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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, WEDNESDAY, 11 DECEMBER 2019

Continued from 10.12.19

DAY 71

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

MR D. VILLA SC appears for Ms Gardner

COMMISSIONER PAGONE: Mr Knowles.

MR KNOWLES: Good morning, Commissioners. I first wish to deal with the evidence of Mr Hamish MacLeod. Mr MacLeod has made a written statement to the
5 Royal Commission about his experiences living at a residential aged care facility in a suburb of Melbourne. He was scheduled to be the first witness to give evidence at the hearing today, but due to health problems he's unable to do so. The evidence in his statement though is nonetheless important. It's the only evidence given for this
10 hearing by a person who is actually living in residential aged care and in his statement Mr MacLeod describes his experiences of problems at the interface between the aged care and health care systems.

I therefore propose to make some brief observations to you, Commissioners, and then having done so, to seek to tender his witness statement.

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COMMISSIONER PAGONE: Yes.

MR KNOWLES: Mr MacLeod is 74 years old. He has a number of ongoing health problems, including diabetes and macular degeneration. He has lived in residential
20 aged care since 2013. Over that period of time he has lived in two residential aged care facilities, the last of which since 2018. While living in residential aged care, as I've already said, he has had difficulties in accessing medical care for his various health problems, including from both GPs and specialists. He's also had to change his GP on a number of occasions when his GP stopped attending the residential aged
25 care facility and was replaced by someone else.

In his statement, Mr MacLeod observes that earlier this year his current GP was called to look at fluid build-up in his legs and after the consultation he was transferred to hospital. Upon arriving there he waited in the emergency department
30 for about eight hours, he says in his statement, before he was admitted. He was later told by nurses at the hospital that he had developed a pressure injury while waiting in the emergency department because he had not been moved on a sufficiently regular basis. Ultimately, the fluid was removed from his legs and a blood clot in his right lower leg was treated. He was discharged from hospital but only after having to wait
35 for three hours to be transported back to the residential aged care facility.

He was told later, he says in his statement, by facility staff, that they had to contact the hospital to obtain information about his condition on discharge and his ongoing treatment, including the medications prescribed by hospital doctors. He was told by
40 the staff at the facility that his hospital records had mistakenly been sent to another hospital and not to the residential aged care facility. Obviously, such a mix-up has the potential to jeopardise the delivery of quality care to Mr MacLeod. What this goes to is the need for adherence to guidelines relating to discharge. It arguably also supports changes to existing discharge guidelines which generally only require that
45 hospitals provide discharge information to a treating GP within 48 hours.

Rather, they should also require, in the case of people who are living in residential aged care, that the information be provided directly to the residential aged care facility and that it be made available at the time when the person arrives at the facility. Mr MacLeod in his statement also refers to circumstances in October this
5 year when he contracted shingles around his eye. He was seen by the facility GP who gave him eye drops. When his eye got worse, he arranged an appointment with another GP at a nearby clinic. He had to walk there himself for that appointment. The local GP prescribed tablets for the shingles and then walked Mr MacLeod back to the facility. The local GP told staff about his condition and what had been
10 prescribed for it.

After this incident Mr MacLeod changed his doctor from the facility GP to the local GP, but that GP, he says, unfortunately, doesn't visit the facility and as such, Mr MacLeod has to walk about 650 metres to the local doctor's clinic whenever he has
15 an appointment. This evidence points to problems with the incentives that exist, arguably, to get GPs to attend on patients at residential aged care facilities. It also goes to what provision is made for residential aged care staff to assist residents with the transfer of residents to external appointments of this kind. In saying that, that's not intended in any way to be a criticism of staff. It just goes to what might
20 potentially be a resourcing issue.

Mr MacLeod has also given evidence about the inability of facility staff to assist him with his catheter and their reliance on people outside the facility, such as his general practitioner, to deal with any difficulties with the catheter. This has at times given
25 rise to a lack of timely or adequate attention to difficulties that he is having with the catheter. It also goes to the need for a clear understanding of the respective roles and responsibilities of those caring for people living in residential aged care. Finally, due to his various health problems, Mr MacLeod has had to see a number of specialists, including an eye specialist, a nephrologist and a urologist.
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In his time in residential aged care since 2013 he has never been seen by a specialist at the aged care facility itself. He has always had to go off site for that purpose. He had previously had some assistance from volunteers to attend appointments with
35 specialists. He has also been able to on occasions ask his sister to assist him to get to such appointments and due to his previous service in the Royal Australian Navy he has sometimes received help from an advocate from the RSL who arranges a subsidised taxi. He can't however afford to pay someone to take him regularly to his appointments and so when other options aren't available he has had to undertake the trip to his specialist appointments on his own, using public transport on trips that can
40 take him up to one and a half hours, he says.

He has, in his evidence, referred to a recent trip to his eye specialist who administered injections in his eye that caused him to feel off-balance after the
45 consultation such that he found his return journey on public transport to the aged care facility very difficult. Mr MacLeod's account illustrates the need to improve access to GPs and specialists for people living in aged care facilities. His account also illustrates what can go wrong at the point of discharge from hospital back to

residential aged care and how it might be avoided. Commissioners, we have his statement which is dated 30 November 2019 and it bears on its first page the document identification number of WIT.1309.0001.0001. If it pleases the Commissioners, I seek to tender the statement of Mr MacLeod.

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COMMISSIONER PAGONE: Yes. Thank you, Mr Knowles. The statement of Mr MacLeod will be exhibit 14-17.

10 **EXHIBIT #14-17 STATEMENT OF MR JOHN MACLEOD DATED
30/11/2019 (WIT.1309.0001.0001)**

15 COMMISSIONER PAGONE: Was there a summons to attend issue that needs to be dealt with?

MR KNOWLES: There was no summons for Mr MacLeod, Commissioner, and his evidence was produced pursuant to notice NTP-039.

20 COMMISSIONER PAGONE: Yes. Thank you.

25 MR KNOWLES: The first witness to give oral evidence today is Ms Catherine or Kate Davis. She has prepared a statement for the Royal Commission in which she describes her mother's experience in residential aged care in Canberra and, in particular, access to palliative care services. I now call Ms Catherine Davis.

<CATHERINE ANNE DAVIS, SWORN

[10.07 am]

30

<EXAMINATION BY MR KNOWLES

35 COMMISSIONER PAGONE: Yes, Mr Knowles.

MR KNOWLES: Ms Davis, could you tell the Royal Commission your full name.

MS DAVIS: Catherine Anne Davis.

40 MR KNOWLES: Yes. And you prepared a statement for the Royal Commission dated 27 November 2019.

MS DAVIS: Yes, I have.

45 MR KNOWLES: And that bears on its first page the number WIT.1304.0001.0001.

MS DAVIS: Yes, it does.

MR KNOWLES: And have you read your statement lately?

MS DAVIS: Yes, I have.

5 MR KNOWLES: And are there any changes that you wish to make to your statement?

MS DAVIS: No, there is not.

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

MS DAVIS: Yes, they are.

15 MR KNOWLES: I seek to tender the statement of Ms Catherine Anne Davis dated 27 November 2019.

COMMISSIONER PAGONE: Yes, thank you. That statement will be exhibit 14-18.

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EXHIBIT #14-18 STATEMENT OF MS CATHERINE ANNE DAVIS DATED 27/11/2019 (WIT.1304.0001.0001)

25

MR KNOWLES: Thank you, Commissioner. Now, Ms Davis, in your statement you've described your mother's experience in residential aged care here in the ACT from 2011 to 2015.

30 MS DAVIS: Yes, I have.

MR KNOWLES: And your mother, Ms Noeline Taylor, passed away on 16 August 2015 in Clare Holland House hospice.

35 MS DAVIS: Yes, she did.

MR KNOWLES: How old was she at that time?

MS DAVIS: She was 83.

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MR KNOWLES: Can you tell the Royal Commission a little bit about your mum; what was she like as a person?

45 MS DAVIS: She was an incredibly witty, warm, intelligent, most of all loving person. She loved her family dearly and we always knew it, yes.

MR KNOWLES: In terms of family - - -

MS DAVIS: Yes.

MR KNOWLES: - - - she was married to your dad.

5 MS DAVIS: She was.

MR KNOWLES: And how many siblings do you have?

MS DAVIS: I have one brother, Stephen.

10

MR KNOWLES: And did she have health problems, your mum?

MS DAVIS: She did. She did.

15 MR KNOWLES: What were they?

MS DAVIS: She suffered with some mental health issues from the moment my brother was born; we can kind of trace it back to. At that time it was called a nervous breakdown or, you know, there was all sorts of – all sorts of references to it but we now know she was diagnosed with paranoid schizophrenia and suffered with that for the rest of her life from the moment my brother was born. She had difficulty conceiving and there was all sorts of issues that led to that, but yes, that did impact her life greatly.

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25 MR KNOWLES: And how was that so; what were her care needs that she had?

MS DAVIS: She needed prompting to take medication a lot of the time. You know, there were – there were episodes that she would become a little bit – a little bit more unwell, where she would take to her bed and she couldn't function, day-to-day tasks. My father performed those most of the time and as I got older I did as well, yes.

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MR KNOWLES: And your father passed away in 1991.

MS DAVIS: He did, yes. He was only 55 and my mother at the time was only 59 so that had a huge impact also on my mum's care needs, yes, because Dad had been a huge support to her.

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MR KNOWLES: Did you take over that role - - -

40 MS DAVIS: I did.

MR KNOWLES: - - - of being her primary carer at that point in 1991?

MS DAVIS: I did. I certainly did. I had three children at the time as well. I was married to my husband Jeff and we had three children. It became - over the course of about a year it became obvious that we would need to probably do a little bit more to care for Mum. She wasn't eating well, she wasn't taking medication. There were

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some financial things that were happening that weren't, you know, normal. So we made the decision as a family to care for her from that point, yes.

5 MR KNOWLES: And you cared for her up until about, I think, in your statement you say 2002, which was the first time she went into a residential aged care facility.

MS DAVIS: That's correct, yes.

10 MR KNOWLES: And what prompted the decision for her to go into a residential aged care facility at that point?

15 MS DAVIS: I think it was becoming increasingly difficult to manage her behaviours and as a family - I had, at that stage, four children. So a young boisterous family and my mum's mental health needs just didn't really mix very well.

MR KNOWLES: Yes. And you took her back in though - - -

MS DAVIS: I did.

20 MR KNOWLES: - - - to your family household in 2009; is that right?

25 MS DAVIS: Yes. That's right. Yes. It became obvious that Mum wasn't happy and it was hard to know - discern whether it was her mental health issues that were - her paranoia that was causing her distrust at the facility and her unhappiness at the facility but, regardless, we felt as a family if she wasn't happy we had no choice but to take her home. She was always very happy around family and, as I said, she loved us all very much and we always knew it. So, yes, we felt very, very much the need to care for her ourselves.

30 MR KNOWLES: Yes. After a couple of years, though, your mum returned into residential aged care in 2011.

MS DAVIS: That's right.

35 MR KNOWLES: What prompted that?

40 MS DAVIS: Again, I think a boisterous family; I had teenage children at the time, her care needs were growing. There was more and more episodes where she was becoming unwell. Her psychiatric illness was morphing into a form of dementia so that was creating all sorts of difficulties and, again, it was about her happiness, yes, yes. It was also - she had been fairly institutionalised and I had underestimated how institutionalised she had become. The routine was so important and I couldn't provide that with a family of boisterous teenagers.

45 MR KNOWLES: Yes. Now, can I ask this: at that time of entry into the second residential aged care facility how was her condition and its symptoms being managed?

MS DAVIS: She was seeing a psychiatrist at that point and she was taking some psychiatric medication to manage that and she was going okay, she was doing pretty well at that point. Yes. It was difficult, however, to find a facility that was willing to take on someone with her behaviour issues, yes.

5

MR KNOWLES: Yes. But ultimately that was something that was able to be done.

MS DAVIS: That's right, yes. Absolutely.

10 MR KNOWLES: Now, on entry into that residential aged care facility, did your mum have an advance care plan already in place?

MS DAVIS: No. No, she didn't.

15 MR KNOWLES: Did staff at the facility discuss advance care planning at that time?

MS DAVIS: Not at that time.

20 MR KNOWLES: Now, can I ask you, once your mum was in the residential aged care facility, how often would you visit her?

MS DAVIS: At least weekly, sometimes twice or three times a week.

25 MR KNOWLES: Yes. And what were your impressions at that time of the care that was being provided to your mother in those early stages of her time there?

MS DAVIS: It was very good. She settled in quite quickly. Yes, she was classified as a low-care resident so she was placed a bit farther away from a nurses' station and dining room, for example, because she was – she was fairly mobile – she was very mobile. So she was – she did well, yes, at that time.

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MR KNOWLES: What was the access that she had at that time to doctors when she was at the residential aged care facility like?

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MS DAVIS: Well, at that time I would take her to our family GP, a GP that she had known her pretty well her whole life and that had looked after us all, and my father when he was dying, and myself and my children, so it was a family practice, quite literally. And I would pick her up and take her to the doctor. As time went on it was more difficult to get her physically to the doctors. Various reasons, she didn't want to go; she became really belligerent. "No. I don't need to go and see a doctor" – for whatever reason, and the GP was unable then to visit the facility.

40

MR KNOWLES: Did you ask the GP why she or he was unable to visit the facility?

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MS DAVIS: I think he made it clear, that he did not make the nursing-home visits; that's what he would say to me, "I don't visit facilities". He was also on the way to

retirement; so I think he was winding down and just – yes. He may well've visited facilities that were closer to the practice or closer to his home, but he, certainly, didn't visit Mum unfortunately.

5 MR KNOWLES: Is there anything that, you think, might've made it more likely, that that GP would've had an incentive to come to the residential-aged-care facility to treat your mother?

10 MS DAVIS: I'm not quite sure, what it was. At the time – I don't know whether payment of any kind would've helped, because Mum was being bulk-billed at that time. I don't know – proximity to – may be he just did a certain radius around his practice. I'm not sure. But – I really couldn't hazard a guess as to what would make him attend. I would've thought just the sheer contact with our family because he had known us for such a long time – that that might've been an incentive, but not
15 necessarily.

MR KNOWLES: Yes. And what sort of assistance did you get from staff at the residential-aged-care facility in facilitating those appointments with the local GP?

20 MS DAVIS: Well, they actually ended up advising me to take on board the GP that visited the nursing-home, the residential-aged-care facility; their recommendation was – that it's much easier because this man – this doctor comes to the facility, he doesn't have a practice as such, so he's solely – solely looks after residential-aged-care clients, and so their recommendation was that we utilise that service. Otherwise
25 it was very difficult. I would have to – yes; they were just reluctant to – there was no transport available from their side of things to get Mum to appointments. So I would have to leave work and come pick her up and take her, and it was often very difficult, to take her. So – yes. I really had no choice in the end but to take on board the facility's recommendations.

30 MR KNOWLES: Yes. And how did you find that GP, the facility GP?

MS DAVIS: I felt very much cut out of the loop. I had been responsible for my mum for such a long time that I felt a very intrinsic need to know what was going on,
35 and it would require me to chase – I was given a number, a mobile-phone number. He never answered it. I would have to transfer messages through the staff to get to him, and I felt very cut out of the loop, I would say, very, yes, uninformed. I didn't know what was going on, and I couldn't rely on Mum. She was unable to provide me any information as to what was going on.

40 MR KNOWLES: What would've improved that situation from your point of view?

MS DAVIS: Just to be able to be communicated with every time that Mum would see a doctor, every time they called a doctor, if they could tell me. They would tell
45 me after the fact but not necessarily before; yes.

MR KNOWLES: And just to be clear on this: did you have an enduring power of attorney for your mum at this time?

MS DAVIS: I did. Yes, I did. Yes.

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MR KNOWLES: So you were the person with responsibility for assisting with decisions in relation to her medical care as well?

MS DAVIS: I was. Indeed. Yes.

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MR KNOWLES: But you were not contacted prior to these appointments?

MS DAVIS: No.

15 MR KNOWLES: Can I just go back to when your mum was living – before she was in residential aged-care and living in the community. Was she able to get extra assistance to get to medical appointments at that time?

20 MS DAVIS: We – there was patient-transport services available. We tended not to use them, because we – she tended to go to day groups and things at times; so I would try and utilise a service for that, because it was during the day, when I was at work. But I tried to make doctor's appointments around a time that I could get her there, because then I would be there with her to attend the appointment; yes.

25 MR KNOWLES: Yes. Were you aware of those services, patient-transport services being available once she had entered the residential-aged-care facility?

30 MS DAVIS: No. No, I wasn't. I kind-of assumed that we should be feeling fairly lucky, we were in the facility – let alone access other services – and they were more for people that were not residents of an aged-care facility. I think that's how I tended to look at it. Knowing that they were very scarce, I didn't – I thought that, possibly, the fact that she was getting so much care at one level – that maybe patient transport was pushing the envelope a little.

35 MR KNOWLES: What about access to specialist by your mother while she was the residential-aged-care facility – you referred a moment ago – at this time - - -

MS DAVIS: Yes.

40 MR KNOWLES: You referred a moment ago to a need for psychiatrist assistance or psycho-geriatricians.

MS DAVIS: Yes.

45 MR KNOWLES: What sort of assistance or access was she able to get from specialists when she was in the facility?

MS DAVIS: I, usually, would have to take her to a specialist appointment. As I said, she did see psychiatrists for a long time in the lead-up to, probably, the change into dementia; it was very hard, to figure out what it is, she actually needed at that point. I think one doctor said it's like a ball of string. "Which one do we pull?
5 There's so many different complexities with your Mum's health"; we just didn't know which way to go. So it was really up to me, I guess, to take her to a specialist. There was never any recommendation from that facility that – "May be you should see a geriatrician, or may be you should see a psychiatrist or a" – yes

10 MR KNOWLES: What about the GP – obviously, the GP's instrumental in referral to specialists - - -

MS DAVIS: No. No referral to specialists at that point.

15 MR KNOWLES: Now, you've said in your statement that over time during your mother's stay at the facility her condition gradually declined.

MS DAVIS: It did.

20 MR KNOWLES: But in late 2013 you noticed a more rapid deterioration in her state of wellbeing.

MS DAVIS: Yes.

25 MR KNOWLES: Can you describe what happened around that time?

MS DAVIS: That's where she became very agitated. She sometimes would complain that her legs wouldn't work, and she wouldn't be able to get out of bed. She wouldn't eat anything. I would – she – I would notice that she was losing
30 weight; so I would try and bring in snacks and leave them in her fridge, and still we would go back the next time and she would not have eaten anything. Agitation was a real issue, particularly with the staff. They weren't equipped to deal with the kind of agitation or the kind of – I wouldn't say it was abuse, but she would sometimes
35 scream at them and call them terrible names and that sort of stuff. So it just became difficult for them. There was a couple of hospital callouts as well around that time.

MR KNOWLES: So was that the way that – at least so far as you were aware – staff were ultimately responding to the behaviour of your mother?

40 MS DAVIS: Yes. I think so. I think it just became – there was a bit of a pattern to it. She had about five hospital visits in the lead-up to a long hospital stay, where they were

45 MR KNOWLES: Can I just ask there, Kate, that – you say there was about five hospital visits.

MS DAVIS: Yes.

MR KNOWLES: Over what period of time did that - - -

MS DAVIS: About five or six weeks. Yes. So it was, probably, one a week

5 MR KNOWLES: Yes. So we're now heading into 2014.

MS DAVIS: We are. That's right.

10 MR KNOWLES: And was there any trend in terms of the time of day when these hospital visits occurred?

MS DAVIS: Middle of the night; always middle of the night. And it would be either – because her legs wouldn't work, she had fallen out of bed or the staff basically couldn't manage her behaviour, she was shouting or there would be something not right about the situation, and I did notice a pattern, that it was a particular staff member at the time, that would always call the ambulance. It was just a go-to mechanism for them to deal with the situation. So I would often get the phone call. "Your mum's been to hospital, but she's back again." So – they didn't even call me in the middle of the night; they would call me in the morning to say "We had to call them again, but she's back, and everything seems okay". Yes.

25 And I believe at the time, when I looked at hospital notes – that she was being given some antipsychotic medication. So – it was olanzapine, she was being – Seroquel – sorry – that she was being given at that time. That would calm – and she would be calm for another couple of days, and then – yes. A bit of – and she was also being hydrated, because she wasn't eating or drinking at that time. So once a hospital visit came around, they would put a drip in as well as a matter of course, and by the morning she would be a little bit better and just return back to the facility.

30 MR KNOWLES: So the – so far as you understand it, the key interventions were a prescription of antipsychotic medication and a drip to address dehydration.

MS DAVIS: Yes.

35 MR KNOWLES: Were those the sorts of things that you might have expected could've been done at the residential-aged-care facility itself?

MS DAVIS: I think so. But I think, given that it happened over a number of times, that perhaps there would've been some idea that there's something more going on here and that, probably, the need to go to hospital should've been addressed a bit more thoroughly.

MR KNOWLES: Yes.

45 MS DAVIS: Yes.

MR KNOWLES: And from what you've just said a moment ago am I right in understanding you to say that on each occasion she was only in hospital for a brief period of time?

5 MS DAVIS: Hours. Yes; hours.

MR KNOWLES: Yes. What effect did that have on your mother on each occasion, when she presented at hospital and returned within hours?

10 MS DAVIS: Very distressing. At that time she was – her cognitive awareness was low. She wasn't really aware of her surroundings or anything like that. But she did react to, obviously, the clinical atmosphere of a hospital, and it was very distressing for her. And it was always very distressing for me, to know that she had gone alone, and I wasn't there, because they just didn't call me. You know? "We didn't want to
15 bother you. We knew" – there was all sorts of reasons why, and it became a bit like the boy who cried "wolf"; you know? And you start to think "Is she just bunging it on, or are they just – is it just something that we shouldn't really worry about too deeply?". So you become a little bit desensitised to it, I guess; yes.

20 MR KNOWLES: Do you think it would've helped, if staff had training in dealing with these particular matters, management of behaviour or assessment of a person of this kind, better training at least than what was in

MS DAVIS: Absolutely. Absolutely; yes. I think there were particular staff who
25 found it very difficult, to deal with Mum, because she had some – obviously, some difficult behaviours to manage. So I think, yes, some of the staff really found it difficult, yes, to deal with her.

MR KNOWLES: Do you think there might've been some benefits, if there was
30 some sort of hot line or telephone contact to an experienced gerontic nurse who could assist with diagnosis of what was going on and how it might be addressed?

MS DAVIS: Yes. Yes, I do; yes – and someone who actually knew Mum, because
35 I think every case is an individual. So it's very difficult, to put – and that was always the case with Mum; she was never the – she was always the square peg in a round hole. She never quite fit the mould in any – so it wasn't necessarily – didn't follow a similar pattern to anyone else. She was very unique; so I think someone who knew her and knew her behaviours and – which at the time felt like it was only me – it was only me, that knew what was going on with her.

40

MR KNOWLES: Now, you said that there was ultimately a longer stay in hospital, which occurred in March 2014.

MS DAVIS: Yes. There was. Yes.
45

MR KNOWLES: At that time the doctor on her arrival at the emergency department ordered some tests in relation to her health. What happened at that time?

MS DAVIS: That was the first time we actually – Mum received the care of a geriatrician, and it's – it was a bit of a case of – we lucked out again to get a really good doctor at the ED. And he was the one that decided to be a little bit more thorough in Mum's care. "Okay. She's had a few admissions; we haven't found a
5 solution properly. So let's investigate further." So they discovered then that she had a brain tumour – after some tests, and she had a long hospital stay then, about five weeks.

10 MR KNOWLES: And what did you and your mother decide in terms of her treatment for that brain tumour?

MS DAVIS: I had known for a long time Mum's wishes around not wanting too much intervention in her later years. Actually from her early years, she wasn't a big fan of – she was a nurse herself; so she was well aware of all the things that could
15 occur. She wasn't a fan of having any medical intervention. That was the first time that I was actually – had a social worker assigned to me and some continuous care over that time.

20 MR KNOWLES: Yes.

MS DAVIS: Yes.

25 MR KNOWLES: And what decisions were made about her treatment in terms of the cancer itself – what was decided?

MS DAVIS: We just – yes; we decided not to proceed with any treatments.

MR KNOWLES: Yes.

30 MS DAVIS: So – and the geriatrician was of the view that Mum would, likely, just pass away, have a stroke sooner rather than later, things would just – she would just pass away gently, I think. Was kind of my assumption anyway.

35 MR KNOWLES: What was done to address the tumour in her brain?

MS DAVIS: She was given what, I understand, were steroids, and it shrank the tumour a little bit – as far as I am aware. She had no further tests after the initial diagnosis; so I'm not sure what exactly happened. But her behaviour improved. She actually became a little bit more lucid. We could have conversations; she
40 returned to as normal as Mum could've been at that time. Yes. It improved her overall wellbeing greatly.

45 MR KNOWLES: And after five weeks she was transferred back to the residential-aged-care facility.

MS DAVIS: That's right. Yes.

MR KNOWLES: Was it around this time, that you received some advance-care planning - - -

MS DAVIS: That's right; yes. We did.

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MR KNOWLES: And who did you have those discussions with, and what did they entail?

MS DAVIS: It was with – it was a follow-on from the hospital visit and it was the manager of the aged care facility saying, you know, really important that we know what the advance care directive is and, you know, I assumed that meant that we didn't want any intervention, any medical intervention, there was a do not resuscitate, obviously, order on there, but I don't think I was prepared for actually what medical intervention would be required as she progressed, as her illness progressed, yes.

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MR KNOWLES: And in that regard, did you feel that the advance care planning that you received at that time was satisfactory?

MS DAVIS: At that time I did. I knew no better so I assumed it was, yes.

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MR KNOWLES: With the benefit of hindsight, how do you regard it now?

MS DAVIS: It was completely inadequate. Wholly inadequate.

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MR KNOWLES: And why do you say that?

MS DAVIS: Because towards the end there were plenty of medical interventions that were required for Mum to be comfortable, you know, catheters, some bowel cleansing, that sort of thing to make sure that she was resting comfortably, and I don't think I was aware of that at the time. I just assumed medical intervention meant something invasive that would harm – or make Mum uncomfortable but in actual fact there are some that make patients comfortable so, yes, that probably could have been explained a bit better to me.

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COMMISSIONER BRIGGS: Can I understand that; so are you saying, Ms Davis, that you ticked no to medical interventions - - -

MS DAVIS: Correct.

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COMMISSIONER BRIGGS: - - - because you didn't appreciate that they would include pain relief and various other treatments?

MS DAVIS: Correct.

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COMMISSIONER BRIGGS: And that you should have been taken through that?

MS DAVIS: Correct, yes. So that – what that resulted in, Commissioner, was I would then be consulted again whenever there was any requirement for anything, so okay, your advance care plan says this, but how about this. So we were forever revisiting it, it felt like we were forever revising it rather than having something that was locked in place and a real understanding of what we required, yes.

COMMISSIONER BRIGGS: So what you're saying, in effect, is that advance care plans are pretty important technical and guiding documents - - -

10 MS DAVIS: Yes.

COMMISSIONER BRIGGS: - - - and that the older person, if they're cognisant, should be taken through these carefully but, similarly, somebody such as yourself with a power of attorney should be as well.

15

MS DAVIS: Yes.

COMMISSIONER BRIGGS: Thank you.

20 MS DAVIS: Yes, indeed. Thanks.

MR KNOWLES: And on discharge back to the residential aged care facility, what access did your mother have to doctors at this time?

25 MS DAVIS: It was the continuation of the GP visiting. It was around that time, it was not long after that that the facility, which was – Mum was classified as a low-care resident at that point – approached me and said I think it's – “I think it's time that – I think your mum needs some higher care, she needs, you know, her care needs have increased and she is now classified as a high-care resident and we don't have any beds for her here. We recommend that you go to another one of our facilities that has a memory unit that would be able to adequately care for Mum”, so - - -

30

MR KNOWLES: Was there any access to specialist- - -

35 MS DAVIS: No.

MR KNOWLES: - - - medical assistance in the nature of geriatricians?

40 MS DAVIS: Again, the geriatrician we had seen in the hospital, we could well have gone to see her afterwards private in her rooms, but the difficulty of getting Mum to such an appointment was just enormous. I couldn't have gotten her there, let alone waiting in the doctor's surgery for your appointment and, yes, it just - it was not possible at all. But I don't recall anyone ever saying “a geriatrician will come and visit you”. It wasn't until I was at the third facility that I understood that they did do that and that – yes.

45

MR KNOWLES: Did it just not occur to you as a possibility - - -

MS DAVIS: It just didn't.

MR KNOWLES: - - - in all the circumstances?

5 MS DAVIS: It didn't. And it seems – it seems in hindsight a bit ridiculous but at the time I just didn't. Yes. You're in the middle of a situation like that, it's very difficult to see outside the square.

10 MR KNOWLES: Yes. Now, in terms of that second or I should say it's now the third facility - - -

MS DAVIS: The third facility.

15 MR KNOWLES: - - - but the next facility that she moved to, was that around about July of 2014 that she - - -

MS DAVIS: Yes, it was.

20 MR KNOWLES: - - - ended up moving there?

MS DAVIS: Yes, it was.

25 MR KNOWLES: And how was that facility different to the one before insofar as it catered to your mother's care needs?

30 MS DAVIS: It was enormously different. There was a greater ratio of staff to patient. There was – rooms were placed around the dining room and the nurse – where the nurses were so – where the staff were, so that, you know, there was just – she was much more comfortable there. I felt much more comfortable there that she was receiving a greater level of care.

MR KNOWLES: And you've said in your statement that your mother was complaining of headache and was picking at the bridge of her nose.

35 MS DAVIS: She was.

MR KNOWLES: How did you come to notice that?

40 MS DAVIS: It was an ongoing – it was a sore and it was – she just kept – she just kept picking at it. It became a big crevice in her face because she just kept pick, pick, picking at it. The GP would prescribe cream and all sorts of stuff. The staff would always raise it with me and say, you know, this – this – "She's picking at it again, it's a real problem, we'll get some more of that cream. And the doctor has been in and prescribed some more of it." It went on like this for a while and it
45 wasn't until I had met the nurse practitioner, the palliative care nurse practitioner, Nikki, who came and said, you know, "I think that's something to do with her pain. It's probably why she's doing it, it's how her pain – she's indicating she's got pain."

But it was months before that conversation had taken place, so in the meantime she literally had a hole in her nose where she was picking at it all the time.

5 MR KNOWLES: And did her condition improve after she was provided with pain management?

MS DAVIS: It did for a short time, but it was – it was actually, she was on the decline then. The increased pain medication only came about after I had seen a geriatrician at the third facility which was again prompted by the palliative care – by
10 Nikki at palliative care, yes.

MR KNOWLES: Can I ask you about that?

MS DAVIS: Sure.
15

MR KNOWLES: You've referred in your statement to first coming into contact with Ms Nikki Johnston from specialist palliative care at Clare Holland House in October 2014.

20 MS DAVIS: That's right.

MR KNOWLES: How was that contact initiated with you?

MS DAVIS: I understand that the hospital had referred Mum to palliative care
25 services once the diagnosis was made of a brain tumour and things, so there was always this thing, this referral going on in the background. I know that Nikki visited Mum a lot and she would always call me when she visited her but our – you know, it was just – it was just that, she would visit occasionally and call me.

30 MR KNOWLES: That's after October of 2014.

MS DAVIS: That was after - that's right.

MR KNOWLES: But going back to that time in October 2014, you say you knew
35 things were going on in the background.

MS DAVIS: I understand there was a referral.

MR KNOWLES: You understand that now but not at the time.
40

MS DAVIS: Not – look, it's very vague at the time. I'm not sure exactly what was going on but I knew that there was some - something going on in terms of there would be a support service there for her in terms of palliative care but I think everyone assumes that when someone is in an aged care facility that death is part of
45 their core business, I guess. I guess you assume that they know exactly what's going on. So palliative care in aged care facilities, you don't kind of think that they're a

separate entity. You think that they are just a joined entity but that sadly is not the case, in my situation, anyway.

5 MR KNOWLES: Yes. And do you know why it was – I mean, your mother was discharged some six months prior to this, or - - -

MS DAVIS: Yes, that's right.

10 MR KNOWLES: - - - five to six months. Why was it only in October of 2014 that you were first able to see Ms Johnston?

15 MS DAVIS: I think it's because the level of Mum's requirements changed over that time and I think it was just – it was such a natural organic process, it didn't seem to be invasive or, you know, I wasn't sort of – you know, "Your mum is going to die and I need to talk to you about this". It was very much a very gradual thing. So I think that's why it doesn't – it doesn't, you know, resonate in my mind as was something that was very urgent or very, yes, impactful. It was just a very gradual organic process of us getting – yes - - -

20 MR KNOWLES: And can you describe to the Commissioners what Ms Johnston's role was, precisely?

25 MS DAVIS: I understand that she was there to liaise between the residential aged care facility and Mum and her family about her palliation needs.

MR KNOWLES: And what assistance did she provide you and your mother with in terms of advance care planning?

30 MS DAVIS: Enormous assistance. I think she was able to, in a very clear gentle way, explain to me what was going to be – what could be required and where there might be some gaps, and that's when – she was the one that actually introduced me to Dr Ramila Varendran who was the geriatrician that saw Mum at that time.

35 MR KNOWLES: And how was the advance care planning different - - -

MS DAVIS: Detailed.

MR KNOWLES: - - - compared - - -

40 MS DAVIS: Much more detailed. Much more – much – I was much more prepared for what might – might ensue, yes.

45 MR KNOWLES: And you've already referred to some of those details. Were there other things that was included in the advance care planning now that had not been included previously?

MS DAVIS: I think little things like – this has just come to me, actually – little things like having photos of the family around Mum, and what music Mum liked and – it was little things, really, that you started to think about what would make her comfortable, what would make her feel loved and, you know, in a safe place.

5

MR KNOWLES: Now, in terms of – you said earlier Ms Johnston’s assistance, one of the things that I think you said was that she assisted with pain management.

MS DAVIS: Yes, she did.

10

MR KNOWLES: What did that comprise initially?

MS DAVIS: So, initially she was the one that said we need to – we probably should consider, because of the nose thing and everything ramping up, the pain relief and how about we get a geriatrician to come and – come and have a look at what the requirements might be. And that’s when she - I felt like Nikki was the liaison for me. In every step of the way she was a support person, she was the conduit between the facility and any other – the geriatrician and anything else. She was the person that got stuff done in a very quiet way. She was certainly not pushy in any way, shape or form but she made sure things were done.

15

20

MR KNOWLES: Yes.

MS DAVIS: So once – once she had recommended us to the – or asked the geriatrician who was visiting the facility and I only know that now, I didn’t know that at the time, that the geriatrician visited the facility, she was on her rounds and said, “Come and look at this lady, I think she would benefit from seeing you”. And that’s when the pain management ramped up and a syringe driver was recommended. Dr Ramila also recommended Mum have an air bed to make her more comfortable. Again, they’re very small things but they made such a difference to Mum’s comfort, yes.

25

30

MR KNOWLES: What was the role of your Mum’s GP at the facility in all of this?

MS DAVIS: To be honest, I can’t quite recall. I know there was lots of prescriptions that he probably was responsible for but I never saw him. I can’t recall seeing him. I’m sure he might have been there somewhere in the background but he doesn’t, you know, come to the fore of my mind as someone who was there at the time.

35

40

MR KNOWLES: Yes. Do you think that your mum’s GP was acting as a care coordinator of sorts for your mother at this time, or was that role being undertaken

45

MS DAVIS: No.

MR KNOWLES: --- by someone else?

MS DAVIS: No. I think Nikki was performing that role.

MR KNOWLES: That's Ms Johnston.

5 MS DAVIS: Ms Johnston of palliative care, nurse practitioner.

MR KNOWLES: Now, you said a moment ago that the geriatrician arranged an air mattress for your mum.

10 MS DAVIS: Yes, she did.

MR KNOWLES: And what was the purpose of – sorry, pardon me – what was the purpose of the air mattress for your mum?

15 MS DAVIS: To make her more comfortable.

MR KNOWLES: Yes. And had she not had an air mattress provided to her before that time?

20 MS DAVIS: No. I didn't even think it was something that was available.

MR KNOWLES: In terms of the syringe driver to administer pain medication - - -

MS DAVIS: Yes.

25

MR KNOWLES: - - - had that been proposed at some earlier time?

MS DAVIS: No.

30 MR KNOWLES: No. So what point in time are we talking about now in terms of your mum's history?

MS DAVIS: We're talking of probably a month before she died.

35 MR KNOWLES: Yes. So this is in, we've now moved into 2015.

MS DAVIS: July. Yes, that's right. We're in July probably, that first quarter.

40 MR KNOWLES: Just in between October 2014 and the middle of 2015, what sort of engagement did Ms Johnston have with staff at the facility on your behalf?

MS DAVIS: I'm actually not sure. I know she was – she was there, but I didn't – she would call me when she saw Mum and she would say your mum looks pretty good today. It was during those conversations that she noticed – she was talking to me about the sore on Mum's nose, and I do remember contacting Nikki first when I –
45 it was my birthday and I was planning a trip away with the family and I actually called her and said, "Do you think I should go?", and that was probably the first

conversation. She said, “Yes, go, you’ll be fine. She’s fine. It’s okay. I’m here”, and she just provided that security for me, I guess, as a carer, knowing that Mum was going to be in good hands if I was not there.

5 MR KNOWLES: Just in terms of the wound on your mother’s nose, did that resolve when she was provided with adequate pain medication?

MS DAVIS: Yes. Yes, it did.

10 MR KNOWLES: Now, in terms of the syringe driver, who was the person responsible for administering pain medication through that?

MS DAVIS: So I understand it was a registered nurse was – was the only person that was able to administer – to change the medication in the syringe driver. I’m not
15 using very technical terms here I’m sorry, but she would, yes, you had to have a certain qualification to change the syringe driver.

MR KNOWLES: Now, you’ve said in your statement that by early August 2015 your mother was – and these are your words – “actively dying”. What do you mean
20 by that?

MS DAVIS: I think that’s a term that I learnt from Nikki. It meant that she was, probably, in the final stages, she was heading towards death rapidly and – yes; that’s how I understood the term. That’s why – that’s what – yes.
25

MR KNOWLES: Did staff at the facility recognise that your mother was in that stage of her life?

MS DAVIS: No. I don’t believe they did.
30

MR KNOWLES: Why do you say that?

MS DAVIS: Small things; we would have the personal – the people that were responsible for personal care leaving a cup of tea and biscuit on Mum’s bedside
35 table, when she was clearly not awake or not able move. She hadn’t been out of her bed for weeks at this point, and they were still coming in, leaving a cup of tea and biscuit. “She must eat.” “No. She’s beyond the point of eating now” – and just this sort of look of horror – “It’s not good here.” You know? It was like they were shocked – that someone was dying. It felt like that, anyway, to me. The other –
40 we’d have the personal-care attendant come in to say “We get your Mum up for a shower today”. I said “No; we’re not going to get her up for a shower today. She can’t get up at this point”. So that’s when it first really became obvious to me, that they were not equipped for this part of Mum’s life; yes. I had – some of the staff there were visibly distressed when they saw Mum. They would be very upset; they
45 would cry and say “This is so sad, so terrible for you”. Yes.

MR KNOWLES: How did that make you feel?

MS DAVIS: Distressed and worried, because I knew that they were not able to look after Mum. Was around that time – I think it was around that first part of August, that I started to stay overnight with Mum to make sure, that she – I just wasn't comfortable – that she was getting 24-hour care; so I would stay the night with her to make sure, that was happening.

MR KNOWLES: Were there any problems with the administration of adequate pain medication by the syringe-driver round this time?

10 MS DAVIS: Yes; there was one particular occasion that was very distressing.

MR KNOWLES: What happened?

15 MS DAVIS: There was one registered nurse on duty between a number of facilities. I can't recall exactly how many, but – between four and six facilities spread across Canberra, various suburbs. It was late at night, and they – Mum was left without anything in her – no pain relief at all for three hours and was moaning in pain, was so visibly distressed and in agony that - - -

20 MR KNOWLES: Were you there at that time?

MS DAVIS: I was, yes, and powerless to do anything about it. When the – I would speak on the phone to the registered nurse. There was, obviously, staff at the facility who were visibly distressed too; they couldn't do anything. Yes; there was – yes. In the end, I believe, I contacted Nikki, and this is – yes, and she arranged for the syringe-driver to be changed, but the registered nurse was really distressed – that she couldn't get across everything, everybody, and she was so stretched; she couldn't – she just couldn't do it. It was beyond her capabilities. But it was only afterwards, I understood – well, I knew at the time there was only one registered nurse across all these facilities at this time.

MR KNOWLES: The answer to this question may be obvious, but how do you think that situation might've been prevented?

35 MS DAVIS: Just needs to be more registered nurses and more ability to make sure that this pain medication is administered correctly at the correct time.

MR KNOWLES: Now, you said earlier that you actually moved into the facility and lived there with your Mum.

40 MS DAVIS: Pretty well. Pretty well.

MR KNOWLES: How well equipped was the facility for that to occur, and what was their response to you doing that?

45 MS DAVIS: Not at all. They were very welcoming. They, certainly, didn't say "You can't stay", but there was – I slept – there's only so many nights you can sleep

in a chair, comfortable chair, mind you, but not comfortable sleep. So I would – there would be some days that I would go home to my own bed, but, yes, for the most part I was sleeping in a chair.

5 MR KNOWLES: Now, standard 3 of the aged-care-quality standards currently requires that an organisation demonstrate that the needs, goals and preferences of a consumer nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. Do you feel that the level of care that your mother received met this standard?

10

MS DAVIS: No.

MR KNOWLES: And why is that?

15 MS DAVIS: I feel like the facility was not equipped at all and that, had it not been for – it seemed also, the palliative-care services filled in a gap and the aged-care facility allowed that to happen. You know? They were filling in the gaps that they had; the inadequacies that the facility had were being met by somewhere else, but they just were not equipped.

20

MR KNOWLES: Yes. Do you think that – sorry; pardon me. Did Ms Johnson around this time suggest a change for your mother in terms of where she was living?

25 MS DAVIS: Yes. She did suggest that, probably, the best option for Mum would be transfer to the hospice Clare Holland House. She indicated that that would provide a much better level of care for Mum at that stage. So we went about trying to make that happen, and again I think it was a kind of wait-for-a-bed kind of situation. Yes.

30 MR KNOWLES: And was she ultimately moved into that hospice?

30

MS DAVIS: She was, yes.

MR KNOWLES: And how was it there?

35 MS DAVIS: Amazing. Yes. Mum was moved there, transferred there on her birthday, the 12th of August. And – 2015. It felt at that time, that Nikki was with us 24-seven. It feels like she was an ever-present face at that time. And she at that point, the moment we entered the hospice – it was this gradual removal of herself from this – from our care. She just – it was such a gentle transition; you hardly
40 knew what happened, but it just was – she handed us over pretty well to Clare Holland House. From the moment Mum got there, she seemed at peace. There was a relaxed nature. The pain medication was adequate and on time and pre-emptive almost. She was in a comfortable bed. They washed her hair. They put on a clean nightie. She had a – rosy cheeks almost. It was – she – there was a visible
45 relaxation; there was a divan for me to sleep on, and you just felt enveloped in this support and care. That's the only way I can describe it.

MR KNOWLES: What were the staffing-levels like at the hospice?

MS DAVIS: It seemed like there were people everywhere all the time; yes, but they were very discreet and very quiet and very – yes; everything just happened.
5 There was never any – me always standing up, looking out the door to see if the registered nurse was around or to see what staff was around. They just came. They just turned up.

MR KNOWLES: And what was the communication between you and staff like at
10 the hospice?

MS DAVIS: Frequent. Often; they would speak to you on a regular basis about what was happening now, why her breathing was the way it was, what was happening with the pain medication, what would, likely, happen from this point. We
15 were at that point. Mum passed away on 16 August; so that was – it seems like an eternity, but it was four days. But – yes. It seems like it was a really long time.

MR KNOWLES: Can I ask you finally – how was your Mum’s care funded – at
20 Clare Holland House?

MS DAVIS: I have no idea. Isn’t that – it’s quite extraordinary. But I – there was never any talk of money at all at this point. I have no idea, how it was funded; yes, but the level of care was – I’m not sure, you could put a value on it. It was so
25 immense.

MR KNOWLES: Having regard to your experience and the experience of your mother, what would you like to see improved in access to healthcare for those living in aged-care?

MS DAVIS: I would, certainly, like to see more registered nurses and more staff – ratio to patients. I think that’s really important. I think the role of palliative care needs to be enhanced in a aged-care facility. As I said earlier, I think we all assume that a core business for an aged-care business is death, but in my experience they were completely – it might be okay, if you just pass away in your sleep, but if you
35 have any kind of extenuating or extended death, they are just woefully ill-prepared, in my experience; so – certainly, more funding for beds at the hospice. I think that would be amazing; to have more accessibility to a hospice earlier for someone who is dying would be a very good thing.

MR KNOWLES: Is there anything else that you wish to say to the commissioners today, Ms Davis?

MS DAVIS: No; not really. I think I would like to say that for the most part my Mum’s experience through an aged-care facility was a good one. She was a complex
45 character, and she had complex needs; so I’m forever grateful for the staff that did meet those needs. The end of – I’ll be eternally grateful to the palliative-care staff

and Nikki in particular and Dr Varendran for ensuring that Mum had such a peaceful death too; yes.

MR KNOWLES: No further questions, commissioners.

5

COMMISSIONER BRIGGS: Ms Davis, it's quite disturbing, to hear that one's end-of-life care, short though that generally is, can be much better than one's care in the several years before that.

10 MS DAVIS: Yes.

COMMISSIONER BRIGGS: So I want to ask you a specific question that flows from some of your evidence today, which is around the fact that, in palliative care, the nurse – the palliative-care nurse who stepped in and took charge seemed to be able to co-ordinate the services, make sure everything happened, put your mother at the centre of the care.

15 MS DAVIS: Yes.

20 COMMISSIONER BRIGGS: Is this the kind of model that we should be looking at within aged-care facilities themselves, a dedicated nurse, person who's the key interlocutor and management of – manager of care and supports for people like your mother?

25 MS DAVIS: Yes, commissioner. I believe that's – that would be an ideal situation. That continuity of care was integral. While I don't feel that I saw lots of Nikki in the beginning, she was always there, and she was always – she always knew what was going on, and I always felt in the loop. She would always call me, and there was that interaction, whereas previously I had felt that I had been cut out of the loop to a point, and I think for carers and – obviously, not everyone has someone that is by their side all the time; so to have that continuum of care is crucial.

30 COMMISSIONER BRIGGS: And the issue about staff having neither the knowledge or the information to do their jobs with your mother when her care was deteriorating: do you see that as a training-issue or a communication issue or many things combined?

35 MS DAVIS: I think it's a bit of both. I think palliation methodology changes all the time. I'm sure, it does. I'm sure, that if staff at residential-aged-care facilities were better trained in what happens when someone dies, not just goes to sleep and dies, but when they actually are dying like Mum did – that would help, just some awareness. Again no fault of the staff themselves, but their visible distress when Mum was in distress was distressing for me, and may be, had they been trained a bit differently – there was, obviously, a more stressful situation at Clare Holland House, and I never felt that it was – the way they handled it was just so different to the way the residential-aged-care facility operated, and communication, obviously – I think, is the key.

40
45

COMMISSIONER BRIGGS: Thank you.

MS DAVIS: Thank you.

5 MR KNOWLES: I have no further questions.

COMMISSIONER PAGONE: Ms Davis, thank you for giving your evidence. It's important to us, that we hear the experiences of people like you; it is distressing, to hear it. It must be very distressing, to have given it and to have done so publicly.
10 We thank you for coming forward and doing that and to remind us that all of these systems that we create affect people's lives like your mother and yours. Thank you very much.

MS DAVIS: Thanks, commissioners.
15

COMMISSIONER PAGONE: You're free to go.

<THE WITNESS WITHDREW [10.58 am]
20

MR KNOWLES: Commissioners, I understand there is a brief adjournment in our schedule.

25 COMMISSIONER PAGONE: A short break? Yes. We'll adjourn till 11.15.

ADJOURNED [10.58 am]

30 **RESUMED [11.14 am]**

MS HUTCHINS: Commissioners, the next witnesses is a panel of individuals who are involved in the management of residential aged care facilities. We have Ms Fiona Lysaught, Ms Judith Gardner and Mr Thomas Woodage.

MR D. VILLA SC: If it please the Commission, my name is Villa; I appear for Judith Gardner.

40 COMMISSIONER PAGONE: Yes. Thank you.

MS HUTCHINS: Sorry, excuse me, associate – Olivia, perhaps before swearing in the witnesses, with apologies, we have some appearances that are being made.

45 COMMISSIONER PAGONE: Do we have any others?

MS HUTCHINS: Thank you.

5 <THOMAS WILLIAM WOODAGE, AFFIRMED [11.15 am]

<JUDITH LYNNE GARDNER, AFFIRMED [11.15 am]

10 <FIONA MAREE LYSAUGHT, SWORN [11.16 am]

MS HUTCHINS: Mr Woodage, can you say your full name for the Commission.

15 MR WOODAGE: Thomas William Woodage.

MS HUTCHINS: You have prepared a statement for the Commission.

20 MR WOODAGE: I have, indeed.

MS HUTCHINS: Operator, please call WIT.1310.0001.0001. Is this a copy of your statement dated 29 November 2019?

25 MR WOODAGE: It is.

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

30 MR WOODAGE: They are, yes.

MS HUTCHINS: I tender that statement.

35 COMMISSIONER PAGONE: Yes, the statement of Mr Woodage will be exhibit 14-19.

**EXHIBIT #14-19 STATEMENT OF MR WOODAGE DATED 29/11/2019
(WIT.1310.0001.0001)**

40 MS HUTCHINS: Ms Gardner, could you please state your full name to the Commission.

45 MS GARDNER: Judith Lynne Gardner.

MS HUTCHINS: Have you prepared a statement?

MS GARDNER: Yes, I have.

MS HUTCHINS: Operator, please call WIT.1312.0001.0001. Ms Gardner, is this a
5 copy of your statement dated 29 November 2019?

MS GARDNER: Yes, it is.

MS HUTCHINS: And are there any changes you wish to make?

10 MS GARDNER: No.

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

15 MS GARDNER: Yes.

MS HUTCHINS: I tender that statement.

COMMISSIONER PAGONE: The statement of Ms Gardner will be exhibit 14.20.
20

**EXHIBIT #14-20 STATEMENT OF MS GARDNER DATED 29/11/2019
(WIT.1312.0001.0001)**

25

MS HUTCHINS: Ms Lysaught, can you please say your full name for the
Commission?

MS LYSAUGHT: Fiona Maree Lysaught.

30

MS HUTCHINS: And have you prepared a statement for the Commission?

MS LYSAUGHT: Yes, I have.

35 MS HUTCHINS: Operator, please call WIT.1311.0001.0001. Is this a copy of your
statement dated 27 November 2019?

MS LYSAUGHT: Yes, it is.

40 MS HUTCHINS: Are there any changes that you wish to make?

MS LYSAUGHT: No, there isn't.

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

MS LYSAUGHT: Yes, they are.

MS HUTCHINS: Thank you. I tender that statement, Commissioners.

COMMISSIONER PAGONE: That statement is exhibit 14.21.

5

**EXHIBIT #14-21 STATEMENT OF MS LYSAUGHT DATED 27/11/2019
(WIT.1311.0001.0001)**

10 MS HUTCHINS: Now, each of the witnesses on this panel today are registered
nurses who currently hold management positions at not-for-profit residential aged
care facilities. Starting with you, Ms Lysaught, you are currently the director of care
services at The Whiddon Group for two residential aged care facilities in Narrabri,
New South Wales.

15

MS LYSAUGHT: Yes.

MS HUTCHINS: And you have held this role since October 2018.

20 MS LYSAUGHT: That's right.

MS HUTCHINS: Prior to your current role you've had 40 years experience
working in the public health care sector, including working in a hospital emergency
as a registered nurse and a manager role and also as a clinical nurse consultant in
25 palliative care services.

MS LYSAUGHT: That's true.

30 MS HUTCHINS: And Ms Gardner, you are currently the clinical care manager at
Buckingham Gardens which is a residential aged care facility located in Brisbane.

MS GARDNER: That's correct.

35 MS HUTCHINS: And from 1984 you've worked in a number of hospital settings,
including in rehabilitation and surgical wards.

MS GARDNER: Yes.

40 MS HUTCHINS: And after a period of time away from nursing to have children,
following a lapse in your registration, you received a scholarship to commence a re-
entry course into registered nursing.

MS GARDNER: Yes.

45 MS HUTCHINS: Which you undertook and at the same time commenced working
as a personal care worker.

MS GARDNER: That's correct.

MS HUTCHINS: And you then worked for a residential aged care provider for a period of eight years before commencing your current role in November 2016.

5

MS GARDNER: Yes.

MS HUTCHINS: And Mr Woodage, you are currently employed as a facility manager for Baptistcare residential aged care.

10

MR WOODAGE: That's correct, yes.

MS HUTCHINS: For the past 10 years you've worked in residential aged care facilities as a facility manager.

15

MR WOODAGE: That's correct.

MS HUTCHINS: You've worked across five different organisations in Perth metropolitan areas. For these five organisations you've experienced working across 13 different facilities in Perth and regional areas in WA.

20

MR WOODAGE: That's correct, yes.

MS HUTCHINS: You are currently the facility manager at Gracehaven in Rockingham.

25

MR WOODAGE: Gracehaven in Rockingham and Graceford in Byford, yes.

MS HUTCHINS: And is the Graceford in Byford role a permanent - - -

30

MR WOODAGE: That's a temporary role which I've held since June and I will be handing that facility over to a permanent manager in January.

MS HUTCHINS: And how many residents do you have, Mr Woodage, in each of your facilities?

35

MR WOODAGE: At Gracehaven in Rockingham we have 98, and at Graceford in Byford we have 68 residents.

MS HUTCHINS: What is their profile in terms of acuity of needs?

40

MR WOODAGE: So in the Gracehaven facility we have two memory support wings of 16 and 10 beds, and the rest of the residents there are pretty much high care. We only have low care, traditional low-care resident, low in ACFI funding. And in Byford we have a 20 bed memory support unit and the rest of the 48 residents are high care.

45

MS HUTCHINS: Ms Gardner, how many residents do you have at your facility, and what is their acuity of needs like?

5 MS GARDNER: We have 50 residents in our facility. So our facility is done on a cottage model. We have five houses with 10 residents in each house. We have one dementia-specific house. We have two what we consider to be our high high-care houses, and we have two houses which are high care but with lower care – lower care requirements for the residents. So those ones are more mobile, and a little bit more independent.

10 MS HUTCHINS: And Ms Lysaught, how many residents at your facility and what are their acuity of needs?

15 MS LYSAUGHT: I manage two separate facilities at Narrabri, and together there's 98 beds. The acuity of needs ranges from low care to high-high using ACFI model, and so there's – and we – at one of the facilities we have dementia-specific unit.

20 MS HUTCHINS: And what are the arrangements that you have in place for access to GPs at your facility?

MS LYSAUGHT: Currently, we have four Narrabri GPs who visit the facility and they have – they self – you know, they come themselves and said that they would do that, and they visit on a weekly basis.

25 MS HUTCHINS: Do you have in place any types of formal engagement arrangements with them or is that done on an ad hoc basis?

30 MS LYSAUGHT: They – the formality is that they will come weekly and more frequently if we require them.

MS HUTCHINS: Yes. And is that pursuant to some type of, you know, written agreement or is that just a verbal understanding?

35 MS LYSAUGHT: It's a verbal understanding.

MS HUTCHINS: Ms Gardner, what are the arrangements that you have in place at your facility in terms of general practitioner access?

40 MS GARDNER: I have one GP who looks after 38 residents. I have one GP who looks after five residents, one GP who looks after two, and then a single GP who looks after one, and then the remainder of the residents see GPs outside in their own practices.

45 MS HUTCHINS: And what's the nature of the arrangements that you have between the facility and those GPs?

MS GARDNER: The same as everyone else's in terms of we have a, you know, a verbal agreement that they come to see their residents.

5 MS HUTCHINS: Yes. And Mr Woodage, is the experience the same at your facilities?

10 MR WOODAGE: That's correct, yes. Our verbal agreement with GPs. It's been over a decade since I've had a written agreement with GPs at a previous organisation, and I haven't seen a written agreement with GPs since then, yes.

MS HUTCHINS: What has been your experience in terms of the ability to obtain access to GPs within your facility? Is that something that you've needed to proactively engage in to obtain their assistance?

15 MR WOODAGE: Yes, I have in the past. Currently we – we are okay for GPs coming into both facilities. It is something that I actively have done at the Gracehaven facility is brought other GPs in. This has been by using contacts within other facilities that I've worked at, kind of head-hunting good GPs that provide really sound good clinical experience for the residents and also engaging in local GPs in the
20 area. So making appointments to see them in their practices, attending their practices to visit their residents, support them in community engagements as well. And it was largely those - the two main ways I've been able to obtain further GP services, especially for my Gracehaven facility which is in the suburb of Rockingham.

25 MS HUTCHINS: Ms Lysaught, you identify in your statement that there are some challenges in obtaining access to GP support in your facility. What do you think are some of the biggest barriers?

30 MS LYSAUGHT: The barriers are that the GPs are so strapped for time. They're doing this as part of their normal practice. So they will see people in their surgeries during the day. And so often they will visit us after-hours. And we have certainly have had no issues in getting a GP to see our residents. It's just that they are really strapped for time and, yes, they're supportive.

35 MS HUTCHINS: Ms Gardner, in your experience, what do you think are some of the challenges or barriers that you face when it comes to receiving GP access within your facility?

40 MS GARDNER: The same as everyone else, it's the time that they can spare. You know, GPs will come in their lunch hour sometimes. They will come after-hours to see them. Yes, they're just – GPs in a normal practice who have only got a limited number of residents, then they're very limited to the time that they can come. Our GP who comes one day a week, she comes to do a round. We have access with her through – we can phone her, we can email her, we can fax to her, so that does make
45 it a bit easier for us sometimes.

MS HUTCHINS: In previous hearings, the Commission has heard evidence to the effect that establishing more formal engagement arrangements between aged care facilities and GPs may result in better care outcomes for residents. The types of engagements might be, for example, entering into a direct employment relationship with a general practitioner who's on staff or entering into a service agreement. This is a question for – open to the panel. Do you think an arrangement like that could be possible for your facility in the current climate and if not, what are the types of measures or changes that you think might make that possible?

10 MS LYSAUGHT: I should mention that in rural areas these GPs also have – are visiting the hospital. So they have – so in our rural areas they also visit – have – they may be an anaesthetic or a surgeon as well. They have extended roles at the health services that they provide. I do see formal agreements as being helpful. However, as I said, it's a very positive experience that we have now.

15 MS GARDNER: I just think that if you had a formal agreement, you know, if it's – if the person's employed by the company or the business, then how do they have enough residents to be able to have their – a sustainable practice? Yes, it's – and there's no easy answer to that one, I don't think. I know that in the – when I worked for my previous company they did talk about employing a GP but, again, finding someone who is prepared to take on just aged care residents and in a limited number, is that sustainable for them.

25 MS HUTCHINS: Mr Woodage.

MR WOODAGE: I think if you were to do that they would be – unless you have a very large facility they would be forced to travel amongst facilities and more kind of co-share with other service providers in the local area. And to get that off the ground would be enormously difficult, I would imagine, both for funding and also travelling reimbursement, time lost because obviously their funding would come through Medicare, one would presume, and that would be, you know, travel time would not be taken into account. So yes.

35 MS LYSAUGHT: And we also are very lucky with the GPs because they have such a wide experience and they're seeing such a wide number of clinical issues in their practice. And this does help with us in our aged care facility. We're nursing more and more comorbidities in our aged care population, so to be able to care for them well, it's great that we can have someone with so much experience.

40 MS HUTCHINS: Mr Woodage, you note in your witness statement I believe that your concern of encouraging GPs to only work within residential aged care facilities might be that they lose that breadth of practice and experience?

45 MR WOODAGE: I think so. And I think that goes to – part of the issues that we heard from the previous witness this morning is – having GPs that are solely attributed to aged-care, I think, is largely a detriment to the scope of practice, and as the other lady just said, we lose that scope of practice that they have in thinking

outside the box and be able to look at the resident issue, especially with the comorbidities that we have from other different mindsets, which is helpful to our residents.

5 MS HUTCHINS: Going back to the practical experience that you have in your facilities with general practitioners – when they come to visit patients in your facility, where are those consultations held?

MS LYSAUGHT: With us they're held in the residents' rooms.

10

MS HUTCHINS: Ms Gardner.

MS GARDNER: And that's the same for us as well.

15 MR WOODAGE: Same for us.

MS HUTCHINS: And do residents in all of your facilities have private rooms?

20 MS LYSAUGHT: Yes. Some of our rooms are shared; however, if there was a GP seeing that resident, more than likely we would have the other residents out of the room. It'd be during a time when they were by themselves.

25 MS HUTCHINS: Yes. So if a requirement was introduced into the quality-of-care principles to the effect that residential-aged-care providers are obliged to provide a private room for GP consultations to occur, even say that could be a resident's own room that they're staying in – is that a type – the type of measure that you would support?

30 MS LYSAUGHT: It's a privilege, to be invited into a resident's room. It's their home. So often they want the GP to be there. So I've never – I haven't had a resident say "I don't want this person in my room", and I think they're proud to have them in their own home. So it's like a home visit.

35 MS GARDNER: It is, and they get to show off the things that are important to them in their rooms. And that gives the opportunity to generate conversations, and the doctors can then assess their mental health while they're talking to them.

MR WOODAGE: I agree; yes.

40 MS HUTCHINS: And, Ms Lysaught, in terms of residents that are sharing a room

MS LYSAUGHT: Yes.

45 MS HUTCHINS: Would you see any difficulties in ensuring that they have a private room available for those consultations?

MS LYSAUGHT: I don't – I believe – it's very similar to being in a public hospital and having that private curtain drawn around you for a conversation, although it's even high-lightened in an aged-care facility where these people are in their own home, sharing a room with people they know very well. So I don't see that as an issue, but I'd be alerted to that, certainly, if a resident – if it was a very private conversation, I'd make sure, that – I know my staff would ensure that they were left privately.

MS HUTCHINS: When a visitor – when a GP attends your facility to visit residents, is there any particular equipment that they bring themselves or that is provided by the facility that's required for those visits? I'll start with you perhaps, Mr Woodage.

MR WOODAGE: We provide very little equipment for the GPs. We have a sphygmometer and simple, basic nursing – more equipment, tend to expect the GPs to bring their own equipment, if they need to do more specialist treatments; we expect them to bring that with them. We don't provide that.

MS HUTCHINS: If a requirement was introduced – that aged-care providers be responsible for the provision of certain equipment – what would your views be on the appropriateness or otherwise of that?

MR WOODAGE: Generally the outlay to purchase that equipment is quite high, to maintain that equipment is quite high, and we are not funded in residential aged-care for that specific need. So there would need to be funding allocated along with that, in my opinion – to be honest.

MS HUTCHINS: Yes. And, Ms Gardner, what's the position in your facility in terms of the provision of equipment for general practitioners?

MS GARDNER: All our GPs will bring their own equipment that they might need to examine a resident with. We're the same as everyone else. We'll provide equipment for – dressings, that sort of thing. We have beds that are – we can raise and lower; so that makes it easier, for the GP to deal with any procedures that they might want to do. Yes. Lighting is always a big issue, having a good light for them if they're doing some kind of a procedure, making sure, that – yes, that your environment's well lit.

MS HUTCHINS: Yes, and so when it comes to ensuring adequate lighting or that it's well lit, is that a matter of, say, making a lamp available – that might work or that there needs to be a consultation in a particular room that's lit appropriately?

MS GARDNER: In my previous role we had a room set aside – that had a nice lamp in it. Currently we don't have anything like that. My facility's little, and so access to storage for any of that sort of stuff becomes an issue as well. But – yes; we should – there are things that we can provide for them, but there are things that they need to bring for themselves as well.

MS HUTCHINS: Yes. And would you have any concern about the introduction of a requirement requiring facilities to provide particular items?

5 MS GARDNER: Again it's that financial position that we're all in. We only have so much money, and being able to provide medical equipment, which is costly, because it's called medical equipment, makes it difficult for facilities.

10 MS HUTCHINS: And, Ms Lysaught, what's the position in your facility in terms of the equipment for general practitioners?

15 MS LYSAUGHT: I, certainly, would – none of the GPs have ever asked me to provide any specialised equipment. The only one that's ever bought specialist equipment is the dentist, when he's visited. So – look. I work for a wonderful company that, I'm sure, would say, if we needed something, "Buy it", and we're happy to meet regulations

MS HUTCHINS: Yes. And – well, perhaps outside of your particular expertise, do you understand you're in that position by virtue of your not-for-profit status as well?

20 MS LYSAUGHT: Yes.

25 MS HUTCHINS: When it comes to GPs visiting residents within your facilities, what do you see as the role of your staff in providing assistance to – sorry – in providing clinical assistance to the general practitioner? Perhaps, Ms Gardner, I could start with you.

30 MS GARDNER: I do the round every week with the regular GP who has the most residents. So that will take us anything up to about three hours to get through. I, certainly, make sure, that when – the other GP who comes to site are also escorted by registered nurse, if I'm not available, so that we can support the GP through their visit and we can support the resident through the visit.

35 MS HUTCHINS: And what is the practice that you have in place when it comes to information-sharing with the general practitioner about residents' care histories and current medications and status and whatnot?

40 MS GARDNER: All the GPs who come to site have access to our electronic care system. The lady who comes every week: she hops on the computer and does what she needs to do and will look at everything. The others – usually, we talk to them, and we will provide them with a printed-out copy, or we'll show them on the screen what's been happening.

45 MS HUTCHINS: Yes. And then how are their notes – where are their notes entered into?

MS GARDNER: So my weekly GP: she will go back to her clinic and write up her notes straight into our system. Our other GPs: we give them a progress-note page,

and they write their progress-note entries onto that, and then we scan them into our electronic system.

5 MS HUTCHINS: Yes. And, Mr Woodage, what's the process at your facility in terms of clinical assistance that's given to GPs when they visit patients?

10 MR WOODAGE: So we prefer to have a registered nurse with the GP; like some of the other ladies have said, sometimes our GPs, especially GPs that may only have a handful of residents, will come after hours, after their surgery is closed for the day, and sometimes that can be a little difficult to do; at my Rockingham facility we're
15 lucky enough to have three enrolled nurses of the afternoon. So, generally, then they will assist the GP. We have GPs that do multiple things; so – some that will go back and write in their progress notes on their GP management and send that through as an email to my registered staff. Some will write in the electronic notes while they're on the facility, and then some will write in the electronic notes when they're back at their GP practice, and it integrates between the GP-management record and our electronic record; yes.

20 MS HUTCHINS: Yes. And of those various approaches taken - - -

MR WOODAGE: Yes; we have everything.

25 MS HUTCHINS: As a bit of a sense – what proportion of GPs are entering their notes straight into your system, compared to how many your staff are then required to manually put in?

MR WOODAGE: On – so the GPs that do it on site would be the majority, and then only one or two currently that do the other options.

30 MS HUTCHINS: And in terms of GP attendances that you mentioned that will occur after hours perhaps when a registered nurse might not be on - - -

MR WOODAGE: Yes.

35 MS HUTCHINS: How is it, that information is exchanged with that GP when they enter the facility?

40 MR WOODAGE: So if we – largely, the GPs will let us know they're on site; sometimes they don't, and at my Rockingham facility half our residents have their own doors to the outside. So particularly – one of the GPs will enter through the side door; so generally it's actually, that the resident's telling us that the GP has just been, and then the nurses will ring the GP to get the handover as an interim – waiting for the progress notes, but largely it's the GP making themselves known to the registered staff or the enrolled nursing-staff and they're on site and they're – to see
45 the residents, if they've got any other referrals who needs to be seen or if there's anybody that's unwell that they need to see while they're there. That's the general practice.

MS HUTCHINS: Ms Lysaught, what's the practice at your facilities in terms of the provision of staff to assist general practitioners when they visit?

5 MS LYSAUGHT: It's an expectation, the registered nurse will provide a round with the doctor, and so what's what happens with us.

MS HUTCHINS: And what is the process in terms of exchange of information between your facility's staff and general practitioners?

10 MS LYSAUGHT: So in the – between visits, the GP may receive a phone call, if it's urgent, or a fax sometimes, but there's a – we also keep a log of concerns that can wait for the – till the visit. Then they are given to the GP when they arrive.

15 MS HUTCHINS: And in terms of records of the general practice – the general practitioners' attendances – how are they communicated to your staff?

20 MS LYSAUGHT: None of our GPs currently write into our electronic record. So there's a paper base, like the notes we were just talking about, that are kept separately for the doctors to write into, and that information is passed on in a short-hand over to me every morning, after – we do it daily, but after doctors' rounds, any changes made: they're put directly in the notes by the registered nurse, and I also get a copy of that.

25 MS HUTCHINS: Do you see difficulties ever arising in relation to a lag in time – of the timeliness of information that could occur because of these different processes that are not, I guess, mirrored together with the use of some common information-technology systems?

30 MS LYSAUGHT: It's not perfect, but it's working for us at the moment.

MS HUTCHINS: Do you think your facility would benefit from the use of a care-software program that was interoperable with the general practitioner's systems?

35 MS LYSAUGHT: That would be wonderful. That would be wonderful. It would be – I'm sure, we'd all agree with – that'd be great.

40 MS HUTCHINS: And do you have a sense of what the general practice – your general practitioner's appetite might be in becoming involved in the use of a system like that?

MS LYSAUGHT: I'm sure, if they, especially, had the choice of either doing that on their visit or after, in their rooms – that would be also really helpful for them.

45 MS HUTCHINS: Ms Gardner, do you have a view about whether you would support a requirement introducing a care-software platform that's interoperable with third parties such as general practitioners?

MS GARDNER: I think, if we could have access to the notes of general practitioners who don't come to the facility – that would be good, because often we don't see a lot of notes from those GPs. So we don't really have a great understanding of what's going on; yes.

5

MS HUTCHINS: Mr Woodage, what would your view be in relation to a requirement to introduce some interoperable software system?

MR WOODAGE: I think it would be ideal; yes. I think nowadays in my interactions with GPs there's very little that don't have a GP-management software or electronic records back at their practice. So I think a lot of GPs are already using some form of electronic record-keeping, and to have that interface with our system and My Health Record going forward, if people choose to have that as an option would be – would be great.

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COMMISSIONER PAGONE: Was it Ms Gardner who said that there are some GPs who enter the details directly into your system from their practice or was it - - -

MS GARDNER: I have one GP who does that, yes.

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COMMISSIONER PAGONE: Who does it? Was it difficult to get the – is that through a particular software or a hard software to find or is it something you could buy down the local shop?

MS GARDNER: No, in – in – we use a program called AutumnCare and we give the GP permission.

25

COMMISSIONER PAGONE: To enter your site.

MS GARDNER: To enter – enter that, yes. She has limited access to what she can actually see of all the charting and stuff that we have, and she has limited access to what she could write on. For example, like if we have a diabetic health directive, she can't – she can't write on that; she has to actually come to site and write on that, but she can do her progress note entries externally.

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COMMISSIONER PAGONE: So that is a system, a process where you give a GP access, limited access to your software?

MS GARDNER: Yes.

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MS HUTCHINS: I turn next to the topic of access to specialists. Ms Lysaught, in your regional location, do you find access to specialists difficult?

MS LYSAUGHT: It's difficult in that they're highly sought. So they may only visit a health service or practices in town, you know, monthly or every second month. So their appointments are highly sought.

45

MS HUTCHINS: Yes. And do any of those specialists visit your facility?

MS LYSAUGHT: No, none of them currently visit our facility. We have to go – we actually – the two facilities I manage are positioned either side of the hospital so
5 that makes it easy for us, but usually the specialists visit at the hospital.

MS HUTCHINS: So how are residents usually transferred from your facility to see the specialist?

10 MS LYSAUGHT: Either we would make – we would take them ourselves or family members might choose to take them. So either – if it's something we have to book an ambulance for, we would, or we could take them in our cars.

MS HUTCHINS: Yes. And what are the most common types of specialists that
15 your residents need to see?

MS LYSAUGHT: We've got a visiting gerontologist who comes from Tamworth, so he, you know, we do like our residents to see him and often they've been seen in the community by this man so it's lovely to have that continuing care.
20

MS HUTCHINS: Ms Gardner, how is access to specialists for your residents?

MS GARDNER: I work in a metropolitan area so we don't have any difficulty accessing specialists.
25

MS HUTCHINS: And do any of the specialists see your patients within the facility?

MS GARDNER: I have a visiting psychiatrist.

30 MS HUTCHINS: How often does that psychiatrist come?

MS GARDNER: Hopefully every three months.

MS HUTCHINS: And when your residents need to see a specialist, how are
35 transfers arranged?

MS GARDNER: If they're seeing a specialist through the hospital system, so in the public system, if they're mobile, then usually their family member will take them. If they're not mobile, we will organise the Queensland Ambulance Service to transport
40 them to their appointments. If they're seeing a private specialist in his private rooms, if they require stretcher transport, they generally don't go because you can't get stretchers into those sorts of spaces. If they're going to see a specialist at a private hospital's outpatient clinic, then we will just – family transport or Queensland Ambulance if that's appropriate.
45

MS HUTCHINS: So when you say if the private rooms aren't appropriate to be able to receive - - -

MS GARDNER: Usually they've got narrow corridors or tight doorways, so stretchers – or a short lift. You know, a lift has to be big enough to put a stretcher in
- - -

5 MS HUTCHINS: Yes. And so what will occur in terms of next steps for that resident's care in circumstances where they can't see the specialist that they were needing to see?

MS GARDNER: It would depend on why they see the specialist. If it's just
10 continuous routine follow-up care and the person has become bed-bound, it might be a family decision about whether they want to continue to see the specialist. If it's – and a problem that is ongoing that needs a specialist intervention, it might be that we have to have them referred to the public system so then we can get them to their appointments.

15 MS HUTCHINS: And what are the most common types of specialists that people in your facility need access to?

MS GARDNER: Cardiologist, nephrologist, so kidney doctors, renal doctors,
20 orthopaedic specialists, geriatricians, ophthalmologists.

MS HUTCHINS: And have you ever asked any of these specialists to attend at your facility?

25 MS GARDNER: Every now and again I try.

MS HUTCHINS: What's the response you usually receive?

MS GARDNER: Well, the answer will always be no.
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MS HUTCHINS: Are you ever given a reason?

MS GARDNER: They're specialists; they don't have to give reasons.

35 MS HUTCHINS: Sure. Mr Woodage, how has the experience been at your facilities in relation to access to specialists?

MR WOODAGE: So with geriatricians, we found an increase in access and then they - besides I forgot earlier in my statement about the psychiatric services that are
40 provided. So besides psychiatric and the geriatricians, we don't get any other specialist medical. Dentistry will come in. The government dentistry.

MS HUTCHINS: To be clear, were you saying that the geriatricians will visit at the facility?
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MR WOODAGE: Yes, they will. Yes, geriatricians will, but no other specialists will visit in the facility.

MS HUTCHINS: Yes. And are the geriatricians visiting on an as-needed basis or
- - -

MR WOODAGE: As needed. That's correct. Yes. Yes, so per referral. Yes.

5

MS HUTCHINS: And are they private geriatricians or through the public system?

MR WOODAGE: Through the public system. Yes, yes. Dermatologists will occasionally come in. We have two very good dermatologists south of the river in Perth, two brothers, and they will come in on referral. It's normally about a six week wait and normally it's while their daughter is at hockey or something in the local area that they will come into the local aged care facilities. So you normally don't get a warning that they're actually coming, and yes, that's about the only other specialist that will come in.

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MS HUTCHINS: Yes.

COMMISSIONER BRIGGS: Can I ask a question there. Clearly, specialists can earn a lot more money by seeing people in their rooms or in private hospitals or so on, and so they don't feel a financial need to attend. But the question is, is there a moral and ethical need to attend? And I would like to hear your views on that, please.

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MR WOODAGE: I think our residents go without and we have conversations, really around treatment options quite often because there is a lack of access, especially when people are bed-bound or large wheelchair-bound that they can't go and visit specialist centres, or they have to go through outpatients which sometimes then if treatment is an option, means going through the ED system and through the hospital system for our residents. And I think we can all safely say that's not a good thing.

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COMMISSIONER BRIGGS: So would it be appropriate for the various colleges associated with the various types of surgery practices and possibly also the AMA to be invited to consider these possibilities?

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MR WOODAGE: Yes, I think so. I think so, yes, yes. Thank you, Commissioner.

COMMISSIONER BRIGGS: The views of the other members of the panel, or is it just a waste of time?

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MS GARDNER: I don't think that you could make them do it. I think, you know, if we could have a list of people who are prepared to come, that would be really helpful because then we could, you know, make appointments with those particular people. I mean, I understand that they're busy - they're busy people, they have a lot of people that they have to see. And yet, we work in aged care and the requirement for all the - the perception that people in aged care don't need that type of specialist input is out there.

45

MS LYSAUGHT: I manage two very rural facilities and visit other facilities, and these are full of people who have waited a long time or travelled a long way to go and see a specialist, all their lives usually. So I don't feel that if we're lucky enough to get visiting specialists, they're happy and their families are happy to go next door to a hospital if that's what it means, or travel to – you know, oncology is an ongoing issue because oncology services are a long way away from us, especially if you're not feeling well. However, these are country people who have done that all their life so it's something we accept, I think.

10 COMMISSIONER BRIGGS: I understand. Thank you.

MS HUTCHINS: Turning to the topic of nurse practitioners, Mr Woodage, do you have any experience working with nurse practitioners in your facilities?

15 MR WOODAGE: I do, yes, yes. Quite varied, yes.

MS HUTCHINS: And what role has the nurse practitioners played?

MR WOODAGE: So we've had nurse practitioners that work alongside or underneath a group of GPs, or a single GP. I have had an organisation where we actually contracted out some nurse practitioner services and got a local – one of our GPs that service that facility to actually sponsor the nurse practitioner. The benefit for our residents in terms of accessing nurse practitioners is they have more time than the GPs, so they can gather more in-depth personal history than the GPs can. They act a little bit like that coordinator, clinical coordinator of care, especially with increasing comorbidities for our residents. Someone with a kind of finger on the pulse of what's going on and pick up things and alert things, then there's the advantage of increased simple medical care through antibiotics, pain management, prescriptions, things like that that the nurse practitioners can provide. So it provides a more timely, accurate and in-depth service to our residents.

MS HUTCHINS: Yes. And in your experience have those nurse practitioners been employed by the facility or have they been associated with the general practitioner's practice?

35 MR WOODAGE: So we didn't employ the nurse practitioners but we contracted – had a formal agreement in place and then I've also had nurse practitioners with the GPs and working under the GPs.

40 MS HUTCHINS: Yes. Ms Gardner have you had any experience with nurse practitioners at your facility?

MS GARDNER: We've used the dementia outreach service so that's headed by a nurse practitioner and we've had meetings with her in the past about managing residents. And I also have – we have another lady who visits a specialist who has a nurse practitioner in his practice and so we've had dealings with her as well.

MS HUTCHINS: Do you see a benefit in the nurse practitioner role in terms of do you think they have a place within the system that you would like to see encouraged?

5 MS GARDNER: I think if you've got a big enough facility or facilities that are in really close proximity to each other, you would have major benefit from having one. Churches of Christ have a facility at Bribie Island that has a nurse practitioner attached to it, and that makes their life easier because they're a 30-minute drive from the local hospital and their GPs don't come in – their GPs visit regularly but don't come after-hours, sort of thing, so they are quite reliant on nurse practitioner to order
10 them things like antibiotics and Panadol.

MS HUTCHINS: Would you be comfortable with an arrangement where, say, your usual general practitioner practice has the supervision for nurse practitioner staff who could come into your facility and do particular tasks or duties under that supervision
15 of the GP?

MS GARDNER: I think in my facility, because it's so small, there's probably no – not really any benefit even from a GP's perspective but certainly, you know, in facilities that are larger.
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MS HUTCHINS: Ms Lysaught what's your experience with nurse practitioners in your facility?

MS LYSAUGHT: Unfortunately, we haven't got access to nurse practitioners. And the further west you go the fewer there are, I'm afraid, yes.
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MS HUTCHINS: Is the role of a nurse practitioner as an individual you might be able to access, say, through an outreach service or through your general practitioner, is that something that you would have a use for in your facility? Is there a need that they might be able to fulfil?
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MS LYSAUGHT: I think there's a fantastic scope of practice, especially with dementia care, that there could be a lot of work done by a nurse practitioner. I have a great deal of respect for their roles.
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MS HUTCHINS: Would you encourage any recommendations around additional funding or, say, a scholarship program for a nurse practitioner role to try to encourage development of that section of the workforce?

40 MS LYSAUGHT: Currently, the – all the facilities that I know and including the health service, the hospital are having a terrible issue recruiting staff. And that is simply registered nurses. There's lots of roles open. My biggest concern is there wouldn't be – this is a recruitment issue that - I can't see how if we can't fill registered nurses roles, how are we going to fill a specialised area like that. To me,
45 that would be a big issue for us.

MS HUTCHINS: Mr Woodage, did you have something you would like to add?

MR WOODAGE: I would like to see that – you know, a scholarship thing for nurse practitioners, but agree that trying to get sometimes qualified good registered staff is hard enough, even in the metro areas. If we were to have that as a requirement, it would be very difficult to meet, but have that available would be good, I think, too,
5 for nursing in general and aged care in general, yes.

MS HUTCHINS: The next topic we turn to relates to the role of a care coordinator within aged care facilities. Who do you see as being responsible for the determination and management of your residents' care needs within your facility? I think, starting with you first, Ms Lysaught?
10

MS LYSAUGHT: I believe we totally are - as providers, we're these people's advocates. We know them really well, especially country areas where a lot of my staff have known some of their residents - - -
15

MS GARDNER: All of their life.

MS LYSAUGHT: All of their life. That's right. So we are their greatest advocates so I believe it's our role.
20

MS HUTCHINS: And if there was an introduction for a requirement that there be a designated person for each resident's care coordination, who do you think that appropriate person would be?

MS LYSAUGHT: With Whiddon we have what we call – sorry, I just got a bit – we currently work under a relationship-based care system where – where our residents are assigned or – or it just happens by nature, a person. So we actually know a lot about their care and a lot about their needs to start with. So I think it's – it suits our model really well that – that that's what we would do.
25
30

MS HUTCHINS: Yes. And what do you think the minimum level of training or qualifications or experience would you expect a person should have to be able to properly fulfil a care coordinator role?

MS LYSAUGHT: I think a care coordinator role should be a registered nurse or in some cases an experienced enrolled nurse because we – I think we've agreed today we've got fantastic enrolled nurses. And not taking away from the fact that assistants in nurses don't have that insight. However, I believe that a care coordinator role should be one of a registered nurse or an enrolled nurse.
35
40

MS HUTCHINS: The suggestion has been made that general practitioners might be the appropriate person to take on that care coordinator role. Do you see that there's some advantages of having facility staff perform that role which, I guess, might be shortcomings of general practitioners being in that position?
45

MS LYSAUGHT: The shortcoming I see in a general practitioner doing that role is the fact that they are not with these people like we are for eight hours a – or, you

know, for a longer period. We have the time. We have the knowledge. We are their – we start off as advocates for them. We know these people.

5 MS HUTCHINS: Ms Gardner, do you share a similar view or different?

MS GARDNER: From my experience in the facility that I work in, I'm the clinical care manager. I don't have a care coordinator, but in a larger facility the clinical care manager would have a care coordinator role underneath her who would do what it says, coordinate the care of the residents. They're the ones who – who see the residents frequently and know what's going on with them. So in my facility, my registered nurses know all of the residents, I know all of the residents, and so between the two of us, we will cover that – that role of a care coordinator and we will share what bits of coordinating needs to be done. I think it's a RNs role, I think, because we – we're the people who are with the residents all of the time and we advocate for them.

MS HUTCHINS: And do you think it would help to encourage better health outcomes for residents if there was a clearer identification of responsibility for who that care coordinator is?

MS GARDNER: Again, I think it depends on the size of the facility. In a big facility you do need those care coordinator – that level of registered nurse because then they're overseeing what the other more junior registered nurses are doing, and they can pick up on what's happening with the residents. In a small facility like mine, that's my role as well.

COMMISSIONER BRIGGS: Can I ask a question to both of you. And it's around the line of sight of a particular care coordinator. The reason I ask, the prelude to that is we've heard a lot of evidence about how there might be a single care coordinator for an entire aged care facility and they've got Buckley's chance of knowing the people and working with them and delivering the care. So are there insights that any of you might wish to give or one after the other around what is ideally the scope of practical practice in this regard?

MS LYSAUGHT: Currently, a registered nurse is assigned or given residents' care provisions for things like reviewing care plans. So in the – they have a number of residents that they would – we would assign. So I see that as – they are – they are doing that care role now, in my facilities – at Whiddon facilities, that's what we do. So I guess it makes – it's a smaller bite of a large number of residents. So that's how I see that could be done.

MS GARDNER: I've lost track of the conversation again. Could you ask the question again - - -

45 COMMISSIONER BRIGGS: Sorry, I'm neglecting you and learned counsel, too, I fear. But it's fundamentally around what is the scope of a practical arrangement for

care coordination in a facility in terms of numbers of residents that a care coordinator can usefully and, indeed, effectively look after?

5 MS GARDNER: I could say that I've got 50 residents currently that I do that for
and in my previous role I had 60 residents that I did that for because I was the
registered nurse on the floor, five days a week looking after them, so I knew what
was happening with them all of the time. Is there a finite number that they should be
looking after? I think it depends on how you describe their role to them, you know,
what do you want the care coordinator to do. Because they're there to oversee
10 what's happening with the residents. It's about having – the registered nurses look
after them on a day-to-day basis and the care coordinator going, this is what we're up
to with this resident. Have we thought about doing this or do we need to do this, or
who have we spoken to about what we need to do for the resident or what the
resident needs, not what we need to do, but what the resident needs, yes.

15 MR WOODAGE: And I think that is the – to answer the question is how much they
can take on and who really does this role. My facilities, we tend to use more of a
team-based approach. We are lucky enough to have physiotherapists and
occupational therapists as well as the clinical and registered staff employed. So we
20 take this role on, really, as a group, rather than an individual. Our RNs and ENs
work together to create and formulate, assess the residents, get to know the residents
and redo their care plans, but I think this is a more senior level than just the RN on
the floor, and it probably takes some expertise or training really to coordinate and do
quite well. So I think for that instance it is – comes down to competing priorities of
25 the registered staff on the floor and what they actually have to do in their day-to-day
job.

Our clinical staff up the line and where they, you know, are doing – if you've got
them, if you've got a facility that's big enough to have more senior clinical staff, how
30 that role fits in and whether that's assigned to an individual for a certain number of
residents or a team of individuals, and I think then the hardest thing to do and
coordinate all of that is that a lot of our staff are part-time rather than full-time. So
our physio, our OTs we will share across other facilities within the organisation. Our
RNs, ENs, a lot of them are part-time staff so it's – they're not there a large – they
35 may only be doing 30 hours a fortnight or 40 hours a fortnight so to have them
coordinating care when they're not there a large chunk of the time then becomes
quite problematic, and then you have that rolling over from morning, afternoon and
night and having that all coordinated, so yes, it becomes quite a big issue.

40 COMMISSIONER BRIGGS: It's certainly a challenging conundrum.

MR WOODAGE: It is.

45 COMMISSIONER BRIGGS: Counsel.

MS HUTCHINS: And would you see the introduction of particular funding mechanisms to support a greater role of the care coordinator within a facility as being something that would be beneficial?

5 MR WOODAGE: Yes.

MS LYSAUGHT: Yes.

10 MS HUTCHINS: Do you think that the time that would be currently spent in, say, coordinating, you know, GPs or other external specialists is adequately funded through the current ACFI system?

MR WOODAGE: It's not funded at all. Yes.

15 MS HUTCHINS: And in relation to how the role of, let's say, a nurse practitioner coordinator, care coordinator might work in practice, do you see any difficulties with the fact that GP supervision of a person's care is a required element in that equation? Ms Lysaught?

20 MS LYSAUGHT: Sorry, you will have to repeat that one again. Sorry.

MS HUTCHINS: Sure. So is the fact that the GP supervision of a person's care needs in residential aged care is a component of the equation, do you think that that means that a nurse practitioner sitting in the facility kind of independently –
25 independent of that GP system might present some difficulties in being able to effectively coordinate the care that's being provided?

MS GARDNER: I think it's about having good relationships, isn't it. If your nurse practitioner has got a good relationship with all of the GPs then things will work
30 really well. If people don't have good relationships then things start to fall apart.

MS LYSAUGHT: And for all of the negatives living in the bush has, relationships is one of the positives; you know, it's a really good – we have a great relationship with our GPs and visiting specialists.
35

MS HUTCHINS: Thank you. In your statements you've each identified different outreach services that your facilities access. During the course of this week's hearings, the Commission is testing a proposition about supporting the introduction and funding of a local hospital network-led outreach health service for people in
40 residential aged care services. Part of this service might involve the availability of multidisciplinary teams which would include, say, people like nurse practitioners, allied health practitioners and pharmacists, along with access to care groups of relevant specialists.

45 Do you think that access to an expanded scope of hospital-led outreach services of this nature would be of assistance to your facility in the delivery of care to your

residents? I know there's a lot in that question, so I might start with you, Mr Woodage?

5 MR WOODAGE: I think so. I think that would be beneficial to have, and when you add in the My Health Record in, you know, coming – I know we have it, but not a lot of our residents and we don't have access to it largely, but I think if you add that scope into tying into our electronic record systems, having a central place in the local hospital for our residents and for coordinating of the care, especially specialist care and as we have comorbidities for our residents that increase as we live longer, that's
10 an area where we're going to have more need. And we're seeing that in residential aged care. We're expected, I think, societally and governmentally through that to actually have a better finger on the pulse of what's happening with our residents. So to have that access to better specialist networking and coordination would be very – a very welcome change, yes.

15 MS HUTCHINS: When we're looking at the design of what an outreach service like this might involve are you able to point to any limitations in the current outreach services that you obtain that you would like to see improved - - -

20 MR WOODAGE: Yes.

MS HUTCHINS: - - - in kind of any system – a model that might be rolled out?

25 MR WOODAGE: Yes. After-hours service is pretty much a limitation that we have at the moment through our outreach services. There's – once 6 o'clock rolls around, there is no kind of service availability. The only service availability is ED.

MS HUTCHINS: Yes.

30 MR WOODAGE: So – yes; that's where you do see more presentations to hospitals overnight, because one – our staffing-numbers are always reduced overnight. While we have registered staff on the floor at both of our facilities overnight, the availability for outreach services is not there. And it's a long period of time after hours.

35 MS HUTCHINS: In your statement you identify that the availability of X-ray equipment within the facility is something that would be of benefit to your residents. Do you think that's something that should be included in the types of services that would be offered?

40 MR WOODAGE: Yes; to have a mobile X-ray that is publicly funded would be a good thing. There is one in Perth that is private. That doesn't come to any of the areas that I currently manage. And to fork out – it is quite expensive in terms of – four, five hundred dollars a visit. So for families, the benefit of having to spend that
45 sort of money as opposed to putting Mum or Dad in ED through a hospital – for ambulance, which is free – while that – I think having a mobile X-ray ability would, definitely, be – lead to better outcomes for our residents and less hospital transfers.

MS HUTCHINS: Ms Gardner, do you have any views about whether a multi-disciplinary outreach health service of this nature is something that you would encourage?

5 MS GARDNER: I'd like to see, probably, more specialists attached to an outreach service. Currently we have access to CARE PACT, which, I think, you spoke with yesterday; so – they have a geriatrician who heads up their team. I'd like to see more specialists, I think.

10 MS HUTCHINS: What about you, Ms Lysaught?

MS LYSAUGHT: I've had a very positive experience with Hunter New England Health in the public system with the use of multidisciplinary services, especially in Aboriginal health. And I've seen the comorbidities decrease, because they really
15 work. Those systems really work; where specialists are brought into an area, people are seen and treated and the care is co-ordinated. So I think this would be wonderful. We've done it in public health; so it'd be great, if we could have more access to that.

MS HUTCHINS: And for areas like yours, where there is not a ready – not an easy
20 access to specialists, do you think that services such as telehealth could play a greater role in the delivery of care to your residents?

MS LYSAUGHT: They do. They're clear and concise; the specialist can see that
25 person. And what I've found, especially in my experience with residents receiving oncology treatment – and often until their death they may have chemotherapy. I offer that to all our residents. "You don't have to travel to Tamworth; you can actually – we can arrange telehealth", and often it's about the relationships; they formed a relationship with people at those units, and they want to go back. So that's the only thing that's stopped us using it in the past, but we do have access to that at a
30 cost to us, but we can use it.

MS HUTCHINS: Yes. Do you use telehealth at your facility, Mr Woodage?

MR WOODAGE: No; we don't have any telehealth facilities or ability in my
35 current facilities. It is something that I set up or helped set up when I was a student nurse in regional areas of Western Australia many, many years ago. It is something that through another organisation there was about 2012, 13 – may be before that – some funding from telehealth through the Government – to set up. And the organisation I did work for at the time – we did set up telehealth. Unfortunately
40 there was a lack of take-up back then with specialists using it, and to get the funding off the Government you actually had to do a – I think it was two or three sessions on telehealth. So largely it ended up coming out of that organisation's back pocket, because we couldn't engage in the specialists in the local area to do that, but it is something that, especially in Western Australia in public health, has increased. So I
45 think going forward, if that was available – would be beneficial.

MS HUTCHINS: What's your view, Ms Gardner, in relation to encouraging the use of telehealth?

5 MS GARDNER: I think telehealth would be great for residents. It would save them having to be transported for their appointments. We used telehealth for wound care before, which now is a fee-for-service program; so we don't use it anymore. So we now rely on CARE PACT for that sort of thing. We do have another resident who has been seeing his specialist by telehealth, and we plan to continue to do that for him.

10 MS HUTCHINS: In relation to hospital transfers of residents to and from hospital, the Commission is testing the idea that the national health-reform agreement should include a requirement that discharge from the hospital to residential aged-care should only occur once a discharge summary has been provided by the hospital and
15 acknowledged by the residential-aged-care facility. Mr Woodage, firstly would you support such a requirement, and do you currently experience any difficulties in this regard which such a requirement might address?

20 MR WOODAGE: I think I'll go backwards first, as we have enormous difficulty, getting discharge summaries. We even have difficulty, receiving information to say that a handover – to say that our resident is actually going to come back from hospital to us in the residential-aged-care facility. We will still often have residents come back by an ambulance, and that's the first thing we know, that they've – the ambulance are knocking on the door. We see them driving in the carpark and going,
25 "Who's – no one's going; who's coming back?". So to have that would, definitely, address – we have – my manager went to some education back in September, August, September, where she was told that under standard 6 – and I believe it's the National Health Standards for public hospitals – they actually have to provide a discharge summary to the residential-aged-care facility.

30 And I had an experience a couple of weeks ago where one of our local hospitals was refusing to provide a discharge summary to my nurses, refusing to provide a handover to my nurses of a resident that had been in hospital for an extended period of time. My nurse was quite distraught at this and came and told myself, and I said –
35 gave her this information. I – "Ring them back; tell them under standard 6" – and within two minutes we had that discharge summary on the printer, faxed to us, which meant, that the hospital, one, was lying to us, that they had prepared a discharge summary and they just weren't prepared to give it to us and, two, that they have the information at hand to give us a handover and they were refusing to do that. So to
40 have this as a requirement previous to the residents returning would solve quite a few of our issues that we have with our public system that we see, yes.

MS HUTCHINS: Yesterday – just because of the time I will now direct questions to each of you in turn; yesterday we heard evidence from Ms Tess Oxley, who is a
45 paramedic, who gave evidence to the effect that sometimes, when ambulances attend a residential-aged-care facility, there will be no one there to see them. Ms Lysaught,

do you have systems in place to be able to meet paramedics and provide them with information when they attend your facility?

5 MS LYSAUGHT: Yes; it's the continuum of care. We want our residents, who should be at the centre of all this, to get the best care when they're coming or going. So it's an expectation that they'll be given a complete handover and be given documentation, the appropriate documentation to take or be received back.

10 MS HUTCHINS: Yes.

MS LYSAUGHT: It's about continuum of care.

15 MS HUTCHINS: And when you say "appropriate documentation" – a suggestion's been made for the introduction of a requirement by amending the quality-of-care principles, which mandates the provision of certain information to ambulance officers when they attend. Would you support such a proposition? Do you think it has any practical difficulties?

20 MS LYSAUGHT: I certainly would support that. Our ambulance officers are highly-qualified people, and we want them to – we have to feel safe at handing over care of the people we care about to them. So – I don't see any issues with – I can't imagine there'd be an ambulance officer who wouldn't expect the same.

25 MS HUTCHINS: Ms Gardner, what's your views on the appropriate of mandating a requirement for information exchange?

30 MS GARDNER: It's something that we should just do automatically. It's about continuing the care of our residents from our care to the next person who's got them, and I – it's just something that we should just do.

35 MS HUTCHINS: And in terms of the information to be exchanged it's been suggested, there should be an up-to-date summary of the resident's health status, including any medications and any advance-care directives they may have. Do you think that that list goes far enough, or there should be further - - -

40 MS GARDNER: Well, for example: I would provide them with the summary care plan, the medication chart, the comprehensive medical assessment, which is the GP's document. I send pathology results. I send any sorts of observation charts, weight charts, bowel charts. I try to give the hospital as much information about this person as I can to make their job easier as well.

45 MS HUTCHINS: Yes; the Royal Commission has heard evidence that there are too many ambulance callouts for residents who could've been cared for within the residential-aged-care facility - - -

COMMISSIONER PAGONE: Ms Hutchins, just before you go there – I know we’re running out of time, but could I just ask Ms Gardner this question. Why do you think that it sometimes doesn’t happen?

5 MS GARDNER: That the information doesn’t get shared?

COMMISSIONER PAGONE: Yes.

10 MS GARDNER: Sometimes like – we use a yellow – the yellow-envelope system to indicate that the person is in residential aged-care; sometimes the yellow envelope gets lost somewhere in transit. Sometimes it turns up at hospital but it gets lost at the hospital. Sometimes, even though you’ve provided them with all that information, the hospital will then ring you and say “What does this person eat?” or “What’s their mobility like?” or “What’s been happening with them?”, because they just want a bit
15 more background information than they get through the documents that you’ve supplied them with.

COMMISSIONER PAGONE: I suppose I was really asking you a different question. So we’ve heard that sometimes the facility doesn’t give the information.
20 Now, I’m not asking you to ’fess up about whether you do or you don’t. I’m accepting that you always do, but why might it be, that in some facilities it doesn’t happen, that there’s a transfer of information?

25 MS GARDNER: I guess sometimes that depends on how fast the ambulance service arrive.

MR WOODAGE: And if the nurse can – sorry to interject. If the nurse can leave that resident safely to actually print off that information to give to the ambulance officers – they would be the only times I could see that that information isn’t given;
30 because if the nurse can’t safely leave the person to go – or after hours, when you’ve got limited staffing, to actually print that information off – but 99.9 per cent of the time we give that information to them; yes.

35 COMMISSIONER PAGONE: And presumably, Ms Gardner, there’d be some mechanism within the computer system that you were talking about whereby some of the information could be made available – not all of the information about the resident, but some of the information about the resident could be made available electronically or online.

40 MS GARDNER: If you had an interface with the hospital system; yes.

MS HUTCHINS: So there’s been a suggestion that it might be appropriate, to collect data regarding the amount of ambulance callouts to residential-aged-care facilities to be provided to the Aged-care Quality and Safety Commission for them to consider in their processes. Would you – do you think the collection of hospital data
45 – sorry – of ambulance-transfer data is, firstly, readily achievable by the facility and,

secondly, whether it would be an appropriate indicator for the Aged-care Quality and Safety Commission to be looking at?

5 MS LYSAUGHT: Not the facilities I manage, but the facilities further away from me that are owned by Whiddon that – we’re always going to have to call ambulances; we don’t have doctors. Visiting small places without a doctor – so our choice – and the choice is to ring an ambulance for better care for that person to be seen in a hospital situation. So I can see that we could support the collection of data. I just can’t see how for my facilities, that’s going to be helpful.

10 MS HUTCHINS: Ms Gardner?

MS GARDNER: I would question the validity of collecting that information. Are we going to equate lots of ambulance calls with good care, or are we going to equate lots of ambulance calls with poor care. That’s really difficult.

MR WOODAGE: Second that. Also in Western Australia, if we need a resident to be transferred to hospital for care under specialist treatments, they have to go through emergency department. So all our transfers to hospitals are through the emergency department, through hospital, and exactly what Ms Gardner was saying – is it going to be equated with poor care or good care. If you’ve got a facility with a lot of clinical needs, you’re going to be sending more residents to hospital as part of our good care practice. If you’re – may be a little hospice facility with very-low-care-needs residents with low comorbidities, you’re probably not going to be sending too many to hospital. So it’s not only collect that data, how is it going to be used, and is it going to be standardised as well – would be my concern.

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

30 COMMISSIONER PAGONE: Thank you for coming to share your experience. It’s very helpful, and we’ve learnt a lot. Thank you very much.

MS LYSAUGHT: Thank you.

35 MS GARDNER: Thank you very much.

<THE WITNESSES WITHDREW

[12.31 pm]

40 MS HUTCHINS: Commissioners, I call the next panel of witnesses, which is Ms Nikki Johnson and Mr Peter Jenkin. Commissioners, before the witnesses are sworn, I understand, there’s an appearance to be announced.

45 COMMISSIONER PAGONE: Yes.

MR JONES: Commissioners, my name is Jones, and I appear for Ms Johnston.

COMMISSIONER PAGONE: Yes. Thank you, Mr Jones.

MR JONES: Thank you.

5

<NIKKI DANIELLE JOHNSTON, AFFIRMED [12.32 pm]

10

<PETER GRANT JENKIN, AFFIRMED [12.32 pm]

<EXAMINATION BY MS HUTCHINS

15 MS HUTCHINS: Ms Johnson, could you please state your full name for the
Commission?

MS JOHNSTON: Nikki Danielle Johnston.

20 MS HUTCHINS: And you have prepared a statement for the Commission?

MS JOHNSTON: Yes.

25 MS HUTCHINS: Operator, please call WIT.1315.0001.0001. Is this your statement
dated the 2nd of December 2019?

MS JOHNSTON: Yes, it is.

30 MS HUTCHINS: Have you had the opportunity to read it recently?

MS JOHNSTON: Yes.

MS HUTCHINS: And are there any changes you wish to make?

35 MS JOHNSTON: No.

MS HUTCHINS: Are its contents true and correct and the opinions genuinely held?

40 MS JOHNSTON: Yes.

MS HUTCHINS: I tender that statement.

45 COMMISSIONER PAGONE: Yes; the statement of Ms Johnson will be exhibit
1422.

EXHIBIT #1422 THE STATEMENT OF MS JOHNSTON

COMMISSIONER PAGONE: I take it, this is the Ms Johnson about which we – about whom we’ve heard previously.

5 MS HUTCHINS: Yes; that’s correct, commissioner. Mr Jenkin, could you please state your full name for the Commission.

MR JENKIN: Peter Grant Jenkin.

10 MS HUTCHINS: Operator, please call WIT.1314.0001.0001. Is this a copy of your statement dated 27 November 2019?

MR JENKIN: Yes, it is.

15 MS HUTCHINS: And I understand that you wish to make an amendment to paragraph 81 of your statement by striking out the words that appear in brackets, “not Resthaven”, in the first sentence. Is that correct?

MR JENKIN: That’s correct.

20 MS HUTCHINS: Besides that amendment – are there any further exchanges you would like to make to your statement?

MR JENKIN: No.

25 MS LYSAUGHT: Are the contents of the statement true and correct and the opinions expressed genuinely held?

MR JENKIN: Yes, they are.

30 MS LYSAUGHT: I tender that statement, commissioners.

COMMISSIONER PAGONE: That statement will be exhibit 14–23

35 **EXHIBIT #14–23 STATEMENT DATED 27 NOVEMBER 2019**

40 MS HUTCHINS: Ms Johnson, you are currently employed by “Little Company of Mary” Healthcare Limited, known as “Calvary” in the Australian Capital Territory, as a palliative-care nurse practitioner.

MS JOHNSTON: That’s right.

45 MS HUTCHINS: You work in palliative aged-care specialist team at Clare Holland House.

MS JOHNSTON: Yes.

MS HUTCHINS: And you are the clinical lead of a research team involved in developing, piloting and training specialist palliative care in residential-aged-care facilities in Canberra, which is called the palliative-care-needs round.

5 MS JOHNSTON: That's right.

MS HUTCHINS: And what qualifications do you hold that are relevant to these roles?

10 MS JOHNSTON: I've got a master's – master of nurse practitioner. I've got registered nurse, obviously, a bachelor, and I've got a certificate in palliative care and another certificate in oncology.

MS HUTCHINS: And you have practiced as a registered nurse for 30 years and a
15 registered nurse practitioner for 12 years.

MS JOHNSTON: That's right.

MS HUTCHINS: Mr Jenkin, you are employed by Rest-haven Incorporated as a
20 palliative-care nurse practitioner.

MR JENKIN: Yes. I am.

MS HUTCHINS: And what qualifications do you hold that are relevant to this role?
25

MR JENKIN: I'm registered as a registered nurse. I hold a master of nursing, nurse practitioners. I also have a master of primary healthcare, which has a palliative-care specialty.

30 MS HUTCHINS: And you have been involved in a number of research, education and project roles, which are detailed in your statement, and I include that this covers your role as a project-manager and clinical consultant for the development of the residential-aged-care palliative-approach toolkit.

35 MR JENKIN: Correct.

MS HUTCHINS: This week the Commission is exploring the idea of developing a model for a palliative-care outreach program, which is intended to deliver specialist palliative-care services to residential-aged-care facilities and also to upskill staff that
40 are within those facilities. I'd like to ask you both about how such a model might operate with reference to your experience that you both have. And an important concept in this equation is what is general palliative care as distinguished from specialist palliative care and why is it relevant in the current regulatory frame-work. Ms Johnson, perhaps I'll start with you.

45 MS JOHNSTON: Okay. Palliative care as a general principle is about living well when we know that your life is limited, whether that's from a disease process or

whether that's from being old. When we're defining palliative care versus specialist palliative care, I think, we need to be really careful not to have those definitions too defined, because people are going to fall through the gaps, if people say "I do specialist" and "I do primary". So generally what, I think, we need to do is talk
5 about complexity of need. So if the needs of the resident is – are managed by or can be managed by primary care and their needs are such that they're dying relatively comfortably or living and dying relatively comfortably – may be with not-complex pain syndromes, or may be there's not complex family situations. So when there's a complexity of need: that's when the specialists need to get involved. But both – all
10 need to work together as a team so that nobody falls through the gaps.

MS HUTCHINS: Mr Jenkin, what do you understand to be the difference between general palliative care and specialist palliative care, and why is it an important concept within the frame-work of the existing system?
15

MR JENKIN: I think it's worth taking half a step back to start with and just being clear about what we're talking about as palliative indeed. If you look at all of the regulatory – the funding, the research and all of the other different stake-holders involved in aged-care and palliative care generally, some will talk about palliative
20 care as an approach, some will talk about palliative care as care at the end of life, others will talk about end-of-life care, and we – that makes it very difficult, because there may be funding-criteria based on just the end of life for instance. So more generally, though, palliative care is an approach for anyone with any life-limiting illness where the goals are quality of life as opposed to just curative for the sake of it.
25 So that can happen well before somebody is reaching the very end of their life and – we heard before – is actively dying, whereas specialist palliative care is what Nikki and I and many others do; we're there to help when it's complex. We're there to help when there are care needs above and beyond what is reasonably expected to be able to be provided by a primary care-provider, whether that's a GP, a district nurse,
30 an aged-care residential nurse or anyone else for that matter.

MS HUTCHINS: And so what palliative care should reasonably be provided to people that are living within the residential aged-care settings – in broad terms?

MR JENKIN: People – in broad terms: people should be able to get care that meets their physical needs, their symptom management, pain, breathlessness and other symptoms, to have enough information to know that they are reaching a stage, that they need palliative care, to have enough information to make decisions about what their care needs are going to be and not just go to hospital and get treated again for
40 the sake of it, that their family and loved ones are involved as well in the decision-making, and advance-care planning, I mentioned – I think, is really important as a process for the person to be able to demonstrate their autonomy in directing what – sort of care that they want.

MS HUTCHINS: And in your experience is that level of care being seen throughout aged-care facilities in Australia?

MR JENKIN: I think already at the Commission there have been enough instances demonstrated, where that hasn't happened. I think we've moved very much from a social model of – a housing-model of – in aged-care to what really is subacute care these days, and people are coming in older, sicker, frailer, multi morbidities and are
5 needing much more care, and they're coming – because of that they're coming in – significant numbers of them needing palliative care in the first instance. So it should just be core business for what we do.

MS JOHNSTON: Sorry. Could I just add to that too. So I think everybody who is
10 in residential aged-care is there because they have a complexity of need. So – low function, high disability and needing help with activities of daily living. People don't end up in residential aged-care, usually, by choice. They're there because of their care needs, and they can no longer stay at home to be safe. So I would argue that every single person in residential aged-care has palliative-care needs.

15

MR JENKIN: I agree.

MS HUTCHINS: And in your experience, Ms Johnson, what are the – I guess,
20 causes or barriers to people receiving the palliative-care needs – sorry – the palliative-care services that they might require within residential-aged-care facilities?

MS JOHNSTON: I think they're many and complex. So I'll start with a few. Generally we haven't caught up with our aging population and the needs that these people have. So we're living longer, but I'm not sure, that we're living better, and
25 by the time we are getting old, we have multiple comorbidities and multi-morbid diseases. If we look at that landscape, that changing landscape – I'm not sure, that we've actually caught up with how to care for these people properly, and I think this is even when they're transferred to hospital. I'm not sure, we're doing that overly well. I think there's a lot of room for improvement across medicine, nursing, to
30 actually upskill on how to care for people in their last year of life for example, to improve their quality of life. So I think we have barriers and gaps across the whole health system. We have problems in accessing medicines at end of life. That's – when I say “end of life”, I'm going to be talking about the last year of life – just to confirm that. So access to pain medicine, there – specially with this population
35 living in residential aged-care, pain is underdiagnosed, under-recognised and undertreated; we know that.

MS HUTCHINS: Why do you think that is occurring in residential-aged-care
40 facilities for example?

MS JOHNSTON: Yes; so people don't have the skills to pick it up. When we started our research, it was interesting, because a lot of the people who were working in residential aged-care didn't actually think they'd be working with as much death and dying. They didn't understand that people are most likely in their last months of
45 life. The average length of stay has shortened. So – I think it's only months now, where it used to be years. And the complexity of need is really high, and people

aren't – don't have – well, don't have the skills to pick up pain, don't understand that diseases like dementia cause pain. There's education that needs to happen.

5 MS HUTCHINS: Mr Jenkin, what do you see as some of the major barriers for aged-care providers to be able to give appropriate palliative-care services to residents in their facilities?

10 MR JENKIN: In their facilities there's a number of them but accessing specialist support is one. There are a number of specialist palliative care services that have roles like Nikki's and others that are there specifically for residential aged care. But the majority of them around Australia have fairly inconsistent referral criteria and response times to be able to provide some services. We'll just say we don't have the resources to be able to go into nursing homes, we can only visit people at home in the community. You know, in rural and regional areas a palliative care service may
15 just be one nurse trying to cover everything. So it really is difficult that way, in terms of the referral criteria.

20 Variable access to GPs as well, the primary, you know, the majority of palliative care is provided by primary care providers, you know, and if you can't get a GP and maybe even just rely on locums it's going to be difficult, and some aged care facilities don't have a registered nurse around the clock. So the ability to provide not only to have access to medicines but then to actually be able to administer them. But even before that, to do an accurate assessment of whether that's what the person needs in the first place is another barrier.

25 MS JOHNSTON: Can I just add one thing; so in terms of specialist palliative care access, there's a major discrepancy for residents accessing specialist palliative care. 50 per cent of residents have a diagnosis of dementia, and then we have another neurodegenerative disorders as well. If we look at access to specialist palliative care,
30 if you have a diagnosis of cancer, 75 per cent of people with cancer will have access to specialist palliative care. 2.4 per cent of people with dementia have access to specialist palliative care.

35 MS HUTCHINS: Thank you. I would like to explore with you both what the requirements and expectation should be upon the nature and type of care that residential aged care provider staff should be in a position to provide, and what are the types of palliative care services that need to be referred out to specialists, and I would like to do so with reference to both of your models. The Clare Holland House model is something that has been identified by a number of witnesses as a model that
40 has attributes that has ended in beneficial outcomes for people. Operator, could you please pull up Ms Johnston's statement at paragraph 78.

45 So this part of your statement sets out the components of the Clare Holland House Needs Round model. The three components involve the PCNRs; what does that stand for?

MS JOHNSTON: That's the palliative care needs round itself.

MS HUTCHINS: So what is the palliative care needs round?

MS JOHNSTON: So the palliative care needs round itself, so that the whole model of care has the three components. The palliative care needs round is a 60-minute
5 triage meeting that is - a specialist palliative care clinician has with the staff in the residential aged care facility. So that's with carers, nurses, managers, whoever – whoever is interested in coming. At that meeting the first thing we do is teach the staff how to recognise death and dying, how to end – how to choose residents that they wouldn't be surprised if they died in the next six months and they don't have a
10 plan in place. So the first thing is that they have to look at their residents and pick up to 10 people.

They bring those residents to the meeting and we go through each case file. We use it for case-based education and what we learn about Mary can be used for Bill and there's cross-fertilisation of that. So we start with each person's file. I teach the
15 staff about different – different disease management processes, so that could be for heart failure or dementia and what – what they may – what maybe their end of life might look like, what are they at risk of. Then we go through their legal documents and we see if they've got an enduring power of attorney or alternate decision-maker,
20 we see if they've got an advance care plan and the answer is usually no, because that's why they're at the meeting.

And then we discuss different symptom management, and then there's a referral sort of system that comes out of that. So do we refer them on to a case conference, do
25 they need a specialist palliative care referral. Do they need to see a geriatrician, do they need to see people from the dementia specific services. So it's actually just working out exactly where the referrals need to go.

MS HUTCHINS: And in terms of these steps that are taken as part of this – the
30 PCNR, are a number of these steps really actions that could be taken by facility staff that aren't occurring and hence the need for your service to step in?

MS JOHNSTON: Absolutely not. We believe that the – why our model has worked is because it's true integration between specialist palliative care and residential aged
35 care. We come together as a team and this is a new way of working. It's not a project that's going to end. It really enhances communication so that the other steps of this are the case conferencing where we do advance care planning, we do goals of care discussion and that's when we sit down with the general practitioner, the staff, the facility staff, ourselves, the resident, their families and we all come up with a
40 really good plan together. So in a way, I'm wondering whether that's actually a better way forward than care coordination because actually we're making a plan for that resident only at that time.

MS HUTCHINS: And in relation to care coordination, during these rounds and the
45 case conferences, do you tend to have those organised by one of your staff members or by a facility staff member?

MS JOHNSTON: So the facility – it's the facility's responsibility to organise the case conferencing.

5 MS HUTCHINS: Yes. And how important is by and by the facility staff and the GP and any other people that might be involved in the process for the process to be effective?

10 MS JOHNSTON: Yes. From my experience, facility staff soak this up like a sponge, they absolutely love it. They – their ability to care for people really changes and they are much happier in their workplace. We have had some problems with engaging general practitioners. The majority of general practitioners who come on board with this program really, once they have a multidisciplinary in case conference once they see the benefit. Like it does take an hour and a half but they may not have to come back again for a long time because we've got a really clear plan in place.
15 What we have done is got some GPs on the phone. It would be best practice if the GP was there all the time, but sometimes we get them on the phone.

20 Some general practitioners can't come because they've got a practice. So we tend to go ahead anyway and do some planning. But it would be much better if the GPs were there.

25 MS HUTCHINS: Yes. And in relation to the clinical work with residents who have complex specialist palliative care needs, is this part of your model something that might be more traditionally seen as specialist care.

MS JOHNSTON: Yes.

MS HUTCHINS: Palliative care.

30 MS JOHNSTON: Yes, sure. So the way the model works is the palliative care needs round itself is upskilling and increasing capacity of staff. Then the next part is the planning where we put plans in place for individual residents, and that includes injectable medicines for when they can no longer use medicines, take medicines orally, and this has saved, or stopped people from going to hospital when they didn't
35 need to a lot. We saved 2.5 million for the State by reduced hospital transfers. The third part of the model is our clinical work where, when people like Noeline that we heard about this morning, has specialist palliative care needs, they have every right to have access to specialist palliative care just like anyone else, and that's where we do our clinical work.

40 But occasionally we will have somebody who's discussed at a palliative care needs round then we do a case conference and they don't have specialist palliative care needs, so we're not needed. The staff can do this work and we don't get a referral. And that's good.

45

MS HUTCHINS: A major component of this model involves the upskilling of residential aged care facility staff. How prevalent is the need for further palliative care training of staff in the facilities that you've had interactions with?

5 MS JOHNSTON: It's incredibly important. They lack the knowledge and skills and it's not because they don't care that – I've been astounded by the care they have and the goodwill. It's just that they've never been taught and I think any of us who haven't been taught, how can we know. So when you see their faces light up and they – we kind of catch this wave together and everyone feels good about their work,
10 and we are a team, we stick in there as a team.

MS HUTCHINS: And when you teach residential aged care facility staff about advance care directives, I think you were present this morning when you heard the evidence about the misunderstanding or misapprehension that our witness earlier had
15 about what was really involved in the advance care directive and planning. Is that a common type of problem that you encounter?

MS JOHNSTON: Yes. Doing – doing advance care plans for this population requires a lot of skill. So in the case conferencing, I am teaching registered nurses
20 and – and even care staff how to have end of life conversations. And so we sit there with the GP and we run through the things that the family or the resident might be concerned about. We go through their health status. What's important to them; so is being comfortable and being at home and being in an environment that's safe for them more important over longevity, say. What are the goals, what are we trying to
25 achieve. So we go through all of that. There's usually tears. You know, people have a chance to talk about their person and we get to know them more.

And then – then a really good plan, a clear plan and an effective advance care plan is made. So we do a lot of do not – do not hospitalise, not, do not resuscitate. We do,
30 for antibiotics, for a trial, if they get aspiration pneumonia once, if they get it again, we're not going to do that. So it's really specific to the needs of that person.

MS HUTCHINS: Do you think that there should be some minimum level of training or qualifications or experience that the person has that is going to be
35 involved in assisting residents or family members - - -

MS JOHNSTON: I really – I really do. I think there's a lot of risk if we don't actually train people how to do these. Having an advance care plan and having a tick
40 box is – is – it doesn't work. It's got to be an effective care plan. It's got to be one that the staff can – an agency staff member can pick up on a Sunday morning and read and know what to do for that person. And therefore it's – it takes skill. So at the beginning of the palliative care needs round when we're doing the case conferencing, I will teach staff how to do that and that is a skill that they learn. And
45 after a while I don't have to be there unless it's complex.

MS HUTCHINS: And is there a minimum level of training for staff that you would encourage, be involved in, in the advance care planning?

MS JOHNSTON: Yes, well, it is within our model, but yes.

MS HUTCHINS: Sorry - - -

5 MS JOHNSTON: Sorry.

MS HUTCHINS: - - - should that person be, say, a registered nurse or can a carer perform that role or someone - - -

10 MS JOHNSTON: I – I would – I would like to see – I would like to see these really valued and by that I mean I think they need to be done by a registered nurse.

MS HUTCHINS: Yes. Thank you. Commissioners, if that’s a convenient time.

15 COMMISSIONER PAGONE: Yes, we’ll adjourn until 2.15.

ADJOURNED

[12.59 pm]

20

RESUMED

[2.13 pm]

25 COMMISSIONER PAGONE: Yes, Ms Hutchins.

MS HUTCHINS: Mr Jenkin, you are a specialist nurse practitioner - palliative care nurse practitioner and you’re employed directly by Resthaven.

30 MR JENKIN: Yes, I am.

MS HUTCHINS: Yes. And what’s the position that you’re employed in there?

MR JENKIN: I’m a specialist palliative care nurse practitioner.

35 MS HUTCHINS: Yes. And what does the scope of your duties involve in that role?

40 MR JENKIN: My role is to provide specialist clinical care, so in the most clinical sense, that’s symptom management for older people in the residential aged care but also in home care as well. We have a large home care component so symptom management, end of life care more specifically. I’m involved in a lot of education of our staff because I’m in-house, that’s sometimes easier. My – really a lot of the – helping with advance care planning as well, and a lot of work for specialists in this area is about helping sometimes people negotiate the goals of care as well. So someone can have an advance care plan, what does that actually mean now. And I
45 think Nikki’s role as well, she mentioned before, is about helping older people just exercise their autonomy and recognise that maybe there are some options that haven’t been presented to them yet.

So things I might do in terms of those goals of care are having conversations that if somebody has a fall, is very frail, in advanced disease and they have a fall, a routine thing would be to do regular neurological observations and if there was any sense there was something wrong, send them off to hospital. If someone is very frail,
5 maybe that's not necessary anymore. Maybe that the goals of care actually reflect that they could be looked after very well in the organisation. But a routine reflex thing is for a lot organisations is no, we just send them off. Or weighing somebody who's losing weight, things like that as well.

10 MS HUTCHINS: Yes. And in terms of sending people off or referring them to outside services, you say in your statement that you've noted that there is a trend towards this idea that that might be required and you say that palliative care is everyone's business, and not necessarily something that needs to be outsourced. What is the approach that's adopted at Resthaven in relation to the provision of
15 palliative care to enable appropriate palliative care to be able to be delivered in-house without the need for outreach services?

MR JENKIN: Okay. So the first part of probably four elements of it is my role, which is a criteria-based referral pathway to me for those specialist services, but my
20 role is there when it's complicated. That's why I said that it's everyone's business and that's something Palliative Care Australia talks about a lot as well. Really, the majority of care should be able to be provided by the registered nurse, the carers, the GP, the lifestyle staff and everyone else. I see less than 50 per cent of the people of the over 400 people who die every year in the Resthaven aged care facilities because
25 I don't need to see the rest, you know, which really leads onto the second part of the model which is having a model of care so that there are systems in place to direct care and to allow people to not have to rely on an individual to come up with is this necessary at the moment, but to have structures.

30 So that model of care came from that – that palliative approach toolkit that I helped develop quite some years ago now with Dr Deborah Parker, which has been rolled out nationally to every aged care facility in the country. Every facility has one of those toolkits in their facility that was given to them. Whether they choose to use it or not is a different matter. But that model focuses on three particular things; one of
35 them – the first one is advance care planning, so helping someone – ensuring someone has the opportunity to, if they don't already, state their wishes about what would happen to them in the future if they're not well enough to be able to tell someone, which doesn't just reflect end of life but includes that.

40 The second part which I actually think is the most important, is to be able to have a process that picks up when somebody's health is starting to deteriorate. So when the ball starts rolling, I mean people are coming to us older, frailer, as we talked about before anyway, but when the ball starts to roll a little bit faster. It could be that they've had some unplanned hospitalisations or falls or infections or something like
45 that. That's the thing that can sometimes be missed and we use a particular tool; it's called the SPICT tool, Supportive and Palliative Care Indicators Tool as a framework

for – that’s not for me, that’s for the registered nurses to use to pick up that information and then have that as a trigger for some more focused care planning.

5 And that tool looks at general indicators of deterioration as well as more disease-specific ones, but if that’s – if – if we use that tool and come to the conclusion that we wouldn’t be surprised if this person died in the next six to 12 months then that’s the focus for usually a case conference, or some sort of more focused care planning where not only is, if the person has an advance care directive, where we revisit that to see if it’s still relevant but to start talking about what next. We’re not focusing on
10 end of life but that starts to come into it. So ideally you would have the resident there, if it’s appropriate and possible, family members, a GP, nursing staff, hopefully a carer as well, and you talk about what’s happened for us to come to this conclusion, but also then what do we do next, and to start giving people some understanding if they don’t already about what can be done in an aged care facility.

15 Because often people end up in hospital simply because no one has talked to them about options or there’s just an assumption that, well, of course, I’d have to go hospital if that was the case. And that – and the third part of the model is actual end of life care so, you know, when someone looks like they’re likely to die in the next
20 days or weeks, and then we use, from that toolkit, an end of life care pathway which is simply really a roadmap and a care plan just to direct – to make sure we don’t miss anything. It’s just a paper tool. If it’s used properly it’s a really good clinical tool, though, to capture information and also to direct not only nurses but even carers about the important things to do at certain stages.

25 The middle one is the most important though because at 10 o’clock on a Saturday night when suddenly someone has deteriorated and maybe they’re dying now, when we ring the family up, the last thing we should be saying is should we be sending Mum to hospital and putting it onto the family or the decision-maker. We should be
30 saying to them, look, do you remember when we had that conversation, however long ago it was, hopefully some months, these are the things we talked about that we could put in place. You know, they’re no longer able to swallow medicines any more, you know, we’ve got the medicines here, this is what we can do, and that stops people ending up in an emergency department in the middle of the night. It’s a
35 systematic process.

MS HUTCHINS: Yes.

40 MR JENKIN: So that was – sorry, and the last part just – I talked about was about having a good clinical governance framework in an organisation to direct all of those things. So you know, we have a clinical practice manual which has all sorts of instructions and work instructions and information for clinical staff. It’s fairly comprehensive around palliative care and symptom management. Our electronic records, we use AutumnCare which was mentioned before, it’s just one of many, but
45 we use that and we’ve been able to put some of those tools around case conferencing and advance care planning and things, into the electronics of it, into the forms so that they’re just used all the time and can be extracted as well, probably more importantly

and to have resources available on our intranet and other areas for staff, just so at the point of care at the time they actually know what to do, because I'm not around all the time.

5 MS HUTCHINS: And in terms of what occurs when you're not around, so if there is a situation that requires your more specialist attention, what are the – what are the measures that are taken by staff in those circumstances?

10 MR JENKIN: Okay. It's a big incentive to plan ahead. And I know we will talk about outreach services and having access. We still need to call for help after-hours but if you put – if you look at those things that I just talked about, you can minimise or mitigate a lot of the potential crises out of hours, you know, having access – not only having access in - each of our facilities has the medications that – for injection, that you would need if somebody, you know, suddenly couldn't swallow and was at
15 the end of life. We just have them there. We have a pharmacy agreement. We can get things after-hours if it's urgent, just because that was what the contract was that we stipulated that that was very important as well.

20 That we have advance care directives that are accessible, that they're current, that – and if it looks like things have changed and the person is deteriorating, then we've turned that into a clinical plan. Because if someone has an advance care directive that says, "I really don't want to be resuscitated if I was not able to recognise my family" or, you know, "It looked like I was dying, I don't want any life-prolonging treatment". What does that mean right now; the person may be looking like they
25 might have a chest infection. Does that mean we treat their infection for their quality of life or not. Does it mean that maybe they're willing to take antibiotics by mouth but they wouldn't want to take the next step which is intravenous which usually means a hospital presentation.

30 Just having it clear so that in the middle of the night a registered nurse can go and have some fairly clear direction about what they need to do, not just pull out an advance care directive that is aspirational but doesn't have any actual sort of meat or detail to it. And that's something that has to be clear. A directive is the person's that they fill out. We have – we use a plan which is our document as clinicians to
35 actually guide what happens next. In terms of after-hours as well, no, I will leave it. I'm sure we will come back.

40 MS HUTCHINS: In terms of the expectations that should be put upon facility managers or providers of aged care in facilities, what do you think the appropriate expectations should be in terms of the level of care that's provided before a resident might need to be hospitalised, say?

45 MR JENKIN: Before they need to be hospitalised. Really, for someone who's needing palliative and approaching the end of their life you would hope they don't need to be hospitalised, you know. And that's something – I spend a fair bit of time talking to residents and their families about, not everyone has been in an emergency department before and once you explain what that means, they're pretty clear that

that's not necessarily something they would want. So a reasonable expectation would be that there were the – that clinicians were skilled enough and we had the resources enough to be able to manage most symptoms, you know, pain, breathlessness, incontinence, certainly around dementia, you know, that's – it adds to the management of all of the symptoms I've mentioned but just the behavioural issues as well.

Swallowing, the changes, that's – those things are care. They're not palliative care, they're not end of life care, they're just care, and really just because someone has the label palliative care doesn't realistically mean that they need any higher level or capacity of what we're giving. It might just be a bit more focused, that's all. There will still be people who fall – who have acute urinary retention. In South Australia we have the benefit of extended care paramedics – I don't know if that was mentioned yesterday – who can come out and insert a catheter into a male which is not usually something many nurses can do or give some fluids to rehydrate somebody or start some medications and their aim, really, is to keep the people out of hospital as well. And we've also got outreach services as well. So keeping someone out of hospital, it's not that hard if you try.

MS HUTCHINS: Yes. And at what stage is it – or in what circumstances is it that your service might require the assistance of an outreach service, in relation to palliative care?

MR JENKIN: For palliative care; I would have to say rarely. Again that's just because we have in-house expertise, but I'm a nurse practitioner, I'm a nurse, I'm not a specialist medical practitioner. I'm not a physio, I'm not a social worker. So there are specialist services out there, and so we would – I have the benefit of being able to call on those for, again, things that are out of my scope of practice, you know, people with very difficult pain management. We have an advanced practice nurse whose focus is on dementia and mental health and that's only been a recent role. In the past we've certainly needed to call upon people for that, again around palliative care and meeting some of their needs and just assessing whether we're getting it right. Yes.

MS HUTCHINS: Thank you. And Ms Johnston, in your experience, do you have instances where residential aged care providers might need your assistance to perform tasks or deal with circumstances that you would think the staff should be adequately able to deal with themselves?

MS JOHNSTON: I think that's a really, really hard question because, like I said before, there's a lack of understanding throughout the whole of our health system on how to care for this group. So I think instead of putting it that way, I would put it as we have an opportunity to teach and upskill and I think that's more important.

MS HUTCHINS: In terms of providers' obligations, particularly I'm thinking of standard 3, do you get a sense from your experience with providers whether those obligations are being met?

MS JOHNSTON: I think if they have an opportunity to learn how to do this, they fly. I think without that mentoring and support, the registered nurses often come from non-English speaking backgrounds. Often they will have their first registered nurse position and because they're on 457 visas they're not allowed to participate in
5 new grad programs in hospitals. So they end up working in residential aged care because that's where they can get a job. So if you can imagine, we've talked about this – the complex needs of these people, then we've got basically new graduate nurses with no senior nurses and no – nobody to mentor them.

10 That's why I think integrating specialist palliative care into residential aged care fills that need for mentoring and education for that group of staff that are really trying their hardest, but like I said before, you don't know what you haven't been taught.

MS HUTCHINS: And Mr Jenkin, in your experience, have you seen or do you
15 think that there are aged care providers relying on outreach or inreach services to undertake care that they should be providing themselves?

MR JENKIN: It's a qualified yes. I think – I think it's difficult if you are the only
20 registered nurse on a shift to be able to manage everything when you have a number of people who have complex needs, not just in palliative care as well. But, clearly, there are some organisations, as the Commission's already shown, that are not meeting those standards absolutely. I think one of the issues Nikki mentioned just then about the importance of – having capacity-building for staff is really, really important as well. And I feel like I'm swimming against the tide a little bit. There's
25 a lot of talk about outreach or in-reach services. As far as I'm aware – correct me, if I'm wrong – I'm still the only specialist in this area employed by an aged-care provider in the country.

30 Resthaven doesn't get any more funding than anywhere else to be able to support this role, but I think the benefit of my role is because I'm in house. I'm one of the team. I can influence things more than just coming in. And that's no disrespect to the other services. I think Nikki's service – and there's – a couple of others in the country really stand out, but most palliative-care services don't provide that sort of support. So I can not only provide the clinical care, but I can influence policies and the
35 systems in the organisation; the education I provide is very specific to the context at the time and even to different facilities. Things are changing and going on as well. I think that's a really important thing to highlight.

MS HUTCHINS: Yes. And in relation to funding, which you've just raised – how
40 is it, that Resthaven's palliative-care services are funded or, say, your role's funded?

MR JENKIN: Palliative care, generally, is funded through aged-care funding, and I
know there's been many others over the past months who've talked about ACFI
45 funding or the lack of. Just before the Commission I did a quick snapshot, and we have one resident in all of our 1200 beds who currently has had a claim for palliative care using the question in ACFI, and I imagine we're no different than other organisations that – we will chase that, if we can, because it's dollars. Some of that

is – sometimes it is because you don't need to, because the person is – I hear the term
“maxed out”. They've already reached the highest capacity, but it's just so
restrictive. It ultimately is only there in terms of the definition of it for when
someone is about to take their last breath, is actively dying, and the amount of work
5 often to put in another claim for that is onerous, and you could be spending that time
with the nurse, actually providing the care in the first place. In terms of my role –
the majority of it is – the salary is provided by Resthaven from wherever they get
their money. “From their own money” is what I'm trying to say. I – as a nurse
practitioner I have access to the Medicare benefits schedule; limited as it is at the
10 moment, barely 10 per cent of my income – of my salary is – comes from Medicare
at the moment for that reason.

MS HUTCHINS: And do you think that the current funding-arrangements could be
15 modified in some way to greater encourage high delivery and provision of palliative
care within facilities?

MR JENKIN: Yes, yes and yes. Not just nurse – the MBS is being reviewed at the
moment, and there has been a significant focus on general practitioners and nurse
practitioners being able to provide care that increases access to good care by older
20 people and effective care and timely care and care out of GP practice or out of a
clinic so that – being able to do home visits is more important as well. So –
absolutely, and not only just increasing amounts of money but different item
numbers for case-conferencing, for contributing to care plans, for other things that –
there are many GPs who do that sort of work actively and well. There are just as
25 many residents in aged-care facilities who have GPs who might not have that level of
capacity or interest, and I still meet residents who really rely on locum GPs. They
may have a listed general practitioner who followed them in, but getting them to –
one just recently: the only way they could see them was if they went to their clinic.
And so – this person had multiple medical conditions and was deteriorating, and we
30 were relying on locums, and we could not find another GP to take on their care.

MS HUTCHINS: So noting the restrictions that you have raised on funding, the
availability of funding for palliative-care services and services such as – introducing
the role of a palliative-care nurse practitioner within a facility, do you think the
35 model that you've implemented at Resthaven is something that could readily be
rolled out to other residential aged-care facilities particularly keeping in mind, say,
variances in their sizes or locations?

MR JENKIN: With the current funding and regulatory systems, no. MBS wouldn't
40 allow that. The MBS review recently – and there has also been a KPMG review of
the cost-effectiveness of nurse practitioners – has demonstrated overwhelmingly that
the salary of a nurse practitioner – just the amount that's saved in the health system
from hospital presentations is – would easily pay for that just by itself. I was going
somewhere else as well. I'll come back.

45 MS HUTCHINS: Ms Johnson, how is it, that the Clare Holland House model is
funded?

MS JOHNSTON: Do you mind if I just come back to something that was said earlier just quickly?

MS HUTCHINS: Certainly.

5

MS JOHNSTON: And then I'll go on to that. Specialist palliative care in Australia is, generally, funded by the States. Commonwealth funds home-care packages and residential aged-care. So at the moment there's many State-run services that won't walk through the front door of a residential-aged-care facility. There's other services that won't as well – community nursing, wound care, lots of other people that just don't – so that reduces access. So we said that we would go through the front door, because they were Canberra citizens, and we would provide the same State-run service to these people as the rest of the community were getting, and really that's only fair. So I just wanted to make that point, that that is something that could change across Australia today, if that was recognised.

On to how we're funded – so like I said, we're a State – Territory-run service. So it's a public service. We really only started using this model in 2015, and at that stage there was just one of me, and I was, basically, told to – “Prove yourself, and if you do, we'll refund you.” So that's where we came up with this model. And then my position has been recurrently funded, and then through the randomised control trial we got recurrent funding for a second nurse practitioner, and the – ACT Health, who funded the randomised control trial, saw that we saved 2.5 million out of that. So they've actually given us recurrent funding now for four palliative-care nurse practitioners in Canberra to integrate special palliative care into residential aged-care. So now we have an opportunity to do this model effectively, efficiently, across the territory.

MS HUTCHINS: And do you think greater efficiencies could be achieved if the model was rolled out, say, nationally?

MS JOHNSTON: Yes; so funding isn't my expertise. However, in my opinion, I would say that this model could be adapted and used across Australia in small regional hospitals in – where they don't have residential aged-care in – using telemedicine, telehealth and, definitely, increasing access to specialist palliative care for all older people needing these services. Just on that: of course, we'd need to build a workforce; so what I would suggest is – and again not my expertise, but I would suggest some Commonwealth-supported places that would fund nurse practitioners and registered nurses so that we increase the nursing workforce, registered nurses who would then work in residential aged-care and palliative-care nurse practitioners who would work for specialist palliative care. This would take about four years, I suppose, at least, to happen. So we'd have to think about other ways of getting this to happen sooner rather than later in the mean time.

But we, definitely, need investment in palliative-care nurse practitioners and registered nurses who would then stay in the aged-care system, and I think that can only happen if we start valuing our registered nurses and paying them equal to those

who are working in the public sector. At the moment there's not a lot of – they feel very undervalued is what I'm trying to say.

5 MS HUTCHINS: Yes. And in terms of building the workforce there's been idea made – that there could be a place for the introduction of a scholarship for nurse – for specialist nurse practitioner roles.

MS JOHNSTON: Yes. Yes.

10 MS HUTCHINS: Is that something that, you think, there's a need for?

MS JOHNSTON: Absolutely. So I'm not sure what a nurse-practitioner degree costs at the moment, but I know it's a few thousand.

15 MR JENKIN: And the rest.

20 MS JOHNSTON: And the rest. So having that fully funded – Victoria did that a while ago with palliative-care nurse practitioners, and they've had really good outcomes. But I really think we have to not only do it for palliative-care nurse practitioners but also registered nurses in residential aged-care.

MS HUTCHINS: Mr Jenkin, do you have a view on whether a scholarship program to support the development of nurse practitioners would be a beneficial endeavour.

25 MR JENKIN: I do. I think it would be an excellent idea. I don't think it should be restricted just to palliative care. There are many nurse practitioners working in more-general aged-care roles which are providing immeasurable benefits. A scholarship just for university fees isn't going to be enough, though. You need – because part of the training as well as the academic preparation is actual training,
30 hands-on training and being supervised and needing a certain number of hours of supervised practice. So I was the beneficiary before I came to Resthaven for a little while of a State-Government-funded scholarship. Part of that was that the – my employer had to guarantee me a role at the end of it; otherwise what's the point. And so you would really need to have something that was locked in so that – and the
35 other option perhaps would be a return of service; you know? If I won a scholarship, then I'm obliged to put X amount of time back in, and whether it's in a regional, rural area necessarily or just in an – aged-care's an area of need by itself. So that's, probably, enough.

40 MS HUTCHINS: Yes. And in what ways would Resthaven's services benefit from greater availability of the nurse practitioners?

45 MR JENKIN: I'd like another one of me. We've got eight metropolitan facilities. I have three that are about a two-hour round trip, just if I drove there and back, and another one that's four and a half hours. It's a bit of a stretch. And without good infrastructure and, just, systems for telehealth at the moment it makes it really difficult. So simply – that would be good. We have not a nurse practitioner but an

advanced-practice nurse; he should be a nurse practitioner. He just hasn't followed that route – in mental health and dementia – and also just general aged-care, being able to – and look. I'd like to make it clear. Nurse practitioners are – shouldn't be seen as – and we're not trying to be substitutes for doctors.

5

MS JOHNSTON: No.

MR JENKIN: I'm a nurse. I bring 30 years of nursing-science and skills to my role. I have many skills and knowledge now that intersect and I share with my medical
10 colleagues, but I don't want to be a doctor. I'm a nurse, and I look at people with my nurse goggles on, as I sometimes tell people, and those other things are extras that I would use as well. So GPs are absolutely complementary to what we do, not as an alternative. Because we know there are lots of gaps, accessing medical care though in aged-care – nurse practitioners can fill that role. One of the benefits of them if –
15 particularly if they're employed by the provider, is they're available. Despite what I just said about distance and everything, I can still, if it's urgent, apart from our site at Mount Gambier – I can still, usually, get there, if not same day, certainly, first thing the next day, if there's something significant and critical. And accessing a specialist palliative-care service or a GP – sometimes there's – there can be quite a gap for that
20 reason. I've forgotten your first question.

MS HUTCHINS: No; you've answered it adequately. Thank you.

MR JENKIN: Do you mind if I go back to the funding? I'm not sure I answered
25 that – just quick, about my – about rolling it out nationally?

MS HUTCHINS: Yes; certainly further.

MR JENKIN: I think I said, no, it couldn't be – it couldn't work. I think using the
30 current sort of funding-parameters, it would – an in-house model like mine would only work based on an organisation choosing to direct money that they had into that.

MS HUTCHINS: Yes.

MR JENKIN: There's no external sort of funding for that reason. Telehealth would
35 certainly help, and yes, I think I just wanted to clarify that particular.

MS HUTCHINS: No problem. So a suggestion has been made that a – the
40 introduction of a outsourcing multidisciplinary team might be of advantage to residential aged care facilities which might go beyond the scope of just palliative care services but to involve, you know, a wider breadth of specialists. Ms Johnston, do you think, when looking at how such a service might operate there's elements of your service that could be used as a model?

MS JOHNSTON: Yes. Absolutely. The things I haven't been able to say about our
45 model so far is because I am part of a specialist palliative care service I actually have access to doctors who, when it is out of my scope, which does happen, I can ask one

of the palliative medical doctors to come with me to do a joint visit. So that is increasing access even more. The other thing that I have access to is to take people like Noeline to Clare Holland House to die when the needs are specialist. That, previous to this model working, rarely happened. We rarely had people coming in from nursing homes. So that has changed that. Because I am working in a multidisciplinary team, you know, we can refer to geriatricians, drug and alcohol. We work regularly with drug and alcohol. We've actually changed some regulation around that because people in residential aged care can't go to the chemist every day and pick up their takeaways for their methadone.

So my colleague and I helped to change that regulation so that palliative care can now – palliative care specialists can now prescribe the methadone replacement program on top of prescribing opioid medications for pain. Previous to this we weren't allowed to prescribe pain relief for people on an opioid replacement program. So I think any – any barrier that comes up, there is a way forward. I have had some problems accessing mental health when I've needed it. I was looking after a woman who had schizoaffective disorder and she had a delirium and thought that her medicine was poison and food was poison. I tried to get the mental health team who had known her for many years and they weren't able to come.

So what I did instead was got the GP and a geriatrician and we went there that day to try and help this woman, who really, really, really needed some mental health help. We did work out a plan and she – she was – she was okay, but that getting access to mental health, I think would be really vital.

MS HUTCHINS: Yes. And Mr Jenkin, in terms of greater availability to specialists outside of your service, is there any particular specialisations that your residents would benefit from having greater access to?

MR JENKIN: Geriatricians who are able to visit in a timely manner with – I have access to some but they are so busy because there are so few of them that not always but sometimes the problem has progressed past them by that stage. I can get palliative medicine physicians to come and do visits or social workers or other people as I've mentioned before. Psychiatrists is a very useful thing; people come with pre-existing mental health issues that can often escalate and when someone is deteriorating and dying, sometimes because of changes in their medicines or sometimes just because their health is changing, that needs specialist help as well.

We're blessed in Adelaide with two of the three specialist services having an on-staff - palliative care services having an on-staff psychiatrist which is not normal and they're fabulous as well. Geriatricians will be the main one. Psychologists is – and again, not medical but having a – we have one psychologist I'm aware of in Adelaide who will visit an aged care facility and bulk bill, and if we could have more of those because people again, you know, aged care facilities don't – aren't expected to provide that service. We have some social workers and some chaplains who provide some more of that sort of support but people need much more of that.

MS JOHNSTON: Could I just mention one more thing and that's dentists. We don't have access to dentists. I looked after a woman only 10 days ago. She was just about to turn 100, and her very last tooth was rotten. I actually had to get her taken by ambulance – I couldn't get a dentist to come – I had to get her taken by
5 ambulance and to have that tooth removed. She died a few days later. It would have been much better for her if I could have had access to dentistry.

MS HUTCHINS: Yes. Thank you. Next turning to advance care directives which we have touched on briefly throughout your evidence today and you also identify in
10 your statements that they are a key element of advance care planning. Mr Jenkin, in your experience, how many of your residents have advance care directives in place?

MR JENKIN: More than the national average; let's start with that. We have made a concerted effort to encourage people to have an advance care plan or directive and we have – people who still have capacity to make decisions, clearly that can be a
15 statutory document. In South Australia it's called an advance care directive, but if people don't – have lost capacity or just choose not to, there are other avenues as well. We were involved in a national study for Advance Care Planning Australia in 2017. It was a prevalence study looking at the number of people who had advance
20 care directives in GP practices, in hospitals and in aged care facilities and we – well, they chose for us one of our 12 sites just randomly and picked, and we were well over 90 per cent of residents having an advance care directive. Nationally in that study it was 46 or 47 per cent, I think. I can't attest - and that actually surprised me
25 that number.

In 2013 I did an audit and it was 60 per cent. I'm well aware it's risen. I think we were just lucky with that site. I think it would be very close to that across the organisation anyway. The quality of them, still we have mechanisms in place to try and help people, make sure that they're a quality one. If people come in with an
30 aged – with an advance care directive, they may have written that however many years ago and have, so one of the first things we would try to do is revisit that with them and see if it's still relevant to their needs, but we have a - we're doing all right.

MS HUTCHINS: So the proposition has been tested that it might be appropriate to
35 put a positive obligation on residential aged care providers to assist residents in preparing an advance care directive should they wish to do so. What do you think would be the appropriate scope in terms of that assistance that a provider should be
- - -

40 MS JOHNSTON: Would you mind if I just made some other comments - - -

MS HUTCHINS: Yes.

MS JOHNSTON: - - - first, before we went on to that.

45 MS HUTCHINS: Certainly.

MS JOHNSTON: So three things: the law around end of life is different in every jurisdiction across the country so that causes issues when we're planning, doing our planning. So too, interchangeably we have advance care directive, advance care plan, they all mean different things wherever we go. So that – there's some problems
5 that I think need ironing out. The second thing is that's missing is a goals of care discussion. So with the goals of care discussion what we're doing is we're setting - resetting expectations of what can be done in residential aged care, what transfer – the burdens and benefits of transfer to hospital.

10 We're having more realistic conversations around treatments that are wanted, treatments that aren't wanted. And so when we get round to talking about hospital, hospital is the right place if, for example, you can fix a fractured hip and it's the best pain relief. If there's a benefit to going to hospital, older Australians deserve the right to go, right. And I had one other – 105-year-old woman who broke her hip on a
15 Friday afternoon, and was picked up in the ambulance, went to the hospital and because her advance care plan said not for resuscitation, they didn't even get her out of the ambulance, and they sent her back to the nursing home with no pain relief. So that's the other side to these problems that we're having, okay.

20 So the jurisdictional problems, the fact that we're not setting expectations, we are not having goals of care discussions, I think all of that has to happen. That's got to change – we've got to change the process because at the moment there's just so many flaws and holes in it.

25 MS HUTCHINS: Yes. Thank you.

MS JOHNSTON: Sorry, I just wanted to preface with that.

MS HUTCHINS: Thank you. So Mr Jenkin, returning to the question I asked you,
30 do you recall or would you like to be asked again?

MR JENKIN: Let's try again.

MS HUTCHINS: Sure. So the Commission is contemplating encouraging a
35 requirement upon providers to assist residents with putting an advance care directive in place, should they wish to do so.

MR JENKIN: Yes.

40 MS HUTCHINS: If such a requirement was put into place, what do you think would be the appropriate boundaries of the assistance that should be required by facility providers and who are the right types of people to be engaging in that process?

45 MR JENKIN: I think it is necessary. I think care needs to be that it's not just a tick box of a standard to say yes, we gave them the brochure and we said there was someone they could talk to if they wanted to. If that's all that happens, then it's not

worth even pursuing. I mean, we've both mentioned, and I talked about our model of care, about the importance of not only someone having a directive, but in our organisation on admission we visit the person's directive with them. At the six monthly care evaluations we come back and - it used to just be when I started, you
5 know, is there one or not, and it was a tick. These days we are getting - we're having a conversation about, "So is it still relevant, I see you've got one, what's changed in the last six months in terms of your health. Is this still relevant, do you think it's important that you need some help to change it or not". That is still something - it's a process. It's not just an outcome of a form.

10 In fact, I think the conversation is more important than the form. I've met people who just refuse or haven't filled in an advance care directive but have had very clear discussions with their families and - and those around them and also the people who are providing care to them - with them in the aged care facility. So everyone is
15 actually on the page and knows what they want but there's - but I think the most important reason to have an advance care directive in an aged care facility if there is still the opportunity the person might end up going to hospital, because you need something just to direct when there may not be someone who's an advocate if you can stand in front of someone and say, "Stop, I don't give you consent for that, they never would have wanted it".

In terms of the scope, having those discussions is not easy. It's not something that's innate just because you're a nurse or a doctor or a social worker or anyone else. It's something I had to learn, Advance Care Planning Australia and other organisations
25 provide training. I spent some time, almost two years ago now, with our senior nurses at each site doing some communication training which was partly around advance care planning. So we did some teaching about communication processes and the importance of the advance care directive, but then we had actors coming in and role-played it in a safe environment so that you could practice it and - like a
30 playground almost; you couldn't hurt anyone.

And there has been so much feedback that that has helped, and I've - I've noticed that I'm not being called as often for those discussions unless it is complicated and sometimes it's very complicated. And staff are just saying they're more competent
35 and confident in that, and we're planning to do that with more nurses and also in our community sector as well.

MS HUTCHINS: Thank you. Commissioners, I see we're out of time. There's no further questions from me.

40 COMMISSIONER BRIGGS: I do want to ask one, and it's something that has been bugging me throughout this Royal Commission. We've heard many occasions when people who are in serious pain from serious things happening to them, and the health professionals do not provide pain relief. What's going on? I would have thought
45 this is core business, particularly for a hospital.

MS JOHNSTON: Yes.

MR JENKIN: You go first.

MS JOHNSTON: I'd – I'd have to agree, and it's something that really upsets me. I think that there's a opioid phobia out there. I think there's regulation that stops
5 people from prescribing opioid medicines. Opioid medicines are incredibly safe when used at appropriate doses. They don't interact with other medicines. So there's lack of knowledge. For example, like my 105-year-old who came back from hospital, so I stayed back so that she would have pain relief that night. If we rang the
10 afterhours general practitioners – they are reluctant to prescribe opioids for people that aren't their patients. I see this a lot.

Also having – not having stock of those medicines in residential aged-care – so in Canberra, there's only allowed stock of five ampules of morphine for the whole facility, and that's it. And that's legislation which we need to change. So what we
15 do to get around that is – when we're doing our case conferences, we're doing anticipatory planning that includes advance care planning. So the anticipatory planning is where we write up pain relief in injectable forms so that they have it.

And pain relief doesn't always have to be an opioid; so someone who's got heart
20 failure, whose lungs are filling up with fluid – and they've got pulmonary oedema; we write up subcutaneous Lasix for them so that they can be kept comfortable. So feeling like you have the knowledge to prescribe these medicines is really important. I do experience a lack of wanting to prescribe these medicines by some doctors.

25 COMMISSIONER BRIGGS: Thank you.

MR JENKIN: I think the letters that went out to GPs, however long ago it was, to the ones who seemed to have the highest prescribing-levels of – and I know there's –
30 of opioids – and I know there's something similar around antipsychotics at the moment. I'm aware of a few GPs that it scared, and I have anecdotal evidence from nurses in our facilities, where GPs were coming through and ceasing opioid patches for long-term chronic pain and other opioid drugs for other reasons. I haven't had a chance to ask them. So I think that's scared some. I also work with some GPs,
35 though, who got those letters and were quite happy to say "I'm doing this, because I care, and these people need good symptom management". So there's – there is a bit of that regulatory stuff as well.

There's another issue around cognitive impairment, people with dementia and other illnesses where they don't have the capacity to understand or communicate. Sadly
40 there are still people out there who think that they don't feel pain the same, which is just plainly ridiculous, and there's no evidence to suggest that it all. It's more difficult, to assess their pain, but there are so many tools out there to help, even at the carer level, to be able to do that. So there really is no excuse.

45 MS JOHNSTON: Would you mind if – sorry – I said one other thing.

COMMISSIONER PAGONE: Please do.

MS JOHNSTON: Is it okay? I just wanted to clear something up that happened earlier today. I want to make it clear, that nurse practitioners do not need to be supervised by doctors. So nurse practitioners – if we are working in the private system and want to access MBS and PBS, we need to have a collaborative arrangement. It's not supervision. If we're working in the public system, we don't have to have that. So I just wanted to make that clear.

COMMISSIONER PAGONE: Well, having said that, is there anything else either of you would like to say? This is a great opportunity for you to – what would you like us to do?

MS JOHNSTON: I would like you to give the same access to quality care for our older Australians that our – is afforded to the rest of our community.

COMMISSIONER PAGONE: Thank you. Mr Jenkins?

MR JENKIN: I could just say "what she said". I think the way that a society looks after its vulnerable, whether they be old, young, disabled, is just a sign of what sort of society we are really. And I hope that Government will take on whatever comes out of your – the Commission at the end and makes a change, because there are many of us in this room who at some stage will, potentially, need the care, and there will be less people paying taxes to pay for it. So it's going to be interesting future.

COMMISSIONER PAGONE: Thank you to both of you for coming. It's been very informative. We're very grateful, that you've shared your experience and knowledge with us. It's been really very helpful indeed. Thank you both very much.

MS JOHNSTON: Thank you. If you need anything else – thank you.

30 **<THE WITNESSES WITHDREW** **[3.05 pm]**

MS HUTCHINS: Thank you, commissioners. Mr Knowles will call the next witness.

COMMISSIONER PAGONE: Yes, Mr Knowles.

MR KNOWLES: Thank you, commissioners. The next witness is Professor Chris Poulos. Among other things he's a consultant physician in rehabilitation medicine, with extensive experience in aged-care. I now call Professor Poulos.

45 **<CHRISTOPHER JOHN POULOS, SWORN** **[3.06 pm]**

<EXAMINATION BY MR KNOWLES

MR KNOWLES: Thank you, Professor Poulos; take a seat. Can you state your full name?

PROF POULOS: Christopher John Poulos.

5

MR KNOWLES: And you prepared a statement for the royal Commission?

PROF POULOS: Yes. I did.

10 MR KNOWLES: And that's dated the 5th of December 2019 and bears the document ID number WIT.1316.0001.0001

PROF POULOS: That's correct. Yes; that's correct.

15 MR KNOWLES: And you will see the first page of that document displayed on the screen in front of you.

PROF POULOS: Yes.

20 MR KNOWLES: Yes. And have you read your statement lately?

PROF POULOS: Yes, I have.

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

PROF POULOS: Yes; it is.

MR KNOWLES: And insofar as you've expressed opinions in your statement, are
30 they opinions genuinely held by you based on your expertise and experience?

PROF POULOS: Yes, they are.

MR KNOWLES: Thank you. I seek to tender the statement of Professor
35 Christopher Poulos dated the 5th of December 2019.

COMMISSIONER PAGONE: Yes; that statement will be exhibit 14–24.

40 **EXHIBIT #14–24 THE STATEMENT OF PROFESSOR CHRISTOPHER
POULOS DATED THE 5TH OF DECEMBER 2019**

MR KNOWLES: Thank you, commissioner. Professor Poulos, you're a specialist
45 in rehabilitation medicine.

PROF POULOS: Yes; that's correct.

MR KNOWLES: You are a fellow of the Australasian college of rehabilitation medicine and have been since 1989.

5 PROF POULOS: Yes; it's the Australasian faculty of rehabilitation medicine, which sits within the royal Australasian college of physicians.

MR KNOWLES: Yes. The faculty – you're a fellow of the faculty since 1993; is that right?

10 PROF POULOS: Correct. Yes.

MR KNOWLES: Yes. And you were the president of the faculty between 2012 and 2014.

15 PROF POULOS: Yes, for a two-year appointment.

MR KNOWLES: Yes. Now, from 1991 to 1995 you were the director of community, rehabilitation and geriatric service at St George Hospital, Sydney.

20 PROF POULOS: Correct; yes.

MR KNOWLES: Yes. And from 1995 to 2011 you held various senior clinical management roles at the Illawarra-area health service, in the south-eastern-Sydney-Illawarra health service, including the role of director of rehabilitation, age and extended care at the Illawarra-area health service?

25

PROF POULOS: Yes; that's correct. Yes.

MR KNOWLES: Yes. And since 1989 you've held various conjoint academic positions, including in particular since 2016 conjoint professor at the university of New South Wales?

30

PROF POULOS: Yes: that's correct.

MR KNOWLES: Yes. And visiting professorial fellow – Australian health-services research institute at the university of Wollongong.

35

PROF POULOS: Yes; that's correct.

MR KNOWLES: Yes. And since 2016 you've also been the head of research and aged-care clinical services at Hammond Care.

40

PROF POULOS: Yes.

MR KNOWLES: And you currently maintain a small community-based clinical practice predominantly seeing on referral from GPs older people with cognitive impairment and/or physical causes of functional decline.

45

PROF POULOS: Yes; that's correct.

MR KNOWLES: Yes. And is it fair, to say that you have, over your career,
experience in consulting people living in residential aged-care facilities including by
5 telehealth and work closely with geriatricians, GPs and other clinicians in that
regard.

PROF POULOS: Yes. I have.

10 MR KNOWLES: Yes. Thank you. Professor Poulos, data available to the royal
Commission has indicated that access to specialists by Medicare Benefit Schedule
fee for service outside inpatient hospital settings for people in residential aged-care is
poor. Does that accord with your own experiences?

15 PROF POULOS: Yes; it, certainly, doesn't surprise me, that it is poor.

MR KNOWLES: And you've described in your statement some practical barriers to
the provision of specialist medical services to people living in residential-aged-care
facilities. You've said that one such barrier is a financial one. And you've referred
20 to relevant MBS items for specialists who are not geriatricians.

PROF POULOS: Yes.

MR KNOWLES: And can I bring up on the screen in front of you table 1, which
25 appears under paragraph 37 of your statement? Do you see that there, Professor
Poulos?

PROF POULOS: Yes, I do.

30 MR KNOWLES: And can you just explain how those MBS items work to the
commissioners in terms of the way in which they treat geriatricians compared with
other consultant physicians?

PROF POULOS: Yes. These are, basically, time-based items for conducting
35 comprehensive assessment. So in terms of the geriatric-medicine item numbers 141,
143, 145 and 147 – they refer to comprehensive assessment and development of a
fairly complex management plan, and they're time-based; so you have to spend a
minimum of – 60 minutes or more with a patient. They're specific. Those item
numbers are specific to the practice of geriatric medicine. Other physicians – the
40 only item numbers that are close to those geriatric item numbers are items 132 and
133, which are items also requiring a fairly complex assessment of people with
multidimensional problems and producing a similarly complex plan, and the time for
those is slightly less, but the table demonstrates that the remuneration is not
consistent, even though it's sort of a time-based model.

45

MR KNOWLES: And if I can point to item 145, which has the greatest amount of remuneration – that is applicable for consultations that must occur in a place other than a consulting-room or hospital.

5 PROF POULOS: Yes.

MR KNOWLES: I take it, that a typical place of that nature would be at the actual residential-aged-care facility.

10 PROF POULOS: Yes; it can be. Yes.

MR KNOWLES: Yes. And there's no specific item of that kind in terms of other consultant physicians there; is that right?

15 PROF POULOS: That's correct, although items 132 and 133 can also occur – it's my understanding, that they can also occur within a residential-aged-care facility, but, no, there are no similar item numbers for consultant physicians.

20 MR KNOWLES: Is it the case, that the particular rate associated with item 145 is higher because of the time that's spent – to your knowledge – as well as the place of the consultation?

25 PROF POULOS: Well, I think that – my assumption is that item 145 was designed that way, taking into account that it could occur within a residential-aged-care facility and therefore may've had – it may've had some sort of travel or whatnot built into it. But items – item 132 – items 132 and 133 are sort of general items that apply to – my understanding is – consultation rooms or hospital or outside of those. So – not specifically designed for residential aged-care.

30 MR KNOWLES: Yes. And in terms of this distinction between geriatricians and consultant physicians – are you in a position to say why that particular distinction has been drawn in the preparation of these item numbers?

35 PROF POULOS: Sure. I would say that there's, certainly, an evidence base behind comprehensive assessment in older people, often referred to as comprehensive geriatric assessment; so I think that those item numbers for undertaking that form of assessment are – actually quite appropriate, to have item numbers like that. I suppose the point of highlighting this is that other physicians who might do similar comprehensive assessments with patients with similar degrees of complexity and, as mentioned, develop similar comprehensive plans that require lots of liaison and
40 follow-up post the event don't have those – don't have similar items, and I'm suggesting that they should have access to those items for doing similar types of work.

45 MR KNOWLES: So is that one of the changes that you would propose in terms of financial barriers as such to access by specialists other than for instance, geriatricians?

PROF POULOS: Yes. I think – addressing these MBS – disparities in the MBS is something that, I think, is important. But on the whole, I don't think that the MBS is really a particularly fit-for-purpose way of remuneration for people with complex needs. These item numbers refer to time, direct time with the patient. And people
5 that have many sort of comorbid conditions and complexity, a lot of the time must be spent in preparation and in developing management plans and doing that liaison work afterwards that is not built into this. So it's not necessarily that – that – I don't think that the MBS is really designed for those sorts of – those sorts of patients. Now, it may be – they may have – those geriatric medicine item numbers have
10 probably taken some of them into account but then I wasn't there when they were designed. I'm not sure of the exact details around how they were designed and how those numbers were derived.

MR KNOWLES: What sort of funding arrangements, from your experience as a
15 specialist, would improve access to specialists more generally; do you have any views in that regard if, as you say, for this particular cohort the MBS fee for service model will not always be entirely appropriate?

PROF POULOS: Yes. I think that – that some of this could be fixed quite rapidly
20 by basically addressing the disparity that currently exists, but I think that there is also scope to develop perhaps supplementary or other either MBS items, item numbers that might take into account preparation and non – for preparation of management plans and the non-direct contact with the patient time that is required to undertake the, you know, liaison follow-up.

MR KNOWLES: You would be aware of funding models that exist based on
25 volume for general practitioners to provide incentives for them to see more people in terms of practice incentives programs.

30 PROF POULOS: Yes.

MR KNOWLES: Do you have a view about the likely utility of a funding model of
35 that kind in respect of promoting access to specialists for people living in residential aged care?

PROF POULOS: Yes. That – that funding model might be appropriate for certain
specialists who see a certain volume. So if they are – if they were seeing enough people that they were reaching the volume targets then that might be another way of incentivising specialists to visit residential aged care facilities. However, I think that
40 the funding model should also allow for those situations where a particular specialist, for example, may have been seeing someone for a number of years, they know them well, they're not going to do the volume but they're quite prepared to go and see someone within a residential care home that the MBS should in some way stand alone for those people as well to create those incentives.

45 So maybe – maybe the answer to the question is that there could be different payment models, depending on the nature of the specialty practice. Certainly,

incentives as you suggest, could encourage some specialists to develop more of an interest in visiting residential aged care, and I think that would be – that would be something that would be worth encouraging.

5 MR KNOWLES: Just on that, in terms of the interest that you refer to, is there a need for something more than just financial incentives of that kind to encourage some – a greater number of specialists to actually go to residential aged care facilities to provide treatment at the facility itself?

10 PROF POULOS: Yes. I don't think the answer is entirely a financial one. I think that many specialists would see that going to a residential aged care facility is something that they – that they're either not familiar with, they don't know who to see or when they get there, they're not sure what facilities might be available for them. They're not sure if somebody is going to be able to meet them, if someone can
15 be with them and relay relevant clinical information. So I think that for many specialists it's probably quite a foreign thing for them that they may not have ever visited a residential aged care home in a professional capacity at all.

MR KNOWLES: And what do you see as being one way of or ways of dealing with that, improving that situation?
20

PROF POULOS: I think that – I think there are a number of ways of dealing with that. I think that if we go back to medical student training, for example, I think that we should be – we should be looking at ways in which we can introduce what is
25 good residential care to medical students during their training. I could expand on that but just looking at – looking at some of the options, that would be one option. I think within training programs themselves, particularly the specialty training programs that – that would involve older patients in residential care so thinking particularly of general practice, geriatric medicine, rehabilitation medicine, some of
30 those other specialty training programs, that exposure of advanced trainees in those programs to residential aged care practice would familiarise them with practice.

And I think some practical suggestions around having some guidelines. So that if a specialist is coming to visit someone in a residential aged care home, that the home
35 might have contacted them in advance, that they would be able to, you know, provide basic information such as, you know, who they're going to meet and whatnot so that it's not a foreign experience for them.

MR KNOWLES: Just in relation to those guidelines, who do you see as
40 promulgating those?

PROF POULOS: I think that – I think that there's a role for the professional societies to be working closer with the aged care sector to be looking at models around what is good practice, what is good specialist practice within aged care. And
45 I would see that there would be scope for guidelines around that to come out of – to come out of that process whereby the colleges, the societies, the specialty societies. So I can just basically outline for the Commissioners that – that as well as an

overarching body for specialists, which is the Royal Australasian College of Physicians there exists a number of specialty societies as well. So I think there's scope for those groups to be working together with the aged care sector.

5 MR KNOWLES: And in terms of those guidelines, would you say that they would go to some of the matters that you referred to a moment ago about a process or the requirements that specialists would expect to have met on attendance at a residential aged care facility to ensure that they are – that their visits are successful and effective?

10

PROF POULOS: Yes. I would think that those guidelines would certainly be a help. It may be that those guidelines might exist on a local basis somewhere but I'm not aware of them.

15 MR KNOWLES: Yes. And in that regard, can I just ask you about those sorts of conditions that as a specialist you would want to have at a residential aged care facility to conduct your practice on a consultation there with a patient. Would you want a particular space in which to conduct the consultation that was private and well lit and the like?

20

PROF POULOS: Yes, you certainly would. And that may vary depending on the aged care home. That space may well be the resident's room if it was adequately lit and there was good access, but I think that it's important that there is a – someone who has a clinical background from the aged care home to be present as well. I think both of those things would be helpful.

25

MR KNOWLES: What sort of equipment should an aged care facility have for specialists who are visiting; is there anything that you think that they should have as a minimum requirement or will it vary from case to case, depending on the nature of the visiting specialist?

30

PROF POULOS: I think it varies from case to case. It also varies between specialties. Now, of course, for some specialties, it's the requirement to have diagnostic equipment that is part of their professional, you know, examination and assessment. It's not going to be transportable, it'll only be available in rooms. But I think that – I think that it would really be on a case-by-case basis I think, but certainly somewhere to adequately conduct an examination in privacy and other, you know, basic equipment which the specialist could bring with them or could be provided, you know, blood pressure machines, those sorts of things, but basic equipment which I would imagine should be available anyway.

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That could be part of the list of “this is what we have” in a guideline; this is what we have, is there anything you require? And if there's a mismatch and it can't be done, and if the person cannot receive an adequate assessment on that basis then maybe we need to look at an in-rooms assessment. I'm not saying that everything should be done within the aged care facility; I think the important thing here is that the person is getting access to the right type of specialist assessment according to their needs.

45

MR KNOWLES: You mentioned earlier, Professor Poulos, that one of the ways in which that interest might be improved was in terms of the curricula in courses of education. Can you just elaborate on how that might occur and do you see any obstacles to it being put in place?

5

PROF POULOS: Yes. Medical schools generally are responsible, my understanding is, for their own curricula but under certain, you know, guidelines with, I believe, Australian Medical Council accreditation. I would think that there are ways that one could look at introducing, you know, what is good practice, what is residential aged care and what is good practice within a curricula. There could be over-arching principles that must be in the curricula of every medical school. Another potential model would be to task maybe a consortia of medical schools with developing an innovative teaching model for students which could be used as, you know, a template or a benchmark that other medical schools could adopt.

10

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There's always competition for time in any medical curriculum. Everyone wants to make sure that their specialty has sufficient time. I think one of the differences with residential aged care is that unless you specifically make allowance for it, students are not going to be exposed, as they would be exposed to the other medical specialties in the course of their training in their general practice attachments and as part of their hospital training. Now, of course, general practice attachment could be one way of exposing medical students but not all general practices, of course, have a nursing home component to their practice.

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MR KNOWLES: Professor Poulos, other than the financial barriers and what you've just referred to now in terms of the issue of interest as such, you mentioned the practical barrier of just the sheer lack of availability of specialists within a particular locality, particularly in rural and remote areas; what are the ways in which you see that being possibly addressed?

30

PROF POULOS: I think – I think once again we need to look at – we need to look at local solutions. I think that hospital outreach models are one model that could address gaps in access to specialists. I've mentioned potential barriers and ways that those barriers could be overcome. But I also think that within the practice of medicine there are fairly strong – often strong relationships that exist between general practitioners and medical specialists in terms of referral networks. People have - GPs will have specialists whom they often refer to, and if they get good service from in terms of rapid assessment of patients and good communication back, and I think we could also perhaps leverage some of that.

35

40

I'm not sure how many GPs specifically will ask a specialist, could you visit a particular patient in the residential aged care facility. I'm not sure how many of those personal approaches happen but certainly that personal interaction between GPs and specialists is something that occurs in general practice in the community.

45

MR KNOWLES: Professor Poulos, obviously that's a more informal mechanism that might arise from one case to another but do you see any way of formalising that

type of arrangement whereby there is a greater access remotely to specialists? I mean, you've mentioned outreach services and you yourself for instance have, as I understand it, consulted patients by telehealth as well.

5 PROF POULOS: Sure. Yes. So turning to telehealth as one possible means of
accessing specialists I think that telehealth has a role. I think that the role of
telehealth – I mean, telehealth will overcome a tyranny of distance. It will – it will
allow a certain amount of work to be done. But it's not necessarily the full answer to
10 the picture, but certainly telehealth as a supplement. So my own experience of
telehealth into residential aged care facilities, not so much for where a patient needs
to have a – where physical examination is a really important part of the assessment
but the telehealth consultations that I've been involved in have been more around
advising on overall management plans and have generally involved the family as
well to a large extent, as well as team members from the residential aged care
15 facility.

So I think telehealth in that sense I think is very – is very important. It – you need to
certainly have sufficient time to be able to undertake that telehealth consultation.
You need to be able to have enough information to be able to put the picture together
20 and you still need to be able to see the patient via a video consultation and have
somebody demonstrate, you know, physical signs with the patient and be able to
communicate with the patient directly. I think telehealth has another important role
particularly in following up patients. I think that – I think it would be very difficult
to do a comprehensive assessment over telehealth because you need to be there but
25 once you've seen somebody and you've done that and you know that person, I think
telehealth has a much greater role in those follow-up consultations and in looking at
how patients have been progressing.

30 MR KNOWLES: To what extent are telehealth facilities in existence in residential
aged care facilities from your experience as someone who's consulted by telehealth
into residential aged care from time to time?

PROF POULOS: I've got a fairly low-tech approach to telehealth. As long as
you've got a good internet connection with good bandwidth and a mobile device with
35 a camera and a microphone and you can get it close enough to the patient and it's
mobile, telehealth generally tends to work for the sorts of consultations that I do. So
they're not diagnostic intensive in the sense that, you know, in high resolution video
or other particular diagnostic techniques over telehealth. That's not the sort of work
that I do.

40

MR KNOWLES: So it really depends on the nature of the consultation - - -

PROF POULOS: Correct.

45 MR KNOWLES: - - - involved as to what type of degree of sophistication one
might require for a telehealth consultation.

PROF POULOS: Correct. Yes, certainly good bandwidth is the most important thing. I think the devices are much less expensive now. I think that devices that are appropriate for telehealth are more readily available.

5 MR KNOWLES: Can I ask you this; you've mentioned outreach services as something that might provide a way in which people in residential aged care get greater access to specialist medical treatment. In your statement you've said that those services, in your view, don't provide a full answer to the issue of access. What limitations do you perceive that they have?

10

PROF POULOS: I know of some very good outreach services, particularly geriatric medicine outreach services and I think that they have a definite role and the role that they have should be expanded and I think that we should learn from the good models and develop those models further, and there should be much more broader coverage. 15 If I had concerns about the outreach models, it is that – that the focus of them has – my understanding of the focus has been that they started and they – they very much have a role in admission avoidance and that's not necessarily admission avoidance in a bad sense, it's basically being able to provide more appropriate care for the person within the aged care home. So I certainly support that role.

20

In terms of those programs having a longer term role in the ongoing management of people in residential aged care homes, I think that that's – that to me has not been the primary purpose for which they've been designed, but it doesn't mean that they could not do that as well. But certainly one doesn't – if the primary – if the primary 25 purpose of these programs is admission avoidance, and the – the purpose is also to provide good long-term care, I think that admission avoidance would trump long-term care in terms of pressure placed on those services, so I think there needs to be a deliberate way of designing those programs so that both can be provided.

30 I think there may be a role for those programs, particularly around the acute episode but the most important thing for me is knowing who is going to be providing that care. So is it going to be the outreach program or is it going to be the GP in association with local specialists or local geriatricians perhaps in private practice. Who is actually going to provide the long-term care. So we don't want to get into a 35 situation of role confusion, that it's going to be the outreach service is going to be doing admission avoidance and long-term care. If that's not the case I think clarity around who has the responsibility is probably the most important thing and those outreach programs may well be part of the picture but I would also say that there is also a role for specialists in private practice working with GPs, certainly those 40 willing to go to residential aged care facilities, and being able to identify who might be willing to go to residential aged care facilities.

I think that I've heard that people often don't know if a specialist will go. A 45 specialist may never have been asked to go but a way of identifying specialists would be helpful.

MR KNOWLES: How do you see those two modes of accessing specialists; on the one hand if there were an outreach service which was designed not necessarily for admission avoidance, as you put it, but rather for longer care as well, as well as a more traditional method of accessing specialists when in the community and not an inpatient by way of referral from GP, how do you see those two measures working together, if at all, in the context of specialist care being delivered to people living in residential aged care?

PROF POULOS: Yes. Both of those models could, of course, work side-by-side, depending on local needs. It is also possible that you could design a model where a specialist outreach service was providing good longitudinal care and those specialists in private practice were providing that as part of the outreach service. So there are various models that could be considered and I think that in designing these models we need to sit down and look at them and maybe compare different models and evaluate which ones are working best. But it may be that there are local requirements as well that influence the way a model might be designed.

COMMISSIONER BRIGGS: Is that really, apart from the training aspect, the reason you would engage the specialist colleges because the colleges are basically where these people are registered and work together and maintain their professional links and qualifications and whatnot?

PROF POULOS: Yes. Yes, I think in my witness statement I talk about a potential role for the colleges. I have a view that might be considered a little altruistic but our health care system is largely public-funded, including the private aspects of our health care system, and I think that it would be entirely appropriate for the colleges to be charged with the responsibility of developing these models, working with the specialty societies and coming up with some solutions to the problem. I don't recall – I don't know if – if the government or – has – whether the colleges are actually being specifically approached to say you need to be – we would like you to work on these models and, you know, the carrot could well be that we're going to try and fix the MBS to make them work as well or look at other funding models such as specialist outreach programs and how those could be funded.

So I think that there's a lot of potential here, and I think the colleges are ideally placed. They have strong roles in education and in policy and advocacy so yes, I would see a role for that.

COMMISSIONER BRIGGS: And it seems to be the way you could more effectively systematise these arrangements rather than the current ad hoc arrangements which often just work on the basis of personal connections; a doctor has moved in, or a doctor appears at the local, for example, MBS service as we saw in Rylstone and says, "I'm here, I've just bought a hobby farm".

PROF POULOS: Yes. No, I agree.

COMMISSIONER BRIGGS: Thank you.

MR KNOWLES: Professor Poulos, you say in your statement at paragraph 75 that in your experience people living in residential aged care with serious illness or injury have lower rates of access to rehabilitation.

5 PROF POULOS: Yes.

MR KNOWLES: And then if I can take you to paragraph 77, there you set out some reasons why you told that view that hospital-based rehabilitation is limited for people living in residential aged care facilities.

10

PROF POULOS: Yes.

MR KNOWLES: And it extends just across the page to those reasons that appear in sub-paragraphs (a) through to (f), just looking at those matters that are set out on the screen there, can you just say, in your view, how you see each of these potential – or these barriers to access to hospital-based rehabilitation, potentially being addressed, or improved?

15

PROF POULOS: Yes. So just clarifying the question, did you want me to go through these barriers or are they – will we take this as read in the statement?

20

MR KNOWLES: Yes, so take them as read but if I can go to the first one, there in sub-paragraph (a) you've referred to the pressure on hospital beds. Now, can you just explain how that issue might be addressed in some way to ensure that there are great – there's greater access to rehabilitation for people living in residential aged care facilities?

25

PROF POULOS: Yes. Well, assuming that there will always be some pressure on hospital beds, I think that we need to be looking at other models that don't necessarily rely on hospital beds. So rehabilitation in the home is clearly one approach that – that I think can well be utilised, particularly for people living in residential care where I think it's likely that rehabilitation in the home provided to someone in residential care is likely to be cost effective, and it's likely to also provide better care, particularly for people who are living with dementia and might have cognitive impairment where the familiar environment and the care staff are able to better provide for their – for their care on that sort of regular basis within the aged care facility, the aged care home.

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MR KNOWLES: Just pausing in relation to rehabilitation in the home, are you aware of models of rehabilitation in the home that exist in Australia?

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PROF POULOS: Yes. I'm aware of some local models.

MR KNOWLES: Yes.

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PROF POULOS: My understanding is that rehabilitation in the home is not – it's a concept that is – that is gaining – that is gaining pace, as I believe it is internationally

as well, as we're looking at ways to address pressure on hospital beds and also provide more appropriate care. I know of three local models in Sydney. One of those is – has – is currently not being funded, it hasn't been funded for a couple of years, but at Hornsby Hospital there's a rehabilitation in the home service. The one
5 that – that was established by St Vincent's Hospital, my understanding is that it hasn't been funded by that health service for a couple of years, but that particular program did provide rehabilitation within residential aged care homes for people with amputation in particular.

10 And there's a model in South Western Sydney area health service which is very much a hospital substitution model. So they run eight virtual rehabilitation beds in the community, but they don't have capacity to see people in residential aged care; they mostly are seeing people in the community. But that is a hospital substitution model. There are, of course, also models, and I think I refer to this in paragraph 67,
15 for specialised brain injury and spinal cord injury rehabilitation programs. Certainly in New South Wales they are specialised state-based programs and they will provide outreach into residential aged care homes.

MR KNOWLES: What are the kinds of rehabilitation service – you've mentioned a
20 range of models there from a hospital substitution model to other models that perhaps provide a slightly different nature and extent of rehabilitation. What are the kinds of services that people get access to in a home environment pursuant to these models so far as you understand it?

25 PROF POULOS: We're talking about people living at home, not in – not living at home in a residential-aged-care home or both?

MR KNOWLES: In either environment, but just, generally, are you able to say
30 from one case to the next as to what the types of models might be and what services are actually provided by way of rehabilitation to people getting rehabilitation in the home in this way?

PROF POULOS: Sure. Firstly I would say that there is not a lot of access to
35 rehabilitation in the home because these are not wide-spread programs and they're still quite small in scope. The sorts of programs – so if I look at the south-western Sydney one for example – it includes specialised allied health staff. I believe they use nursing from a community nursing-service and a rehabilitation advance trainee with access to a rehabilitation-medicine physician. And they also have access –
40 because it is hospital substitution – some of these patients will require – and particularly these – this service is particularly referring to people who are living in the community, not in a residential-aged-care home; people will often need access to personal-care support, during, particularly, the early stages of their recovery. So that particular program in south-western Sydney will access State-based post-acute personal-care services, I think, called compacts. Or they rely on the person having a
45 willing and able carer who's able to provide that sort of personal-care support.

In terms of specific programs that go into residential-aged-care homes – one that I know of, which is, probably – the only one that I know of at least was a – only done as a randomised trial in – I believe, in Adelaide a few years ago, which I reference in my witness statement, which was a program specifically designed for people post hip fracture in a residential-aged-care home. And the design of that particular trial was –
5 the resident received an in-reach from a hospital program involving specialised physiotherapy, dietetics or nutritional assessment and access to a geriatrician versus usual care, usual care being in the nursing-home, post transfer back from acute. So these are the patients that have not had rehabilitation in a hospital. They've gone
10 straight from the hospital back to, either, the treatment group, which was the outreach program, or into the nursing-home for usual care, and that trial – they didn't deliver a lot of care, but compared to usual care it was a lot of care.

So the intervention group, I think, received between 10 and 11 hours of
15 physiotherapy over four weeks, specialised physiotherapy over four weeks, and the usual-care group, which involved a large number of nursing-homes, I believe, 76 – those residents received only – less than – around about two hours over four weeks. So we're looking at 10 to 11 hours versus two hours' usual care. Now, the intervention in that trial showed that at four weeks residents had greater mobility
20 and, certainly, decreased mortality as well, which is important. But I don't know if those programs are wide-spread. There's, certainly, a need for them. I would think that residential aged-care is the ideal place for us to be developing rehabilitation-in-the-home models.

Because of the fact that – one of the big barriers to rehabilitation in the home is that provision of personal-care support during the recovery phase. Now, you've got that in a residential-aged-care home. You've got it 24-seven. So it's a matter of then looking at innovative ways of bringing the rehab to the home, to the aged-care home, which can be done by I think, a number of models, by hospital-outreach programs. I
30 think there could be – well be private providers who are specialising in those programs, or residential-aged-care homes could develop capacity with guidance from specialised services to be delivering those programs themselves, particularly some of the larger providers, where there's more scope to develop that capacity. So I think a range of models could be developed, and, certainly, I think that whatever we do
35 develop, though, should be formally evaluated, and we should be benchmarking and learning so that we can continually improve the models that are developed.

MR KNOWLES: Professor Poulos, one of the ways in which, you say, that might be capable of being delivered is through – as part of a hospital-outreach service.
40 How might that work?

PROF POULOS: Yes; certainly. As part of a hospital-outreach service – those rehabilitation programs could, certainly, be part of those outreach services. Outreach services are already multidisciplinary, and it would be just a matter of making sure
45 that you have the multidisciplinary staff able to deliver rehabilitation programs and access to appropriate medical specialists, including geriatricians and rehabilitation-medicine physicians. I think that that outreach model is an ideal way to do that, but

as I said, I wouldn't discount other providers providing those services. I think we should be looking at the best way that those services can be provided. And whether they're provided on a separate basis or provided through the outreach program depends on the model that you've developed, whether it's a full model, where the
5 outreach service provides it all, or they use some brokerage to provide elements of it.

COMMISSIONER BRIGGS: Could I just ask – we've heard a lot of evidence about people going into hospital because they've broken a hip or some other part of their body, excluding the back. And the advice given from the hospital is really – to them
10 and their families – “You can't go home; you have to go into residential aged-care.” Now, what you seem to be saying is what's often behind that is there's no personal-care support to help them go back to their own home, therefore residential aged-care is the only option. So I suppose my question is “Is there the possibility of something
15 like that, where personal-care support might be made available to assist the person go back to their own home while undergoing a period of rehabilitation?”

PROF POULOS: Yes. For somebody who isn't already in a residential-aged-care home when they've had their hip fracture for example, there is the availability of the
20 transitional aged-care program.

COMMISSIONER BRIGGS: Yes.

PROF POULOS: That has some capacity to provide personal-care support as well
25 as the rehabilitative- or restorative-care elements. So there is that. There is also, I think, potentially, capacity – if we've got overstretched hospitals and we've got residential-aged-care facilities that may not be fully utilised, I think, there is capacity to be looking at some more – slower stream – if you like, for term that's used –
30 rehabilitation within a nursing-home environment. You mentioned the cottage environment or – the cottage environment could be one environment or – within a residential-aged-care home that was specifically set up to be able to provide that. I think that that's a model that we don't have. I understand that that's a model that is
35 in place in the Netherlands, and, of course, in the United States they have a model called – where people go to skilled-nursing facility, which is not too dissimilar to a residential-aged-care home in my understanding, but – where people can get access to this – may be not as intense, but – a bit-more-prolonged program.

Our hospitals are designed around – even our rehabilitation hospitals are very much
40 designed around – it's got to be intense, you've got to be out in a certain period of time, but, of course, for older people that – it's often better, if it's not as intense and it's actually a bit longer in duration and we're looking after nutrition. And these things take time. So I think we should be looking at other models. I don't think that
45 we've looked at the rehabilitation-in-the-nursing-home model at all in Australia because we – because of various conflicts between Commonwealth and State, and no one's really got together to design some models. But I think that that's somewhere where we could be looking.

COMMISSIONER BRIGGS: Thank you.

MR KNOWLES: Professor Poulos, on that, if I can just return to what's on the screen before you in paragraph 77 and in particular subparagraph (c) – I think you
5 might have just in your response to the Commissioner now mentioned one way in which you might actually address that particular issue, that people who are living in aged-care or older people who are generally – may be seen to be unable to tolerate the more intensive rehabilitation associated with hospital-rehabilitation services and the existence of alternatives would operate as some way of addressing that. Is that –
10 do I understand your evidence correctly in that regard to be something that would address what is in paragraph (c) there?

PROF POULOS: Yes; that would be one way of addressing paragraph (c). I think that it's implied – if I haven't made it entirely clear in my witness statement – that
15 rehabilitation is at one end of a spectrum in terms of addressing functional decline, and then in – and then there are other approaches that are variously called restorative care, re-ablement that also similarly address functional decline that are often less intense. I think the important thing to note here is that people in residential-aged-care homes don't – who are already in a residential-aged-care home don't have
20 access to, either, the transitional aged-care program or the relatively new short-term restorative-care program, and in terms of the latter, the short-term restorative-care program – people on a home-care package can't access that particular program. So there are those other barriers with access to both of those programs, particularly for people in residential aged-care but also for people on home-care packages, who
25 would benefit from restorative approaches.

MR KNOWLES: Just briefly could I ask you to go back to paragraph 77. In terms of ways in which access to rehabilitation might be improved for people who are living in residential-aged-care – and just starting at paragraph (b), you've referred to
30 misconceptions held by people about people living with dementia and the benefits or otherwise of rehabilitation for people living with dementia. Could you just explain what you see as being the solution there?

PROF POULOS: Yes. I think firstly there's a recognition that people who are
35 living with dementia will benefit from rehabilitation. There is evidence to suggest that, if you've got marked degrees of cognitive impairment, you may do less well in terms of some of the outcome measures used, but in terms of relative improvement or improvement nonetheless – people who are living with dementia, certainly, certainly, do benefit. I think in the case of people living with dementia – I think that hospitals
40 are the wrong place for people to be. I think, if you're from a – I'm talking about people here from a residential-aged-care home, of course, that – I think you would get better care, your better day-to-day care in terms of being able to engage with residents by people who know them.

45 I think the mismatch comes about because hospitals aren't good at – environmentally and sometimes from a staff-training perspective aren't good at being able to manage well people living with dementia. But they're good on the technical aspects of

rehabilitation, particularly around for example, post-hip-fracture rehabilitation, where there are going to be different requirements depending on the nature of the fracture and the way that the fracture has been surgically corrected. The residential-aged-care home, of course, doesn't have those sort of technical skills but is – has better skills – and the environment is often better placed to manage people living with dementia and engaging them, and so I think that's where we need to be combining the two, which, I think, is what that trial in Adelaide tried to do through an outreach program. And I think particularly for people living with dementia we should be trying to bring the rehabilitation to them.

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MR KNOWLES: Professor Poulos, in terms of the remainder of those matters that you've referred to there – can I just move directly to paragraph (f), where you've talked about the split in responsibilities between federal and State, territory Governments. One of the things under consideration in this hearing is a proposition to the effect that the national health-reform agreement should include performance targets for States and territories to ensure that patients over 65 years old, particularly those living in residential-aged-care facilities, should receive an appropriate period of subacute rehabilitation with funding tied to that requirement. Do you have anything to say in respect of that kind of proposal in principle? Would it be effective in some respects in addressing some of the concerns you have, particularly in relation to what's set out in paragraph (f)?

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PROF POULOS: In principle I would support that proposition, that people should have access to subacute rehabilitation. Another potential way of looking at it is, if with – as if – would be looking at whether the funding could perhaps be somehow tied to the resident or the patient so that they would be entitled to that funding and they can, in a similar way to the way that the home-care market may have gone – I'm throwing this in as a thought, and, clearly, the detail needs to be worked out, but whether it's done at that high level of reform or whether there are other models that could ensure that people do actually get access to those rehabilitation services on the ground – if the funding somehow sat with the person and they were able to use that funding to access the program.

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MR KNOWLES: I have no further questions for Professor Poulos, Commissioners.

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COMMISSIONER PAGONE: Mr Poulos, thank you very much for giving us the benefit of your experience and knowledge. It's been very helpful indeed. Thank you.

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PROF POULOS: Thank you, Commissioners.

<THE WITNESS WITHDREW

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MR KNOWLES: Think that concludes proceedings for today, Commissioners.

COMMISSIONER PAGONE: For the day? All right. We will adjourn till 10 o'clock tomorrow morning.

5 **ADJOURNED**

[4.01 pm]

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