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**TRANSCRIPT OF PROCEEDINGS**

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O/N H-1037311

**THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner  
MS L.J. BRIGGS AO, Commissioner**

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

**DARWIN**

**10.08 AM, FRIDAY, 12 JULY 2019**

**Continued from 11.7.19**

**DAY 35**

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

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. This morning Ms Jo-Ann Lovegrove has  
5 come to give evidence about the experiences of her father in the aged care system in  
the Northern Territory, and amongst other things, she will also speak about her  
reflections on those experiences. I call Ms Lovegrove. Ms Lovegrove is already in  
the witness box.

10 COMMISSIONER TRACEY: Thank you.

<JO-ANN MAYSE LOVEGROVE, SWORN [10.09 am]

15 <EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Ms Lovegrove, is your full name Jo-Ann Mayse Lovegrove?

20 MS LOVEGROVE: Correct.

MR GRAY: Have you made a statement dated 3 July 2019 for the Royal  
Commission?

25 MS LOVEGROVE: Yes.

MR GRAY: Operator, please put on the screen document WIT.0209.0001.0001.  
Ms Lovegrove, is that a copy of your statement?

30 MS LOVEGROVE: Yes.

MR GRAY: Ms Lovegrove, if you please look at page .0003, which the operator  
will bring up, paragraph 22, the last sentence of that paragraph you wish to delete, I  
understand; is that right?

35 MS LOVEGROVE: That's correct.

MR GRAY: So, subject to that amendment being made, to the best of your  
knowledge and belief, are the contents of the statement true and correct?

40 MS LOVEGROVE: Yes, they are.

MR GRAY: Thank you. I tender the statement.

45 COMMISSIONER TRACEY: Yes, the witness statement of Jo-Ann Mayse  
Lovegrove, dated 3 July 2019 will be Exhibit 6-31.

**EXHIBIT #6-31 WITNESS STATEMENT OF JO-ANN MAYSE  
LOVEGROVE DATED 03/07/2019 (WIT.0209.0001.0001) AND ITS  
IDENTIFIED ANNEXURES**

5

MR GRAY: Ms Lovegrove, I invite you to read your witness statement from paragraph 5.

MS LOVEGROVE: Thank you.

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MR GRAY: Thank you.

15

*My dad is 79 years of age and I've acted as his attorney under an enduring power of attorney since 31 August 2011. Dad has been diagnosed with Alzheimer's and macular degeneration since approximately 2013 and requires full-time care. My dad was on a level 4 care package up until he was, as it is referred to, a respite in a permanent bed. I call it this because I have to make an application for extension of Dad's respite every 21 days because of proceedings before the Administrative Appeals Tribunal.*

20

*In 2016, due to Dad's Alzheimer's and macular degeneration becoming worse, I looked into permanent residency and full-time care that he required. Dad then became respite in a permanent bed in a residential aged facility in a regional location in the Northern Territory on 24 February 2017, known as a regional facility. The regional facility was the best choice for my dad because he was close to his immediate family, other than myself as I am based in Darwin. He wanted his dog close by and the facility allowed him to keep his dog with him. He was also allowed to smoke. Ultimately, the regional facility was set up for my dad's lifestyle and needs.*

25

30

*The regional facility is outdated and old with around 50 to 80 residents who require medium to high full-time care and I've only seen handrails in his bathroom. As I live 300 kilometres away I was unable to visit Dad on a regular basis while he resided at the regional facility. Although I am aware that he would often be neglected while staff cared for other residents, additionally I had requested from staff a weekly call to keep me updated on my dad's condition and time at the regional facility. However, I never received a call. I, therefore, had to contact the regional facility for general updates and to see if he needed anything.*

35

40

*Even though Dad has Alzheimer's and macular degeneration, his room was not equipped with crash mats, motion sensors, bed rails or handrails. I had continually asked the hostel if they had a plan in place to deal with Dad's condition and as it progressively got worse. The regional facility response was always "Yes, we are in touch with Dementia Support Australia regularly". I also had to remind staff that Dad needed water frequently. He doesn't always remember he needs it, nor to ask for it. This should have been a regular task to*

45

give Dad water but because the carers left him alone regularly, he wasn't getting enough. We also tried giving him a water bottle but these were going missing.

5 My visits to the regional facility were limited to weekends due to the distance in travel. During my visits, I would notice that his room and en suite were not always clean. This had meant that there was constantly urine on the floor and around the toilet area. There was also an incident where I found a roll of toilet paper soaked in some fluid and covered in mould behind the toilet. There were less staff employed on weekends and even seemed as if no employees were there to clean. The three staff that were there on weekends, that I had seen, had to do everything for the residents such as giving medication, handing out cigarettes, doing their washing, et cetera.

15 Dad would often share his meals with his dog by dropping food on the floor for him. This encouraged flies in his room. Outside there was also a water bubbler where Dad spent most of his day and we had to bring it to the staff's attention on more than one occasion that it had mould growing in it. While my dad was a respite resident at the regional facility there are four occasions that I would like to raise. The first one was Dad slipped on what was assumed to be urine whilst getting out of bed. Secondly, Dad collapsed and was rushed to hospital via ambulance. His blood pressure had fallen dramatically and his heart rate was extremely low. It was believed to have been caused by an internal bleed.

25 However, given his condition, it was decided that further investigation ran a higher risk than benefits and so he was monitored via regular blood tests. Dad was constantly dehydrated and our family constantly had to remind staff to give him water.

30 And the fourth incident was Dad was involved in an altercation with another resident resulting in a wound on his back. We believe the altercation resulted from inappropriate words being said by my dad due to the era he grew up and thoughts that are not politically correct in this era pertaining to Indigenous people. He therefore spoke badly to those that were Indigenous which resulted in an altercation. I had explained to staff of this when Dad was admitted in the hope that the knowledge would prevent and minimise contact with the Indigenous residents. I undoubtedly believe that the incident mentioned could have been preventable had the staff members of the regional facility understood the severity of my dad's condition and taken appropriate care for him and subsequently other residents.

45 Dad had a fall while a resident at the regional facility in March 2018 and was rushed to the regional hospital. At this time, I applied to have Dad transferred from the regional facility to another facility near Darwin so that he could be closer to me. Dad had another fall on 16 September 2018 at the regional facility and broke his hip. He was taken to the Royal Darwin Hospital on the

5 same day. The staff members of the regional facility and I are unsure on what caused his fall. The staff at the regional facility had contacted me at approximately 1.30 pm on 16 September to inform me that Dad had a fall at around 9.30 am that day and had been taken to the regional hospital. Dad was airlifted via care flight from the regional hospital to the Royal Darwin Hospital at around 11.40 pm.

10 On or about 13 December I was advised by the discharge planner at the Royal Darwin Hospital that negotiations had taken a place and my dad was to be moved to a residential aged care facility in the Darwin area, on 14 December. The Darwin facility was not my choice of nursing home for Dad. Unfortunately, due to the appeals tribunal process, no nursing home would take Dad. I/we had no choice but to accept this outcome. I wanted Dad to go to another facility as they would allow him to smoke. However, they refused to take him unless he paid the bed deposit in full.

20 The Darwin facility was enclosed and fully air-conditioned. Dad had never used an air-conditioner nor a fan. It had a small outside area. The Darwin facility, other than being in a metro area and being close to me, didn't really suit Dad as he was not allowed to smoke or have his dog with him. I attended a meeting on 17 December with the clinical manager at the Darwin facility where I was informed that my dad had had a fall while in their care. From this information, I requested that my dad's bed be fitted with side bars for his safety. I was informed that the Darwin facility will not provide these bars as they were considered to be restraints on the resident. The staff assured me that there were motion sensors below the bed to inform the staff that the resident was out of bed.

30 On this occasion, however, the sensors did not activate and my father had the fall. The clinical manager had explained to me that she was to assist the risks of residents on Monday of each week. She also claimed that there only 10 falls over the weekend and none of which caused serious injury. It seemed as if she was quite proud of this number. Dad was constantly cold, and I provided the Darwin facility with socks and shoes as well as long-sleeved clothing for this reason. Although – staff would not always do this, and I had to ask that they put his shoes and socks on for him. Again, this shouldn't be something that I have to ask for, especially considering I'm not always there. On the 17<sup>th</sup> of December 2018 I telephoned the Darwin facility to request an update on the assessment and what steps would be taken to prevent my dad from falling again. I was informed that nothing had been done.

45 On the 18<sup>th</sup> of December 2018, I visited Dad at the facility, the Darwin facility, and was confronted by my dad covered in bandages all over his body and dried blood on his face. To my knowledge: these injuries occurred because of his attempt to get out of bed or his wheelchair. Injuries would also include skin tears to his arms and legs, which he had almost daily, injury to his cheek, nose, bruising to his arms, legs, feet, and he had a bedsore on his bottom. I do not

5 know why my dad still had dried blood on his face prior to my visit, and I'm concerned as to the length of time it takes staff members, to care for my dad after these incidents. Days later it was agreed, that Dad's bed should be placed against the wall so that he could only get out on one side of the bed and, hopefully, limit any potential falls. There were also crashmats and motion-sensor mats placed on the floor, and Dad was given a low bed with a concave mattress to prevent him from getting up.

10 I believe the staff of the Darwin facility notify me each and every time an incident occurs – for example: when Dad manages to get himself over the concave mattress and set off the motion mat – however, this is, usually, hours later of – which, I assume, is due to time to address Dad's injuries and other pressing matters. I am, usually, advised of steps taken, which include cleaning and dressing the wound.

15 One of the calls from the Darwin facility was to advise that Dad had punched a carer who was wheeling him around. She stopped and bent down to do something, and he punched her. I believe, because he cannot see very well, that she had startled him. I advised the Darwin facility as to my dad's politically incorrect communication with Indigenous people that cause problems at the regional facility. However, on one of my visits to the Darwin facility – one of my visit the Darwin facility – had placed Dad at a table with an Indigenous man who was playing the clapsticks and singing loudly. This had really aggravated Dad, and the staff at the Darwin facility did nothing. So  
20 I had to remove him from the situation.

25 I met with another staff member, as the clinical-manager was on leave, regarding Dad's want to walk and subsequent falls and thought that some intense physio might help him. The staff member advised me that the Darwin facility do not offer intense physio and that it would have to be done externally. Dementia Support Australia were coming to see him, and I wanted to be there for the meeting to find out how to get Dad up and strengthening – strengthen his legs so that he could walk safely and – therefore preventing further falls. My dad was not been able to walk since he broke his hip while at the regional facility.  
30

35 I rang Dementia Support Australia regarding the intensive physio to try to get Dad strong, but they suggested that only supported walks were required to achieve this. After my phone call with the Dementia Support Australia, I was advised by the Darwin facility that the meeting with the Darwin Dementia Support Australia had been cancelled because his want to walk was, apparently, not a dementia-related issue. He can't remember that he can't walk. I really believe that it is a dementia-related issue.  
40

45 Doctors had prescribed risperidone, which was not effective, and subsequently lorazepam to try and calm him. The lorazepam keeps him calm for approximately two hours, of which – they use this time in the mornings to wash

and change Dad. It was concerning, that the doctor did not seek my authorisation, as Dad's power of attorney – to issue or administer any medication. The nurse rings me after the doctor's visit to advise me of the medication that has been decided, that the doctor has decided to give Dad. I would ask why, and they would explain it was to calm him. During these conversations I would Google the drugs to see what they were. I didn't ask for the decision to be reversed; however, I had been advised that the dose of lorazepam has been halved.

I have noted that, since the doctor prescribed lorazepam, Dad seems to spend more time in bed. This has led to a bedsore on his bottom. I'm disturbed by the amount of time he now seems to spend in his bed, and I can't help but feel that this suits the staff of the Darwin facility more than it suits Dad. These drugs had put my dad into such a confused state; he looks as though he has – he isn't mentally present. Please see the photos attached – of my Dad prior to entering the Darwin facility.

MR GRAY: Ms Lovegrove, I'll just stop you there. We'll display Tab 45, please, operator. Is that a photograph of your father before entering the Darwin facility?

MS LOVEGROVE: Yes, it is.

MR GRAY: And we'll now display Tab 48.

MS LOVEGROVE: This is the attached photo of my dad after the lorazepam was prescribed.

MR GRAY: Please continue, Ms Lovegrove.

MS LOVEGROVE:

On or around ANZAC Day, 25 April 2019, I received a phone call from the Darwin facility, advising that Dad had an unwitnessed fall from his bed, and on consulting with the doctor, I was advised that he required stitches and was being taken to the Royal Darwin hospital by ambulance. I asked if anyone from the Darwin facility was going with Dad to the hospital and was advised, no, it was not policy, for this to happen. I expressed my dissatisfaction with this, stating with Dad's condition, dementia, it was a bad idea, to send him alone. I expressed this at least five times during my phone call. Dad's cognitive function does not allow him to understand where he is, what is happening, what medication he is allergic to et cetera.

I travelled immediately into the RDH, which is about a 50-minute drive. Dad had not yet arrived. When he did, I was taken to the bed he was being admitted into. During the examination and treatment process, the doctor asked a lot of questions that he, clearly, couldn't answer, what day it was, what injury he had sustained and where it was located on his body, what medication he was on, if

5 *he had any allergies. He is allergic to penicillin, but he couldn't tell him that. They advised Dad that they were going to put a local sedation on his wound so they could treat it, it was going to be painful. I suggested to the doctor that Dad would, probably, lash out, if it hurt, and, therefore, we should seek assistance from one of the nurses so that we could, the nurse and I, restrain Dad's arms during this procedure. Dad was at the Royal Darwin hospital all day and did not return to the nursing-home until late. I don't believe that the doctor was aware of my dad's aggression, and I'm very concerned – should this happen again and I'm unable to go to the hospital with Dad, what could, potentially, happen to him.*

15 *After the event, the following Monday, the 29<sup>th</sup> of April, I spoke with a staff member at the Darwin facility. I understand from the staff member that a handover note from the Darwin facility was provided to the ambulance officers, which in turn is passed to the treating doctor at Royal Darwin Hospital. The staff member printed out a document and showed it to me, but I didn't get a chance to read it. It wasn't – I wasn't given a copy of the document. The staff member told me that it was standard practice, to provide that note. I do not know what was in the note or what happened with it on the day. All I know is that the doctors seemed unaware of my dad's aggression, which led to myself and the nurse restraining him. This is a major issue, as his carer was not with him to explain to staff his medical condition or his attempt to keep him calm throughout the day. I have since asked the Darwin facility for a copy of the document provided by the RDH, and I was provided with a hospital transfer form.*

30 MR GRAY: Just stopping you there, Ms Lovegrove, we'll now display Tab 49. Please continue, Ms Lovegrove. Operator, please leave the transfer form on the screen for a moment. Thank you.

MS LOVEGROVE: The hospital transfer form refers to Dad's diagnosis of Alzheimer's but does not refer to his behavioural risks.

35 MR GRAY: And, Ms Lovegrove, that's around the middle of the page that's now displayed, around the areas where there's black redactions; correct?

MS LOVEGROVE: Correct.

40 MR GRAY: Thank you. Please continue.

MS LOVEGROVE:

45 *I was told three different stories regarding this injury. The first call on the day was that – staff said Dad had hurt his arm while getting out of bed. I called the staff the following day, seeking what had happened to cause my dad's injury on his arm. I wanted to see what was near his bed that could cause the injury but was told that it was in fact his shoulder. However, Royal Darwin Hospital did*

5                    *not treat his shoulder. They treated his arm. Finally, staff of the Darwin facility told me that in fact it was an old skin tear on his arm that he had ripped open. Dad has declined dramatically, and it breaks my heart, to see this once-fit active kind gentleman left in his bed or princess chair. He's confused, lonely and fading.*

MR GRAY: Ms Lovegrove, would you like me to read the remainder of the paragraph?

10 MS LOVEGROVE: Yes, please.

MR GRAY:

15                    *He is left in his bed or princess chair, confused, lonely and fading fast. I want to see my dad cared for and looked after by the staff of the Darwin facility the way he should be.*

Shall I continue?

20 MS LOVEGROVE: Yes, please.

MR GRAY:

25                    *My other concern is with the staff training and knowledge of dementia residents. For example: one carer was unable to put socks on my dad's feet, which led to my dad getting aggressive. I had asked the carer to give my dad something to hold onto while I put his socks on. The carer then gave my dad a wooden block. Knowing my dad gets aggressive due to his dementia, I was instantly concerned – that the carer gave my father this block, as it was very*  
30 *likely he would hit me or the carer with it. I quickly put the socks on with no problem at all.*

MS LOVEGROVE: Thank you.

35 MR GRAY: Now, Ms Lovegrove, would you like me to ask the questions that we discussed earlier?

MS LOVEGROVE: Yes, please.

40 MR GRAY: Reflecting on the experiences of your father in the aged-care system in the Northern Territory and focussing for the moment on the care of your father and care issues relating to your father as opposed to bed deposits, what outcomes are you hoping for – from the royal commission?

45 MS LOVEGROVE: I would like to see more funding for staffing-levels. I believe, especially in a dementia ward, due to the high level of needs and the requirement – the lack of mobility for the dementia patients, the fact that my dad requires three staff

to hoist him up to change his incontinence pad, to shower him, to dress him et cetera, it's high-level staffing needs, and I don't believe that at the moment they have the ability, with the staffing-levels, to do this on a regular basis throughout the day. So – more funding, definitely. We need more staff. He needs help with all of that. He  
5 also needs help to be fed at mealtimes, and he needs the time to be able to eat his meal at a slow rate. He's a very slow eater, and if he takes an hour to eat sometimes, they think he's full, and they'll take the meal away. He's not. He's just very slow. Hydration needs to be kept up at all times, which requires people to do that consistently.

10 MR GRAY: Is he on a special hydration regime?

MS LOVEGROVE: Yes, he is. He has to have pureed food and thickened fluids.

15 MR GRAY: And, with respect to nutrition, how long does it take your father to eat a meal?

MS LOVEGROVE: It can take up to an hour.

20 MR GRAY: Did you have any other matters you wish to raise around staffing?

MS LOVEGROVE: There appears to be quite a lot of staff that English is a second language, and I see that my dad struggles to understand what they're trying to communicate to him and this can make him very aggravated. He has trouble hearing  
25 and it just creates such aggression and confusion within him.

MR GRAY: Can I ask you about the bed deposit issue you mentioned in your evidence. What has been the impact of dealing with that issue on you, on behalf of your father?

30 MS LOVEGROVE: It has been very traumatic. I have had to spend two and a half years focusing on that which has distracted me from actually being my dad's carer. I am an only child so I don't have siblings to support Dad's care level and that has been really, really sad for me. It's devastating, actually.

35 MR GRAY: Are there any other matters that we haven't covered that you would want to speak to? I believe we have covered the matters you mentioned to me.

MS LOVEGROVE: Yes. Yes. The situation with Dad going to the hospital in an ambulance without a carer, I really feel, is extremely appalling; it's just not a good  
40 idea with somebody with dementia to be sent off. That would have been very distressing and confusing on its own, let alone without a familiar face. I find that extremely disappointing.

45 MR GRAY: I have no further questions for Ms Lovegrove, Commissioners.

COMMISSIONER BRIGGS: I wondered, just as an issue of fact, if I may, when you were looking for alternative nursing homes, you found one you liked and they rejected you on the basis that you couldn't afford the level of the bond up-front. What kind of money was the institution asking for?

5

MS LOVEGROVE: I believe it's \$345,000.

COMMISSIONER BRIGGS: \$345,000, and they didn't see a way that you could pay some money and maybe some money on a rental basis? They just wanted it all up-front; is that right?

10

MS LOVEGROVE: Correct. You either have to pay the bed deposit in full or 5.76 per cent thereof.

15 COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: Ms Lovegrove, thank you very much for sharing your very distressing experiences with us. They will certainly assist us in better understanding the difficulties confronted by people who are looking after loved ones who are in aged care and we will certainly be better informed now as to the sorts of problems that can arise and hopefully craft some solutions that will make sure that they don't occur in the future. Thank you very much for your evidence.

20

MS LOVEGROVE: Thank you.

25

COMMISSIONER TRACEY: Mr Gray, do you want to take a break now, before the next witness?

MR GRAY: Well, we're in your hands, Commissioners, we are perfectly willing to proceed now or take the morning break now.

30

COMMISSIONER TRACEY: Yes, we will continue.

MR GRAY: Thank you. Ms Lovegrove, I believe you are excused.

35

MS LOVEGROVE: Thank you very much.

40 <THE WITNESS WITHDREW [10.39 am]

MR GRAY: Our next witness is Doctor, or Professor Janet Kathleen Sluggett. I call Janet Sluggett.

45

<JANET KATHLEEN SLUGGETT, AFFIRMED [10.39 am]

**<EXAMINATION-IN-CHIEF BY MR GRAY**

5 MR GRAY: Thank you, Dr Sluggett. Should I refer to you as Dr Sluggett?

DR SLUGGETT: You may, yes.

10 MR GRAY: Thank you. I'll ask that a document be brought up on the screen; it's  
WIT.0251.0001.0001. Dr Sluggett, you made a witness statement for the Royal  
Commission dated 27 June 2019. Is that document, the code which I've just read  
out, a copy of the first page of that statement?

DR SLUGGETT: Yes.

15 MR GRAY: To the best of your knowledge and belief are the facts referred to in the  
statement true and correct and the opinions in it opinions which you hold?

DR SLUGGETT: Yes.

20 MR GRAY: I tender the statement.

COMMISSIONER TRACEY: Yes. The witness statement of Dr Janet Kathleen  
Sluggett dated 27 June 2019 will be Exhibit 6-32.

25

**EXHIBIT #6-32 WITNESS STATEMENT OF DR JANET KATHLEEN  
SLUGGETT DATED 27/06/2019 (WIT.0251.0001.0001)**

30 MR GRAY: Dr Sluggett, your statement is very detailed and informative. I wish to  
ask you questions about aspects of your statement. I'm not for a moment  
diminishing the importance of all the statement, but we will start with your  
professional background. Operator, on page .0001, if we could call out paragraph 3  
35 and 4. You have an early career fellowship from the National Health and Medical  
Research Council.

DR SLUGGETT: Yes.

40 MR GRAY: What is your current role?

DR SLUGGETT: My current role is as a research fellow, so an NHMRC early  
career fellow at Monash University in the Centre for Medicine Use and Safety.

45 MR GRAY: And you've also got a one-day per week position as a research  
pharmacist within a provider; is that right?

DR SLUGGETT: So I am – as part of my employment with Monash University, I am embedded two days per week as part of that four days within a residential aged care provider – or aged care provider organisation.

5 MR GRAY: And I will ask you about that role when we get towards the end of your statement.

DR SLUGGETT: Yes.

10 MR GRAY: Because it has clearly got very important implications for what can be achieved in terms of understanding the use of medications in the aged care context, hasn't it?

DR SLUGGETT: Yes, it has.

15

MR GRAY: Thank you. Now, you are yourself a registered pharmacist.

DR SLUGGETT: Yes.

20 MR GRAY: You're also a research pharmacist and that's essentially your current role; is that right?

DR SLUGGETT: That's correct.

25 MR GRAY: You've got a lot of experience in actually conducting medication management reviews both in the community and in the residential care context: haven't you?

DR SLUGGETT: That's correct.

30

MR GRAY: And, again, I will be asking you about the mechanics of how one does those reviews a little later in your evidence. Is it the case that for two years running, you were the South Australian and Northern Territory Pharmacist of the Year?

35 DR SLUGGETT: In 2017, I was named the SA/NT Pharmacist of the Year by the Pharmaceutical Society of Australia.

MR GRAY: Your formal qualifications include a Bachelor of Pharmacy, a Graduate Diploma in Clinical Epidemiology. You have other qualifications as well  
40 but principally I should mention your PhD in pharmacy.

DR SLUGGETT: Yes, that's correct.

MR GRAY: That's all correct, isn't it, thank you. Now, if we – operator, go to the  
45 next page, and just have that available. You refer to various other professional appointments of relevance; I won't detain you by asking about them. You then refer to your research background and you say that under your early career fellowship

from the NHMRC you are focusing on using big data to understand and improve medicine use in older Australians receiving community and residential aged care services What is big data in that context?

5 DR SLUGGETT: Yes. Big data refers to the process of pulling together the large amount of information that's collected in the course of health care ...

## 10 **PORTION OF FAULTY OR MISSING AUDIO**

## **ADJOURNED**

15 **RESUMED** [11.04 am]

COMMISSIONER TRACEY: Sorry about that, Professor. These things happen unexpectedly. I assume communications are restored.

20

MR GRAY: So we're told, Commissioners. We understand there was a power failure that interrupted court services and transmission and power has now been restored and the link has now been restored, so we can continue with the evidence.

25 COMMISSIONER TRACEY: Very good. Please proceed.

MR GRAY: Thank you. Dr Sluggett, I was asking you about the meaning of "big data" in the context of your description of the focus of your research, namely, using big data to understand and improve medicine use in older Australians receiving community and residential aged care services.

30

DR SLUGGETT: Yes. Thank you. So in the context of healthcare and the data I work with, "big data" refers to the large amount of routinely collected information that occurs within – as part of the process of accessing healthcare, and so it refers to the volume of data that's collected routinely but also ways that we can pull that data together from different sources and link it all together with the purpose of better understanding processes and outcomes associated with that care.

35

MR GRAY: Thank you. You mentioned in your research background your current study on simplification of medications. I'll come to that towards the end of your evidence as well. Before we go into the particular content of your statement relating to some of the side – risks associated with the use of various medicines, particularly in the older population, I want to ask you about a research group known as the Registry of South Australians within the South Australian Health and Medical Research Institute. You've been collaborating with the Registry of South Australians; is that right?

45

DR SLUGGETT: Yes. I have for the last several months as part of my fellowship.

MR GRAY: Thank you. I want to ask you about two preliminary reports of a project being conducted by the Registry of South Australians, which is known as ROSA, isn't it?

DR SLUGGETT: Correct.

MR GRAY: I'll ask firstly about antipsychotic medicines dispensed before and after in residential aged care, preliminary report of ROSA, which is Tab 129. So, Dr Sluggett, firstly, what's the nature of this particular project?

DR SLUGGETT: Thank you. So this particular project set out to look at how psychotropic medicine – so, in this example, antipsychotics – the use of those medicines changes in the 12 months before someone is admitted to residential aged care and then the 12 months afterwards.

MR GRAY: Thank you. And if we go to page .0002, we see that there's a particular cohort of not just South Australians but Australians generally who are the subject of this study; is that right?

DR SLUGGETT: That's correct. So there's two main parts to the ROSA registry. There's a national historical component, which has linked health data for residents – all residents who have had an aged care assessment and accessed aged care services, I believe, since 1977. So it's a very long historical amount of linked data about those residents, and then there's also a prospective component, which follows residents of South Australia prospectively. So this particular analysis looked at using the historical component of the registry.

MR GRAY: And was the focus on people who entered permanent residential aged care in a two-year bracket between 1 July 2013 and 30 June 2015?

DR SLUGGETT: That's correct.

MR GRAY: And it also looked at the year either side of that bracket. Is that right?

DR SLUGGETT: That's right; so we looked at medicines use the year either side. So that way, if somebody entered in the 1<sup>st</sup> of June 2013 – we still needed to look back the 12 months earlier to look at their medicines use.

MR GRAY: Thank you. And if we look at the data sources for the study and call out the paragraph immediately under that heading on page 2 – please just explain in summary terms the data that was used.

DR SLUGGETT: Yes, certainly. So we linked the ROSA historical component links together a range of different data sources. Some of that data comes from the Australian Institute of Health and Welfare, and it tells us about what types of – when

someone had an aged care assessment, the date, the data that was collected as part of that assessment. It also tells us what aged care services they access.

5 And so for this particular study we were interested in what was the date that the person accessed residential aged care. It also contains information about the data collected as part of the ACFI assessment process; so we have access to all of that type of data. It collects information – we used information from the Medicare Benefits Schedule, which is claims submitted by GPs for services that they may provide under that Schedule, and also from the Pharmaceutical Benefits Scheme; so  
10 we can see when medicines are dispensed under that subsidy scheme to residents.

MR GRAY: So just pausing there – would it be fair, to say that the study that is conducted under this project is resting on an inference that, if a medicine is dispensed, it's probably being administered as well?  
15

DR SLUGGETT: That's correct. So dispensing is close to the point of care, but it's not at the exact point of care. So we're making an assumption that, if a medicine was dispensed, it was administered. We don't know, when a medicine is dispensed, if it's for – necessarily, for regular use or for when-required use. So we don't know the exact duration of use from this study, but we can infer it in some analysis using the data.  
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MR GRAY: We'll now go to page 5, and, Dr Sluggett, could you please just outline, for the Commissioners, the characteristics of the cohort. It seems to have been a very large cohort.  
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DR SLUGGETT: It was, and that's because it includes all eligible Australians who access residential aged care during that two-year period. So it is a truly national representative study, because it includes everybody. And so there were 90 – more than 97,000 residents included in this study. And so we saw in the three months after somebody entered residential aged care – 21 per cent of all residents were dispensed an antipsychotic at least once during that three-month period.  
30

MR GRAY: Perhaps we should now go to the graph which is on page 7, and if you would, please explain the first, perhaps – the top graph, and then we'll go to the second graph, which is a separation of two groups within the overall cohort; is that right?  
35

DR SLUGGETT: Yes. Thank you. So in the top graph we can see on the bottom axis – that is the three-month intervals in the 12-month period before someone enters residential aged care and the 12 months afterwards, and on the vertical axis – that represents the proportion of people who were dispensed an antipsychotic. So what we can see is, 12 months before the group of people entered residential aged care, there was around – just over five per cent of people were dispensed an antipsychotic at least once during that nine-to-12-month pre-period. And then, as we move closer to the point of entering residential aged care, there is – the prevalence of use of an antipsychotic or the proportion of people dispensed an antipsychotic starts to  
40  
45

increase. And so in the three months before somebody enters residential aged care, it's roughly – around 12 per cent of people are dispensed an antipsychotic at least once. And in the three months after somebody has residential aged care, it's around 20 to 21 per cent – it's around 21 per cent of residents, and in that year afterwards, there doesn't seem to be a large change in the proportion of people using – dispensed an antipsychotic. So it stays relatively stable.

MR GRAY: What are your reflections on that step change between three months before and three months after?

DR SLUGGETT: A couple of comments. So I guess these are a cohort of people that all enter residential aged care, and so when they're living in the community, we may expect that their symptoms are starting to progress, and they may need – the goal of care may – one of the goals of care may be to remain at home, in the community as long as possible. And so it may be that an antipsychotic may be trialled to help to manage some of the behavioural and psychological symptoms of dementia.

And then – so, certainly – that may explain some of the increase leading up to the time of admission. There seems to be a large jump in antipsychotic-dispensing in the three months before and the three months after, and so it tells me that during that time of transition, whether it's when people are transitioning from the community to residential aged care or from community to hospital to residential aged care, there seems to be an initiation of psychotics, particularly during that period.

I imagine that, for some residents, the transition from home to residential aged care may cause stress or distress, and so that may present as – more people may present with sort of behavioural symptoms of dementia during that time, particularly if they're unable to communicate verbally. And so antipsychotics may be commenced to manage those symptoms. And so I guess it indicates to me as well that non-pharmacological techniques to manage the behavioural and psychological systems of dementia are going to be particularly important during those – that transition time and during those first few months of stay in a residential aged care facility.

MR GRAY: The Commission has heard a lot of evidence in the Sydney hearing, including from Dr Juanita Westbury, about whether the prescribing of antipsychotics for people showing behaviours associated with their living with dementia was appropriate, given the very significant risks, many of which you explain in your statement. So we'll come to those issues. I should let you explain the graph below as well, which identifies who within the cohort had a diagnosis of dementia; is that right?

DR SLUGGETT: That's correct. So in this particular graph – we've taken those analyses, and we have stratified by – the results by whether a person had a formal diagnosis of dementia, and so in the orange line we see people who are living with dementia, and in the grey line we see people who do not have a formal diagnosis of dementia. And what we can see is that increase in antipsychotic-use is particularly

pronounced among people who have a formal diagnosis of dementia, and that is consistent with one of the indications of use for antipsychotics.

5 COMMISSIONER TRACEY: In this context what does “at least once” mean? The writing of one prescription which, potentially, could, as we have been told, provide for the availability of the drug for up to 12 weeks; is that right?

10 DR SLUGGETT: The – “at least once”: it means that they received a – one PBS supply of the medicine during that time. So it depends on what dose the medicine is prescribed at and what the frequency is and whether – if it’s prescribed for regular use or occasional use. And so it’s true, that a medicine may be dispensed just in case, if it’s on a when-needed basis, and never used, or it may be dispensed for regular use. So we’ve just looked for one dispensing during a three-month period.

15 COMMISSIONER BRIGGS: Interestingly, however, that the high rates of dispensing thereafter don’t peak. They remain at that level.

20 DR SLUGGETT: That’s correct. That’s correct. So the rate of – that tells me that, during that period after which somebody enters residential aged care, it may not be the same people, who are on antipsychotics each quarter, but the rate of initiation must be very similar to the rate of discontinuation, because it plateaus.

25 MR GRAY: Thank you, Dr Sluggett. I’ll now ask you about the second preliminary report, which is Tab 130, which appears to relate to different families of psychotropics.

DR SLUGGETT: Yes. This report mentions the use of antidepressants and also benzodiazepine medicines.

30 MR GRAY: And is it otherwise, essentially, using the same data and the same methodologies?

35 DR SLUGGETT: Exactly; the same data, the same methodologies for exactly the same group of people who access residential aged care services.

MR GRAY: Thank you. So shall we go to the summary on page 3? And if you could please explain that, and then we’ll go to the associated graphs.

40 DR SLUGGETT: Yes. So using the same methodology, we looked at whether a person received a supply of an antidepressant in the three months following entry to residential aged care, and we found that 38.8 per cent of residents received at least one antidepressant during that time period. We also found that 28.6 per cent of residents were dispensed at least one benzodiazepine medicine during that time period.  
45

MR GRAY: Thank you. We'll go to page 5, which appears to be an overlay of both the benzodiazepine and antidepressant-dispensing, and if you could please explain that graph to us.

5 DR SLUGGETT: Yes. So the green line represents benzodiazepines. So benzodiazepines are medicines which are used for a range of different conditions but some of the most common indications for use are trouble sleeping, insomnia, and also for anxiety. So what we can see is around 15 per cent of people are dispensed a benzodiazepine at least once every quarter in the lead-up to sort of entering  
10 residential aged care. In the three months before entering residential aged care we can see it slightly increases to around 17 per cent of people and then in the three months after entering residential aged care, it increases to around 25 per cent, and then it starts to drop off a little bit and it remains at around 20 per cent of residents every quarter receiving a benzodiazepine at least once.

15 MR GRAY: Do you have any reflections, just pausing there, on that peak, although it must be said the prevalence of dispensing of benzodiazepine doesn't return to the base line but there is a marked peak there.

20 DR SLUGGETT: Yes.

MR GRAY: Do you have any reflections on that, Doctor?

25 DR SLUGGETT: Yes. Again, during that transition period I suspect that, you know, people may be transitioning from community to residential aged care. It might be via hospital. This can – this, you know, could be a stressful time for some people and this could present as people feeling stressed, people feeling anxious, or people not being able to sleep and so that might be one of the reasons why we're seeing an increase in the dispensing of that medicine at that point.

30 MR GRAY: Thank you. And please go on and explain the antidepressant - - -

35 DR SLUGGETT: Yes. So antidepressants are used for a range of conditions including depression but also things such as pain. And so there was quite a high prevalence of use 12 months before entering residential aged care. We can see that it's around 28 per cent of individuals were dispensed an antidepressant nine to 12 months before entering. Then we see a gradual increase in the use of antidepressants so it's roughly around 32 per cent in the zero to three months before entering residential aged care and it's roughly around 37 per cent in the three months after.  
40 So we're seeing more of a gradual increase in the use of those medicines.

45 MR GRAY: I might now ask the operator to display both page 6 and 7 at the same time, splitting the screen into two. Is it the case that these are graphs which again separate out different subgroups within the cohort?

DR SLUGGETT: Yes, that's correct. So in these figures we have again stratified our findings by whether a person has a formal diagnosis of dementia or not. And

what we can see is in Figure 2 that the prevalence of antidepressant-dispensing is very similar among people with and without dementia in the lead-up to entering residential aged care and thereafter. And what we can see when looking at Figure 3 when looking at the proportion of people dispensed a benzodiazepine the use  
5 benzodiazepines follows a similar pattern in both cohorts of people but we're seeing a reduced prevalence of benzodiazepines in people living with dementia as compared to people without dementia.

10 And that is – I think, that is a positive part of the finding because we have also seen in the previous graph that people with dementia are much more likely to receive an antipsychotic and so antipsychotics and benzodiazepines are both sedating medicines and that can lead to a range of medication-related harms. And so it's possible that because people may be on an antipsychotic, there's recognition of that and less use of benzodiazepines in that particular group of people, but it is still a reasonably high  
15 prevalence of use.

MR GRAY: Thank you very much. We can close those documents now. And we will return to your witness statement at page .0003. In the heading under  
20 "Relationship between medicines use and selected resident health outcomes", you identify five risk factors in relation to medication use or perhaps overuse in the context of residential aged care; is that right, Doctor?

DR SLUGGETT: That's correct.

25 MR GRAY: And we will go through those in succession, falls, urinary incontinence, infectious diseases and antimicrobial resistance, weight loss and diabetes management. In respect of falls, you refer to research conducted within the Centre for Medicine Use and Safety, I take it.

30 DR SLUGGETT: Correct.

MR GRAY: And you've also acknowledged all your collaborators in that Centre whose work has provided much of the foundation for what appears in the statement, I understand.  
35

DR SLUGGETT: Correct. It's very much a team effort so I've drawn on evidence from a range of different people's research projects as part of our Centre. So, yes, I definitely acknowledge those people.

40 MR GRAY: Could you please give the Commissioners an overview of the studies conducted and what the research is saying in respect of falls risk associated with medicine use within – medication use within aged care.

45 DR SLUGGETT: So some of the evidence that I've presented in this section is around an ongoing cohort study that we've been conducting in residential aged care. It's involved six residential aged care services in South Australia. The residents included in that study were recruited in 2014 and we have been following them over

time since that period. So there's 383 residents that have been involved in this particular study. And so we have done a range of different sort of research studies involving this cohort of residents and it has been valuable in providing clinical information and risks associated with medicines use. So we know that there are  
5 certain medicines which can increase the risk of a person falling and those medicines include medicines such as psychotropic medicines which we've heard about, opioid pain reliever type medicines, and also medicines that can cause orthostatic hypotension, which is when there is a sudden – a drop in the blood pressure when you are going from sitting to standing or from lying to standing.

10 And so these are some of – we know are some of the high-risk medicines that can increase the risk of falls. So in this particular study we were interested in what is the prevalence of use of those types of medicines associated with an increased falls risk among residents, and then also how many falls do residents have. And what we  
15 found was that of the 383 residents included in this study, 92 per cent of residents took at least one medicine known to increase the risk of falls. And when we looked at that a little bit closer we saw 74 per cent of residents took at least one psychotropic medicine or an opioid medicine and 86 per cent took a medicine that could worsen orthostatic hypotension. Interestingly, in this cohort of residents, there was a  
20 relatively low prevalence of use of antipsychotic and sedative hypnotic medicines.

MR GRAY: Thank you. And there seems to have been an analysis in two parts of that cohort, and the effects of the use of those medicines that increase the risk of falls. What was the finding in relation to the first stage - - -

25 DR SLUGGETT: Certainly. Thank you. So we followed the residents for 12 months and we looked to see how many falls they had during that time. And what we found was that the median number of falls per resident was one. And so – but there were 206 residents, so just over half of all residents who had at least one fall.  
30 And so on average, the average number of falls for those residents was three during that 12-month follow-up period. And then we also looked at hospitalisations for falls or conditions relating to falls, so fractures, so falls and fractures and what we - - -

MR GRAY: Was that the second stage of the analysis?

35 DR SLUGGETT: This was a second part of the analysis.

MR GRAY: Thank you.

40 DR SLUGGETT: And so what we found was that when looking at hospitalisations for falls and fractures from residential aged care services they account for one quarter of all hospitalisations over a 12-month period.

45 MR GRAY: Thank you. Could you speak to the separate root cause analysis and, firstly, could I just ask, when you use that expression “root cause analysis” in a context of association with medication and falls risk, what's the methodology, how do you go about - - -

DR SLUGGETT: Certainly. So in other studies, we have looked at what medicines are associated with falls. In a root cause analysis we are really trying to identify some of the underlying processes or contributing factors that are the main causes for an event. So it's really a process of identifying who the cases are, so in this case they  
5 were people who were hospitalised for falls and then collecting data about those people to understand more about potential causes for those falls and those hospitalisations. And then reviewing that data and finding potential contributing factors and then generating some recommendations about how we could prevent this from happening in the future, or minimise the risk of this happening in the future,  
10 and then looking at implementation of those recommendations.

MR GRAY: So just stopping you there, the process seems to be a painstaking inquiry-based process rather than a statistical analysis; is that - - -

15 DR SLUGGETT: That's correct. So it's - - -

MR GRAY: And then the findings, so to speak, are submitted to a panel of experts; is that right?

20 DR SLUGGETT: Exactly. So we engaged a panel of experts as part of this process. I believe it might to be 10 to 12 experts as part of a multidisciplinary panel so we included a geriatrician, a GP, aged care provider staff, a physiotherapist, pharmacists, a consumer representative and other people. And so we asked them to give us advice on what kind of data do we need to collect to start with, and then also we presented  
25 to them some of our findings and asked the clinical panel what were their recommendations moving forward about how we could reduce the falls and reduce the hospitalisations potentially.

MR GRAY: And there were a range of strategies that came out of that expert panel,  
30 as I understand.

DR SLUGGETT: Correct.

MR GRAY: Distilling them all – perhaps that's not possible, but what was the  
35 headline recommendation that you've noted in your evidence?

DR SLUGGETT: Yes, I've noted that there were quite a few recommendations relating to the potential contribution of medicines to the falls and the fall-related hospitalisations and this involved things like increased doses immediately before a  
40 person fell, a falls risks medicines and also use of when required and regular falls risk medicines at the same time, and also other factors such as – there were a range of other health services that we sort of identify.

MR GRAY: And a recommendation you highlight out of this is the need to have a  
45 falls risk status section up front so every carer can see it in the care documentation for the resident; is that right?

DR SLUGGETT: That's important. And, also, we reflected on that, you know, a community pharmacist is dispensing a medicine that could be associated with an increased risk of falls but the community pharmacist may not have any clinical information or knowledge about that resident. And it would be nice for, you know –  
5 a community pharmacist could play a role in flagging this person is being dispensed a medicine that could increase the risk of falls. Perhaps you should consider monitoring this resident a little bit more closely in the next couple of weeks to see if they are at an increased risk of falls. But because the community pharmacist doesn't  
10 have a lot of information about the person's baseline falls and whether they are low risk, medium risk, high risk, it was felt that displaying that type of information more prominently on the medication chart and giving that information to all stakeholders involved in care might help to reduce some of the risks associated with falls.

MR GRAY: Thank you. The Commission has heard evidence about the devastating impact that falls can have on the quality of life, indeed, the life, of a person in aged care. It can really be a crisis which leads to a far worse outcome for them for the rest of their lives, can't it?

DR SLUGGETT: Yes.  
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MR GRAY: So this is a very important measure.

DR SLUGGETT: Certainly.

MR GRAY: Now, could I ask you about the second side effect or risk factor that you've identified as particularly acute in connection with the use of medications in aged care, which is urinary incontinence. This is a section of your statement beginning at page 5 and going over the next two pages. Firstly, you've, in effect, defined it for us and then you've referred, based on administrative data from the  
30 ACFI process, to what you understand to be the prevalence of urinary incontinence.

DR SLUGGETT: Yes, that's correct.

MR GRAY: Which is extremely high.  
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DR SLUGGETT: Yes, approximately two-thirds of residents experiencing one episode of urinary incontinence each day.

MR GRAY: And Dr Sluggett, you've identified every likelihood of a connection with medication in respect of at least a significant number of those people; is that  
40 right?

DR SLUGGETT: Yes, it seems that there is quite a lot of use of medicines which could be associated with urinary incontinence, either new incontinence or worsening existing incontinence. So data from the general Australian population suggests that  
45 nine out of 10 older Australians could be using a medicine that is associated with urinary incontinence.

MR GRAY: And you've given us a table on the next two pages of a number of common medication groups.

DR SLUGGETT: That's right.

5

MR GRAY: That have a worsening effect or an exacerbating effect or a causative effect even.

DR SLUGGETT: That's correct.

10

MR GRAY: For urinary incontinence.

DR SLUGGETT: And so there's a wide range of medicines – types of medicines that can be implicated in urinary incontinence and different types of urinary incontinence.

15

MR GRAY: So, without going to them all but just for the purposes of in effect public education on this - - -

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DR SLUGGETT: Yes.

MR GRAY: - - - there's ACE inhibitors, blood – they are blood-pressure-lowering medicines.

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DR SLUGGETT: Yes; that's correct.

MR GRAY: There are other medications used to lower blood pressure, alpha-1-adrenergic antagonists.

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DR SLUGGETT: Yes.

MR GRAY: You've referred already to antipsychotics. They also have this effect on urinary incontinence as well.

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DR SLUGGETT: They can impact on urinary incontinence in a variety of different ways.

MR GRAY: And you've already mentioned benzodiazepines.

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DR SLUGGETT: Yes. So the antipsychotics and benzodiazepines – one of the mechanisms is through – it could exacerbate functional incontinence. So functional incontinence is when a person is not able to get to the toilet in time, and so if a person is taking a sedating medicine or a medicine that affects their movement or their alertness, then – that could impair their ability to get to the toilet in time.

45

MR GRAY: Thank you. And particularly in the context of residential aged care, we know that there's quite a significant prevalence of people living with dementia.

DR SLUGGETT: Yes.

MR GRAY: We're told it's over 50 per cent.

5 DR SLUGGETT: Yes.

MR GRAY: And so one of the other families of medicines you've mentioned, cholinesterase inhibitors, seems particularly relevant in that respect for those people with Alzheimer's disease.

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DR SLUGGETT: Correct.

MR GRAY: Is that right?

15 DR SLUGGETT: Correct. If they're – if they are being treated with a cholinesterase inhibitor – there is a side effect associated with that medicine that some people may potentially experience, which is urinary incontinence.

MR GRAY: And that, presumably, may have a compounding effect on some degree of cognitive impairment they already may be living with; is that a fair .....

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DR SLUGGETT: So the cholinesterase inhibitor is used in the treatment of – to – helping to improve memory among people living with Alzheimer's disease.

25 MR GRAY: But if they have a degree of cognitive impairment, that may - - -

DR SLUGGETT: That condition itself may be impacting on your ability to recognise when you need to get to the toilet.

30 MR GRAY: And you also mention that diuretics are used for certain cardiovascular health conditions.

DR SLUGGETT: Correct; so things like heart failure – to get rid of the fluid that accumulates in the body.

35

MR GRAY: And a couple of families of antidepressants are mentioned there, and I haven't mentioned all of the families of therapeutic substances in the table, but it's quite an extensive table.

40 DR SLUGGETT: It's quite an extensive table, and so – some of these medicines are used quite commonly among residents. And so I think it's a challenge, because it's how – is everybody able to recognise all of these medicines and how they might contribute to urinary incontinence.

45 MR GRAY: And with reference to the points that you've given us in paragraph 15, what do you suggest could ameliorate the effect of medication on urinary incontinence?

DR SLUGGETT: Yes. Certainly. So I think pharmacists as medicines experts are really well placed to be able to identify potential medicines that may be contributing to someone's incontinence, and so increasing the input from pharmacists into residential aged care setting could be one mechanism to achieve this. Another  
5 mechanism could be involving pharmacists at the time that an ACAT is done, because, obviously, urinary incontinence is an important contributing factor that can contribute to the decision to move to residential aged care, and so looking a little bit earlier at medicines that may be impacting on urinary incontinence could also be beneficial.

10 MR GRAY: Thank you. The third factor which you have identified as associated with the use of medications in the aged care context is infectious diseases and anti-microbial resistance.

15 DR SLUGGETT: Yes.

MR GRAY: And you've identified for us that there are antimicrobial-stewardship initiatives currently in progress. Is that right?

20 DR SLUGGETT: So in the hospital setting, there's dedicated antimicrobial-stewardship activities. Internationally there are dedicated antimicrobial stewardship initiatives in residential aged care, and so I guess as part of our research we were looking at what are some of the factors around that. So we conducted a root cause  
25 analysis, looking at hospitalisations for infection, using a similar methodology that I talked about before, and I guess, skipping to the recommendations – one of the recommendations of that clinical panel was around the importance of antimicrobial stewardship in residential aged care and the need to establish those systems.

30 MR GRAY: So there's a gap in the aged care setting by comparison with hospitals, is there?

DR SLUGGETT: I believe so. Yes.

35 MR GRAY: And this study was – was this study addressing the extent of that and what should be done about it?

40 DR SLUGGETT: It wasn't addressing it so much in terms of anti-microbial-stewardship activities; it was looking more – what are the contributing factors to infections and hospitalisations for infections, and some of the contributing factors were, potentially, suboptimal use of antimicrobials in the residential aged care setting and inability to administer certain types of antimicrobials, and so – a range of issues  
45 around quality use of antimicrobials. And so therefore it was thought, if we could improve the way those medicines were used in the residential aged care setting, then – perhaps that may reduce some of the need to hospitalise people. So that was where the antimicrobial stewardship recommendation came about.

MR GRAY: Thank you.

COMMISSIONER BRIGGS: I'm not sure I understand that.

DR SLUGGETT: Yes.

5 COMMISSIONER BRIGGS: Can you put it a bit more in layman's language. Are you saying that more effective prescribing could reduce the incidence of microbial problems or not? I just didn't understand.

10 DR SLUGGETT: Yes, certainly. So we know that factors such as selecting too broad a spectrum antibiotic or using antibiotics for too long or at inappropriate doses or inappropriate routes of administration can increase the risk of – contribute to antimicrobial resistance in the community.

COMMISSIONER BRIGGS: So it's about resistance.

15

DR SLUGGETT: So it's about improving the way that antimicrobials are used, initiating treatment at the right time, at the right dose, the right selection, and so therefore the antimicrobial stewardship-type program could contribute to improved use of antimicrobials overall.

20

MR GRAY: And you mention in paragraph 18(b) that there's actually a mandatory program to, in effect, encourage appropriate use of antibiotics in the US in the aged care setting.

25 DR SLUGGETT: Yes. I don't have a huge amount of detail on that program, but it is a mandatory program that exists to really try to bring together stake-holders to improve the way that infections are managed.

30 MR GRAY: Yes. And when we're talking about antimicrobials, is it antibiotics, or is it a broader group than antibiotics .....

DR SLUGGETT: Yes. So it's antibiotics and also things like antivirals. So they're all related to the treatment of different types of infections.

35 MR GRAY: And if they're overused – that can encourage the development of pharmaceutical-resistant strains of the relevant microbes. Is that right?

DR SLUGGETT: That's correct.

40 MR GRAY: Such as MRSA and so forth. Is that right?

DR SLUGGETT: Yes. So you could develop strains of – we could – antibiotics may not work against the conditions that they used to work against.

45 MR GRAY: And this might, for example have very adverse effects on infection of, say, open pressure injuries and things of that kind within an aged care setting; is that one of the concerns?

DR SLUGGETT: I guess, if antibiotics aren't working as well, then it's difficult to resolve an infection.

MR GRAY: Yes.

5

DR SLUGGETT: Yes.

MR GRAY: You also mention influenza.

10 DR SLUGGETT: Yes.

MR GRAY: Could you tell the commissioners what the current status of any influenza program is in our country in the aged care setting and what your recommendations would be about that.

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DR SLUGGETT: I'm sure there's a lot of variation in different areas, but in some of the services that I'm aware of, there is a structured program for staff vaccination, but in some settings it's more dependent on the GP coming to see the resident on an individual basis and prescribing and then arranging for the administration of an influenza vaccine. We know the Australian immunisation handbook strongly recommends that all residents should receive an influenza vaccine to prevent the risk of the flu, but evidence suggests that not all residents receive a vaccination, and of course, obviously, resident choice around the decision about whether they want to have a vaccination is important, but I do also feel that perhaps a more structured approach to vaccination of residents could increase vaccination rates and then, therefore, reduce the risk of influenza in this setting, which is a cause of hospitalisation and adverse outcomes such as death.

20

COMMISSIONER TRACEY: A disproportionate percentage of the deaths from influenza in the current round in Australia have been residents of care facilities for the elderly. I appreciate they're more vulnerable, but is there a case to be made for compulsory medication – anti-influenza vaccines both for staff and residents of such facilities?

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DR SLUGGETT: I think resident choice is still important, but I think it needs to be an informed choice. And so – I think sometimes having a discussion with a resident or then contacting a family member to discuss the pros and cons of influenza vaccination can take time, and I'm not sure if that time is dedicated across all services for all residents. And so I, certainly, see that there could be a more structured approach where there could be a more dedicated effort to try to vaccinate as many residents as possible but still balancing resident choice and preferences, I suppose.

35

MR GRAY: Thank you. Dr Sluggett, I'll go now to the fourth risk factor or side-effect factor that you've identified from use of medications in the aged care setting, which is weight loss, on page .0010, and you've in fact under that heading "Weight loss" referred to a number of conditions which, it appears, would have an impact on

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somebody's quality of life, not limited to weight loss but around other aspects that might affect appetite.

5 DR SLUGGETT: That's correct. So there's a range of different ways that medicines could contribute to, eventually, a person losing – unintended weight loss. So of course, if you're taking a medicine that causes you to feel nauseous, you might not feel like eating, if you have a dry mouth or you're having difficulty swallowing because of a medicine. That could impact on your food intake and therefore lead to unintentional weight loss. And, certainly, if you – if there's a difference in your taste of – in your sense of taste or smell, which sometimes medicines can impact – this  
10 could also reduce your – the amount of food that you're eating.

MR GRAY: And you raise here the need for a residential-medication-management review in the event that those events occur, if for example, weight loss is noticed.  
15

DR SLUGGETT: Correct. That's right.

MR GRAY: And I'll be asking about those reviews shortly. But this is, in effect, a mechanism by which the pharmacist becomes involved and what? Reviews whether  
20 the medication regime's appropriate.

DR SLUGGETT: Certainly. Yes. And I guess my point with that section was that there's such a broad range of medicines that can affect your appetite and your food intake, and it sometimes can be difficult, to pick out which particular medicines may  
25 be – if any, are contributing. And so that's where input from a pharmacist and their sort of medicines expertise can be beneficial.

MR GRAY: Thank you. Let's go to the fifth risk factor, which is the effect of the medications on diabetes-management, and in the centre – have you recently  
30 conducted a broad literature review or - - -

DR SLUGGETT: That's correct. This work was led by one of my PhD candidates, Jacqui Stasinopoulos, and we really wrote sort of synthesised information available in the Australian and some international studies to really outline some of the  
35 important factors relating to medication-management in people with type 2 diabetes in residential aged care.

MR GRAY: You refer to the McKellar guide-lines for managing older people with diabetes.  
40

DR SLUGGETT: Correct.

MR GRAY: And what's the thrust of those guide-lines as – a person with, say, type 2 diabetes is getting older, and they're in their older years. Is there a sort of a  
45 balancing process that has to take place about - - -

DR SLUGGETT: That's correct. So, traditionally, when somebody's younger, we might have more-intensive management, because we're trying to prevent some of the long-term complications of diabetes. So – things like macro-vascular effects, which are sort of cardiovascular effects, heart attacks and strokes, and microvascular effects. So – things like problems with your kidneys and your eyes. So we might manage someone more intensively when they are younger, to try and prevent those long-term complications.

When somebody gets older and they're in their final months or years of life, you know, their response to medicines can change and their ability to process medicines can change and people can be sometimes more at risk of the harms associated with medicines. So they may be more at risk of things like hypoglycaemia which is when your blood sugar drops too low, and there may be difficulty recognising when someone is presenting with hypoglycaemia. And so sort of the focus of management in those guidelines stresses it's more about quality of life and balancing – balancing sort of the symptoms of hyper and hypoglycaemia with quality of life.

MR GRAY: And just circling back from hypoglycaemia to the first risk factor you've identified, falls risks – is there an association?

DR SLUGGETT: Yes, there is. Yes.

MR GRAY: Now, you refer in 22(e) on page .0011, to strategies to reduce the risk of those side effects once this sort of balancing process - - -

DR SLUGGETT: Yes.

MR GRAY: - - - is occurring and quality of life is assuming a greater importance than preventative strategies in diabetes management. Could you just elaborate on those strategies.

DR SLUGGETT: Yes, certainly. So I've identified there that it's important to assess the resident's risk of hypoglycaemia and there is a glucose-lowering medicines risk assessment tool in the McKellar guidelines that we have mentioned. It's also important to consider things such as medication reviews, education for residents and staff, looking at whether we can de-intensify or deprescribe and withdraw some of the diabetes medicines if there's a risk of hypoglycaemia and harm.

Strategies such as avoiding the use of sliding scale insulin so when the insulin dose is prescribed as a range and then staff administering that dose will vary the dose based on a person's blood sugar level, and also particular emphasis on looking at medicines management and use at glucose-lowering medicines in the final weeks and months of life because there may need to be changes to a medication regime in those final weeks and months of life, particularly as your symptoms progress and you've got reduced food intake and things like that.

MR GRAY: Dr Sluggett, thanks for your evidence on those five risk factors that you've drawn out. Could I just ask you, in effect, a general question by way of a conclusion to that part of your evidence. In effect, you're telling the Commissioners that there are risks associated with the prevalence of prescribing of medicines along  
5 the lines of those five risk factors at least. Do you have any basis – at present do you have any views about whether the levels of prescribing of the medications that produce those risk factors are too high at the moment in the residential aged care setting in particular?

10 DR SLUGGETT: I think we can see that some medicines, the prevalence of use is very high. So we just looked at the data around psychotropic medicines which are prescribed to a large proportion of residents. So certainly there is a problem with overuse of certain types of medicines. There are lots of medication-related problems that can lead to hospitalisations and poor health outcomes for residents. And so it's  
15 certainly about prevalence of use but it's about a lot of other factors underpinning the way that medicines are used as well.

MR GRAY: This Royal Commission is called, amongst other things, to inquire into the extent of substandard care. Where you have, in effect, the risks outweighing the  
20 benefits, in your view is it reasonable to regard that as substandard care, if prescriptions are made in circumstances where the risks outweigh the benefits?

DR SLUGGETT: Yes, I guess so. I guess what we need is a mechanism to identify people who are at risk of medicines-related problems and resolve those problems,  
25 and so I think we can improve on that process in residential aged care.

MR GRAY: Thank you. Could I ask now about the next topic you address in your statement beginning on page 12 and going for three pages. You've identified the issue of polypharmacy in residential aged care which is something the Commission  
30 has heard about, but if you could give the Commissioners a brief outline of your interpretation of polypharmacy and where it becomes a problem particularly in the aged care setting.

DR SLUGGETT: Yes. So polypharmacy refers to the use of multiple medications.  
35 So in the general community setting we generally use a definition of five or more medicines on a regular basis could be termed as polypharmacy. In the residential aged care there's a high – a high burden of medication use and if we're using polypharmacy as an indicator, if we were to use that definition of five, it would probably pull up most residents. So in residential aged care we tend to see a different  
40 definition used and the most common definition used is the use of nine or more regular medications to define polypharmacy.

It's very common in the residential aged care setting to be taking multiple medicines so we have done some work looking at the prevalence of the polypharmacy in the six  
45 residential aged care that I mentioned early and we found that 63 per cent of residents are taking nine or more medicines so around two-thirds of residents.

MR GRAY: What are the potential difficulties – clinical difficulties that can arise from polypharmacy if it's not very carefully monitored and reviewed?

5 DR SLUGGETT: So polypharmacy itself, so the number of medicines that you take has been associated with a range of poor health outcomes in the community setting and also in the residential aged care setting, so an increased risk of side effects, an increased risk of hospitalisations, of falls, of cognitive impairment; a range of those types of poor health outcomes.

10 MR GRAY: Is this because certain families of therapeutic substances have a compounding effect over the other or what is - - -

15 DR SLUGGETT: Correct. So if you are using a medicine that is associated with a risk of falls, there is some evidence to suggest if you are using multiple medicines or cumulatively higher doses then you may have a greater risk of falls, for instance.

MR GRAY: And are there also other forms of potential interaction between the active agents in these drugs that have to be taken into account, like cancelling effects and things of that kind.

20

DR SLUGGETT: Of course, so there's things like drug interactions where two medicines may not mix very well together and so that can affect the dosing or the types of side effects you might see.

25 MR GRAY: You refer in paragraph 27 to work of Jokanovic and others in connection with identification and prioritisation of strategies to manage polypharmacy in Australia. Now, you've identified quite a few strategies there. Are there any you wish to single out as particularly important in your view?

30 DR SLUGGETT: Yes. So I think often people are taking a lot of medicines when they come into residential aged care so it's something that sometimes starts in the community and continues on. And so I think when a person first comes into residential aged care it's really important to have a list of – an accurate list of the medications that they're using. And so that's why it's important to have medication  
35 reconciliation at the point at which people are entering residential aged care. So that's really pulling together a best possible medication list for a resident. And there's good evidence from the hospital setting that pharmacists can play an important role in that process and developing a best possible medication history so we have got a good starting point.

40

There's a range of other strategies that we have talked about there. Or that Natalie has identified as part of her research. Another strategy is audit and feedback to all stakeholders involved in medication management around the prevalence of polypharmacy in the residential aged care setting. And there's also been mention of  
45 deprescribing scripts, which is discussion points that GPs and aged care provider staff and pharmacists can use when talking to residents and family members about polypharmacy.

So practical tips and ways that they can approach that conversation. I guess deprescribing can – so deprescribing is the process – I guess all of these strategies are around – a lot of them are around deprescribing so I should mention that deprescribing is sort of the planned and targeted withdrawal of certain medications based on after an assessment of whether a person may be benefiting from that therapy any more. So what are the risks of that therapy, what are the benefits of the therapy and do the risks outweigh the benefits and how can we, is the medicine still necessary and do we need to consider withdrawing it.

5  
10 MR GRAY: This emphasis on deprescribing, it's something the Commission has heard before. Is there a tendency for the decisions that have been made to prescribe on various occasions just to accumulate without a review occurring as to whether the cumulative effect of those medicines that have been prescribed at different times is still appropriate?

15 DR SLUGGETT: That's correct. So it's important to have a regular review as to whether medicines are still necessary. So one point at which that can occur is, you know, at a regular interval when you are rewriting a medication chart, you could do a review of the medicines. The GP could review the medicines and say, okay, are all of these still necessary when I write up the new chart or when a resident first comes into residential aged care, that is a good time to reassess whether all of the medicines are still likely to be necessary and providing a benefit.

20 MR GRAY: Dr Sluggett, the recommendations you've been making to this point are well adapted, if I may say so, to the care of the particular individual, the tailoring of an appropriate medication regime for that person.

25 DR SLUGGETT: Yes.

30 MR GRAY: At the end of this section of your statement you then take a wider view, don't you?

DR SLUGGETT: Yes.

35 MR GRAY: And you propound some recommendations around a broader system of monitoring. Could you explain that to the Commissioners.

40 DR SLUGGETT: Yes. So as part of my statement, I have identified that there is scope for a national pharmacovigilance system in residential aged care. So pharmacovigilance is really around surveillance of the safety of medicines use in the broader population, and so I think we could definitely – polypharmacy is one sort of factor that could be monitored, but I think there's scope to monitor a range of medication-related issues that can arise in residential aged care so that can be the prevalence of polypharmacy, the use of certain high-risk medicines and the proportion of people using those medicines. Also, information about medication-related incidents, the proportion of residents who receive a medication review, the prevalence of medication-related hospitalisations.

So I kind of see that we could have a national system which draws on routinely collected data, so administrative data, data from incident databases, information from clinical systems that we could pull together to really monitor aspects around quality and safety of medicines use in residential aged care and that information could be fed  
5 back to all the stakeholders involved. So it could be fed back to the individual aged care facilities, the prescribers who work in those facilities, the pharmacists visit or dispense for those residents in those facilities, and it could be important for benchmarking and understanding where, you know, your service fits in terms of other similar services. And also it can be helpful for you if that information is fed  
10 back routinely. It can show you, you know, if interventions that you are implementing locally help to improve medicines use over time.

MR GRAY: Thank you. Dr Sluggett, to a layperson hearing that there are people who are taking nine or more medications, therefore meeting the criteria in aged care  
15 of polypharmacy as you have explained it, that that is surprising in itself, and then to hear that based on the six facility, 383 resident study in South Australia that almost two-thirds of the people in that study are taking nine or more medications, that is even more surprising to a layperson.

DR SLUGGETT: It's a high burden of medicines use but I think it's also important to understand that sometimes polypharmacy is appropriate. And so when we do a structured review of medicines we try to look if all of those medicines are still providing benefit and are appropriate and sometimes we can't – it's appropriate polypharmacy, but often there may be medicines which are no longer necessary or  
25 could be discontinued. And so it's really important when we're sort of identifying someone with polypharmacy that that is a marker and then we need to do a bit more work around understanding if all of the medicines are appropriate for that person so that's when a medicines review would come in.

MR GRAY: So you are not drawing an inference from the mere fact that the percentage might be around the 63 per cent mark, that that in itself is inappropriate. It really needs an individual review in each case.

DR SLUGGETT: Yes, It's basically a flag. It's a flag to say this person might be at  
35 more risk of medication-related harm so we should investigate this further.

MR GRAY: Thank you. The next topic you move to along the lines of identifying what the pharmacist does - - -

40 DR SLUGGETT: Yes.

MR GRAY: - - - and therefore perhaps leading to recommendations about more things that the pharmacist could be doing in this space.

45 DR SLUGGETT: Yes.

MR GRAY: This discussion begins at paragraph 15 of your statement. You identify different roles for pharmacists or different categories of pharmacists in paragraph 29, and who are the pharmacists of particular relevance to aged care, both in the community and residential setting.

5

DR SLUGGETT: Yes. That's right. So we have the involvement of the community pharmacists, who are based in the community pharmacy. And so they're involved in dispensing and supply of medicines and a range of other activities. They may be involved in the provision of QUM services, quality-use-of-medicine services, but these services could also be provided by accredited pharmacists. When I talk about accredited pharmacists, which is, potentially, another group of pharmacists – these are pharmacists who are accredited, who have gone through an accreditation process and are accredited to perform medication – residential-medication-management reviews in residential aged care facilities.

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MR GRAY: And just stopping you there for a moment and asking you about another form of medication review, which, I believe, is now called the home-medication review, the HMR - - -

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DR SLUGGETT: Correct.

MR GRAY: Is there likewise an accreditation required for that purpose?

25

DR SLUGGETT: Yes. So an accredited pharmacist is someone who's gone through an accreditation process, and they can provide either or – and – RMMRs and home-medicines reviews, HMRs. So the accreditation process is the same.

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MR GRAY: Thank you. In paragraph (d), 29(d), you also refer to pharmacists integrated into residential aged care.

DR SLUGGETT: Yes.

MR GRAY: Is this still something of a rarity?

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DR SLUGGETT: Yes, definitely.

MR GRAY: But you've got a fair bit to say about it later in your statement.

40

DR SLUGGETT: Yes.

MR GRAY: Now, in the next section of your statement, you begin to explain this topic of having a pharmacist integrated or embedded in a pharmacy.

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DR SLUGGETT: Yes.

MR GRAY: And later in your statement you refer to the – this is at paragraph 34 – the ACT pilot program. What are the advantages of embedding a pharmacist?

DR SLUGGETT: I think pharmacists have a real value in identifying medication-related problems and helping to resolve those problems and also preventing any future medication-related problems from occurring. And so this can be done when you're dispensing a prescription, but I think bringing pharmacists closer to the point of care, the point at which medicines are prescribed in residential aged care, the point at which they are administered in residential aged care will really help to increase capacity to identify and resolve these medication-related problems that we're seeing in residential aged care.

10 MR GRAY: And have we seen any evaluations of the effects of embedding pharmacists yet, or is it a little too early to tell ..... waiting on - - -

DR SLUGGETT: There is emerging data from a research trial in Canberra. I have not been a part of that trial, but as part of that study there was a pharmacist embedded within an aged care facility, and they followed up changes in medicines use and other outcomes associated with that.

MR GRAY: And the Commission has also heard about the halt-and-reduce programs.

20 DR SLUGGETT: Yes.

MR GRAY: Now, on page 17 you refer to this concept of embedding a research pharmacist in an aged care provision organisation, and that was a topic you mentioned at the beginning of your evidence.

DR SLUGGETT: Yes.

MR GRAY: Could you please now expand on that concept and its potential advantages and what gap it might be addressing, gap in data for example, it might be addressing.

DR SLUGGETT: Definitely. So an embedded researcher is somebody who is employed by a university or an academic institution, but they undertake their work in a different setting or organisation. So in my case, I'm employed by Monash University as a researcher, but I'm – I work directly within an aged care organisation, have worked one to two days per week over a certain number of years.

And so I guess this is not a new concept, but it's a relatively unique concept, particularly in residential aged care. And it's a bit – we know that in terms of aging-research – residential aged care is very much an under-researched population, and so it has been estimated in one paper that, of all aging-research studies, only two per cent are conducted within the residential aged care setting. So – definitely an under-researched population.

45 So this is a method that we're using to – I guess it has a number of benefits, being embedded within a residential aged care organisation. It really helps to – when

you're undertaking a project to improve medicines use in residential aged care or in any setting, it's really important, to understand the barriers and enablers to changing a practice in a certain setting. And so being embedded within a residential aged care organisation means that I can fully understand some of the challenges in that setting and what some of the enablers to change are – in that setting. So it really helps to inform the design of the research, and we can work together on designing a research program – project that's going to fulfil everybody's needs and answer the research question in a way that works for everybody.

10 It also increases the researcher's knowledge of residential aged care, which is important for understanding what some of the challenges are and translating that research. It also helps to improve the research capacity of the aged care organisation. So they have an improved understanding of what research methods are, what the ethics process involves, how to recruit residents to participate in studies and understanding of, even, things like, "As part of this research we use this particular care assessment to assess nutritional status. We don't use that assessment at a moment. We use a different one. What's the benefits and cons of using a different assessment?" and asking those kind of questions. So there's a range of benefits both for the researcher and for the research – and for the aged care provider organisation.

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20 And so I guess it's really about ensuring that the – putting the research in the best possible way to ensure that it's taken up into practice and translated.

MR GRAY: And is encouraging a greater take-up of this model a matter of reaching out individually to service-provider organisations and advocacy directly to them? Is that the only .....

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DR SLUGGETT: I think that could be a way to achieve it. I think increasing awareness among universities and also aged care providers – some of the providers that I've worked with are very innovative and very interested in research. So I think it's something that is, definitely, something that we – could take this model further.

30

MR GRAY: Thank you. Now I want to turn to a different topic, which you begin to address at page 18 of your statement, which is the information flows that are involved, and they're multifactorial, and they move in many dimensions and directions. In paragraph 36 you identify the key stake-holders around the medications-management topic, and there's those three kinds of pharmacists that you've mentioned, potentially, community, accredited and integrated. But, in addition, there a number of other stake-holders. Could you identify those, please.

35

DR SLUGGETT: Yes. There are aged care provider staff who are involved in administering medicines, also general practitioners who are involved in prescribing medicines; nurse practitioners may also be involved. I've neglected to mention residents in there as well, and that's an important omission. So residents and also their family members are also an important part of the medication-management process.

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MR GRAY: Thank you. And yesterday the commission heard a deal of evidence around the risks involved in the current methodology for conveying prescribing positions through the chain all the way down to dispensing and administration.

5 DR SLUGGETT: Yes.

MR GRAY: So I won't ask you about those risks; you've identified that there are risks in that process at various stages, miscommunications, but just focussing on the prescribing-decision aspect, the sort of initial – the initiation of the process which  
10 leads to administration, do you have some observations about some features of the current landscape that impact on whether quality decisions are being made?

DR SLUGGETT: I'm sorry. Could you direct me to which part of the statement that we're currently - - -

15

MR GRAY: Yes, certainly.

DR SLUGGETT: Is this page 27?

20 MR GRAY: At the top, page 20, paragraph – I think it's 37(a), you refer to.

DR SLUGGETT: Yes. Okay. So I reflect on that, when a person enters residential aged care, there may be a change in all types of their healthcare providers. So their usual GP who is in the community may not be able to continue to provide services to  
25 them in the residential aged care facility. So they may get a new GP. They may also have a new community pharmacy. So they won't have any history about what medicines they've used before.

And so – and also, obviously, a resident can be new to the staff members when they  
30 first enter residential aged care as well. And so I guess I've emphasised that there can be difficulty in obtaining an accurate medication list and also a history of what medicines have been tested before, what's been successful, what hasn't, when a person first enters residential aged care, and I've emphasised the need for reconciliation. So – establishing a best-possible medication history when a person  
35 enters residential aged care.

MR GRAY: Thank you. Under the next heading, you address residential-medication-management reviews.

40 DR SLUGGETT: Yes.

MR GRAY: And at the outset of your evidence you explained to the commissioners that you've actually had many years as an accredited pharmacist, doing those reviews and indeed doing home-medication reviews as well.

45

DR SLUGGETT: Yes. Yes. So – home-medicines reviews and RMMRs as part of residents who were living in a transitional care facility. Yes.

MR GRAY: Thank you. What's involved in doing one of these in practical terms?  
How do you go about it?

5 DR SLUGGETT: Yes. Certainly. So with an RMMR – it requires a referral from a  
GP. It requires a written referral. So that referral may be sent to the community  
pharmacy that usually supplies the medicines for a resident, or it may be sent to an  
10 accredited pharmacist who provides – routinely provides RMMR services at a  
facility. The pharmacist will look at the review. It will generally have a reason for  
referral, and it will have sometimes a list of the resident's current medications and  
some of their health conditions, and this is a referral that's generated from GP –  
15 practice-prescribing software generally, management software, and then the  
pharmacist will visit the residential aged care facility. They'll speak to nursing staff  
and the resident. They will, potentially – family members.  
20 They'll sit down with the medication chart and some of the clinical records, review  
what medicines are current and go through each medicine and see – and conduct a  
clinical review, basically, to see if the medicines are appropriate, if they're at  
appropriate dose, if there's over-treatment or under-treatment, if the medicines are  
interacting with each other and a range of different sort of screening for medication-  
related problems, basically.

25 Then the pharmacist will prepare a report with a series of recommendations on how  
to improve medicines management for that resident, and a copy of that report will be  
sent to the GP who provided the referral, and it would also go to the aged care  
provider as well. And then as part of my RMMRs I would give the GP a call and ask  
them if there's anything – initiate any discussion points and ask the GP if there's  
anything they'd like to discuss about the referral or the findings.

30 MR GRAY: Thanks very much. So it involves at least a bilateral process between  
GP and pharmacist.

DR SLUGGETT: It does.

35 MR GRAY: And it involves a great deal of work by the pharmacist no doubt, but it  
also involves a decision at the front end to refer and at the back end to consider de-  
prescribing or re-prescribing by the GPs .....

40 DR SLUGGETT: Yes, that's right. So the GP will then use that information and  
develop a medication-management plan for – with input from the pharmacist have a  
medication-management plan for the resident.

MR GRAY: And you refer in your statement – I'll come to remuneration for these  
matters when we come to the end of this topic.

45 DR SLUGGETT: Yes.

MR GRAY: But you refer in your statement at 39(d) to – well, at 39 to a literature review or a synthesis of the published literature about the process and its effects.

DR SLUGGETT: Yes.

5

MR GRAY: There are a number of points there. I won't seek to restrict you, but in particular it seems interesting, that the acceptance rate of GPs is quite variable at 39(d). What was the nature – what were the other important points that you draw out of that literature review?

10

DR SLUGGETT: This was a literature review that was led by one of my PhD candidates, Esa Chen, and so – it was really looking at synthesising information about medication-review processes in residential aged care, and we looked over a period of 1995 and 2018. We found 13 studies, and eight of those studies specifically focussed on the RMMR program. I think one of the important findings of this particular synthesis of the literature is that on average – we know that this – an RMMR will identify between 2.7 and 3.9 medicines-related problems per resident.

15

MR GRAY: That's 39(b).

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DR SLUGGETT: That's correct. 39(b). So it's an important process for identifying potential and actual medicines-related problems and then also the acceptance rate. So it's a – that speaks to resolving some of those medicines-related problems and sort of the value in working collaborative to resolve those problems.

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MR GRAY: Thank you. You identify a gap in 39(f) as well.

DR SLUGGETT: Yes.

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MR GRAY: What should be done in this space?

DR SLUGGETT: There is – because of the way that the program is run, there is very limited capacity for an accredited pharmacist to follow up after performing an RMMR as to whether the recommendations were implemented and be involved in the ongoing medication-related management plan for that resident. And so, therefore, there's very few studies which have then looked at, I guess, long-term clinical and resident outcomes associated with the RMMR program so that remains a gap in the literature. But certainly there's a small number of studies that suggest that nursing staff and GPs find the process valuable.

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MR GRAY: There's a sort of a sporadic nature, is there, to when these reviews are and can be done.

DR SLUGGETT: Yes, so the Pharmaceutical Society of Australia has produced guidelines for pharmacists around the provisions of medication reviews in residential aged care, and they suggest – and as does, I believe, the Medicare Benefit Schedule

45

criteria, suggest that these reviews should be provided as soon as possible after a resident enters residential aged care for the first time.

5 MR GRAY: If we just put that up on the screen, if I may, Dr Sluggett. Operator, please put up Tab 143, item 903 and related information. That's information in relation to item 903 of the Medicare Benefits Schedule. And is this the information you had in mind a moment ago, Dr Sluggett?

10 DR SLUGGETT: Yes.

MR GRAY: And under patient eligibility, it said that:

*RMMRs are available to new residents on admission into an RACF –*

15 that's a residential aged care facility –

*...and existing residents on an as-required basis where, in the opinion of the resident's general practitioner, it is required because of a significant change in medical condition or medication regimen.*

20 If we please, operator, go over to the next page, under the heading "Claiming", we see there's a 12-month exclusionary criterion – just that first paragraph will do; thank you.

25 *A maximum of one RMMR rebate is payable for each resident in any 12-month period except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.*

30 There is a disparity, I understand, between the remuneration that is available to the GP through item 903 on the one hand, and the remuneration that is available to the accredited pharmacist for conducting the RMMR; is that right?

35 DR SLUGGETT: The program rules for accredited pharmacists suggest that an RMMR can only be funded once every two years unless there is a significant change in the resident's condition and another GP referral is required.

40 MR GRAY: Doctor, can I just stop you there again and ask the operator to now put up Tab 144. Now, this is information in relation to the Fifth Community Pharmacy Agreement and I understand there's now a sixth.

DR SLUGGETT: Yes.

45 MR GRAY: However, this was the relevant change to that particular timing criterion, I think. Is that right?

DR SLUGGETT: Yes. That's right. So over the life of the program there has been a number of changes to the eligibility criteria.

MR GRAY: And if we go down the left column to the bottom, the heading “What are the Program Changes from 1 March 2014”. It said a number of changes will occur across the fifth agreement programs. And over the top of the next column, one of those, point 3, is a timeframe of 24 months, two years is being imposed between repeat and additional HMR and RMMRs for a single patient.

DR SLUGGETT: That’s correct.

MR GRAY: So has this had the effect of withdrawing an incentive on accredited pharmacists to perform HMRs and RMMRs?

DR SLUGGETT: Yes, well, it restricts the amount of times that you can – you can visit and provide this service. I guess we know that sort of the average time that a resident would spend in residential aged care is, I think it’s roughly around 33 to 36 months so just over two years. Or two to three years. And so in some cases that means that a resident may only receive one RMMR during the entire amount of time that they spend in residential aged care and that’s dependent on receiving a referral.

MR GRAY: Now, I won’t ask you about any data on this because I don’t believe you’ve got any, but anecdotally speaking what’s your impression of the take-up of the proviso for changed circumstances in which both a GP can refer and a pharmacist can conduct an RMMR or an HMR?

DR SLUGGETT: I think there’s capacity to increase the proportion of residents who receive a medication review from a pharmacist, definitely. So I suspect – I don’t have any hard data on it and that’s something that I’m planning to look at within the ROSA registry but I think – I suspect that medication reviews could be provided to more residents and in a more timely way as well.

MR GRAY: Dr Sluggett, you go on to discuss a number of other topics. I won’t ask you – this is page 23, I won’t ask you about the National Residential Medication Chart; the Commission heard evidence about it yesterday.

DR SLUGGETT: Yes.

MR GRAY: You do speak to deprescribing for residents of aged care services but in a way you’ve already addressed that in your earlier evidence.

DR SLUGGETT: Yes.

MR GRAY: You then, at the next page, page 24, begin a discussion about simplifying medication use in residential aged care and at the outset of your evidence, you referred to an ongoing study, it’s early in your statement and it’s the GRACE - - -

DR SLUGGETT: Yes, the SIMPLER study. Yes, MRS GRACE and SIMPLER. Yes. So there’s two acronyms. Correct. So I can speak to that now.

MR GRAY: Please do. What is the concept of simplifying as opposed to deprescribing?

5 DR SLUGGETT: Yes, that's right. So what we found from all of our work in residential aged care and spending many time looking at medication charts is that residents are obviously administered multiple medicines but they can be administered medicines multiple times throughout the day and we felt anecdotally by looking at medication charts that perhaps we could give the same medicines but fewer times per day. And we hypothesised, well, if residents could have the same  
10 medicines fewer times per day then this could potentially improve their satisfaction with care. It could increase their ability to participate in other activities and not have to feel restricted by having medicines multiple times during the day.

15 And it could also – because medication administration is a very time consuming activity in residential aged care, if we could reduce the amount of time administering medicines then that would free up staff time to provide other types of important care activities. That was sort of the basis of the trial. When we, one way to sort of reduce the complexity of medication use is through deprescribing and that's withdrawing medicines. Another way to reduce the complexity is really just consolidating  
20 existing medicines, so trying to take the same medicines fewer times per day. So using strategies such as administering medicines at the same time rather than spacing them out, or using longer-acting forms of medicines or using combination products to reduce the tablet burden, essentially.

25 MR GRAY: Thank you. And have you reached any findings in that study?

DR SLUGGETT: Yes.

30 MR GRAY: Is it effective and does it reduce the risk of errors?

DR SLUGGETT: We are still looking at whether it reduces the risk of errors but what I can say is that – so as part of the study we had a – we recruited 242 residents across eight aged care facilities, and we had an intervention in four of the facilities and the other four facilities were a control group. So they received usual care. So as  
35 part of the intervention we had a pharmacist come into the facilities and use a structured tool which our research team had developed to identify opportunities to simplify the way that medicines were given. And the pharmacist went through the medication list and spoke to the residents and staff and made some recommendations about how to make medicines use simpler.

40 Then these recommendations were forwarded to the staff and to the GP for consideration and implementation. And so what the pharmacist found was as part of that process was that two-thirds of the residents could take the same medicines in a simpler way. And then we - - -

45 MR GRAY: Which in itself is a finding that simplification is effective because you're saving time in the manner you describe.

DR SLUGGETT: That's right, yes. That's right.

MR GRAY: Are you still looking at whether by doing so you are reducing administration error?

5

DR SLUGGETT: Yes. Well, we've seen at four months there is a significant reduction in the amount – the number of administration times which was the primary outcome for this study.

10 MR GRAY: Thank you very much. Now, the next topic you deal with involves medications management and administration errors. It commences at the foot of page 26, and, again, I will mention that the Commission heard evidence from Professor Westbrook yesterday about error in communication of the information regarding prescription through to the point of dispensing and administration. But  
15 Professor Westbrook wasn't speaking to the quality of the decision made to prescribe  
- - -

DR SLUGGETT: Yes.

20 MR GRAY: - - - or the particular mechanics of administration. Now, I've already asked you about the quality of the decision-making and you've addressed a number of points regarding that and the prospect or the potential for errors to occur in that respect.

25 DR SLUGGETT: Yes.

MR GRAY: You've identified more detail on that in paragraph 48, but is there anything in particular that you wish to highlight there that you haven't already explained to the Commissioners?

30

DR SLUGGETT: I think I've highlighted there that errors can arise when the person is making the decision to prescribe and selecting whether a non-pharmacological strategy or a medicine is necessary and then selecting which medicine to prescribe and which dose to use and, you know, how long do we wait for reviewing. And so I think that's an area where problems with medicines use can arise, and so at the moment we know that there's a lot of separation between the important stakeholders in medication management and community pharmacists and pharmacists are based offsite and so I see a role for, I guess, pharmacists working in a collaborative way with GPs at the point of care, at the point of prescribing to  
40 inform and work together to improve that process.

MR GRAY: At the other end of the process where you're storing and administering medications on page 29 - - -

45 DR SLUGGETT: Yes.

MR GRAY: - - - beginning at paragraph 52, you refer to storage and distribution and 53, perhaps even more pertinently, administration and the potential for errors there. Are there particular issues there that you could highlight for the Commissioners?

5

DR SLUGGETT: Yes, the issues that I've raised there, that there's a lot of time spent administering medicines and sometimes medicines need to be altered before they are given so – by ways such as crushing and so there's also issues around giving particular medicines and at certain time and that because medication rounds are quite long there's a risk that some medicines won't be given at the exact time they're prescribed and often that may not be a problem but for a small number of medicines, there are time-sensitive medicines where that could be a problem. So I've talked about those types of issues.

10  
15 MR GRAY: Just stopping you there, crushing is actually risky, isn't it? You've said you need a great deal of knowledge to know which - - -

DR SLUGGETT: Exactly. You need to know whether it's appropriate to crush a medicine because it involves safety for the resident but also for the staff member. So safety for the resident in that if you crush a medicine with a particular coating, if you are getting rid of that coating the medicine may not be able to work anymore, but it also could cause side effects. So crushing – if you are crushing a slow release medicine that's supposed to release over, say, a 24-hour period; if you are crushing it then it means all of that dose could be delivered at once, and so it is putting a resident potentially, depending on the medicine, at risk of side effects.

20  
25  
30 MR GRAY: Thank you. And I won't ask you to comment on all of the matters you've addressed in your statement, but they will certainly be given full weight and taken into account.

DR SLUGGETT: Thank you.

35 MR GRAY: If we could finish with the final topic of your statement beginning at page 32 on the connections between the medication management issues you've mentioned and quality of life.

DR SLUGGETT: Yes.

40 MR GRAY: What are your reflections in this regard?

DR SLUGGETT: I guess I've reflected on the fact that medicines can have a range of different side effects and so they can impact on quality of life for a resident, potentially. And so I've really discussed types of examples of when that may occur and how changing the way that medicines are given or changing the types of medicines could improve quality of life, potentially.

MR GRAY: There was one part of this part of your statement which I found particularly moving, I suppose, and it's in paragraph 61 where you, in effect, make a plea for forethought and consideration about what the choices of the resident are when looking at the medications they're being prescribed on a regular basis. For  
5 example, if they're going to go out on a special outing the next day, think carefully about whether the usual medical regimen, which might include diuretics, is appropriate.

DR SLUGGETT: Yes.  
10

MR GRAY: And I suppose there are myriad examples of that kind but do you have any reflections on really what is needed here to achieve that - - -

DR SLUGGETT: Yes, I agree. I think having a good knowledge of the resident and also a good knowledge of medicines is really important to inform those kind of decisions and taking the time to have a discussion with the resident about their preferences as well and so I see a key role for pharmacists in those types of activities.  
15

MR GRAY: Commissioners, I have no further questions for Dr Sluggett.  
20

COMMISSIONER BRIGGS: Dr Sluggett, I found your evidence today incredibly interesting. There are many things that arise from it but I think counsel has covered most of them. I just wanted to go back to the early charts you showed about the incidence of prescribing of certain drugs on entry and for the first 12 months afterwards. You don't have to bring up the chart. What that chart said to me is that  
25 we have got an issue more generally around people's expectations that drugs will manage behaviours. So if you're struggling at home with somebody who has got dementia, you go with that person to the doctor and seek to get something that can control their behaviour. Similarly, when they enter a residential care facility they're  
30 disoriented and so forth and they get drugs to control their behaviour.

This is a serious – you are nodding – this is a serious societal question, and runs to something we've heard evidence about, about managing behaviours through alternative mechanisms. And I think, am I right in saying that the conclusion of that  
35 part of your – or one of the conclusions of that part of your evidence is that there needs to be wider community education and understanding about what some of the non-pharmacological alternatives might be.

DR SLUGGETT: That is definitely one of the most important points, I think. I  
40 think we also need to have education and also support for people in training around, potentially around – in training about non-pharmacological strategies and how they can be used and should be used. And that, you know, that should be the mainstay or the focus of treatment.

COMMISSIONER BRIGGS: Maybe I can throw in a second one. The thrust of the  
45 latter part of your evidence was around the reviews, medication management reviews.

DR SLUGGETT: Yes.

5 COMMISSIONER BRIGGS: And from reading your statement and hearing your evidence you believe that there should be a review when somebody enters residential aged care and then you say more often than each two years. But given that chart where we've got the increase in incidence of prescribing and then it levels out for the most part, would a review six months after that entry be appropriate or what have you or the society got in mind?

10 DR SLUGGETT: Well, I can only speak for myself but I think it's about tailoring a medication management plan to an individual resident so having flexibility in that the pharmacist and the GP can determine a plan as to, okay, the pharmacist will re-review this person at a certain point in time. So I guess having flexibility for an individual resident to see whether – so the pharmacist will make some  
15 recommendations and to see, well, if we implement this, let's monitor and see what happens. So I think it really needs to be tailored to an individual resident and have flexibility.

20 COMMISSIONER BRIGGS: Okay. And at the moment we don't know, do we, how many people have a review of their medications on entry.

DR SLUGGETT: No, we don't. And so that's work that I've just started to commence with the Registry of Older South Australians. Yes.

25 COMMISSIONER BRIGGS: Thank you.

DR SLUGGETT: Thank you.

30 COMMISSIONER TRACEY: Anything arising, Mr Gray?

MR GRAY: No. Thank you, Commissioner.

35 COMMISSIONER TRACEY: Professor Sluggett, thank you so much. I join my colleague in thanking you are for the very detailed exposition of the importance of pharmacy in dealing with people in aged care, and we've certainly learned a lot about what should not be done and you've given us some clear guidelines as to what can be done to improve the situation. We're very grateful to you for that. Thank you.

40 DR SLUGGETT: Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until quarter past 1.

45 <THE WITNESS WITHDREW

**ADJOURNED**

**[12.39 pm]**

**RESUMED**

**[1.22 pm]**

5 COMMISSIONER TRACEY: Yes, Mr Knowles.

MR KNOWLES: Yes. Thank you, commissioners. We have Catherine Maloney in the witness box as the next witness.

10 <CATHERINE MARY MALONEY, AFFIRMED

**[1.22 pm]**

<EXAMINATION-IN-CHIEF BY MR KNOWLES

15 MR KNOWLES: Ms Maloney, can you tell the Commissioners your full name for the transcript.

MS MALONEY: Catherine Mary Maloney.

20 MR KNOWLES: You have prepared a statement dated 30 May 2019.

MS MALONEY: Yes.

25 MR KNOWLES: Yes. And you have a copy of that in front of you there.

MS MALONEY: I do.

30 MR KNOWLES: And that is WIT.0198.0001.0001. Ms Maloney, have you read your statement lately?

MS MALONEY: I have.

35 MR KNOWLES: Yes. And are there any changes you wish to make to your statement?

MS MALONEY: No.

40 MR KNOWLES: Thank you. And are the contents of your statement true and correct to the best of your knowledge and belief.

MS MALONEY: They are.

45 MR KNOWLES: Thank you. Now, Ms Maloney, you are currently employed as the acting chief executive officer of Services for Australian Rural and Remote Allied Health?

MS MALONEY: That is right.

MR KNOWLES: Otherwise known as SARRAH.

5 MS MALONEY: That's correct.

MR KNOWLES: Yes. What are your qualifications?

10 MS MALONEY: I am a physiotherapist by background.

MR KNOWLES: Okay. And what did you do before your present position at SARRAH?

15 MS MALONEY: I have – so I previously worked at Nganampa Health Council as General Manager, and prior to that over a 10-year period I had a range of health management positions where I was overseeing allied health teams, providing services into hospital, sub-acute and aged care settings.

20 MR KNOWLES: Before I proceed any further, if I might just tender Ms Maloney's statement.

COMMISSIONER TRACEY: Yes, certainly. The witness statement of Catherine Mary Maloney dated 30 May 2019 will be Exhibit 6-33.

25

**EXHIBIT #6-33 WITNESS STATEMENT OF CATHERINE MARY MALONEY DATED 30/05/2019 (WIT.0198.0001.0001)**

30 MR KNOWLES: Thank you, Commissioner. Now, can you tell the Royal Commission precisely what SARRAH does?

35 MS MALONEY: SARRAH is a member-based organisation, a peak body that represents allied health professionals who live and work in rural and remote Australia. SARRAH exists so that rural communities have equitable access to allied health services to support their wellbeing.

40 MR KNOWLES: And you say it's a member-based organisation. Who typically are the members of SARRAH?

MS MALONEY: They will be allied health professionals working across public, private and not-for-profit sectors.

45 MR KNOWLES: Yes. And are you yourself a member of the organisation?

MS MALONEY: I am, yes.

MR KNOWLES: Now, you mentioned its role or at least part of its role is to promote equitable access to health service in rural and remote areas and particularly those services as provided by allied health professionals. You've given some evidence in your statement about access to allied health professionals contributing to better health and quality of life outcomes. Can you just elaborate on that for the Royal Commission as to how, by reference to particular disciplines, that occurs?

MS MALONEY: Certainly. Allied health professionals come from a range of disciplines. So in terms of health benefits and in terms of the aged care setting particularly, speech pathologists have a role in identifying and managing communication issues and dysphagia – speech and swallowing issues – and the prevention of difficulties arising from those areas. If swallowing difficulties, for example, are left untreated or not managed properly, they will result in chest infections, malnutrition, dehydration, weight loss and in some cases, aspiration and death.

Allied health professionals such as occupational therapists, psychologists and diversional therapists can assist in the management of neurodegenerative conditions such as Parkinson's disease, dementia, and stroke. Allied health interventions can mitigate the impact of challenging behaviours, reducing the incidence of falls and make substantial contribution to the quality of life of older Australians.

MR KNOWLES: You've also referred in, I think, paragraph 6 of your statement to other disciplines such as dental hygienists and oral health therapists who provide assistance with oral health care, and that's at the bottom of page 2 in the last dot point there.

MS MALONEY: Yes.

MR KNOWLES: What type of conditions can they be used to treat? And what are the side effects if they're not used properly?

MS MALONEY: So they can provide assistance with oral health care, conduct oral health assessments and prepare oral health care plans, facilitate referral to dentists. The issues that might arise if older people are not accessing these services are things like reduced nutritional status because people are unable to eat properly and the other associated health conditions arising such as cardiovascular disease.

MR KNOWLES: You've also mentioned, across the page in the last dot point under paragraph 6, the position of allied health assistants. What are those people and what role do they play in the provision of care services to older people?

MS MALONEY: Allied health assistants are Certificate IV qualified assistant workers who work under the direction of allied health professionals to carry out the care plans required to meet the needs of patients or older people living in aged care facilities. This supports the work of the allied health professional by allowing the allied health professional to focus on the higher complex clients that they might be

treating and so the assistants are in a position to undertake the more routine work that allied health professionals prescribe.

5 MR KNOWLES: And have you, yourself, not necessarily in the aged care setting, observed a model of service delivery using allied health assistants?

10 MS MALONEY: Yes. I was involved in a pilot project that began in 2009 in New South Wales that looked at the implementation of allied health assistants working across disciplines in rural settings. So an example would be an allied health assistant embedded in a multi-purpose site in a rural community and undertaking work prescribed by visiting allied health professionals. So where you didn't have an allied health professional embedded in that facility and providing an outreach service to that community, the allied health assistant would undertake the prescribed care by that allied health professional. So that enabled an increase in frequency of the allied health services that were being delivered and better continuity of care for the clients, the recipients of that care.

20 COMMISSIONER TRACEY: Am I right in understanding that what sets your members apart from other allied health professionals who do the same sort of work is that your members do it in rural and remote Australia?

MS MALONEY: That is correct.

25 MR KNOWLES: And in relation to allied health assistants, you've referred to some benefits there in terms of the way that increases the ability to provide regular allied health services to people in rural and remote areas. What potential do you see for people occupying those allied health assistant roles in terms of their ability to work in a range of disciplines?

30 MS MALONEY: What we observed during that pilot was that the assistants in those roles had vision across the various allied health professions that they were operating under the supervision of. So for one particular client that allied health assistant might be working under a physiotherapist and a speech pathologist and a dietitian, and so they were in a position to see the combined effect of those various allied health interventions. So this has a number of benefits in terms of the quality and the continuity of care that those clients are receiving and the allied health assistant is in a position to make a determination as to whether or not a client is progressing against a care plan as expected, and part of that allied health assistant's role is to report back to the professional with regard to the client's progress against that care plan.

45 I think a future role for the allied health assistant is that given this exposure and this experience, their role in care coordination for complex clients who have, for example, chronic disease, is quite significant. At this point, I think that the allied health assistant workforce is still evolving and so the capacity to take on these roles is not quite there yet but I think this is an important development that allied health assistants could – it's an important role that they could undertake in the future. And

the importance of that is that it would free up other health professionals working with a client to focus on their scope of practice. And that would include the nursing staff that might be involved in a person's care.

5 MR KNOWLES: And so is that model that you observed one which, so far as you are aware, is employed in aged care?

10 MS MALONEY: Yes. So what I have seen is, particularly in multiple purpose sites, so where you have both acute care and aged care services being provided, you will have an allied health assistant who is located and employed within that facility, and is undertaking care provided by the visiting allied health services into that community.

15 MR KNOWLES: How common is it in terms of its use in the aged care setting?

MS MALONEY: I think it could be a lot more prevalent than it is. So I think that there are probably pockets of care where that is occurring but I think that there is significant scope to yes, to embed that practice and that model of care into the aged care setting.

20 MR KNOWLES: And I take it particularly in a rural and remote setting where there are potentially fewer people of those allied health profession disciplines available to the population.

25 MS MALONEY: Yes, absolutely. Ideally, we would like to see allied health professionals being accessible to all aged care settings but in practical terms in rural settings where that's not possible, allied health assistants are an important part of improving access to allied health services.

30 MR KNOWLES: Now, if I can return to your statement and, in particular, paragraph 7, and there you refer to some research undertaken by SARRAH in respect of cost savings of use of allied health professionals where there is a strong preventative focus on the part of those professionals. Can you give the Royal Commission some details about that research?

35 MS MALONEY: Certainly. This piece of research was undertaken because there is a relative lack of research into the impact and the value of allied health services in general and that speaks to, you know, it having lesser presence in research agenda more broadly. And in part because of that, this is a literature review of existing  
40 research that was able to identify eight interventions where allied health services are involved.

45 And, as a result of that, the findings of this report probably are a conservative estimate as to the relative benefits of allied health services. So the three key areas of research that are talked about with this report include diabetes, where the cost/benefit was in reducing the negative outcomes associated with diabetes including cardiovascular disease, eye disease, kidney disease and the rate of amputations.

In osteoarthritis, what was seen – the cost/benefit was seen in the reduced rate of joint replacements for people accessing allied health interventions for the management of osteoarthritis. And the third area was in stroke and the cost/benefit there was realised in the reduced admission rate to residential aged care facilities.

5 So, in general, this study showed that \$175 million per annum could be made in annual savings through preventative care measures provided by allied health services.

10 MR KNOWLES: And, as you I think just pointed out, that was a saving but only through eight particular allied health interventions. Other allied health interventions conceivably could have led to further savings.

15 MS MALONEY: That is correct. So this is a very conservative estimate as to the potential savings to be made, you know, in addition to the improved quality of life that the clients - - -

MR KNOWLES: Indeed. Can I ask why there were only eight allied health interventions that were looked at?

20 MS MALONEY: Because they were the only ones that met the requirements for the literature review. So there was a lot of other data out there that for the purpose of this literature review did not meet the requirements.

25 MR KNOWLES: Right. And when you say there was a lot of other data, is there a lack of accessible and – data that can be interpreted properly in terms of allied health professionals use and take-up in the broader community but particularly in aged care?

30 MS MALONEY: Yes. So, in general, the research funding that's available for the allied health services and particularly around cost/benefit and the impact is very small compared to the larger research agenda. So what this means is that there is not the level of available information about allied health services and their impact that there are for other parts of the health workforce.

35 MR KNOWLES: I see. And does that have an impact on the ability to undertake research into the benefits or otherwise of use of allied health professionals.

40 MS MALONEY: Absolutely. Yes, it has that impact. The other issue is that we do not have access to the same level of information regarding the allied health workforce. So the impact in terms of being able to plan and incorporate allied health services into future planning for health and aged care is restricted because of that.

45 MR KNOWLES: You've also referred, in paragraph 8 of your statement, to other research conducted by SARRAH on the use of other allied health professionals to avoid further interventions, which I take it is in some ways related to the research the subject of paragraph 7, but can you just tell the Royal Commission what that research showed in terms of use of allied health professionals at an early stage.

MS MALONEY: So this research, there are a few areas that we can refer to, for example, a podiatry clinic run in Queensland between 2009 and 2010 resulted in nearly 50 per cent reduction in non-urgent waiting list for orthopaedic foot surgery. And then in terms of osteoarthritis management, a multidisciplinary team comprising  
5 of physio, occupational therapist, dietitian, orthotist, social worker and rheumatologist were able to reduce the demand and the waiting list for joint replacement surgery by 15 per cent.

MR KNOWLES: I see. So again, this is an example of research going to the  
10 savings and avoidance of further costs down the track.

MS MALONEY: That is correct. Yes.

MR KNOWLES: Okay. And in terms of these pieces of research that you've  
15 referred to in paragraph 7 and 8 of your statement, neither of them is confined to an aged care setting; is that correct?

MS MALONEY: That is right.

MR KNOWLES: They're looking more broadly at the use of allied health  
20 professionals in the community.

MS MALONEY: That's exactly right. And in particular with regard to health  
25 benefits and savings to the health system.

MR KNOWLES: Yes.

MS MALONEY: The sequelae there is that by maintaining people in the  
30 community healthily for longer, you will avoid the costs associated with admission to an aged care setting.

MR KNOWLES: And the research on the other hand that's referred to in your  
statement at paragraph 9 was focused on residential aged care facilities, wasn't it?

MS MALONEY: That is right, yes.

MR KNOWLES: Can you just tell the Royal Commission about that research and  
what it entailed.

MS MALONEY: So this looked at the input of oral health professionals in  
40 residential aged care facilities. It highlighted that staff in residential aged care facilities may not be appropriately trained or not comfortable in delivering oral health care and despite training were still unable to provide an adequate level of care. So the conclusion of that particular piece of research indicated that oral health  
45 professionals, in this instance, should be embedded in a multidisciplinary team in an aged care setting.

MR KNOWLES: Yes. And can you tell the Royal Commission, broadly speaking, what you see is the significance of research such as the research that is referred to in these paragraphs of your statement, in respect of the use of allied health professionals for aged care.

5

MS MALONEY: So I think that, in general, allied health professionals are under-utilised in an aged care setting; that multidisciplinary care is critical to quality of life for older people and particularly older people who have multiple morbidities and complexity, and that their presence in an aged care setting has – there is evidence to suggest that this will improve the quality of life for recipients of aged care services.

10

MR KNOWLES: And do you take this research to also present a basis for suggesting that there may be economic benefits for the use of allied health professionals in aged care?

15

MS MALONEY: Absolutely. So – yes.

MR KNOWLES: Now, otherwise you've referred at paragraph 10 of your statement to the mal-distribution of allied health services between on the one hand urban areas and on the other hand rural and remote areas, and you described there the research that was undertaken by SARRAH, and it's referred to in footnote 6 of your statement. Can I take you just to the cover sheet of that. It's at Tab 115 of the general tender bundle, document number RCD.9999.0096.0113. Now do you see that, Ms Maloney?

20

25

MS MALONEY: Yes.

MR KNOWLES: Can you tell the Royal Commission what the aim of that research was?

30

MS MALONEY: The aim of this piece of research, again a literature review, was to look at the evidence base for strategies that improve the recruitment and retention of the allied health workforce in rural settings.

35

MR KNOWLES: And I take it from that aim, that it was responding to a perceived lack of allied health services in rural and remote settings.

MS MALONEY: That's correct. So the paper will – it explores the mal-distribution of the workforce in – of the allied workforce in rural and remote Australia. It draws comparisons for example with the medical workforce, and so what we know is that allied health professionals – when you break it down by profession – are less numerous than general practitioners, and it is at a similar level to specialist medical services in terms of the access by head of population.

40

45

The paper then goes on to look at the sorts of mechanisms that might improve the number of allied health professionals available to rural and remote communities, and it takes a pipeline perspective. So – looking at the growth of the allied health

workforce, right from student, undergraduate programs that look at early exposure to rural clinical placements as part of your undergraduate program, rural – quotas for people – students of a rural background, because the research tells us that they are more likely to come back and practise in rural areas, looking at the support

5 requirements for early-career health professionals so that they get a good exposure to quality allied health services in their early years and then the ongoing supports for allied health professionals as a mature professional, which may include pathways to specialisation and linkages to universities and academic research.

10 MR KNOWLES: And to your knowledge, what is the extent of implementation of those suggested approaches to improve access to allied health professionals in rural and remote areas?

MS MALONEY: The – I think, if the recommendations made in this document

15 were to be taken up, that we would see a substantial improvement in the number of allied health professionals returning to practise in rural and remote settings. And I think the fact that we've had to bring this paper together in the first instance demonstrates a relative lack of focus on the allied health workforce in comparison to

20 medicine and nursing over decades. So the – so if we can pick up and provide similar levels of support to the allied health workforce across all of those disciplines that we have seen for nursing and medicine, we will make some changes there. We will see some improvement in that distribution of the workforce.

MR KNOWLES: Now, Ms Maloney, you're aware that there has recently been a

25 national-rural-health-commissioner's request for feedback on a discussion paper for consultation in respect of rural allied-health quality, access and distribution.

MS MALONEY: That is correct.

30 MR KNOWLES: And that document is at Tab 135. If that could be brought up on the first page – sorry. That's not - - -

MS MALONEY: No, that's not it.

35 MR KNOWLES: 132; pardon me. Thank you. Now, is SARRAH going to be providing a submission by way of feedback in respect of that discussion paper?

MS MALONEY: Yes, we will. So this document was released a week ago, and we are still formulating our formal response, but we will be, certainly, along with a

40 range of other peak bodies, developing our own response to this document.

MR KNOWLES: Yes. And in terms of that response – are you able to indicate any aspects of it at this time?

45 MS MALONEY: SARRAH largely endorses the policy directions suggested by this document. In particular, in terms of its relevance to the aged care setting, I would like to look at policy area 3, which looks at the - - -

MR KNOWLES: Yes.

MS MALONEY: Sorry.

5 MR KNOWLES: And that is at page .0035, I understand.

MS MALONEY: Page 24, structured rural training and career pathways. One of the concepts that Dr Worley's paper refers to is the concept of allied-health rural generalism, which for the allied health disciplines is about a particular discipline. So  
10 – a physiotherapist or a speech pathologist working within their scope of practice but across a breadth of conditions and client populations. And this is relevant for rural and remote settings, because in order to meet the needs, the health needs of that community, a health professional will need to consider every aspect of that community's needs from birth to old age. And so the – a rural-generalist pathway  
15 supports the development of allied health professionals to be able to deliver services that meet rural communities' needs.

MR KNOWLES: Thank you, Ms Maloney. Now, was there anything more you wish to say about that particular request for feedback before I move to another area?  
20

MS MALONEY: Just that in addition to that, Dr Worley does talk about allied health assistants, and so again that strengthens the argument that the role of the allied health assistant under the direction of an allied health professional will go some way to meeting the needs of rural communities.  
25

MR KNOWLES: Yes. Now, in your experience, including the work experience that you described earlier, have you observed the delivery of allied health-profession services in remote areas, not just rural but actually remote areas?  
30

MS MALONEY: I have, yes.

MR KNOWLES: Yes, and can you give some description of that to the commissioners?

MS MALONEY: So I spent six months of last year working on the APY lands for an Aboriginal community controlled health service that included an aged care facility, and so my observation there was that, while that service was of a good quality, culturally appropriate, again access to allied health services was severely restricted. So the capacity to bring allied health professionals into that community and that facility was very restricted.  
40

MR KNOWLES: How did it work, in effect, in terms of bringing allied health professionals in to attend to people's needs?

MS MALONEY: It would be on a referral basis only, and there would be delays in terms of when that service was accessed, because it would depend on the small team that was providing services onto the APY lands, the timing of that. So there may be

some gap between a need being identified and a referral made and the access to that service.

MR KNOWLES: Were there any allied health assistants working - - -

5

MS MALONEY: No.

MR KNOWLES: No. Do you see that they might've – do you think that they might've been of benefit in this circumstance?

10

MS MALONEY: Absolutely. So again – and I think the cultural issues around providing services in those settings would be paramount. So even the existence of Aboriginal health workers as a prime need in those communities would improve primary-healthcare standards for remote communities, but then as an extension of that, allied health assistants or Aboriginal workers with allied-health-assistance competencies would then be able to support the work of allied health professionals providing outreach services.

15

MR KNOWLES: Was there telehealth used at all in that particular setting?

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MS MALONEY: No.

MR KNOWLES: No, and can you talk to the Royal Commission about telehealth and the benefits that you see, that would provide for the provision of aged care in rural and remote settings by allied health professionals?

25

MS MALONEY: Certainly. Again the – ideally, all people should be able to access services directly, face-to-face with an allied health professional, but where that's not pragmatic or possible, telehealth can be used as an adjunct to services. So there's a number of ways in which this can happen. An assessment – so telehealth can be used to increase the adherence to a program after an initial assessment has been made by an allied health professional. So the follow-up appointments and sessions can be conducted by telehealth.

30

In addition to that, you can have some assessments undertaken by telehealth, but you would need to have somebody at the patient end of that exchange to assist the patient but also assist the therapist in undertaking certain assessment procedures. And in some circumstances, telehealth may be the preferred mode of service delivery. For example: psychological services. There is evidence to suggest that they are quite effective when they're delivered by telehealth. So it's a combination. Again, I would stress that direct access to allied health services would be ideal, but there should be more availability of telehealth services in general.

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40

With regard to aged care settings, the sorts of things that I have seen would be the use of telehealth at the bedside for an aged care resident accessing general-practice services. So where there wasn't a GP available to attend the residential aged care – that's done by telehealth. So I have seen models of that occurring. And so by

45

extension: under certain circumstances telehealth delivered by allied health professionals could be undertaken as well.

5 MR KNOWLES: And you referred earlier to having an allied health assistant or – sorry – having someone else to assist with the telehealth at the actual facility.

MS MALONEY: Yes.

10 MR KNOWLES: If that were an allied health assistant who had abilities across a range of allied health areas – that would, I presume, go some way to allowing a multidisciplinary approach to be provided from time to time by telehealth.

15 MS MALONEY: Yes. An allied health assistant embedded within an aged care team would be in a position to assist with those telehealth consultations, as well as, because they are working under those allied health professionals, be in a position to pick up where those services might be required and request assessments to be made, either because somebody has – there’s been a change in somebody’s functional status or they’re not progressing as they would be expected to.

20 MR KNOWLES: From your experience, would you say that allied health professionals and allied health assistants are properly utilised in aged care generally?

25 MS MALONEY: In my direct experience I would have to say “no”. I think that allied health professionals are underutilised in the first instance, and I think that there’s a number of reasons for that. I think that because workforce profiles do not always incorporate allied health professionals they are not involved at the assessment point. So when a client is being admitted to an aged care setting, it’s not standard that allied health professionals are involved in that. And so I think that a lot of care needs for that individual may not be picked up on admission.

30 Following on from that, I have observed that the care needs or where there’s a change in somebody’s condition that the benefits to allied health services may not be identified and, therefore, those referrals are not necessarily made. So, in rural settings where access to allied health services are difficult, the needs aren’t identified and even if they are, sometimes because the staff are used to the fact that there aren’t  
35 – you know, there’s just not that access or it’s not easy, that those services are not requested.

40 MR KNOWLES: Just going back to you saying that the needs are not identified, does that relate to a lack of knowledge of the effectiveness that allied health professionals may have?

45 MS MALONEY: Yes, but also that something can be done about something. So I guess an example would be with regard to communication issues, that where that might be just accepted, that a client has a communication issue, you know, that there is something that can actually be done about that and so if they had adequate access to allied health services that that might be improved.

MR KNOWLES: How does one raise awareness of the impact that allied health professionals may have in terms of those, say, communication issues that you refer to or other difficulties that a person may be experiencing?

5 MS MALONEY: If we had access to a truly multidisciplinary team that had input from relevant allied health professionals, I think that that would have a positive impact on the rest of the clinical team and non-clinical team that are supporting that client. So some of it is about the fact that allied health professionals – and, again, I’m talking in terms of rural and remote settings, are providing services on a  
10 sessional basis and they’re not part of the care team surrounding that client, and so the opportunities for the care team to understand the impact of allied health and understand when it’s appropriate to refer is restricted because of that.

MR KNOWLES: And when you say that sessional basis, that’s a reactive – reacting  
15 to a problem that has been identified, or is it a regular - - -

MS MALONEY: That is – so it can either be – it’s generally by referral. So, again, from my observations in rural settings where you don’t have an existing allied health service, when it’s identified that a particular assessment is required, that is made on a  
20 referral basis. But, at best, you will have a sessional allied health professional providing a service to an aged care facility. And, again, the observations leading from that are that an allied health professional may undertake an assessment and make care plan arrangements for a particular client but if the facility doesn’t have the appropriate skills to, or the resources, to carry out those care plans then potentially  
25 nothing will happen between one session and the next.

MR KNOWLES: Now, you’ve also mentioned in the context of use of allied health professionals in aged care in rural and remote areas the issue of funding arrangements and do you see there being deficiencies in that area yourself?  
30

MS MALONEY: Yes. So I guess the sort of things that we have just been talking about in terms of allied health input and the opportunity to be involved in the assessment of older people as they are entering aged care facilities, the funding doesn’t support that. And so that has an impact on the care planning arrangements  
35 for that client. And, in addition, because the funding arrangements vary depending on what level of care a care recipient is eligible for, that results in a degree of confusion about who can access allied health services under the ACFI and who may not. And so I think that that is a barrier to access to allied health services for the care recipient.  
40

MR KNOWLES: And how would you propose that that be remedied?

MS MALONEY: I would suggest that allied health services should be accessible to all older people who are accessing aged care in general. So access to allied health  
45 services is an integral part of a person’s capacity to maintain a quality of life. The impact of not having that access, when somebody goes into care is that where they may have been accessing rehabilitation, for example, before they enter into an aged

care facility, that ceases as soon as they go into an aged care facility. And so there is the risk of functional decline occurring when somebody enters into an aged care facility.

5 MR KNOWLES: Do I take it from that, that you are suggesting that funding models as they exist are quite reactive to decline rather than being funding models that promote preventative measures and prevent decline?

10 MS MALONEY: The current funding model in my experience does not support the ongoing functional capacity of an older person. So the importance of maintenance rehabilitation, for example, or the importance of effective management of challenging behaviours through access to allied health professionals with particular skills in that area, the current funding instruments don't support that, generally.

15 MR KNOWLES: We were talking earlier about telehealth and I think you've said in your statement that there is funding available under the Medicare scheme for telehealth by general practitioners; is that right?

20 MS MALONEY: I think there has been recent changes.

MR KNOWLES: Yes.

25 MS MALONEY: Yes. To improve the access – so until recent times the telehealth was accessible for specialist to GP but not necessarily GP to patient.

MR KNOWLES: I see.

30 MS MALONEY: So the models that I've observed were actually funded by a third party that were implementing a pilot.

MR KNOWLES: Right. And do you see that as being something that would be the subject of a funding model to promote allied health professionals having access to rural and remote areas?

35 MS MALONEY: Absolutely, yes.

MR KNOWLES: From your perspective, what would be an ideal model of care at a residential aged care facility that incorporates an emphasis on allied health?

40 MS MALONEY: In rural and remote settings?

MR KNOWLES: Yes.

45 MS MALONEY: Yes, I think that you need a multidisciplinary team supporting the care of those residents. I would advocate for the inclusion of an allied health assistant, as part of that workforce profile. On a significant employment – so, you know, at least full-time depending on the number of residents in that facility – to

undertake the prescribed plans by allied health professionals. So where it may not be feasible to have the complete multidisciplinary team in an aged care facility in a rural setting the allied health assistant can work across those professions to deliver services to aged care residents.

5

In addition to that, I mentioned earlier that the role of the allied health assistant is still being developed and there's still capacity to grow. At the moment, for example, we have allied health assistants and leisure and health assistants who are focused on the social programming for residents of aged care facilities, and I would advocate that those roles would be merged, so that you are getting the best of both of those roles to support the social and emotional wellbeing of residents but also their physical and functional needs to stay well.

10

MR KNOWLES: Yes. And do you have a view about what the clinical governance arrangements might be in that set-up that you've just described?

15

MS MALONEY: So I think there needs to be a dedicated allied health assistant component there, and because, again, my observation is that the role is often tagged on to an assistant in nursing or an enrolled nursing role. So they're not necessarily have the formal qualifications to undertake the care plans as directed by allied health professionals. And, in addition to that, that person has conflicting priorities so that in an MPS facility, for example, as soon as there is a high acuity patient in the facility, attentions and resources are direct there at the expense of the aged care residents in that facility. So by having a dedicated workforce that sits within the aged care component of that facility, you are going to improve the current standard for care for aged care residents.

20

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MR KNOWLES: Some of this you may well have covered, I suspect, in your evidence thus far, but can you tell the Royal Commission what you think can be done overall to improve the situation for delivery of allied health services to people in aged care in rural and remote areas?

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MS MALONEY: So I think clarity around funding for the aged care managers – of aged care facilities to ensure that residents can access services as they're needed. Allied health professionals being part of the assessment process. And - - -

35

MR KNOWLES: Just before you go on from that - - -

MS MALONEY: Sorry.

40

MR KNOWLES: - - - can I just ask you about clarity of funding. At paragraph 25 of your statement on page 7 you refer to the design of:

45

*A funding mechanism that supports quality multidisciplinary care for older people with complex needs residing in aged care facilities.*

What would some of the characteristics of such a funding model look like?

MS MALONEY: So I think you need that broad-based assessment or access to allied health at the point of entry. And the current funding mechanisms don't support that. So it needs to be a more blanket approach, I think, that at least at the point of entry you've got that multidisciplinary care. And so in terms of clarity, it's about if  
5 somebody is at the point where they are needing aged care services whether it's community based or in residential settings, that allied health services are a part of that, I think is the ideal position because to make it an optional item risks underutilisation and that's the current situation that we have.

10 MR KNOWLES: And was there anything else, before you move to the next issue about improvements that you wanted to say about funding? In paragraph 21 you make some other observations about funding arrangements and funding models. Is there anything you wish to elaborate on in terms of those matters there?

15 MS MALONEY: So, I've spoken about embedding allied health services into the funding instrument and we have also talked about flexible funding arrangements for rural and remote aged care providers, blended funding models and private sector engagement so there's a number of different strategies involved there to look at  
20 improving the viability of allied health services that are existing in rural communities at the moment. So it's partially about funding so that an aged care provider might engage a private-sector allied health professional in a way that is viable for that allied health professional to take up.

25 And so that speaks to arrangements under MBS or DVA for example, to make it viable, for that person to leave their clinic and go into – provide a service at an aged care facility or for an aged care provider in collaboration with other health-service providers in a community to look at pooling their funds in order to attract allied health professionals to provide a service into those communities, and there are some good examples of where that happens at the moment.

30 MR KNOWLES: Those good examples being - - -

MS MALONEY: So there is an example where a health service has pooled funds with a primary-health network to commission a private-sector allied health  
35 professional to provide services into rural communities where there were no previous – in this instance, it was a physiotherapy service. So what that enabled is those townships to access services across a range of sectors. So – chronic-disease management, primary healthcare in general, the acute hospital setting and aged care. And so – but that was – that's unusual, I guess, is the point that I'm making here. So  
40 seeing more of that would enable allied health professionals who are working in the private sector to think more broadly about the services that they're providing.

MR KNOWLES: Now, aside from funding, what other improvements – and I interrupted you; apologies. What other improvements are there that you see as being  
45 capable of being made to the provision of aged care in rural and remote areas by allied health professionals?

MS MALONEY: So we talked a little bit about the inclusion of maintenance rehab as an important part of service provision to people in aged care. So at the moment that doesn't really happen. If somebody has been – has had some sort of health event, has gone through the hospital system, undertaken a period of rehab and for  
5 some reason has then been admitted to an aged care setting, all of those rehabilitation services then stop, and again my observation is you see a functional decline as soon as that person goes into that aged care facility, and some of the gains that were made as part of a subacute-care phase is lost when they enter into an aged care setting.

10 So some arrangement that provides for the continuation of what I will call maintenance rehab to maintain that person's function would be a critical part. And it does – I'm not saying it doesn't happen, but where you don't have allied health professionals embedded in the staff or in the services there, then you will see that functional decline. In addition to that, the importance of social programming is  
15 something that needs to have more weight, I think. Allied health services can contribute to the social and emotional wellbeing of aged care residents through tailored programs that support not only their social wellbeing but can also be very important in managing challenging behaviours. So there are a range of services that allied health professionals can take on that would reduce reliance on medical  
20 interventions, pharmacological interventions for example, in managing the health conditions of aged care residents.

MR KNOWLES: And would an allied health professional in the nature of a  
25 diversional therapist be one such person who might provide that service?

MS MALONEY: That's correct, and if I can just clarify that – diversional therapists are more recently emerged allied health professions. So they are degree-qualified to the Australian degree qualification at level 7 and above. So when I'm speaking about diversional therapists, I'm speaking to that cohort, because – there are  
30 diversional-therapy assistants and diploma-qualified diversional therapists that are employed and working within aged care facilities, but I'm speaking to the allied health professionals with the degree qualification.

MR KNOWLES: I understand. Are there other matters that you would like to  
35 mention now by way of potential improvements to access and availability of allied health professionals in aged care in rural and remote areas?

MS MALONEY: Just coming back again to the ACFI as the funding instrument for residential aged care – ensuring that amendments allow allied health professionals to  
40 provide evidence-based care. So the particular item that I'm referring to there is domain 12, the complex-care domain and, specifically, pain-management. That does not reflect current evidence-based practice and is quite restrictive in terms of how high-quality care might be delivered to people in aged care settings.

45 MR KNOWLES: And why do you say that doesn't reflect current practice?

MS MALONEY: It is – because it refers to passive treatment modalities that do not reflect the current evidence base in the management of pain.

5 MR KNOWLES: Was there anything else that you wish to say by way of ways in which there may be improvements made to the provision of aged care by allied health professionals in rural and remote settings?

MS MALONEY: I think we've covered it. Thank you.

10 MR KNOWLES: I don't have any further questions for Ms Maloney.

COMMISSIONER TRACEY: Ms Maloney, I'm going to ask you to help me, if you would, as to the sort of practical problems that confront an allied health professional on the ground in remote areas, and I think you said you spent six months of last year  
15 in APY lands. Were you there as a physiotherapist or - - -

MS MALONEY: No. No. I was there as a - - -

COMMISSIONER TRACEY: What role were you there in?  
20

MS MALONEY: As a health-service manager.

COMMISSIONER TRACEY: I see. And did you observe the work of allied health professionals such as physios while you were there?  
25

MS MALONEY: Yes, but services were very scant. So there were – I met an occupational-therapist, and I heard of a physiotherapist – that work as a team. They were employed by the state community-services agency, and they provided a fly-in-fly-out service on a very intermittent basis. Yes; so access was extremely limited.  
30

COMMISSIONER TRACEY: But they weren't living on the lands.

MS MALONEY: No.

35 COMMISSIONER TRACEY: And when they were there, how did they get their clients? Were they referred to them by general practitioners or – how else did they know that a particular person was in need of their services?

MS MALONEY: So they received – so, to my knowledge, the health service did  
40 not make referrals to those allied health professionals. Their referrals came from community, from other organisations for example, who were providing services onto the lands. And so they may be disability-related services or aged care-related services, focussing on community settings.

45 COMMISSIONER TRACEY: And what about the physical facilities in which the services were provided: were they already there and available for use, or how did it

– or did the allied health professional go to the homes of the people who they were looking after? How did it work?

5 MS MALONEY: I think that, because of the nature of the services they were providing, they would often be for example, undertaking home assessments. So they were looking at – I wouldn't necessarily say that therapeutic services were being provided; they were more at an assessment level. So for the OT that would be looking at home environments and a person's capacity to operate within that environment and then making recommendations about how to improve that. For the 10 physiotherapist it would've been about that person's functional capacity and prescribing exercises and the like to maintain their level of function or improve it; yes.

15 COMMISSIONER TRACEY: And for the most part I would assume that the allied health professional had to bring his or her equipment in with them.

MS MALONEY: Yes. But for that type of service, the equipment needs would have been portable. So as I said, it's more an assessment level of service and not necessarily around interventions. And I would suggest that access to therapeutic 20 equipment and therapeutic facilities was non-existent.

COMMISSIONER TRACEY: So when the health professional left, the equipment to assist with exercise for example, went with them.

25 MS MALONEY: Yes, that's right. Yes. So – yes.

COMMISSIONER TRACEY: Anything arising out of that?

30 MR KNOWLES: No. Thank you, commissioner.

COMMISSIONER TRACEY: Well, you've clarified for me the great difficulties that exist in this country in delivering services to rural and remote communities; if I may say slightly flippantly – I was very interested to see that you were running matrimonial-meeting arrangements as part of the training programs that you were 35 encouraging people to undertake, and I hope they work. We might get more people staying in rural areas, if both parties are committed to the role.

40 MS MALONEY: Are you referring to “a farmer wants a wife” or something like that or - - -

COMMISSIONER TRACEY: But it's been a most interesting exposé of just what life is like in those areas, and we have to turn our minds to thinking about what we can do to improve them, and you've, certainly, made some very helpful suggestions, for which we thank you.

45 MS MALONEY: Okay. Thank you.

**<THE WITNESS WITHDREW**

5 COMMISSIONER TRACEY: The commission will temporarily adjourn.

**ADJOURNED** [2.28 pm]

10 **RESUMED** [2.39 pm]

COMMISSIONER TRACEY: Yes, Mr Rozen.

15 MR ROZEN: Thank you, Commissioners. Commissioners, our last three witnesses for our hearing here in Darwin are in the witness box. They live and work in aged care in Darwin and I formally call three witnesses: Ms Morgan, Ms McCall and Ms Johnson, if they could be sworn or affirmed please.

20 COMMISSIONER TRACEY: Certainly.

**<SHARAI JOHNSON, AFFIRMED** [2.39 pm]

25 **<MICHELLE McCALL, AFFIRMED** [2.40 pm]

30 **<ANNA ELISE MORGAN, AFFIRMED** [2.40 pm]

MR ROZEN: Thank you. Ms Morgan, can we start with you please and can you confirm your full name is Anna Elise Morgan.

35 MS MORGAN: Yes, that's correct.

MR ROZEN: And Ms Morgan, you're an independent director of the Larrakia Nation Aboriginal Corporation.

40 MS MORGAN: That's correct.

MR ROZEN: You have held that position since May of 2017.

45 MS MORGAN: Yes.

MR ROZEN: You have a long history in public service generally but particularly in organisations concerned with Aboriginal affairs.

MS MORGAN: That's correct.

MR ROZEN: Turning to you, Ms McCall, there are some biographical details about you in the statement which I will come to in a moment at paragraph 10, but your full  
5 name is Michelle McCall?

MS McCALL: That's correct.

MR ROZEN: And you are the aged and disability program manager for the Larrakia  
10 Nation Aboriginal Corporation.

MS McCALL: Yes.

MR ROZEN: You have held that position since October 2017.  
15

MS McCALL: That's correct.

MR ROZEN: You are a qualified assistant in nursing, you also have a certificate III  
20 in aged care.

MS McCALL: Yes.

MR ROZEN: And you have a long history, over 30 years, working in aged care?

25 MS McCALL: That's correct.

MR ROZEN: And the last 13 of those has been in the Northern Territory.

MS McCALL: That's correct.  
30

MR ROZEN: Finally, Ms Johnson, your full name is Sharai Johnson.

MS JOHNSON: Yes.

35 MR ROZEN: And Sharai is spelt S-h-a-r-a-y.

MS JOHNSON: A-i.

MR ROZEN: A-i. I'm sorry. It's pronounced Sharay, isn't it, not Sharai. Thank  
40 you. And you are a Larrakia and Gooreng Gooreng woman.

MS JOHNSON: Yes.

MR ROZEN: And I think you wish to at this point extend a welcome to us.  
45

MS JOHNSON: Yes, please.

MR ROZEN: If you could please do that.

MS JOHNSON: Thank you. Good afternoon. My names is Sharai Johnson. Thank  
you for inviting me to do this welcome here today. I am a Larrakia woman and I  
5 respectfully acknowledge the past, present traditional custodians on this land of  
which we are meeting, the Larrakia people. The Larrakia are the traditional owners  
of the country around Darwin Harbour, east to the Adelaide River and south to the  
Finniss River. Larrakia people are also known as Gulumirrgin or Danggalaba people  
after our main totem, the crocodile.

10 We are saltwater people and traditionally our lives are dependent on the coast and the  
sea. As traditional owners we have a responsibility for looking after everyone that  
visits or lives on our country. You have come by way of the Larrakia land. You will  
hear the voice of Larrakia ancestors. When you leave, the Larrakia message will say  
15 with you. I pay respect to elders, past, present and emerging. It is my privilege and  
on behalf of my elders and the Larrakia people, I welcome you all to our land. On  
behalf of the Larrakia, welcome.

COMMISSIONER TRACEY: Thank you very much. We have been blessed both  
20 on Monday, as we began, and this afternoon as we conclude with very generous  
welcomes from the Larrakia people. We thank you for it and we assure you that the  
work of the Commission will do its best to ensure the ongoing wellbeing of your  
people and Aboriginal and Torres Strait Islander people throughout this nation.  
Thank you.

25 MR ROZEN: Thank you, Commissioners. Ms Johnson, you are the aged care  
coordinator with the Larrakia Nation Aboriginal Corporation.

MS JOHNSON: Yes, I am.

30 MR ROZEN: That's a position you have only come into recently in May of this  
year.

MS JOHNSON: Yes, it is.

35 MR ROZEN: All right. You hold a certificate III in age and community care.

MS JOHNSON: I do.

40 MR ROZEN: You, too, have a long history – perhaps not as long as Ms McCall's  
but a long history of involvement in aged provision.

MS JOHNSON: That's correct.

45 MR ROZEN: Now, there is a little video, at the risk of embarrassing you, which is  
at Tab 147 of the tender bundle and you do tend somewhat to star in this particular

video recording but I think it usefully introduces you to the Royal Commission. Perhaps if that could now be played please, at Tab 147 of the general tender bundle.

5 *My name is Sharai. Here at Larrakia Nation, I am the social group coordinator. Larrakia Nation has nine programs in total, the one I'm working for currently aged care, which is fantastic. There's not enough young people who do it. I'm not too sure why. I think they're scared of the ageing population, have a tendency to move more towards nursing. I feel personally it's really important to implement a lot of activities outside outdoors for the clients. Some of them, you know, may have*  
10 *mobility issues where they can't access vehicles or don't have the appropriate support to take them places. So I try to alternate, one week in the office where we generally have a really nice morning tea, lunch, playing bingo, socialise and then the alternate week head to the museum or to go on a picnic.*

15 *When I initially moved to Darwin, obviously I was searching for a career change. So I started applying for jobs. That was in March 2016 and then sure enough, the aged care position became available and I thought you know what, working with the elders, it doesn't matter where you're from, is really important to me. I'm a firm believer in caring for elders, looking after them, they were once young themselves. A*  
20 *lot of people don't have family, so if I can be the one person to make that difference then that's what I'm going to do. And I've been here and I'm still here.*

MR ROZEN: Thank you. Apologies for the sound recording there; it was a little bit off key but I think we got the general message. If I can come back to you, Ms  
25 Morgan, for the moment. You have prepared for the purposes of the Royal Commission a witness statement and it's a statement dated 9 July 2019 and it's up on the screen there, WIT.0255.0001.0001. As was the case with the statements that we received on Monday from a panel that we heard from, this is a collaborative effort, is it not?

30 MS MORGAN: Yes, that's correct.

MR ROZEN: All right. It has got your name on it but the work that has gone into it was a joint effort by your colleagues. Have you had an opportunity to read through  
35 the statement before giving your evidence today, Ms Morgan?

MS MORGAN: I have.

MR ROZEN: Is there anything in that statement, as you have signed it, that you  
40 would like to change?

MS MORGAN: Nothing.

MR ROZEN: All right. Before I tender it, I might ask you, Ms McCall, so far as it  
45 reflects the contribution that you made to the preparation of the statement, is there anything in there that you would like to change?

MS McCALL: No.

MR ROZEN: All right. And are you comfortable that the contents are true and correct?

5

MS McCALL: Yes.

MR ROZEN: And finally, Ms Johnson, as far as your contribution is concerned, is the position the same? All right there was a fourth contributor who is not with us.

10 Ms Natalie Quall. Ms Morgan, can you tell us a little bit about Ms Quall and her role at the Larrakia Nation Aboriginal corporation. Or is it better coming from Ms McCall?

MS MORGAN: It's better coming from her manager, actually.

15

MR ROZEN: Indeed. I'm sorry.

MS McCALL: So Natalie Quall is a Larrakia woman who has been with Larrakia Nation aged care for almost 11 years now. She has advocated for the clients for that whole time. She works – has worked across the whole range of areas within aged care but her passion is cooking. So she actually is the Meals on Wheels coordinator now.

20

MR ROZEN: And she is unwell presently.

25

MS McCALL: Yes.

MR ROZEN: And was unable to join you three today. On that basis, a little bit like we did on Monday, Commissioners, I would seek to tender the statement of Ms Morgan, the contents of which are agreed to by her colleagues.

30

COMMISSIONER TRACEY: Yes, on that basis, the statement of Anna Elise Morgan dated 9 July 2019 will become exhibit 6-34.

35

**EXHIBIT #6-34 STATEMENT OF ANNA ELISE MORGAN DATED 09/07/2019 (WIT.0255.0001.0001) AND ITS IDENTIFIED ANNEXURES**

MR ROZEN: If the Commission pleases. Ms Morgan, can I start by asking you to tell us a little bit about the Larrakia Nation Aboriginal Corporation and perhaps if we could have on the screen paragraphs 30 and 31 which are on page 6. That may be of assistance to you. I hope you will be able to see that screen or you've got a copy in front of you. So the corporation has been in existence since 1997.

40

MS MORGAN: That's correct.

45

MR ROZEN: Why was it established?

MS MORGAN: It was established as an advocacy organisation to represent the interests of the eight Larrakia families. In particular, to assist in returning land and  
5 facilitating land management activities so that people could remain connected to country.

MR ROZEN: Yes. So we see that the corporation provides a range of services, and we will talk about a number of those in a moment, one of which is aged care  
10 services, and I see at paragraph 31 that during the 22 years now since it was established it has expanded significantly; is that in terms of employees or in terms of service provision or both?

MS MORGAN: Both.  
15

MR ROZEN: Right.

MS MORGAN: So in particular and in the last three years, our membership has increased quite significantly but we now are a 600 member strong organisation. In  
20 addition to that, our staffing levels have doubled, and that includes Indigenous, non-Indigenous and Larrakia employees.

MR ROZEN: Yes.

MS MORGAN: And our program delivery has expanded enormously, so a doubling of outreach services from night patrols to day patrols and looking after people  
25 euphemistically known as long grassers who are people who are sleeping rough, connecting them with services, youth link-up services, a whole plethora of services, some of which existed already but have now been quite dramatically expanded.  
30

MR ROZEN: I take it number of those services were just not previously being provided before the establishment of the corporation?

MS MORGAN: Well that's correct. Larrakia people, as traditional owners of this  
35 land have a very strong sense of needing to look after the welfare of those people on the land be they as the welcome says, visitors or residents. And in thinking about the services that Larrakia provides, one could say that it actually goes beyond the remit of simply representing the interests of Larrakia, it's also about caring for the people on Larrakia land.  
40

MR ROZEN: Yes. And we will see in a moment that the services that are provided are not just to Larrakia people.

MS MORGAN: No.  
45

MR ROZEN: They're not just to Aboriginal people. They extend beyond that to others on the land and we will come to that in a moment. Ms McCall, perhaps if I

could just come to you – sorry, Ms Mitchell, if I could come to you presently. The range of services that are provided, those personal services, outreach programs, day and night patrol, and so on, do they all fall under your area of responsibility?

5 Perhaps you can just explain to us the internal arrangement within the corporation and what you're responsible for.

MS McCALL: No, so what falls under my area is aged care. So it will be in-home care. So it will be home care packages and Commonwealth Home Support packages. So both high level and lower level. Part of the CHSP, which is Commonwealth  
10 Home Support packages, is the ACHA program which assists with care and housing. So that program is to link long grassers or those people living rough with accommodation so that aged care can come in and provide services to them in their own homes.

15 MR ROZEN: Can I just ask you about that. It's dealt with at paragraph 36 of your statement, the ACHA program, so that's Commonwealth assistance with care and housing for the aged. It is an area the Commission has a particular interest in. Can you just explain, in a practical sense, how that program is applied in this area in Larrakia Nation area.

20

MS McCALL: Okay. So we have one staff member – we have funding for one staff member to provide services for those. That staff member will be on the road all working week. That would involve identifying long grassers in need of care, also through referrals of word of mouth from other service providers. And then he will be  
25 tasked with ensuring that these people are getting into accommodation, whether it be short-term emergency accommodation but the view is for a longer term more stable accommodation. And also linking them up to other services not just aged care but aged care to get them into – get services into the house. But if they have any other, such as renal – hooking them up with renal, finding a health practitioner or a health  
30 clinic for them that they haven't been using. So it's intense case-management initially till a service-provider comes in and provides a service.

MR ROZEN: Yes. Now, I neglected to raise something with you, and I think I should, probably, do it at this point, because it is a matter that's dealt with in the  
35 submission. Just by way of background, attached to the statement that the corporation has provided that is now part of the evidence was a very detailed and comprehensive submission that was prepared and provided to the royal commission. And we don't really have time to go through all of this, but you can rest assured – it's all been considered by the commission staff. There's one area that I wanted to  
40 specifically raise with you; the submission is at Tab 67 of the general tender bundle.

Perhaps if that could be brought up with particular attention focused on paragraph 12 at the bottom of the third page, page 3 of 9 – and there are many attachments. You'll see at the bottom there paragraph 12, which will be highlighted on the screen for you.  
45 There's a reference to the MMM geographical classification system, which we – commission heard a bit of evidence about in Broome. That's the modified Monash model. I think I've got that right. Yes. You're nodding. Thank you. And there's a

particular concern about the application of that model that's identified in the submission at paragraph 16 on the following page. I wonder if I could just – yes. Sorry. It's the next page, page 4. That's right. Paragraph 16 being highlighted there. In a practical sense can you assist us to understand the concerns the  
5 corporation has with the application of the model here in Darwin.

MS McCALL: Sure. So the application of the model is based on where your office is situated, not where you are providing services. So the issue with Darwin is that it's a large area. So even the satellite city of Palmerston – if you are going from the  
10 city into some suburbs of Palmerston, it's a 30-minute drive, but because our office is based in Darwin, we're still classified as urban. Five minutes out of Palmerston: it's classified as rural, and five minutes again is classified as remote. So the issue that we're facing is – service provision and the viability of service provision when we are classified as urban – is it can take us an hour round trip to provide half an  
15 hour of service.

MR ROZEN: Thank you. I wanted to ask about one other service that is identified in – back to the statement, if we can, go back to the statement on paragraph 33, on page 7; there's a heading, "Return to country", and the statement says the return-to-  
20 country program assists people to get home. We had a deal of evidence about the importance of returning to country on Monday, earlier in this week. Perhaps I can just ask you firstly, Ms McCall, and then I will come to you, Ms Johnson, on this topic, because I know you've got a contribution to make – how does that service work; what service is provided there?

25 MS McCALL: Okay. So, Anna, would you like to speak on behalf of return to country?

MS MORGAN: Yes. So one of the big issues in all remote communities is access  
30 to services.

MR ROZEN: Yes.

MS MORGAN: And for Aboriginal people in remote areas that have to come to Darwin – for example: for medical services or family reasons or whatever – the  
35 issue for them is – they will simply arrive. There'll be no accommodations support for them. There'll be no referral officers to guide them in where they go and what they do, and so, invariably, they end up sleeping rough. And so the night patrols, for example would come in to the areas where people are congregating, and they would,  
40 basically, perform an outreach referral service. So they'd check why people are here – do they need to be transported to hospital; do they need doctors' appointments; is there medication that's required – all those sorts of things so they can help people to get to where they need to be. And then on a return journey, through arrangements with the Northern Territory government, they also arrange for people to get home.  
45 And one of the things Larrakia is doing at the moment is working on a database that will allow people to advise us when people from remote communities are coming

and why they're coming so that we can link them into services straightaway and then organise for people to get home again.

5 MR ROZEN: Yes. Thanks very much. Ms Johnson, if I can come to you now and ask you if you can give us an overview of the aged care services that are provided by the corporation, because – the corporation of course is an approved provider of aged care services under the AgedCare Act. So can you give us a sense of the different sorts of services that you're involved in providing.

10 MS JOHNSON: So, on a daily basis, Larrakia Aged Care provides multiple services, which include transport, meals on wheels, personal care, domestic assistance, social-support individuals. So that could also include taking clients out on a daily basis, assisting them with hobbies that they may be participating in, swimming and whatnot. Whether they have hydrotherapy sessions, doctors' 15 appointments – so there's various services that we provide to support our clients with.

MR ROZEN: Yes. And is that under the banner of the CHSP program?

20 MS JOHNSON: Yes.

MR ROZEN: All the services that you've been talking about.

25 MS JOHNSON: Yes.

MR ROZEN: At paragraph 37 of the statement, you give us some statistics about the numbers of clients receiving assistance, and you've got – there are 99 clients receiving Commonwealth home-support program, and you've – they're given a description of the sort of services they're getting.

30 MS JOHNSON: Yes.

MR ROZEN: And they're, obviously, quite varied, the services that are provided as part of CHSP.

35 MS JOHNSON: Yes. They are.

MR ROZEN: And then there are 14 clients in receipt of home-care packages. We've heard a lot of evidence, here in Darwin and elsewhere where the royal 40 commission's been, about delays in people getting home-care packages once they've been assessed. Is that part of your experience, the delays particularly of the level 3 and 4 home-care packages?

45 MS JOHNSON: Yes. There is.

MR ROZEN: Can you tell us a bit about that, how you experience those delays ..... clients experience those delays.

MS JOHNSON: So for instance generally we should be waiting – approximately 18-months wait period - - -

MR ROZEN: Yes. From assessment to the provision of - - -

5

MS JOHNSON: From assessment to the provision of service.

MR ROZEN: Yes. Yes.

10 MS JOHNSON: Yes, that's correct. We do have one client who has waited 28 months from the assessment up until receiving the provision of services.

MR ROZEN: Yes.

15 MS JOHNSON: Yes.

MR ROZEN: We've heard elsewhere that it's not uncommon, for someone to wait so long that they will ultimately end up going into residential care, because they can't keep waiting, and they might be deteriorating. Is that also your experience here?

20

MS JOHNSON: That is. I find – I found in my experience that quite a lot of the clients rapidly decline in health whilst waiting to receive their provision of services.

MR ROZEN: Yes. Yes. Yes. It's not unheard of, is it? For a client to actually pass away whilst awaiting the receipt of services.

25

MS JOHNSON: That's right.

MR ROZEN: Is that part of your experience?

30

MS JOHNSON: Yes.

MR ROZEN: That must be a very difficult thing for you and others dealing with the clients to have to deal with.

35

MS JOHNSON: Absolutely.

MR ROZEN: I didn't ask you, but is it just you, providing aged care services? Presumably not. You've got a team of people working for you in the provision of aged care services?

40

MS McCALL: Yes, we have 20 staff members.

MR ROZEN: Right. Okay. And can you give us a bit of a sense of their backgrounds in terms of age and gender, please?

45

MS McCALL: Okay. So out of the 20 staff members, we have 13 Indigenous, 12 of which are Larrakia staff members.

MR ROZEN: Yes.

5

MS McCALL: But we also have different cultures, such as Nepalese, African, as well working with us.

MR ROZEN: Yes.

10

MS McCALL: We're bucking the trend at the moment. So we are – actually been lucky enough to have – we're attracting young staff members. We're also attracting young male staff members, which is not something that is usually – happens, but we've been lucky enough to be able to do that.

15

MR ROZEN: Well, I can assure you that on our travels around the country we have very rarely come across male workers in aged care, let alone young male workers in aged care. So this is an opportunity for the commission to find out what your secret is, I think. What – how – that's been a deliberate strategy, has it? To try and attract male workers?

20

MS McCALL: It has been a deliberate – young and Indigenous was the initial strategy.

25

MR ROZEN: Yes.

MS McCALL: So – and it so happens to be, that we're getting young Larrakia men.

MR ROZEN: Yes

30

MS McCALL: So – yes. So the strategy was to do that and to bring that into force, but we're also selling aged care different. Aged care is quite commonly viewed a certain way.

35

MR ROZEN: Yes

MS McCALL: And that I think ..... the point being in Sharai's video, that we're looking for passion; we're selling aged care for helping the elders. We're selling aged care as – it's not just all doom and gloom. It is – it can be fun; you're making a difference to the quality of people's lives. You're supporting people to remain in their homes, and I think that's one of the key things that've been able to us – able for us to attract and retain our workforce.

40

MR ROZEN: And just – if we can just stick to the male workforce for the moment, one of the services-provider is a men's group, is it not? I think – which, I think, happens to be today.

45

MS McCALL: Yes.

MR ROZEN: That's a – Friday is the men's-group day.

5 MS McCALL: Friday.

MR ROZEN: You tell us about the men's-group service to the extent that you're able to, please.

10 MS McCALL: Okay. So the men's group was formed out of need.

MR ROZEN: Yes.

15 MS McCALL: We had a social support as part of the Commonwealth home-support program. And we filled up very, very quickly, and we were getting staff – clients asking us for women's and men's group. So the men's group meet each Friday, and they can do a range of things. So they might be in there, painting or woodcarving. They might be back on land, collecting long bums to cook up. They'll be having picnics in the park. So – and they look forward to it. The clients look forward to it.  
20 They know when we pick them up in the mornings and drop – when we come around to pick them up for the social day, if we're two minutes late, we'll get a phone call. So they really look forward to that social interaction and the men's-only group.

25 MR ROZEN: If I can come back to you, Ms Johnson, if I could, please – we got a bit of a sense of your passion of working in the aged care from the video, of course, but do you agree with what Ms McCall says about the positive experience of working in aged care? Has that also been your experience?

30 MS JOHNSON: Absolutely.

MR ROZEN: And why is that? What is it, that makes it so rewarding?

35 MS JOHNSON: What makes it so rewarding is that you know that you're impacting – you're having a positive impact on each individual's life, daily life, their daily living, and if you can be that one person to make that change on a daily basis, then that's a wonderful outcome, not only for my personal satisfaction, my professional development, and giving that back to the community, giving that back to the workforce and also mentoring younger staff members, just the younger generation in  
40 general, showing them that aged care is – it's a great place to be. It is a wonderful place to be. It is so rewarding, and you know what? You just keep going every day.

MR ROZEN: You spoke about mentoring. Ms McCall, if I can come back to you – is that an important part about the ability to retain staff?

45

MS McCALL: Yes. Absolutely.

MR ROZEN: And why is, probably, obvious. But if you could, just expand on why that is and the sort of mentoring arrangements that you have in place.

5 MS McCALL: Okay. So we made the decision to employ people initially with –  
for the view to get in younger staff members and Indigenous staff members, we made  
the decision to employ highly qualified and highly experienced staff members first  
and fore-most. So we have those in place. So we're able to attract the younger staff  
members, and they're learning the right way. They're being taught and mentored by  
10 qualified staff. We've also – on the cultural side of it, we have not only Sharai, but  
we have also Natalie, who is a co-ordinator, and also another Larrakia man, who's  
another care co-ordinator, who are in a position there now to mentor those  
Indigenous staff members.

15 MR ROZEN: Ms Johnson, I see that one of the training programs you've done is  
related specifically to dementia care. Firstly, could you tell us what that was, is that  
something you did online or it is something you did locally here?

20 MS JOHNSON: Okay, so I participated locally for and with Dementia Australia  
here in Darwin. They provide three-day courses, you know, brief short courses that  
staff here in Darwin are readily able to access. So I've been participating in  
extensive dementia essentials training, which ultimately provides a broad overview  
of what it is like for an individual living with dementia. Fantastic.

25 MR ROZEN: I know that just from talking to you that one of the features of the  
training has been a simulation exercise.

MS JOHNSON: Yes.

30 MR ROZEN: Can you tell the Commissioners about your experience of that and  
how that has assisted you in the work that you do.

35 MS JOHNSON: Yes, so the last round of training I participated in was called  
Enabling Eddie, which ultimately consists of wearing virtual reality goggles. So you  
place the goggles on and, for me, you have a visual aspect, an overview of what it's  
like for a person living with dementia. So something such as these carpets that we're  
looking at today, in the eyes of a person living with dementia would be a black  
sinkhole. The writing on this paper in front of me would be something that  
constantly fluctuates, so it's very difficult. From my personal experience, that course  
40 which was scheduled to take four hours was something that took me six hours  
because it was physically making me feel sick, having to take the goggles off and put  
them back on. So that gave me a great insight and, you know, that was knowledge  
and skills I was able to bring back to Larrakia Aged Care mentor and discuss with  
my staff. And yes, it was a great experience.

45 MR ROZEN: There's another aspect of dementia care that I wanted to ask you  
about; it links back to people returning to country. And can you share with the  
Commissioners your experience of that program that you've described for me when

we met the other day, of taking people, Aboriginal people with dementia back on country and how that program assists them. I hope you know what I'm talking about.

5 MS JOHNSON: Yes. So under the service provision of the CHSP program, one of the – what would you call it – one of the deliveries we provide is social support individual. And what we've found with clients of ours who have dementia is taking them out of their homes into public places or places that would be fairly familiar to them and it brings back positive memories of theirs that they wouldn't generally  
10 discuss on a daily basis. So reminiscing about things in their past, people that they have met, being in a certain place could remind them of what they were doing at a certain time in their lives. It has been a wonderful experience to watch a lot of our clients show positive – positive signs. So that's because we have had such a positive outcome in doing that that's something that we are now providing regularly and it  
15 has been great.

MR ROZEN: Ms McCall, is there anything you would like to add on that front?

MS McCALL: I would like to add in the written submission, you will see the case  
20 study and the one that Sharai just touched on those, so with that particular client - - -

MR ROZEN: We will bring that up on the screen, it's in Tab 67. I'm sorry to interrupt you. It's on page 8. I think it's case study 1. Is that the one we're talking  
25 about or maybe I've got that wrong. There's four case studies on that page.

MS McCALL: No.

MS JOHNSON: No.

30 MR ROZEN: Do you have a copy of the submission in front of you?

MS McCALL: I have, I'm just trying to find - - -

MR ROZEN: Is it one of those case studies? There's four there on that page.  
35

MS McCALL: No, that's not the one that I was thinking of.

MR ROZEN: Okay. Put that to one side and go back to telling us about it.

40 MS McCALL: I'm terribly sorry.

MR ROZEN: No, that's all right.

MS McCALL: So this client had significant behavioural – complex behaviour  
45 issues. When we identified a staff member to go with this client on a social support individual. That client, as Sharai was saying, was then taken to places to invoke memories, places of significant importance, and we have seen such a stark

improvement in the behavioural – complex behaviours of that client since that has been occurring. That client used to have behaviours on a daily basis. We can't – we were just talking this morning, we can't remember the last time that client actually had a complex behaviour issue.

5

MR ROZEN: I wanted to ask you about something which appears at paragraph 55 of your statement, and Ms Morgan, this might be a matter for you, I'm not sure. But there's reference to the dignity of risk and the importance that's played there. Is that something you can expand on?

10

MS MORGAN: I think that – I know what it means, but Michelle is the person with the personal experience.

MR ROZEN: All roads leads to you, Ms McCall, so can you help us there, please.

15

MS McCALL: Okay. So the dignity of risk. So what we also stress is that we're a support service. We take the care out of it. We do care but we make it very clear that we are a support so that that person can remain independent as long as possible. We – the care that they are provided is the care that they choose to get, when they choose to get it. So if they choose to do something that is risky to themselves or choose not to do something that could lead to risk, we will stand by the dignity of risk. So we – our staff members or us ourselves will speak to that client. We will explain the risks, should they choose to follow the path that they were doing, but if they choose to continue down that path, then we stand by dignity of risk. That is their choice to stand by that.

20

25

MR ROZEN: Can you give us an example of the sort of, are you talking about risky behaviours, say smoking for example or - - -

30

MS McCALL: Exactly. It can be from smoking to drinking alcohol or to allowing repeat aggressive people into their homes. Even down to a bath mat that is fringed which is a huge slip risk. But if they want that bath mat there, as long as they are aware that they can be – they can trip on it, they can – it can cause injury, they could end up in hospital. If they still choose to have that bath mat there, then that's their choice. That's the dignity of risk.

35

MR ROZEN: I meant to ask you before, you have a long history in aged care previously in Queensland, is that right, originally?

40

MS McCALL: Originally in Queensland; the last 13 years here.

MR ROZEN: But only recently working for the Larrakia.

MS McCALL: That's correct.

45

MR ROZEN: Where were you previously, you don't have to mention the name, but what I'm trying to get a sense of how the aged care services provided by the corporation compared to your previous experiences in aged care generally.

5 MS McCALL: So I was working for a government – Commonwealth Government as an NT investigations manager. And that was predominantly aged care.

MR ROZEN: Yes. Resi care primarily, was it?

10 MS McCALL: It turned out to be resi care primarily but it did cover everything. So it was also home care. So not only did we investigate complaints from either service providers or clients or their family, we could also do our own motion, so if we thought there was a systemic issue or we were identifying a systemic issue we would investigate that, but we also monitored compliance with the Aged Care Act, service  
15 providers, or approved providers, compliance with the Act.

MR ROZEN: And so you weren't so much involved in the provision of aged care but rather the oversight of others doing it. With that in mind, how does the aged care work that you're now involved in at the corporation, how does it compare to other  
20 experiences that you've seen in aged care?

MS McCALL: It's significantly different.

MR ROZEN: In what way?  
25

MS McCALL: The choice. So it's consumer-directed care and it's something that, you know, we have taken a stand, Larrakia Nation has taken a stand with. It's the care, you know, this is the client's care, the way the client wants it. So the older model was basically you are assigned to an approved provider, you didn't have a  
30 choice on who the approved provider was going to be. And also we are very much for the support. It's about support in the home to maintain that independence, not to just ship them off into a residential facility once their needs are too high. We will do everything we can to keep them in their homes where it's safe and as long as possible, as long as they choose to be there.

35 MR ROZEN: Is another aspect of that consumer-directed approach something that you deal with at paragraph 60 of the statement, if I could ask you about the – this is under the heading Challenges, the awareness of entitlement to support. Is that a problem? We have heard a bit about this this week, people not being aware of what  
40 they are actually entitled to.

MS McCALL: Absolutely.

MR ROZEN: Could you expand on that here?  
45

MS McCALL: So in that paragraph again you will see that we've had a – recently had a significant increase of 160 per cent in service provision. The majority of that

was word of mouth. We would give assistance, obviously the referrals come through the My Aged Care portal but for people to know about that in the first place. So it is a challenge of people knowing that they are entitled to aged care services, that services are available and how to access those services. So they are the three main  
5 hurdles. We have got clients who had no idea, you know, we have got clients now in their 90s that were struggling at home and their family were providing as much support as possible but they weren't aware that they were entitled to services.

10 MR ROZEN: So how – what's the answer to that? How can people be made more aware or what do you do to spread that awareness?

MS McCALL: Okay. So we advocate for aged care constantly, Larrakia aged care constantly. We advocate also with our ACHA but also we've got the other services like day and night patrol. They might do a referral to us but also letting people  
15 know, we have got the host now, there are brochures are up there in the host. But, you know, just education people needing to be aware. And I think it goes down to other service providers as well, such as clinics and that knowing that the services are available.

20 MR ROZEN: Yes. We heard just on that point on Monday from the Danila Dilba service that you are no doubt very familiar with and also the Congress service down in Alice Springs and they were all making the point really that there needed to be more information sharing between primary health networks and aged care services, and I see you're nodding. Is that something that resonates with you and has it been a  
25 problem in a practical sense, that lack of linkages between primary health and the aged care sector.

MS McCALL: I think traditionally it was. I can't say that I've experienced that with, in this role with Larrakia Nation. We work quite significantly with Danila  
30 Dilba. Congress is obviously central, but we work significantly with Danila Dilba, from case – through – from case management with our clients so, you know, they're fully involved.

35 MR ROZEN: Ms Johnson, can you add anything there from your perspective? Do you think more needs to be done to provide those linkages or do you think it works pretty well in your experience?

MS JOHNSON: I think it works pretty well with what we have been doing, yes.

40 MR ROZEN: Yes. Now, you told us earlier about the positive aspects of working in aged care very clearly. Can you tell the Commission, are there – I'm sure there are hard parts about your job too, can you tell the Commission what perhaps is the hardest part about working in aged care in your experience.

45 MS JOHNSON: So the hardest part that I've ever had to face working for Larrakia aged care would be that I had worked tirelessly and effortlessly with one client in particular and built an absolute great rapport for her, and for medical reasons she had

to go to the hospital and she never returned home. So as part of Larrakia Aged Care providing the social-support groups, the mixed group on Tuesday, the ladies' group on Wednesday and the men's group on Friday, and having participants who do have dementia that were looking for this client and wondering why she wasn't there, why she hadn't been showing up – so for a person with dementia – they have such rapid memory-loss. So it's something that we could explain to them, but then no more than 30 seconds later they would forget. So that was a very emotional – I mean it still is very emotional, because working in the aged care sector, it's not something that's just going to happen one-off; it's something that is consistent. It is something that is continual, and it is a part of our life-cycle. So you just – you keep going.

MR ROZEN: Now, finally, if I could ask you to focus on the – it's the second-last page of the statement; there's a heading, "Aged care service's challenges", and, obviously, I'd like you to focus not only on challenges but opportunities that might present themselves to meet those challenges. The first one that's there, not surprisingly, is funding. And the point that you refer to there is subsidising people from other funding where there's decline. Ms McCall, are you able to expand on the point that's being made there at paragraph 57?

MS McCALL: So the point that's being made there is that – as you're aware, the HCP, the home-care packages are individually funded.

MR ROZEN: Yes.

MS McCALL: The issue is the length of the waits for the HCP. So those clients are being – having to utilise CHSP; so – the Commonwealth home-support programs. That's block-funded with certain amount of units. Not only are the units not covering the unit cost to the service provider; there is insufficient unit numbers. So we're knocking back people, 30 people a month. We're saying, "I'm sorry. We can't provide you services, because there's no room for negotiation in increasing the service unit numbers," which is – we'll be able to provide more servants or more services to existing clients as well. But, also, the viability of aged care in the long-term – aged care's all about the client. However, we have to be realistic with the funding. It has to be viable in the future. We would have – if our unit prices aren't able to be negotiated and additional funding coming in, then we are going to have 112 clients who wouldn't be able to be sustained in the future.

MR ROZEN: Can I just clarify that, if I can.

MS McCALL: Sure

MR ROZEN: Try and understand it – is there an annual process of funding being provided under CHSP? Is that how it works?

MS McCALL: So it's a two – it was a two-year cycle.

MR ROZEN: Yes.

MS McCALL: That two-year cycle – the contract is provided, saying it's going to roll over. Another one is going to roll over again for an additional two years this month. But that's it. You've got – we have got – other than the small increment of 2.5 per cent in costings, there is no room for negotiation. So you sign that contract to  
5 continue providing services, but there's no room to negotiate the unit numbers or the unit costs. So whereas new providers – so if you're walking in as a new provider, you are able to negotiate.

MR ROZEN: Yes. So you're calling for a bit more flexibility in the contractual  
10 arrangements.

MS McCALL: Absolutely. So that people aren't missing out on services.

MR ROZEN: Can I ask you about the paragraph 62. There's a reference there to  
15 client contributions, and that's you, Ms McCall, again. What's the issue there?

MS McCALL: So there's an issue with both CHSP and HCP. So HCP is individually funded. The client gets assessed, and we will get a review, quarterly review saying this client is able to pay this amount of money daily for the service  
20 provision. On the website it says that you may be asked for a client contribution. Well, in fact, that money will not – will be taken out of the money paid to the service-provider for their care.

COMMISSIONER TRACEY: Even if you don't get the money from the client.  
25

MS McCALL: That's correct.

COMMISSIONER TRACEY: And I assume the source of money from the client is government pension or something of that kind.  
30

MS McCALL: That's correct.

MR ROZEN: And the point you're making there is the end result is the client doesn't get the service.  
35

MS McCALL: Well, that's right.

MR ROZEN: Yes.

MS McCALL: That's right; it limits the amount of service that they can provide.  
40

MR ROZEN: Yes.

MS McCALL: Yes.  
45

MR ROZEN: And the final point there is under the heading “Carers”, paragraph 63. I can just understand that, if I can. This is family members as carers, and there’s a particular dilemma that arises here. Can you just explain it, please?

5 MS McCALL: So people – so what our experience is in the Northern Territory is that people, family members decide to become carers of the elderly.

MR ROZEN: Yes.

10 MS McCALL: They only have to be living there to be able to go in and say “I’m caring for this person” to get the funds, to get payment for a carer, carer’s payment. Those carers have nil experience – very, very little experience in providing care to that elderly client. So we’re seeing quite a significant amount of abuse, whether it be neglect, financial, a whole range. And because the carers are not experienced in  
15 providing care to the client, they have no idea, and it’s the service-providers or the ..... providers, that really need to pick up that slack to ensure that that person is getting the care that they required.

MR ROZEN: Yes. Yes. Ms Johnson, is there anything you wanted to add on that  
20 point or any of the other matters that have been raised?

MS JOHNSON: That’s everything. Michelle captured everything.

MR ROZEN: Yes. All right. Terrific. Commissioners, they’re the questions that I  
25 have for the panel members.

COMMISSIONER TRACEY: Yes. Thank you, Mr Rozen. Am I right in thinking that a lot of the clients that you look after are not Larrakia people?

30 MS McCALL: 59 per cent are Indigenous, and then we have a whole range of other clients.

COMMISSIONER TRACEY: And does your government funding take account of that fact?  
35

MS McCALL: No.

COMMISSIONER TRACEY: If you weren’t looking after these people in the long grass, I assume, nobody else would be.  
40

MS McCALL: That’s correct.

COMMISSIONER TRACEY: But you’re expending your resources to do that, and the funding that you’re using to do it is not taking account of the fact that they’re not  
45 local people.

MS McCALL: That’s correct.

COMMISSIONER TRACEY: Anything arising?

MR ROZEN: There's nothing arising. Thank you, sir.

5 COMMISSIONER TRACEY: Well, it has been a fascinating end to our Darwin  
sittings. Thank you so much for explaining to us how services are provided here and  
the difficulties you encounter and the highlights and the good bits that you  
experience in providing those services. We're very grateful to you. Thank you very  
much, and we will, certainly, be taking your submission and what you've told us  
10 today into account when we come to make our recommendations to Government.  
Thank you very much. Please feel free to go back into the body of the hearing room.  
Mr Rozen is going to deliver a short concluding submission, and then we'll be  
adjourning.

15

**<THE WITNESSES WITHDREW**

**[3.34 pm]**

COMMISSIONER TRACEY: Yes, Mr Rozen.

20

MR ROZEN: Thank you, commissioners. One small house-keeping matter – and  
then I'll make some closing remarks. It's merely just to place on record that the  
tender bundle which Mr Gray QC tendered at the outset, which is exhibit 6-1, has  
grown during the course of the week and now has 147 tabs, and there is an index that  
25 is, of course, available to anyone who wishes to know what those tabs are. That will  
no doubt continue to grow during the Cairns hearing, and I'll update everyone in  
relation to that.

Commissioners, as opened by Mr Gray QC on Monday of this week, the themes of  
30 the royal commission this week and next week are quality of care, including its  
personal and clinical dimensions, quality of life for people receiving aged care and  
access to aged care for rural, regional and remote Australians, including Aboriginal  
and Torres Strait Island people living in the Northern Territory. The royal  
commission is still to hear evidence in Cairns. We will provide a detailed closing at  
35 the end of the Cairns leg of this hearing. Now we'll provide a short closing,  
focussing on the issues particular to the Northern Territory.

Before I commence that, I repeat what has been said a number of times in opening  
and closing addresses that counsel assisting have made, and that is the importance of  
40 submissions for the royal commission. We place great emphasis on submissions that  
have been received from members of the public, and we encourage all members of  
the public that wish to be involved in the proceedings of the commission to provide  
us with submissions about their experiences, as, I think, Commissioner Tracey,  
you've said on previous occasions, both good and bad, of the aged care system; they  
45 are invaluable to us in our work.

On Monday of this week and earlier today we've heard some powerful evidence about the stark challenges faced by Aboriginal and Torres Strait Islander older people living in the Northern Territory. Challenges include poverty, food insecurity, service accessibility, lack of culturally safe and secure services and distance. We've  
5 heard about the profound impact on quality of life of being away from family and being away from country.

We are very grateful to have heard from Ms Mildred Numamurdirdi, an Aboriginal elder and traditional owner from Numbulwar, who had to travel around 800  
10 kilometres from her home because of her care needs and is now resident in a Palmerston residential aged care facility. Ms Numamurdirdi told us that she was crying for four weeks following her admission after a hospital stay, she missed her family, she missed ceremony and she missed eating the food that she ate at home. We heard about the personal impact of her connection to country and her role as an  
15 elder in her community. Memorably she said – and I quote –

*My heart is crying, because I far away from my family, yes, because if I pass away here, I've got my spirit, my culture, my ceremony way back home – at home, and my  
20 family: they don't want that way, because we've got everything there in the home, and that's my motherland, Numbulwar; yes, I'm the eldest out of my family, and so they worry.*

Moving away from your local community is of course not only an issue for Aboriginal Territorians, with Ms Lovegrove earlier today describing the challenges  
25 her father faced, having to relocate to Darwin as his care needs changed. Aboriginal elders being away from country can have profound consequences for their family and community and Australia as a whole because of the cultural knowledge that they hold. Commissioners will recall on Monday Ms Sarah Brown, the chief executive of that remarkable organisation Purple House, who said to us – and I quote –

*We've got senior people with the cultural knowledge of particular bits of land of  
30 Australia that has been passed on to them, and they're away from their country. If they don't get an opportunity to return to teach their kids and their grandkids their cultural heritage, it's lost not only for those families but the whole community, and  
35 the whole of Australia loses that knowledge.*

The royal commission has heard about the high clinical and health needs of Aboriginal and Torres Strait Islander people, building on the evidence that it heard in the Broome and Perth hearings. We've heard that older Aboriginal and Torres Strait  
40 Islander people in the Northern Territory, as across the rest of Australia, have high rates of diabetes, renal failure and other multiple complex health problems.

Yesterday, commissioners, we heard from diabetes expert Professor Sussman. He told us that the number of Aboriginal women with gestational diabetes is ten times  
45 that of non-Aboriginal and Torres Strait Islander community. He told us that death rates from diabetes are much higher among our Aboriginal and Torres Strait Islander citizens – when compared to the rest of the community. He said that these and other

similar figures are what he described as a shocking reflection on us as a community. The conditions are of course compounded by poor quality of life, poverty and remoteness.

5 We have heard that these health and clinical needs are often not being met either in  
community care or residential settings. You heard a panel comprising  
representatives from Central Australian Aboriginal Congress and Danila Dilba here  
in Darwin on Monday and they told us that care needs to be made culturally safe and  
10 that this can be achieved through cultural safety training, the use of interpreters and  
cultural workers and a workforce that includes people who speak relevant languages.

Dr Giles of Danila Dilba told us of what she described as the shameful inequity that  
results from an Aboriginal language speaker not having free access to the Aboriginal  
interpreter service whereas a care worker speaking any other language has free  
15 access to the national translation and interpreting service. In relation to community  
aged care we heard about the centrality of basic necessities of living to support  
people being able to live on country.

Ms Kim McRae, a team leader NPY Women's Council, explained the impact of  
20 poverty on care needs, noting that the biggest need in community aged care was for  
nutritious food. She said most people are dependent on Centrelink benefits. There's  
an obligation to share and support your family and sometimes the end result of all  
these things can mean that old people aren't getting enough to eat because they're  
making sure their grandkids are eating before they're looking after themselves.

25 So making sure that people get access to the meals program, she told us, that they are  
getting regular nutritious food can make a huge difference to someone's life. Ms  
McRae also noted that access to laundry facilities was very important to maintain  
health particularly when older people were experiencing incontinence. She said  
30 being able to access laundry services, because most people don't have a washing  
machine in their house, so being able to wash bedding, blankets, clothing,  
particularly if incontinence is an issue, is really important in terms of maintaining  
people's health.

35 These examples illustrate the interconnection between quality of life, personal care  
and clinical needs, themes which we will return to in the Cairns hearing. The  
witnesses also expressed concerns with access to and the quality of clinical care  
provided in the community setting. Employees of the Larrakia Nation Aboriginal  
Corporation, who've just given evidence minutes ago about the average wait time in  
40 Darwin for a home care package being over 18 months. And Ms Johnson, you will  
recall, gave evidence about the difficulties faced by people waiting very long periods  
of time, upwards of two years, she told us in one example, waiting for home care  
packages. Ms Ah Chee of Congress noted that people with high clinical needs are  
waiting long periods before receiving level 3 and 4 services that they're eligible for,  
45 and you heard similar evidence just now from Ms Johnson.

Ms McKay of the Top End Health services, the Northern Territory Government, talked about the flow-on impact of waiting lists particularly for clients needing a level 4 home care package. She noted that the health of these highly complex clients will continue to deteriorate and hence they will be more likely to need residential aged care or if residential aged care is not available they will need to go to hospital. Both of these options take the clients off country prematurely. Ms Ah Chee and Dr Boffa noted the high clinical needs of people on level 4 home care packages and they called for nurses providing that care to be part of a primary health organisation so they can benefit from the clinical governance and support of a professional team. Ms McKay agreed this was a concept that was worth exploring.

Dr Boffa, you will recall, lamented a decline in community nursing as a result of the nationalisation of aged care and jurisdictional tensions around responsibility for nursing, noting that it's well established that home visits from nurses to older people with multiple chronic diseases prevent hospitalisations. Monday afternoon's panel also called for greater transparency and information sharing with primary health providers about community aged care eligibility and services. And Ms Ah Chee talked about discovering that a very complex patient had already been assessed as eligible for a home care package, but nobody knew and the client was not receiving the services they were entitled to and needed. The client and the family had not themselves understood what they were eligible for.

Commissioners, we also heard that clinical and personal care needs are not being met in the residential aged care setting in the Northern Territory and residents' quality of life is suffering. Dr Giles of Danila Dilba talked about challenges in the integration of care for residential aged care recipients such as access to specialist services in the health system. She gave the example of a client not being able to access assessment from ophthalmologist for a possibly preventable cause of diminishing vision. First, the client needed an optometrist appointment which itself was too costly to attend. Dr Boffa of Congress referred to the need for sufficient numbers of nurses in residential aged care to make the care clinically safe particularly in relation to medications. He said if you don't have enough registered nurses the system can be unsafe.

He also queried whether there's a degree of professional isolation when there are only a handful of registered nurses in a facility, noting that in workplaces where there are a lot of health professionals they support each other. Dr Boffa also called for salaried GPs in residential aged care that could do more than just provide Medicare rebateable services. They could help the nursing home deal with other issues, he said, such as quality and improvement. And they could support nursing staff in providing good quality medical care. Ms Ah Chee and Dr Boffa questioned at what population level smaller communities should have access to an aged care facility noting that whilst Mutitjulu which is a community of 500 Aboriginal people has a residential aged care facility.

Numbulwar, which has a larger population of 750, did not. Dr Boffa noted there are large remote communities in the Top End that don't have residential aged care

facilities and he called for planning for aged care facilities based on population levels similar to that in the health care context. We heard about what is needed to address care needs not being met including self-determination, resolving workforce issues, allowing for flexible funding and increasing access to aged care services. All  
5 witnesses emphasised the importance of self-determination in health care. Dr Boffa noted that Aboriginal community-controlled health organisations protect cultural security, particularly in the context of a history of racism, including in health care.

Ms Ah Chee provided the example of the Institute of Urban Indigenous Health in  
10 Brisbane, whom we heard from in the Perth hearing, providing a whole range of aged care services, including residential care and in this regard, Commissioners, you will recall the evidence of Mr Moore during the Perth hearing about that experience. Many of the witnesses talked about the staffing and workforce challenges in the Northern Territory. Ms Brown, Ms McRae, Ms Ah Chee, Dr Boffa, Ms Havnen and  
15 Dr Giles all talked about the importance of having cross-cultural workers, increasing the Aboriginal and Torres Strait Islander workforce and improving non-Aboriginal and Torres Strait Islander people's knowledge of culture and working in appropriate ways.

20 Ms Brown told us how the Purple House organisation works malparara way and she told us non-Aboriginal staff working with local Aboriginal people who have the expertise in language and culture. She spoke of the flexibility of their approach, developing job specifications around people and people's strength and what they want to do. Dr Giles, Dr Boffa and Ms Ah Chee discussed the need for better use of  
25 interpreters, cultural workers and mandated cross-cultural safety training in aged care facilities. Importantly, Dr Boffa challenged the Royal Commission not to be defeatist – he challenged all of us not to be defeatist. He said that it's a myth in his view that it's impossible to recruit health workers to work in remote locations.

30 He said if the necessary accommodation and other infrastructure are provided it is possible to attract and retain staff even in the most remote locations. And Commissioners, you couldn't do better than what we heard from Ms Johnson about the attractions of working in aged care which she so eloquently described to us. The Royal Commission heard about the impact suitable funding can have and particularly  
35 for the need for flexible funding models in aged, health and community care services. Ms Brown of Purple House talked about the game-changing impact of obtaining a Medicare item number for community-delivered dialysis programs, removing difficulties with cross-border work, jurisdictional challenges and it offered certainty of funding providing sustainability.

40 Ms McRae explained the need for funding for people to return to community even for visits when they're in residential aged care. And Dr Boffa noted the need for appropriate funding of nurses in residential aged care. He called for a funding model that allocated a loading for cultural safety in employing Aboriginal staff and in  
45 providing training, and he gave us the example of the Northern Territory General Practice training organisation which sees a loading added so there are additional resources to employ Aboriginal workers to ensure cultural safety. Together with Ms

Ah Chee, he called for greater funding of primary health care services for nurses providing level 3 and level 4 home care services so that consistent care could be provided.

5 Ms McKay queried the relevance of funding premises on consumer-directed care and  
community care when there are thin or no markets, noting the benefits of block  
funding and pool funding in providing certainty to service providers in smaller  
communities. You heard also just now from Ms McCall about the challenges in  
relation to funding of the Commonwealth Health Support Program, the CHSP.  
10 Lastly, the Commission heard that equity of access to aged care services is  
fundamental. Ms Havnen, in discussing Top End communities with relatively larger  
populations noted the inequity of Aboriginal people's needs not being met, and we  
quote her evidence here at some length because it captures the frustration of a long-  
fought battle and the shared views of the panel on Monday. She told us:

15 *I cannot believe that you would find similar-sized towns anywhere else in this  
country that would not have a residential aged care service. It is simply shocking  
that a town like Numbulwar for years have been told and promised, yes, you will get  
an aged care facility, and I can remember consultations going back as far as 2007  
20 and we still don't have an aged care service there. The point I really want to  
emphasise is that Aboriginal people have by far the most complex health conditions,  
complex level of needs and who actually receive the least level of service and these  
are things that are not new.*

25 *We have talked about it for decades, as Donna and Dr Boffa have said. You know  
we have done a lot of the research. I simply do not understand how we can still face  
such an inequity. And I get it that, you know, there are competing economic and  
other sorts of priorities but it's like when the hell do Aboriginal people's needs get  
met.*

30 Access to aged care for Aboriginal and Torres Strait Islander communities and  
remote populations more broadly is one dimension of the issue of access to aged care  
services for people outside the mainstream. The evidence relating to issues  
influencing the quality of care received by older Aboriginal and Torres Strait  
35 Islander people in the Northern Territory shows that the responsibility for  
improvement does not rest solely with the aged care sector. The critical influence of  
state and territory health services is particularly important in this regard. The Royal  
Commission will consider these themes of service interfaces and access for groups  
with special needs at hearings later this year.

40 Lastly, Commissioners, we wish to close with Ms Mildred Numamurdirdi's simple  
and dignified request. If I can quote from her again, she said:

45 *Can I ask for aged care in a remote community, please. We don't have aged care  
closer in our community. I'm asking to build aged care in our community.*

Commissioners, by way of final remarks at this point, can I indicate that counsel assisting consider that it's appropriate, as envisaged at the opening on Monday, for directions to be made at this point. I understand that they may already have been made in what's now become the usual form of directions for written submissions in respect of the case studies.

COMMISSIONER TRACEY: Those directions have been made and will be, if they're not already, on the Commission website.

MR ROZEN: And finally, I only need to just conclude, Commissioners, by noting that the Commission will be resuming in Cairns on Monday, 15 July 2019 at the Cairns Convention Centre.

COMMISSIONER TRACEY: What you haven't told us is what time we are starting?

MR ROZEN: I'm very wary of doing that after the experience of the other day.

COMMISSIONER TRACEY: Well, you had better get instructions, hadn't you?

MR ROZEN: I would assume 10 o'clock.

COMMISSIONER TRACEY: All right. I've just got them from behind you.

MR ROZEN: That's where all the instructions are coming from.

COMMISSIONER TRACEY: Thank you. The Commission extends its sincere thanks to counsel, instructing solicitors, support staff, technical staff, administrative staff who have made all this possible. It has been very long, intense week here in Darwin. We have learned a lot and crammed a lot into a relatively short amount of time and that's only possible as a result of the hard work of all of the staff who sit before us, and we thank you. The Commission will adjourn until 15 July in Cairns at 10 am.

35

**MATTER ADJOURNED at 3.54 pm UNTIL MONDAY, 15 JULY 2019**

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