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TRANSCRIPT OF PROCEEDINGS

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**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**

ADELAIDE

10.02 AM, WEDNESDAY, 13 FEBRUARY 2019

Continued from 12.2.19

DAY 4

**MR P. GRAY QC, Counsel Assisting, appears with DR T. McEVOY QC, MR P.
BOLSTER, MS E. BERGIN, MS B. HUTCHINS and MS E. HILL**

**MR S. FREE SC appears with MR CROCKER for the Australian Bureau of Statistics
and the Australian Institute of Health and Welfare**

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Thank you, Commissioners. I wish to mention a matter concerning management of the exhibits from yesterday's hearing. Specifically it relates to the bundle of statistical graphs and information referred to by Ms Boland and Ms York, RCD.9999.0004.0001. That document is currently part of exhibit 1-6, Ms Boland's statement and annexures. However, because that document was partially verified by Ms Boland and partially verified also by Ms York, I wish to excise it from exhibit 1-6 and tender it separately as the next exhibit in the hearing.

COMMISSIONER TRACEY: Yes. Well, if it's convenient to do that now, we can do it now, or if you prefer to do it at another time, that's also a matter for you.

MR GRAY: Thank you, Commissioners. I seek to tender that now, RCD.9999.0004.0001, which I believe would be the next exhibit number, 1-13 I believe.

COMMISSIONER TRACEY: Yes. Very well. The document entitled Projected Population Age 65 Years and Over Australia bearing the code number that you've just read out will be exhibit 1-13.

EXHIBIT #1-13 DOCUMENT ENTITLED PROJECTED POPULATION AGE 65 YEARS AND OVER AUSTRALIA (RCD.9999.0004.0001)

MR GRAY: Thank you.

COMMISSIONER TRACEY: Yes, Ms Bergin.

MS BERGIN: I call Associate Professor Edward Strivens.

<EDWARD STRIVENS, AFFIRMED [10.04 am]

<EXAMINATION-IN-CHIEF BY MS BERGIN

MS BERGIN: Associate, please bring up document number WIT.0021.0001.0001. Associate Professor Strivens, is this your statement?

ASSOC PROF STRIVENS: It is.

MS BERGIN: There should be a hard copy in the witness box in front of you. Do you wish to make an amendments to the statement?

ASSOC PROF STRIVENS: No, I'm happy as it stands.

MS BERGIN: Are its contents true and correct to the best of your knowledge and belief.

5

ASSOC PROF STRIVENS: To the best of my knowledge and belief, yes.

MS BERGIN: I tender the statement of Associate Professor Edward Strivens, document number WIT.0021.0001.0001.

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COMMISSIONER TRACEY: Yes, the witness statement of Associate Professor Edward Strivens dated 28 January 2019 will be exhibit 1-14.

15 **EXHIBIT #1.14 WITNESS STATEMENT OF ASSOCIATE PROFESSOR EDWARD STRIVENS DATED 28/01/2019 (WIT.0021.0001.0001) AND ITS IDENTIFIED ANNEXURES**

20 MS BERGIN: Associate Professor Strivens, could you please summarise your professional background and qualifications?

ASSOC PROF STRIVENS: Yes, I'm a geriatrician, so that's a fellow of the Royal Australasian College of Physicians and I'm currently president of the Australia and New Zealand Society for Geriatric Medicine. So we're the peak body for geriatricians and trainees in geriatric medicine within Australia and New Zealand, with around 1200 members across Australia and New Zealand. Clinically, as I said, I'm a geriatrician based in Far North Queensland and I cover both inpatients and outpatients and also domiciliary care and the care of older people within residential care facilities. I've worked in Far North Queensland for around 20 years and have been a specialist in geriatric medicine for around 15 years. My clinical interest and specialty is around the care of complex older Australians around geriatric evaluation and management units, dementia and delirium care as well as models of integrated care and primary care models of geriatric medicine as well.

35

MS BERGIN: Okay. What is the main reason that older people move into aged care facilities from the perspective of a geriatrician?

ASSOC PROF STRIVENS: From the perspective of a geriatrician, I think it's important to realise that often the trigger for entry to either complex coordinated care or residential care is often a physiological or a medical one. Although we know that there are complex psychosocial situations that may result in people needing to enter residential care, the majority of the times it's actually due to an acute or subacute medical event. It might be progressive cognitive decline. It might be an acute event like a stroke or it might be more progressive chronic disease. But in the majority of cases there is medical comorbidity contributing to that admission.

45

MS BERGIN: Perhaps in contrast, what's your experience of the triggers for applications for home care packages by people as they age?

5 ASSOC PROF STRIVENS: And this is an interesting question because often we
hear that for a single service such as, say, Meals on Wheels or home care that this is
often a purely social reason for receiving care, but some of the work we did even two
decades ago now looking at the old home and community care program up in Far
North Queensland found that actually people who were referred just for home care
over half of them in the next 12 months had a hospital admission. And this really
10 indicates, I think, that we often see that there are – that these presentations for
request for services are often sentinel events and a time in someone's care where you
can actually intervene, both diagnostically and through management techniques as
well.

15 MS BERGIN: How do geriatricians work with other professionals in the care of
people as they age?

ASSOC PROF STRIVENS: Geriatricians as medical specialists work very closely
with an expanded interdisciplinary team. I think it's important to realise that
20 geriatricians, if you like, play very well with others. We work well with primary
care, with general practitioners, but also the whole extended interdisciplinary teams.
So here we're talking about trained nursing staff, allied health professionals, be that
physios, occupational therapists, dieticians, social workers and speech pathologists as
well as pharmacists, psychologists and other experts in the mental health care of
25 older Australians as well. I guess our role as geriatricians is often in the diagnostic
side of things but also in the team coordination as well and providing that
coordinated care for older Australians, especially those with complex medical
comorbidities and increased frailty.

30 MS BERGIN: Associate, could you please turn to document number
ESG.9999.0001.0002. I want to ask you about comprehensive geriatric assessments
and what does a comprehensive geriatric assessment cover.

ASSOC PROF STRIVENS: Well, as you can see we defined in our position
35 statement here that comprehensive geriatric assessment is a multidimensional usually
interdisciplinary diagnostic process used to quantify an older individual's medical,
psychosocial and functional capabilities, so it's a diagnostic process. In a lot of ways
it's analogous to a surgeon's scalpel, or a gastroenterologist's endoscope. It's our
diagnostic and therapeutic tool to look at intervening to find the causes of functional
40 decline in older people but also to look at strategies to remedy them as well.

MS BERGIN: And what are the guiding principles that are applied in
comprehensive geriatric assessments?

45 ASSOC PROF STRIVENS: Well, the guiding principles is really, first of all, this is
person-centred so the assessment process really has to be central to an older person's
needs as well as their wishes. It's something that's not – it shouldn't be applied

indiscriminately but used with precision. It needs to be multidimensional. So when we talk about multidimensional assessment, what we're looking at is medications and we're looking at medical causes. We're looking at the social situations, we're looking at functional deficits. We're also looking at cognition, physical examination
5 and then using this and tying this all together to come up with a series of recommendations. As I said, it should be targeted and it should be interdisciplinary.

When we talk about interdisciplinary care, that's using the different disciplines together to come towards a common plan of action rather than multiple agents
10 working independently. So it's not just the people involved; it's actually tying together those people as well.

MS BERGIN: Operator, could you turn to page ESG.9999.0007. Here on the screen I've asked the operator to pull up the Australian and New Zealand Society for
15 Geriatric Medicine position statement number 8: Comprehensive Geriatric Assessment and Community Practice. I would ask you, Associate Professor Strivens, to further describe the domains that are covered in a functional assessment of a person.

ASSOC PROF STRIVENS: When we talk about functional assessment we often separate things out according to the personal activities of daily living which really are referring to things like mobility, they're referring to walking, they're referring to bathing and grooming, dressing and toileting, incontinence and feeding. Those basic activities which we do on a day-to-day basis. Instrumental activities of daily living
25 are a slightly higher order functional assessment. So this is looking at us interacting with our environment as well, things like being able to prepare a meal for ourselves, being able to look at doing our own shopping, being able to manage our own medications, our transport and our finance. It's important to realise when you're looking at functional assessments, this is not a binary system.

30 It's not something you can either do or you can't do. There's often gradations within it. This is where some of the finesse of assessment comes in, it's not like one day you can manage to cook and the next day you can't. It's often that you see changes that occur where maybe the repertoire of cooking is reduced. It may be people over
35 season and under season, become more reliant on recipes and these can be indicative of cognitive or functional decline prior to the loss of those skills. So again it's – you will often find that, for example, with cognitive impairment in dementia people will lose those instrumental activities of daily living before they lose personal care activities.

40 MS BERGIN: Okay. Following a comprehensive geriatric assessment, what clinical conditions and interventions might a care plan provide for?

ASSOC PROF STRIVENS: So the care plans that we might produce at that point
45 will be around looking at multiple interventions. So those – I will take, for example, maybe a person that presents for a comprehensive assessment following a fall. What we would look at then would be the medical reasons for their falls. Are they, for

example – do they have vision impairment? Are they on a number of medications that might drop their blood pressure and make them faint and more likely to fall over. But also look at interactions with their social and functional abilities as well. So is it to do with the fact that they have poor lighting at home, is it to do with scatter rugs.

5 Is it to do with the fact that they actually have reversible causes of disability; do they have cataracts, for example. Do they need corrective lenses. Do they actually need to look at an occupational therapist visiting them at home to minimise their risk of falls as well.

10 So what you would come up with is a person-centred multidimensional series of recommendations that would start with the most urgent and pressing and go through all those examples of where you may intervene. And that's what's key here is the intervention before irreversible disability. And I think we too often look at an assessment coming out with a recommendation for a service. You know, somebody
15 is falling so therefore you look at them needing to go into residential care whereas actually what we're suggesting and what is well published and well researched is that a comprehensive geriatric assessment coordinated with a geriatrician can actually have an impact before that need for supportive care to actually look at treating those reversible causes of disability. What you treat you treat. What you can't treat you
20 ameliorate.

MS BERGIN: So here when you're talking about early intervention, is that while the person is still, for example, living at home?

25 ASSOC PROF STRIVENS: Yes, still, for example, living at home but also looking at presentations within residential care. So, again, it's not that someone is static with their functional decline and there are opportunities to intervene at sentinel points during a person's journey through residential care as well, looking at falls prevention, looking at cognition, looking at medications as well.

30 MS BERGIN: Turning to the topic of medication and psychotropic prescription, what role do geriatricians have in monitoring appropriate use of medication in people as they age?

35 ASSOC PROF STRIVENS: Well, medication and medication review is a key component of a comprehensive geriatric assessment and we – I mean, we look at the number of different medications they're on and I'm talking specifically about psychotropic medications so these are agents such as antipsychotics but also including other sedatives and antidepressants all of which have a central action.
40 Geriatricians, as I said before, work very well as part of that interdisciplinary team and that review of medications would also involve primarily general practitioners and primary care physicians as well as community pharmacists as well and nursing and other allied health staff. But geriatricians carry with them some expertise to look at both the impact of the medication on the person and the impact of the person on
45 the medication as well.

MS BERGIN: Okay. So when you talk about the impact on the medication on a person, does that include monitoring their oral health and dental hygiene.

5 ASSOC PROF STRIVENS: Yes. It's a good question about dental hygiene and oral health in older people and it's something, of course, I would again defer to dentists and dental health specialists who have a far greater in-depth knowledge of the technical aspects of dental care, but I would comment around the fact that poor dental health impacts significantly on people's wellness generally, their quality of life, their ability to swallow certain medications. And also if we look at say, for
10 example, drugs that are used to treat osteoporosis or thin bones, poor dental health means you can't use these agents because of a risk of a rare but incredibly significant side effect called osteonecrosis of the jaw. So poor dental health removes one of the interventions that we have that can prevent people from breaking their hips which is often a very serious consequence of a fall.

15 We also know that the cumulative inflammation that can be caused by chronic dental ill health is also bad for you in many other ways including to your cardiovascular system and also as a portal for infection. It increases the risk of, if you have a poor swallow, for example, of aspiration events and bad bacterial infections affecting the
20 lungs.

MS BERGIN: So would you say this emphasises the importance of an integrated approach to the medical care of people as they age?

25 ASSOC PROF STRIVENS: Yes. And I think that too often we sort of exclude dental health as being an absolutely vital part of that extended interdisciplinary team and access to that is key wherever you are, be that in the community but even more so within residential care.

30 MS BERGIN: So continuing on the topic of appropriate use of medication, how are psychotropic medications used to manage people with dementia?

35 ASSOC PROF STRIVENS: Look – and I think this is an area of key interest to all of us working within the field – I think we've seen occasions where psychotropics are used inappropriately and we know that although it's part of what can be used I think when we're talking about behavioural and psychological symptoms of dementia it's important to realise that these are often, I guess, an expression of unmet need and actually indicative more of cognitive disability rather than necessarily psychosis. So if you're looking at psychotropic medications there is sometimes a
40 role for them but, I mean, to use an example that I did refer to in my evidence, if we treated 1000 people for a few months with antipsychotic medications we would get some improvements, for want of a better term, in some of those target symptoms in around 10 per cent, maybe 12 per cent of those people.

45 However, we would see an excess of 10 extra deaths in those 1000 people and 16 strokes as well as around 10 to 12 per cent of people taking those medications more likely to fall over. So they do work, for want of a better term, however, the side

effects will often outweigh the possible benefits. They are a last resort but too often we see them used as a first resort. And the use of medication should never be a substitute for good quality care and non-pharmacological management strategies are always and should always be the first step and we shouldn't be using strong
5 medications as a substitute for care.

MS BERGIN: So what proportion of use of psychotropic medications to manage people with dementia is appropriate, in your view?

10 ASSOC PROF STRIVENS: Well, I mean, I guess the figures speak for themselves in terms of how much they're used at the moment. We see probably about 80 per cent of people in residential care with dementia on one form of psychotropic. And remember this isn't just antipsychotics, this is antidepressants, this is sedatives as well and around 10 per cent of those might benefit. So if you're looking at, for
15 example, I commend the Commission to look at some of the work of Professor Henry Brodaty and Brodaty's pyramid of looking at interventions with BPSDs – behavioural and psychological symptoms of dementia – and, really, those severe symptoms really are seen in sort of one to 10 per cent rather than 80 per cent of people. So we don't have a precise figure but if you're looking for a ballpark figure
20 it would be on the lower side rather than the high side.

MS BERGIN: So biological consequence, what proportion of use of psychotropic medication is inappropriate? Is that the balance that you're talking about?

25 ASSOC PROF STRIVENS: Yes, that's the balance there, is that when all you have is a hammer every problem looks like a nail and I think this is one of the issues with antipsychotics is it far too often becomes the first step to look at, say, managing somebody who's presenting with agitation, sometimes some physical outbursts, rather than actually looking at the reasons behind this. And when we're looking at
30 these conditions more as a cognitive disability this can be actually due to the physical changes that happen within the brain. Agnosia, for example, or the inability to recognise people or objects for what they are can actually lead to a significant amount of stress, and there are non-drug strategies that can reduce this.

35 The same with looking at a whole person's life story and why they're presenting like this. You know, for example, I work up in the far north; we've got a lot of old bushies up there who are used to getting up very early in the morning. I saw a gentleman not that long ago who was a baker and he used to getting up at 2 o'clock every morning. He would continue to get up at 2 o'clock in the morning but within
40 the setting of his residential care facility that was a potential problem to the facility. It wasn't necessarily a problem to him.

MS BERGIN: What are some other risks of the inappropriate use of psychotropic medication?

45 ASSOC PROF STRIVENS: Well, as well as – I sort of pointed out before about the risk of death. There's also the risk of permanent disability in terms of increasing

stroke risk. Also of increasing postural instability and risk of falls. We also see that there are studies that even show that risk of pneumonia increase within the first two weeks of treatment with an antipsychotic because of that sedation effect as well. But as I said, there are – I wouldn't like to say that they're never appropriate because they are in that small proportion of people, around 10 per cent of people who would benefit. And this may rise according to other conditions and, of course, it would vary according to the patient mix. It may look different, for example, in someone with a high proportion of people with cognitive impairment within the facility or within the hospital or community setting.

10

MS BERGIN: So what can be done better in this regard?

ASSOC PROF STRIVENS: I think there's a case here for medication stewardship. We hear talk about how we manage antibiotics and some of the good work that's done within hospitals in terms of antimicrobial stewardship. I think there is role here for antipsychotic stewardship as well. We know that there are, I guess, levers in terms of looking at indications throughout the PBS and the use of medications off label as well, and the use of medications at varying doses. The principles of, I guess, aged care pharmacotherapy are around the start low, go slow and review regularly. So it is about if you have to use an agent, it's about using the smallest possible dose for the briefest possible time and making sure it works.

15

And if it doesn't work you don't just keep on increasing or adding different agents, you look at withdrawing and trying other things. And again I would emphasise that non-drug treatments should always be tried first and this is often more time consuming and more labour intensive but it's what we need to do.

20

MS BERGIN: Operator, could I ask you to turn to ESG.9999.0003.0002. Now, before I ask you some questions about position statement 29, Prescribing in Older People, Commissioners, I need to tender the exhibits together with the statement, if that – if the exhibits to Associate Professor Strivens' statement could be included in exhibit 1.14.

25

COMMISSIONER TRACEY: Is this document referred to in the statement?

30

MS BERGIN: Yes, Commissioner.

COMMISSIONER TRACEY: Well, in that event I will simply indicate that the exhibit 1-14 includes both the statement and the attachments to it.

35

MS BERGIN: Thank you, Commissioner.

Now, I want to ask you about psychotropic – I want to ask you about pharmacokinetic and pharmacodynamic changes that occur with normal ageing but before I do that could I ask you to explain those terms, please.

40

45

ASSOC PROF STRIVENS: Essentially what the terms mean is what the drug does to the body and how the body responds differently to the drug. When we're talking about these changes that medications have in the elderly we're looking at both changes in the older person's body that actually impact on how drugs are
5 metabolised which might be, for example, changes in kidney function, changes in the liver function, changes in the way the body is made up in terms of the proportion of fat and muscles which implicate how the drug is distributed throughout the body and how the body processes drugs. So we can't assume that how somebody responds to a drug at 20 is the same as they're going to respond to a drug at 80. And this has
10 particular challenges because of the number of medications that people will be on. I mean, we have to invent a whole new term of hyperpolypharmacy to catch up with people on 10 or more drugs because really polypharmacy or five or more drugs wasn't actually cutting the mustard in terms of differentiation because so many people are on so many medications.

15 This becomes one of the issues with working with clinical guidelines and I would come back to again, I guess, some of what we do as geriatricians, whereas single organ specialists like a cardiologist or respiratory physician will be looking at particularly the impact of these medications on heart health, but it might have a
20 contrary effect on brain health. So it's actually tying together the risks and benefits of both individual agents and multiple agents together. And many drug trials are actually done on younger Australians or younger people throughout the world. Very few drug trials are done on people over the age of 75 or 85 which is the people that we're predominantly seeing within a residential care setting.

25 Very few drug trials are done on people with coexisting cognitive impairment and clinical guidelines will tend to suggest treatment for a single condition rather than looking at multi-morbidity which is what we see in the majority of complex frail older people, especially within residential care who will have cognitive impairment
30 as well as arthritis as well as heart disease who may have had a stroke before and have got problems with their bowel and their bladder. So there's multiple medications there and it's also the – I guess the idea of a prescribing cascade as well, where we see that a medication is started for a particular condition – and an example I might use and this is referred to in one of the documents is around the drugs that we
35 use to sometimes treat the symptoms of dementia. These are a class of drug called a cholinesterase inhibitor. That's one of the chemicals which is lost when we see certain types of dementia within the brain.

40 We use a drug to treat that but one of the side effects of an increased amount of this chemical within the body is that it may cause increased urinary incontinence. So then we start another medication which actually goes contrary to the first medication to decrease the activity of the bladder which then causes increased confusion because it reduces the level of this chemical within the brain which then means we add
45 another medication and before you know it we've got half a dozen different medications, half of which are contrary – are opposing the effects of the others. So when we're looking at that, we're really trying to evaluate the overall drug burden, if you like. We're looking at opportunities to reduce inappropriate medication but also

to not fail to be able to manage or treat conditions that are remedial or treatable as well.

5 MS BERGIN: So what are the implications of frailty, for example, on polypharmacy and drug prescription?

10 ASSOC PROF STRIVENS: Well, frailty is – I guess when we're using frailty as a term, frailty is really, I guess, a physiological syndrome characterised by decreased reserve and resistance to stresses. So I guess it's that cumulative decline, lots of little events or a few major events over time that occurs across multiple health systems and multiple physiological symptoms and increases someone's vulnerability. It's one of those hard things to define. A colleague of mine refers to it a little frailty is like art. It's hard to define but you tend to recognise it when you see it. I think that's very much the case with frailty is we all know people who are in their 80s who are 15 still contributing and still have an active role and very few medical conditions versus someone in their 70s who has had multiple events and, of course, that frailty has an impact on how people respond to medications and also has an impact on their likelihood of side effects and the impact of those side effects on their everyday life.

20 If you think of frailty or pre-frailty, if you like, as a threshold, the more reserve you have the bigger the insult you need to slip into disability. If you have multiple existing comorbidities then often the insult can be minimal to actually dip into that degree of frailty.

25 MS BERGIN: So what are the implications for dosage in terms of medication prescription of frailty?

30 ASSOC PROF STRIVENS: It's recognition of frailty. It's management of frailty and it's also in terms of drug prescriptions it's again the – looking at starting low, going slow and reviewing regularly and making sure that you – it's almost an art of choosing the least worst side effect of medications. For example, if a medication has – if someone is frail and has been losing weight then, you know, the medication you use to treat their depression might be one that encourages weight gain rather than weight loss, where medications can be equal efficacy but their side effects profile is 35 different. And that involves skill, knowledge and education.

MS BERGIN: Just unpicking that a little further, can lower doses of medications achieve a similar result in a frail person.

40 ASSOC PROF STRIVENS: Absolutely. Absolutely. And if you look at some of the doses of medication that are used in older people they can be fractional to what you would use in a 20 or 30 year old. You would use lower doses. As I said, start low, go slow in terms of the incremental increases and you will find that lower dose will have a similar therapeutic effect.

45

MS BERGIN: What does that mean for quality and what quality principles should be applied.

ASSOC PROF STRIVENS: The quality principles there is around making sure that you've got the right dose for the right person, so it's about individualising care, but it's also around the issues of consent. And I guess that has been one of my concerns when we've looked at consent for the use of some of these antipsychotic agents and there's a good study from New South Wales to suggest that only six and a half per cent of people actually on antipsychotics have been adequately consented. So by adequately consented we're really talking about a discussion on the side effects and benefits. And I think that's the idea of targeting your interventions. I think it's – although we've talked about lower doses having a similar effect, it's important not to look at under-dosing as well and I guess I come to this a little bit in my evidence when we're talking about pain because there is an issue of under-treatment of pain as well is that we have to be careful in making sure we get the lowest effective dose. And the second part of that, the effective dose, is important as well as always combining it with non-drug treatments as well.

MS BERGIN: So should pain be sort of conceived of differently in the approach to medication management and separated out.

ASSOC PROF STRIVENS: No. No, look, I think it's again, it's not saying that you wouldn't treat pain at an initial low dose. It's just the importance of prescribing your medication to get the desired clinical effect and the desired clinical effect in cooperation and directed by the person that you're treating. So this might be that someone will say I am willing to put up with X side effect to get Y benefit. But that's the idea of informed consent with medications, is to actually talk about risks versus benefit and what risks will you accept to gain what benefit.

MS BERGIN: How important is consent and consent from sort of family members in addition to consent from the person?

ASSOC PROF STRIVENS: That's one of the concerns here, I think, is that agents are being used without a full discussion in terms of benefits and side effects, and these discussions with – ideally with the person themselves and if they're unable to consent due to issues with capacity, but even with reduced capacity I would still be discussing this with the individual, but also with their substitute decision-maker.

MS BERGIN: So what screening tools are available for – to assist in the task of prescribing medication?

ASSOC PROF STRIVENS: Yes, there's a number of screening tools that are appropriate for use in older people. There's – I refer to them as the stop/start combination which is the screening tool for older person's prescription and this is around looking at what medications might be able to be ceased and also looking at which conditions are able to be treated and aren't being treated. So I think that's the delicate dynamic here is we don't want to say, you've got to stop all medications because you are going to miss opportunities to positively impact on quality of life and prognosis as well. From an Australian viewpoint we have the Drug Burden

Index as well as an American tools, the Beers Criteria which, again, is looking at sequentially what medications you might try and remove.

5 MS BERGIN: Operator, if you could turn to ESG.9999.0003.0004. So is this the publication produced by the Australian and New Zealand Society for Geriatric Medicine and your society's description of each of the tools that you're talking about.

10 ASSOC PROF STRIVENS: It is. It is.

MS BERGIN: And how effective are these tools?

15 ASSOC PROF STRIVENS: Look, I think – we know that they are effective and can be used by a combination of geriatricians, pharmacists and primary care physicians and they can start guiding a conversation. I think, again, it's about guiding that conversation of benefits versus side effects for each of these medications and guiding prescribers and practitioners as to which medications you would look at trying to remove first. Which are the ones with the highest level of side effects. And, again, it's about minimising the overuse as well as the underuse of medications.

20 MS BERGIN: Okay. Now, turning to the topic of dementia, what is the clinical definition of dementia?

25 ASSOC PROF STRIVENS: So dementia is an acquired condition of the brain characterised by multiple cognitive impairment across multiple cognitive domains and severe enough to cause a decline in social or occupational function and not better accounted for by delirium or depression or another medical or psychiatric condition. So breaking that down I guess, one, it's progressive, so something that has got worse from point A to point B. It causes deficits in multiple cognitive domains and by 30 those cognitive domains the one we think of most commonly is memory. But not all dementia causes an issue with memory, at least in the early stages and it can often impact on other cognitive domains as well such as speech, such as a purposeful movement, such as recognition of people or objects and also comprehensive planning and executive functions. So this is sort of amnesic symptoms, aphasic symptoms, 35 agnostic symptoms and apraxic symptoms as well as dysexecutive functions.

It's often multiple domains that are affected. It might be memory but also someone might have problems remembering names, remembering faces or getting themselves dressed or planning, and that executive function is often an early stage – it can be an 40 early stage condition where people have problems, say, managing complex financial or some of those high level instrumental activities. It's progressive over time so we see someone get worse and, as I said, it impacts on that day-to-day life.

45 MS BERGIN: What numbers of Australians live with dementia?

ASSOC PROF STRIVENS: At the moment around 400,000 Australians living with dementia and around 25,000 people under the age of 65 living with dementia as well

who might have what we call young onset dementia. So it's not only a condition of older Australians, although the biggest single risk factor for the development of dementia is increasing age. We know that by the predictions by the middle of this century we're likely to see up to a million older Australians suffering dementia and it's the greatest cause of disability in those over the age of 65 years of age and now as some of the evidence that was presented yesterday is the leading cause of death. It's now our ninth national health priority area as well.

MS BERGIN: When you mentioned the evidence led yesterday was that from the AIHW witness?

ASSOC PROF STRIVENS: Yes.

MS BERGIN: What proportion of people living in residential aged care live with dementia?

ASSOC PROF STRIVENS: So around 50 per cent of people living within residential care facilities have a diagnosis of dementia and this compares to around 10 per cent of the older Australian population in general. So you could see that, as mentioned, that the early part of the discussion today that the likelihood of cognitive decline being a precipitant for residential care.

MS BERGIN: And what are the behavioural and psychological symptoms of dementia?

ASSOC PROF STRIVENS: So we talked a little bit early in the evidence about, I guess, what they are, and there's – I would acknowledge some of the tremendous work that's done by some of the advocacy groups that are actually led by people living with dementia such as DAI or Dementia Alliance International that are really trying to get away from the use of the term behavioural or psychological symptoms of dementia. You know, I would certainly acknowledge that these symptoms are often symptoms of cognitive disability and often an expression of unmet need. This may be things such as wandering which, again, you know, the trouble with a lot of these terms is they can become slightly pejorative in nature as well, but in terms of wandering or agitation or aggression, sometimes psychotic phenomenon and these are perceptual phenomenon like visual hallucinations, auditory hallucinations, feelings of persecution as well.

And it can also refer to some coexisting mental health condition such as anxiety and depression as well. They are reasonably common, certainly as an estimate around 90 per cent of people living with dementia will have experienced at least one behaviour or psychological symptom of dementia during their journey in life with dementia but that doesn't mean everybody gets every symptom at once. They can vary in terms of their severity, their prevalence and their characteristics throughout someone's journey with dementia.

MS BERGIN: How is dementia treated?

ASSOC PROF STRIVENS: So we have no dementia-specific treatment that will reverse or arrest the progression of any of the more than 70 causes of dementia that we have. And probably just worth talking about causes a little bit at this point, is that the most common cause for dementia is Alzheimer's disease followed by probably a mixture of Alzheimer's and one of the other causes of dementia followed by vascular dementia and dementia with Lewy bodies, or dementia associated with Parkinson's disease and frontotemporal dementias and those together make up around 90 per cent plus of all sorts of dementia but they're characteristic conditions caused by different neuropathology so different changes within the brain.

10 So you can see that there would never be a single cure for dementia because it's caused by a number of different diseases that characterise the syndrome. At the moment what we have is mainly around symptomatic treatments, so these are non-drug treatments as well. And around looking backwards a little bit as well and looking at how we can live well with dementia and things like exercise, diet, attending to mid-life vascular risk factors, things like high blood pressure, high cholesterol, risk of stroke, risk of heart disease. Treating that in mid-life has a potential impact later in life as well as looking at other aspects of ageing successfully that have a positive impact on cognition which again is socialisation, which is purpose, which is social engagement, which is exercise.

20 So the treatments we have aren't a pill, aren't a particular injection or something at the moment. However, you know, again there are a lot of good work done at the moment to look at potential cures and where we've come on a long way in the last decade has been around early diagnosis because in the end any treatment for dementia will have to involve picking people up before they develop irreversible changes.

25 MS BERGIN: So then is the recommendation more around management through using non-pharmacological tools as well as pharmacological tools?

30 ASSOC PROF STRIVENS: Yes. We do have, for symptomatic treatment, classes of drugs that can, if you like, hold the symptoms at bay for maybe six or 12 months but they're not always successful and as we mentioned previously, no drug with an effect is without potential side effects, but we know the diagnostic process in attending to comorbidities so, again when we talk about the nondrug treatments of dementia absolutely key, but also managing associated illness because people with emerging cognitive impairment may have problems with compliance with medication. They might not be taking their diabetes tablets or their blood pressure tablets and thus you actually have the interaction of cognitive health and physical health and the two driving each other. So it's about attending to the medical comorbidities as well as the non-pharmacological management.

40 MS BERGIN: So do geriatricians make recommendations for non-pharmacological management such as for exercise to an older person as a treatment for dementia?

ASSOC PROF STRIVENS: Absolutely. Absolutely. And one of – we run memory clinics within an interdisciplinary team and, again, I would emphasise this is working with our colleagues here in terms of physiotherapists, in terms of nurses and nurse practitioners, in terms of occupational therapists and psychologists to actually look at those non-pharmacological management. Too much – and, again, I will defer to an Adelaide resident and dementia advocate, Kate Swaffer, in terms of – her term of prescribed disengagement – is one of the things that happens far too often is being told that you have a diagnosis of dementia and go home and prepare yourself. But actually if we take a more rehabilitative model for dementia of actually looking at working on people’s strengths and their existing strengths rather than concentrating on their weaknesses, we sometimes come out of a memory clinic appointment having spent an entire hour – and I apologise – talking to people about what they can’t do rather than celebrating and enhancing the things that they can do. And I think within that interdisciplinary framework there’s a lot that can be done to enhance function rather than just look at any inevitable functional decline.

MS BERGIN: Is that a matter for the particular geriatrician to explore or would a comprehensive geriatric assessment also typically consider non-pharmacological management strategies such as exercise and social engagement?

ASSOC PROF STRIVENS: A comprehensive geriatric assessment would absolutely include that and we’ve also worked through the State-wide dementia network in Queensland to look at GP guidelines for post-diagnostic enablement as well, so to work with general practitioners on how they can help, I guess, promote and facilitate a move towards independence.

MS BERGIN: It’s obviously a large topic and one that the Royal Commission will come back to, but moving along to a new topic or a different topic at least, mental health. So what proportion of older Australians have symptoms of depression or anxiety?

ASSOC PROF STRIVENS: Overall, in the community, we see symptoms of depression and anxiety in around 10 per cent of older Australians, and this rises to anything up to 50 per cent when we look in residential care facilities. The numbers are a little bit woolly in terms of their confidence range and we can see that the range can be sort of between 25 to about 80 per cent, but as a ballpark figure we see depression and anxiety being a much more common problem as people enter residential care. And there are reasons behind that, of course, in terms of looking at more reactive mood issues with a loss of independence and the medical comorbidities that we see precipitating an admission to residential care as well.

MS BERGIN: You indicated that you heard the evidence yesterday from the AIHW; is that right?

ASSOC PROF STRIVENS: Yes.

MS BERGIN: Would you agree with the AIHWs evidence – I think it was in the written evidence – that there's a gender differential between women and men and their experience of depression and anxiety as they age?

5 ASSOC PROF STRIVENS: Yes. And, look, I guess the other thing is that we know that some of the dreadful impact of mood disorders in older Australians as well is that we, for example, the group that has the highest level of completed suicide is over – men over the age of 85 years and this is, I think, a shocking statistic. And I think as well we, again, probably reach for the script pad a little bit too early when
10 we look at treatments. We know that when we're looking at mental health treatments the non-pharmacological management is as effective. Talking therapies work well in older Australians as well. Cognitive and behavioural therapy probably has its limitations when people have cognitive deficits but so do medications and we know that antidepressants are less effective later on in the course of cognitive decline as
15 well. So looking at those non-pharmacological and lifestyle and environmental changes have a significant beneficial impact.

MS BERGIN: How does treatment of mental health differ for older people, if at all, as compared to the general population?

20 ASSOC PROF STRIVENS: Again, I think when we look at the risks versus benefits we have to be very careful about pharmacotherapy and looking at, again, which agents we use. Agents that work well in younger Australians may have side effects that outweigh their benefits in older Australians. So it's about choice – if
25 you're looking at pharmacological treatment, it's about choice of agents and dosage. If you're looking at non-drug treatments it is again about managing comorbidities. It's about burden of disease and what you can do to alleviate symptoms of disease to help with mood. It's about adequate treatment of pain and it's about looking at, you know, some of the psychosocial aspects of care as well.

30 MS BERGIN: Associate Professor Strivens, we've got a number of topics. I'm going to keep moving along even though that's obviously another large topic to explore. On the topic of mobility and falls, why are falls more common in older Australians?

35 ASSOC PROF STRIVENS: Falls are more common and there's a number of reasons behind that. When we look at falls we see round about 40 per cent of older Australians will have a fall within a 12 month period and the ones we're particularly concerned about are either the large falls or the 10 per cent of these people who have
40 recurrent falls. It's often multidimensional. It can be due to cognition. It can be due to sensory loss, either be it visual loss or problems with balance or hearing. It can be multiple medications and particular medications associated with falls will be ones that cause sedation or ones that cause problems with either blood pressure dropping too low or heart rate dropping too low. We know that things like environment are
45 important as well and, you know, there's, I guess, the impact of individual medications versus cumulative multiple medications as well.

MS BERGIN: What interventions are recommended?

ASSOC PROF STRIVENS: Look, we have guidelines that we use based on the British Geriatric Society and the American Geriatric Society of looking at looking at
5 a comprehensive assessment, looking at falls risk, so looking at someone's cognition,
looking at their number of medications, looking at sensory loss, looking at footwear.
Screening for visual impairment and a comprehensive review of people's
medications. It's important to realise that falls are often a serious – have serious
sequelae of people needing to access either hospitalisation and residential care. And
10 even in the absence of injury that loss of confidence and the loss of self that's
associated with fallings can be an important psychological stress on people as well.
So falls prevention is a key, I guess, part of the overall assessments that we look at
doing with people.

15 MS BERGIN: On the topic of continence, are problems with urinary or faecal
continence inevitable consequences of ageing?

ASSOC PROF STRIVENS: Not at all. And this is, again – I guess while we know
that overall many conditions may increase in prevalence as you get older they're not
20 an inevitable consequence of ageing. As we know, even if we're talking about
dementia in residential care there is still 20 per cent of the population in residential
care that don't have dementia. And with continence it's neither an inevitable
consequence or seen with absolutely everyone.

25 MS BERGIN: What management strategies may assist?

ASSOC PROF STRIVENS: So, again, interdisciplinary assessment is key, looking
at reversible or remedial causes. When we look at urinary incontinence we may see
issues of stress incontinence. This is the continence issues you have with coughing
30 or sneezing versus urge incontinence when you don't get to the loo in time. Versus a
mixed picture or functional incontinence where you can't get to the loo. And I think
that's where we talk about interventions, we're not just talking about containment
strategies. We're also looking at regular toileting. We're looking at making sure
medications aren't impacting on someone's ability to get out of bed and get to the
35 loo.

We're making sure people can recognise where a toilet is. We see far too often white
on white on white bathrooms where it's very difficult to differentiate where the toilet
is, whereas something as simple as blue toilet seats can make a difference.
40 Something as simple as lighting at night or a bedside commode can make a
difference. And, again, pads should really not be used as a substitute for care. It's
analogous, again, I think to some of the issues with antipsychotics is that we should
be looking at facilitating independence rather than just using containment strategies.

45 MS BERGIN: Is there a connection between rationing of incontinence pants and
development of infections?

ASSOC PROF STRIVENS: I think we know that the sort of things that will contribute towards infection risk especially looking at skin infections or urine infections would be both urinary and faecal incontinence. Pads have different capacities and need different, I guess, time intervals of changing but, again, shouldn't
5 be used as a substitute for a regular toileting program. But, yes, if a pad is left on too long it will encourage a site that would be vulnerable to infection. And even the best pads don't tend to take more than a litre or so of fluid and the longer they're left on the more likely there would be to be a breakdown of barriers.

10 MS BERGIN: On a related topic how is skin affected by the ageing process?

ASSOC PROF STRIVENS: So we know when we're looking at the layers of skin that skin is the biggest organ in the human body and has the functions of both an organ but also a protective barrier as well. It works to control some of the movement
15 of electrolytes in and out of the body as well. As we age we know that certain characteristics of the skin changes. A lot of the junctions become looser. You can lose some of the connective tissue that binds it together. You can lose some of the protective factors of fat and muscle layers that make the skin more vulnerable to pressure and make it more vulnerable to shearing pressures which can impact on the
20 development of pressure areas or the development of injuries. And those changes as well increase the likelihood of developing either pressure areas or infections around pressure areas and can happen frighteningly quickly.

MS BERGIN: So how is infection risk otherwise affected by the ageing process in
25 addition to skin integrity?

ASSOC PROF STRIVENS: Well, we've talked I guess about the overall pattern of multi-morbidity that can be seen, especially in frail older people and, again, I would emphasise this is not the majority of older people but if we're talking about people
30 within a community care or residential setting they're far more likely to interact with the acute care setting. They're far more likely to have, for example, antibiotic treatment. You know 70 per cent of people within residential care get at least one course of antibiotics every day – sorry, every year and 20 to 30 per cent get more than one course of antibiotics. This encourages the development of side effects from
35 antibiotics as well as resistance and shockingly, some of the data suggests that up to three-quarters of those antibiotics are incorrectly prescribed. And by that they might be the wrong agent for the wrong duration with the wrong strength. And, you know, up to one in five prescriptions, there seems to be little indication for it at all. So you're then going to select out the development of resistant organisms. You've also
40 got the issue of things like, as we mentioned, the increased prevalence of continence having an impact on infection risk; the increased interaction with resistant bugs from the hospital setting as well as indwelling devices such as catheters increasing that as well.

45 MS BERGIN: What practices can assist the control of infection risk in residential care facilities?

ASSOC PROF STRIVENS: Well, when we're looking at, I guess, larger outbreaks of infection, so this is talking about things like gastro outbreaks or flu outbreaks there's the common principles of hand hygiene and hygiene fields as well as the importance of vaccination as well, both of health care workers and of older
5 Australians for influenza as well as looking at things like cohorting as well, of making sure that when you've got – you've got strong public health strategies in place to deal with outbreaks earlier as well.

10 MS BERGIN: What are the implications for someone in residential care, for example, of reduced mobility?

ASSOC PROF STRIVENS: Well, reduced mobility will impact on your infection risk by increasing the concerns with pressure areas. It will also make you more vulnerable to wounds that can be infected as well, and also has an impact on chest
15 infections, for example, if your mobility is poor you're more likely to get problems with the supply of air to the lower part of your lungs and develop something called atelectasis which is where the lung bases collapse and there are more sites where infection can come, as well as issues with immobility contributing to constipation which in turn can contribute to problems with urinary continence as well which
20 increase the risk of urinary infections.

MS BERGIN: Now, turning to the topic of hydration and nutrition, what sources of risk to proper hydration and nutrition arise as people age?

25 ASSOC PROF STRIVENS: Well, again I would defer to my colleagues in dietetics and speech pathology to talk to some of those risks with hydration and nutrition, but one of the issues here, again, is immobility. It's also of multiple medications that might impact on someone's ability to maintain adequate hydration. We also use multiple medications that impact on hydration, maybe causing dry mouth or also
30 contributing by using diuretics or water tablets that try and drain off fluid in the case of someone having cardiac failure, and the balance between adequate treatment and concerns regarding dehydration are significant.

We know that nutrition can be an issue as people get older as well and adequate
35 nutrition, if people develop, for example, problems with swallowing, then actually obtaining adequate nutrition without the input of dietetics and nursing staff can be difficult as well as working towards patients or people's preference around what sort of modifications to diet and hydration that they have.

40 MS BERGIN: How should unexplained weight loss be managed and monitored?

ASSOC PROF STRIVENS: Well, first of all looking at reversible causes. So, again is this a matter of intake; is this a matter of another serious underlying condition
45 such as cancer or malignancy. Or is this an indication that someone is approaching the end of life and at that point it's actually moving more into a person-directed end of life care. It's also about making sure that patients' preferences are met and in terms of looking at food choices that people want to eat and looking at the adequate

nutrition associated with person choice as well. But, yes, essentially it's looking at reversible causes and what you treat, you treat and what you can't treat, you ameliorate.

5 MS BERGIN: So you mentioned problem swallowing. What are the common causes of swallowing difficulties in people as they age?

ASSOC PROF STRIVENS: Even the act of ageing itself, some of the muscles of swallowing can deteriorate as you get older, but when we look at conditions
10 particularly associated with it, one would be stroke, the other would be other neurodegenerative disorders such as Parkinson's disease and, in fact, most dementias as well as they progress will impact on swallow as well. It can also be a side effect of medication and we talked about medications that might cause an overly dry
15 mouth. Medications that actually sedate an individual that have an impact on the muscle control and, again, antipsychotics potentially impact on the muscles of swallowing as well, so a combination of medical conditions, ageing and reversible causes of dysphagia associated with swallowing.

MS BERGIN: And apart from dehydration how else can dysphagia cause risk to
20 people as they age?

ASSOC PROF STRIVENS: The other risk that we know around dysphagia is around aspiration so this – by aspiration this is when either secretions or food or
25 fluid, rather than going down the oesophagus into the stomach go down the trachea and into the lungs. Discoordinated swallow – and, again, I would apologise to the Commission, this is where we rely very much on our interdisciplinary team of speech pathologists – but the incoordination swallow can actually mean that food or fluids goes down the wrong way. Now, aspiration of other secretions can occur
30 independent of any modifications you may make to diet or fluid and is, again, very much a part of how you manage oral health as well.

MS BERGIN: Now, moving to the topic of advanced care planning, what should advance care and end of life care planning – when should those topics be discussed
35 with someone?

ASSOC PROF STRIVENS: Look, I guess my – and the society's feeling on this is around that it's never too early to actually have those discussions on end of life care and I would encourage all of us to actually have those discussions with our family,
40 friends and loved ones about what our personal values and beliefs are because they vary according to who you are and they vary according to when you are and whether or not you're in your last 100 days, your last 100 hours or your last 100 minutes, your perspective changes with that, but we have a common set of beliefs. So I would actually encourage those discussions early on.

45 There are particular trigger points as well. A hospital admission with a severe illness, entry to community care, entry to residential care is times when, if those haven't been discussed, they should be discussed at those trigger points. We have

across different jurisdictions within the country different – slightly different approaches to this, but I guess the concept of advanced health directives, of medical or health care enduring powers of attorney are that you’re actually discussing those wishes with the person before, if they ever do lose capacity as well. So it’s about the wishes of the individual and clearly communicating those wishes because it’s – in the end it’s about that self-advocacy. It’s not necessarily about what we want for others; it’s what they want for themselves.

10 MS BERGIN: And how can geriatricians assist with those conversations?

ASSOC PROF STRIVENS: Again, I think it’s around those trigger points, the trigger points that may look at the need for a comprehensive geriatric assessment. Part of that comprehensive assessment should be a discussion around end of life and this can seem like a difficult conversation and I think as a society we’re not great about talking about death. But it’s one of those conversations that I think you actually – the more you get used to having the conversation, the easier it becomes. I mean, it’s not a good thing to do at the time that you’re necessarily making a diagnosis but it’s something that can be incorporated within that whole process of comprehensive assessment.

20 MS BERGIN: We talked a bit at the start of your evidence and throughout your evidence, really, about the role of a geriatrician. What motivates geriatricians to sort of visit ageing people in residential care facilities? Are additional motivators required?

25 ASSOC PROF STRIVENS: Look, I think most geriatricians feel that care of older Australians within long-term care is actually a core part of what we do. It’s one of our core duties and certainly, you know, the complexity of the medical conditions that we see within residential care lend themselves to the expertise that a geriatrician can bring. The majority of geriatricians work within hospitals as well, so can actually help to coordinate care across care transitions as well and I think that’s – when we’re talking about how geriatricians contribute, I think it’s around that integration of health services across the acute, subacute community and residential care setting and bringing together those health care and personal and social care teams as well.

30 There is, as the Commission will be aware, an item number under Medicare for comprehensive assessment which differentiates between both clinic-based assessment and community-based assessment which does help facilitate that, but I would emphasise again this is what we consider a core duty for specialists in geriatric medicine.

35 MS BERGIN: And to what extent is the availability of those Medicare codes limited by time or in other ways?

45 ASSOC PROF STRIVENS: Look, I think we know that when you’re looking at how you provide services to residential care, we do look at targeting interventions.

We're not saying that every single person every – sort of every week needs a comprehensive assessment but at those trigger points that's when there's potential benefit and it benefits the individual as well as benefiting the system. In the end no older Australian should have to enter residential care for want of diagnosis and management of a potentially treatable medical condition.

MS BERGIN: That concludes my questions. The Commissioners may have additional questions.

10 COMMISSIONER TRACEY: Thank you, Ms Bergin. Professor, am I right in understanding your evidence to be that for the most part geriatricians in this country are hospital based?

15 ASSOC PROF STRIVENS: I would say that the majority of geriatricians have at least some part of their role within hospitals but we have fully community-based geriatricians and many geriatricians will also have a domiciliary and community-based role as well.

20 COMMISSIONER TRACEY: I was going to ask you about that. Is it common for geriatricians to attend, for example, at a nursing home or to visit somebody who is being cared for in their own home?

25 ASSOC PROF STRIVENS: I think it's – I think the answer to that would be not as common as it should be. It's dependent on a referral and it's dependent on the availability of services and those availability of geriatricians will vary according to where you are in the country as there's significant parts of Australia where we don't have easy access to geriatricians within the community and within residential care, and, in fact, within hospitals in regional and rural Australia provision can be lower as well. Having said that, there are also methods of providing that support through virtual teams and through technology as well.

35 We've had trials of telehealth-based interventions in residential care and community which show a tremendous amount of promise as well. So distance and availability – local availability shouldn't limit the application. Perhaps one of the things that has limited it has been the disaggregation of health and social care, is the – I guess the lack of appreciation of the need for – I guess clinical management of complex medical comorbidities through an interdisciplinary team and the move towards just looking at accommodation. It's probably, you know, don't take this the way that we're suggesting that residential care facilities become mini hospitals; that's entirely not the point. They are people's homes and should be set up in that way. But we shouldn't lose the opportunity to actually correctly provide the medical care that these complex frail older Australians deserve.

45 COMMISSIONER TRACEY: Do you get called on from time to time, for example, to give advice to general practitioners or people who you've described as the, I think, frontline clinicians about how to treat a particular patient without yourself being called on to go and see that patient?

ASSOC PROF STRIVENS: Absolutely. And that's the – that's the – I guess one of the great advantages of trying to look at an integrated care model and we've seen models like this that have worked in the past, the aged care panels that were brought in that looked at bringing together the hospital specialists, the GPs, the residential
5 care facilities to both discuss individual cases as well as system-based issues was a promising but unfortunately relatively short-lived initiative. We've also done some very interesting trials looking at integrated care of taking geriatric medicine out of the hospital and into primary care and actually doing clinics for community based complex for older people within GP practices.

10 And the advantage of that it's where people are comfortable with going and the knowledge and skills transference in both levels between geriatricians and GPs as well as the other way round – I learn an awful lot from the GPs as much as I impart information – has been very promising as well. And I think there are ways we can
15 look at trying to drive integration. Unfortunately, a lot of our systems and financial systems at the moment create artificial divides between State and Commonwealth-funded, between hospital and community, between community and residential care. Our systems should drive integration and excellence rather than encouraging silos.

20 COMMISSIONER TRACEY: I'm assuming that there are a lot of people, both in home care and in residential care, who cannot easily be moved to a hospital for the purposes of an outpatient consultation. Is there a case to be made for people at your level of the profession being funded to go to nursing homes and review the treatment of patients?

25 ASSOC PROF STRIVENS: Yes, and those existing funding levers are there. There is – as I said, there's an item number for comprehensive geriatric assessment once a year and a review comprehensive assessment once a year under Medicare. The good thing about trying to integrate those services is that you can actually go to visit the
30 person in situ and I think that's – we all – we've always known as a profession and, I mean, geriatric medicine grew out of that need to look at reversible or remedial causes closest to the person's place of residence and we know that that's what people want. I think there's a risk of saying that older people shouldn't ever go to hospital because I think that's not true and it carries with it risks that people will discriminate
35 against older people in residential care saying they shouldn't go to hospital where, in fact, sometimes that's the place they need to be for a short period of time to treat. But we would much rather provide care closest to home.

40 COMMISSIONER BRIGGS: Picking up on Commission Tracey's questions, I really have some similar issues that I wanted to raise with you, and the first, Professor, is about the relationship between your multidisciplinary approach within the hospital setting versus assessment teams within the community that apply to aged care. Are there linkages? Are there overlaps? Is there any relationship at all?

45 ASSOC PROF STRIVENS: Yes, and that's where I was trying to, I guess, get the idea across of interdisciplinary rather than multidisciplinary. I think when we talk about multiple disciplines, often they can do their own thing and come up with their

own set of recommendations without it tying together as a whole. With interdisciplinary we're coming together with common recommendations. I think you make a very good point about the need to integrate comprehensive assessment within a multidisciplinary or interdisciplinary team in hospital and community-based teams.

5 ACATs as they were initially designed, actually included medical components as part of the interdisciplinary team and we have seen a progressive reduction, I guess, in some of the medical input to that team.

10 But there's encouraging signs in the opposite direction now and we would certainly encourage the involvement of geriatricians and general practitioners in that – in that assessment. I think otherwise we do run the risk of really just assessing for a designed program rather than looking at potential reversibility and enablement. It has been encouraging the way that we've looked more at enablement or restorative care or rehabilitation, if you really want to use a different word to enablement, but

15 we're not fully there yet. I think we want to make sure that people have access to the services they need by the people who need to deliver it at the time that they need it.

COMMISSIONER BRIGGS: We've seen in the past, as you alluded to in your evidence, quite a few attempts at integrated care and it becomes a key approach. We

20 certainly saw it in the nineties and the 2000s. Why does it fall over and what needs to occur to implement the sort of team based approach that you're suggesting to us?

ASSOC PROF STRIVENS: I think targeting is important. I think, you know, it can be difficult, if you try and apply an expensive intervention to a large number of

25 people, it soon – budgets will blow out. So it's about targeting that intervention and it's probably now about using new technologies as well. It is, you know, looking at telehealth, looking at video case conferencing, looking at, you know, rather than multiple paper charts integrating them into electronic records. There are probably options now that will drive success that weren't there in some of the trials in the

30 nineties and early noughties. I'm still a strong believer in integrated care and we've been trialling a number of new initiatives in that space over the last few years. I must admit there are some encouraging signs that I think there's probably a renaissance in integrated care.

35 COMMISSIONER BRIGGS: The story that you've told today through the evidence around the range of conditions, the interrelationships of conditions, medications and various forms of preventative treatments are fundamentally important to maintain elderly people's good health as best we can, and to improve it. To what extent do the training programs for personal care workers and nurses in the aged care sector shed

40 any light on those things for the people working in the sector?

ASSOC PROF STRIVENS: Yes, and I guess some of the things that we've looked at in this space has been around how you provide education support across a vast variety of different skill bases, and moving from people with essentially certificate

45 level education through to people with postgraduate education. I think a lot of it is around, you know – and I'm not an expert in education and training within that workforce – but what I see from our experience is around the integration of the

whole team and actually looking at all levels of training to contribute within the team and not just having a clinical team or a health professional team and a personal care team but having an integrated team with the ability to gain knowledge in those particular conditions.

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I think it is about – and it's very interesting when we talk about cognitive disability. You know, once you get your concept around that this isn't someone doing something for the sake of being awkward or deliberate; this is actually around how the brain is reacting to the set of circumstances around it. It does make your approach to things different and I don't think we should avoid the necessity for education and training support for every person within the organisation and this is from, you know, from one end to the other including high level executives as well.

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COMMISSIONER BRIGGS: I'm constantly interested in how whenever the health sector more generally and the care sector talks about integrated teams, each profession says they should lead the team. So the evidence that we will hear now says nurses might do that. I expect next week we will hear the general practitioners might do that because I've certainly heard that before. Your evidence says the geriatricians should and in some ways I think they're the tranche you will meet and that's really leading into my next question about how does an integrated team work or how does an effective integrated team work in practice so that each of the players can effectively contribute in a way they have proper exchange of information – you've alluded to that I think in your evidence – but as well they're engaged in the care of that person, so that person is at the centre?

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ASSOC PROF STRIVENS: And, look, I think you've answered your own question there with actually the person driving and coordinating the care is the individual in the centre of care, rather than the what I consider one of the biggest risks to integration is tribalism between different health professions and within different craft groups. I think there are ways of, if you keep that person at the centre of care there are ways of integrating that don't involve leadership. I was careful to use term more coordination than leadership and I think that is where it falls apart, is if someone is going to think that they're the big boss in a situation. It's about coordination of those disparate groups and I think that's where it comes on down to, again, that concept of interdisciplinary or transdisciplinary care.

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COMMISSIONER BRIGGS: If then an elderly person or their family decides that they would like to have an integrated team work with them about their needs so they get the best balance of drugs and so on; how do they do that?

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ASSOC PROF STRIVENS: Well, they can ask their general practitioner to make a referral to a geriatrician to access the geriatrician and through that an interdisciplinary team. There are also other Medicare items to involve allied health teams. Again they probably drive multidisciplinary rather than interdisciplinary care because you're funding each individual components, rather than wrapping a service around the individual. So if you're looking again at levers, you want to try and look

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at systems that maybe fund that whole service and the whole gamut of interdisciplinary assessment rather than individual components separately.

5 COMMISSIONER BRIGGS: And in other countries where these arrangements are used, how are they funded?

ASSOC PROF STRIVENS: Often through public health services.

10 COMMISSIONER BRIGGS: Yes, that's what I thought. Okay. Thank you.

COMMISSIONER TRACEY: Anything arising out of that, Ms Bergin?

MS BERGIN: Nothing arising, thank you, Commissioner.

15 COMMISSIONER TRACEY: Professor, you've given us enormous assistance in understanding the ways in which we provide medical services to the elderly in this country and we're very grateful for your insights. Thank you very much for your evidence.

20 ASSOC PROF STRIVENS: Thank you.

<THE WITNESS WITHDREW [11.27 am]

25 COMMISSIONER TRACEY: The Commission will adjourn until midday.

30 **ADJOURNED** [11.27 am]

RESUMED [12.01 pm]

35 COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Thank you, Commissioner. I call Professor Deborah Parker.

40 **<DEBORAH PARKER, AFFIRMED** [12.01 pm]

<EXAMINATION-IN-CHIEF BY MR BOLSTER

45

MR BOLSTER: If document number WIT.0017.0001.0001 can be brought up, please. Professor Parker, that's the statement that you prepared at the end of January of this year?

5 PROF PARKER: Yes.

MR BOLSTER: And do you wish to make any amendments to that statement.

PROF PARKER: No, I don't.

10

MR BOLSTER: And are its contents true and correct to the best of your knowledge and belief.

PROF PARKER: Yes, they are.

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MR BOLSTER: I tender, Commissioners, the witness statement that's number WIT.0017.0001.0001.

COMMISSIONER TRACEY: Are there any exhibits that go with it?

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MR BOLSTER: No, there aren't.

COMMISSIONER TRACEY: The witness statement of Deborah Parker dated 31 January 2019 will be exhibit 1-15.

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EXHIBIT #1-15 WITNESS STATEMENT OF DEBORAH PARKER DATED 31/01/2019 (WIT.0017.0001.0001)

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MR BOLSTER: Professor Parker, you are currently the chair of the Ageing Policy Chapter of the Australian College of Nursing.

PROF PARKER: That's correct.

35

MR BOLSTER: And could you please give the Commissioners some background as to the role and function of the College.

PROF PARKER: So the College represents the peak body for nurses in Australia. We have approximately 10,000 members. It provides opportunities for education, for leadership for – and for advocacy as well as providing opportunities for scholarships and grants programs.

40

MR BOLSTER: And how many of your 10,000 or so members are registered nurses?

45

PROF PARKER: Almost all of them. About 92 per cent, I think it is, in the document but we also represent some nurse practitioners as well who are also registered nurses to be a nurse practitioner.

5 MR BOLSTER: And enrolled nurses?

PROF PARKER: Yes, about five per cent of enrolled nurses.

10 MR BOLSTER: Now, the College's courses in aged care, I would like to talk about. What do they comprise?

PROF PARKER: So we have a fairly comprehensive list of courses in aged care which includes things around wound care – have you got a list there? I think I did provide a list.

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MR BOLSTER: I think I have a list. There was one particular course I wanted to ask you about, that's the graduate certificate in aged care nursing.

PROF PARKER: Right.

20

MR BOLSTER: How long does that course run for?

PROF PARKER: So a graduate certificate is a six month full-time equivalent course.

25

MR BOLSTER: And I believe that it involves the following issues: assessment of the older person, clinical issues in the care of the older person, assessing and managing adult pain, continence management, dementia care, healthy ageing, Parkinson's care, wound management and leadership. That's the principal course that's offered to your members and others?

30

PROF PARKER: Yes. It is one of many courses around Australia so there are other – the universities that offer postgraduate courses in aged care, graduate certificate, diploma, masters level, so there's quite a lot of training opportunities available for registered nurses.

35

MR BOLSTER: This sort of education though is voluntary education after a nurse has graduated and been registered.

40 PROF PARKER: That's right.

MR BOLSTER: And the other people in that market would be the Nurses and Midwives Federation?

45 PROF PARKER: Yes, I'm not sure they offer courses; I presume that they do. But certainly universities are in the market of offering postgraduate courses.

MR BOLSTER: Now, nurses are also required to do continuing education.

PROF PARKER: That's right. We have to do 20 hours a year for our registration.

5 MR BOLSTER: And what content is mandated for that sort of course?

PROF PARKER: So that's about your professional development. So it really depends on the area in which you practice. So for me, I'm an aged care nurse so my 20 hours would be perhaps doing a short course on something like dementia care to, you know, make sure that I'm contemporary with that. It requires some reflective practice so I have to set learning objectives, reflect on whether those learning objectives have been met as doing part of that course. It can be attending a clinical update session which some professional bodies might provide. It can be attendance at a conference, and again it's about setting some learning objectives, what do I want to learn from attending that conference and then reflecting on that and keeping a log of that.

MR BOLSTER: For the registered nurse who works in a residential aged care facility who is dealing with aged care people all the time, is there any requirement that their continuing education embraces the field in which they're working?

PROF PARKER: No requirement. To get – to be – to keep your registration, you do need to be across contemporary and current practice. So it would be unusual if you were a registered nurse working in the aged care setting not to do your professional development that was related to that, but, of course, that's quite broad.

MR BOLSTER: And, of course, in the case of nurses and enrolled nurses their registration involves oversight by State bodies.

30 PROF PARKER: That's right.

MR BOLSTER: Transparent legislative complaints mechanisms.

PROF PARKER: Yes, that's right.

MR BOLSTER: They're ultimately accountable to those professional bodies.

PROF PARKER: That's right.

40 MR BOLSTER: So complaints can be made about them.

PROF PARKER: Yes.

MR BOLSTER: Is the CLE – CLE is for lawyers, but continuing education for nurses and midwives, is that audited by - - -

PROF PARKER: Yes, yes, I have been audited, yes.

MR BOLSTER: So the auditor would be the registration body?

PROF PARKER: Yes.

5 MR BOLSTER: That's the nurses and midwives board.

PROF PARKER: That's right. Yes.

10 MR BOLSTER: And it's the nurses and midwives board which is a Australia-wide body.

PROF PARKER: Yes.

15 MR BOLSTER: And it sets the standards for nurses in terms of education.

PROF PARKER: Yes.

20 MR BOLSTER: Now, does that extend to requirements for their education at university?

PROF PARKER: Yes, it does.

25 MR BOLSTER: So the undergraduate courses must meet requirements set by the nurses and midwives board?

PROF PARKER: That's right.

30 MR BOLSTER: All right. Now, just wanted to talk about the undergraduate courses for nursing, just to get a very broad idea. We're not going into any great detail here. That's a full-time course.

PROF PARKER: Yes, we offer it full time, yes.

35 MR BOLSTER: Over how many years does it take to complete a Bachelor of Nursing?

PROF PARKER: It's a three year degree course.

40 MR BOLSTER: Now, face-to-face teaching – and by that I mean experiential teaching actually in a hospital or a residential facility – how many hours are required in a undergraduate degree?

45 PROF PARKER: So in the complete undergraduate degree, 800 hours are required across all settings, and all specialties. There's actually no set requirement for a particular aged care number of hours. In the university that I work at, we set that internally as 80 hours, so all of our undergraduate students will have at least 80 hours either in the aged care setting specifically – preferably or they may be looking after

older people in a hospital ward. And we also have a set unit within the curriculum specifically around aged care. Some universities have it woven through the curriculum but there is a requirement that the curriculum does address the care needs of older people.

5

MR BOLSTER: All right. Now, in addition to that you would be aware that often graduate nursing students or undergraduate nursing students often work in hospitals or in aged care facilities as assistants in nursing.

10 PROF PARKER: Yes, that's right.

MR BOLSTER: An assistant in nursing is what?

15 PROF PARKER: So an assistant in nursing is what we call an unregulated worker so it's a worker that may have a certificate qualification but is not diploma or degree prepared.

MR BOLSTER: All right. Now, I just wanted to ask you about the extent to which the university face-to-face patient contact involves or embraces aged care. Is it a major part of that program or is it a minor part?

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PROF PARKER: Look, within most universities I would say that most students probably would go to an aged care – residential aged care facility for some component of their training, possibly in first year or second year rather than third year and, as I say, in some universities we have dedicated units where we focus on that, and then there is the postgraduate options as well.

25

MR BOLSTER: Yes. All right. If the witness's – if that exhibit could be brought up on the screen, please, to page 9, exhibit 1-15. That's – yes, thank you. Keep going to page 9 at the foot of the page. Thank you. Now, when you were asked or when the organisation was asked and you answered on its behalf, what you considered the most important issue for the aged care sector over the next 20 years, you indicated there the skill mix of the workforce. And I was wondering if you could please develop that concern.

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35

PROF PARKER: Sure.

MR BOLSTER: In your oral evidence, please.

40 PROF PARKER: So currently we have within the workforce within aged care, and that's referring to the aged care workforce survey that's done every four years by Flinders University, we know that the number of – or the percentage of registered nurses has gone down from about 21 per cent in 2003 down to about 14.9 per cent now. So we – and correspondingly there has been an increase in what's called the assistant in nursing, or personal care worker, the unregulated worker. So I guess from our perspective representing the registered nurses in the workforce, is that we're concerned from what we heard this morning from the College of Geriatricians

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of the high level of acuity of people within either home care or residential aged care with complex needs requiring complex assessment, care planning and as he rightly pointed out, a lot of non-pharmacological options in terms of providing appropriate care for people with complex needs, that we believe that the role of the registered
5 nurse is crucial in this as is the role of the enrolled nurse.

So the enrolled nurses operate under the supervision of the registered nurse but the unregulated worker with a very short certificate training, with approximately 120
10 hours in care – in the facility is not prepared and does not have the level of assessment and planning skills required to meet the needs of the current aged care clients.

MR BOLSTER: Now, you say the word “acuity”, just so that we’re all clear, that means that the complexity of the patient need is going up.
15

PROF PARKER: Yes. That’s right.

MR BOLSTER: The number of nurses is going down.

20 PROF PARKER: That’s right.

MR BOLSTER: If the page could be scrolled down to a paragraph beginning – it’s the second last paragraph on the page. You see you mention the scope of practice for the registered nurse there which you set out.
25

PROF PARKER: Yes.

MR BOLSTER: If there are fewer nurses being asked to deal with greater acuity, the tasks that you list there need to be addressed in a much more – in a much more stressful environment, may I suggest.
30

PROF PARKER: Yes, that’s right.

MR BOLSTER: Could you go through those issues that would appear to be
35 fundamental tasks of a nurse – a registered nurse in a residential aged care facility?

PROF PARKER: Sure. So like the geriatricians, our role is part of that interdisciplinary or multidisciplinary team, so part of our role is to do a comprehensive clinical assessment of the – either the residents in residential aged
40 care facilities or people requiring home care. We need to understand what’s in that – what that assessment is telling us to then plan the care that those people may require. It also means that we have to understand who else is in the team. So like the geriatricians, we don’t operate as solo operators either. So we, as part of our training, understand the role of allied health, we understand the role that the GP
45 plays, the geriatrician plays and other people within the team. And so for us it’s about who might best meet the needs that we’ve assessed and in that care plan and bringing those team together and monitoring that.

It's also – we have a supervisory role so we have – we do supervise enrolled nurses so it may be that we are planning care that can be delivered within their scope of practice and then, of course, we are working with the unregulated health workers so it's about setting the plan of care for them as well.

5

MR BOLSTER: Were you here this morning when the professor was talking about – or he listed a number of situations that require assessment? For example, continence, skin integrity, pressure areas, infections, antibiotics, etcetera. Who is the person in the residential aged care facility who has to make decisions and assessments about that on a day-to-day basis?

10

PROF PARKER: Well, preferably it would be the registered nurse who has the skills in doing a comprehensive pain assessment, wound assessment, looking at continence issues. Sometimes some of that information can be collected by an enrolled nurse or an unregulated worker, but the – putting that information together to then communicate with a geriatrician or with a general practitioner who may be the people who are required then to look at, you know, medication management for that person really should come to the role of the registered nurse, because we have the skill sets to do that.

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MR BOLSTER: In the last paragraph on page 9 you talk about nurses being utilised only for “legislative requirements”. What do you mean by that?

PROF PARKER: So in New South Wales we have the situation where for any facility that has high level residents there is a requirement that a registered nurse is on staff at all times for those facilities. That's peculiar to New South Wales. But being available on-site as a registered nurse, it may mean that, you know, a larger facility that they may be tied up with other tasks in terms of doing ACFI assessments or other quality activities and are not actually on the floor supervising and doing the assessments for – for the residents and that might be falling to an enrolled nurse or an assistant in nursing.

25

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MR BOLSTER: Thank you for that. Now, I wanted to ask you about the people who would seem to be doing these services that nurses perhaps in the past have done, the personal care attendants. What level of education do they have in the domain?

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PROF PARKER: So they can either do a certificate III or a certificate IV through the registered training authorities. As I said, there was a review of that in 2015 where they looked at the quality of that training that was available and they found that quite variable in terms of who was providing the training and the level of hours that that training included. Also the timeframe by which it was over, whether it was face to face or whether it was online. So they have put in a minimum of 120 hours of clinical placement for – for the certificate training. I'm not sure how they ascertain the 120 hour number, what that's based on, but again 120 hours of good supervision in clinical placement may well be adequate.

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The problem is because we have a low number of registered nurses within the organisations in the first place, the supervision may in actual fact be occurring by people at the same level of the worker that's being supervised. Because if you have a large proportion of unregulated workers in the workplace and that person is coming
5 for clinical supervision, then there's no guarantees that they will be supervised by the appropriate level of person for that 120 hours.

MR BOLSTER: It really depends upon the quality of the people they're placed
10 with.

PROF PARKER: It does, yes.

MR BOLSTER: And if there are no registered nurses on duty to look after them or the registered nurses are too busy because they're run off their feet, what training do
15 they get?

PROF PARKER: Yes. Yes.

MR BOLSTER: All right.
20

COMMISSIONER TRACEY: Well, the same would presumably apply to the nursing placements that you send out into these places if the local registered nurse is so busy, he or she may not be in a position to provide the assistance that you hope will be provided on these occasions. Has the university got some arrangements with
25 particular nursing homes, residential care facilities that provide a degree of assurance that adequate time will be devoted to the placements?

PROF PARKER: Yes. Many – we do, and many universities do that for that very reason, in that we want to be sending our students to the places where we know that
30 there is registered nurse support. But even within those placements though on a very busy shift, on a very busy day it is sometimes, you know, difficult for the provider to provide the level of supervision all the time for those students. There is some models which is the teaching nursing home models that were around about 10 years ago where there was much more formalised arrangements with that. I know Helping
35 Hand here in South Australia, I think, still has that arrangement with the University of South Australia where it's quite a formal agreement between those two organisations and there was a number around the country, but, you know, they – they sort of slip away with – I think it was dedicated funding at one point to try and set those relationships up and I think that's something that, you know, we should look at
40 in the future around having really good relationships with – between universities and providers.

COMMISSIONER TRACEY: And is the management of the institutions to whom you send students for practical tuition generally cooperative and want to assist in the
45 ongoing education of the next generation of - - -

PROF PARKER: Absolutely. The industry is very receptive to partnerships with universities and to receiving our student placements. The hope is that a positive placement as part of your undergraduate training will lead to a workforce within the industry. So working with providers, you know, who are able to do that means
5 potentially when the student has finished and is a registered nurse that they would actually go back to that provider and seek employment so that we can build that workforce. So yes, they're very cooperative and keen to work with universities.

10 COMMISSIONER TRACEY: Yes, Mr Bolster.

MR BOLSTER: Thank you, Commissioner.

I wanted to just talk now about the training – go back to the training for personal care attendants. You said it's provided by a range of providers.

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PROF PARKER: Yes.

MR BOLSTER: I want to get an idea of that market. Is State TAFE involved in those sorts of programs?

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PROF PARKER: Yes. Anybody that's what's called a registered training organisation can provide that level of training. So – so while the College of Nursing is also a registered training organisation we don't provide training for the cert III and IV4 worker. We provide training at the postgraduate level. So you – as an RTO you
25 decide what training courses that you will offer and then you have the staff available to do that. And it's a market driven economy, so you advertise your courses and people come to those.

MR BOLSTER: The – there's supervision, the oversight of that market, who
30 decides what's taught and when and how?

PROF PARKER: It's the – I think it's the – and I probably won't get the name right but the Australian Quality Skills Council I think, yes.

35 MR BOLSTER: All right. Now, registration of personal care attendants. What's the College's view about that?

PROF PARKER: So as I said, we would view assistants in nursing as what we
40 would call the unregulated workforce in comparison to the registered nurses, enrolled nurses, where we're legislated to practice. If we have an error in our practice, then we can get reported to the Nurses Board of Australia and that will be investigated. That – if we're found that we are in error, that will be publicly available against our registration number. So you could search for the name of a registered nurse in
45 Australia and that is on a website. So in the unregulated workforce, we don't have that level of protection. So there is a – something called a national code of conduct that has come out for that workforce which is a – supposed to be in force by the – at the State level and I think that has been variable in how that has been taken up so

that's like a code of conduct for the unregulated worker but it doesn't give protection for somebody who may have, you know, not acted in the best interests of somebody within a workplace. There is no record of that and nowhere to take that through other than a – you know, a criminal prosecution.

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MR BOLSTER: When you say “enforced” what enforcement is there? If someone breaches the code of conduct - - -

PROF PARKER: Yes, it's a voluntary code of conduct so - - -

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MR BOLSTER: And who writes this code of conduct?

PROF PARKER: Well, it's a national code of conduct that has been written.

15 MR BOLSTER: By whom?

PROF PARKER: I'm not sure who wrote it to be honest but I guess, you know, what would be interesting is I know my code of professional conduct and standards of practice because they're – and they're freely available, you know, for people to look at. I'm not sure how many of the unregulated workers, if you ask them do you
20 adhere to the voluntary national code of conduct, I'm not sure how many of them would actually know that there is one.

MR BOLSTER: If we go over to page 11 of your statement, at the foot of the page you endorse a recommendation that an immediate review of current electives for the certificate III and certificate IV take place to identify if these electives should be changed to core units. Can you please explain what you mean by that? Does that have to do with the extent to which there is enough aged care/dementia content in the training that's provided to personal care attendants?
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PROF PARKER: So all of the core units are aged care specific but they're – they're at the level of teaching people how to provide personal care, so, you know, how to wash somebody, dress somebody, assistance with meals. So very much on the sort of functional side of things. There is within that pain assessment and some – some assessment skills taught within that, within the core units. But we have – and what the work that John Pollaers' workforce taskforce found was that within the certificate III and certificate IV options is a whole range of what we call elective units. So there's palliative care electives, there's dementia electives, there's medication management electives.
35

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But when you sign up to do your training, you're more likely just to do the core training and not to add those electives into your program. So what he's suggesting and what we endorse is that, again, given what we've heard already this morning about some of the key issues that we're facing with people in care, should we be
45 looking at what's in the core training within those.

MR BOLSTER: Is the problem that someone could go through their certificate III or certificate IV course, do no aged care extra components, no dementia components, and end up working in a nursing home?

5 PROF PARKER: They may go through without doing extensive training on dementia. As I say, all of the units are aged care specific so they are focused on care of the older person, so that is the specific training, because in TAFE there is other training, so there's disability certificates that you can do which is different to the aged care units that you can do. But it's a short course and so it really is, is it fit for
10 purpose for the emergent needs of the client group that we're seeing.

MR BOLSTER: How short?

15 PROF PARKER: So it can be as short as six months.

MR BOLSTER: So that's six months – that's not full time at TAFE, is it?

20 PROF PARKER: No, I think it potentially – it does vary because people do it in different ways. You can do a component face to face, you can do some online, you've got your clinical placement, so it does vary.

MR BOLSTER: Would you be working in the industry whilst you were doing the course, typically?

25 PROF PARKER: Again, it's difficult to get those figures. For some people they may have come from a different industry and they're re-training, particularly in Australia with the manufacturing industry – so we are getting workers from other industries and they may not have started work within a facility. And for some they're working within a facility and they're doing the training.
30

MR BOLSTER: How many – just – I just want to get an idea of the content that is face-to-face learning in that course. How many hours does that course involve, whether it's full time or part time?

35 PROF PARKER: I can't give you the theoretical hours unfortunately because I don't provide that level of training. I didn't have that information. But the clinical hours that was set after the 2015 review was 120.

40 MR BOLSTER: All right. Now, if we could go then back to page 8 under the paragraph numbered 5, you make some comments about the new Aged Care Quality and Safety Commission. About two-thirds of the way down the page you say that:

Quality outcomes for residents will not be realised through a compliance-focused accreditation approach.

45 Now, the first question is, is it, in the College's view, the case that the current system, the new system is a compliance-focused accreditation approach?

PROF PARKER: Yes.

MR BOLSTER: And what's wrong with that?

5 PROF PARKER: So to meet the accreditation standards – and they do stress that –
it's the minimum level that you would require an organisation to operate at. So what
we would be hoping for would be more than minimal level and for us to, you know,
be able to deliver best practice, then we would need to be able to have a system
10 where we have – we're measuring indicators of that best practice, and you will see in
the submission as well that currently we have a voluntary quality indicator program
within the residential aged care facilities in Australia and we actually have three
indicators within that.

MR BOLSTER: Just pausing there - - -

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PROF PARKER: Sure.

MR BOLSTER: - - - if we can bring up page 7, from about halfway down the page,
that's the mandatory National Aged Care Quality Indicator Program.

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PROF PARKER: Yes.

MR BOLSTER: It's two, nearly three years old.

25 PROF PARKER: Yes.

MR BOLSTER: And who is involved in that program? How many facilities are
involved in that program?

30 PROF PARKER: I believe it's about 10 per cent of facilities are currently
participating in that quality indicator program because it's voluntary. What we're
calling for is it to be mandatory. Now, that's not to say that other providers don't
participate in quality indicator programs. There is providers that you can sign up to
where you can put your indicator data in and they can benchmark you against similar
35 facilities or services of similar size, and you can get that information back. So it's
not that the industry as a whole isn't doing that. It's just that we don't have that on a
national transparent level for consumers to see so - - -

MR BOLSTER: We will come to that in a minute but I just wanted to talk about
40 this program and just how it works. So a facility presumably enters data about these
three criteria - - -

PROF PARKER: That's right.

45 MR BOLSTER: - - - onto a web page.

PROF PARKER: That's right.

MR BOLSTER: And the data is collected.

PROF PARKER: Yes.

5 MR BOLSTER: Do they measure that on a daily, weekly or monthly basis?

PROF PARKER: It's a quarterly report.

MR BOLSTER: Quarterly.

10

PROF PARKER: Yes.

MR BOLSTER: Is that best practice? You refer to an Ontario study where there's
15 12 factors at play. Do they – I would have thought you need to measure those
indicators more often than quarterly.

PROF PARKER: Well, what you do is you measure it quarterly but it's reporting
for that quarter.

20 MR BOLSTER: Right.

PROF PARKER: So you are actually reporting the number of falls for that quarter.
So rather than entering in the – it's not live data daily from your systems that's
actually doing that. The Ontario system and in the Carnell Paterson report there was
25 quite an extensive review of the US system as well which uses what's called the
minimum data set or the MDS. So every three months in the US and in Ontario there
is an assessment made and uploaded into a – a national system of various indicators
for each of the residents. So we have that when we do an ACFI assessment when
somebody enters care and if they need reassessment, but what we don't have is that
30 three monthly or quartering reporting on a range of indicators.

MR BOLSTER: So the system has been going since 2016. What is the data
showing? Who collects it, for a start?

35 PROF PARKER: So it goes to the department. I don't know what the data is
showing. I have not seen the data.

MR BOLSTER: Is it publicly released?

40 PROF PARKER: No.

MR BOLSTER: So it tells the department how nursing homes in 10 per cent
performing on three criteria but no one else?

45 PROF PARKER: No, and one of the – I think that is their – the intent that that
program gets to the point where it is publicly available, and what it requires is a

certain level of data to be entered into the system to be able to do what's called benchmarking.

MR BOLSTER: Yes.

5

PROF PARKER: So I think that is, from what I've read, the long-term plan is to do that. Now, the Victorian public aged care facilities have been doing this work on five indicators, so the three indicators that are in the voluntary Commonwealth program have come from the Victorian work. They have been putting that data in for almost a decade, I think. What they've done with that data is also wrap around a quality program for staff working in those public hospital facilities so that the staff are looking at that data, they're looking at the benchmarking against a facility of a similar size and similar acuity and saying, am I within the benchmark range here, and if not they're putting in programs of quality activities, you know, to make those improvements. As I said, in other aged care facilities around the country that is happening as well - - -

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MR BOLSTER: Yes.

PROF PARKER: - - - in that everybody has a quality assurance program and you're looking at your data internally and making changes and making improvement. It's just that it's not available to other people to see.

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COMMISSIONER BRIGGS: So what you're saying is that if the data, when the system becomes more widely available, was publicly available, then there – that would introduce a level of competitive tension to ratchet up quality outcomes across the sector?

25

PROF PARKER: Yes, potentially. And it also gives an idea of – so last night I went on and had a look at the Ontario data set, it's an Excel spreadsheet, I can pull it up, I can see by the name of the facility in Ontario exactly their rates of falls and the indicators that they've got. So if I was a consumer I could go on and I could have a look at that. So it also, I guess, gives the consumer some idea, you know, of – and what we – the reason that we have to be careful about introducing this system, which is why the benchmarking is so important and also looking at comparing like with like, because if you've got a dementia specific unit with very high level acuity residents, your falls rate may be higher than if you've got a unit where you've got people who are more independent. So you can't just look at the raw figures. So it is a complex system to introduce but certainly something that obviously the department is interested in and working towards and I guess we would want to see that just, you know, pushed along as quickly as possible.

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MR BOLSTER: You say that the individual providers do this themselves. Are there programs? Are there software that they can buy that do this sort of process?

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PROF PARKER: Yes.

MR BOLSTER: For their own purposes?

PROF PARKER: Yes, so the departmental one has its own web page where you go in and enter your own data. As I said, there is other companies around Australia
5 where they provide the software for you, so you enter your data and it produces graphs and tables and reports. And then some providers do it internally. So if you're large enough you may have your own business analysts where you're producing your own reports.

10 MR BOLSTER: Tell me, you may not have the expertise to answer this question, but for a large provider with multiple facilities across States - - -

PROF PARKER: Yes.

15 MR BOLSTER: - - - or even within a State, say they've got 15 or 20, do understand that they keep these sort of statistics?

PROF PARKER: Yes. Absolutely. It's part of meeting your accreditation standards. You need to show that you're able to provide the level of care that's set
20 by the standards. As part of that you would keep that level of information.

MR BOLSTER: That sort of information goes to the standards, does it?

PROF PARKER: Yes.
25

MR BOLSTER: Would that equate with the sorts of indicators that we're talking about in the Ontario study?

PROF PARKER: Yes, similar. And one of the difficulties about these quality
30 indicator programs is how you measure the person's experience of care. So it's much easier to measure concrete things like did you fall, didn't you fall, do you have a wound, don't you have a wound, and much harder to measure experience. But there is now and in the submission we do refer to the consumer experience reports that are now done as part of accreditation visits where they interview 10 per cent of -
35 and they've come up very positive, those first year of reporting of those consumer experience reports.

MR BOLSTER: The consumer experience reports really go to more - the factors
40 about how the person feels in the nursing home - - -

PROF PARKER: Yes.

MR BOLSTER: - - - communication, things like that. It doesn't really address, and
45 you wouldn't expect a resident to be able to address, the sort of statistical - - -

PROF PARKER: No.

MR BOLSTER: - - - care issues that this sort of approach needs to address.

PROF PARKER: That's right. But in that, to provide person-centred care, of course, we want the whole experience and not just the clinical indicator experience
5 but the whole experience.

MR BOLSTER: On a related topic, moving to the top of page 7 under the heading Lack of Robust and Integrated Data Systems, this would seem to be fundamental to what we've been talking about. What sort of data collection should the industry or
10 the sector be moving towards? Should it be seamless? Should it be across the entire sector?

PROF PARKER: Yes. Not only across the aged care sector but we're also talking about is that many people interface with the primary care sector and the acute care
15 sector. And so if I transfer somebody to an acute care hospital, the records sit within the acute care hospital and I don't have any access to those records. The GP doesn't have access to those records. I don't have access to the GP records. My records sit with me. There's a level of reporting that goes through the – to the Australian Institute of Health and Welfare who you've heard from in terms of some of the data
20 but even they struggle to link people's journey across the system and to understand what happens to people when they move from, say, a home care package into residential care in and out of hospital. They have to do what's called data linkage to be able to understand that. They can't pull that easily – that information easily.

25 MR BOLSTER: The new website, the My Care - - -

PROF PARKER: Yes.

MR BOLSTER: Does that fulfil this function?
30

PROF PARKER: The My Aged Care? No.

MR BOLSTER: The new system that we all now have unless we've opted out.

35 COMMISSIONER BRIGGS: My Health Record.

PROF PARKER: Sorry, the My Health Record.

MR BOLSTER: My Health Record
40

PROF PARKER: It is starting to fulfil some of those gaps and, again, hopefully we will get there over time where there is an area where we will be able to have that centralised portal but at the moment I think it's – there's not enough data within that.

45 MR BOLSTER: All right. Now, there were three other issues that you address in your report about – that involve the need for further training, and they were

dementia, mental health in the aged care context and palliative care. Now, I think we've dealt with the dementia side.

PROF PARKER: Sure.

5

MR BOLSTER: Can you tell the Commissioners, what's the tension that's at play in a nursing home with an older person who has a mental illness, as opposed to dementia or other problems that they may have. What's the problem in the care patient or care resident interface when it comes to mental health?

10

PROF PARKER: So you see the figures that one of the major mental health problems for particularly people in residential aged care is the issue of depression and anxiety. So you can be – you can have an assessment made as to whether you do have depression or anxiety and a care plan can be developed that may include pharmacological management or non-pharmacological management. But we – we are not mental health nurses. We are not trained even in providing mental health and so I think we don't have that level of expertise that was referred to this morning in terms of how do we manage from a non-pharmacological point of view dealing with people with depression and anxiety who also have potentially dementia as part of that. So I think we do need to think about the training skills required and whether that's from a professional development point of view of having more skills in that area.

15

20

25

MR BOLSTER: Now, with palliative care, I know that's a particular - - -

PROF PARKER: Yes.

MR BOLSTER: - - - research interest of yours. Is it effectively the same situation?

30

PROF PARKER: Yes. Although the Department of Health has invested substantially in providing funds for upskilling the aged care sector in palliative care, which has been, you know, well received by the sector.

35

MR BOLSTER: What does that program involve?

40

PROF PARKER: So there has been a number of programs. I'm involved at the moment with a program called End of Life Directions in Aged Care. It's a three year program funded by the Department of Health where we're providing online resources across the sector and also to GPs where we outline and provide education – online education to people within the industry about palliative care and advanced care planning. There's also – we're looking at some quality indicators specifically around palliative care because we don't have those quality indicators, so there's work done around that. The program prior to that was called Decision Assist and I was involved in that. And that had face-to-face workshops around the country over a 18 month period where we were educating staff around advanced care planning and palliative care. So there is improvements in that area and there is quite a lot of education now available for staff around that.

45

MR BOLSTER: Does that extend to the personal care attendants as well?

PROF PARKER: Yes, it does.

5 MR BOLSTER: Thank you. Now, just before we conclude, at the end of your
statement you refer to some good news, some innovation that you wish to highlight.
Can I, firstly, take you to the technology situation because I understand that is a very
– it's a matter of great interest to the Commission. The situation in Singapore with
the linking of databases and analytics, could you please explain to the Commission,
10 just how that works, how pervasive is it?

PROF PARKER: Yes, so they have one centralised electronic platform for their
health records. So in Australia because we're federated, in New South Wales we use
a particular electronic record system. In Adelaide here you use a different system.
15 And so again with the Australian Institute of Health and Welfare, if they want to
know what happens to – around the country they have to amalgamate the information
from the different systems and then the aged care system is different again. So it's
about that talking between systems.

20 MR BOLSTER: Doesn't the federal Department of Health keep its own national
system or does it have to import data from the States?

PROF PARKER: No, they have to import data from the States, yes.

25 MR BOLSTER: In the aged care context how could this improve the ability of a
nursing home, or a nurse, or an enrolled nurse to care for a patient, in real time?

PROF PARKER: Yes. So what we really want to know is if a person has been
transferred to the emergency department or the acute hospital and then they return to
30 you after, you know, a day, three days, five days, what would be really useful for
your ongoing care planning and meeting the needs of that person is for us to be able
to log into that system and actually see what happened. So what happened when
they arrived, what were the tests that were done, what was the treatment decision,
and that would all be available seamlessly. And at the moment what we get is a
35 discharge letter or, you know, outlining roughly what – sort of what went on so - - -

MR BOLSTER: You mentioned innovAGEING that is being dealt with by LASA.

PROF PARKER: Yes.

40

MR BOLSTER: Does that go anywhere near towards this sort of situation?

PROF PARKER: No, they're probably more at the level of innovation within the
industry, so looking at more linking the providers with the tech companies for things
45 like smart housing and other sort of innovations around that level of technology.
Really, the only people that can sort out the records management systems and
technologies are at the level of – of the government.

MR BOLSTER: All right. Can we turn then to the geriatric outreach and inreach services.

PROF PARKER: Yes.

5

MR BOLSTER: Why are these so good? What's the secret to having a good outreach service and what difference can it make?

PROF PARKER: So these were set up – and I've just given you, you know, one
10 example there of the Geriatric Rapid Acute Care Evaluation or the GRACE service. Acute hospitals recognise that many of the people that come into the emergency department or their hospitals are coming from residential aged care facilities and they're coming into the emergency department because a GP wasn't available after-
15 hours or they haven't been able to get somebody to do an assessment or even write a script, you know, for somebody that requires a review of their medications. So the idea of these outreach services is that you can ring the – your local service and you can say what the problem is, and they can get somebody out to you, or they can provide assistance over the phone. And what they've shown is that they can reduce the number of what would be called inappropriate admissions to the hospital by
20 getting those teams out.

MR BOLSTER: Yes.

PROF PARKER: And so they often have a geriatrician, they often have a nurse
25 practitioner, people that are skilled in aged care.

MR BOLSTER: All right. And finally, the Nurse Navigator, what does a Nurse Navigator do?

PROF PARKER: So that's a program in Queensland and because I'm not currently
30 working in Queensland I'm not completely familiar with that. I think it's – again, it's looking at that coordination model for people with chronic and complex care so that was again discussed this morning. Is there a proportion of people where it is actually very difficult to navigate the different parts of the system, the primary care
35 system, the acute care system, the aged care system and having somebody shepherding you through that may actually improve your outcomes.

MR BOLSTER: If it was easy to navigate through the system perhaps the Nurse Navigators would be able to do clinical practical nursing.

40

PROF PARKER: That's right, we wouldn't need a Nurse Navigator.

MR BOLSTER: We wouldn't need them.

45 PROF PARKER: Yes.

MR BOLSTER: All right. That's the end of my questioning, thank you, Commissioners.

5 COMMISSIONER TRACEY: Professor Parker, I just want to get a sense of what it's like out there in the real world in respect to care planning. Do I understand from your evidence that the person principally responsible in an aged care facility for constructing care planning is the registered nurse?

10 PROF PARKER: Yes, that's right.

COMMISSIONER TRACEY: And is that done in consultation with a general practitioner, perhaps a geriatrician?

15 PROF PARKER: Yes, and also allied health is very important as well. So there may be input from dietitians, speech pathologists, social work, physio, OT. So it is a comprehensive assessment that's important to meet the holistic needs of the person.

20 COMMISSIONER TRACEY: Does that mean that the registered nurse has to seek out these other members of the team, for want have a better word, that is looking after an individual resident, and coordinate their activities? Or do the members of the team actually sit down periodically and review the particular patient, the care that patient is receiving - - -

25 PROF PARKER: Yes.

COMMISSIONER TRACEY: - - - and discuss how that could be improved?

30 PROF PARKER: Yes. Yes. People do get a comprehensive assessment certainly on admission into a service and then at regular intervals. How that is structured may include all members of the multidisciplinary team coming together at a team meeting. It may be done more with people using an electronic system where they're writing reports that go to the overall picture of the person. So it really depends on how that service operates.

35 COMMISSIONER TRACEY: And presumably this whole process is dependent for its success on all the people involved being fully informed about the medical condition of sometimes complex conditions?

40 PROF PARKER: Yes.

COMMISSIONER TRACEY: And do I understand from your evidence that that could be improved if there was a single medical database for each resident that has got on it their medical history, and a lot more detail than is there at the moment?

45 PROF PARKER: Yes. You probably – some people when they enter a residential aged care facility may have moved out of the area in which they've lived for many years or all their life, and their general practitioner may not be able to visit the

facility which they've relocated to. And so that general practitioner may be meeting that person and that – and the family for the first time and trying to get the sense of what – you know, what's your history, what are all the needs, what's your medications and so they don't have a lot of, depending on what's coming to them
5 from the different services, what the complete clinical picture is for that person.

COMMISSIONER BRIGGS: How then does the Health Record help that? Will it provide that kind of comprehensive information or does it fall short?

10 PROF PARKER: Yes. Look, potentially it will and again it depends on the uptake rate of that because it's voluntary but I think that's where we would want to get to, is if that's going to be the central repository that we're going to be relying on, but also there will still be a level of detail that's not potentially in there where, you know, greater interface between the sectors would also assist.

15 COMMISSIONER BRIGGS: Yes. Because doctors have a similar problem with the discharge of people from hospitals as well. They just don't at the moment get enough information.

20 PROF PARKER: Yes.

COMMISSIONER BRIGGS: Can I go back, if it's okay, to your earlier evidence about the declining proportions of registered nurses providing aged care versus the increase in personal care workers. Is this happening by accident because the sector is
25 growing so quickly to deal with the demographic pressures, or do you think that there's a move by providers to change that mix to a level of staffing by qualification that they think more appropriately meets the people who are receiving care?

PROF PARKER: I think it's a complex issue. It's partly that there is a particular
30 funding envelope and we know that, and so there is no legislation that says you have to have a registered nurse on duty 24 hours a day, seven days a week. You have to have the skill mix required to meet the needs of the residents or the clients. So individual providers will make that decision. Partly it's in some rural areas, it may be a supply and demand concern in that it may be harder to attract registered and
35 enrolled nurses to the sector. One of the reasons it's hard to attract registered and enrolled nurses to the sector though is because we have a small number of people within those positions and so if I go to work in an acute hospital I will have a level of support that I won't have necessarily in the aged care industry. So it's a complex, you know, problem.

40 Again, we're not probably training people to – through the university training, we're probably not getting enough interface with the sector that says I really want to make a career in the aged care sector, and it's attractive. You do get paid less in the aged care sector than you do in the acute sector, so there's a pay differential as well. So
45 you have to weigh that up. So it's – it's – yes, it's a problem with multiple issues, I think, to solve of is it just – is it legislation? Is it remuneration? Is it the image of the sector within our industry? Is it the competence or the confidence as a new

graduate? We don't have many new graduate programs within aged care either so that means that my exposure as a new graduate as a registered nurse will be in the acute hospital and so that's my comfort zone, so I need to be exposed more into the aged care arena, which is what happened to me when I finished my training. I was
5 fortunate, you know, to – my first job was in aged care and I've stayed ever since so – and it was a good experience.

COMMISSIONER BRIGGS: And am I correct in saying that the National
10 Disability Insurance Scheme excludes nursing care so the real issue in terms of the competition for the workforce is between the health system proper and the aged care sector?

PROF PARKER: Yes.

15 COMMISSIONER BRIGGS: Yes. Thank you.

COMMISSIONER TRACEY: Anything arising, Mr Bolster?.

MR BOLSTER: Nothing arising, thank you, Commissioners.
20

COMMISSIONER TRACEY: Professor, thank you very much for your evidence.

PROF PARKER: Thank you.

25 COMMISSIONER TRACEY: It has given us a lot to think about about how individual aged care people are being cared for and how we can improve their lot and we will certainly be taking on board all your evidence. Thank you.

PROF PARKER: Thank you.
30

<THE WITNESS WITHDREW [1.04 pm]

35 COMMISSIONER TRACEY: The Commission will adjourn until 2 o'clock.

ADJOURNED [1.04 pm]

40 **RESUMED [2.01 pm]**

COMMISSIONER TRACEY: Yes, Mr Bolster.

45 MR BOLSTER: Yes. Thank you, Commissioner. The next witness is Ms Annie Butler. I call Ms Annie Butler.

<EXAMINATION-IN-CHIEF BY MR BOLSTER

5

MR BOLSTER: If document number WIT.0020.0001.0001 could be brought up. Thank you, Commissioner.

10 Do you have that document in front of you, Ms Butler?

MS BUTLER: Yes, I do.

MR BOLSTER: That's your statement or it's your amended statement?

15

MS BUTLER: Yes.

MR BOLSTER: And do you wish to make any amendments to that statement at this stage?

20

MS BUTLER: No, thank you.

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

25

MS BUTLER: Yes, they are.

MR BOLSTER: Commissioner, I tender the statement. I will be tendering other documents but if I could do those in seriatim - - -

30

COMMISSIONER TRACEY: You want to do that separately?

MR BOLSTER: Yes. Thank you, Commissioner.

35 COMMISSIONER TRACEY: Yes. Very well. The amended statement of Annie Butler dated 1 February 2019 will be exhibit 1-16.

40 **EXHIBIT #1-16 AMENDED STATEMENT OF ANNIE BUTLER DATED 01/02/2019 (WIT.0020.0001.0001)**

MR BOLSTER: Now, Ms Butler, you are the federal secretary of the Australian Nursing and Midwifery Federation?

45

MS BUTLER: Yes.

MR BOLSTER: Now, that organisation has two distinct hats, does it? One, it's a political organisation and it's involved in a political campaigns at a whole range of levels?

5 MS BUTLER: That's right.

MR BOLSTER: On another level it deals with quality, safety, educational issues on behalf of its members, the nurses, the enrolled nurses and others, in the broader health sector?

10

MS BUTLER: Indeed.

MR BOLSTER: Now, the federal body is essentially the collection of State and Territory unions. Is that a fair enough description?

15

MS BUTLER: That's right. We describe ourselves as the union and the – so the industrial and the professional organisation for nurses and midwives carers across Australia. It's a federated structure comprising eight branches from each State and Territory.

20

MR BOLSTER: Within each State and Territory branch there would be politically focused units and on the other hand there would be units that are focused on more professional issues associated with care and, in particular here as we're focused on aged care, you would deal a lot with aged care related issues; correct?

25

MS BUTLER: Indeed, across the country.

MR BOLSTER: There's a degree of overlap between the two spheres but I would like to focus if we could today on the quality and safety aspects of the aged care, unsurprisingly, and I would like to start by talking about barriers to the retention of staff in aged care and start with that issue. What are the significant barriers that stop nurses remaining in aged care?

30

MS BUTLER: What we hear most often from our members now is the increasing pressure they're experiencing with workloads. So many of them across the country describe their workloads now as unsafe, they're untenable. They report to us that that's why they're leaving the sector and increasingly leaving the sector, and that's across both nurse and carer members. For nurses, and that – so nurses includes registered and enrolled nurses. That also encompasses attention for – because they have a professional registration, they have specific requirements – they find increasing difficulty in being able to meet both their professional obligations as required of them under the national law and then employer expectations.

35

40

MR BOLSTER: All right. Is remuneration a barrier to retention?

45

MS BUTLER: Remuneration is definitely a barrier, when you're trying to recruit into the sector, and when you've got the public system, the private hospital system, a

whole range of other systems that are offering more attractive pay, but also more attractive conditions and a whole range of more attractive, both professional opportunities and professional supports.

5 MR BOLSTER: Let's talk about that. I would like to give the Commission a snapshot of where remuneration is for aged care nurses. Could we bring up the two documents that I've listed to the Commission staff. That's RCD.9999.0001.0105 and 112 and you will see that the two documents, Ms Butler, are side by side. Now, on the left we have a calculator for the New South Wales public health system award.
10 That's not the award itself but it's - - -

MS BUTLER: The calculator.

15 MR BOLSTER: - - - a ready reckoner that your members can go to on your website and see what the rates of pay are. And on the right-hand side we have a generic enterprise agreement from an organisation for this – at this point it will remain nameless, but you can assume that they are a large organisation with multiple facilities inside New South Wales in the aged care sector. If we could go down a page on each, please. Now, I hope it's clear enough, Commissioners, does that need
20 to be highlighted?

COMMISSIONER TRACEY: No, no.

25 MR BOLSTER: All right. If we could just start towards the bottom of the page, you will see there the pay rates for registered nurses and midwives in each operation. So for a graduate first year nurse in the State sector, which is on the left, they start out with an hourly rate of around \$31.60.

30 MS BUTLER: Yes.

MR BOLSTER: And the comparable position for a registered graduate nurse in the private organisation is \$31.89. Now, if we go down to the eighth year, this particular graduate has been in the system for eight years, and we see a differential immediately. If we could – we're still back on the same page, sorry, both should be
35 on – yes, that's correct. So by the eighth year in the public sector the hourly rate is \$44.34; you see that?

MS BUTLER: Yes.

40 MR BOLSTER: And whereas in the other – in the comparable situation it's only \$39.65. So there's a very gradual uptake in salary over eight years for a nurse in the aged care situation, and this is a registered enterprise agreement in New South Wales. What's the position after eight years? What happens to nurses' pay after eight years? Does it go up incrementally or is that – have we effectively reached the
45 ceiling for a basic registered nurse?

MS BUTLER: You reach the ceiling in terms of if you want to stay within the RN category, but, of course, overall general wage increases are negotiated for each agreement. So it does continue to progress. If you take the example of, say, the New South Wales public State award, then nurses have significant choices about where
5 they might want to go. They might want to stay as working in a registered nurse classification and that's where they stay. Or they might want to go into a clinical nurse education specialisation, etcetera.

MR BOLSTER: So if we could go to the portion of the page that deals with clinical
10 nurse educators for the hospital system and we see that – let's look at a clinical nurse at the foot of the page, a clinical nurse midwife specialist, grade one, year one and we compare that with the same position in the aged care sector, which should be on the next page of that document on the right. Sorry, we just need to go on the document on the right, we need to go one more page on. You will see there the
15 comparable rates are quite different even there. So your clinical nurse specialist in the State system is on \$46 an hour, whereas in this particular facility it's only \$40.96 an hour.

MS BUTLER: The classification is also slightly different because we looked at the
20 clinical nurse specialist in New South Wales. They also have a clinical nurse consultant which is the classification you're comparing it to in the other agreement. So it's not just that the pay rates don't match, but the types of clinical, you know, extended positions you can go into are also much less in the aged care sector.

MR BOLSTER: That's understandable. In the State sector you have multiple
25 hospitals across - - -

MS BUTLER: Of course.

MR BOLSTER: - - - multiple area health services and the scope for work is
30 virtually limitless.

MS BUTLER: Yes.

MR BOLSTER: Whereas in the aged care sector providers really have the same
35 organisation. It is a residential aged care facility and they have patients. They don't have surgical, they don't have midwifery, they don't have neurology. They have face-to-face care to older people. That's basically it, isn't it?

MS BUTLER: Well, that's true. We would still argue that there's a level of
40 specialisation involved that doesn't exist as it should in the sector. We've heard this morning from our medical and nursing colleagues about some of the areas that are unique and specialised areas to the elderly populations. Of course, it doesn't have surgery, you don't need all the expansive layers of extended clinical expertise that
45 you do in a big public health system, but we would argue that you probably need more than we have, particularly while we have classifications existing in many of these agreements across the country, we don't have many people in them.

MR BOLSTER: Yes. Right. Is it your experience that remuneration overall at all levels in the State health system is better than the equivalent in the aged care sector?

5 MS BUTLER: Yes. What we're looking at, the examples that you have shown actually happen to be typical of what the average pay gap between aged care sector and public sector across the country, the nationalised average.

10 MR BOLSTER: All right. Now, let's – can we explore how that happens. When you're negotiating an award on behalf of your State public sector members, I would anticipate that you have much more bargaining muscle with government. Is that a fair assumption?

MS BUTLER: It's a completely fair assumption.

15 MR BOLSTER: All right. And when you are negotiating an enterprise agreement with a not for profit 50 bed residential aged care facility, perhaps in regional New South Wales or even more remote than that, what bargaining power do you have with the provider?

20 MS BUTLER: There's a number of factors involved. As you indicated earlier obviously we're dealing with a public health system that is an enormous system with all sorts of levels of expertise in the system. Significantly, HR expertise, industrial relations expertise. You might not always agree initially but we respect the expertise. What we find – well, we find multiple things in the aged care sector but
25 one of the things is that – so you've said there's this 50 bed facility, is it a standalone? Is it part of a big aged care operator? These are all sorts of factors.

MR BOLSTER: Well, if it's a standalone.

30 MS BUTLER: Yes.

MR BOLSTER: I'm wanting to tease out the two different levels of bargaining power, standalone facility what's its bargaining power against - - -

35 MS BUTLER: You've got 40,000 employees and we are members, you know, and we might have – well, 50 – we would have probably – there might not be many RNs in the sector. The care workers could be covered by us, they could be covered by another. We do have joint agreements around the place. We might not have many members. What we also have is because of the long-term nature of care and we have
40 people – two things we have where because in – particularly in one of those small facilities like that there's a very direct relationship between the worker and the management that eyeball them all the time. The other thing is is that – and they have a long-term direct relationship with the clients, the residents and so that is often used
45 as a tool in terms of trying to bargain.

We also have this complication that in the aged care sector broadly, the funder is not the employer. So this – when you go to questions of, well, what's capacity? What's

capacity to pay? What's capacity – the funder sits separate and the opaque nature of the system makes it very clear – very difficult to work out what capacity really is. There are also other complicating factors.

5 MR BOLSTER: Yes, please.

MS BUTLER: Because – and expanding just from your 50 bed example, the industry itself is still a little bit cottage-based, is now consolidation with large corporations. So there's still the mixed nature of the sector and one of the things is especially in those little ones they don't have IR expertise. Even the bigger ones we find don't dedicate time to getting better IR expertise and we often find that communication from employers to employees in the aged care sector is very poor. That is complicated by the fact that there are many people who don't have English as a first language, that they also tend to be – they're a transient workforce. They're low paid and gendered – they're very much a female work force. They have significant impacts. They tend not to be IT-literate. Communication from us even to our members is difficult.

MR BOLSTER: Right.

MS BUTLER: So all those factors compounding against us, single employer, 40,000, you know, members, that's a much more direct negotiation.

MR BOLSTER: All right. I want to move on to another topic, if I may. Firstly, can I tender as a joint tender the two documents on the screen. That's 112 and 105.

COMMISSIONER TRACEY: You had better read onto the record the title of both documents.

MR BOLSTER: I will, Commissioner. It's RCD.9999.0001.0105 and RCD.9999.0001.0112.

COMMISSIONER TRACEY: What is the title of the award that's the subject of the first tender?

MR BOLSTER: The Public Health System, Nurses and Midwives State Award 2018 for New South Wales.

COMMISSIONER TRACEY: And the other document is - - -

MR BOLSTER: Is a - - -

MR BOLSTER: - - - an enterprise agreement with an unnamed employer.

MR BOLSTER: Call it a generic health New South Wales enterprise agreement to 2018.

COMMISSIONER TRACEY: Well, in that case the public health award will be exhibit 1-17.

5 **EXHIBIT #1-17 PUBLIC HEALTH SYSTEM, NURSES AND MIDWIVES
STATE AWARD 2018 FOR NEW SOUTH WALES (RCD.9999.0001.0105)**

10 COMMISSIONER TRACEY: And the enterprise agreement will be 1-18.

**EXHIBIT #1-18 GENERIC HEALTH NEW SOUTH WALES ENTERPRISE
AGREEMENT TO 2018 (RCD.9999.0001.0112)**

15 MR BOLSTER: Thank you, Commissioner. Now, if this document could be brought up, ANM.0001.0001.787, please. Ms Butler, this is a survey that the federation carried out of its members and others in aged care in 2016.

20 MS BUTLER: Indeed.

MR BOLSTER: It's titled the Nurses and Midwives Federation National Aged Care Survey. What was the process that was adopted to survey your members and others about the sector?

25 MS BUTLER: The process was an online survey that the – you mean that kind of process?

MR BOLSTER: Yes, how did it work.

30 MS BUTLER: Yes, how did it work. So we used Survey Monkey and we advertised the survey online and through our branches, and in just general Facebook – Facebook is a useful tool for communication, to not just members, just people working in the sector and also to community members, relatives, friends, other
35 interested people.

MR BOLSTER: If we could go to page 7, which is 793, you will see the number of participants in this survey. It's quite a large survey, almost 2400 participants across
40 virtually all of Australia. If you go over the page you will see that a very large proportion of them worked in aged care. Just around half by my brief calculation. You will see that in the second graph, at the top of the right hand page of the screen. And if we could go forward to page 10 the survey addressed people from metropolitan, regional, rural and remote, in those particular proportions. Do you see that? Now, I wanted to ask you about some of the feedback that you received, the
45 anecdotal feedback. It's quite confronting when you read it. There are a number of matters that I would like to take you to that I think bring out some of the issues that the Commission is looking at. The first one I would like to raise with you, so this is

– correct me if I’m wrong – this is actual testimony of people through a computer survey, an internet survey of your members; correct?

MS BUTLER: More broad than our members.

5

MR BOLSTER: More broad.

MS BUTLER: Yes.

10 MR BOLSTER: Okay. If we can go to page 25 which is page 811, and the third paragraph on the page commencing with the words “I have been”. This deals with retention. And this is an account of why someone has left the workforce. It says here:

15 *I have been a registered nurse since 1972 and worked in aged care since 1988, and for almost all of that time worked in senior management positions running large aged care facilities for the same not for profit organisation. Last year there was a roster review at the facility I was running and the organisation made the decision to cut 16 hours per day from my care staff roster. The only*
20 *option I had was to resign as I could not stay and work under those conditions, knowing that the care I would be responsible for delivering would not be of a high standard. I am now working as a registered nurse seven shifts per fortnight in an aged care facility for another not for profit organisation, and they have just reviewed their staffing hours, and are going to cut nine hours per*
25 *day from the care staff roster. I am saddened and disillusioned with aged care and fear for our vulnerable residents and the standard of care they are going to receive.*

30 Now, how typical is that of the situation that is conveyed to you by your members across the country?

MS BUTLER: Well, unfortunately it’s an increasing situation, and in this survey we describe – obviously comments get pulled out because they reflect the broader views, but these are the consistent themes that we’re hearing from our members. Earlier
35 today we heard about the increasing acuity in the sector and the declining skills in the sector. So this is an example, and so many nurses in the sector, care workers as well, they’re there because of the – their love for the job and this is someone who, after all these years, is having to leave the sector she – she loves because the primary concern for nursing is she can’t give the care she knows these people need to receive. And
40 she feels no option but not to be part of that system anymore.

MR BOLSTER: And the next – if you could go, please, to page 24 which is page 810, the fourth paragraph on the page. In fact, I will read the paragraph before it and that one as well, if we could just go back up one paragraph:

45

One RN to 60 residents for day hours only.

Does that come as a surprise to you, that sort of ratio.

MS BUTLER: No. Well, unfortunately that's not the most extreme.

5 MR BOLSTER: All right. And it says here:

What happens when our residents are sick during the night? The policy is to call the ambulance. The paramedics get very upset with us because we are wasting their time, however, this is what we must do for action to be taken.

10

You heard what Professor Parker had to say about some programs that are sort of gradually being implemented around the country that involve access to hospital call-out. Just pausing there, what's your – what's the federation's understanding of the prevalence of that sort of program?

15

MS BUTLER: If I could be so bold, so one of the things with those programs, it is – it is excellent to have nurse practitioners visiting facilities, general practitioners. There's just not enough and there's not enough allied health support staff, all the things that we need to keep people well. The problems with some of those programs is not the – not at all the problem with the program itself but this concept of a flying squad to come and patch up problems that actually the facility should be responsible for managing. And so that will – can I – am I allowed to say?

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MR BOLSTER: Yes.

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MS BUTLER: That's also, that's a public health funded – like a State health system funded program that's actually reaching into a Commonwealth funded program and because of its failings, the State is having to pick up the pieces. So that is not to say that those outreach programs, the Nurse Navigators, that all of those things in place aren't wonderful things and the big benefits that we should be looking to gain from them from our perspective is how do we have better integration, but integration between aged care primary sectors, when do we need to interface with the acute sector, all of those sorts of things.

30

35 MR BOLSTER: We will be talking about working models and staff modelling and the next quote seems to be a lead-in to that. It says here:

Most aged care workers want to provide the best care possible but are just not afforded the time. I remember as an AIN –

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that's assistant in nursing –

...I would plead with management doing the math and showing them that I would only have 15 minutes with each patient in the morning. I would be expected to shower and dress and attend to the needs of high care dementia patients. I was just told to work on my time management. It is sad that such love and compassion goes into a career in aged care but so many are chased

45

away by lack of support, worse wages, but such high expectations. I hope that things can change for the better.

I want to turn to the question of food.

5

MS BUTLER: Can I just say something?

MR BOLSTER: Yes.

10 MS BUTLER: That is a story that we hear all the time, just again and again and again, and people are time clocked, you've got six minutes to do each shower.

MR BOLSTER: Yes. On page 23 there is this history, it's right at the top of the page, the first paragraph:

15

Staff who are always rushing between tasks cannot give quality time and care to frail elders. The food is also a problem. It is often not nutritious and well presented. Food is important when you are in aged care. The meals break up the day and good meals provide pleasure and nutritional value. Hygiene is an issue: dirty hair, infrequent showers. Residents have the right to refuse but when does a refusal become neglect? Qualified staff are expert as working around refusal, they have the skills to persuade an elder that a shower or bath is needed and afterwards the resident is clean, happy and cared for. Relatives can then feel assured their loved one is being well looked after. Toenails and fingernails are another problem. Staff just don't have the time in the day to do these tasks, so family end up having to help.

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25

That wouldn't come as any surprise to you, would it?

30 MS BUTLER: None at all.

MR BOLSTER: All right.

MS BUTLER: Can I make – am I allowed to make extra comments?

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MR BOLSTER: Yes, please.

MS BUTLER: Because one of the important things in here is about, of course, person-centred care is at the heart of nursing and we heard about that earlier, it just is. But there's a thing about you've got to respect residents' right, but this point that goes to talking about, well, what do you do with a resident's refusal that you know is – is maybe not going to lead to ultimately the best outcome and so there's so much talk in the sector about respecting residents' choice but to do that what you need to do is involve the resident in the processes and the decision-making and the steps involved. That takes time.

40

45

MR BOLSTER: Well - - -

MS BUTLER: And skill.

MR BOLSTER: Correct me if I'm wrong but just from listening to the experts in these sorts of things over the last couple of days it would appear that some
5 considerable training is needed for someone who's a personal care attendant to be able to understand what's going on in that situation and to have a strategy that they can call upon to get a result.

MS BUTLER: That's right. Absolutely.
10

MR BOLSTER: Is that sort of training prevalent?

MS BUTLER: No. Absolutely not. And Professor Parker went to some explanations of it earlier today. But – and one of the things that we have, and I have
15 to say yet again we're looking at the failures of yet another structure and another system, whereas the VET system – so how it works is you have this Australian qualifications framework. You have these level qualifications, everyone can pull out the certificate III qualification and then deliver it if you're accredited as an RTO. The thing is that these qualifications are competency-based. They don't have
20 curriculum hours built into them. You tick it off by achieving competency. So we know of some of these courses that are done in two weeks online. We know that wonderful courses are done by the TAFE system and some other good, including a couple of our own branches, 18 weeks, the full – the full – like, the best the course could possibly be.

25 One of the other things is that trends, fashion changes, so we will go into let's specialise. There used to be very good personal care units of competency, we call them, in the qualification and then the fashion will be no, let's not be specific, let's be more general. And so providers will even complain that they don't get a person
30 coming out of the system who has the specific understanding required to deal with the elderly. That's even in some of the better ones and so then they struggle and the person, of course, has gone in good faith to try and do a qualification that they think is going to deliver an outcome and, you know, lead to reasonable employment. One of the things that is being done is the establishment of the Aged Services IRC. So
35 that has been an outcome from the work that's been done by John Pollaers and – because one didn't exist. So he chairs the Australian Industry Skills Council that sits over 66 different industry groups and there wasn't one for aged services.

MR BOLSTER: Yes.
40

MS BUTLER: So that, we hope, working with them, you know, to now let's build proper qualifications that are going to be better.

MR BOLSTER: So the federation is involved in that process with Professor
45 Pollaers?

MS BUTLER: We absolutely are. Yes.

MR BOLSTER: There's two more portions of this that I need to get to because I think they pick up themes. On page 22, about a third of the way down the page, the largest paragraph there, this is a – this is about the time staff are afforded to deal with matters. It reads as follows:

5

There were 53 residents including an eight bed special care unit, and 85 per cent of these required high care, according to their ACFI scores.

We will come back to what ACFI scores are in a minute:

10

Overnight there were two only two PCAs registered and an RN on call. These staff were expected to wake residents at five to commence their personal hygiene tasks. If they didn't do this, the morning PCAs would be openly angry because they didn't have time and weren't able to help all the residents with their personal hygiene according to their needs. Both morning and afternoon staff were rushed and, therefore, the residents were rushed. There was an RN rostered on both morning and afternoon shifts. The afternoon RN was required to administer all medications during all the evening rounds. As a result of the staffing levels, the facility has a high rate of falls and medication errors. The RNs are too rushed to monitor the staff, leading to a culture of bullying, and there's no safe handover process for the RNs given the gap during the night.

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Just pausing there, I just want to talk about ACFI stores. The ACFI, for people that don't know and I expect that a lot of people watching that don't, that's the Aged Care Funding Instrument, isn't it? It's fair to say that it is a calculation that sets out in minute detail every dollar that a provider receives for each resident in their care. And it calculates the benefit of the Commonwealth grant to them by reference to their needs and they're classified accordingly. We won't go into that now, but it's fair to say that the dollars are allocated on the basis of the particular need and the particular need takes into account what actually has to be provided for that resident on a day-to-day basis. Is that a fair summary?

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MS BUTLER: That is a fair summary. It's – we – the sector just refers to it as ACFI, is the way they phrase it, and so it has three key sections, if I could – and they're called activities of daily living, behavioural section and then complex health care domains. And then there are different domains in those sections. And, yes, you – a resident is assessed and they're assessed of what their need is in each of those domains. They get added up to what the funding will be from the government for direct care needs. There are other funding mechanisms and stuff but for direct care needs, yes.

45

MR BOLSTER: Okay. So when that funding finds its way to the provider, and the provider has those funds in its keeping, what regulation – what standards, what controls are in place about ensuring that that funding is delivered in that – in the way that the test provides for?

MS BUTLER: The short answer is none.

MR BOLSTER: Yes. I had a feeling you would say that. All right. We will come to that later in your evidence. Finally, with the survey, I wanted to touch on this last case, if we could go to page 20, and I can indicate that it is unpleasant, this topic, but it seems to, in my submission, Commissioners, articulate and bring together a
5 number of issues where things can fall down. So unpleasant as it is, this is from an agency nurse. Just by way of background, are agency nurses members of your association?

10 MS BUTLER: Yes. Yes. If they choose to be, yes.

MR BOLSTER: And what's the prevalence of agency nurses in the aged care sector?

15 MS BUTLER: High.

MR BOLSTER: Do you have any statistics or any background that you can assist the Commission to understand just how prevalent the reliance on agency nurses is?

20 MS BUTLER: I don't. Just it's in the top of my head but I know that the Pollaers work, he will talk around a range of 15 to 30 per cent of having to use and fill positions that way across the sector.

MR BOLSTER: Right. Let me read from this:

25 *I worked as an agency nurse in an aged care facility. The PCAs told me that the gent in such and such room required Panadol routinely at night to sleep. I asked further and was told the gent who was aphasic post CVA, that is, very vulnerable.*

30 CVA is that he has had a cerebrovascular accident, which is a stroke.

MS BUTLER: A stroke. And aphasic means he can't speak.

35 MR BOLSTER: Yes.

And he had a sore penis. He was grimacing as I approached. I asked if I might look. He nodded. He had a urinary catheter in place. Instead of exiting from the meatus, the glans had a split down the side to the level of the shaft.

40 I will pause over some of the words that follow:

I'm still horrified to this day. The wound was not new. It took time to erode through with pressure from the IDC –

45 That's the - - -

MS BUTLER: Indwelling catheter.

MR BOLSTER: Indwelling catheter.

MS BUTLER: Sorry.

5 MR BOLSTER: Thank you –

...tunnelling into his penis. The GP had not been informed and obviously I faxed them a message there and then for urgent review. A follow-up shift, he was in hospital for an urgent urology review –

10

and it says –

I am blown away the staff did not report the erosion as it was happening, take steps to prevent it. More educated staff had not looked at the source of his pain. He had Panadol every night.

15

That is an extreme case but let's just pick it apart. One would have thought, firstly, when the gentleman comes back from the hospital after the stroke there would be a handover – some sort of handover between the hospital and the facility about his ongoing care and there would be a care plan in place?

20

MS BUTLER: Yes, there should be.

MR BOLSTER: Certainly when the casual came on duty, you would expect for someone in his situation that there would have been a handover from the nurse who had his care before that?

25

MS BUTLER: I'm going to say these things clearly should happen. It's obvious that they don't always happen.

30

MR BOLSTER: Well, how often do they not happen, in your experience?

MS BUTLER: We hear from members that handover is one of the areas of greatest concern. It's one of the areas that tends to get missed and sometimes is not even allowed, particularly – and as another example said, we don't – so that's just a de-identified isolated, you know, particular example. We don't know whether there's always an RN on duty. We saw in another example, is there one on night shift? We don't know what the ratios are. We don't know what the facility's practices are in allowing proper handover and detailed clinical information. We do hear that despite all the effort that has to be put into claiming your ACFI documentation, oftentimes, not universally but oftentimes actual clinical – and it probably goes to some of the thing that – way too often the health care needs are just ignored as being a key component of aged care but the clinical records can tend to be very poor – clinical documentation can tend to be very poor across too many aged care facilities.

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MR BOLSTER: Well, if the sort of data was – a data system was in place that Professor Parker was talking about this morning – you were here when she was

speaking about that – so the handover, if there could be a seamless electronic handover from hospital back to facility for someone like that, the risk of this would be significantly reduced, wouldn't it?

5 MS BUTLER: Indeed. So the two things that she was talking about: one is the way that the – or she was talking about Oregon specifically but she was also talking about in the US because once you're over 65 and in a nursing home you attract the US style version of Medicare funding, the reporting is pretty strict and so these things do get picked up. The other thing is that the My Health Record has just – it was 31 January, 10 I think, was our timeline to opt out, so that's going to take time to build. And while there were the privacy concerns that needed to be sorted out, one of the great benefits over time will be that we will be able to build clearer datasets. We will be able to identify particular issues, pockets of issues, specific health and other concerns that can then be acted on.

15

MR BOLSTER: All right. I want to move on to another topic but before I do, can I tender ANM.0001.0001.787, Commissioners.

20 COMMISSIONER TRACEY: The ANMF Aged Care Survey dated July 2016 will be exhibit 1-19.

**EXHIBIT #1-19 ANMF AGED CARE SURVEY DATED JULY 2016
(ANM.0001.0001.0787)**

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MR BOLSTER: I understand there's a new survey, the 2019 survey is about to - - -

30 MS BUTLER: Yes, so we backed this survey up with a shorter one specifically focusing on the situation post the ACFI changes in 2017. We've just done some pilots. December 2018 and two thousand – January in New South Wales and Victoria for the next national one that we have prepared, and we will administer in the coming weeks.

35 MR BOLSTER: All right. Now, I want to move on to another topic and for this purpose might this document be brought up. ANM.0001.0001.3151. You have that in front of you. It's the National Aged Care Staffing and Skills Mix Project Report of 2016. Now, just to set the scene, this was a report or a project that the federation funded. It was research carried out by Flinders University and the University of 40 South Australia. It's a peer reviewed and published medical article; correct?

MS BUTLER: Indeed.

45 MR BOLSTER: I understand this does not come under the political hat of the federation. This is focused on the care side of things.

MS BUTLER: Yes, we direct particular activities for specific purposes. But one of our big things is, you know, one of the core purposes of the federation is the advancement of our professions and there – and thereby advancing the careers of our members. And we have expanded more and more, because that is the sort of basic
5 tenet of health care, evidence-based health care, we've extended more and more into that territory.

MR BOLSTER: Evidence based.

10 MS BUTLER: Yes.

MR BOLSTER: Is it fair to say that this is an evidence-based system for ascertaining how nursing homes should model their staff mix?

15 MS BUTLER: Yes. What we would say it is – so it's an evidence based staffing methodology to ensure that all assessed care needs for each resident in the country can be met.

MR BOLSTER: All right. With your assistance, I would like to spend a bit of time
20 teasing out the methodology of the study. And if we could go, please, to page 3157. The evidence that it's based on is data from a large cohort of South Australian aged care residents.

MS BUTLER: Yes, so – so this particular project comprises two key stages, each of
25 which had their distinct steps, let's say. The significant thing with this – okay, there's none other in the country. The other significant thing with this particular project is that it actually looked at how do you staff against care demand. We had previously looked at other – how staffing is done and staffing is done in many aged care facilities just by fixed rostering and what people do is that they benchmark
30 against what the sort of hours of care are just as an industry benchmark and that's purely about supply. That's about, well, what staff do you put in there, that adds up to this hours of care. That's the industry benchmark. It had nothing to do with – and when you referenced the ACFI before, it's not about applying the staff to actually make sure you tick off all those needs. That's what this one does.

35 MR BOLSTER: Yes. Thank you for that. If we look on page – on that page that's up on the screen, page 7 in the report, you will see there that there are three methods involved in this process. The first involves establishing resident profiles, six resident profiles.

40 MS BUTLER: Yes.

MR BOLSTER: Now, from my reading of the report that would seem to have been done by taking a statistical cohort of South Australian residents.

45 MS BUTLER: Yes.

MR BOLSTER: 225-odd.

MS BUTLER: Yes.

5 MR BOLSTER: Some unrepresentative members of that group were eliminated. You were left with 200 people.

MS BUTLER: That's right. Normal process, you remove the outliers.

10 MR BOLSTER: Yes. And that was then used to distil six typical resident profiles.

MS BUTLER: Yes.

15 MR BOLSTER: And the profiles were by reference to their characterisation or the way they would be classified under the ACFI.

MS BUTLER: Yes.

20 MR BOLSTER: All right. Well, let's just have a look at the profiles. Did you want to add, I'm sorry.

25 MS BUTLER: I'm sorry, I'm talking too much. You will tell me if it's too much but the – because what we did here is, yes, with the ACFI but what we did is looked at – took the care plans.

MR BOLSTER: Yes.

MS BUTLER: The care plans – you were getting there.

30 MR BOLSTER: That's what we're going to now. And these care profiles are all – they're not real people.

MS BUTLER: No, they're – well, they're de-identified - - -

35 MR BOLSTER: De-identified, okay.

MS BUTLER: - - - of the actual care plans. The profiles are a typical person that we've personalised.

40 MR BOLSTER: This has already been published and been in the public domain.

MS BUTLER: Absolutely.

45 MR BOLSTER: If you go to page 47, please, that's 3197. We will just go through the six resident profiles. And these go from least in need of care to most in need of care. So profile number one is a person who's named as Voula. That is not her real name.

MS BUTLER: No, it's not her real name.

MR BOLSTER: Let's just clarify that. If you go over the page there is, say, profile
of her care needs. So she is someone who is alert, has some confusion. She's a
5 dementia patient who has just come out of home care. She wanders at night. She has
generally good nutrition. She drinks, there's no problem with her drinking. She
showers with little assistance and she walks without aids. So she's mobile, she's
continent. Her skin is intact but fragile and she has no history of falls. Someone like
that is right at the bottom end of the amount of time needed for their care in a nursing
10 home; correct?

MS BUTLER: Very much so.

MR BOLSTER: Go back a page, the – in preparing the profile, the people – the
15 researchers who established the profile took a view that her residential care hours per
day, that's the RCHPD, was about two and a half hours a day.

MS BUTLER: Mmm.

MR BOLSTER: All right. Now, you see under that focus group moderation is 3.
20

MS BUTLER: Yes.

MR BOLSTER: Let's explore that. After the profiles were established and these
25 evidence based figures were attributed to each resident based on their care, the
profiles went to a focus group and how many were in the focus group?

MS BUTLER: There – I would have to look that up but they were small focus
30 groups.

MR BOLSTER: Around Australia.

MS BUTLER: Around Australia but with small amounts, like 10 roughly, less
35 participants in each focus group to validate. Now, what happened – do you want to
leap to that place because – so associated with this is the list of – what we're looking
at is the interventions that are required.

MR BOLSTER: Yes.

MS BUTLER: Then what that means and who should do it. Now, what this – what
40 our study did was aim to be conservative because we're looking to set the minimum
– the minimum requirements.

MR BOLSTER: Just pausing there, I just wanted to explain that the 3 is a figure
45 that the focus groups came up with after they had been through all of the profiles;
correct?

MS BUTLER: Yes.

MR BOLSTER: Now, we will come back - - -

5 MS BUTLER: Okay, sorry.

MR BOLSTER: - - - to the actual individual care plans for the particular participants. So going back over the page to 48 and we see the care provided across shifts for this particular category of resident and you will see that there in the middle of the page. So that that's broken down. You say that there is a - there is a portion of the report that deals with how that should be allocated to nurses and personal care attendants?

MS BUTLER: When - yes, when - so what was examined was what's the minimum level of qualification, knowledge and skill required to give each of this - each of these interventions.

MR BOLSTER: Yes.

MS BUTLER: So, and so what can happen a registered nurse, of course, can do all of these because nursing care encompasses the whole lot and so personal care is - you know, the more, what we would call basic nursing care, essential nursing care, sort of component. So in terms of us trying to come up with a methodology that would set the minimum staffing required, that's why we took that approach.

MR BOLSTER: All right. So in looking at someone in that category, it would appear, based on the table at page 49, box 3.1, that there were interventions that would ordinarily be missed from someone in her position in the event that a nursing home was under stress.

MS BUTLER: Yes.

MR BOLSTER: Or that staff were unavailable or that a casual came in or, for example, that there were only personal care attendants on duty at that particular time. And these typical missed interventions are set out in box 3.1. You see those there?

MS BUTLER: Yes.

MR BOLSTER: So, for example, this lady being an early stage dementia patient, the first dot point is managing sundowning. Sundowning would appear to be calming them down when there's a sense of aggravation or - - -

MS BUTLER: Agitation.

MR BOLSTER: Yes. Okay. And the second dot point is on the same basis, that is, redirection, reorienting the resident whether they're confused. All right. Well, if we could move then to the second profile, and this is of the lady called Gwen. She's at

the next level up. So in the case of this lady, it was ascertained that at least three hours. Commissioners, I'm instructed - - -

5 COMMISSIONER TRACEY: I'm sorry to interrupt but I've just been advised that the video stream isn't working to the outside vision areas. So we will adjourn briefly.

MR BOLSTER: Thank you, Commissioner.

10 COMMISSIONER TRACEY: And resume the moment the problem is corrected.

ADJOURNED [2.58 pm]

15 **RESUMED** [3.05 pm]

20 COMMISSIONER TRACEY: I'm told the problem has been rectified. Yes, Mr Bolster.

MR BOLSTER: Thank you Commissioner.

25 I think we will go back and start with the resident profile 2 from the beginning. Ms Butler, this is the next step up in severity. The evidence-based calculation for this lady was three hours of residential care per day. The focus group moderated that up to 3.5. Let's have a look another some of the things that she needs. Firstly, she has asthma. She's alert but she has a hearing problem. She needs some assistance with showering because of breathlessness associated with her asthma. She has got a mobility difference from the previous lady. She needs a frame for short distances. Continent most of the time. Her skin is intact and no history of falls. Again, we're at the bottom edge – end of the spectrum for ACFI funding purposes. But she also needs some analgesia – that's pain management – every day.

35 Going over the page to the box at 3.2, the interventions that were often found to be missing in someone like her really picks up one of the themes of Professor Parker this morning, that is that she has a depressive illness that leads to sleeplessness and anxiety. And as you can imagine that might involve extra care from a nurse. Why would that be from a nurse and not a personal care attendant?

40 MS BUTLER: It's just, you're going to require just – it's better if you can have deeper understanding of what depression means and the measures – we've heard the talk about particularly the non-pharmacological measures that you can implement to deal with the issues arising.

45 MR BOLSTER: Yes. All right. Let's move to profile three. This is George. The next level up again. 3.5 hours of care time that was moderated up to four. So he's

84. He has previously had a stroke and he has been through rehabilitation. So he has got mobility issues and he would have weakness in his left leg. So the issues would seem to arise because of his previous medical history. We don't have a dementia issue or a depression issue but there would be physical problems here associated with delivering him his care. And if we go over the page, you will see that's borne out in the assessment at the top of page 54. You agree with that?

MS BUTLER: Mmm.

10 MR BOLSTER: And the box 3.3 which identifies the sorts of things that might ordinarily be missed in the event that he was not being provided with person-centred care are listed there. I don't think we will dwell on them for now.

MS BUTLER: Could I just say one thing.

15

MR BOLSTER: If you could, yes.

MS BUTLER: The supervision, that is a very significant problem. The supervision of fluids to prevent choking. That that gets missed is a very significant problem and there's research being done to show that that is causing significant issues in the sector at the moment.

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MR BOLSTER: All right. Would you be able to provide the Commission with details of the research on that particular topic - - -

25

MR BOLSTER: Most definitely.

MR BOLSTER: - - - because it's not something I had heard of.

30 MS BUTLER: Yes.

MR BOLSTER: Could you explain that a bit more, please, if you could.

MS BUTLER: Most definitely. So you may be aware that Professor Joseph Ibrahim has done some research and what he did was look at 13 years of Coroners' reports of incidents that have occurred in aged care. He found that over that time there had been a 400 per cent increase in preventable deaths and by extrapolation preventable situations. Falls was the greatest but choking was in the top four. It's a very significant situation and – so linked to what we're talking about, when what gets allocated as the task for people to do is just set the meal down, maybe position the patient, and off you go to the next one. Not there – the person with any of the right skills is not there to make sure that it – you've got to check that the right diet gets provided. You've got to check, you know, because it says soft diet here that there are thickened fluids so that people who have these problems don't choke and then you've got to assist and supervise.

45

MR BOLSTER: All right. If we could move on to page 56 and the fourth profile, the gentleman with the name of Walter. The evidence-based figure for care was four hours moderated up to 4.5 hours. We have an 82 year old with dementia who has behaviour, falls, incontinence and wandering. So immediately you can see why he is someone who needs quite a bit more care than someone else. Now, could you expand upon the way in which the assessment has been characterised in his case over on page 57? Do you have that there?

MS BUTLER: This – so that – it has been – it’s characterised in the same way. It’s just that he has more complexity across his domains requiring more interventions and more high level skills.

MR BOLSTER: All right. Can you go – if you go down to the care provided across shifts, you can pretty quickly get an idea of all of the tasks that apply to caring for Walter; correct?

MS BUTLER: Yes.

MR BOLSTER: All right. The same goes for each of these.

MS BUTLER: Yes.

MR BOLSTER: - - - profiles.

MS BUTLER: Yes.

MR BOLSTER: But is four hours a day enough. That’s the question I ask myself. One would expect you would need a fairly skilled team of a nurse and a personal care attendant to deal with all of those things for that person in a day.

MS BUTLER: Well, as I say – or as I was starting to say earlier, this is what the evidence suggests. So our evidence which is collected, it has been through a series of evaluations to check that we have our evidence correct, and even though each group did moderate – the moderation goes up by 30 minutes, that’s across all profiles, they are – there’s reasons for them wanting to do that, and when – when they were asked to – because what was – the timings associated with these came from a tool that had been developed here in South Australia with the assistance of SA Health. It itself went through a rigorous process in order to know how we would construct those timings. So when the focus groups looked at these profiles and assessed the needs and then looked at who’s doing them and how long it takes, at first they weren’t shown the timings.

MR BOLSTER: Yes.

MS BUTLER: So that they didn’t have any influence. We actually consider that overall statistically, we’re not too far off the mark.

MR BOLSTER: Yes.

MS BUTLER: I mean this – we published this at the end of 2016. You know, it’s – it could be arguable that we do need to review it.

5

MR BOLSTER: Yes.

MS BUTLER: And need to review it ongoing, of course.

10 MR BOLSTER: Let’s go back a step. There’s no other analysis of this kind in the space.

MS BUTLER: No.

15 MR BOLSTER: In this country.

MS BUTLER: None.

MR BOLSTER: No one is saying that this is the only model or that it’s cast in stone as if it were the Ten Commandments. You’re not saying that?

20

MS BUTLER: Not at all. We’re saying in the absence of anything else this is an evidence-based staffing methodology which would allow facilities to staff appropriately to ensure all care needs are met.

25

MR BOLSTER: All right.

MS BUTLER: But, you know, people might want to go and do other – provide other evidence.

30

MR BOLSTER: All right. And finally the last profile – sorry, the second last – the second last profile is for patient Sara. It goes up another half an hour. The evidence based approach was 4.5 hours. The focus group moderation went up to five hours. And Sara is an 82-year-old widow and she has had a fall, she’s not able to bear her own weight. She has a 10 year history of dementia. So we see the coming together of the physical problem with the dementia presenting a compounded issue for assessment, treatment - - -

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MS BUTLER: Yes.

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MR BOLSTER: - - - and continuous care.

MS BUTLER: Yes.

45 MR BOLSTER: All right. And on page 60, we see the assessment by reference to the same categories that we’ve been looking at and very similar process. In terms of what she needs, in terms of care, that’s in the table in the middle of page 60, she

needs assistance to shower, obviously dental is an issue. She needs to be transferred with a lifting machine, etcetera, etcetera. The interventions that are missed in her case, if you have a look at box 3.5, would you like to expand upon those on page 61? Do you have that?

5

MS BUTLER: Yes. So these are the sorts of things that are often missed, and I don't know whether you want me to talk about it here or when we talk about the missed care survey but it goes to heart – the heart of many of the things that people have to – just don't get the time to actually do.

10

MR BOLSTER: Yes.

MS BUTLER: And so what happens is that there's – particularly nurses – and it's not unique to high pressure situations in the aged care sector – but they will ration, they will ration care and so they will pay attention to the absolute must dos. So many of these other things that are significant and important end up getting missed. What – could I just add that I – in terms of – it is important to recognise that what we're suggesting is a minimum so some of the – the profiles we're now looking at are very complex. There would be occasions where in a perfect world we would want to increase those hours on particular days, in particular circumstances as an event happens and that's where clinical and professional judgment are so important.

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MR BOLSTER: Can we move to the last profile. So this is in the case of Norma, end stage palliative care. Sadly people don't remain in this stage for very long.

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MS BUTLER: No.

MR BOLSTER: But the complexities are even more pressing. So we have a metastasised breast cancer with a condition that is sharply deteriorating over time for an 85-year-old woman who is obviously in some considerable difficulty. The fact that she has had mastectomies, chemotherapy and radiotherapy would mean she would come into the facility in a very difficult state to start with, let alone the other problems that she has. So the sorts of care that are required here you would imagine would be quite intense. The evidence-based hours allowed for someone in her position was five. The moderated group after the focus group came up with six. So six hours a day, that's a quarter of the day for someone in such a difficult situation.

30

35

MS BUTLER: Yes.

MR BOLSTER: It would seem to be warranted. The care tasks missing, I think, is worth focusing on in the case of this particular profile. And that's at page 64. That first dot point I expect would be a very difficult situation to deal with because this is where it's – we're at the pointy end and the end is close for this particular resident. And the family would be there and that would take up some time dealing with all of that and the stress associated with that. What would you – what do you have to say about that?

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45

MS BUTLER: So, and you heard from Professor Parker as well – like, there are some things being done to try and address palliative care in the aged care sector but palliative care currently being delivered in the aged care sector is so different from palliative care being delivered in - - -

5

MR BOLSTER: In a hospital.

MS BUTLER: - - - palliative care units and hospices where they would all be nurses as well because we're starting to look at some very high level skills and things that are required here in the assessment. But once again it's the same – and the goal – the goal here is for this person to have the most comfortable and dignified death that they can and for their family to be in the most supported environment they can. And in aged care we're not doing that as well as we need to and, again, it's as I was saying before, that rationing process, they will go to what must – you can, of course – you would argue that this is a must do but they will go to the high care health must do needs and other things just get missed.

10

15

MR BOLSTER: There's nothing unreasonable about repositioning Norma every two hours to make sure that she's comfortable at this stage, is there?

20

MS BUTLER: Not at all.

MR BOLSTER: The management of the medication would be complex.

MS BUTLER: Yes, it would involve the DDA is talking about drugs of dependence and addiction so, you know, morphine, etcetera.

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30

MR BOLSTER: So morphine. And if Norma was in a hospital – if she was in acute care in the same situation, there wouldn't be personal care attendants looking after her, would there?

MS BUTLER: It would be – no. So the situation is a little variable across the country because there are – I think we talked earlier about some undergraduate students of nursing but there wouldn't be the PCW as we think of them in the aged care sector.

35

MR BOLSTER: Palliative care in the hospital for someone like this would be just nurses.

MS BUTLER: Yes.

40

MR BOLSTER: And doctors.

MS BUTLER: Indeed, and, you know, others.

45

MR BOLSTER: All right. Now, after you created the profiles, worked them up, had the focus groups, the results went out to a survey of some 3000 people.

MS BUTLER: Yes.

MR BOLSTER: What was the result of the survey, where we are now at pages 66 and following?

5

MS BUTLER: So this was the first time – the first time we had a baseline for what should the actual care be.

MR BOLSTER: Yes.

10

MS BUTLER: You know, what are – here are the series of interventions, nursing and personal care interventions that should be happening. Are they actually happening? So the MISSCARE survey is a tool that has been used in other places across the world, so we customised it to the environment and what we found were there were significant gaps in the care being delivered across everywhere, across the country, across – it did differ but across not for profits, for profits. What we did find that most often, they said it was because of lack of staff. We found that only 8.2 per cent of those participants said that they always had adequate staffing.

15

20 MR BOLSTER: We will come to that in a minute.

MS BUTLER: Okay.

25

MR BOLSTER: If we could go to pages 82 and 83, and if we could look at those two pages together, the survey – and it commences right over on the left side at the foot of – at 5.7. The survey yielded some responses about why care is missed. This is the qualitative survey you were just talking about.

MS BUTLER: Yes.

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MR BOLSTER: And I don't want to go through all of them in detail. They really all speak for themselves. But I just want to look at the – on page 83 at the foot of the left-hand side, there's a statement:

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Lack of realistic goals from management. Somehow the residents who need the most care do not attract sufficient funding to allow for the extra staffing that they need. Yet the management and the families seem to think that those residents should be getting one-on-one care for their waking hours, or even 24/7. And this quite simply is impossible.

40

What do you say about that?

45

MS BUTLER: Because one-on-one – well, one-on-one care in any sector is unusual. It does happen very – occasionally in public sector – we call it specialising – for a whole range of different reasons, where a nurse will be with a particular patient all the time but that's not typical. So even the most – if we use an hours of care model, even the highest hours of care we use in the public sector are six hours.

MR BOLSTER: Yes.

MS BUTLER: 6.5 in some, so that's normal, that's the normal nursing hours across a 24 hour period. Now, our study here used ACFI as the basis because it's the thing
5 that exists, it's the only tool that exists in terms of identifying what the – what the care domains are. It didn't go to any commentary about how they were funded, but just because we use that as the basis doesn't mean that we think ACFI is the most appropriate funding tool because there's some merit in that comment in that ACFI doesn't quantify how you provide that emotional and social care necessarily. It
10 doesn't – the people with, you know, low – very low needs might attract zero dollars. There isn't an incentive in that instrument to keep people well. There's an incentive to make them sicker in terms of getting a return.

MR BOLSTER: Finally, on this – on the topic of the survey, if we go to page 84
15 and the conclusion. There's a passage there that I did want to take you to, about halfway down that paragraph headed Conclusion, it says:

The primary reason for missed care –

20 Do you see that?

MS BUTLER: Yes.

MR BOLSTER: Continuing –
25

...was identified as a lack of staff, increased resident acuity –

Which we heard about today –

30 *...the skills mix with unbalanced resident allocations also being implicated. Workload, staffing and skills mix issues were also evident in the qualitative responses to the survey as was a perception that the management of aged care was out of touch with the realities of care delivery. The MISSCARE survey was undertaken to establish that, under the current staffing complement, care is not*
35 *being performed.*

All right. That's the second stage of the process completed. The final stage – a process of validation was what's called a Delphi survey. That's where the results were put forward to experts in the field who were identified as being – correct me if
40 I'm wrong – a range of managers.

MR BOLSTER: Yes.

MR BOLSTER: Of residential care facilities. That is the people who are
45 responsible for implementing and setting up staffing profiles in their institutions.

MS BUTLER: We believed that to be important - - -

MR BOLSTER: Yes.

MS BUTLER: - - - because the rest of it had been from people who were delivering care on the floor and these were the people who were running the facilities.

5

MR BOLSTER: So you had focus groups based on nurses.

MS BUTLER: Yes, and carers.

10 MR BOLSTER: You have a survey, 3000 people based on - - -

MS BUTLER: Those working in the sector across the country. Yes.

15 MR BOLSTER: And then the final Delphi survey goes out to the managers of these facilities.

MS BUTLER: Yes, experts.

20 MR BOLSTER: Now, the survey results on that commence at page 90 and we just might focus on their responses to the questions they were asked. They were asked a number of questions and they really do speak for themselves but I just want to focus on a few. Page 90, the first one, 98 per cent agreed that resident care needs have increased in volume and complexity over time and continue to increase. 5.2, 83 per cent agreed that:

25

A person with complex care needs who comes to live in residential aged care is now living a much shorter time given the complexity of their care needs.

30 99 per cent agreed that residents require more frequent and complex assessments to be undertaken by the staff. So that's one task that definitely needs to happen more often. There definitely needs to be more assessment. The poor gentleman – his situation would not have happened if there was a greater - - -

35 MS BUTLER: Indisputably.

40 MR BOLSTER: And 5.4 you see that the percentage of experts who agree residents require more frequent and complex interventions and interactions to be implemented to meet their assessed needs, and it goes on. All of them speak for themselves. But if I could then go to page 93 where they were asked about the staffing methodology because I think that's the critical thing for present purposes. 94 per cent agreed a staffing methodology is needed to be built around assessing and meeting the assessed needs of residents for morning, afternoon and night shifts. So you've got to do it by reference to the care on each shift.

45 MS BUTLER: Yes.

MR BOLSTER: And as we saw in the profile, that's precisely the way in which it was approached.

MS BUTLER: Yes.

5

MR BOLSTER: 5.12:

10 *The percentage of experts who agree a staffing methodology must include the building block of identifying the lowest level in the skills mix of staff who can perform the assessed activities a resident requires.*

Well, that really speaks for itself.

15 *The percentage of experts who agree a staffing methodology must include the building blocks of identifying the time and frequency of interventions.*

And I could go on.

MS BUTLER: Yes.

20

MR BOLSTER: And go through them all, but they all point in the same direction. What do you want to say about this survey process and the results that it achieved?

25 MS BUTLER: So this is a technique that is just generally used as part of research, the Delphi method where you typically have a group of experts to assess whether your findings are correct or incorrect. You're probably aware of it. We had 102 experts and specifically went to managers so that we're getting that particular view. This was overseen – this part of the process was overseen by the University of South Australia and they were actually astonished how quick – because what you do is aim
30 to reach consensus. They were astonished how quickly consensus was reached. And, you know, you can see it's – so you've got to set – part of a Delphi is setting a benchmark. It has got to be – like, it's not like a 50 per cent – if you – 80 per cent is considered to be a good and appropriate consensus point for, like, validating your evidence. If you had 80 per cent of the experts consistently agree you can see how
35 dramatic, how it's not just 80, it's close to 100 at times. So for that it showed us that the steps previously, the methodology that we were putting forward was right on the money.

40 MR BOLSTER: All right. Now, I would like to go back to – go to the finding, the key findings of the study. If you go to page – please, to page 99. And you will see there the four key findings. Well, one is fairly obvious given the discussion we've had.

45 MS BUTLER: What we've talked about.

MR BOLSTER: Two, there doesn't seem to be any science at all in the current skill mix. Are you aware of literature about that, about practices, is there any uniformity, is there any standard about allocating staff mix?

5 MS BUTLER: No, what I referenced before about the benchmarking comes from a person who's – an organisation that's reporting on financial performance. This is where the benchmark is coming from and it's purely about what you're supplying. What we think our research clearly indicates, is there's just a gaping hole in the Aged Care Act currently in terms of how you actually staff against genuine care needs in
10 residential aged care.

MR BOLSTER: All right. The third key finding, an evidence- based staffing methodology is needed. And that the principles underpinning the methodology tested in this study are appropriate for residential aged care. Now, the formula that
15 has been worked out, you will find at page 105 on the top, on the right. So this is going to vary, obviously, from institution to institution.

MS BUTLER: That's right.

20 MR BOLSTER: The more category six - - -

MS BUTLER: That's right. That's right. Also there's other – this does – we tried to take account of – you will see it says direct nursing and indirect nursing so there are things that – like a personal care worker might do like stocking equipment, to do
25 with the patient but, you know, so it takes account of that but there are other factors that are important out there, not to go – there's a lot of missed care, geographic circumstances, layouts, several floors, several buildings, all of those sorts of things. But basically this is, you know, you add it up and you get the number of hours. So what we've tried to develop and we're now in the process of developing is a staffing
30 – a calculator tool. We use them in the public system where a facility could go and say, well, I've got 90 residents. I know I've got X type number one profile, etcetera, etcetera. You input that and you – it delivers you the stuff at the end. It is a work in progress at the moment, yes.

35 MR BOLSTER: Well, it would seem that if there's a method for determining funding based on the care requirements of each individual person, it's not beyond the wit of man to develop a system, a formula, a tool, a spreadsheet, a computer program, even a iPhone app - - -

40 MS BUTLER: That's right.

MR BOLSTER: - - - that could calculate what staff must be at the facility as a minimum on any given occasion.

45 MS BUTLER: I would say it's completely within our realm to be able to produce it.

MR BOLSTER: All right. And - - -

COMMISSIONER BRIGGS: Can I ask a question while you draw breath? In the work that has been done – and it's very impressive work and I'm sure there's similar work in the hospital system – in the hospital system we have acute care needs. What you're talking about for the most part is clinical care needs. Given that a person who
5 enters residential care is there for a considerable period of time, that brings with it a requirement around personal engagement and so on. Do your considerations take any account of that in framing where you go with the clinical staffing requirements or do you put those in the other two proportions of the ACFI?

10 MS BUTLER: They should be integrated, most definitely. And you're completely correct, one of the things we have seen is that – and you've heard it talked about – the increasing acuity. So we're seeing this drift towards residential aged care facilities now being more subacute facilities and even though that's long-term care. One of the things is – and we mention it several times throughout the text of the
15 study, is that rehabilitative – I didn't say that properly – and restorative care is just – it just doesn't exist. So obviously we would want that to be built in. And what we've heard as well is about, it's not just the nurses and the carers; we need a range of people being able to contribute to our elderly people living well. So this – we see our – if we could get this staffing properly mandated, we see that as a core plank of
20 improving quality and safety. It's not the only one, but we do see that you're not going to achieve it without it.

MR BOLSTER: Just to wrap up on this report, if we go back to page 9, a conclusion is reached in the box at the top - - -

25

MS BUTLER: Yes.

MR BOLSTER: - - - of page 9 in point 3, it says that the average – there should be an average of 4.3 hours per day. That's four hours and 18 minutes, if you look at it
30 that way.

MS BUTLER: To be precise.

MR BOLSTER: With a skills mix of nurse 30 per cent, enrolled nurse 20 per cent, and personal care worker 50 per cent. That is a minimum.

35

MS BUTLER: Yes.

MR BOLSTER: That's a minimum.

40

MS BUTLER: That is an average, so that's an average and because – because we've just examined that we go from 2.5 to 5 and yet the average is sitting up at 4.3, that's to do with the distribution of the current population. It's much more heavily weighted to the high care end.

45

MR BOLSTER: Can I suggest this to you, that may need to be – and this is where there's some subtlety in the system, if you are in a high dependency – in a home

where most of the residents are levels 5 and 6 on your schedule, it may need to be more. The minimum may need to go up. The average though for a typical home, which has representatives of each of the cohorts – of each of the examples, because we've got to remember that the starting point here is that these examples are driven from a batch of 200 South Australians who have – whose conditions, whose needs have all been statistically brought together into these six profiles.

MS BUTLER: Yes.

MR BOLSTER: In other places, there may be more high care on a particular facility.

MS BUTLER: It's going to vary by facility. And you – you will see that some – some providers certainly operate much more in the high care than the other end of the market depending on where they are, who they are, all those sorts of things. It is not at all to – when we think realistically that our first profile of Voula, the 2.5, we might not be seeing them in residential care much any more, because of the way the home care packages are working, not working. That policy is driving a situation – we completely support trying to maintain people well at home, absolutely – but it is driving a situation, by the time people get to residential aged care they're in a much more frail, complex, you know, vulnerable state.

MR BOLSTER: Yes. In the little – in the time we have left, I wanted to turn to another document.

MS BUTLER: Yes.

MR BOLSTER: But might I at this stage tender, Commissioner – Commissioners, the National Aged Care Staffing and Skills Mix Project Report 2016, which is ANM.0001.0001.3151.

COMMISSIONER TRACEY: The National Aged Care Staffing and Skills Report dated 2016 will be exhibit 1-20.

EXHIBIT #1-20 NATIONAL AGED CARE STAFFING AND SKILLS MIX PROJECT REPORT 2016 (ANM.0001.0001.3151)

MR BOLSTER: 20. Might the – might we see the following document. ANM.0001.0001.3308. Now, Ms Butler, you didn't stop with that document. You went and got Flinders University to carry out a financial cost benefit analysis of the recommendations. That is, what it would cost the budget, what the implications would be in terms of benefits, intangible benefits, etcetera. I just very briefly wanted to take you to the conclusions of that report because obviously you would appreciate that funding for such a staff skills mix would be – would involve increases in funding at some level?

MS BUTLER: In – yes.

MR BOLSTER: If we could go, then, to page – to the end of that report at page 20
5 which is 3335, if you could perhaps take us through the results that you got from
Flinders Uni when you asked them to cost this.

MS BUTLER: Yes. So obviously we anticipated that the first question would be,
well, how much does it cost? We don't have the money. So we wanted to conduct a
proper cost benefit analysis because we already knew that there's a lot of cost
10 shifting happening because of all the things we've talked about, the transfers to
hospital, etcetera. We're obviously not economists so we went to economists and got
them to do the modelling for us. So based – now, this is based on 2016 figures and
the identified 2016 demand. There's a National Institute of Labour Studies puts out
an aged care survey report periodically, so that founded the – in terms of numbers
15 and what the needs would – so you heard earlier that there's only about 14 per cent
registered nurses in the sector, so in terms of working out, well, what's it going to
cost, how many do we need, etcetera, etcetera. So – and we did two parts. We did
just the – and this is full implementation of the recommendations of the report.
What's it like just as a baseline and what's it like adding a 10 per cent wage increase.

20

MR BOLSTER: If you go over to page 22 and 23, if we could have those two side
by side you will see the two longitudinal analyses that were carried out.

MS BUTLER: So what the – am I allowed to talk – what the study – what this
25 concludes is that it would say and it claims that it has made conservative estimates
because parameters haven't been tested, etcetera. It's cost benefit neutral. While it
will cost 5.3 billion to fully implement the increased staffing and skills mix
requirements, that will – and it also factors in the – like, the additional support costs
that will be required, that is offset by a number of different features. So one of them
30 is that includes the increased tax take, when you increase that sort of thing. Then
there's also a significant component is what you offset by hospital avoidance, all of
those sorts of complications in requiring any other medical health professional
assistance, etcetera.

35 MR BOLSTER: Can we just go through the offsets one by one. You've got an
offset there of savings re staff attrition.

MS BUTLER: Sorry, yes.

40 MR BOLSTER: Does that mean if you spent a little bit more to make the care better
you might lose fewer staff.

MS BUTLER: It would, indeed, because you know if you had proper staffing in the
places, people would feel satisfied, fulfilled in their jobs as nurses and carers and we
45 wouldn't see the churn that we see. We identified it as about 500 million. John
Pollaers' report, he identified exactly the same thing as 488 million. So we're pretty

much on the money there. So that's a significant – so that's a significant offset. Then the other ones are the – sorry, it's such tiny writing.

MR BOLSTER: The cost shift to productivity factor, what's that?

5

MS BUTLER: That's about not having to – you're – the cost shifting is sending the care elsewhere all the time but if you have the right staff you can do the things where you need to do them because you've got the right people and you've got enough of them to be able to deliver the right care. So then obviously the hospitalisation –
10 thank you – the hospitalisation cost and the tax take. Then we – they used a specific modelling that I won't attempt to – it's an economic model, to quantify these intangible benefits. Now, reduced mortality, quality of patient life and quality of relatives' experience. Reduced mortality. Now this might sound a little harsh but if
15 if you keep somebody alive for longer and living well in the residential aged care facility you actually save money because resident churn, to describe it in a horrible way, actually costs money.

So the other thing is the quality of patient life. What it actually would add up to by keeping someone happy and not socially isolated, engaged, living – you know, living
20 with dignity, etcetera. What – what's not covered here but should be recognised, and this is the part that we always ignore, we just always ignore that, but what research now internationally is starting to explore, it's starting to explore the impact of the quality of patient life on improving health outcomes. So you start to get a bit of a sort of snowball effect where if you keep that, well you also keep their health, well
25 you keep them, it just keeps compounding to deliver benefits.

MR BOLSTER: Yes. All right. I tender that document, Commissioner. It is – go back to the number – ANM.0001.0001.3308. It's the Financial and Cost Benefit Implications of the Recommendations of the National Aged Care Staffing and Skills
30 Mix Final Report by the Australian Industrial Transformation Unit of Flinders University.

COMMISSIONER TRACEY: The Flinders University report on the costing of the recommendations made in exhibit 1-20 dated May 2017 will be exhibit 1-21.
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EXHIBIT #1-21 FLINDERS UNIVERSITY REPORT ON THE COSTING OF THE RECOMMENDATIONS MADE IN EXHIBIT 1-20 DATED MAY 2017 (ANM.0001.0001.3308)
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MR BOLSTER: Just one more question – one more very small topic I wanted to raise. Could the transcript of yesterday at page 89 be brought up on the screen – on –
45 from the 11th, sorry, 11 February. Yes, 11 February, please. Can you see that there? I believe you were shown a copy of this before you gave evidence today.

MS BUTLER: Yes.

MR BOLSTER: This was some comments that Mr Yates made about the role of nurses in service delivery in residential aged care facilities, and can I draw your attention to, firstly, the question that he was asked. It was about ratios, how ratios have changed between qualified and enrolled nursing staff and the other personal care staff in recent years, and Mr Yates was asked what had been – what was driving that and did he think it was appropriate. He says, and this is the question – this is the comment that I would like your response to, he says at line 19:

10 *I mean, is everything that a nurse used to do have to be done by a nurse?
Sometimes, in fact, and I'm going to get into trouble about this –*

I think he was right there –

15 *But sometimes the strong command culture of nursing historically and I
recognise that that has also been addressed has meant that in terms of things
like consumer-directed care, consumer-centric practice that there has been
more resistance from nurses and nurse administrators and that than there have
been to others whose experience might be, for example, in the hospitality
industry.*

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What's your reaction to that?

MS BUTLER: It's not the first time we've had this particular – it's not an altercation at this point but we have had a discussion previously around comments of this nature. What's unfortunate I think with this is I would like to know what evidence that comment is based on, in the very first instance. To me it seems solely opinion. There is a confusion for someone – he's not in a position to understand what nursing is, what nursing care is. As I've just said, nursing care encompasses the whole of the sorts of things that we're talking about. Clearly – clearly from our study, we are saying that 50 per cent of the time we believe a personal care worker can perform many of the care interventions that are required in the sector. But what we're saying is that for the best care to be delivered we need the skills mix that has been identified by evidence of 30 per cent, 20 per cent and 50, ideally, and 50 per cent. It – I mean, I'm not exactly sure about what he's saying about the strong command culture. Are we talking about World War II? I'm not exactly sure what that comment is meant to mean.

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MR BOLSTER: All right.

40 MS BUTLER: But it just demonstrates a significant lack of understanding of the nursing profession.

MR BOLSTER: They are all the questions that I had, Commissioners.

45 COMMISSIONER TRACEY: Ms Butler, thank you very much for your evidence. It's very important that we have an insight into the way in which the principal caregivers in this industry are working and the demands that are being placed on

them and their capacity to meet those demands. Your evidence has been most helpful. Thank you.

MS BUTLER: Thank you.

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<THE WITNESS WITHDREW

[3.53 pm]

10 COMMISSIONER TRACEY: The Commission will adjourn until 10 am on 18 February.

MATTER ADJOURNED at 3.53 pm UNTIL MONDAY, 18 FEBRUARY 2019

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