you could think about whether the aged care standards and the health care standards should be the same thing. And that's a massive statement but I also think the specific ones around transitions of care and clinical communication should be, could be the same across both groups.

MR KNOWLES: Yes.

DR HULLICK: And that the specific needs, as I said, of the aged care facility residents which are much more complex than people living in the community, could

actually be detailed in that standard. So yes, I think that we should include this in the standard specifically around this group.

MR KNOWLES: Dr Burkett?

DR BURKETT: So I would just like to make the point that I think that there is a risk in having a separate set of standards for the hospital care of residents of aged care facilities. In my view, integration of the needs of cognitively impaired persons and residents of aged care services into existing health care standards would be a wise approach because that means that they won't be disadvantaged within the acute health care sector, but have their individual needs met under existing standards. So I think adopting an approach of integrating the needs of older persons into universal approaches to quality of care is important to not further disadvantage the cohort.

MR KNOWLES: Can I turn now to standards that exist as such for the passage of information, transitional communication from residential aged care facilities to hospitals. Dr Hullick, what do you see as being necessary there by way of improvements to documentation of those standards?

DR HULLICK: I mean, ideally, again as we keep alluding to, the system could be electronic, and if you think about the poor aged care facility nurse who's by herself with some pretty complex patients trying to find all these pieces of paper at – when they've got a resident to manage, must be very stressful. So I think, ideally, the system is electronic and live, and that they actually don't need to be uploading or providing specific – they need to provide information about that incident, "Why did this person need to come to hospital today? What was the trigger?" – but in terms of what medications they're on, what kind of advance care plan they have, who their – who the person is that needs to be contacted; a whole lot of that information in the – in the world that we would like to work in would already be there.

But as I said before, I don't know that – I don't know, I would have to check the aged care standards, whether they actually talk about transitional communication as part of the standard. I think that they're not included, but I think that the standards that we require are actually the same as the hospital standards.

MR KNOWLES: So one way or another you would advocate for standards of the same nature as what is imposed on a hospital in sending a person back to residential aged care facility to be the same for the residential aged care facility sending a person to the hospital.

DR HULLICK: Be much simpler for everybody because we're all asking for the same things.

MR KNOWLES: Yes.

DR HULLICK: Yes.

MR KNOWLES: And in that regard, whether that were to involve amendment to legislation or otherwise, that's something that you see as being worthwhile.

DR HULLICK: Yes, particularly around this area of transitions, I think.

MR KNOWLES: Yes.

DR HULLICK: And I like Ellen's word of continuity, it's around continuity of care, but you know, we use lots of negative words about failed discharge and in some ways the – it needs to be a continuous transition or continuous patient journey is a another kind of good word to think about; that person doesn't actually – shouldn't have to recognise that they're going through different parts of the system. Ideally, that's a smooth transition across the whole system with clear handover from one person to the other and delivering them the care that they want.

MR KNOWLES: Just in terms of what you say there about the care that they want, can I ask each of you to explain in the context of your roles as emergency physicians what you see as the significance of advance care planning?

DR HULLICK: The significance to me as a clinician is that every single day in my workplace, I'm required to make decisions and talk to families around what residents of aged care facilities would want if they were able to speak for themselves. So for me, we've done an audit in our hospital, some medical students looked at two months of documentation from aged care facilities and I think something like 54 per cent of the patients had some kind of advance care planning so that was actually – or documentation, I should say, that came with them to the emergency department.

But our ability to make decisions based on that information is variable and some of it's, you know, tick boxes and some of it's a meaningful discussion around what that person values and what their goals of care are. So I think, again, advance care planning is an ongoing conversation, an ongoing discussion and it needs to be modified across time but it also needs to be meaningful about what kind of outcome that person would want if they were able to speak for themselves.

MR KNOWLES: And in terms of modification across time how is that best achieved where a person may suffer from a significant cognitive impairment on presentation to an emergency department?

DR HULLICK: Sorry. Explain that again.

MR KNOWLES: Sorry.

DR HULLICK: Yes.

MR KNOWLES: In terms of what you say about the changes that might occur across time in terms of a person's advance care planning.

DR HULLICK: Yes.

MR KNOWLES: How is that best addressed when a person presents with a cognitive impairment. It may be that there is a need for some change to a plan that was prepared some time ago?

DR HULLICK: So I don't necessarily see it's my role to change the plan at that point in time. It's my role to deliver the care based on what the plan says if that makes sense.

MR KNOWLES: Yes.

DR HULLICK: As the Commissioner mentioned earlier there's different stages of life around whether people are in a curative model or they're in an end of life period of their life and what that actually means. So I suppose – and I think the – the lady who spoke earlier this morning spoke about her mum and her need to change her advance care plan across time and that the palliative care nurse had come into the aged care facility and said we need to modify your advance care plan.

So I suppose that's the things that I'm talking about, which is why it can't be – and, again, it goes back to what we were talking about with My Health Record. If someone uploads an advance care directive at the age of 60 and then 25 years later they're in an emergency department, and all we've got is the one that's 20 years old, which will happen, then I can't put my hand on my heart and make a decision around whether that person wants to be resuscitated or not based on the information in that document.

So it's a continuous – I know we keep saying continuous the whole morning, but it's a continuous process that needs to be thoughtfully and diligently followed and documented, I think.

MR KNOWLES: Do see there as being a need to require residential aged care providers to assist people in preparation of advance care planning where they wish to do so?

DR HULLICK: Yes, I think so, but it needs to be with staff and clinicians and maybe people that are – maybe it's people rather than clinicians even, but people that are actually comfortable in having those conversations. My experience in the emergency department is that those conversations aren't – are often not difficult. We talk about them being difficult conversations, and I know I'm seeing the residents in time of crisis but generally most patients and families, actually when you ask them, know what the person would want.

MR KNOWLES: Yes.

DR HULLICK: So I think it's actually giving – and as a society, as a culture, really, giving permission for all of us to be able to talk about that in a way that's not

inflammatory, emotive, you know, and it's about supporting families in that communication, but also talking to them about – there's still a belief that hospitals are a safe place and – and one of them – I think the last talk I gave recently was called Not Safe for Admission, and I think residents in aged care facilities, some of them are so frail and so complex and so near the end of their life that coming into hospital and being subjected to the things that are just structurally happening in hospitals are not necessarily within their best interests and we actually need to change our mindset from thinking that hospitals are a safe place, because they're not.

MR KNOWLES: How might that change of mindset occur for those who are working in residential aged care in the performance of risk assessments of transfers to hospital?

DR HULLICK: So the way – I suppose as I talked about with the aged care emergency program, a lot of our work has been around communication and relationships and the first meeting that we had at the hospital, at John Hunter which is a very busy hospital, was to have it on a Monday afternoon at 5 o'clock which is a bit naughty, really, but, you know, there was 10 ambulances lined up outside, there were patients everywhere. It was chaos and I think getting the aged care facility staff to actually come into the emergency department and see what they were actually sending the residents to was actually a really important thing. So I think for me it's a shared understanding of risk.

MR KNOWLES: Yes.

DR HULLICK: And then some of the systems that we've built in place are around management of risk, so how the – how the care plans, the algorithms work that are in relation to residents in the aged care facility.

MR KNOWLES: Yes. Dr Burkett, do you see there as being a need to require, just going back to advance care planning, to require residential aged care providers to assist people with, if they wish to do so, preparation of advance care plans and regular review of them?

DR BURKETT: So I think that what I would like to see happen is that we, as an Australian community, actually start having the courage to express what it is that we would like to see for our own future care at a time where we're cognitively able to do that for ourselves, and I think that having a consistent way of that information being shared across Australia would be very helpful because people do travel inter-jurisdictionally and documentation that is fulfilled in one State under their legislation may not then be recognised or understood by other States. So I think that having an approach where we have the courage as a community to recognise our own mortality and to recognise our need to plan for how we'd like the end of our days to be would be the best approach.

Secondary to that, I think is an approach where we do ensure that residents entering aged care have an opportunity to have facilitated discussions around how they would

like their care to be provided, and importantly that that be informed by an accurate picture of what's feasible and what's able to be provided safely in which environments. I do think that mandating a requirement for advance care planning is something that I feel challenged by because I think that people entering aged care are often at a very vulnerable time. They're not always in the best state at that particular time to make decisions around what it is that they would wish to have seen happen in future.

So I think that some flexibility around the process and, ideally, bringing the process forward to that it's actually occurring at a point where people are cognitively able to document their own wishes would be the ideal scenario but I would certainly support the provision of advance care planning discussions and facilitation of those in aged care environments.

MR KNOWLES: Yes, Dr Hullick.

DR HULLICK: I agree with Ellen. It needs to be an ongoing conversation. A lot of families, particularly, feel very guilty, and as I said, failed when a person is admitted to an aged care facility and to be making decisions around their health care needs in that context is really challenging, I think. So, you know, but on the other hand, that's the time when the person – the resident is most likely to deteriorate and come to hospital, in those first few weeks that they've been admitted to the aged care facility. So kind of – it's a balance and it's – as I said earlier, it needs to be thoughtful and respectful and ongoing and meaningful in order for us to be able to trust it in the time that we need to make a decision.

COMMISSIONER BRIGGS: So can I ask how do you make that happen? Clearly, it needs to be a standardised electronic system. Are you suggesting when somebody turns 60, for example, that the government for want of a better generator sends them a suggestion that they go into mygov.com and work on the system themselves, or do you envisage doing it with a GP or how do you think this would work?

DR BURKETT: I think that the GP involvement would be very central because the GPs in general would be aware of the person's health context and be able to help guide the understanding that people need to have of where they're at in order to make informed choices. So I think that GP involvement is important. I think that the other thing that's very important is that there be a process of review of the actual document to ensure that it hasn't got inherent inconsistencies that mean that it is not able to be understood by those that need to understand the document in order to deliver care that the resident would wish to see happen.

So in Queensland, our documents are faxed to the Office of Advance Care Planning who undertake such an audit and who then upload the document onto the viewer if it is deemed to be internally and inherently consistent. If it doesn't meet the quality requirements, then it is sent back to the care coordinator, usually the GP, with recommendations as to what needs to happen to make it meet those requirements. So I think that having a central repository of documents is very helpful because as an

emergency physician, it's my wish to always provide care that is in keeping with the resident's wishes, and to be respectful of what it is that the resident would like.

I ideally would always confirm the wishes that are documented in an advance care plan with the decision-maker for that resident or the resident themselves if they're able to participate in those discussions. However, we all know that in the reality of life there are times when people are not contactable, we're unable to get onto those folk, and so having the advance care plan there is a way to understand the context of that person's wishes to guide decision-making.

DR HULLICK: Yes. I think also the issue around jurisdictions is actually really important so the law is different in every State in relation to advance care planning, so it's a kind of fundamental thing. The other part of it is the way people from aged care facilities die, if that's really what we want to talk about. That many of them have chronic disease and I think the traditional palliative care model of people dying with cancer is much more predictable than the dying trajectory of people that are dying with chronic disease, and I think emphysema or chronic obstructive airways disease is a really good example. Those patients tend to have acute exacerbations. They come to the emergency department. We give them very acute lifesaving treatment that changes that course over the next few hours and they often get better and go home.

And they often have increasing presentations to the emergency department in the last 12 months of their life but as an emergency physician, knowing is this going to be the last admission or not is actually very challenging and I think that's part of the reason why people are dying, from aged care facilities, in hospital because if they've got a condition like that the conversations with the family are, well, we would like to try the non-invasive ventilation. If they're going to get better, that's great, they can go home tomorrow. But if they're not, then they're going to be – you know, they're coming to the end of their life and we need to palliate them in the hospital, and then I feel pretty strongly that if someone is actively dying we shouldn't be putting them in an ambulance and sending them back to the aged care facility, you know, because it's – that's not the way to spend the last few hours of your life.

DR BURKETT: I think that that's where bringing forwards the decision-making so that there is the ability to have that specialist-led information shared with those who are making decisions on behalf of the resident or with the resident around what their options of care are and what the likely outcomes are, bringing that forward so that it's occurring in the aged care facility is helpful because then the resident does have expanded choice options. I agree that – with Carolyn that when a person is acutely in the process of dying and they've been brought into the hospital, whether it be consistent or not consistent with their wishes, it's then – even if their wish is to die at home, sometimes transitioning them back home is, simply, not feasible within the time-frame that's required.

MR KNOWLES: I have no further questions of the witnesses, commissioners.

COMMISSIONER PAGONE: Yes. Thank you. Doctors, thank you very much for your wisdom and thoughts. It's been very, very helpful and informative. Thank you very much.

DR BURKETT: Thank you.

DR HULLICK: Thank you.

COMMISSIONER PAGONE: You're free to go.

<THE WITNESSES WITHDREW [12.20 pm]

MR KNOWLES: Mr Gray will take the next witnesses.

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you, commissioner. The next panel carries on with this hearing's inquiry into the interfaces relating to acute deterioration of people in the aged care system and how the health system can and does respond to those needs. I call Dr Terry Nash, Ms Meegan Beecroft and Dr Michael Montalto.

<TERRY STEWART NASH, SWORN [12.21 pm]

<MEEGAN MARIA BEECROFT, AFFIRMED [12.22 pm]

<MICHAEL MONTALTO, AFFIRMED [12.22 pm]

MR GRAY: Thank you. Dr Nash, I'll start with you. What's your full name?

DR NASH: Terry Stewart Nash.

MR GRAY: I'll ask that the witness statement that you've made for the Royal Commission be displayed for you – WIT.1296.0001.0001. Do you recognise that to be a copy of your statement dated 18 November 2019?

DR NASH: I do.

MR GRAY: Do you wish to make any amendments to the statement?

DR NASH: No, I don't.

MR GRAY: To the best of your knowledge and belief: are the factual contents of the statement true and correct, and are the opinions stated in it opinions which you sincerely hold?

DR NASH: I do.

MR GRAY: I tender the statement, commissioners.

COMMISSIONER PAGONE: Statement of Dr Terry Nash will be 14–13.

EXHIBIT #14–13 STATEMENT OF DR TERRY NASH

MR GRAY: Thank you. In the general tender bundle, at tab 53, there's the CARE PACT service profile for Metro south, 2019 to 2020, which is referred to by Dr Nash. Ms Beecroft, what's your full name?

MS BEECROFT: Meegan Maria Beecroft.

MR GRAY: I'll ask that your statement be displayed – WIT.1297.0001.0001; is that a copy of your statement dated 11 November 2019?

MS BEECROFT: Yes, it is.

MR GRAY: And to the best of your knowledge and belief: are the – I beg your pardon. I should ask you; do you wish to make any amendments?

MS BEECROFT: No.

MR GRAY: To the best of your knowledge and belief: are the factual contents of the statement true and correct and the opinions in it opinions which you sincerely hold?

MS BEECROFT: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: The statement of Ms Beecroft will be exhibit 14–14.

EXHIBIT #14–14 THE STATEMENT OF MS BEECROFT

MR GRAY: In the general tender bundle, at tab 36, there's the CARE PACT CNC role description for Ms Beecroft's current role with CARE PACT Metro south. Dr Montalto, what's your full name?

DR MONTALTO: Michael Montalto.

MR GRAY: Thank you. I'll ask that your witness statement be displayed – WIT.0624 .0001.0001. Is that a copy of the statement you've made for the Royal Commission – dated 22 November 2019?

DR MONTALTO: It is.

MR GRAY: If we go to page 10 – and I will ask the operator to bring up paragraphs 59 and 60; is it the case, that you've done some further work, made some further inquiries and you wish to make an amendment to paragraphs 59 and 60, deleting the reference to New South Wales in paragraph 59 and inserting a reference to New South Wales in paragraph 60?

DR MONTALTO: Apologise for the inconvenience, but, yes, that's what I would like to do.

MR GRAY: Thank you very much. Having made that amendment – are there any other amendments you wish to make to the statement?

DR MONTALTO: No, Mr Gray.

MR GRAY: To the best of your knowledge and belief: are the factual contents of the statement true and correct and the opinions in it opinions which you sincerely hold?

DR MONTALTO: They are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes. The statement of Dr Montalto will be exhibit 14–14.

EXHIBIT #14–15 THE STATEMENT OF DR MONTALTO

MR GRAY: Thank you. Dr Nash, you're a staff specialist, emergency physician at the Princess Alexandra hospital, and you are the clinical lead of the comprehensive aged residents emergency and partners in assessment care and treatment, CARE PACT; is that so?

DR NASH: That's true.

MR GRAY: You're an employee of Queensland Health?

DR NASH: I am.

MR GRAY: And you're in effect a successor of Dr Burkett in the role as clinical lead of CARE PACT.

DR NASH: Yes. I am.

MR GRAY: Dr Nash, you've been a registered medical practitioner since 2003, and you've held various medical roles, including working as a general practitioner. I've mentioned that you're the clinical leader of CARE PACT just very briefly and building on what Dr Burkett has already explained about CARE PACT; is it the case, that amongst the main components of the service there's telephone triage and planning, inpatient, resource and early-discharge services and then assessment services and outpatient services to the standard of inpatient hospital – acute care, otherwise called mobile substitution services?

DR NASH: That's correct; yes.

MR GRAY: And there are also educative functions that CARE PACT performs, and it also acts as a referral service for GPs and the ambulance service; is that right?

DR NASH: That's right. So the inputs can be from patients who are presenting to Emergency or thought to be from the facility, patients that have been identified as needing an ambulance – but the paramedics have identified that it's possible, that an alternative could be provided – or GPs referring to us directly.

MR GRAY: Now, is it the case, that your role as clinical lead of CARE PACT involves the highest level of decision-making, providing oversight and support to the staff providing all of those services?

DR NASH: That's correct; so for five days a week, where we're manning our outreach team, myself as the consultant emergency physician or one of my colleagues, who's a consultant geriatrician, is able to assist in that decision-making and then continue to provide that support to our clinical-nurse consultants, providing triage services over the weekends.

MR GRAY: Thank you. And within CARE PACT does "outreach" refer to the teams that go to, for example residential-aged care facilities?

DR NASH: That's right.

MR GRAY: And "in-reach" refers to services that are provided in – say typically – the emergency department in assisting in the care of people who are actually in-patients in hospital.

DR NASH: That's right; the in-reach team are the ones that are providing care in Emergency, and if they're on the inpatient wards as well, they're the ones doing the more comprehensive gerontic nursing-assessment and working as a conduit to assist

in, either, better care in Emergency in the inpatient space or assisting them to get back to their aged care facility sooner, if that's appropriate.

MR GRAY: Thank you. Ms Beecroft, you're a registered nurse, and for the last five years you've worked as the clinical-nurse consultant at CARE PACT for Metro south. Is that - - -

MS BEECROFT: Yes.

MR GRAY: And Metro south is one of the hospital and health services in Queensland; in other jurisdictions they can be known as local hospital networks.

MS BEECROFT: Yes.

MR GRAY: Yes. Your role involves clinical advice and triage by telephone to staff at residential-aged care facilities to assist them to manage a resident's health need, particularly in case of acute deteriorating conditions.

MS BEECROFT: Yes.

MR GRAY: And you might send out the CARE PACT mobile outreach team including medical specialists, nurse practitioners and clinical nurses; is that right?

MS BEECROFT: Yes.

MR GRAY: If a resident requires hospitalisation, you'll liaise with hospital to ensure a smooth transition on admission and during hospital stay and to ensure discharge summary is provided back to the residential-aged care facility.

MS BEECROFT: Yes. Yes.

MR GRAY: And there's also a follow-up service that CARE PACT provides seven days after discharge.

MS BEECROFT: Yes.

MR GRAY: Is that right?

MS BEECROFT: Yes; there is.

MR GRAY: In your role as clinical-nurse consultant you also supervise the clinical nurses based at the two - - -

MS BEECROFT: There's four hospitals.

MR GRAY: Beg your pardon. Four hospitals.

MS BEECROFT: Yes.

MR GRAY: Thank you – in the Metro south area, and you provide education to residential-aged care facilities and linkage to relevant outreach services.

MS BEECROFT: Yes.

MR GRAY: Dr Montalto, you're the medical director of the Epworth hospital-in-the-home unit, and you have been since 1999. Now, Epworth is the first private hospital to have established a hospital-in-the-home unit and still one a very – and that unit is still one of very few such units in the private sector.

DR MONTALTO: Correct; yes.

MR GRAY: You've got extensive background in hospital-in-the-home not only in the private sector but going right back to its inception, I understand.

DR MONTALTO: Yes. I was the director of Mornington Peninsula – which is a public hospital – hospital-in-the-home unit, and I was a director of Royal Melbourne Hospital, another public hospital in Melbourne – their hospital-in-the-home unit for 13 years.

MR GRAY: And your Ph. D in 1999 was completed in relation to the hospital-in-the-home model. Is that so?

DR MONTALTO: Yes.

MR GRAY: You're also the director of Aged care Imaging Proprietary Limited, an Australian company that delivers mobile radiology services to aged care residents.

DR MONTALTO: Correct.

MR GRAY: You're the convener of the first world congress of hospital in the home.

DR MONTALTO: Correct.

MR GRAY: You're a fellow of the Royal Australian College of General Practitioners, and been an associate professor at the University of Melbourne.

DR MONTALTO: Yes.

MR GRAY: You've overseen the successful implementation of mobile X-ray and ultrasound services in Melbourne and Brisbane through that company, and that has had the effect of decreasing hospital transfers for diagnostic purposes. You're also the sole author of the application to the Medicare-schedule advisory committee for

the introduction of MBS rebates for mobile X-ray services to aged care residents. That application was successful and has very recently been implemented.

DR MONTALTO: That's correct.

MR GRAY: Members of the panel, I'll briefly explain the general context of the questions I intend to direct to you. The data available to staff of the Royal Commission indicates that access by a Medicare Benefits Schedule fee for service to specialists outside inpatient-hospital settings for people in residential aged care is very poor. The evidence also suggests that hospitalisation can place a strain on the wellbeing and health of people who are in the aged care system. Both of the models which you, the panellists, are involved in providing, CARE PACT and hospital in the home, offer access to specialist subacute care as an element of care outside of hospital settings, and in the case of CARE PACT that's in an integrated multidisciplinary-team setting. And in the case of hospital in the home – that's for substitution for inpatient hospital care.

We on the Counsel Assisting team are exploring a proposition that there should be a system-wide implementation of teams which are capable of providing subacute care outside hospital settings to people who are in the aged care system who need them, particularly with a focus perhaps on residential aged care, and that there should be dedicated funding through local hospital networks for the nationwide systematisation of teams of this kind. Now, that's the general context, and in that context I wish to put a number of questions up for discussion by the panel. First question for the panel is "If the Royal Commission were to recommend the systematic implementation of such programs, what goals and purposes should such programs be designed to achieve?". And if in the course of responding to that question you're able to explain how services of this kind would be designed in order to achieve those goals, please do so, beginning with you, Dr Nash; what goals and purposes should such systems be designed to achieve?

DR NASH: I think that it's already been spoken of very well by Dr Hullick and Dr Burkett already, but I think the primary goal is to improve the quality of care, and if that is the first goal of any of these services, then there will be further flow-on benefits to the system through efficiencies that will happen from it. I think that the systemic – systematic implementation of these things is complicated by elements of service that's already provided in different regions and bringing them together to actually co-ordinate what's happening, and I think that it needs to have a perspective – which we've mentioned already today – of the entire patient journey and not just one element of it, and so that – from the point of acute deterioration – for example from our service, where we're looking at a potential that a patient may have come to emergency, providing advice and triage that actually decides – is this an event that, definitely, should be coming to Emergency and to optimise that, or is this something where we should provide an equivalent substitution to that emergency medicine, care but provide it at the bedside.

And to integrate with models in the region, for example – and we do as well with our hospital in the home so that it's a continuous experience for the patient – of care that starts with the emergency assessment, continues to a treatment plan that's delivered at the bedside and then once that episode of care is completed, to use a quality framework that then ensures that that treatment has either been effective or optimised or – what are some improvements that can happen from it. And I think that's where our model of care has focussed so much over the years – to improving.

MR GRAY: Shouldn't it be possible in formulating a program of this kind, to describe the criteria for the program in sufficiently flexible terms to allow the relevant local hospital network to consider what existing services are present in that network area and to stand up a service that takes account of those existing services and fills gaps?

DR NASH: Absolutely. I think understanding the network of people that are trying to provide care in your region is the starting-point. Another big starting-point is understanding the data, and I think that it's been referenced enough already today – about how we collect information about whether someone is from a residential-aged care facility or not, because then once you implement these services and you want to measure their success – you need to base that on accurate information.

And I think bringing together the people that are incredibly passionate about improving specific episodes of care – for example: dementia and behavioural specialists, psycho-geriatricians, palliative-care specialists and another disease-specific – either – in Queensland for example, the nurse-navigator concept – with sub-specialty services and bringing them together to work out what their inputs and outputs are so that you're moving them through – this is all about that early stakeholder engagement that ensures you're not trying to repeat service, you're not trying to absorb demand, you're trying to optimise what is, essentially, service that can be provided but making sure it's getting to the right person at the right time.

And then whenever we're thinking about substitutive care and providing someone options for their care – those options need to be considered to be provided as equivalent to what would be provided in the hospital. And so things like hospital in the home or our outreach service is designed to look after patients at the same level or better than what they would be provided with in the hospital system.

MR GRAY: Dr Nash, I just want to display tab 53 of the general tender bundle, which is the service profile for the Metro south health EDNFS, in particular, the Princess Alexandra hospital EDNS and CARE PACT, and if we go to page 0005, aims and objectives – we've also, in addition to those objectives – do you wish to say anything about partnership with RACFs and general practitioners in describing the objectives of a system that could be systematised?

DR NASH: I think that's the key; understanding your own local RACFs, understanding general practitioners that visit those RACFs, understanding as well how primary health networks co-ordinate those GPs and their education and making

them a part of the process of rollout or expansion or trying to create services that are providing this area – it has to involve those key people, because most of what happens with a service like ours is that – we need to explain where we're trying to fit and how we're trying to assist, because once RACFs and GPs understand where we fit within the whole health system, they're incredibly positive about the impact that we can have for the residents.

MR GRAY: If we just go down that page, under the heading "President" – I beg your pardon – "Present service", to third paragraph – CARE PACT began as a restricted pilot; there's then some information there about hospitalisation avoidance. Now, in your statement you've referred to, at paragraph 50 – beg your pardon – paragraph 47 – you referred to it being inappropriate and unethical, to describe the success of services like CARE-PACT purely in terms of hospital presentations avoided. Can you elaborate on that.

DR NASH: I think this is philosophically where services like this need to start with the approach to improving the quality of care for the residents. I think that if the primary driver for health activity is to reduce its own activity, I don't think we've got the right attitude and I think that taking a quality approach is where it all needs to start. Ultimately, when you do improve quality – and I think this is what CARE-PACT is showing – improving quality ultimately will improve the health system because we are avoiding patients but we're not avoiding care. We might have situations where patients are being cared for in a way that's more meeting their wishes and their needs and providing that choice is a greater goal than trying to reduce hospital presentations.

MR GRAY: Nevertheless, hospital avoidance or reduction of hospitalisations has been mentioned there, and there's also reference to independent reporting by Deloitte demonstrating a significant return on investment and release of capacity to Metro South Health. Is there a connection with the current ability of hospital networks such as Metro South Health to be able to justify funding outreach services of this kind?

DR NASH: I think that this is an appropriate justification in the long term, absolutely. And I think looking at it from a system point of view and looking at how health systems need to look at their spending, this is an incredibly useful metric from that point of view to decide on budget and to decide on investment for a health service, but I think running a service and keeping a service going to the extent that I'm happy with, my primary driver is improving quality, and I think that is how you select people to run these kind of services; you need people who are driven by that, not driven by trying to improve hospital presentation rates or ambulance transfer rates.

MR GRAY: Ms Beecroft, any additional comment from your frontline role as clinical nurse coordinator?

MS BEECROFT: Okay, so from a nursing perspective, a lot of my goal would be to support the nursing home staff with their clinical decision-making within their

environment and within their skill set. There's a lot of new graduates and new staff in nursing homes and they don't have the resources that are available in a hospital setting. So to be able to empower them with the right decision-making skills is a huge factor to improving patient care as well. An example I can give you is there was a triage that I took from a new graduate and he had been utilising the clinical pathways handbook that had been outlined – that the facilities have.

He had – he was using the pathway at the time of the phone call and it was a really good triage and he – the feedback we got from him after that was – he wouldn't have known what to do had it not been for that clinical decision pathway that he had available to him and the phone call. So being able to empower them with that. Also to support them to be able to communicate those clinical decisions in a manner that supports best practice as well, using a standardised communication tool as well. So there's an SBAR tool, so that's pretty much the standards communication tool that is utilised throughout Metro South, across all, you know, staff so nursing, medical and allied health will use the SBAR format. So it's about supporting the nursing homes staff to be able to utilise that SBAR process as well to make sure that they're getting the best quality information across as well.

MR GRAY: What are the categories of information in the SBAR tool?

MS BEECROFT: So the situation, background, assessment and recommendation, so that breaks it down. Nurses like to tell stories, and sometimes the critical information that we get on the triages don't actually occur until at least three, four minutes into the phone call so if we can get them to identify what is the situation at hand right now, give me some relevant background information, tell me what your assessment is right now of this person and what do they want to achieve, so what are the recommendations. You know, do they want the outreach team, do they want to send them to hospital, do they just not know where to go next, that sort of thing. So if we can get them to use a structured communication tool it helps with that whole assessment - - -

MR GRAY: Is the clinical pathway resource that you provide specifically tailored to Queensland, to Metro South in particular or is it of a more general nature?

MS BEECROFT: Initially, it was Metro South and now it's been rolled out statewide. So it's able to be – you know, people – you know, the facilities outside of Metro South are able to – help - - -

DR NASH: The handbook now is under the governance of the health innovations unit and rolling it out to regions that also have an equivalent service to CARE-PACT so the guide – the handbook is designed as a decision assistance tool where there is a service like us in existence, where there is the opportunity to provide a mobile emergency team and the handbook actually customised as well with what all the local resources are for that particular area so what are the other players in the game, so to speak.

MS BEECROFT: That's exactly what I was trying to say.

MR GRAY: Ms Beecroft, are there any other main points you wish to make about the goals of an outreach service of this kind?

MS BEECROFT: Yes, and it's just letting them know, like linking them into the community services that can help support them best because – because of the high staff turnover they often don't know where to go next. So it's helping us link them in with those community services and the referral processes, things like that. Yes.

MR GRAY: Dr Burkett mentioned that linkage function as an essential characteristic as well.

MS BEECROFT: Absolutely. Absolutely.

MR GRAY: Dr Montalto, in your opinion what – if there were to be a systematic implementation of outreach services of this kind, what would be the key goals that should drive the design of such services?

DR MONTALTO: I mean, they've already been outlined particularly well, I think. I've been in the situation of straddling a period of introduction of what you might, what's been termed an outreach model of nursing home management and saw referrals to and activity in Hospital in the Home increase dramatically through that. That is to say, a team that's thinking about this kind of care all the time, thinking about what the options might be, is going to be necessarily better informed and, you know, better aware and better plugged into what those options might be. We struggled in Hospital in the Home despite having, you know, all the inputs and being capable of doing this kind of work, struggled to convince emergency departments to divert patients or refer patients to us.

Some of that was rational on the basis that someone had taken an ambulance ride in, they weren't necessarily keen to put them in an ambulance back even if they convinced that the care was going to be equivalent. But by having an outreach model of care where the patient wasn't subjected to that transfer and also didn't also trigger the kind of conveyor belt that happens once a person presents in an emergency department meant that referral to us and activity to us improved and I would hope that that meant that the care for that patient was better. So really from my point of view it means that the kind of innovations that Hospital in the Home is one of has the ability to contribute more to the care of these people.

MR GRAY: Thank you. Dr Montalto, I just want to return to a point I raised with Dr Nash about whether an underlying principle behind mobile substitutive care should be the concept of measuring the degree of avoidance of hospitalisations. One of the propositions that counsel assisting have under consideration in this hearing is a suggestion that residential aged care facilities should be subject to a metric or an indicator as to how many ambulance callouts they instigate in a particular period, say, financial year. Do you have a view on that?

DR MONTALTO: I mean, I appreciate the sentiment in the comment. Broadly I agree with it, but in practical terms if the mechanism we're talking about, for example, resulted in an increase in ambulance referrals, albeit with greater quality, I think people would be concerned about that. So I agree with you. I think that that is a reasonably hard measure of – of activity that doesn't necessarily need to be interpreted negatively in its own right but certainly can be used as a flag to perhaps measure year on year the impact of innovations like this, because at the moment the ambulance is seen as the cavalry and so they're there and I think that given you can count them and given that they're at the moment the – the fallback position, it's not unreasonable to use that.

MR GRAY: Dr Nash, I will give you the opportunity to respond.

DR NASH: I think – I think I completely agree with Dr Montalto in what he's saying. I think that – I think we need to understand ,as a key performance indicator, do we know what success is in that. What is – what is – what is the right number, and I don't think we know that. And I think that possibly has a lot to do with us not understanding – not measuring it first of all, and it may be useful to look at this data. I think that if we're going to judge the success of a service like my service or equivalent services under the title RaSS in Queensland then what we really need to measure is the number of ambulances that are arriving to emergency departments from RACFs and the total number of RACF patients that are turning up through all modes of transport because that's what we're trying to influence.

I also think that this goes hand in hand with trying to provide a nursing home – an RACF with something meaningful to do with this data. What do they do with this KPI because otherwise we're going to drive change in a direction that may not necessarily improve the care of elderly in a nursing home. We may drive change to act or make decisions to alter the results of last year's KPI with ambulance transfers either up or down, and if the human drive to improve that number, I am not confident that that would be based on trying to improve care for the individual. It may be more process driven and more of a KPI that's trying to drive change in a facility without consideration of individual needs.

MR GRAY: Thank you. I want to now go to the topic of funding. We may have to break for lunch in the middle of this topic but we will commence it. Dr Nash, I want to commence with you and your knowledge about how CARE-PACT in particular is funded. When we consider hospital-based outreach services of the kind represented by CARE-PACT in the public sector, how is a service like that typically funded; is it funded from hospital budgets and subject to hospital caps? And Dr Montalto, you in your statement provide quite a lot of detail on this and I will come back to you on this. Dr Nash, are services provided by CARE-PACT or at least some of the services provided by CARE-PACT treated as admissions or treated as national weighted activity units in wards that are subject to the National Health Reform Agreement funding split? How does the funding work?

DR NASH: They – we are recurrently funded through Metro South Health as a hospital and health district to provide a permanent budgeted FTE and expenses beyond that. We report against activity-based funding and so our activity in providing both hospital avoidance and review of patients does generate that activity-based funding sort of revenue source, so to speak. The origins of CARE-PACT though, and I think a lot of services that are attempting these things, are often through pilots. They're often irregularly funded, briefly funded, six months, 12 months, maybe two years and that provides a significant difficulty or a significant barrier to those sort of services progressing into a recurrently funded model.

And I think that that poses a significant risk for things – very simple things like recruitment, you know, I think when you want to employ passionate people, you need to employ people who also care about their family and they want to make sure they can pay their mortgage and I think that, you know, the concept of permanently funding these things gives people that freedom to have a job where they can give it their all and I think that pilot projects of this nature, I think are not really the way forward. I think that – I hope that out of this we can say, look, models like this do work, you don't need to pilot it even further. It's time to fund these things in a permanent way so that you can recruit appropriately and get the staff that are going to continue to evaluate it into the future.

MR GRAY: So the permanent recurrent funding has been in place, I think you say in your statement, since 2016.

DR NASH: It has.

MR GRAY: And in addition to that, CARE-PACT reports against activity-based funding for the purposes of claiming through the hospital system the amount of state and Commonwealth funding that's available for ..... in a hospital setting; is that right?

DR NASH: That's correct. Yes.

MR GRAY: And are they treated as outpatient services?

DR NASH: They are. They are. And because we've got tight links with our hospital in the home service they're the ones that will continue to provide ongoing care. So if a person is requiring the equivalent of inpatient care but in the facility, just like we would in emergency, we hand that over to our HITH team who continue the admission for that patient at their bedside. And so the funding then for that person's admission will be under that service, not ours.

MR GRAY: And the funding stream that's attributable to the claims for the ..... presumably is just a subset of the total recurrent funding.

DR NASH: That's correct.

MR GRAY: And it would be unsustainable for the model to exist simply on activity-based funding; is that correct?

DR NASH: It is true that it may be. However, with the level of activity that we perform in hospital avoidance through all of the different arms as well as ensuring the quality of our care through a follow-up phone call, that activity is quite significant and it exceeds our budget each year and our activity goes beyond the money that we are provided in our budget.

MR GRAY: Would it be a fair thing for me to say that it can be inferred there that the hospital, that is, the hospital and health service, the local hospital network constituting those four hospitals, is seeing a sufficient benefit, a sufficient cost benefit ratio in those additional services that you just mentioned to justify the top-up - - -

DR NASH: Absolutely.

MR GRAY: - - - by the recurrent funding.

DR NASH: It completely justifies our budget every year.

MR GRAY: Dr Montalto, we may not get through all the of the funding issues that you've addressed in your statement and which I would like to ask you about now, but could we start with the private sector because that's where you are now and there are particular complexities by the sounds of it.

DR MONTALTO: There are.

MR GRAY: Would it be possible for outreach services of this kind to operate in the private sector environment given the differential approaches taken by different private insurers, the differential approaches taken by different private hospitals which you mention in your statement.

DR MONTALTO: No. We tried, can't see a way around it.

MR GRAY: And somehow the Epworth Hospital in the Home model you've managed to ensure its sustainability by exactly how, by obtaining agreement of the hospital to - - -

DR MONTALTO: So – well, the Hospital in the Home – nursing home patients form a relatively small part of the overall Hospital in the Home activity so we could do more, but within the private sector at the moment we don't do as much as I was doing in the public sector for that reason, the reason I mentioned earlier which is that if you're privately insured, there may – you know, the publicly funded outreach service might not necessarily be engaged for you. You catch an ambulance into the emergency department when things are going particularly badly and at that point the emergency department makes a decision about where they're going to put you. And

as I've just said there's already reluctance to put a person back in an ambulance the same day they've come and also there are, you know, competition issues which exist in a public hospital as well as private hospital about, you know, who catches that work and who does that work and who's reimbursed for that work.

So there's plenty of scope and plenty of activity in private Hospital in the Home there to be had for hospitals that are willing to rise to the challenge of negotiating with health funds, but in terms of this particular cohort, because they require ambulance transfer, you really need to be at the front door of the facility and assessing and accepting that patient. Now, we still do that work. We're referred that work by GPs who know what we do and so we will get direct referrals by general practitioners and occasionally if people are – families are involved and looking for alternatives at the point of before the ambulance is called, then we get that work too. And we do get work from those people who are referred into the ward but that's a very small proportion.

So it happens that yesterday I had three patients in that circumstance. Two of them were referred directly by general practitioners and one was referred to us from a ward, a hospital ward. So the work is there but it's not as – it's not as – it's not as compelling as when you have an in-reach service or an outreach service triaging that work to you.

MR GRAY: Thank you. Commissioners, is that a convenient time, I will break the funding topic there and ask Dr Montalto to turn to the public sector after lunch.

COMMISSIONER PAGONE: Yes. Thank you. We will adjourn to 2.15.

ADJOURNED **[1.00 pm]**

RESUMED **[2.15 pm]**

MR GRAY: Dr Nash – beg your pardon. Dr Montalto, I was in the middle of asking you questions about funding, and I wish now to ask you some questions about funding of outreach services in the public-sector context. I'll ask the operator to display page 0011 of Dr Montalto's statement and paragraph 64. You refer there to the Victorian public-hospital hospital-in-the-home funding-model as being the exemplar for funding hospital in the home. What's – what are the key characteristics of how that funding-model operates?

DR MONTALTO: Now, the first thing I have to be clear about is I'm speaking strictly about hospital in the home, which in Victoria is quite separate to any in-reach or outreach model. And actually that also refers to my comments before lunch in terms of private funding. That was about a private in-reach – outreach funding. So this is really – these comments are directed towards hospital in the home, which is

separate. What's exemplary about it is that it funds hospital in the home on equal terms to inpatient re-imbursement; so what that means is it removes – it gives an incentive for hospitals to invest into this service provision without any financial penalty, and so they see it as something that's worth their investment and their time, and it also allows hospital in the home the ability to construct models that can genuinely replicate standards of care that might be delivered in a hospital setting. So we have more capacity to deliver more specialist services, both nursing and medical, and in terms of the technologies that are associated with hospital in the home, which can be quite expensive, and the drugs associated with hospital in the home – all of those costs can be adequately covered through using an inpatient-reimbursement model.

MR GRAY: In respect of Dr Nash's evidence before lunch and his reference to the funding of CARE PACT involving a blend of recurrent funding from the local hospital network for the service itself but then the service reporting for the purposes of activity-based funding – is that element, reporting for the purpose of activity-based funding, similar to the way in which hospital in the home is funded in Victoria?

DR MONTALTO: Correct. Identical.

MR GRAY: And the terminology's a little different, I understand, in Victoria in that weighted inlier-equivalent separations or WIESes referred to instead of EIWARS. Is that correct?

DR MONTALTO: Yes. Correct.

MR GRAY: But otherwise it's the same.

DR MONTALTO: It's the same.

MR GRAY: Now, you make a point at the end of paragraph 64. You say there's an important incentive created by reason of the fact that the hospital or the hospital network achieves a double benefit by managing a residential aged care facility patient in hospital in the home. Those services for that person are funded on equivalent terms, and they gain bed access in the traditional hospital.

DR MONTALTO: So, in other words, the hospital's gaining capital expansion. So not only are they able to be reimbursed for the work that they're going to do, but hospital in the home is a form of expanding the capacity of the hospital without building beds. So therefore, if they have the negotiated ability to fund that extra capacity, then hospital in the home gives them that capacity.

MR GRAY: You make the additional point – thank you for explaining that; you make the additional point straight after that, that breaking that association could re-introduce perverse incentives. Could you explain that?

DR MONTALTO: Well, if hospital in the home were funded from an out-of-hospital or out-of-hospital-network source, it might still be possible, to deliver the care, but it – hospitals would not reap the benefit of that directly, and so their ability to plan for or see it as part of their regular work would be lessened, would be diminished, and I think that therefore they would see it as a less critical part of their planning, and therefore it wouldn't necessarily form part of their expansion; they wouldn't necessarily presume that that activity would be activity that's part of their regular work.

MR GRAY: When we consider the more expanded or integrated models that are available when compared to hospital in the home – so take for example CARE PACT, where there are mobile, substitute, acute services but there are other services forming part of that model; do you see the same association or incentive as being important in the case of services of that kind? Or are you restricting this point to hospital-in-the-home services?

DR MONTALTO: Well, it's clearer and easier to count and easier for hospital executives to consider, if they're separate. If hospital in the home continues to form an acute-inpatient substitution service and CARE PACT or in-reach or outreach forms a pre-admission if you like, triage function that's not counted in that – I think that separating those functions – well, put it the other way; integrating those functions can really muddy the waters, and I'm always conscious of gaming within hospitals to shift budgets where perhaps they shouldn't be. By separating it – it makes hospital in the home an equivalent triage kind of end point to any other. You could just as easily, potentially, be in intensive care, or you could be in hospital in the home, or you could go to the emergency department, or you might just need your GP to see you the next day, but as an option for the hospital to consider, it's better, that it's separate and remains an inpatient equivalent. If you were to merge them, which you might be able to do on a staffing – from a staffing point of view and maybe even from an organisational point of view – but from the point of view of the hospital considering where its work is and where its budget will flow, I think that would be detrimental.

MR GRAY: Dr Nash, can I just ask you to respond to that point? Is that the way you see the role of these two models, or do you see a capacity to integrate them?

DR NASH: I think the complexity of all this is exactly how hospital funding works, and there's, probably, a lot more to it. I think philosophically – I think that our – the aspect of our service that is in the RACF at first is the equivalent of an emergency-department visit and that, if that person needs prolonged care and the equivalent of inpatient care – that that funding-model goes under hospital in the home. And – because it's recreating the same care and circumstances for that patient as they would receive on a ward bed in a physical hospital. So I see them as being able to co-ordinate, work together, but it's two different mentalities. What you're trying to substitute in the RACF – and I think that emergency medicine and emergency-department assessment and acute care and understanding where there is an acute episode and what those needs are – I think emergency physicians are well placed to

provide that, and then I think that ongoing care, hospital in the home is best placed by the specialties necessary for that patient. For example: general physicians, infectious diseases, vascular medicine, endocrinology, haematology, those sorts of things, and those services being provided within a model like hospital in the home is in the best interests of the patient. So the longer answer – I think that they can integrate together.

MR GRAY: Thank you. Dr Montalto, I will come back to you. You also say in your statement – this is at paragraph 67 – that it may be beneficial, for the Commonwealth to consider directly funding the hospital-in-the-home and in- or outreach services delivered by hospitals. And then you refer to in effect the activity-based funding-mechanism and the involvement of the independent hospitals-pricing Authority in that regard. Do you also, in addition to that opinion, consider that there's a good argument for a dedicated recurrent funding-stream of the kind that the Queensland State health Authority is providing through the local hospital network for CARE PACT to cover those additional in-reach, outreach services that are not going to be cost-recoverable through activity-based funding alone?

DR MONTALTO: I mean, that's difficult because I don't know all the details at the fringes of that activity. In terms of the Victorian model though, there are some similarities. It is year-by-year. It's outside of the core hospital activity kind of funding model. It's – and so there is insecurity there and there is also a shortfall is my understanding among in-reach and outreach where hospitals will have to make decisions about investing extra in, usually for expansion of either personnel or hours, not necessarily for expansion of roles particularly, I think. But I think in general yes, I think it's a – it's something that can be carved out, it's been identified as being useful, pivotal even for changing the way the system deals with this group of people and there's a – and therefore it can – the Commonwealth can contribute.

My comments with regards to Hospital in the Home are different in that Hospital in the Home albeit well-funded on – and reimbursed on an acute inpatient basis it's still subject to the cap that States impose on hospitals. So in some respects it's a zero sum game. If hospitals invest into Hospital in the Home and Hospital in the Home does more activity someone else will do less or will be funded less. So if this is an area where the Commission felt that we could contribute beyond what the states or even hospitals at the moment feel they want to, uncapping that from within the hospitals cap would promote growth and would promote investment into Hospital in the Home.

MR GRAY: You've mentioned there are some such in-reach/outreach services in Victoria.

DR MONTALTO: There are, yes.

MR GRAY: Is it the case – this is the understanding that the counsel assisting team have, is it the case that the existence of these in-reach/outreach programs is a matter of, in effect, ad hoc chance, depending on the particular local hospital network area,

and there are some local hospital network areas which have in-reach/outreach services well supported and functioning well ,and there are others that simply don't have them at all and it depends where you live in Australia whether you have access to them.

DR MONTALTO: In Victoria, certainly at a State level it's being promoted as something that the State department of health wants to have and so the funding is there for individual hospitals to take it up. As far as I am on aware most have but what comes out of that is very variable I think. I don't know that the state's been prescriptive about what the components of those services should be, both in terms of staff, in terms of hours, in terms of geography covered, so there is still flexibility for the hospitals within that. So it's more a question of how much – how much output is coming from what's coming in, but certainly the department at the State level has decided that this is a service that's worthwhile.

MR GRAY: And what about more broadly around the country? Do you have - - -

DR MONTALTO: In terms of in-reach and outreach, no, I can't tell you beyond Victoria.

MR GRAY: So we're considering the proposition which we're testing in this hearing to the effect that the Australian Government and the State and Territory Governments should agree on the introduction and funding of outreach health services with the ability to deal with acute deterioration - - -

DR MONTALTO: Well, when you say - - -

MR GRAY: - - - for people in residential aged care services to be administered through local hospital networks.

DR MONTALTO: Yes.

MR GRAY: And for that to be funded on a jurisdictional split along the lines of the National Health Reform Agreement.

DR MONTALTO: Okay.

MR GRAY: What are your views on that?

DR MONTALTO: I don't know if you want to split words, when you say "to deal with acute deterioration", I mean, it's about what "dealing with" means, but in general terms, yes, it's there as a triage early response to acute problems that would otherwise require transport to hospital or other interventions, yes, I think that's a reasonable – that's a reasonable goal.

MR GRAY: And to have that dedicated recurrent funding enshrined in the intergovernmental agreement, is that something you support?

DR MONTALTO: I think so. I think so, but that also would then – but I would also add that without having alternatives that are innovative and exist that are capable and ready to take the work that will come from outreach and in particular Hospital in the Home services they will be limited in their effectiveness. So if outreach can go out there and do a great job, that's good but if they have the ability to refer to a Hospital in the Home service then you will get – you will certainly get a magnified response in terms of the effect of what they can do. So the two need to go a little hand in hand. You can have some states of the country where if such a service was to be introduced and they either had an underdeveloped or a Hospital in the Home service that wasn't able to respond to them without the patient coming to hospital you would be undoing a lot of the benefit.

MR GRAY: And Dr Nash, noting the importance of that ability to be flexible with regard to regional conditions, are you also supportive in principle of a dedicated recurrent funding agreement at the intergovernmental level?

DR NASH: In principle I do agree with that, the concept. However, implementation of these things is made exponentially more complex when you start to – actually start to understand demand management and the concept of absorbing demand or understanding as well the role of general practice as the decision-makers in acute deterioration. And the current situation we have is made incredibly difficult by a patient's regular GP in a facility and the ability to contact, ability to make decisions and – and making quick decisions with that GP is complicated and difficult. And I think that the current funding model for GP contributes to that. And that any of these services that are looking at a response to an acutely deteriorating patient in an RACF needs to take into account that complexity.

Otherwise these services just start to absorb activity that GPs are the best people to respond to because they're the experts in that patient's global care and you end up with a non-sustainable service in the long term. So if considering that, demand management and it leads to these kind of services, then I would support it.

MR GRAY: Is the key then that partnership with primary health practitioners that's one of the key elements?

DR NASH: Absolutely. It would fall down without it and without the support of general practitioners who are providing the care, without understanding what the constraints are for them in providing acute care for their deteriorating residents. Without understanding that and knowing where this service fits, it would fall down, it would become overwhelmed too quickly.

MR GRAY: Dr Montalto, Dr Dawda yesterday expressed a view that a program of this kind might be better administered not only through local hospital networks but also in partnership with primary health networks, but I note that in your statement you've expressed some scepticism about the ability of primary health networks to administer a program, at least of the kind involved in Hospital in the Home. What are your views on the idea of involving the primary health networks?

DR MONTALTO: Firstly, in terms of the comments that were just made, they're right; I mean, I think – but in my experience often the outreach services are called once the GP option has been exhausted, generally speaking. So it's not as if they're trying to undercut – I hope they're not trying to undercut or cut out the role of the general practitioner. Look, I think that the services that we're talking about do arise from the hospital and there's a reason for that. It's not just that there's technique and technology and knowledge that's there, but that's what the facilities are looking for.

So – and I think they are aware of the differences between what's available from the primary care sector and what's available from the secondary care sector and, you know, when their fingers are hovering over the telephone to call an ambulance, it's really about them making that decision, well, we've finished with primary care, now we have to move on, them or the families.

I just think that that comes with a set of expectations on their part and from our part they see that we're delivering something that's a bit unique and a bit different and closer to hospital than primary care and that's – that's what they need at that present moment. And so therefore, I think it needs to come from that sector. In terms of the primary health care networks, I just think they're a little too distant from the kind of interventions we're talking about and were they to get involved with what I've seen in the past, and my direct experience with dealing with them I just don't think that you get the level of input that you otherwise might.

MR GRAY: Thank you. I want to now move to a set of topics relating to the potential systematisation of this model of in-reach and outreach support to be made available for, in particular, residential aged care recipients. I want to raise for the panel's discussion the proposition that the model, with due regard to the need for flexibility for regional variation, should – it should be scaled up and replicated across the country, supported by a dedicated funding regime of the kind that I've raised with you just now.

I want to ask you for your views about whether there are particular barriers to that occurring and whether they would be likely to be addressed in the event that permanent recurrent funding were to be made available or are they more deep-seated? Are there cultural barriers? Are there barriers in relation to the attitudes of people who have been making referrals out of facilities and primary care? Starting with you, Dr Nash, what are your views; should they be scaled up and replicated, and what are the barriers?

DR NASH: I think that they certainly lend themselves towards scaling up and replication. I think that in the right districts that can be a very smart move. I think in districts where there are fewer residential aged care facility beds is one barrier in terms of making the same financial arguments we've been able to make for our area because we have a huge density of RACF beds in our area so it means that the numbers coming through actually can actually justify our activity. So without that I think that that's a financial barrier to proving that the service is sustainable. I think that geography plays a huge role as a barrier, in that we do have a mobile emergency

team but it can take upwards of – I mean, Dr Burkett mentioned earlier the residential aged care home that's on Straddie – on Stradbroke Island. And, yes, I still haven't got there.

But it would take upwards of two hours just to cross from the mainland part of our region and the travel time to see one patient at the far extreme of our region would mean we would miss out on seeing several other patients so we do have a take a bit of a utilitarian approach to that and see the most for the most good. I think you mentioned a moment ago culturally, and I think that there is a cultural barrier that needs to be acknowledged which is the belief that the care is definitely better in hospital for everything, that every acute deterioration – and this is not a firmly held belief by everybody but there are certain sections I think within both general practice and in the residential aged care facility clinical teams that believe that every deterioration should get hospital care and I think there are probably elements of the public that believe that as well.

And I think that's mainly because we've never provided opportunity and options. And we've – our service is obviously getting that message out there but as we have changeover of staff in the region that becomes a barrier that we have to go over again, and new staff who don't know that we actually have a team that will come to the bedside and phoning us actually means that the resident gets better care. And once we get that message out there, that barrier disappears but we're continuously having to do it because the workforce continuously changes because of the low retention of RACF clinical nurses. So every time we make these great gains in overcoming that, we're back at it again, and so they become ongoing barriers that we deal with.

I think general practitioners are changing. The number of general practitioners that are providing care in RACFs is certainly diminishing as it's the older workforce of general practitioners that have been providing RACF care and they've got a certain set way of doing things but communicating with them, we've got newer GPs coming through who are trialling for themselves different financial models of how they look after their residents and that actually provides a barrier to communicating to them about where we fit and what we can do. And I say there are all these barriers but they're all equally opportunities because once they're dealt with and we actually get the message out there about what we can do everybody is quite supportive because they see that we're actually value adding in a niche that without us there is no option but to transfer to hospital.

So I think that all of the scalability and things like that has to take all those things into account and it's a really strong communication game with RACF, patients, families, GPs, but I'm yet to see sort of negative feedback about what we do once they understand what we're doing.

MR GRAY: Dr Montalto.

DR MONTALTO: Look, I fully support what Dr Nash has said and I really don't have a whole lot more to say, except – except to point out the obvious that culture change in my profession is a drawn-out, slow and painful thing. And the other thing is, you know, you have to keep showing up. So it would be – it would have to be something that had – was a long-term intervention and then what tends to happen is things snowball. Technologies in particular become affiliated with you and so therefore your scope of provision expands. And over time, you know, these things just will develop into their own – into their own little sub-specialties, I guess.

You know, I remind people that things like intensive care or even emergency medicine in and of itself are specialties. These things weren't great ideas and suddenly became part of the culture of medicine in terms of hospitals. They took decades. So it's a question of sticking at it. If it's a good intervention then essentially it will survive.

MR GRAY: Ms Beecroft, any insights at the frontline level?

MS BEECROFT: Yes. I completely agree with the barriers that Terry has identified. Given that I've been in the role for, you know, five years now so I've seen that change in attitude from, you know, not knowing and understanding what we've done to now embracing our service. And that – I do think that because of the high staff turnover in the facilities, that's – that's one of the really big barriers to them understanding what the service can provide.

We – within my role, especially when we do the seven day follow-ups, if we identify that there's new staff there that we haven't spoken to before, we will ask them, "Are you new to the facility, have you worked in other aged care, do you know about CARE-PACT" and we'll use that as opportunistic education for them just to let them know who we are, what we do. But I think that that high staff turnover, you know, really reiterates that we really need to have that ongoing engagement and education for the facilities.

MR GRAY: Thank you.

MS BEECROFT: Yes.

MR GRAY: I just want to ask you about what you've just said about the ongoing engagement and the education. Is there room for these programs to expand their scope and to be more proactive, to have a more preventative health role than CARE-PACT might do at present. Say, through that educational element of what CARE-PACT does, is there scope, for example, for the clinical nurses who provide that education to move into a mentoring role and assisting rounds and so forth. What are your views?

MS BEECROFT: Absolutely. You know, I – I've – part of my statement I identified that, you know, we identified that there was that lack of education, training sort of thing, so we developed what we call the focus groups which is targeted

education specifically focused to the nursing home staff within our catchment area. We bring in the experts of the topic. We talk about the hospital journey, we talk about the community services that are there to support them and then they can take that back to their facilities. They can take back that, you know, that empowers them, you know, helps upskill them and then they can help, you know, that information can be transferred to the rest of the facility staff and that, you know, improves patient outcome as well.

MR GRAY: In your view should that role merge into a role for the proactive health care of the residents of facilities involving your views or should the service remain in its clinical – direct clinical services aspects, in effect, episodic and reactive to acute deteriorations?

MS BEECROFT: I think if you give them the tools that reactive process will change to that proactive. So if, you know, when you – let's just say, like, once you are a new graduate and there's – and there's something that you're, you know, dealing with for the first time, it's a very reactive response. However, given your experience, get some training, education under your belt, you can potentially foresee that this will happen, you know, changes will occur. So it goes from that reactive to that proactive. Does that make sense?

MR GRAY: Yes. Thank you. Dr Nash, any views about whether CARE-PACT should get involved in proactive preventative health measures?

DR NASH: I think the maximum proactive preventative is what Megan said, which is educational frameworks, pathways of care, teaching how to respond to deterioration, how to communicate that well. The proactivity, I believe, is part of that care coordination and I think that that comes down to how GPs are looking after their patients and I think the responsibility and direction of that is with our general practitioners. I think that that concept of rounding or care coordination or trying to be proactive is a driving force within how RACF should do their normal business and I don't see or understand at this stage why myself as an emergency specialist would be the best person for that.

My training, even though I have also general practitioner training, my training as an emergency physician is who to respond to acute, critical, life-threatening, what's the deterioration, what can my department achieve, but rounding and preventative care and things like that and understanding how an older person deteriorates gradually or episodically, that is the specialist of general practitioner, and I think they are the specialists in that field of medicine and can lead the way in that.

COMMISSIONER BRIGGS: Can I ask a question. I fully understand how these models could work in residential aged care facilities. How do they work in the community where a person is single and has no other supports, so doesn't have a permanent carer with them; can they work in those situations?

DR NASH: I think it's a completely different legislative environment to operate in. I think operating from an emergency point of view for that person when I have no capacity to ensure that that person has any ongoing support, observation beyond that episode of care, I think makes it a very difficult space for me to operate in as an emergency specialist. I think that those people, you know, a community-dwelling older person, for example, with very limited community resource, the assets it takes to support that person does take quite some time, so we've been, you know, working on some innovations in our emergency departments, particularly in Queensland and in my area as well, of looking at how do we support that community-dwelling older person to get home safely.

Now that takes a bit of time and effort by community nurses who understand that really, really well. And that does take quite a bit of time and that's separate to what, you know, the sort of the CARE-PACT sort of ethos in a way. It does have a lot of crossover in that excellent screening and picking up of geriatric syndromes and both the medical and nursing aspect in ED. So at this stage I don't see a huge role for an outreach team for that community-dwelling older person. Because of the resources it may take to support them and the amount of time it might take, I don't think we would be able to achieve it. I'm happy to be convinced otherwise but at this stage I couldn't – I can't conceive how that would work out efficiently or effectively.

COMMISSIONER BRIGGS: No, well, that's helpful because we need to understand that as part of working through these interactions, so thank you.

MR GRAY: Dr Nash, you mentioned care coordination and it's also been said that that functions fall into general practitioner's, primary health care practitioners and you mentioned that in passing. What's your view about whether that's necessarily the right approach in all cases. Should there be a one size fits all as to who the care coordinator is, or should there be the flexibility to designate a different care coordinator, depending on whether a multidisciplinary team of the kind under discussion stepped in, for example. Another alternative might be that the residential aged care facility should have a person who's designated as the person's care coordinator and that the care coordinator function is clearly with that person as opposed to an appointed general practitioner. Do you have any views?

DR NASH: I think understanding medical governance and who is the medical decision-maker for someone, I think we need to get really clear about the communication around that because I think when that is unclear harm happens and it particularly happens to the cognitively impaired patient. This is true across the health spectrum. And I think in this setting, general practitioners who care for the elderly in RACFs are the experts in care coordination for their patients, but I don't think they need to do it in isolation. I think that they need help. I think they need supporting care coordinators, you know, there are GPs that successfully use nurse practitioners and clinical nurses to round with them. There are RACFs in our region, particularly, who've given a particular role and called that person a care coordinator, and their role is to understand all of the different health care needs for their residents

but they coordinate then the rounding, so that the GP can round more efficiently, for example. They're following up on appointments, they liaise with us quite closely.

Now, where we see GPs use a nurse to assist them or where we see RACFs that are using that care coordination role, we certainly have a high quality of communication interaction with those elements because there's familiarity and repetition and we get to know each other quite well. So there's efficiency and quality improvement in that but I still fundamentally believe that the care coordination from a medical governance and decision-making, I think nationwide we should be agreeing that it's the GPs that are doing it, but that we want to assist them to do it optimally, but not to confuse it, not to end up with more diffusion of that governance because that's when we'll make mistakes and we won't mean to, but we will.

MR GRAY: Can a GP be embedded in a CARE PACT team?

DR NASH: I don't see any reason why they can't. I think, fundamentally, we've structured ourselves as an emergency-specialist service, and that's where we've started. But I think that it would depend on the GP, but, yes, I can see a role for us to integrate that. But we take a lot of advice from a lot of GPs about how we should operate and what we should do, and it, certainly, keeps me on my toes and educates me, every time I do a shift at CARE PACT.

MR GRAY: One of the propositions we have under consideration in this hearing is that the royal commissioners might recommend that a requirement be imposed through the aged care subordinate legislation, that older people with high care needs who are in the aged care system, whether that be in the community setting or in residential aged care, must have a designated care-coordinator responsible for managing their various health and aged care needs. Would you see that as an appropriate measure for the purposes of the clarity that you mentioned?

DR NASH: To clarify that, though: as long as that person is that person's GP with the support of someone, I would completely support that. I think understanding – I think Dr Hullick put it best earlier today, that no one person can know everything about the needs of an older person. It does take teamwork. I, certainly, don't – wouldn't be able to do my job without my clinical-nurse consultants and the whole clinical-nurse team and my geriatrician; so I think that, if there is a wording in there that still makes it clear, that the general practitioner is the care-coordinator but their assistance through collaborative geriatric-nursing specialist, nursing-practitioners, that sort of things – that will value add, and that will improve quality.

MR GRAY: Can I raise another topic for the discussion of the panel more generally, perhaps go to you first, Dr Montalto; who are the essential categories of professionals who should be constituting these multidisciplinary outreach teams if the program were to be systematised? We heard from Dr Burkett that it'd be essential, that there be an emergency physician and a geriatrician and that might constitute the leadership of the team, but she mentioned a lot of subspecialties. Of

course there'd be support by clinical nurses. Do you have any particular subspecialties in mind, and what do you think of Dr Burkett's views on composition?

DR MONTALTO: I think those views pretty accurately reflect my views, and also the constraints of having a team going out to an undifferentiated problem – you don't have the advantage of saying, "Well, I'm going out to see a rash" or "The primary problem is rheumatological. So let's have a rheumatologist". I think you're going to go out – you're doing some triage. You're doing some assessments; so you need people who are confident enough to spread their skills across a variety of specialties and then have the ability to sift and pass on and inquire further to people who might have those skills, including infectious-disease specialists and others. I think a special-purpose GP who gives up some of his or her time or expertise into this role, who's been involved in hospitals for a long time as well, could also, potentially, form part of that team. You need people who are, essentially, at that point, at the pointy end, generalists and ED physicians, geriatricians, and some GPs are generalists.

MR GRAY: And what about access to the subspecialties that might then be called for – what's the role of technology here? Is telehealth very important? Is MBS rebatability for telehealth consultations sufficient?

DR MONTALTO: No, it's not. Yes; it's a problem. You're either going to call in on someone's time or expertise on a favour basis, or you won't really at all. These people can't be told to make an appointment in two weeks and see whoever. So you do get people's attention by paying for them, either as co-opted members of the team on some sessional basis – and there might be some subspecialties that are used more than others, and that might be useful, but you still won't cover the whole spectrum that you might come to need. So – yes; on a kind of episodic-reimbursement basis the ability to gain someone's attention would be important. And I think the thing about that is that, when considering that issue – the alternative is or – must always be considered is the cost of putting someone in that transport to take them to that sub-specialist. So if there – if that's factored into any rebate, then you could, potentially, start to get people's attention and – who may well want to do this kind of work or help out a little more, because the cost of transport is, in fact, quite high.

MR GRAY: Ms Beecroft, in your role as clinical-nurse co-ordinator, you're putting together teams when the need arises. What are your views about the model suggested by Dr Burkett and largely endorsed by Dr Montalto, and what are the subspecialties to whom access should be available?

MS BEECROFT: Look. I think the categories of staffing that we've currently got work really well. I think the access that we have to the specialties in the hospital so we can call the – whether it be the dermatology ..... or plastics – we've got access to that as well. Can you repeat that?

MR GRAY: Yes; what subspecialties would you say are essential to have access to for the – for these teams to work properly?

MS BEECROFT: Look; the common ones - - -

MR GRAY: Psycho-geriatricians were mentioned – wound specialist, palliative care.

MS BEECROFT: Yes. So the common ones to get are psycho-geriatricians – that's always a tricky one. There's plastics; anything wound-related is a very big issue that we need as well. We've got access to our consultant, who's a geriatrician; palliative care is a huge one that we liaise a lot with as well. And I think that they're, probably, the main ones.

MR GRAY: Is orthopaedics important?

MS BEECROFT: Orthopaedics is important, yes; we do actually liaise with the hospital orthopaedics a fair bit, but can I also just add that, if we're talking about linking them in with telehealth in the facilities, we've also got to factor in that that takes time from the nursing-staff. So they need to have a dedicated person to be able to set up for the telehealth to be able to be there. This nurse will not be able to answer to the clinical needs of the other residents in the facility. So it needs to be added staffing. Quite often there's only one registered nurse on the floor. You can't take that person away and leave the rest of the facility without access to an RN for the clinical – for their clinical needs in that time-frame. So I think that that needs to be put into consideration.

MR GRAY: So how does it work in practice? Is there an outreach team present at the facility ..... identify, say, a serious pressure injury – and there's a need for a hospital-based specialist to provide advice. What happens?

MS BEECROFT: So the facility would – so let's just say it's a pressure-injury one; they'll give us a call to the triage line. We'll go through; they'll let us know. "We've identified that there's this pressure injury; the GP has been involved and would like CARE PACT to review them." We send out our mobile outreach team; they will assess it, do photos. They'll liaise with the consultant on for the day, and then they will link in with the appropriate referral to the most appropriate provider.

MR GRAY: To the most appropriate specialist within the hospital?

MS BEECROFT: Specialist; yes. Yes.

MR GRAY: And a decision will be made then about whether hospitalisation's required or whether ..... provided in situ - - -

MS BEECROFT: Yes. Absolutely.

With telehealth advice from that specialist?

MS BEECROFT: Sometimes; yes. Yes. There are private services out there that will do telehealth for the wound reviews. There is costs involved in that; so a lot of the nursing-home residents: they don't have the money. So it's – so that telehealth may not be an option for them; so then it may be, that they come into hospital or they go down the palliative route. So it's all about communicating with the family, with the substitutive decision-maker, finding out what their goals of care are and linking in the best way like that.

MR GRAY: Thank you. Is a 24-seven telephone-triage-and-planning service an appropriate measure? Perhaps starting with you, Dr Nash – I note that CARE PACT doesn't provide a 24-seven telephone-triage-and-planning centre, but should there be one ideally? Should there - - -

DR NASH: I think that - - -

MR GRAY: In this program, if the recurrent funding's made available – would it be a good idea, to have one?

DR NASH: Look. I think it's, potentially, problematic and risky thing to do, because I think that, if you're offering phone advice over the 24-seven spectrum, you've got to be offering some meaningful alternative, and you're talking about a phone call about a resident where – and I think Megan would speak very deeply about this, about – that communication is critical. It may or may not include photos or video or telehealth, but ultimately you're – you've got very limited information about someone which to make decisions, and it's really about sorting someone, and without a meaningful assessment service in that out-of-hours space, I think, that's potentially very risky or dangerous.

We only have a limited budget; so we focussed our budget on the peak incidence of emergency-department presentations for RACF parents, and so that's how we focussed our service. I think as well that identifying the 24-seven service of this nature being funded for example, like my services, without adequate reform of general-practitioner availability in that out-of-hours space is, purely, going to shift that demand straight onto that service. I think, instead of calling an out-of-hours GP service or calling the patient's regular GP – I think RACF teams will go, "Well, I'll phone this triage service and see if I can get their outreach team to come and see instead", because our performance measures and our idea of success is that of an emergency department.

We expect to go and see someone make decisions very, very quickly. But, ultimately, at this present way that general practice is funded to receive phone calls out of hours or to see their own patients and to make those decisions, all of that demand is just going to get sucked up into that service straightaway, and I think that that's a major risk.

MR GRAY: Ms Beecroft, we don't – we run up near the end of our session, but – any additional comments?

MS BEECROFT: Yes. Look. Just with that I just want to say it's never just one phone call. If it's a 24-seven line, you need to have – they'll ring us; we'll research on the IMAS computer system what's going on. We'll then liaise with the consultant. We may liaise with family. We may liaise with GP. It's never just one phone call. So you can't just be the phone line, that's available. I just want to give a really quick example of when I was – my last weekend on call. I had three triages that I could have sent outreach out to, but because they weren't available to me, they had to come into hospital. So if you're going to have it 24-seven, you need to have that support there as well.

MR GRAY: Thank you. Look; we are running out of time, but I want to just deal with one further topic. It's a topic that was raised in evidence in the previous session. Dr Burkett in particular referred to inadequate data-sharing as a barrier to systematisation of outreach services of this kind, and she made a case for live data interoperability between My Aged care and hospital-based services. Dr Hullick referred to a need to be flexible about how that might be done but some level of flexible standardisation being necessary, and she endorsed that idea about real-time live access. What are the views of the panel on this important point, Dr Montalto?

DR MONTALTO: Well, that's kind of – very, very aspirational from my point of view, having been someone who will sit at a terminal in a nursing-home, looking for someone to log them in just to get the information when I'm physically there. So I would say that, yes, by all means, if that were possible, then that's a goal that's worthy of being followed, but it's a big task, very big task; so I'm not sure – it'll come down to priorities about where that sits and how much effort that takes, but in principle, it's hard, to disagree.

MR GRAY: Ms Beecroft?

MS BEECROFT: Yes. I kind-of agree. I think in principle it'd be great. In practice – I don't know how it would be achieved.

MR GRAY: Dr Nash, the final word?

DR NASH: I think it would be irresponsible, to fund services like CARE PACT or roll it out or scale it out without having accurate data on how many RACF presentations are coming to hospital. I think it would be a waste of money, because services like ours – just going to pick a number out of the air; let's say we have a 10 per cent improvement in some number, hospital presentations, admission rates and things like that, but if the error rate in my knowing whether someone's from an RACF or not is in the order of 20 or 30 per cent, my 10 per cent improvement is pointless. So we need that data item to be accurate before we can judge whether we're successful or not.

MR GRAY: Is that a slightly different point? Is that a point about big data as opposed to the particular client records of a particular person being transferred between care settings, and in that regard on that different point counsel assisting have

under consideration a proposition in this hearing, that there should be an aged care identifier incorporated in the minimum dataset for hospital data administered by all the States. Do you agree that that's a good idea?

DR MONTALTO: Yes, yes; that is a separate point, and it should be – as Dr Burkett mentioned – I was here for that session; it's very difficult, to know from the hospital level what proportion or which patients are coming from residential-aged care facilities. Those data fields are not – either they're not there, or they're not reliably filled in.

MR GRAY: Dr Nash.

DR NASH: I agree. It's inaccurate data, and we need that accuracy to understand how better to care for patients and whether our services are doing a good job or not.

MR GRAY: I have no further questions.

COMMISSIONER PAGONE: Thank you for giving us your – the benefit of your wisdom and thoughts. Been very helpful indeed. Thank you. You're free to go.

<THE WITNESSES WITHDREW [3.06 pm]

COMMISSIONER PAGONE: Mr Knowles?

MR KNOWLES: Thank you, commissioner. The next witness is Ms Tess Oxley. She's an experienced paramedic. She'll give evidence of her direct experience as a paramedic regularly engaged in among other things transferring aged care residents to and from hospital. I call Ms Tess Oxley.

<TESS LINDSAY OXLEY, AFFIRMED [3.07 pm]

<EXAMINATION BY MR KNOWLES

MR KNOWLES: Ms Oxley, could you tell the Royal Commission your full name?

MS OXLEY: Tess Lindsay Oxley.

MR KNOWLES: Thank you. And you have prepared a statement which is dated on the last page the 27th of November 2019?

MS OXLEY: That's correct.

MR KNOWLES: Yes, and that bears the witness – identification number of WIT.1303.0001.0001. Do you see that before you there on the screen, the first page of your statement?

MS OXLEY: Yes.

MR KNOWLES: And have you read your statement lately?

MS OXLEY: Yes, I have.

MR KNOWLES: And are there any changes you wish to make?

MS OXLEY: No; thank you.

MR KNOWLES: And are the contents of your statement true and correct to the best of your knowledge and belief?

MS OXLEY: Yes, they are.

MR KNOWLES: I seek to tender the statement of Ms Tess Oxley dated the 27th of November 2019.

COMMISSIONER PAGONE: Yes. Thank you. That statement will be exhibit 14–16.

EXHIBIT #14–16 THE STATEMENT OF MS TESS OXLEY DATED THE 27TH OF NOVEMBER 2019

MR KNOWLES: Ms Oxley, you're a qualified and registered paramedic in New South Wales?

MS OXLEY: That's correct.

MR KNOWLES: And you've worked in this role for some nine and a half years?

MS OXLEY: That's correct.

MR KNOWLES: And are you based in Sydney?

MS OXLEY: Yes; in southwest Sydney.

MR KNOWLES: How many shifts do you work each week as a paramedic?

MS OXLEY: I work four shifts and then have five days off.

MR KNOWLES: Okay. And in terms of those shifts that you do work – how long are they?

MS OXLEY: They're, generally, 12-hour-15-minute rostered shifts, with the potential to extend longer.

MR KNOWLES: And at what times of the day do they occur?

MS OXLEY: Where I'm working currently, that's 6.45 am till 1900 for the day shift, 10.45 until 2300 for an afternoon shift and 1845 until 0700 for a night shift.

MR KNOWLES: And in terms of your work – do you rotate through those different shifts over time?

MS OXLEY: I do. So we do two day shifts, an afternoon and a night shift for our set of four.

MR KNOWLES: So you have experience over your nine and a half years of work – working at all hours of the day, all days of the week?

MS OXLEY: Yes.

MR KNOWLES: Yes. And on average how many jobs per shift would involve you attending at a residential aged care facility?

MS OXLEY: Obviously, each day is different but I would say probably between 40 and 60 per cent of our jobs.

MR KNOWLES: And have you observed the numbers of attendances at residential aged care facilities increasing over the nine and a half years that you've been working as a paramedic?

MS OXLEY: Yes, definitely.

MR KNOWLES: And of those increased callouts have you observed any trends in the nature of what you're being called out for in terms of the seriousness or complexity of the conditions that you're responding to?

MS OXLEY: Yes. So I think definitely there's a lot more of dementia-related jobs. When I was first in the job we had a lot more low-care residents, and so we weren't called out as much. Whereas now the nursing homes are increasingly full of high-care residents, which means that the patients that we're looking after have a much greater spectrum of needs that are difficult for us to assess.

MR KNOWLES: I will come back to the issue of how your role might have to be tailored when you're dealing with people who are living with dementia and as a result of that have some degree of cognitive impairment in a moment. Can I just ask

you at this stage though in your experience at the present time what are the most common reasons why you're called out to residential aged care facilities.

MS OXLEY: Falls is the primary - - -

MR KNOWLES: Yes.

MS OXLEY: - - - concern that we're called to. Medical issues, so generally infections and a deteriorating patient, and behavioural issues when it comes to dementia patients so they've had a deterioration in behaviour for whatever reason.

MR KNOWLES: And you mentioned before the increased numbers over time of callouts to residential aged care facilities. Are you aware of any initiatives by New South Wales Ambulance Service for whom you work, as I understand it, or others to examine or address the increased numbers of callouts to residential aged care facilities?

MS OXLEY: I know there have been pilot projects that ambulance has initiated or has been a part of with primary health networks to try and reduce the number of ambulance callouts and we also have the extended care paramedic which was not so much to stop the callouts but to stop the transports to hospital, however, a lot of these are temporary projects that don't become permanent programs within the areas.

MR KNOWLES: What was the first pilot project to which you just referred a moment ago? I will come back to the extended care paramedics in a moment but in terms of that pilot project, are you able to say anything about that?

MS OXLEY: So it was designed that nursing homes – that the facilities would have a geriatrician within their nearest hospital or within the primary health network, that they had to liaise with before they were to book an ambulance and so that geriatrician would then say whether or not it was appropriate for an ambulance to be called or whether it required a GP or alternative treatments.

MR KNOWLES: And are you aware of how that pilot project was ultimately evaluated?

MS OXLEY: I think - - -

MR KNOWLES: Was it regarded as successful or - - -

MS OXLEY: I think while it was running it was generally successful, however, there needed to be a geriatrician available. Quite often that was only within limited hours that they were even rostered on, so then when they were available within that time, and I think the difficulties that they had with that resulted in it generally tapering off and not continuing on.

MR KNOWLES: I see. Now, you mentioned extended care paramedics a moment ago. Can I take you to paragraph 42 of your statement. It should come up on the screen in a moment. It's at page 9 of your statement. At the beginning of that paragraph you say:

> *There are only a certain number of paramedics in the state that have received additional training to, for example, administer a broad spectrum of drugs or do a catheter change.*

Are they the extended care paramedics to which you were referring a moment ago?

MS OXLEY: Yes, they are.

MR KNOWLES: And could you just explain what that program is and what it's designed to aim to achieve?

MS OXLEY: So extended – extended care paramedics are paramedics who have done additional training, an additional course. They respond single in a non-transport vehicle and they're trained in wound management. They can do further assessments such as like a urine analysis to see whether it looks like there might be a urinary tract infection. They can do catheter changes, NG tubes, and it was designed to limit the number of low acuity presentations to an emergency department, whereas generally just, I would say a basic skill but a low level skill that wouldn't require admission or extended treatment within a hospital, that they could just do there and then leave the patient at home. It's designed both for aged care facilities but also patients in the community.

MR KNOWLES: Yes. And are you aware of any evaluation of the success or otherwise of extended care paramedics?

MS OXLEY: I think when they were resourced at the level that it was intended and when they were used for the skills that they have, it's quite successful. However, especially – I can only speak for New South Wales ambulance but operational demand and resourcing means that quite often they're not placed on those jobs because they might be standing by at a 000 job waiting for a transport car and the less that they're available, the less that crews will then ask, you know, this is an ECP appropriate job, can we have an ECP. When you're repeatedly told there's none available because they're on other jobs or whatever, you become less likely to call for them. You just end up transporting.

MR KNOWLES: So by that do you mean that the ECP paramedics, they are diverted to 000 or emergency jobs. Is that what – more urgent - - -

MS OXLEY: That's – yes.

MR KNOWLES: More acute jobs.

MS OXLEY: Yes.

MR KNOWLES: And as a result of that the demand for them is not being met?

MS OXLEY: That's correct.

MR KNOWLES: Yes.

MS OXLEY: Like I said they have – they don't have transport capabilities so if they're put on a 000 job that requires transport to hospital they then have to remain on scene to wait for a transport car to become available which makes them unavailable for ECP appropriate jobs.

MR KNOWLES: Yes. In terms of ECPs other than what you've just mentioned in terms of not being able to transport a person, are there other matters that, in your experience, you perceive to be limitations of the ECP program?

MS OXLEY: Yes, so ECP, they're only rostered on a day shift. So they're only available from quarter to 7 until 1900 or on Sundays 1700. Also - - -

MR KNOWLES: Why is that, by the way?

MS OXLEY: That's - - -

MR KNOWLES: Are you aware of the reason for their only being rostered on during the day?

MS OXLEY: I think the primary reason was for safety. Like I said, they're not always responded just to aged care facilities, and so because they're also responding single, it was deemed that it wasn't appropriate for them to work overnight. I don't know about whether there were also funding issues and budgetary issues involved in that when the program was developed; it was developed as just a daytime thing and that's just the way it's remained.

MR KNOWLES: Just following that particular point, when are the main times of the day that ambulances are called out to residential aged care facilities, in your experience? Is there any particular time where it's busier for ambulances than for others?

MS OXLEY: There are always peaks and troughs but generally a lot of the calls that we get will be throughout the night and on weekends, when there aren't GPs and other health networks available. There's also limited staffing on within the facilities at that time which then makes ambulance the primary, I guess, option for health care.

MR KNOWLES: But extended care paramedics are not rostered on to any services at nights.

MS OXLEY: No.

MR KNOWLES: Is that what you're saying?

MS OXLEY: That's correct. Yes.

MR KNOWLES: Do you think there's scope for them to be rostered on at nights if they're just going out to residential aged care facilities and not elsewhere?

MS OXLEY: I think if – if that was able to be put into practice that would be great. However, as I said, ambulance operates on a operational demand with limited resources, and it is hard to justify having a qualified paramedic sat at a station when you have outstanding 000 calls.

MR KNOWLES: Yes.

MS OXLEY: And then, yes, if you're going to respond them to those calls they are at a much higher risk, being single.

MR KNOWLES: Now, can I turn to another topic. You've said in your statement that in your local area you are able to distinguish between residential aged care facilities that you consider are well operated in terms of their dealings with paramedics and those that are not so well operated. How do you draw those distinctions in terms of the residential aged care facilities that you visit?

MS OXLEY: There's a few different ways. I guess the primary thing is how the staff interact and relate with the residents. So when you turn up and they know them, they know what calms a patient, they know what makes them happy. They know what family are available within a close network. They know how the – you know, if the patient has had a previous presentation for similar and how it was treated and what happened.

You generally know that if that's the way the resident is being treated then other aspects of the facility will be operating well and the patient is well cared for. When you – if the patients have their own room, if the room's clean and spacious, if they've had – even just like if the facility takes the time to rub moisturiser on their skin, they've got really fine skin due to a lot of medications they have, when they take that extra care and that extra time with them, they would be facilities that we've – that I would consider have a high level of patient care.

MR KNOWLES: So those places that are not in that category, what do you see when you visit them?

MS OXLEY: There's generally multiple patients within a room, so you might have four patients or four residents within a room, and if you have dementia or other things, it means they're not – even just like their time to have quiet time or to sleep, the nurses or the staff don't know the patients; there's a rolling casualised staff so

they're not aware of the patient's history and the patient's medical needs. Sometimes you might get there and it's really hard just to find a staff member. They're generally causes for concern as to the quality.

MR KNOWLES: Yes. You mentioned earlier the main cause of – some of the main causes of you being called out to residential aged care facilities such as falls and so on, and you might have heard earlier some of the evidence today that was given about algorithms or flow charts that would assist people in terms of their decision-making and assessment of risk about whether or not the transfer decision to hospital was an appropriate one. Do you see residential aged care facilities engaging in that risk assessment in terms of your being called out; does it appear to you that they have done that in a measured way?

MS OXLEY: I don't think in a measured way. I think if it's deemed to be almost any form of risk, if there's any concern we're immediately called, and expected to transport. I think if there was a measured risk assessment, it would allow for other options. Generally I find that there are no other options.

MR KNOWLES: Why do you think that there is that approach taken by residential aged care facilities to calling out an ambulance?

MS OXLEY: I think it's – I would like to say it's patient welfare but I think it's to try and cover any kind of – whether it's litigation or any kind of detriment to the facility itself. They know that if they've booked an ambulance and they've said that that patient has to go to hospital there's no risk to the facility if anyone deteriorates, that anything bad will happen to the facility.

MR KNOWLES: How do you see transfers to emergency departments that are avoidable, being avoided?

MS OXLEY: Communication. So maybe talk to the resident that's had the fall. If they're able to answer, if they're able to say what's happened and how they're feeling, talk to the patient's family, consider what medications they're on. If they're not anti-coagulated and if they don't have any signs of injury and they're saying, "No, I feel okay" and you've just had to assist them up from the floor, that's going to be a generally low level compared to if they're on warfarin and they've got an obvious head injury, then obviously the risk would be higher. I think also education, so educating on the different types of falls and the different presentations and how often, you know, that may result in an injury and the likelihood of that injury. If we're a little bit more aware of that and we know which signs and symptoms to look at or if the facility's staff are, that can avoid a lot of the unnecessary transportations.

MR KNOWLES: Are there any examples that you can tell the Royal Commission of in which you've been called on to take people to an emergency department where you thought it was unnecessary or avoidable yourself?

MS OXLEY: For a fall or just in general?

MR KNOWLES: Just in general.

MS OXLEY: Yes. Yes, so quite – quite a lot of jobs that we get I think could be avoided. When you get called to a patient who's had a fall, it was unwitnessed but like I said, they're anti-coagulated. They might have a small skin tear, however, they deny any other pain. They've got full recollection of the fall. They're able to recall that fall. They're able to tell you that this part is sore but it's only sore where the cut is, "I don't have any pain, I feel fine, the staff got me up, I was able to walk" and then they say, "No, but they still need to be transported to hospital for a CT", it's time consuming not just for us but for that resident as well. It takes them out of their whole daily routine, and we get that quite regularly.

MR KNOWLES: Well, in terms of that, you say "quite regularly", do you have an approximate percentage of your callouts to residential aged care facilities that you would regard as avoidable or unnecessary?

MS OXLEY: I think over 50 – I would say nearly 60 per cent that we go to, in my perspective, are not necessary to be transported to an emergency department by ambulance, yes.

MR KNOWLES: Have you ever refused – I mean, I don't know whether that's within your power to do so, but have you ever refused to take a person to hospital, and if so, can you tell the Royal Commission of the circumstances in which that might have occurred?

MS OXLEY: Yes. I've not refused, however, I've advised that it's not necessary for the resident to be transported. Generally, I will discuss it with the patient, with my partner. We might get a family member on the phone and discuss the situation with them and then discuss it with the nursing home staff and if we can then tell them that we will take on that decision, that it will be under our advice, sometimes they will be happy for the resident to stay. I will do a complete case sheet including a non-transport case sheet which is a separate form advising everything that I've assessed and all of my advice and I'll leave that with the facility so that that responsibility is taken out of their hands, and put onto us.

I only do that though if – and I'll only ever kind of advise non-transport, not transport, if all parties are consenting and happy with it. So as much as I may feel that someone doesn't need to be transported, if the nursing home staff are adamant that they need to go and that they don't feel comfortable with them staying, that creates an actual – an alternate risk to the patient as opposed to that primary risk and so then we will take them to hospital.

MR KNOWLES: Are you able to tell the Royal Commission what you think would lead to a reduction in avoidable hospitalisations, or transfers to hospital by ambulance?

MS OXLEY: I think within communities we have a whole of health approach and I think we have to look at the aged care facility as its own community, therefore it needs to have all of those health networks available, whether that's occupational therapists, physios, geriatricians, nurse practitioners, mobile X-ray. If those resources are available on a regular reliable basis, a large proportion of residents wouldn't have to be transported to hospital.

MR KNOWLES: And how might you see those resources becoming available in residential aged care facilities. Do you have a view about that?

MS OXLEY: I think if you looked at a population subset so, you know, a population of this requires that then these specialists would be available, whether it's to one large nursing home or dedicated to, say, three or four in the community that are smaller, but I do think they would have to be primarily there for those facilities. It's not effective when they are only able to respond to them in a lunchbreak or in between their – their booked patients and this needs to be who they're dedicated to. Obviously, some – if it's a small facility, it's not appropriate to have specialists just sat there waiting for someone to fall, but when you have multiple then they will be, I think, used appropriately.

MR KNOWLES: Can I ask you now about what happens when you actually turn up at a residential aged care facility in response to a callout. What information do you, as a minimum, expect and require that staff will provide to you about the resident who is to be transferred to an emergency department?

MS OXLEY: Yes. So I would expect a bit of an introduction as to who the patient is and why we've been called, when the change in the patient occurred. So whether it was the patient has had a fall, we noted at this time, or the patient has been unwell since this day and they've deteriorated, how they would normally present. So whether they're normally verbal, whether they're normally conversive, whether they'd normally react happily or angrily. If they've had any presentations similar, or any other illnesses or contributing factors recently that may have led to us being called that day, their past medical and social history as well. That's what we expect. That's not always what we're given.

MR KNOWLES: Would you expect to receive some details about, in that medical history, their current medications that they are taking?

MS OXLEY: Yes. And it would be – it's becoming more, however, those medications need to be legible. So to get the typed list of medications on a medical sheet is always handy. However, quite often, they're handwritten. And when they're handwritten and they are – you know, you've got to decipher it. That can alter what you know about the patient quite considerably.

MR KNOWLES: In terms of those minimum core documents required, is advance care planning documentation a part of that so far as you're concerned?

MS OXLEY: Yes, we'll always ask if a patient has an advance care directive. They're generally not kept with their other paperwork. So you have to ask for that - - -

MR KNOWLES: Yes.

MS OXLEY: - - - separately.

MR KNOWLES: Just in terms of – I think I interrupted you a moment ago, you were going to say "Well, this is what I would expect." How consistently do you get those minimum core documents that you would expect upon attending at a residential aged care facility?

MS OXLEY: It definitely differs facility to facility as opposed to who the individual is handing over. So as I said before, there are some great facilities and some not great facilities. The great ones, that is their standard. There are others where you will just get a lot of I'm-not-sures, I don't know. And it's not – it's not uncommon to get that.

MR KNOWLES: And do you have any recommendations as to how you might raise – sorry, improve the consistency of what you're provided with so that you can expect to receive what you wish to receive as a bare minimum?

MS OXLEY: Again, I think it's education. So it's – if you are handing over as a paramedic, if I'm handing over to a hospital, there is a standard that's expected of me. And as much as I hate KPIs, it's measured through a KPI so that is monitored and it's also measured through the reaction of the hospital to me. So if my – if it's an inadequate handover I would be informed of that. I think we need that within the aged care facility so there is that standard that's expected across all facilities. It shouldn't be an individual – up to an individual company what's given and I think there does need to be that pathway for us to provide feedback if it's inadequate.

MR KNOWLES: Are you aware of transitional communication tools that are used by hospitals which employ techniques like SBAR or ISBAR where you have a situation and so on in terms of the actual – ultimately leading to a recommendation; are you aware of those sort of transitional communication tools?

MS OXLEY: So where you have to meet like each - - -

MR KNOWLES: Yes.

MS OXLEY: - - - ..... of the information? Yes. Yes, we have IMIST-AMBO within ambulance as well, where if you actually cover those - - -

MR KNOWLES: Yes.

MS OXLEY: - - - it is a pretty thorough handover of the situation.

MR KNOWLES: Yes. And are they the sorts of things that you would expect to be part of any standards that might exist for the purposes of provision of information by residential aged care facilities to you as a paramedic?

MS OXLEY: It would certainly be helpful, yes.

MR KNOWLES: In terms of how the information is given to you, obviously some of it is documentary information. Do you consider it beneficial to also get information verbally from people at the facility?

MS OXLEY: Yes, I think you always get additional information when it's handed over verbally. There's that greater ability for you to be able to ask questions, for them to expand on parts of the handover that they may deem to be more important. I think written things can sometimes be hard to interpret exactly to the nature of things, or the seriousness of a scope, whereas if you're being – getting a verbal handover that's able to be enforced a little bit stronger.

MR KNOWLES: Now, can I ask you also, what scope do you see for the introduction of an IT solution whereby there is provision of information over the internet between residential aged care facilities, paramedics and emergency departments at hospitals? Do you have a view about that?

MS OXLEY: If that was able to be integrated that would be great.

MR KNOWLES: What are your views about the ability - - -

MS OXLEY: Ambulance and hospital both operate on a similar platform yet they're still not able to be integrated and we're all New South Wales Health where I work so I think to then bring a whole heap of external stakeholders into that that would be difficult. If it was brought in, that would be great. There is a concern for patient privacy that would definitely need to be considered within that.

MR KNOWLES: Now, in terms of the information that you've got, you've said that sometimes it's not adequate, are you able to provide the Royal Commission with some examples of where information about a particular resident, the resident's identity, their status and so on may have been deficient upon you attending at a residential aged care facility?

MS OXLEY: Yes, this is probably more on the extreme end of the spectrum but it has happened and it has happened more than once where I have been handed over a patient, for example, with abdominal pain and I've loaded the patient onto the stretcher, another staff member has entered the room and has actually said, "Well, actually no, that resident is not the patient. It's this resident over in this corner of the room". When you have patients with dementia who are not always great historians, you can ask them, "Do you have pain in your tummy?" they will say "yes", so you think, okay, there we go, I don't know him and you have to take their word.

But on a more regular basis, it is where you're asking questions and they're just not able to answer. So if I don't know if a patient is normally verbal or nonverbal, if I don't know, you know, do they usually fall or have they had regular presentations with UTIs, it sets us on the back foot right from the get-go in how to provide the best care and treatment for that patient.

MR KNOWLES: And you've just referred to patients who may have a cognitive impairment by reason of living with dementia. I take it that that just makes it even more important that the clinical handover received from the residential aged care facility in those cases is detailed and accurate?

MS OXLEY: Yes, because they're not going to be able to communicate with us or if they are, it's going to be difficult for them, which is also where it's so important that the facility knows the patient so that they can tell us this is the best way to communicate. So they may be nonverbal but if they nod their head that – you can trust that that is a yes that has competency to be able to say that yes. If they don't know the patient or the resident well to know those communication methods, again, it's very difficult for us to then treat the patient.

MR KNOWLES: In addition to written or oral communication with you at handover, is there a – do you find it useful to have pictures or photographs at that time provided to you?

MS OXLEY: I think it definitely would be. It's a rarity that we get those. However, it's not a rarity that we get called to jobs where they would be beneficial. So whether it's a deterioration of a wound, whether it's increased cellulitis, whether it's increased oedema. If we can see photos of how it's changed and a timeframe of that, it definitely would assist, not just us in how we're going to treat the patient because we do only have them for a limited time, but it assists in how we then handover with our clinical handover to the hospital in that continuation of care.

MR KNOWLES: Well, that leads me to the next question I was going to ask. What do you do with the information once you arrive at the emergency department that you have?

MS OXLEY: So we will provide a verbal handover to the triage nurse within the hospital and we will also provide a verbal handover and a written handover to the nurse that's treating that patient, and potentially a handover to a doctor, depending on the seriousness of the presentation.

MR KNOWLES: And have you been – you said before about getting feedback from people in terms of your KPIs in terms of what you present to them. What have you been told by whether it's a triage nurse or an emergency department doctor as to what information they need and how it's best presented to them?

MS OXLEY: I think it's just the degree of frustration on their receipt of the patient as to whether or not they think it's an appropriate – it's so – and I think it's

frustrating to all of us when they're saying, "Well, what about this?", and you say, "Well, I don't know, I asked and the staff weren't able to tell me. I asked, I'm not sure." Yes, it puts everyone on the back foot and it puts the patient at an increased risk as well, if we don't know if they're a regular wanderer and they're a high falls risk if that's not able to be passed on to us, then how does the hospital know. So someone who has presented with just increased shortness of breath has all of a sudden got an extended stay because they've, you know, fallen and hurt themselves further within the hospital.

MR KNOWLES: Can I ask you, just going back a step to explain to the Royal Commission what ramping is, why it occurs and how it affects older people transported by ambulance to hospital?

MS OXLEY: So there's a few different terms for it but ramping is when we transport a patient to the hospital, the ED is at capacity and the wards are at capacity so there's nowhere for us to offload that patient to. There's no beds available. The patient is then delayed on our stretcher with us continuing care for them. Generally, we consider it ramping or bed block when it goes greater than 30 minutes. It can be up to four, five, six hours. Generally, it's around the one to two-hour mark that they're delayed on our stretchers for.

MR KNOWLES: And those stretchers are for people who may be incapacitated or immobile; do they cause any risks in terms of the development of pressure injuries?

MS OXLEY: I think – it definitely can. Definitely can increase the risk of agitation and discomfort, which is going to prolong – if someone's unwell, that's going to, I guess, cause or contribute to further deterioration. Our stretchers are extremely narrow. They're designed for CPR; they're not comfortable. They've not got the air mattresses that hospital beds or the facility beds have – that are designed to prevent things like pressure sores and pressure wounds. They're high off the ground.

They're difficult for things like toileting a patient when you're delayed for four to five hours. So they can also start to take away the dignity of a patient when they're in a crowded triage area, because when we're ramped it's, generally, more than one ambulance. So you'll have multiple patients, limited privacy, and you're having to toilet and care for an elderly patient who may already be agitated or already in pain or discomfort.

MR KNOWLES: And in your personal experience have you observed how this scenario – you alluded to it, but – how it affects elderly residents who – or other elderly people who are in that situation for anywhere up to four, five, six hours?

MS OXLEY: It exacerbates whatever distress they've got. They have to be belted down. That's uncomfortable. We have about – approximately five seatbelts on our stretchers. So they're not able to just to move their limbs comfortably to re-adjust themselves; they're constantly slipping down the stretcher as they try to move, and we're having to slide them up. With respiratory issues – it's very hard, for us to be

able to posture them long-term in a way that assists them. Yes; they just – they get upset; they – the noise and the movement and everything around them – it's a very heightened situation, and that's quite distressing for a lot of them as well.

MR KNOWLES: How often do you encounter that scenario that you've just described when you take somebody back to a hospital?

MS OXLEY: It's becoming increasingly regular year-round. It used to be, primarily, during the winter months, when there were increased presentations to the hospitals and they struggled a little bit. However, we're finding it is – it's just continuous; you just don't know what's going to trigger it, and, generally, if it happens for a day or two, it'll happen for a week or two, because it does take that long, for the hospitals to get things under control in whole of hospital system, which then affects the ED.

MR KNOWLES: Now, we mentioned earlier advance-care-planning documents. How often do you find yourself going to a residential-aged care facility and not being – asking for advance-care-planning information but not being provided with it?

MS OXLEY: Quite often. A lot of the times in the facilities the individuals are only asked if they'd like to have an advanced-care directive when they move into the facility, and when they move in, they may be well. It's traumatic enough for them, that they're having to move into these. A lot of the times it's not by choice. And so the thought of having to do an advanced-care is quite distressing; so they'll say they don't want one. And then it's not brought up again. So when we say "Do they have one?", the answer is "no".

MR KNOWLES: And how's the absence of that information, plan or directive affect you in your work?

MS OXLEY: It's hard, because it means that we are sometimes having to initiate treatment or transport that, you know, is not beneficial to that patient, that may be more distressing, that may be going against what you would consider to be best practice or in the best interest of that patient.

MR KNOWLES: Have you got any suggestions yourself as to how there might be more-consistent provision of advance-care-planning information to you? That is how it might be more consistently applied across the board in residential-aged care facilities, that people have advance-care-planning documentation in place.

MS OXLEY: I think, once you enter a facility that has a nursing-component of it – so not a retirement village or – may be hostel living, but when you move into those nursing-homes, I think, it needs to be, that all residents have an aged care – an advanced-care directive and that that is revisited every 12 months or with significant change to that individual's presentation.

MR KNOWLES: And what are the sorts of details that you as a paramedic would expect to see in advance-care-planning documentation?

MS OXLEY: Whether they would like to be transported to a hospital, what kind of interventions they would like for differing situations. So you have the obviously life-threatening illness, but even if they just have the start of an infection – "Would you like to go to hospital? Would you like IV antibiotics or only oral? Would you like oxygen therapy, and to what degree would you like that?"

MR KNOWLES: Have you ever observed people acting contrary to advance-care-planning documentation in terms of what they've done in requiring a transfer to hospital for a particular resident in an aged care facility?

MS OXLEY: Yes, and I've noticed it's increasing where an individual may have an advance-care directive that says that they don't want to go to hospital. However, the facility will say – either say that it's their policy and so the patient still has to go or that they've discussed it with relatives who may or may not be present and that the relatives would like them to go, and they seem to feel that that supersedes the will of what was signed at the time that the directive was signed.

MR KNOWLES: And what options did you feel were available to you in those circumstances?

MS OXLEY: It's really hard, because – sometimes we can ring the family member and chat to them and discuss from a paramedic's view point what we're looking at, and I think sometimes we may be – and maybe because we deal with it a little bit more often, we're sometimes a little bit better at being a bit more direct about how the patient's presenting and what is going to happen when they go to hospital and what some of these treatments actually entail.

So – when you're talking about intubation, when you're talking about CPR, what that actually does to that patient or how it affects that patient. So we'll chat to them. Sometimes then they will say, "Okay; yes. No. I'm happy for them to stay". As I said before, we are limited a little bit in what the nursing-home staff say; so if they say, "No; you have to take them, because we can't provide adequate care for A, B, C", then we're kind of in a situation where we end up transporting despite knowing that there is an advanced-care, that they don't want to be transported.

MR KNOWLES: Other than what you've earlier said about the need for more-consistent advance-care-planning documentation for residents in aged care facilities, are there any other suggestions or recommendations that you yourself would make to improve advance-care-planning for residents in aged care?

MS OXLEY: I'm, obviously, not there when they sign it. However – so I don't know if it happens or how regularly it happens, but I think there needs to be very clear and concise information as to exactly what an advanced-care directive is, what its legal implications are, how long it's valid for, so that both – the resident, the staff

and any family who may be involved are all aware of exactly what an advanced-care directive is, why we use it, why it's important. Yes. I think that would be beneficial.

MR KNOWLES: Now can I ask you in relation to information that's provided to you by hospitals, whether emergency departments or otherwise, to convey back to residential-aged care facilities – how much information do you get and in what form?

MS OXLEY: We'll get a clinical handover from the nurse who's been caring for the patient. How thorough that is can sometimes depend on how far into their shift – so if they've been looking after the patient for 10 hours, they've, obviously, got a greater understanding of the patient, compared to if they've only been on shift for one hour. We'll also get a written discharge most of the time - - -

MR KNOWLES: Just pausing there - - -

MS OXLEY: Yes.

MR KNOWLES: Is – that clinical handover is that you've referred to: that's a verbal or oral handover?

MS OXLEY: That's a verbal handover. Yes.

MR KNOWLES: Sorry. I interrupted you.

MS OXLEY: No. You're right.

MR KNOWLES: You were going to say then there's a – sometimes a written discharge.

MS OXLEY: And then – yes. So dependent sometimes on the busyness of the department and what else is presented within the department, they may say that they'll email or they'll send through the discharge to the patient's GP. However, they do try to give us a written discharge letter for us to take with the patient.

MR KNOWLES: How consistently is information provided to you to convey to the residential-aged care facility from hospitals? Does it vary from one place to the next?

MS OXLEY: It does. Yes. Yes, and like I said, it does vary, dependent on how long they've been treating the patient. I think it's also important, to note that, while paramedics do do some discharges home, a lot of discharge is done by patient-transport officers, who are not clinicians, and so that can also sometimes limit the information in making sure that it's appropriate and understood when they're discharged home.

MR KNOWLES: Do you see there being – in terms of that consistency, do you see there being merit in requiring that hospitals provide residential-aged care facilities

with discharge summaries and some other relevant information prior to the resident actually returning to the facility?

MS OXLEY: I think so. I think, when a patient who doesn't live within a facility is discharged from the hospital, it's always made sure, that that patient or that the carer for that patient understands what they're being discharged with; so – what the advice is, what the further information is. It's always made sure, that they understand; when residents are being discharged back to a facility, that facility has the caring-capacity for that resident. We need to make sure that they understand all the information around how they're being discharged, why and any further treatment or follow-up that's required.

MR KNOWLES: In terms of further treatment in your experience at least – and I accept what you say about patient transport not always being by ambulance, obviously, but how often do you find yourself not being given medications or prescriptions but some other direction being given to you to pass on to the residential-aged care facility about the medication required for a particular person?

MS OXLEY: Yes. Quite often. So it will be passed on to us – it'll also be written in the discharge summary, but it's for the patient to be followed up by the GP with IV – with oral antibiotics or a course of antibiotics or something like that, and it's not necessarily scripted, and it's very rarely, that they're discharged with the medications in situ.

MR KNOWLES: And it's probably self-evident, but how do you regard that situation in terms of the wellbeing of the person in question?

MS OXLEY: It has a lot of potential, and it quite often happens, that the patient can then deteriorate. If you're transporting someone home particularly, say, on a Friday night or over a weekend, there's going to be multiple days that they have to wait for a GP to be available to come in and write up the script and then for them to be able to get that script to the pharmacy, the pharmacy to fill it and deliver it, or someone to go and pick it up which means, especially in the case of antibiotics, if a patient has then had to wait a further two, three, four days to commence those antibiotics they've again deteriorated, sometimes more significantly than the initial presentation which results in readmission and longer stays back in hospital.

MR KNOWLES: And that leads to my next question. How often do you see people that have been transferred to hospital being discharged and then transferred back to hospital within a short space of time?

MS OXLEY: Often enough for us to have a term of "warranty job" for it.

MR KNOWLES: A warranty job?

MS OXLEY: A warranty job, so it's definitely not uncommon at all.

MR KNOWLES: Yes. And are you able to say why – I mean, you've given one instance – an example of one instance where that might occur; are there other circumstances that you can identify that would lead to that situation?

MS OXLEY: So I think it's when a nursing home or the aged care facility, they do have limited resources and they do have limited ability which means that if a patient is discharged requiring further follow-up, or requiring a higher degree of care, if that's not passed on or if the facility are not capable of doing that for whatever reason, then yes, the patient will further deteriorate.

MR KNOWLES: One of the things that's been considered for the purposes of this hearing is collection of data on rates of ambulance callouts to residential aged care facilities at a facility level to provide data going to a clinical indicator. Do you have any views about that?

MS OXLEY: I think it would be beneficial so long as it's followed up. It's one thing to collect a whole heap of data and to have it sat there; it's another thing to use it. I think it's also important to note not just that an ambulance was called and it was a 000 but what the follow up for that patient was because did they have an extended stay in hospital or were they returned within two hours is a lot more beneficial to know than just that the ambulance came lights and sirens or not, because quite often we will go slow and the patient will be critically ill or we will go fast and it will be something that's not as serious as stated.

MR KNOWLES: So do I take it from what you've just said that while you regard it as something of an indicator, it needs to be considered in context?

MS OXLEY: Definitely, yes.

MR KNOWLES: Now, otherwise, can I just ask you more generally in light of your experience, what would you like to see improved at the interface of the aged care and health systems?

MS OXLEY: A further ability for the staff to be able to care for these residents. So whether that means that they need more staff, that they can have time to sit down, that they can talk to them, that these – they may have dementia but they're still someone's family member and I think that still needs to be – it's really important that that needs to be remembered. That these people have lived lives, that they have a history and that we need to be able to provide a best level of care, not an adequate level of care or a standard of care. They deserve best practice and I think anything that we try to introduce has to be at that level of best practice, not just adequate.

MR KNOWLES: Thank you, is there anything else that you wish to say to the Commissioners today?

MS OXLEY: No, I don't think so.

MR KNOWLES: I have no further questions for Ms Oxley, Commissioners.

COMMISSIONER BRIGGS: Thank you, Ms Oxley. Over the course of these Royal Commissions, particularly in the community meetings, we've heard a lot about the role paramedics have played, and there's no doubt at times it's the paramedics who are confronted with instances of substandard care that is occurring in residential aged care and they're quite disturbing instances. Is there, within the system, a place for reporting of instances such as this that might prevent further problems occurring?

MS OXLEY: Not a direct or a one-way thing of doing it. We – if you know who may be like the clinical nurse specialist is within the hospital or within the primary health network that deals in liaising with the nursing facilities. If you know who that person is you can report to them. You can let the hospital know. You can speak to ambulance management. There is the elder at risk hotline but not in the way that we have within the health system of direct reporting. There's definitely nothing like that which is extremely frustrating at times.

COMMISSIONER BRIGGS: Yes. Do you think it would be a good idea to do that for both paramedics and for general practitioners?

MS OXLEY: I think you should be able to do that for all health staff. Remembering that you may have casualised staff working in these facilities, if a nurse comes, if a care member of staff comes and they notice things that are distressing or that are inappropriate, they shouldn't have to go and report it to a GP who then – that's going to be another obstacle that will stop a reporting process. I think anyone involved in the care of them should be able to have a mechanism of reporting.

COMMISSIONER BRIGGS: The other thing I wanted to ask you about was the transport after hospital because it's my observation that ambulances don't necessarily get involved in that transport and that's indeed your evidence today. Where there's transport between hospitals, is it generally the case that an ambulance is made available?

MS OXLEY: Hospital to hospital transfer? It depends on the acuity of the patient. So there's an increased number of hospital transport and private companies that will now do the lower acuity hospital to hospital transfers. If the patient generally requires intervention or has a potential of requiring treatment or intervention, then we'll – the primary care ambulance will do it. The patient transport are often required to transport multiple patients at once, so they don't have the ability to provide treatment.

COMMISSIONER BRIGGS: And similarly in rural areas, you would expect that would be harder to achieve as well?

MS OXLEY: Yes, so in rural areas there's a much greater dependence on the emergency ambulance network to do the transports home and inter-facilities.

COMMISSIONER BRIGGS: Thank you. I've found your evidence most helpful.

MS OXLEY: Thank you.

MR KNOWLES: Nothing further from me, Commissioners.

COMMISSIONER PAGONE: Thank you for giving your evidence. It has been very helpful indeed. You're free to go.

MS OXLEY: Thank you.

<THE WITNESS WITHDREW [4.08 pm]

COMMISSIONER PAGONE: Anything else?

MR KNOWLES: I don't think there's anything further for today, Commissioners.

COMMISSIONER PAGONE: Adjourn till 10 o'clock tomorrow morning.

MATTER ADJOURNED at 4.08 pm UNTIL
WEDNESDAY, 11 DECEMBER 2019

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