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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**

**SYDNEY**

**10.02 AM, TUESDAY, 14 MAY 2019**

**Continued from 13.5.19**

**DAY 19**

**MR P. GRAY QC, Counsel Assisting, appears with MR P. BOLSTER and MS B. HUTCHINS**

**MS K. RICHARDSON SC appears with MR ARNOTT for the Commonwealth**

COMMISSIONER TRACEY: Please open the Commission. Commissioner Briggs is unable to be here today. She is at a funeral of an old and dear friend. She will read the transcript of the evidence once it's recorded. Yes, Ms Hutchins.

5 MS HUTCHINS: Thank you, Commissioner. You will recall from Mr Gray's opening at the commencement of these Sydney hearings that the Office of the Royal Commission has prepared a background paper titled Dementia in Australia: Nature, Prevalence And Care. This paper includes an overview of the reviews and research and some key studies and reports addressing support and interventions for the care of  
10 people living with dementia. This morning, you will hear evidence from a panel of witnesses who are each leaders of residential aged care facilities. To be explored with these witnesses is the important question for this Commission: what constitutes good practice for people living with dementia, particularly in the context of residential aged care.

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I call our panel of witnesses: Ms Tamar Krebs and Jonathan Gavshon from Group Homes Australia Proprietary Limited, Jennifer Lawrence from Brightwater Care Group, and Lucy O'Flaherty from Glenview Community Services, Tasmania.

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<TAMAR CHAYEN KREBS, AFFIRMED [10.04 am]

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<JONATHAN GAVSHON, AFFIRMED [10.04 am]

<LUCILLE CLAIRE O'FLAHERTY, SWORN [10.04 am]

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<JENNIFER LAWRENCE, AFFIRMED [10.05 am]

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MS HUTCHINS: Ms Krebs, you have prepared a statement for the Royal Commission.

MS KREBS: I have.

MS HUTCHINS: And what is your full name?

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MS KREBS: Tamar Chayen Krebs.

MS HUTCHINS: Is a copy of your statement before you now?

45

MS KREBS: Yes, it is.

MS HUTCHINS: Do you wish to make any amendments?

MS KREBS: No.

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

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MS KREBS: Yes.

MS HUTCHINS: I tender the statement of Tamar Krebs, document WIT.0124.0001.0001.

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COMMISSIONER TRACEY: I don't think that's the one on the screen. The statement of Tamar Chayen Krebs dated 30 April 2019 will be exhibit 3-45.

15 **EXHIBIT #3-45 STATEMENT OF TAMAR CHAYEN KREBS DATED 30/04/2019 (WIT.0124.0001.0001)**

MS HUTCHINS: Ms Lawrence, you have also made a statement for the Commission.

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MS LAWRENCE: I have.

MS HUTCHINS: And what is your full name?

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MS LAWRENCE: Jennifer Lawrence.

MS HUTCHINS: And is a copy of your statement before you now?

MS LAWRENCE: I've got a hard copy, yes.

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MS HUTCHINS: And do you wish to make any corrections to the statement?

MS LAWRENCE: No, I don't.

35

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

MS LAWRENCE: They are.

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MS HUTCHINS: Commissioner, I tender the statement of Jennifer Lawrence dated 1 May 2019.

COMMISSIONER TRACEY: Yes, the statement of Jennifer Lawrence dated 1 May 2019 will be exhibit 3-46.

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**EXHIBIT #3-46 STATEMENT OF JENNIFER LAWRENCE DATED  
01/05/2019 (WIT.0123.0001.0001)**

5 MS HUTCHINS: For the transcript it's document WIT.0123.0001.0001.

Finally, Ms O'Flaherty has also prepared a statement for the Commission. What's your full name.

10 MS O'FLAHERTY: Lucille Claire Flaherty.

MS HUTCHINS: Do you have a copy of your statement before you now?

MS O'FLAHERTY: Yes.

15

MS HUTCHINS: Do you wish to make any corrections?

MS O'FLAHERTY: No, I don't.

20 MS HUTCHINS: Is the contents of your statement true and correct to the best of your knowledge and belief?

MS O'FLAHERTY: Yes, it is.

25 MS HUTCHINS: Commissioner, I tender the statement of Ms Lucy O'Flaherty dated 26 April 2019, document WIT.0122.0001.0001.

COMMISSIONER TRACEY: Yes. The statement of Lucille Claire O'Flaherty dated 26 April 2019 will be exhibit 3-47.

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**EXHIBIT #3-47 STATEMENT OF LUCILLE CLAIRE O'FLAHERTY  
DATED 26/04/2019 (WIT.0122.0001.0001)**

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MS HUTCHINS: Now, Ms O'Flaherty, you're the chief executive officer of Glenview Community Services in Tasmania.

MS O'FLAHERTY: Yes, I am.

40

MS HUTCHINS: And how long have you been in that role for?

MS O'FLAHERTY: Just a tad under eight years.

45 MS HUTCHINS: Under eight years. And what is your professional background leading up to that role?

MS O'FLAHERTY: I hold a Diploma of Community Services and an Advanced Diploma of Community Services plus a Graduate Certificate and Graduate Diploma in Management.

5 MS HUTCHINS: And what is Glenview and what model of care does it adopt?

MS O'FLAHERTY: Glenview is an organisation that's 70 years old. It provides a range of services for the aged care community. So residential, home care, independent living, independent living units and some support for those living with a disability.

MS HUTCHINS: And what type of structure is the facility?

MS O'FLAHERTY: So the residential facility is a 100 bed facility with 97 permanent residents, and we have three respite rooms. We also within that have a secure unit which we call Merton which has 19 rooms.

MS HUTCHINS: What is the profile of Glenview residents?

20 MS O'FLAHERTY: The profile is generally older residents, aged 84 and above, predominantly female, and largely with a diagnosis of cognitive impairment or those living with dementia.

MS HUTCHINS: When you say generally 84 and above, do you have many residents below that age?

MS O'FLAHERTY: There are some younger people in their late 50s and early 60s who have younger onset dementia.

30 MS HUTCHINS: And Ms Lawrence, you are the chief executive officer of Brightwater Care Group Limited.

MS LAWRENCE: I am.

35 MS HUTCHINS: How long have you been in that role for?

MS LAWRENCE: I've been with Brightwater for 16 years, but chief executive officer for just over three years.

40 MS HUTCHINS: And what role were you in before?

MS LAWRENCE: Before I came to Brightwater, my background is in medical science, so I worked in pathology for some years before I moved into Brightwater.

45 MS HUTCHINS: When you first moved to Brightwater, what role was that in?

MS LAWRENCE: Director of care services, so I looked after all of residential aged care, community care, and all of our disability business as well.

5 MS HUTCHINS: And could you describe for the Commission what – who is Brightwater and what model of care it provides.

10 MS LAWRENCE: So Brightwater is a not-for-profit organisation. We've been around since 1901 so it's quite an old organisation. We have diverse businesses: residential aged care, community care, we've got a large disability business, and we also run retirement living, and we have two commercial businesses: a linen business and a catering business. The model of care has evolved over the years but it essentially is based on understanding the person, the built environment, having really good staff that understand what their responsibilities are, and it's more of a carer-led model than a nurse-led model because we believe that these are people's homes.

15 MS HUTCHINS: And in relation to your business structure, do each of the businesses that you've referred to, do they need to be each financially viable or do they prop each other up amongst the group?

20 MS LAWRENCE: So we have a strong focus on sustainability because it's really important that we're around for another 100 years, and so each business needs to be sustainable. Having said that, as a not-for-profit, if we choose to debt fund an emerging business or we're trialling a new business, we will do that, but it's a conscious decision made with the executive and the board.

25 MS HUTCHINS: How many beds do you have in your residential aged care facility?

30 MS LAWRENCE: Just over 750.

MS HUTCHINS: What is the structure of that service?

MS LAWRENCE: Sorry, can you clarify that.

35 MS HUTCHINS: Insofar as are you in a big building or smaller - - -

40 MS LAWRENCE: So our building stock is of various ages, so we have – the smallest building that we have is for 20 people, and the largest is for 131. However, each of those buildings is in a similar environmental make-up. So that they have small homes but within the house, so even if you're in a large building you still live within a smaller home.

MS HUTCHINS: And what is the profile of Brightwater residents?

45 MS LAWRENCE: Brightwater traditionally has taken people that have complex needs and therefore we have people – we have younger people with younger onset dementia so our youngest resident is in their 40s, and we have people that are well

over 100. But we have received, over the last 20 years, extra funding from the state government to take people at the very high complex category. So people with dementia, people that maybe be bariatric that are quite big that need specialised equipment, people that have a neurodegenerative condition.

5

MS HUTCHINS: And do you have receive additional funding in relation to those residents?

MS LAWRENCE: Yes, we do.

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MS HUTCHINS: How is that funding obtained?

MS LAWRENCE: So that's through the state government; it's for 184 residents, and it's mainly to buy extra equipment, to spend more time on the environment and maintenance of the environment, and it also goes to additional staffing.

15

MS HUTCHINS: Turning now to Group Homes Australia, Ms Krebs and Mr Gavshon, you are both co-CEOs; is that correct?

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MS KREBS: Correct.

MS HUTCHINS: And Ms Krebs, you were the founder of Group Homes Australia.

MS KREBS: Yes.

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MS HUTCHINS: How long has Group Homes been around for?

MS KREBS: We opened our first home in 2012.

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MS HUTCHINS: 2012. And what was your professional background leading up to your time with Group Homes?

MS KREBS: I studied originally a Bachelor of Science and became a registered nurse and focused on caring for people with dementia in secure units and became a director of care in facilities not in Australia but overseas, and focussed – and specialised in the area of gerontology. When I came to Australia I did a Masters in Health Service Management and worked in different facilities.

35

MS HUTCHINS: And in your leadership role within the business, do you and Mr Gavshon have particular areas of focus?

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MS KREBS: Yes. So my area of focus is the resident care, and Jonathan's focus is the back of house systems and operations and quality.

45

MS HUTCHINS: Thank you. And, Mr Gavshon, you are the co-chief executive officer.

MR GAVSHON: That's right.

MS HUTCHINS: How long have you been in that position for?

5 MR GAVSHON: So I joined four years ago – I joined as general manager and then, shortly after that, became co-CEO.

MS HUTCHINS: And what was your professional background before then?

10 MR GAVSHON: I lived overseas and worked in investment banking in New York for a number of years, then did a Masters of Business Administration in France, came back and did strategic and operational roles and then joined Group Homes Australia after that.

15 MS HUTCHINS: And could you describe for the Commission what Group Homes is and what model of care it provides.

MR GAVSHON: Sure. So we operate traditional homes in traditional suburbs. There's no signage or markings whatsoever; they blend in with the rest of the  
20 residential street. We offer care for six to 10 residents in a home with 24 hour support delivered through what we call our homemakers, who are universal workers. And those universal workers get to know the residents very closely and build a very strong connection with those residents. The residents get involved in all aspects of running the home, whether it be the cooking, the baking, gardening. And we believe  
25 that that gives them a very strong sense of purpose and meaning in their lives and has a very, very strong element to delivering the right care.

MS HUTCHINS: And so Group Homes Australia is an approved home care provider, but it's not an approved residential aged care provider.

30 MR GAVSHON: That's right.

MS HUTCHINS: Why is that?

35 MR GAVSHON: So, in being an innovative model, we wanted to stay true to the concept, and true to the concept being that we wanted to be a traditional home in a traditional suburb. And so we went down the group home route. But, in doing so, we needed to align to the trend, as well, in terms of funding. And so there's, obviously, a strong push to keep people in the community for longer and, in keeping  
40 people in the community for longer, they were entitled to home care funding. And so the way that we operate is that residents can receive their home care packages while staying in our homes. And that can supplement the funding of their care.

MS HUTCHINS: Certainly. So your model of care, being based in the local  
45 community in the neighbourhood with a focus on a smaller model in a home-like situation, do you think that this is a model that could be – and a way of providing care that can be adapted to other residential aged care environments?

MR GAVSHON: Absolutely. So I will let Tamar answer that one.

MS KREBS: So we do think that this can be adapted to other residential aged care facilities. And many facilities have started moving toward the home-like  
5 environment. Where we believe that it can be further adapted is breaking down the large scale of nursing homes to smaller pods of eight to 10 residents living in a pod. The design would be a home-like environment, so furnishings of homes, not vinyl furnishings, but beautiful lounges and open kitchens, so that the residents could actually participate in the cooking and normal daily living.

10 We also believe that the staffing models, instead of it being very much an assistant and nursing, carers, cleaners, cooks and recreational officers, to create a model where it's very much universal worker that sees the residents in a holistic approach, so really meets their needs on many different levels. And we also believe that the  
15 higher care to resident ratio, having smaller teams getting to know the residents and higher ratios for the residents.

COMMISSIONER TRACEY: Does each resident have their own room with an ensuite or do they have more communal living?

20 MS KREBS: Each resident has their own private bedroom, but ensuite – there are houses that have ensuites for most residents and there are houses that have shared bathrooms. It's like a regular home where the master bedroom would have an ensuite and maybe the guest room. What we have found is ensuites for people that  
25 need assistance very much becomes a marketing tool.

MS HUTCHINS: And, Ms Lawrence, in the Brightwater homes, what's the layout in terms of where the residents have their own bathrooms or rooms?

30 MS LAWRENCE: So we have a number of homes. And it does range from five bedrooms in one home to 20 bedrooms in one home. Each of them, except for two – we've got two shared bedrooms, but each of them have their own ensuite. And each of the homes have its own kitchen, lounge room, dining room and access to gardens, which we think is really, really important for people to be able to go outside and  
35 access the outdoors.

MS HUTCHINS: And, Ms O'Flaherty, how about your facility?

MS O'FLAHERTY: So our facility has been built from the early 40s and every  
40 generation almost there's a new part of the building. So it looks very different and functions very differently, but we've made a virtual division of the facility. So 6 houses within that 100 bed facility. Most of the rooms are ensuites. There are still some, I believe about 10, that have a shared bathroom. And that's because the infrastructure means it's quite difficult to create ensuites in those spaces. Like Ms  
45 Lawrence has said, the outdoor spaces are really important. And we've ensured that there's really, really nice, intimate outdoor spaces that complements the indoor living.

MS HUTCHINS: Yes. And so your facility can be seen as an example of how a pre-existing large institutionalised-type facility can be converted to be used more in this smaller group home model.

5 MS O'FLAHERTY: Absolutely. So we've got parts of the building which operated traditionally in the 70s under a hospital licence that does indeed have two long corridors. So structurally it's a bit difficult to make the smaller spaces. But we've chunked it up so that there are key lounge rooms and dining rooms and kitchenettes in those spaces. Other parts of the building we are able to provide smaller living  
10 areas which constitute up to 10 to 14 residents per house.

MS HUTCHINS: I would like to turn now, firstly to the topic of the needs for people living with dementia. The Commission is interested to receive your insight about what are the particular care needs of people living with dementia, particularly  
15 those who are displaying moderate to severe behavioural and psychological problems. If I could start with you, Ms Lawrence. What do you think these peoples' particular care needs are?

MS LAWRENCE: Well, to start with the very first interaction that we have with a  
20 family and a resident. I think it's so important that we get to know the resident, what their care needs are, but also who they are as a person. Because we can't provide personalised care unless we know their background, who they are, what they like to do. So that first interaction is really, really important. It's really important that the environment that somebody lives in is on a human scale and residents are able to find  
25 their way around that home, because they are their homes. They are people's homes. And that's really important to remember.

So having residential aged care facility on a human scale that aids people moving freely from bedroom to dining room to lounge room and being able to go outside.  
30 And having a clear line of sight around where they're going is really, really important. I can only – I can't really imagine, but, you know, an analogy would be, you know, my hotel today, you know, the colours are all beige. It's actually really difficult to find your way around. And, you know, I'm cognitively okay, so it's really important that the colours and the textures, the wayfinding, is appropriate for  
35 somebody that may have cognitive decline.

Having the same staff around is really important. So, as much as possible, we try to have the same staff rostered to the same clients and the same house, so that the clients and the staff build a relationship. And that's really important. So it's a  
40 family type of – type of atmosphere. A strong clinical governance approach is important, as well. And we've recently adopted the Victorian model of clinical governance to strengthen what we already do, because the people coming to us have higher levels of acuity than ever before.

45 MS HUTCHINS: And what are some of the care needs that those people have, as opposed to, say, an elderly resident that's not living with dementia?

MS LAWRENCE: Look, I think – I think it’s really important to understand that we – we try to have dementia-inclusive environments, rather than be dementia specific. And the care needs are not dissimilar, but there needs to be more focus on enabling somebody with dementia to really feel at home and to – to really understand what  
5 that person needs, particularly if they are anxious or agitated, what they need to soothe them. Whether that’s music, whether it’s going outside, whether it’s talking to one of their family members. So really getting intimately to understand the person with dementia is really important.

10 MS HUTCHINS: And, Ms O’Flaherty, when you have new residents entering your facility, what type of assessments do you do at that point of entry to determine what their care needs may be?

MS O’FLAHERTY: So at Glenview we’ve had a role called the client liaison role  
15 since about 2011. And that role is designed specifically to be able to liaise often with the hospital, where a referral will often come from, to ensure we have all the correct clinical information, but then to support a discussion with the resident themselves, with family, with next of kin, whoever might be with that person. So just, as was said, to better understand what the needs might be, not just clinical, but the  
20 psychosocial needs, as well. And then, from that, we’re able to determine what the specific needs might be at that point in time. But that is continuously reviewed with family and through that client liaison role.

MS HUTCHINS: And, Ms Krebs, what are some particular care needs that you’ve  
25 observed of people that are living with dementia?

MS KREBS: What we’ve observed in our experience is, essentially, that they need to be humanised like any person. It’s not particularly specific for someone with  
30 dementia. But, as the dementia journey progresses, this person can become more disorientated and their experience becomes very much based on their feelings. And so building trust with their – they need to have a relationship of trust with the carers caring for them. We refer to them as homemakers, so having that relationship of trust is very important.

35 And having continuity of care. So seeing the same face day in, day out is really important. We also think taking time to care for the person in terms of not rushing them, if it’s showering or walking or baking or cooking or doing any acts of daily living with the resident. It’s really to give them time to want to enjoy the experience and to create a cherished moment for them. Those are some of the experience that  
40 we think are essential for people living with dementia.

MS HUTCHINS: Yes. And are there any other key factors that you think need to be implemented when you’re trying to provide good care for people living with  
45 dementia?

MS KREBS: Environment is a key factor, so creating small home environments where they can have the sense of home, where there’s smells and sounds of home

and not smells or sounds of an institution per se. That whole sensory experience for them is very important to be able for them to be feel humanised. Finding their way throughout the home, being able to have visual cues, whether it be photos of their family, having pets, their own pets from their own home come into the home with them and be allowed to live with them. So having a very normal way of living, but not being institutionalised and having to conform to rigid routines, tapping into their own routines, if they like to wake up early or like to wake up late. Same thing with bed times, time of eating, but very much personalising the approach and not trying to make a one-size-fits-all approach to them.

10 COMMISSIONER TRACEY: Who does the cooking in the communal kitchens?

MS KREBS: The homemakers do the cooking with the residents. So if a resident enjoys peeling potatoes, they will get them – they will prompt them to peel potatoes. Many of our residents can't cook a full meal, but they can definitely participate, either discuss what they enjoy eating, participate in part of the meal, whether it's mixing, chopping, peeling. Or they can even reminisce around the smells and things that they enjoyed doing when they were living in their own home. So to create a real connective journey for them from home into our group home.

20 COMMISSIONER TRACEY: And are they able to choose their favourite dishes, for example?

MS KREBS: Absolutely.

25 COMMISSIONER TRACEY: Yes.

MS KREBS: Absolutely. And we will buy the ingredients. We create a whole activity per se. It's a purposeful and meaningful engagement, where the resident, they discuss a recipe and then they will go out to the local shopping centre and buy the ingredients. And they will talk about the recipe, they will bring it home. And then it becomes a whole discussion and the families can come in and cook with their loved ones, as well. So there's a whole – it's not just about the cooking experience; we prolong it throughout the day, so that it's something more meaningful and purposeful for them.

MR GAVSHON: And to extend that, we've got no set menus, so in a given home we could cook a few different meals on a given night if different residents have different tastes or different appetites. So it's very much about what is important and meaningful to them, rather than just saying on the 1<sup>st</sup> of the month this is the menu for the whole month of May.

MS HUTCHINS: And do you find the ability for residents to choose their own food is helpful, particularly in the situations of residents with culturally diverse backgrounds?

MR GAVSHON: Absolutely. So a good example is a gentleman that came in that had a very strong Italian background, and we sat with the family for a lengthy period of time to understand his needs and his life before coming in. And we ended up talking to the homemakers around learning how to make particular Italian meals so that as soon as he came in for that first meal at lunchtime he was eating meals and having tastes and smells that were familiar to him. That completely made a different impact on his whole transition.

MS HUTCHINS: Ms O’Flaherty, what do you think are some common misunderstandings or misconceptions that people have about people living with dementia?

MS O’FLAHERTY: I think the biggest misconception is that it’s a one size fits all. If you have dementia you present in a certain way. We certainly work with a range of individuals, both in the community and within the facility who have completely different presentations. Some retain their independence – significant independence and can do everything for themselves, and the reason that they’re living in a residential facility is because often their carers have got to the point where they’re experiencing carer stress or feel that living in residential care is the best option for their loved one.

Others who come in with much more complex presentations and some have challenging – what would be called challenging behaviours, we call it responsive behaviours, behaviours that we’re not able to respond to, then that’s the work we need to do in understanding what’s happening for them. But the misconception that the greater the acuity relates to their mobility. People who have complex dementia are not bedridden. We have a range of individuals, so it’s an individual response for individual residents that come to live with us. It’s not a one size fits all.

MS HUTCHINS: And what do you think are some key factors for providing good care for these people?

MS O’FLAHERTY: So some of the work that we’ve undertaken over the last five or six years was looking at the house model, so within a large facility, the virtual division. To complement that we have staff that work within each home so it is about building the relationship with the residents so that that does a couple of things. One is importantly it builds a relationship with the resident, the family, and also the allied health and the GPs that come into the facility, but it’s also about being able to pick up if Lucy has a cup of tea every morning and then Lucy stops having a cup of tea every morning, that’s an indicator that something has changed. So it’s about building the relationships, the environment, dementia design principles are really important and go to the textures, the contrast, the acoustics, the smells, as has been mentioned, and there are lots of evidence-based approaches to how you meet that need.

We at Glenview certainly spend a lot of time around the lighting, for example, to ensure that there are different lighting levels that tap into the sleep/wake cycle, so

brighter in the morning, so that the brain knows – the brain and the body knows that it's – it's time to be active. And those – that lighting changes at sort of, as the light starts to disappear outside, the internal lights start to change so that it's a trigger or a cue for individuals who may not be able to see that it's at the end of the day, that it's  
5 the winding down part of the day. Similarly with imagery around the facility, we work really hard with researchers and other clinicians to ensure that the imagery we have on the walls and even our fireplaces, you know, everything is an opportunity to be a reminiscence opportunity. So it's not their lounge room but the pieces and the furniture and the imagery are familiar or not unfamiliar to residents.

10 MS HUTCHINS: Ms Lawrence, would you agree with these observations about good dementia care, and would you have anything to add about key factors?

MS LAWRENCE: Absolutely. And I think we can all learn a lot from dementia  
15 guidelines, and I agree with Lucy, having – having objects and paintings and familiar environment is really, really important. You know, even if it's a library of books, you know, we often don't have books at home these days but the generation that are in our homes actually have books, and so it's really important that there's books that people can take off the shelf and thumb through. Lighting also is critical and being  
20 able to see where people are going, having less of the long corridor like you would in a hospital, and being able to go outside is critical. And when you're outside, there's purposeful routes to walk, so that you're not just going out into a garden and not going anywhere. So the paths lead somewhere.

25 There's actually something that you can do in the garden, whether it's plants that are, you know, sensory or whether there's a shed or a table and chairs that people can sit at, something that's familiar that people will have in their own homes.

MS HUTCHINS: Ms Krebs, before your time with Group Homes, did you make  
30 any observations about the effects of the institutionalisation of aged care on people living with dementia?

MS KREBS: Yes, I did. The physical environment – and primarily starting with the  
35 routines, I found that quite distressing for people living with dementia having been woken up at 7 o'clock in the morning to have a shower at 7, to sit at the table at 8, to play bingo at 9, to be toileted at 10, to have afternoon tea, and very much it's institutional routine as opposed to the person's own routine. If they wanted to wake up later that wasn't an option. Same thing with bedtimes, so bedtimes, meals, toileting was very much regimented. In my experience also, if the resident needed to  
40 find someone to meet their needs they didn't know who to go to because there's so many different segregations of staff.

There's cleaners, there's cooks, recreation officers, carers, registered nurses, but for  
45 the person living with dementia that can be quite confusing to know where to go to meet their needs or they simply want a cup of tea. The long corridors, the institutional smells of faeces and urine, as opposed to smells of home can be quite confronting for someone with dementia and it causes a sense of "get me out of here"

and so the industry would say exit-seeking. I would say that that's a natural behaviour that somebody would have if they're living in an environment that is non-conducive to themselves. And the transition from being at home and living at home with some care, or someone might be helping them at home to then being locked up in a space can be quite confronting and the transition sometimes can be very sharp for that person.

The staffing and the use of agency can be very confronting for a person if they don't know the person coming in to shower them. For somebody who already has a cognitive impairment and a disorientation and is woken up to be showered with an agency staff can be very confronting for the person. Those are some of the things that - - -

MS HUTCHINS: Thank you. And Ms Lawrence, would you agree with these observations?

MS LAWRENCE: Absolutely. I would also comment that it's sometimes challenging for providers, too. We've got 2400 staff, and we do have to use agency staff from time to time. Minimising the use of agency staff is really critical because, as Tamar said, the person with dementia doesn't recognise that person, and familiarity is really important and building trust between the care workers and the resident is really, really important.

MS HUTCHINS: What type of staff model do you implement at Brightwater?

MS LAWRENCE: The majority of our staff are care workers and there is a strong overlay of – within our clinical governance framework, of having registered nurses for clinical needs. And we also have an allied health model. Because our approach is to try and ensure that our clients are as independent for as long as possible. You know, we all need to be independent as human beings and our clients or residents are no different. And so having a physiotherapist and occupational therapist that help people to remain independent is really critical for us. We also have speech pathologists that are there if people have swallowing difficulties which can be quite prevalent in an aged care environment.

MS HUTCHINS: And how critical is your workforce and their knowledge of understanding of delivering good dementia care?

MS LAWRENCE: It's probably the most critical. So making sure that you've got the right people with the right skills and the right values is the most critical thing to good dementia care. And, you know, working really hard to make sure that you do get the people with the right values in. So recruitment is very important. Being able to identify with your recruitment which people will have the right skills, which people have the patience and the aptitude to learn is really important.

And then continually supporting staff. You know, it's a really difficult job and it's an important job and being able to support them through training. We have an

employee assistance scheme so that if people do need to speak to someone external about something that they're experiencing, they can, and it's free of charge. But making sure that you support your staff is really the most critical thing that I as a CEO can do to make sure that the care is appropriate for our clients.

5

MS HUTCHINS: And what are the key considerations when you're determining the appropriate staffing levels and mix for any given shift?

10 MS LAWRENCE: That's a really complex question. And I think the way to answer that is that – and somebody else said that – this client group that we support is not homogenous. You know, each person that comes in is an individual and, therefore, if you've got a house of 10 people, 15 people living within that house, it's actually designing the staffing model based on the needs of those clients, because each house will have clients with different needs. And so it's not a one-size-fits-all. So I can't  
15 give you a one-size-fits-all answer, I'm afraid.

MS HUTCHINS: And, Ms O'Flaherty, what recruitment practices does your facility implement when looking for the right staff?

20 MS O'FLAHERTY: So we've changed practices over the years as we've, I guess, better understood the nuances of the right staff with the right skills and the right mix. So we have an extensive recruitment process that includes often group interviews, so we can have some observation of what potential candidates look like in a group, how they interact. We also include residents in our interviews, so that there's an  
25 immediately demonstrable capacity to engage with an older person.

We use emotional intelligence as a measure of having someone with the right aptitude to work in this industry. As was said, it's an incredibly challenging role, and emotional intelligence plays to being able to use common sense and being able  
30 to ask for support and to have the capacity to learn. We look for people who have some experience working with dementia, understanding the theory of dementia, as well as the pragmatics. But in our recruitment process, once someone has been selected, they also undertake in-house dementia training as a core element of eligibility to work at Glenview.  
35

MS HUTCHINS: And what are the main qualities you're looking for in your candidates?

40 MS O'FLAHERTY: We have a tag line, if you like, which is to recruit for kindness and train for excellence.

MS HUTCHINS: And how do you find the level of education that your applicants have before joining you?

45 MS O'FLAHERTY: So that's – there's a mixed – mixed bag, if you like. With candidates coming through who have recently undertaken their certificate III, it can be very different depending on the institution that they might have been trained at.

We often have to provide another layer of training in terms of dementia as itself. Dementia is often not touched upon in any significant way in training. And I have to say that's - - -

5 COMMISSIONER TRACEY: Do you do that internally within - - -

MS O'FLAHERTY: We do. We have an in-house dementia consultant. But we have to do that for nurses as much as carers. But we insist that everyone, from the maintenance man to myself, through to the cook, the carer, that everybody does the  
10 dementia training, so we have all have a shared understanding of what that looks like. And it's theory as well as what we call experiencing dementia, so a simulate exercise so you can get a sense of what it might be like and, therefore, how it informs how you engage and interact with residents living with dementia.

15 MS HUTCHINS: Can you give us an example of a simulated exercise.

MS O'FLAHERTY: So it might be that you, in a preset room that's set up, some people might have background noises that's interfering with their capacity to hear a conversation, so head phones. It might be that someone has their vision partially  
20 obscured. Often there are cards that the trainer gives out where you have to follow a set of instructions and then you have someone talking to you. So it's about understanding, if a resident living with dementia is rushed, the sense of anxiety that that can cause.

25 And it's incredibly informative, because the feedback we have from staff who have gone through that training – and we offer it as a refresher for people that sort of say, “Well, I haven't worked with someone with these particular experiences. I want to go back and do that again.” And they talk really positively about how much it has helped to understand the need to take a breath, slow it down, find out the pace at  
30 which the resident is going or wants to go at and then to meet them where they're at.

MS HUTCHINS: And what challenges have you encountered in finding the right people to work for you?

35 MS O'FLAHERTY: I would say we've been incredibly fortunate. We have on average 500 people that apply for every one personal care role in Tasmania. That isn't the same for nursing, I have to say. That's largely because we don't have enough registered nurses in Tasmania. And that's a conversation we've been having for some years with University of Tasmania. And we hope to change that with the  
40 next few graduations of nurses coming through. So yes, sorry. Forgot the question.

MS HUTCHINS: What are the conversations you've been having with University of Tasmania?

45 MS O'FLAHERTY: So we've been talking to them about the number of graduates that come out of university with nursing and enrolled nursing, as well, because largely the hospital system will take many of the graduates, but then lots of young

nurses will disappear to the mainland. So it's about being able to keep nurses in Tasmania. Similar with physiotherapist and occupational therapists. We don't do the training in Tasmania at the moment, so, therefore, it's really challenging to find physiotherapists and OTs to come and work with us.

5

MS HUTCHINS: And how has Group Homes's experience been in finding the right staff?

10 MS KREBS: In our experience, finding staff is not a problem; it's finding the right staff. And so we can also get about 200 applicants that will apply for the job, many coming out of residential aged care with a very task-focussed approach to care. And so when we hire, if we take someone that that has experience, it's not necessarily beneficial to us, because we spend a fair amount of time having to then rewire them in terms of engaging residents and embracing our model. And so we will take people  
15 without any experience or from different types of industries, child care, teaching, counselling, from the different human industries that are willing to take on dementia care and then we will train them in-house.

20 MS HUTCHINS: And so do you find – you just touched on now that people – staff that have come from other types of facilities often, you know, don't have the same ethos that you try to instil in your staff?

25 MS KREBS: Sometimes they don't and sometimes they do, but it takes a fair amount of training. So even though they come with experience, it's a very task-focussed experience. And so it's about helping them transition from one mindset to a different mindset.

30 MR GAVSHON: An example there might be that a team member might join us and be highly focussed on risk, right, and we will be talking to them about dignity of choice and the fact that we've had a conversation with that family or even with that resident and they're comfortable to take that risk, whereas in their previous organisation it was all about how to manage that risk and ensure that that risk was, essentially, not taken too far, whereas within our organisation we want them, if there's a level of comfort and understanding with the family, to engage in those  
35 activities, rather than just say they're out of bounds.

MS HUTCHINS: And, in relation to dignity of risk, can you explain to the Commission what you understand that term to mean.

40 MR GAVSHON: So it is a fine balance. A good example is a resident who moved in who was going on daily walks around her local suburb. Yes, she was living beyond her diagnosis and yes, there was a challenge that she might get lost during those walks. But the family was comfortable that that was an important part of her level of autonomy in order to live her daily life. When she moved in we had a  
45 conversation with their family and we said, "Are you comfortable with us giving her the door code so that she can go on those walks?" In the event that she does get lost, we will then have a plan in place to ensure that we can find her and bring her back.

But, essentially, giving that opportunity and that independence will probably have a much bigger impact positively than taking it away from her. And, as a result, she has had, again, a very positive transition with us into the Group Home, because we've allowed her to do that and she hasn't got lost.

5

MS HUTCHINS: You've mentioned now engagement with the family in decision-making. How important is family buy-in on the care of residents?

10 MR GAVSHON: So we think it's absolutely critical. And we have a multi-pronged approach here. I guess the first approach that we have is that in traditional environments generally the primary time that a family will get called is around a clinical incident. And so there's a very negative, call it, perception or feeling when the phone rings and you see the number from the facility. You're, essentially – you're straightaway thinking, "What has happened and has something gone wrong?"

15

Our approach is that our homemakers are encouraged to phone the family on a weekly basis with positive news, just share exactly what has happened during the course of the week in a positive framework, rather than only calling when there's a problem or there's a challenge or an incident. The other thing we do is create  
20 WhatsApp groups. So our families have a WhatsApp group with our homemakers. And they're encouraged to communicate very regularly with those families, sending photos, sending updates from the day, don't necessarily need to be clinical updates, but a social update about what their family member has done.

25 And then a third element for us that's very important is the fact that we have a platform calls Salesforce that's our resident management platform and families are given a login to that platform. They can't see everything, but they can see a portion of what can be seen around the resident. And it creates a complete spirit of transparency and trust if they can log in and see a core element around their family  
30 member's care. So overall we're in a very active and detailed dialogue with the family and engaging them and their wishes into the care approach that we deliver.

MS HUTCHINS: And, back in relation to training, what type of in-house training do you offer for your staff?

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MR GAVSHON: So we, again, have a multi-pronged approach here. When someone joins us, they're encouraged – or they're required to go through a series of onboarding procedures with respect to understanding our culture and our philosophy of care. The second part of that is that they're assigned a buddy within the home  
40 system. And that buddy, essentially, allows them to shadow them during an operational day to see exactly what's required with respect to the daily tasks of being a homemaker, which would have been very different to their previous roles.

45 The third thing is we have an e-learning platform, which is the platform where we develop our own content. And that's disseminated on a fortnightly basis with a new topic. And those topics can range all the way from wound care, clinical care, dementia care, you name it. We have a whole pathway – different pathways for our

team members. And the third is we have team development days. And those team development days are all around covering a broad range of topics in person, whether it be carer fatigue, whether it be things like food safety, so that overall a team member is getting an enormous amount of support when it comes to education and content.

MS KREBS: Can I add one more thing.

MS HUTCHINS: Certainly.

MS KREBS: One of the things we have found with homemakers is that empowering them to be a lot more responsible than just showering, toileting and feeding. They're a lot more capable than we give them credit for. And so we've taken the approach if we train them and we mentor them and we coach them, every homemaker gets a weekly mentoring session with a supervisor of that house, as well as identifying areas that they need to be developed, whether it be areas of cooking or engagement with the residents or whether it be dementia, whether it be budgeting or rostering.

There's a lot more that our homemakers have a responsibility – and they're very, very capable, as opposed to what we find in other settings where that's done either by registered nurses or other senior staff. We've flipped it on its head where the homemakers, essentially, are the one empowered to do those things.

MS HUTCHINS: And, Ms Lawrence, how does Brightwater assist residents maintain connections with their families?

MS LAWRENCE: So it's really, really important we get to know the family from the first get-go. And we have a team that actually meets with family and the resident and gets to understand what the resident's background was, but also what the family expectations are.

MS HUTCHINS: Who's involved in that team meeting?

MS LAWRENCE: We actually have a discrete – we call it a welcome team. And we have registered nurses and other allied health staff that actually go into people's homes, meet with the family, meet with the prospective resident, and assess what needs that resident might have before they move in. So that first point of call is actually really important. And then, following the resident into our homes, the service manager that runs the home is responsible for communication with the family. We have regular meetings with residents and families. We invite families to come in and participate as much as they want, which is variable. You know, some families are very participative and some can't be there. The other thing that we're looking at is a client portal which is probably similar to what Jonathan was talking about which we will be trialling in our community business, to actually give our families an understanding of what their loved one has been doing during the day, and it's not just about what clinical issues might have happened. It's about, you know,

Mum went out today and she did some shopping or, you know, the doctor came and saw Mum or Dad today or, you know, the – Mum has been enjoying music therapy and here's a picture of her enjoying music therapy, so that families really have an understanding of what their loved one has been doing during the day which is really, really important to build trust, I think.

MS HUTCHINS: The Commission has heard evidence in this round of hearings which highlight the importance of the induction process, particularly around residents that might not have the cognitive capacity to make decisions themselves anymore. What special measures do you put in place, you know, when a resident like that is entering the home to make sure that their family's involvement and consent to various things is properly obtained?

MS LAWRENCE: There's quite an in-depth process in talking to families, talking to the client if that's possible in terms of what their wishes are, in terms of how they want to be supported, and dignity of risk comes in there, so, you know, a family member may want Mum to continue to be able to go for a walk or to continue to be able to eat the food that they choose to eat, even if they've got a swallowing difficulty. So those conversations are really critical in us understanding what the families would like for their loved one but also what the resident would like, and if they're possible to give their view, that's great. But certainly we would be able to get a sense of what they would have wanted through their family.

MS HUTCHINS: And in relation to community engagement, you mention in your statement that Brightwater implements an intergenerational program. Can you explain to the Commissioner what that involves.

MS LAWRENCE: So we have inter-generational playgroups in a couple of our homes which is mums and bubs who would normally go to playgroups actually coming in and conducting the play group in one of our homes, and we found it really – it's very positive in terms of engaging with our residents who may not have – may actually be quite cognitively impaired and they come alive, you know, I think everybody loves small babies and kids. And, you know, our residents come alive when the mums and bubs come in and often mums will feel quite comfortable in handing their child to one of our residents and certainly the female residents, you know, if you've been a mother that instinct never goes away.

So being able to, I suppose, connect to them and their background and, you know, their love of children and love of people is really important. And I do think we have a number of programs where we bring students into our homes and I think having younger people around just like we would in our normal lives is really important because that's what we live and breathe as humans every day.

MS HUTCHINS: And Ms O'Flaherty, what does Glenview do in relation to community engagement for your residents?

MS O'FLAHERTY: So like Ms Lawrence has said, we also have a child care service that comes in once or twice a month, and I agree wholeheartedly that the therapeutic benefit that that has goes beyond just the visits. In terms of engaging with local community it's very much about when a resident moves in, part of that  
5 initial discussion with the client liaison manager and family and responsible people of that individual is around, you know, what are the connections that we can facilitate, is there a particular church they've gone to, is it a particular community they've been part of, are there particular events or practices that we can include as part of day to day. We bring people into the facility, we have a variety of events.  
10 For example, on Father's Day we've had historically a collector's car group with cars and motorbikes who have come in and sort of taken up the whole car park. There are many residents who have come out and that's been – that's a reminiscence activity. It's something they've been involved with.

15 Other things like harmony week, we will bring many different cultural, dance and meal times, so we can create that familiarity. We also take residents out of the facility. I know one example is we had a particular resident who hadn't been back to where they had grown up in a part of Tasmania which was not that far away from our facility, so we organised one of our bus trips that would go to that part of town so  
20 that the resident was able to talk about what it looked like when they were growing up, where they went to school, pointing out their house and things like that. So it's very much about in the introduction to the facility, getting as much of an understanding as we can of that person's life and how, what would be good; equally what's good in terms of don't go back to that particular space because of, or don't  
25 engage in these activities. So it's the things that benefit but also the things that might take away.

MR GAVSHON: The one thing that I would add here is that – which is probably a slight difference in terms of our respective models is the fact that we work hard to  
30 ensure and engage with our local communities so that our local community becomes a dementia-friendly community because we're a standalone home in a traditional suburb, and we don't necessarily have an enclosed infrastructure. So an example of that is that we will go to a local coffee shop and train the waiters or the shop owner about dementia-friendly service, and you know, if it involves, for example, finding a  
35 quieter table at the back of the restaurant when we come on regular visits that our residents can still engage in that purposeful and meaningful activity of going to a local coffee shop.

40 But, yes, the team there has got an understanding of the care that might be required that's a little bit different to a regular patron. Another case study that we recently experienced is a resident moved in and was experiencing a fair level of agitation around his finances and his bank balance, and what we did was in consultation with his power of attorney, we went to the local bank, explained to the teller that he was living beyond a diagnosis with dementia and went on a regular basis with him to the  
45 bank where the teller printed out a statement for him. That, for him, became a very meaningful exchange where he felt like he was reassured that his bank balance was in order, went back to the home. And so while it wasn't necessarily a transaction per

se he felt like he had engaged with the community and had that experience. So we work very hard to try and ensure that those particular bespoke opportunities we take advantage of.

5 MS O'FLAHERTY: If I might just add, I think it's a wonderful example of when  
good practice is in place. As I mentioned, Glenview has been part of our local  
community for 70 years so we've worked with large conglomerates, I suppose, who  
own shopping centres, and we've trained all their cleaners, their office staff, their  
10 security staff to be able to understand an appropriate response if they are faced with  
someone who might be distressed or someone who – the example they gave us was  
someone who had been looking for their car for three hours but there actually wasn't  
a car. So we worked with the community to work towards being a dementia-friendly  
community, and equally we have the same relationships with the local businesses  
that surround our organisation.

15 MS HUTCHINS: And the type of training and education that you're now speaking  
of in terms of in the community generally, is that something that you find also needs  
to happen in smaller ways with the family immediately?

20 MS O'FLAHERTY: We offer the opportunity for families to work with our  
consultant to understand whether there has been a diagnosis or not, because  
sometimes a label isn't useful and that decision is often made by the family or in  
consultation with a clinician, so understanding what that might mean for the family.  
I wouldn't say training but certainly supportive ongoing meaningful conversations to  
25 understand potentially the trajectory that somebody is on, the way in which their  
dementia may or may not impact their capacity of daily living, their response to  
certain scenarios but ongoing education is provided in those softer approaches.

MR GAVSHON: One example there within our model is that we will help a family  
30 on how to visit. So visiting often becomes quite a challenging experience if you, for  
example, don't have the same points of engagement or ability to converse so we will  
explain to them how to get a meaningful experience out of visiting and having –  
maybe adjusting their expectations, maybe bringing in a prompt like an old family  
photo or doing things that can essentially help to create that level of connection, and  
35 then also looking at the length of time and the time of the day. So we've got a  
daughter who calls regularly before she visits and says "I trust your judgment  
completely; is today a good day to visit or not?" And all of that creates a much  
more positive family connection when you can give them that information.

40 MS HUTCHINS: Ms Lawrence, we touched earlier on the view that an element of  
good dementia care involves the environment that a person is living in and particular  
elements of environment design. What are some of the design elements that have  
been implemented at Brightwater with this in mind?

45 MS LAWRENCE: So we touched on earlier the domestic scale, so each of our  
homes has the domestic scale. Smaller number of bedrooms in a home. Bedrooms  
that aren't off long, long corridors where people might get confused and get lost.

Being able to personalise the bedroom, and building on Jonathan's previous point, you know, it's really important for our residents to – and families to be able to personalise the bedroom and have photos and, you know, objects from home and maybe chairs from home. It's really important it's their bedroom. We use things  
5 like different door colours and styles so that our residents can be familiar with their door so they can find the door to their bedroom.

We also use memory boxes in some parts of our business, and that's a window, I suppose, just outside there's a little box that's got perspex and you can put items,  
10 personal items there so it helps you way-find yourself back into a bedroom. Being able to have clear line of sight to where you're going is really, really important, whether it's back to the bedroom, whether it's to the kitchen, whether it's to the outdoor area, so that residents don't get confused and lost. And that also serves the purpose of our staff being able to keep an eye on residents so that they know where  
15 people are, and if somebody is anxious or is feeling confused, they recognise really quickly where that particular person is.

We've used contrasting colours in terms of carpet on the floor to help people find their way as well. We use things like lighting. We make sure there's not a lot of  
20 noise and external stimuli. It's really important that we build a calm space for our residents. And so having lots of noise is not helpful and – but having perhaps music from time to time, having really lovely smells from the kitchen is really important, and that tends to calm people down and soothe people because it's familiar.

25 MS HUTCHINS: And Ms O'Flaherty, I understand Glenview is currently in the process of the new Korongee development. Could you explain to the Commission what that is and what type of environmental considerations have been put into place in this development.

30 MS O'FLAHERTY: So Korongee is a model based on a village. So it's a village that contains four cul-de-sacs, and cul-de-sacs quite deliberately because if you were to take an aerial shot of the location and the geography of where it sits cul-de-sacs are familiar and part of the vernacular. In those cul-de-sacs there are three houses. In each of those houses there are eight bedrooms. The design of the entire village is  
35 based on two cul-de-sacs at the top, two at the bottom, and in the entry point and the middle of the village you have commercial activities. So there is a cafe, there is a hairdresser, there is a clinician's room, there is a gym, there is an activity centre that can facilitate community activities and a pantry.

40 So the design of the houses themselves are based on dementia design, so orientation as we said is critical. Walking out of the bedrooms, people can immediately orientate where they are, so it comes out into the communal spaces. In terms of the interior of that particular house it will be based on a particular lifestyle, so we've worked extensively with the University of Tasmania to develop a questionnaire that  
45 residents or, if they're not able to, their family members can assist to complete the questionnaire. And once that has been done it will identify which of the six different lifestyle or house categories might be most appropriate for that individual, and that's

based on the – on their shared values, on their life experience, and their background. So by way of example, if someone has been a carer most of their life, a teacher, a nurse, a stay-at-home mum, there is a way of living, potentially, that if you live with others who have had similar backgrounds or experiences, you have some shared  
5 values. So the likelihood of developing relationships or friendships with those other housemates, for want of a better description, is higher.

So the interiors will be reflective of what that household will look like. And families are encouraged to bring in as much familiar accoutrement for the house to make it  
10 home. Once you step out those cul-de-sacs – each cul-de-sac looks different,. So in one cul-de-sac we have a chook shed and a veggie garden. In another, it's more of an ornamental garden. And in other, it's more – not a garden, but architectural. And that is reflective of wayfinding, so that once people venture into the cul-de-sacs they can immediately identify, you know, "I've got a chook shed in my cul-de-sac. That's  
15 not my cul-de-sac."

Once you come into the community space, you have very easy wayfinding in terms of points of reference. So we've included chimneys in some of the cul-de-sac that can be seen from the communal areas. And that's about the local community has  
20 houses of an era where there are still chimneys. We have colours and sounds and smells. Again, the acoustics are really important. There has been a lot of work and science put into the outdoor spaces. So it has been really important to remember that trees that have leaves on it one day, but then shed their leaves is not the same cul-de-sac.

25 So thinking about landscape that doesn't change, that stays the same and also, obviously, doesn't require, you know, every man hour to be spent looking after the garden, but in manageable spaces that don't become overgrown to change, visual lines of sight, so that the environmental considerations that have gone into that have  
30 meant that residents should be able to find their way around the facility reasonably easy. All staff in all the commercial spaces will be trained, and they will be Glenview staff, so that it is more than just the carers or more than the designated house staff that will be able to support and assist someone to return to and from or  
35 wherever they want to go around the village.

MS HUTCHINS: In relation to Group Homes, in your various homes, do you have residents with different capacities in each home or do you try to group residents with kind of like conditions together?

40 MS KREBS: So each home is very unique. It starts – the whole process starts for us in the preadmission assessment. We have a document called How Am I Unique? where the social worker and our registered nurses and sometimes homemakers go out to the resident's home and assess the resident and their family and really identify who they are. Once we identify who the person is, what's meaningful and  
45 purposeful, very similar to what Lucy said, is we identify very similar lifestyles, how these personal interests and group them together.

What's detrimental to our model is if we take the wrong resident to the wrong house. Just because we have a vacancy and a person has a diagnosis, it doesn't mean that they're going to suit the profile of that house. And so it's very important to make sure we're getting the right person for the right house and the similarities and the things that they can enjoy together.

MS HUTCHINS: Do you have people in your houses with moderate to severe symptoms?

10 MS KREBS: Yes.

MS HUTCHINS: And how is it that you care for them and their – how is it that they – you manage their interactions with other residents in the house?

15 MS KREBS: So every house we have anywhere between six to 10 residents in a house. And our ratios can fluctuate between two staff in a house of six residents to sometimes it could be, in a house of eight residents, there could be three to four staff, depending on the time of day. We try to identify the triggers of the residents before they happen. And if we can minimise them or eliminate them, then we will do that.  
20 We try and look at a 24 hour approach, looking at their sleeping patterns, what they're engaging in, what's meaningful and purposeful to them, and so we're not getting to the point of escalation where you have eight residents all agitated all at once. There will be different times of day that that needs to be managed. And the residents and homemaker will spend some one-on-one time together engaging in something meaningful.

MS HUTCHINS: And, Ms Lawrence, how do you manage the various levels of peoples' symptoms that might be living together in a home?

30 MS LAWRENCE: It's very similar to Group Homes. Choosing the right people. You know, the residents that come to us don't choose to live with the people that they often end up living with. So being able to choose who lives together is an art. And we rely on that welcome team to actually give some advice, and also on the staff that are in the home. So they will have a fair idea about who fits and who doesn't.

35 I think identifying potential triggers of behaviours upfront is really, really important. And – and that, again, is understanding the person that's coming to us,. So what are the particular triggers that may cause agitation or anxiety or restlessness? And being able to nip them in the bud really, really early is critical, because it does happen; it's not a perfect world, unfortunately. And being able to place the person into the right home in the right mix and being able to identify those triggers as early as possible is critical.

45 MS HUTCHINS: Yes. And the Commission has heard evidence this week regarding instances such as resident on resident aggression. Is that something that occurs within your facility and how is it managed?

MS LAWRENCE: It does occur from time to time, because of the complexity of the people that we deal with. Again, it's going back to understanding what the triggers of a particular person might be and being mindful, I suppose, as to what might trigger behaviour. And so managing that is more proactive, rather than reactive, in terms of  
5 really understanding the mix of people that you might have in the house. And from time to time if aggression does happen, it's meeting with family and the medical practitioner and the multidisciplinary team and brainstorming what could be done to actually ensure that this doesn't happen again.

10 MS HUTCHINS: And, Ms O'Flaherty, do you have individuals in your facility that exhibit severe behaviours?

MS O'FLAHERTY: We have had from time to time, yes.

15 MS HUTCHINS: And do you find that they're able to be managed appropriately within the context of your facility, or do you think they're better in their specialised unit?

MS O'FLAHERTY: We believe very much that it's the skills and training of the  
20 staff that make the difference. And I believe that when a resident moves into the facility they are – their room is their home and if – it's about ageing in place. So we adapt our skills to make sure that we can support someone that might be experiencing severe behaviour response. It's a response. So it's about us understanding, "What are we not responding to?" That's the approach we take.

25 So it very much is about working with the family; working with the extended family of that individual, if there is family; working with the clinicians, as was said before; looking at what are the things that we can try and put in place to support that resident. Often it's around distress. So it's about not only identifying what the  
30 triggers of that might be and anticipating it through the skills of the staff and their capacity for discrete observation, but also what are some of the things that the family can share with us that works or has worked in the past, so some of their learnings, as well.

35 MS KREBS: So I would like to share with the Commission, if that's okay, a case study that we had with a 74 year old gentleman who was living in residential aged care. And the facility called us and said he was displaying severe BPSD, behavioural and psychological symptoms of dementia, and that he was throwing furniture, he was scaling fences. And the psychogeriatrician who knew Group Homes wanted to refer  
40 him to us. And so we did the How Am I Unique, the pre-admission process. And when he moved in we identified that this was a tradesperson and he was used to waking up very early in the morning and doing physical activities.

45 And what was happening in the facility that he was living, he was sitting idle and playing bingo, and so he was becoming more aggressive. And so the environment and activities were, essentially, triggering him. And so we brought him a small bucket of paint and a small paint brush and we asked him to paint the fence of the

home, in consultation, obviously, with the family and them agreeing. And he ended up doing physical work. Every day he would wake up really early in the morning, he would do the fence, he would do – we have a pool in that house, and so he would tend to the pool, do gardening.

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But it was very much about being proactive, like Jennifer and Lucy said. Being proactive and identifying who this person is and not doing a one-size-fits-all of sitting him in a group, but, rather, identifying he's not going to be aggressive if we can identify who this person is and respond.

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MS HUTCHINS: The Commission has heard evidence this week in relation to the use of chemical and physical restraints on residents. And we're interested to hear all of your views on this topic. Perhaps starting with you, Ms Lawrence. What do you consider constitutes a chemical restraint?

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MS LAWRENCE: So just – just to let the Commissioner know, I'm not a medical practitioner, but chemical restraint within our context is any medication that's used not to treat a diagnosis, but to actually modify behaviour in a resident.

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MS HUTCHINS: Yes. And what do you consider constitutes a physical restraint?

MS LAWRENCE: A physical restraint is something that's used to reduce movement of a person.

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MS HUTCHINS: And are physical or chemical restraints used in your facility?

MS LAWRENCE: They are from time to time as an absolute last resort.

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MS HUTCHINS: And so in what circumstances would it become a situation where they do need to be used?

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MS LAWRENCE: So the decision around whether a restraint is used is made by the medical practitioner, that is, the client or the resident's doctor. And it's made with the family and it's made in consultation with our staff. Many – there's a hierarchy of decision-making around – before you even get to medical restraint, around what else can be done to manage the particular behaviour that the resident might have. And it's only when you've exhausted all of those alternatives that you may talk to the medical practitioner or the medical practitioner may suggest that we trial some chemical restraint from – for a very short time.

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And it's really important that that's trialled and it's reviewed regularly. So it's not prescribing medication and then forgetting about it. It's actually trialling it to see whether or not that reduces the behaviours. From time to time, you know, whilst the term "restraint" is really emotive, it can be that it calms that person down so that they can more fully engage in their day, but that's the territory of the medical practitioner.

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MS HUTCHINS: And at Glenview Community Services, are there circumstances where the use of restraint is necessary?

5 MS O'FLAHERTY: Yes. And apologies. I'm just recovering from a cold. There are instances where chemical and physical restraint are used, but, again, it is the absolute last resort and it is only when a range of other strategies have been tried, tested, put into place, discussions with families. And then it's at that point that we have those discussions with the clinicians.

10 MS HUTCHINS: And, for example, if there was a resident that was greatly distressed or upset, depressed, what type of actions would you implement before turning to medication?

15 MS O'FLAHERTY: So one of – an example I can give is – when working with families, we've been able to identify someone's background, what's of value to them. And in one instance it's the strategy we use is reading passages from the Bible with that particular individual, because that, by nature of that person's background, lifestyle, beliefs, is a very calming strategy. And I've witnessed a particular resident go from a very agitated state to an incredibly calm state in a very quick space of  
20 time. When staff are identifying that individual escalating, they take it upon themselves to put in place a strategy we've talked through and it has resolved the matter.

25 MS HUTCHINS: And what's an example of an instance where you might need to use physical restraints?

30 MS O'FLAHERTY: One example – I mean, it is very much the strategy of last resort. We have one resident who has a – what's deemed a physical restraint, but it's a pillow that is put to their side for comfort, but it is deemed a restraint. So it's about talking through when that's appropriate, when that's not appropriate, what that means for that resident, what it means. It has all been assessed and signed off by the clinician, as well as the family. But it's – in my view, it's for comfort. It is deemed a restraint but it's more for comfort than anything else. So restraints can be as simple as for comfort.

35 COMMISSIONER TRACEY: Might there not be more mundane instances where, for example, an elderly resident is prone to nodding off in a chair, and there's always the risk that they will pitch forward, injure themselves. Is that a circumstance where you would feel it justified to put a lap sash on that person, just to ensure that there  
40 was no injury?

45 MS O'FLAHERTY: No, Commissioner. In my view, that's about the staff training and the observation. If a resident is known to nod off and become at risk of falling, it's about the staff working with them to make sure that as and when they become tired, someone is keeping an eye, and generally trying to engage in activities so that nodding off during the day might not be something that happens, but it's upon the staff to be observant and to ensure that that is as less likely to happen as possible.

MS HUTCHINS: In instances where you have a resident that is known to wander, how do you address that behaviour to ensure that they won't leave the facility?

MS O'FLAHERTY: I guess again it comes down to language. It's not wandering.  
5 They're going for a walk. It's about us understanding where do they want to go for a walk to. In terms of our secure unit, which we call Merton, there are – the unit has been designed so that people can go in and outside within a safe space. All the other residents and including the people with dementia can go outside the facility; there's nothing stopping them leaving the facility. Those with – who live within the Merton  
10 area would just do so supervised with a staff member.

MS HUTCHINS: And at Group Homes, how do you manage ensuring the safety of residents that might want to go for a walk and leave the home?

MS KREBS: We would encourage them to go for a walk; we don't label it wandering. They might have purposeful exploring, and so they want to walk into different areas of the home, and so we ensure that there are different things for them to do. There might be a laundry basket with laundry that needs to be folded at the end of the lounge. And so they might walk over there, they might walk out into the  
20 garden and there's a rake there and they might start raking the leaves, but it's very much not restricting. And if someone does have the risk of falling we would rather put monitoring devices to know that they are up and about and attend staff attend to them than to restrict them from actually mobilising because we feel that that again is actually triggering their agitation, and we prefer to actually walk with them and  
25 mitigate the risk of falls.

MS HUTCHINS: What about, say, if someone wanted to go for a walk down the street in the middle of the night?

MS KREBS: So in the middle of the night probably we would discourage a walk, but we might walk into the garden, make a cup of tea, watch a movie together. There are residents that will come down to the lounge area and need reassurance, and many times there is a level of reassurance that our residents need at night and so they will get that. And the homemakers are trained how to reassure the residents and validate  
35 them at night.

MR GAVSHON: In terms of the day, though, it's probably important to highlight that given our staff ratio if someone was to want to go to the door and go for a walk, a general reaction would be that one of our homemakers would go to the door and  
40 open it and say let's go for that walk so there isn't that sense of being in an environment that's locked and secure. They straightaway feel that sense of freedom.

MS HUTCHINS: Yes. And because you have adequate staff available at your facility to be able to enable that practice.  
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MR GAVSHON: Yes, it might mean that, for example, if one of them is going for a walk they ask a couple of other residents if they want to come too, so that from a

ratio standpoint that is balanced and managed but it still does allow that resident to go for a walk.

MS HUTCHINS: And Ms Lawrence, what's the practice at Brightwater Group?

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MS LAWRENCE: So with homes that have the most complex people, they're configured so that wayfinding encourages people to walk into the central courtyards or gardens. So there's very little cues that, whilst the facility is locked, the doors are not obvious doors. So – and that's really important. So the cue is for people to actually go and engage in the garden or into the communal living areas and we've – you know, from time to time a bit like Tamar has spoken about, you know, we've had, for example, and this was a few years back, a lady who loved, within her life, to get on a bus and, you know, go shopping and so we created a bus stop in the backyard and she would go and sit at the bus stop quite happily for hours on end. And so creating that purposeful destination and engagement is so important.

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MS HUTCHINS: And how do you manage residents that go into other residents' rooms and might interfere with their belongings or, you know, upset that resident by coming in their room?

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MS LAWRENCE: Yes, so that does happen from time to time and, again, I suppose it's more of a proactive approach to understanding the needs and background of that particular resident, but also making sure that residents are engaged and they have something to do during the day. It's so important because if – and just getting back to my original point, if they don't know where their room is, they may wander into somebody else's room. But if they can find their room, it's more often than not they will go into their own room. But during the day and at night, a bit like Tamar was talking about, you know, if somebody does get up at night it's having staff that are there to distract them and make them a cup of tea, maybe go on a walk with them around the facility so that there's no need for people to go into another room.

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MS HUTCHINS: I would like to turn now to some questions in relation to good practice and what makes, I guess, best practice in the area of residential aged care, and particularly for those exhibiting symptoms of dementia. What do you think are the most important characteristics of good providers, and I will open this question up to whoever would like to go first.

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MR GAVSHON: I'm happy to try and go first. I think leadership is critical. So I think having leadership that understands that dignity and that care approach for the residents and for the team. I think valuing the team, and we've spoken quite a bit about the fact that empowering the team, training them, giving them knowledge but also valuing them given that it is a job that I think they need to understand and reward and see the value behind it. And then I think a big point which, again, three of us have all spoken about is the risk versus dignity of choice approach and getting overburdened or over-focused on the risk versus that dignity of choice, I think, is a critical component especially when it comes to dementia care.

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MS KREBS: The only thing I would add is a that good characteristic of a good provider is not having a solely clinical approach to caring for people living with dementia but embracing a social model that embraces the whole person, not just their clinical care needs.

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MS LAWRENCE: I think culture of an organisation and staff, and the types of people you have is the number one, and having a culture that respects and builds trust with an older person is critical to good care. Having staff that are the right people that want to be doing this particular work is critical. Having really good training and having systems in place that support them is important. As I said before, it's not easy work. It's really hard work and, therefore, being able to support your staff is critical. I also think being mindful of the environment and the fact that these environments are people's homes, and I agree with Tamar that, you know, this is not a hospital. It's actually a home and it should be a social model.

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MS O'FLAHERTY: I would concur with what the panel members have said, that in terms of the right staff with the right skills and ongoing learning opportunities, these are really critical, and support for those staff given it is – it's a hard job and I have utmost respect for those that are able to do the work and do it with compassion and integrity. I think leadership is critical, and when I say that I mean leadership from the top and accountability. So I think there is a difference when you have leaders who innately understand the work because of the nature of their own background, so not just having administrators, having people who have an appreciation of the complexity of the work and therefore the capacity to flex and change when things need to change.

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We don't have the same cohort of residents we had two, three years ago and we won't have the same residents in the next 12 to 24 months, that it's an ever changing needs of – in terms of how to support staff and how to truly lead in an industry that's changing.

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MS HUTCHINS: We're hearing instances of substandard care. What do you think are the biggest reasons why these outcomes eventuate for some residents in some facilities?

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MS O'FLAHERTY: I'm happy to go first. I must admit to being stunned at times of hearing what we've heard in recent weeks. I struggle to understand how that – how those instances could happen in some – in most cases. I think if you – if you have the right culture of reporting, you have the right culture of working with staff teams to understand where pressure points are and where needs are to be able to respond to some concerns that have been raised, then you address those issues inherently. But culture drives the performance so if you have the wrong culture you inevitably won't get the performance you're looking for.

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MS HUTCHINS: Thank you. Ms Lawrence.

MS LAWRENCE: I think it's being mindful that we don't always get things right and, you know, having good systems and processes so that you reduce, if possible, instances where things go wrong. I think, like Lucy, culture is so important and getting the right people. And identifying really early what people might want when they come into residential care, what the triggers might be, what their backgrounds are so that you're proactive in terms of managing someone that may have complex behaviours.

MS O'FLAHERTY: If I might add, I think also being clear with families about what their expectations are versus what can be delivered is important.

MR GAVSHON: I agree completely. I think the two things I would add at the risk of being a little bit controversial, in terms of the audit and quality agency approach, we've spoken a lot about the fact that planned audits essentially you can adequately prepare in order to showcase exactly what you need to showcase whereas an unplanned audit really allows you to – or an assessor to see exactly what's going on. So we don't have visiting hours deliberately because we feel from a spirit of transparency that ensures that everyone's approach is that we want to deliver that best care all the time. I think the other point that I would like to raise is, to your point about not always getting it right, the industry hasn't been overly supportive of innovative models and we've had a challenge around the innovative nature of our model whether it be the funding that our families can receive or lack thereof compared to going into a traditional facility. And unless we start to embrace and look at different innovative models and support them, I think we can't necessarily completely raise the bar in terms of that delivery of care.

MS HUTCHINS: Thank you. That brings me onto my next question which is how well does the current aged care system incentivise good practice?

MS LAWRENCE: I will go first. Look, I don't think it incentivises innovation, and I think that that is a problem for providers in terms of being able to afford to do anything that's innovative is actually quite difficult, and I really believe that we should be incentivised for the outcomes we achieve, for our clients, rather than have to demonstrate disability. So being able to incentivise providers, and I'm not sure how you would do that, but being able to incentivise them for actually helping people lead a really good life and be as independent and as well for as long as possible, I think would be a great conversation for us to be having.

MS O'FLAHERTY: I would agree. I think if we look at the way the industry is structured, we are, if I might put it very simply, we are funded for the amount of medications we're giving, how many times we shower someone, what meals we provide. We're not funded for how happy a resident is and how we've reduced their sleep medication because they're happier and sleeping better. Now, that might not seem like innovation but in the funding structure that would be innovative.

MR GAVSHON: I mean, and to extend that, and I agree wholeheartedly, if someone is in hospital and needs to be – and a social worker has a discussion with

them to say we don't support you necessarily returning home, and they're looking at, for example, our model versus a traditional model they can move straight into residential aged care and ACFI will flow in terms of roughly or over \$200 per day. But if they were to go back into the community or go into a model like ours they're getting a level 4 home care package, a long wait list and not transparency around that wait list. If that funding does come, at most \$130, \$140 a per day, so from a funding incentive perspective, it's completely misaligned relative to what might be the best care option for them going forward.

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10 MS HUTCHINS: What are some changes that could be made to the existing system to greater encourage quality and safety of care in residential aged care facilities?

MS LAWRENCE: I'm happy to go first. Look, I think there's a lot of work that could be done about connecting the various systems that are involved with older people, whether it's hospitals and the amount of information that flows to a residential facility. It's really important that we have conversations with the hospital, if a resident is coming from hospital, with the family so that that – the actual admission of somebody into residential care is quite seamless. So communicating with hospitals, communicating with primary carers, the actual GPs that come in, you know, we try and do that electronically but it's really difficult at times and everybody does something different. So being able to have an open and transparent system of communication I think will make a big difference.

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25 If one of our residents, for example, goes to hospital we often don't get a lot of information about what's happened to them in hospital, and what medications they may have been put on in hospital, and that doesn't help when a resident comes back into residential aged care. So improving the system, the connection between the various systems I think would help.

30 MS HUTCHINS: Ms Krebs?

MS KREBS: I believe creating definitely a voucher system. Instead of people getting funding in home care and separately into residential aged care, consumers should be allowed to choose where they want to get care, and once they're entitled to – once they're eligible or they have a diagnosis or they need care, whether it be in aged care or people with younger-onset dementia, they should be able to tap into a voucher system that can fund their care, whether it's in the community or in residential aged care.

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40 MR GAVSHON: Yes, I think that's our main kind of preference point. I would add the transparency point around the home care package system and improving that. I mean, I completely concur with just the interface with various systems because I would add NDIS as well where we're interfacing there a lot with respect to young onset and the point of connection is not always completely seamless. Similarly, being more creative or open to some of those innovative ways of delivering care, so whether it be funded respite options, whether it be rehabilitation in the home, whether it be triage services in the home and hospital in the home services.

All of those are – one other example is a special east dementia care unit, you know, there's a grant process on right now and unless you're a residential aged care provider you can't tender for that grant process. We feel we have an enormous amount of expertise around dementia and yet are precluded from that, so it's  
5 essentially looking at the structure and ways to incentivise players to all be able to participate in that innovation.

MS HUTCHINS: Thank you. And, finally Ms O'Flaherty.

10 MS O'FLAHERTY: I think there's three things if I can remember them. One is change the funding so that it is actually funding appropriate levels of care and appropriate quality, and quality is about the time it takes to appropriately spend with residents and families to ensure they have a good experience. The second thing I  
15 would support is the relationship with allied health, whether it be through hospitals or other ancillary services including oral health. And the third thing is a better connection between academia and practice, support to be able to implement much of the research that's been put out there in terms of opportunities to enhance practice.

MS HUTCHINS: Commissioner, that's all of the questions that I have for this panel  
20 of witnesses.

COMMISSIONER TRACEY: Thank you. Could I add a few. And just picking up where you left off, is there merit in the idea of training courses for both nurses and carers for there to be placements in good homes where they can be mentored for a  
25 period of their training, and learn on the job?

MS LAWRENCE: I think that's a really good question, Commissioner. We've run an inter-professional education program that we receive some funding for. And that brought a number of allied health people, medical students, nursing students in to  
30 work together to learn about aged care. It's often difficult for us to get nursing staff and allied health staff. It's not seen as an attractive alternative. Through this program, we've shown that if they were placed and learnt about the industry before they graduated, they actually – it turns their perception of aged care around and they see that it can be a very attractive career option for them.

35 It's also important, I think, to develop relationships with TAFEs in terms of support workers or care workers. And having them on placement is also important, because I think then you get the opportunity of demonstrating your business and your culture and then the people, the right people, would be attracted to your culture. So  
40 definitely it's a positive.

MS O'FLAHERTY: And, Commissioner, if I might add, we, equally, have a placement program. We don't get funded for it, but we have a placement program for nursing staff, as well as psychologists and social workers and cert III. But we've  
45 just – in July we're kicking off a tailor-made certificate III that we've worked with the local TAFE to – instead of electives, we've actually said there are some mandated things like palliative care and dementia that need to be included. So that

for us is a trial to see the difference in skills and abilities once students have been through that process.

5 COMMISSIONER TRACEY: Could I raise another issue. And that is do you have immobile residents? And, if so, how do you cater for them? You've told us a lot today about wanderers and people being able to go out into the garden and those sorts of things, but are there people who are so frail that they're immobile? And, if so, how do you stimulate them?

10 MS O'FLAHERTY: Can I maybe ask for clarification. So immobile as in bedridden or as in - - -

COMMISSIONER TRACEY: Either that or can only get around in a wheelchair.

15 MS O'FLAHERTY: So we have a number of residents, a small percentage, but a number of residents who rely on aids such as electric wheelchairs or just normal wheelchairs. We're very mindful of how we engage with those individuals, particularly if it's not an electric wheelchair. And it's very inclusive in terms of the practice. They're often the first port of call for all care staff. We often use sensor  
20 technology to assist us when someone has move as an indication of, "Okay. You know, Lucy is awake. Time to go and check if she would like to now get up." Very inclusive of making sure that their preferences in terms of things to do during the day are met. We look at what they can do, not what they can't do, and focus on that.

25 MS KREBS: Commissioner, we have residents that are immobile, but they don't stay in their bed. So they might be in what they call princess chairs, wheelchairs. They get engaged in different – again, meaningful and purposeful engagement. If it's at the kitchen counter or it might be in the garden or it might be going out to local  
30 coffee shops using wheelchair-accessible taxis. So they engage in as many opportunities as the mobile residents; we don't distinguish between offering those opportunities.

35 Even residents that are palliating and going through their end of life journey, there's a great opportunity to be able to offer them the opportunity to be with their families in the homes, in the gardens and within the local community. And so we don't discriminate between the two.

COMMISSIONER TRACEY: And one last general topic. And that is the medical  
40 care of your residents. We've heard many accounts of problems arising because they – residents don't have a dedicated general practitioner. Their care is placed in the hands of somebody obtained on their behalf by the institution. That person may change regularly. We've heard other good stories of general practitioners who followed people from their former life into the institution.

45 And there are also other issues that we've heard about, about the interaction between institution staff and general practitioners. We had the President of the Royal Australian College of General Practitioners come and tell us that when he started it

was always a registered nurse who accompanied him whenever he went to visit a patient. If he wrote a prescription, it was dealt with immediately. These days, he's lucky to get a carer to go along, and usually he sees his patients one to one. How do you ensure that proper care is provided using general practitioners?

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MS LAWRENCE: So just to remind everybody that a resident can choose their own medical practitioner. It's very common that a medical practitioner that you've seen in the community will not come into a residential facility, and so there are doctors that will come in and actually replace the normal medical practitioner. It's actually quite complex. It's not easy. And I think there's some opportunities for medical schools to – well, for a start, for the government to offer incentives for medical practitioners to actually take on residential aged care, but also for education for GPs in medicine or older age.

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15 And it's really important that the GPs come in understand what older people might be experiencing on a medical basis. We've used, and we continue to use, nurse practitioners. And so having a nurse practitioner that has a scope of – where their scope is residential aged care means that you can develop that relationship with the doctors that come in a little bit more fully than some of the other generalised registered nurses. And so I think I would really advocate for nurse practitioners. They serve a really valuable purpose.

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It's really important, also, in terms of supporting a GP that, you know, we use an electronic medication system. And many of the doctors that come in will use the system that we have, the clinical management system and they will put their medication changes on our clinical management system. So it's reasonably seamless. The other thing I would mention is that most GPs visit after-hours, so we have less staff on. And that's often problematic. And so knowing when the GP is coming, it's as simple as that, so that we can make sure that somebody is around to assist them.

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MS O'FLAHERTY: I would support that. We have a condition of entry that you have a GP. But, again, going back to the client liaison role, if somebody doesn't have a GP, then we would support and facilitate what the options might be, sharing who the existing GPs that do visit the site are, so that once someone moves in there is someone in place. We – but for those GPs that visit more frequently or who have more residents under their care, we have a planned arrangement whereby the registered nurse will, as you've mentioned, go round and be one on one on the GP. If we know they're coming, we're happy to do that. We often don't know when they're coming and we don't know when they've been, because, like has been said, sometimes it's 7 am or 7 pm, often before or after surgery hours.

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MR GAVSHON: A couple of things, Commissioner, I would add. One is one of the other, call it, areas that – we completely support, by the way, nurse practitioner advocacy, because we've found that very useful. One of the other things we've found very useful is having a designated clinic or visiting time once a week for either these GPs or nurse practitioners, because, as you say, not knowing when they're

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going to come and not having the right team member there to interface with them can present its problems. So we've worked hard to try and get that routine in place.

5 The other thing that we worked very hard with is ensuring that we can get access to home visits by specialists, because what we feel is there is, obviously, a gap in expertise or experience or knowledge or practice around a GP versus the specialist. And when it comes to certain prescriptions of certain medications or just general oversight of a particular resident, we've needed to get a specialist involved, whether it be a geriatrician or a psychiatrist or the like. So while it's not that easy to get them  
10 to make those home visits, we think that's a critical element.

COMMISSIONER TRACEY: Anything arising?

15 MS HUTCHINS: Nothing further, thank you.

COMMISSIONER TRACEY: As you know, we've heard, over recent weeks, a lot of very challenging stories about things that have been going on in nursing homes. And I must say it has been refreshing to hear how a bit of innovative thinking can produce good outcomes. And I'm indebted to you all for your contribution this  
20 morning. It will all be taken on board when we come to make our recommendations. The Commission will adjourn until 12.15.

25 <THE WITNESSES WITHDREW [11.56 am]

ADJOURNED [11.56 am]

30 RESUMED [12.22 pm]

COMMISSIONER TRACEY: Yes, Mr Gray.

35 MR GRAY: Thank you, Commissioner. This afternoon we have a panel of eminent health practitioner experts who have been convened to assist the Commission in respect of issues relating to dementia in their particular fields of expertise, and in particular in a residential aged care setting. We have a panel of four experts and I will ask the court officer to assist in having them take the oath or affirmation in pairs,  
40 if that's convenient.

COMMISSIONER TRACEY: Yes. Certainly.

45 MR GRAY: I will first ask Professor Dimity Pond, that's Professor Constance Dimity Pond and Professor Elizabeth Beattie, that's Professor Elizabeth Ruby Anne Beattie to be sworn in or take the affirmation.

<CONSTANCE DIMITY POND, AFFIRMED [12.23 pm]

5 <ELIZABETH RUBY ANNE BEATTIE, AFFIRMED [12.24 pm]

MR GRAY: Next, I will ask that Dr Peter Foltyn, and Professor Lynette Goldberg, that's Associate Professor Lynette Ruth Goldberg be sworn or take the affirmation.

10 <PETER FOLTYN, AFFIRMED [12.24 pm]

15 <LYNETTE RUTH GOLDBERG, AFFIRMED [12.24 pm]

MR GRAY: Thank you, Commissioner.

20 Next, starting with Professor Dimity Pond, we will have each of the expert witnesses identify and verify their statements to the Royal Commission.

COMMISSIONER TRACEY: Yes.

25 MR GRAY: Operator, please bring up Professor Pond's statement, WIT.0118.0001.0001. Professor Pond, you've made a statement for the Royal Commission.

PROF POND: I have.

30 MR GRAY: Do you recognise the document that I've just identified as that statement?

PROF POND: I do.

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

PROF POND: Yes, they are.

40 MR GRAY: I tender the document.

COMMISSIONER TRACEY: Yes, the statement of Professor Constance Dimity Pond dated 6 May 2019 will be exhibit 3-48.

45 **EXHIBIT #3-48 STATEMENT OF PROFESSOR CONSTANCE DIMITY POND DATED 06/05/2019 (WIT.0118.0001.0001)**

MR GRAY: Thank you. Next, Professor Beattie, you've made two statements for the Royal Commission.

PROF BEATTIE: I have.

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MR GRAY: I will ask that they be displayed for you on two sides of the screen. Operator, please display WIT.0119.0001.0001. Professor Beattie, do you recognise that to be the statement you've made for the Royal Commission dated 30 April 2019?

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PROF BEATTIE: I do.

MR GRAY: And in respect of the next statement, that's RCD.0011.0026.0001, is that the second statement titled Supplementary Statement, that you've made for the Royal Commission dated 12 May 2019?

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PROF BEATTIE: It is.

MR GRAY: And in respect of both the statements, are the contents of the statements, to the best of your knowledge, true and correct and are the opinions expressed in them opinions which you hold?

20

PROF BEATTIE: They are.

MR GRAY: I tender each of those statements.

25

COMMISSIONER TRACEY: What was the date of the first one?

MR GRAY: 30 April 2019.

30

COMMISSIONER TRACEY: Thank you. The statement of Professor Elizabeth Beattie dated 30 April 2019 will be exhibit 3-49.

**EXHIBIT #3-49 STATEMENT OF PROFESSOR ELIZABETH BEATTIE DATED 30/04/2019 (WIT.0119.0001.0001)**

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COMMISSIONER TRACEY: And her statement dated 12 May 2019 will be exhibit 3-50.

40

**EXHIBIT #3-50 SUPPLEMENTARY STATEMENT OF PROFESSOR ELIZABETH BEATTIE DATED 12/05/2019 (RCD.0011.0026.0001)**

45

MR GRAY: Thank you, Commissioner. Commissioner, I'm informed that the exhibit numbers in sequence should be – I withdraw that, Commissioner. Could I please go to Dr Foltyn, and ask the operator to display WIT.0121.0001.0001. Dr Foltyn, have you made a statement for the Royal Commission dated 3 May 2019, and do you recognise this to be that document?

DR FOLTYN: I have, and I do recognise that document.

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

DR FOLTYN: They are.

MR GRAY: Thank you, I tender the document.

COMMISSIONER TRACEY: Yes. The statement of Dr Peter Foltyn dated 3 May 2019 will be exhibit 3-51.

20

**EXHIBIT #3-51 STATEMENT OF DR PETER FOLTYN DATED 03/05/2019 (WIT.0121.0001.0001)**

MR GRAY: Thank you, Commissioner. And finally Professor Goldberg, have you made a statement for the Royal Commission – I will ask that it be displayed, WIT.0120.0001.0001. Do you recognise that to be a copy of your statement of 4 May 2019?

ASSOC PROF GOLDBERG: I do.

MR GRAY: Thank you. And to the best of your knowledge and belief are the contents of the statement true and correct and the opinions expressed in it opinions which you do hold?

35

ASSOC PROF GOLDBERG: Yes, they are.

MR GRAY: Thank you. I tender the document.

COMMISSIONER TRACEY: Yes. The statement of Associate Professor Lynette Ruth Goldberg, dated 4 May 2019, will be exhibit 3-52.

**EXHIBIT #3-52 STATEMENT OF ASSOCIATE PROFESSOR LYNETTE RUTH GOLDBERG DATED 04/05/2019**

45

MR GRAY: Thank you, Commissioner. I will introduce the members of the panel starting with Professor Pond. Professor Pond, you're a fellow of the Royal Australian College of General Practitioners.

5 PROF POND: I am.

MR GRAY: And a vocationally registered GP.

PROF POND: That's correct.

10

MR GRAY: You have a research background in diagnosing by GPs of depression and dementia. And it's the case, isn't it, that those two conditions be readily be confused and care needs to be taken in that respect?

15 PROF POND: Yes, that's true.

MR GRAY: You participate in advisory groups for the National Health and Medical Research Councils, National Institute for Dementia Research. Is that correct?

20

PROF POND: That's right.

MR GRAY: And the Australian Commission for Quality and Safety in Health Care's Cognitive Impairment Advisory Group.

25

PROF POND: That's correct.

MR GRAY: And also the Health, Education and Training Institute, HETIs, mental health training for GPs.

30

PROF POND: That's correct.

MR GRAY: Professor, you have particular experience and expertise of a research background character in the use of screening tools by GPs to identify dementia, such as the GP assessment of cognition, GPCOG.

35

PROF POND: That's true.

MR GRAY: And we understand from your statement that you've now working on multidisciplinary GP and nursing teams to improve dementia identification and management and on writing a new edition of the Silver book, which is an exhibit, 1-41, Commissioner, from our February hearing tendered through the RACGPs President, Dr Nespolon. Is that so?

45 PROF POND: That's so.

MR GRAY: Thank you. Next, I will introduce Professor Beattie, if I may.  
Professor, you're a registered nurse with a DPhil in Nursing Science. Correct?

PROF BEATTIE: Correct.

5

MR GRAY: You have an academic background in sociology and anthropology and in interdisciplinary studies.

PROF BEATTIE: I do.

10

MR GRAY: You trained in hospitals in Sydney and London and your PhD studies with the University of Michigan – or included work at the University of Michigan. Is that correct?

15 PROF BEATTIE: That's correct.

MR GRAY: You have practice experience as a registered nurse in the UK and in Australia in acute psychiatric and aged care settings.

20 PROF BEATTIE: Correct.

MR GRAY: And you've also been the director of nursing of a residential aged care facility in Australia.

25 PROF BEATTIE: Yes.

MR GRAY: And for nine years a research scientist, including as a director of research in the University of Michigan, in the area of aged care.

30 PROF BEATTIE: Correct.

MR GRAY: Your research experience and expertise includes nurse-resident communication and ambulation behaviour, in particular the assessment – well, these are separate matters. Those behaviours are in the setting of people living with severe dementia; is that right?

35

PROF BEATTIE: Correct.

MR GRAY: And you also, as a separate research project, have inquired into a range of matters related to dementia, including assessment of quality of life.

40

PROF BEATTIE: Yes.

MR GRAY: Meal time nutrition support.

45

PROF BEATTIE: Yes.

MR GRAY: Respite care.

PROF BEATTIE: Yes.

5 MR GRAY: Person-centred responses to behavioural changes.

PROF BEATTIE: Yes.

10 MR GRAY: Wayfinding and getting lost in the context of ambulatory behaviour.

PROF BEATTIE: Yes.

MR GRAY: Carer experiences.

15 PROF BEATTIE: Yes.

MR GRAY: Telehealth consultation in residential aged care facilities.

PROF BEATTIE: Yes.

20

MR GRAY: And does that mean technology which is available to assist in multidisciplinary conferencing?

25 PROF BEATTIE: Correct, but it would be typically used by a geriatrician in this case.

MR GRAY: Thank you. Also, companion robots.

PROF BEATTIE: Yes.

30

MR GRAY: Are they robots that are becoming useful in the Japanese context, do you know?

35 PROF BEATTIE: A number of these robots have originated in Japan, but this study was led by a colleague of mine, Professor Wendy Moore, and it relates to the Paro, which is a companion robot which is responsive to interactive behaviour from the person with dementia.

40 MR GRAY: Thank you. And, also, meaningful activities, consumer-directed care.

PROF BEATTIE: Yes.

MR GRAY: Delirium reduction.

45 PROF BEATTIE: Yes.

MR GRAY: And dementia champion training in acute care settings.

PROF BEATTIE: Correct.

MR GRAY: And champion training in that context means training nurses who will go out and themselves become trainers in their work place. Is that so?

5

PROF BEATTIE: Eventually, yes. So it's a small group of people who specifically have an interest in or skills in looking after people with cognitive impairment and then will transfer them on to others.

10 MR GRAY: Thank you. And currently for the last 11 years you've been Professor of Aged and Dementia Care in the School of Nursing at QUT and a director of Dementia Training Australia, amongst other things.

PROF BEATTIE: Correct.

15

MR GRAY: Thank you. Next, Dr Peter Foltyn, I will introduce you. Dr Foltyn, you're a dentist. You qualified in dentistry from Sydney University in 1971; is that correct?

20 DR FOLTYN: Correct.

MR GRAY: And, Dr Foltyn, you've practiced continuously since then, initially in private practice, moving to what is now a consulting position in a large hospital.

25 DR FOLTYN: Correct.

MR GRAY: And, Dr Foltyn, over those years you've developed a keen interest and expertise in what one might call geriatric dentistry.

30 DR FOLTYN: Correct.

MR GRAY: Although geriatric dentistry, as I understand it, is not yet a recognised specialty. And that's one of the issues you raise in your statement concerning the need for education about particular issues that arise for older Australians in the context of dentistry.

35

DR FOLTYN: There are lecture streams provided in tertiary institutions on some aspects of geriatric care, but overall there isn't – it's not a discipline within itself.

40 MR GRAY: And you have made the point that there are particular issues that arise as one ages that are distinct and different from the conditions under which younger people experience oral and dental issues, and that merits particular attention in an academic context; is that right?

45 DR FOLTYN: Yes.

MR GRAY: You have various educational roles relating to geriatric dentistry and oral health care initiatives. You were involved in 2007 in setting up the first fully functioning dental clinic in a Sydney residential aged care facility which is Montofurey; is that correct?

5

DR FOLTYN: Correct.

MR GRAY: And currently and since 1977, you've been the visiting dental officer at St Vincent's Hospital Darlinghurst and you're now in a consulting capacity.

10

DR FOLTYN: Correct.

MR GRAY: And you're an active member in the Centre for Education and Research in Ageing, CERA. And you also provide dental services to an RACF.

15

DR FOLTYN: Correct.

MR GRAY: Thank you. Next, Associate Professor Lynette Goldberg. I will introduce you if I may. Professor Goldberg, you're a qualified speech pathologist.

20

ASSOC PROF GOLDBERG: Yes.

MR GRAY: You have bachelors degree from the University of Melbourne, a masters from Western Michigan University and, following the award of the masters degree in 1975, you engaged in 14 years of practice in the US in speech pathology.

25

ASSOC PROF GOLDBERG: Yes.

MR GRAY: And during that time you held the directorship of the division of the American Speech Language Hearing Association in Washington DC.

30

ASSOC PROF GOLDBERG: That directorship came after the clinical practice.

MR GRAY: Thank you. And you were awarded a PhD from Wayne State University Michigan and then engaged in various academic roles in US universities.

35

ASSOC PROF GOLDBERG: Yes.

MR GRAY: Professor Goldberg, speech pathologists have expertise in the health of the mouth and related tissues generally, is that correct, not just speech?

40

ASSOC PROF GOLDBERG: Yes, that's true to say, because we are very interested in swallowing function.

45

MR GRAY: Thank you. And in particular in the aged care context, the Commission has already heard evidence relating to swallowing, eating and drinking issues, as well as recognising the importance of communication, including through

speech. Over all of those issues, speech pathologists are recognised to have expertise; isn't that so?

ASSOC PROF GOLDBERG: Yes.

5

MR GRAY: Your research experience includes being lead investigator in a recently concluded NNIDR-funded project on inter-professional support to nurses and carers in residential aged care settings.

10 ASSOC PROF GOLDBERG: Yes.

MR GRAY: And the focus of that research was to improve the oral health of residents and to reduce aspiration pneumonia risk; is that so?

15 ASSOC PROF GOLDBERG: That's true.

MR GRAY: And currently and since 2014 you've been at the Wicking Dementia Research and Education Centre at the University of Tasmania.

20 ASSOC PROF GOLDBERG: Yes.

MR GRAY: You've been focussing there on developing new areas of learning relating to dementia in seldom heard groups, including first nation.

25 ASSOC PROF GOLDBERG: Actually the focus is really on first nations people, working with one particular community.

MR GRAY: Thank you. And is that the Circular Head community?

30 ASSOC PROF GOLDBERG: Yes.

MR GRAY: And you've also been developing modules in relation to dysphagia, which is swallowing difficulties, nutrition and dementia; is that so?

35 ASSOC PROF GOLDBERG: That's as part of a bachelor's degree in dementia care that is offered by Wicking.

MR GRAY: Thank you. I will ask each members of the panel a set of initial questions and then we will move to panel discussions on a range of other questions. Starting with initial questions, I will go first to Professor Pond. Professor, in your statement you've explained how diagnoses of dementia can be difficult to make and how training of GPs is required in this regard. This is in particular in your statement at paragraphs 26 to 39. Professor, what are the common challenges to making an accurate and timely diagnosis of dementia?

45

PROF POND: Thank you for that question. So, first, it needs to be understood that dementia is preceded by quite a long time of deteriorating cognitive function. So it's

difficult to determine when a person has slipped from a cognitive impairment not diagnosable as dementia to frank dementia. This is not a clear definition. So for – so I will make this statement in the context of general practice, and GPs, as I said in my statement, see over 100 different conditions very commonly. So that’s part of the  
5 context that makes it difficult for us to identify dementia because we need an in-depth knowledge to identify dementia and it’s not simple. So some of the complexities are that dementia overlaps with depression, as you mentioned earlier. So a person with depression may get agitated, they may not be able to think clearly, and they may exhibit other symptoms that could be confused with dementia.

10 Another common what we call differential diagnosis is delirium. So someone who’s had an operation, who is sick, perhaps with a urinary tract infection, very common in residential aged care, may also become confused. They may start calling out, they may be agitated, they may wander around, and this is because they’re sick rather than  
15 because they’ve got dementia itself. So – and there are many other causes of delirium other than a urinary tract infection, any sort of infection or derangement of the blood due to medications or something like that. Then a third common differential diagnosis is the medications themselves. Medications can have an effect on the brain functioning. I know that the Commission is looking very carefully at  
20 psychotropic medications which are mainly aimed at brain functioning but there are many other medications that have an effect on brain functioning.

For example, fluid tablets – commonly called fluid tablets – to reduce fluid on the lungs may actually disrupt the balance of salts in the blood and that can be confusing  
25 for people. Some of the heart medications actually are anticholinergic in their effects, and that anticholinergic effect causes confusion. A very common – common medications used for urinary incontinence cause confusion as well. So there’s quite a lot of complexity around the medications. So moving on from the differential diagnosis, so those – the drugs, the depression and the delirium which may present as  
30 though they are dementia, I will then move on to how do we assess dementia. So in residential aged care we commonly used a screening instrument such as the GPCOG which we alluded to earlier, or the Mini-Mental State Examination is commonly used.

35 So these screening instruments are not actually diagnostic; they are simply to give us an idea about whether the person might have dementia or not. A full diagnostic assessment would take more than an hour and use more lengthy complicated instruments than we have available in residential aged care. So both of those instruments are screening. That means they will miss some cases of dementia, and in  
40 some cases they will – people will fall into the dementia range even though they don’t have it. And they may have the depression. They may have the delirium. They may have medication side effects. Or they may, in fact, not be educated sufficiently to be able to do some of the tasks required by those questionnaires.

45 And furthermore, in the case of the Mini-Mental State Examination there’s no questioning of carers or relatives as to whether that person has deteriorated. So if they’ve always been functioning at a fairly low cognitive level, they may not have

dementia at all. They may have a developmental disability. So we need that information about – from the relative about whether they have deteriorated and we do get that in the GPCOG which is both a blessing and a curse in a way because if we don't have a relative available, then we might not be able to make the call. So

5 apart from that, people don't want to know they've got dementia. So most people are quite scared of this diagnosis. I was part of a waiting room survey of around just under 500 people who were asked if they would want to know if they had dementia, and just over 60 per cent of them said they would, and the other 30 plus per cent said no, they wouldn't want to know.

10

And I was part of an in-depth study where a community jury spent a whole weekend debating the pros and cons of screening or case finding for dementia. Case finding is a slightly different process where you pick people at high risk and administer the screening instruments there. People in residential aged care are at high risk so they automatically qualify for that. And this community jury decided in the end that they

15 didn't like case finding, and that they wouldn't advocate it, and that if a GP was proposing any such process, that should be discussed with a person in-depth before they undertook that – that – those questions. So that attitudes are very important. As GPs we don't want to impose a diagnosis on someone who doesn't want to know. So

20 that's an obstacle.

20

Another problem is that people often don't realise themselves that they don't – that they have dementia. It sort of creeps up on them. So – and the nature of the disease itself means that may lose insight into how badly they're affected.

25

MR GRAY: Why is it important to get that diagnosis right and to do it in a timely fashion?

PROF POND: Well, there are many advantages to knowing that you have dementia. You can make plans for the future. You can, in fact, do an advanced care plan while you still have capacity to do so. You can – you and your relatives can look at the probability that you will have a deteriorating course and that you will need care and can make plans for the best way for that to be provided, and you – if you have things that you might want to do – in one facility up the coast they used to give people the opportunity to do the most amazing things before their dementia got them to the point where they couldn't, such as jumping out of aeroplanes with a parachute which is not something I would choose to do, but you might wish to do that. You might wish to have your high tea at the local hotel with all the – all the wonderful cakes and frippery of a high tea before you become incapacitated. So I think there's very good

30 reasons for wanting to know, and I would want to know.

35

40

MR GRAY: You've spoken in your statement about needing to enlist the involvement of family and loved ones, and to engage in some long-term planning.

45 PROF POND: Yes.

MR GRAY: Is that another key reason?

PROF POND: That's right. So the last thing that families need is to have a family member with dementia who can't make decisions, and who has their affairs not in order.

5 MR GRAY: Thank you.

PROF POND: And it's very difficult to sort those out.

10 MR GRAY: Professor Beattie, can I ask you some initial questions. Upon entry of a person with dementia into residential aged care, what's the importance of the registered nurse, in particular, the leading registered nurse, so the clinical care manager assessing the needs of the person and formulating a care plan? And what are the challenges in getting this done correctly?

15 PROF BEATTIE: Well, first I would say that providing optimal nursing care to people living with dementia in residential environments and in any environment, really, is very sophisticated work and it involves a high degree of skill and training and experience. And an RN in a leading position in a residential environment is responsible for a great level of complexity in the sorts of care that people require and  
20 what has to be provided for them. And dementia adds complexity, because of the things that Professor Pond is talking about involving this progressive loss of independence – yes – and the changes that occur in a person over time.

25 So when I talk about these things, I'm really looking at contemporary nursing practice, which would use the over-arching philosophy of person-centred care and the intent on preserving the inherent dignity of that person throughout that process. When somebody comes into a residential environment for the first time, whether that's been a planned admission for full-time permanent care or for respite care, they need to have a clinical assessment. It is the – it underpins the provision of all safe  
30 and responsive care in relation to nursing and also in relation to the work that gets done in teams, be it with the GP or other attending health professionals. And the actual plan of care and the effective communication with other members of the health team starts there and then.

35 The plan has to be responsive to the needs of that resident and it has to be realistic, and, most importantly, it has to be achievable, because there's no point having a plan that doesn't help guide care and that is, effectively, not going to make any sense or result in effective things happening. So it needs to be comprehensive, and I think I've outlined that in my statement. But there are a number of challenges to that.

40

MR GRAY: Thank you. Dr Foltyn, I will direct some initial questions to you. What challenges do the onset of dementia pose to maintaining oral and dental health, and what are the consequences, direct and indirect, if oral and dental health is neglected? And, in respect of the indirect consequences, I won't ask you to go into  
45 great detail. It may be that there are consequential health impacts that are of a medical nature, but if you could outline those please.

DR FOLTYN: Certainly. Look, maintaining good oral health is important for everybody at every stage of life. The difficulty, of course, is when somebody progresses to dementia their cognitive decline might lead to a lessening of the time that they spend looking after their own mouths. They may develop arthritic hands and be incapable of actually providing the level of oral care that's required. They may be forgetful. And, in a residential aged care facility, where there is an expectation that staff will assist with providing oral care, it very often just doesn't happen.

10 Neglecting oral health will mean that you get a build-up of food debris, plaque, that can reside around the teeth, between the teeth, and, for those that wear dentures, can sit under the dentures. And if the dentures aren't removed and cleaned, then that build-up of debris puts that resident at higher risk for aspiration pneumonia. Neglecting teeth in a residential aged care facility, in particular for somebody who  
15 has progressed to dementia and not looking after their mouths, may lead to accelerated dental decay, especially in an environment where food is soft and sweet, where there's inadequate hydration and there's a leaning towards sugared drinks, cordials and juice.

20 MR GRAY: Could we just at this point ask the operator to display one of the annexures of your statement at page 3. It's DPF.0001.0001.0002 at page 3.

DR FOLTYN: And – well, this particular series involves an X-ray of a patient who attended my department and had the tooth marked with the red line extracted because  
25 of pain. Didn't return for follow-up for 18 months. In that period of time, went to a residential aged care facility where there was very little oral health provided or oral health care, and the teeth have more or less disintegrated. So, in an environment where there's soft, sweet food, the mouth responds by having a low pH or an acidity level in the mouth that is encouraged by the sugars and the dryness of the mouth.  
30 And that leads to rapid tooth decay. And you can see the progression that has taken place in the two X-rays and in the photograph.

MR GRAY: Thank you. I might ask the operator to just take that photo down for the moment. Can I ask you, just while we're on that topic, about three examples that  
35 you actually mentioned to me before today, where you have direct knowledge about the impacts of dementia in particular on oral health care of the patients concerned and the consequential difficulties that arose for those people.

DR FOLTYN: One in particular that I would start with, because Professor Pond mentioned it, and that is that the role of urinary tract infection. That does occur in  
40 people with dementia. And one of the examples I gave you was of a gentleman with Alzheimer's who was being cared for at home, and every six months his wife recounted the story that he would have a temperature and the GP would come and see him and automatically would prescribe antibiotics assuming it was a urinary tract  
45 infection. And on the last occasion she noticed that the side of his face was a little bit swollen, a bit red and he just stood there hitting himself on the side of the face, because he couldn't verbalise that he was in pain or discomfort. They came into the

hospital and a series of X-rays showed quite extensive dental caries and abscesses that were the cause of his problem.

MR GRAY: I will ask the operator to put the next image up.

5

DR FOLTYN: And the issue here is that the antibiotics prescribed for the urinary tract infection very often benefit dental abscess formation, so, consequently, those previous episodes of UTIs were probably just relieved with the antibiotics. There were never UTIs in the first place.

10

MR GRAY: And was this the X-ray in question?

DR FOLTYN: It is.

15

MR GRAY: And do the circled areas show an absence of dentine in between the white depicting metal?

20

DR FOLTYN: The white depicts the metal part of the bridgework. And the blue-circled areas are where the decay has just rotted through the supporting parts of the teeth. And the red areas show the dental abscesses. So these dental abscesses would be pumping microorganisms into the bloodstream on a persistent basis.

25

MR GRAY: And I know it may be a medical matter, but do you have indirect knowledge about the consequential health effects if infections of those kind from dental abscesses get into the bloodstream?

30

DR FOLTYN: What has been mentioned already is delirium. And this was how this gentleman came in, as well. I mean, he had delirium. And other patients that I've provided you with the X-rays and images of them are quite similar, where they have come in with a delirium as a direct result of their dental infections.

MR GRAY: You mentioned another report of a 95 year old man with dementia - - -

35

DR FOLTYN: Correct.

MR GRAY: - - - who, when that delirium subsided, withdrew consent for his - - -

DR FOLTYN: Correct.

40

MR GRAY: - - - dental procedure in hospital. Can you just outline what happened?

45

DR FOLTYN: Well, in that situation he was incapable of consenting and his daughter, who had the enduring power of attorney, was concerned enough that we identified infected teeth. And we thought it would be in his best interests to have those removed. And the antibiotics that were given for a couple of days while he was waiting for theatre enabled the infection to subside. And, as you say, he withdrew his consent prior to the actual operation.

MR GRAY: And the third matter you mentioned was a person with Lewy body dementia. Can you explain your knowledge about that case.

5 DR FOLTYN: This particular one is of great concern because in this instance the same set of circumstances, the gentleman was living at home and was working part-time in a voluntary capacity but one morning woke up with a swollen face, incoherent, delirious, wasn't able to stand. His wife brought him into the hospital. We managed to get imaging and that showed a wisdom tooth with a dental abscess, so a reasonably straightforward dental problem per se. But he had most of his teeth  
10 but because of his dementia it was unsafe to even attempt to try and remove that tooth in a conventional manner with local dental anaesthetic sitting in a dental chair.

So it was necessary to have an anaesthetic consultation with the anaesthetist to determine whether he was fit for a general anaesthetic. He was, and eventually we  
15 took him to theatre on about day five or day six. But the combination of the general anaesthetic and his delirium, he went backwards in hospital and he was there for nearly a month. And that's unaffordable to any health system and hospitals to have patients there for one month for a simple – what should be a simple dental extraction.

20 MR GRAY: Professor Goldberg, I will direct some questions to you, if I may. What are the key risks that the progression of dementia can bring to a person's appetite and ability to eat and drink safely?

25 ASSOC PROF GOLDBERG: I think the key risks that result from changes are malnutrition, dehydration and, as you were talking about, aspiration pneumonia. These happen for a variety of reasons because swallowing or eating and swallowing is quite a complex and enjoyable activity. When it works well for us we don't think about it too much, but there are lots of ways in which it can be disrupted for people with dementia.

30 MR GRAY: Thank you. I will ask now a series of panel questions and this, Commissioner, might take us up to lunch. Perhaps, in fact, it might be convenient for the Commission to rise now and I can address these questions - - -

35 COMMISSIONER TRACEY: Well, it's entirely a matter for you and the witnesses. If it's more convenient to sit on, I'm perfectly happy to do that. If the witnesses have luncheon commitments or things of that kind, we will come back at 2 o'clock.

40 MR GRAY: Well, perhaps if we could sit on for 15 minutes.

COMMISSIONER TRACEY: Yes.

MR GRAY: And then we will see how we go in the afternoon.

45 COMMISSIONER TRACEY: Very well.

MR GRAY: The format is that I will ask a question and direct it to two of the panel members or perhaps three of the panel members at a time. In connection with these questions, each of the panel members has been briefed with a set of factual assumptions which reflects what the counsel assisting team consider to be issues  
5 raised in the four case studies that the Royal Commission has heard during this Sydney hearing, but we haven't put those matters to the witnesses as factual findings, simply as de-identified assumptions.

10 Now, the first panel question I would like to direct to Professor Beattie and then to Professor Pond, we've heard that dementia causes progressive cognitive and functional decline. We've heard that it's not reversible and unless another health condition intrudes, it will lead to the end of the person's life. Against that context, what's the general approach or philosophy of care that's needed to deliver quality of life for a person living with dementia, and to deliver good care outcomes for people  
15 living with dementia in residential aged care in particular?

PROF BEATTIE: I would say that in contemporary practice, one of the most important things is the principles of dignity, that there is about 10 of them, and it has to do with dignity of care and that relates to being respectful of the person as an  
20 individual regardless of their diagnosis and the extent of the loss of independence that they might have. And those dignity principles cover things like zero tolerance for abuse, supporting the person to be able to enact the most personalised care that they can, you know, to support them to be able to do as much as they can for themselves. So you want to have a maximum level of independence and choice and  
25 control, and to help that person to express their needs and their preferences so that you're not delivering care that is what the staff want, but is what the person with dementia has indicated as best as they are able, and if they're not able, their support people and their family to do.

30 Certainly respecting their privacy, and helping people to maintain that confidence and their self-esteem in the face of deterioration. I think the other overarching philosophy is that of person-centred care and if I can just look up that paragraph – what I've said.

35 MR GRAY: You referred to person-centred care at paragraph 84 of your statement.

PROF BEATTIE: Paragraph 84, and I think this is really about enriching the environment within which a person is looked after and person-centred care was really first talked about by Kitwood in the mid-1990s. And it really points us all to  
40 the essential person who is within all of us and what is it that is unique about each one of us. And to understand people you have to understand communication. And you have to understand that nursing care, especially high quality nursing care, is built on the development of relationship, and a relationship that is reciprocal and in which you're able to do the things that help that person flourish and that's really the essence  
45 of person-centred care. People living with dementia are no different from us.

This could be us anytime in the future of our lives, and what we're all looking for in our life is the access to – to being appreciated by other people, to feel attached to other people, to experience comfort and warmth and inclusion, all those sorts of things, and to have a sense of who we are as a person. For people living with

5 dementia, there's a lot of threats to their personhood that happen across the journey which is their disease, and staff need to see and honour that essential person. And this is very hard sometimes in situations where you might be working with a person for a very short period of time or where people are, in fact, very severely impaired.

10 But it's still possible, even when people have very little language left and may only be able to communicate with you in terms of gesture or touch or those sorts of things, that people can share moments of connection and meaning and importance that give life a quality that's very, very important. And very meaningful. So talking about experiencing emotions like love and affection and sadness and joy and playfulness

15 and grief, whichever it is, and you can do that with touch and eye contact, and certainly with stillness and presence and very much within that framework of person-centred care.

MR GRAY: Has that become the norm yet or are you still calling for a paradigm shift in paragraph 11?

20

PROF BEATTIE: Well, I think that person-centred care philosophy is very well known in Australia, and I think most facilities that I know would certainly endorse that they have a person-centred approach to care. In our recent study of quality of

25 life of people living with dementia in residential aged care, what we found was that knowledge of person-centred care was very high at management level. It was somewhat lower at the level of the untrained – and cert III and IV level people, and that when you talk to people about person-centred care and what it actually means, they don't express a lot of hope for people living with dementia which is really

30 something that you think that they would, given that philosophy of person-centred care which is looking for that – the kernel of who a person is in every interaction that you have. So I would say that enactment is not where it needs to be.

MR GRAY: Professor Pond, can you comment from the GP's perspective?

35

PROF POND: Yes. I completely agree with everything that Professor Beattie said. I think it's probably not just the cert III and IVs, but also the GPs that need more dementia education, but in the context that we've got a lot of other things to concern ourselves about. I would like to illustrate with a very brief story. Because I think

40 this delivery of person-centred care can happen with the GP communicating with the nurse. So some years ago I was called to a facility because a resident that I was caring for was causing some disruption with the guitar player. The guitar player would come in once a week. He was quite an attractive man. She found him – she indicated to him that she found him attractive. He felt this was difficult to deal with

45 and he said that he would not come anymore unless something was done. And I was called quite urgently to the facility to do something.

Now, there was an implication, I felt, that a medication might do it. But what happened, in fact, was that I sat down with the enrolled nurse, who had done a course on behaviour management in dementia, and I had some understanding of this, and we talked about this lady who was – had been my patient for a couple of years and I  
5 knew her quite well and so did the nurse. And we discussed that, in fact, this lady enjoyed going out into the garden and having a cup of tea and a biscuit. Maybe not good for the oral health, but – and so what we decided to do was, at quarter to 11, just before the guitar player came, we – she would go out into the garden, be sat in a chair, have a cup of tea and a biscuit. Come 12 o'clock be brought back in for lunch.

10 It was – you know, it took 15 minutes for us to really discuss this and decide on it. I know it doesn't sound like complex medical care, but it actually needed two people to work it through and decide on that distraction technique. And it worked beautifully. And we had no more problems with the guitar player. And she didn't  
15 know that she was missing on the guitar player.

MR GRAY: And what a good example of an inter-professional or interdisciplinary approach.

20 PROF POND: Yes. Indeed. I think we need to work together.

MR GRAY: I will move to another panel question, this time directed, firstly, to Professor Goldberg and then to Professor Beattie. I want to ask about care for special populations in the dementia context, in particular with reference to the  
25 knowledge that you have about first nations issues in connection with dementia care. What are the particular issues that you've seen arising in care for the community of Circular Head or for Aboriginal and Torres Strait Islander communities more generally in the context of dementia? Do they have special needs in that regard?

30 ASSOC PROF GOLDBERG: The work that I'm involved in at Circular Head came about because the leader of this Aboriginal community was very concerned about what she perceived as the rise of communication behavioural issues, possibly related to dementia. So she wanted to know more about dementia and that's how we got together. But the beauty of our work together is because it has been community  
35 driven. And so the first part of that was to be invited to meet with folks and just to chat, to yarn about what their perceptions of dementia were, their experiences of dementia, not necessarily in that language, that terminology.

The Wicking Centre has dementia knowledge assessment scales that had not been  
40 used with Aboriginal communities before. And we asked if that would be appropriate to have people complete. And that actually was a very enjoyable exercise, because usually it's done individually; this time it was communal. People were able to ask for definitions of terms they may not have understood. The community leaders agreed that we didn't have to change the scale in any way for this  
45 particular project. So we heard from the community as to what they understood about dementia and their experiences.

And what came out was the importance of having initiatives take place within the community on country. They wanted care – to receive care from trained members of their community. And so that’s where we began. But I can’t stress enough that I think this has been working and been a value because it has been a community-led project.

MR GRAY: Thank you, Professor. Commissioner, the topic of aged care and the particular needs of first nations people will be examined in greater depth in future hearings of the Royal Commission, including in Broome in coming months. And I will ask Professor Beattie about this issue of dementia care in the context of special needs groups. You mention in your statement a lack of cultural competence in the RAC sector. Can you explain what you mean? You made specific reference not only to Aboriginal and Torres Strait Islander groups, but people who are linguistically and culturally diverse, LGBTQI.

PROF BEATTIE: Sure.

MR GRAY: What do you mean?

PROF BEATTIE: Well, respecting and valuing diversity is a very, very important part of being able to provide person-centred care. If you don’t understand who a person is and where they come from and their culture, their nationality, their immigrant experience, their religion, spirituality, this has a major influence on people’s preferences. And if you don’t understand that, you can’t provide preference driven care and people can’t flourish. And seemingly simple things, but very important things relate to this, like food, clothing, manners, language, who’s seen as family, celebrations, everyday routines. If you think about your own routine and what would happen if I didn’t know that well and had to look after you.

This matters particularly for people who have, as their dementia progress, their first language may not have been English, probably wasn’t English, and they begin to lose language. And there may or may not be somebody in the residential environment who understands their language. And it may be they don’t have family who even understand that language. If they’re fortunate, they do. But it’s incumbent upon us to make – to make a lot of effort to find out how to communicate with this person in their original language and to look at all the things that – pay attention to the details, look at the things that are part of this person’s persona and that make a difference in their identity. Yes.

And if you don’t know that, you can’t, for example, think about linking staff who might have the same language to be the carer of that person. You can’t assume and judge from what you see as – in the person and the way that they are presenting themselves in their environment, that this is something good, something bad or anything else. So you can’t come in with judgment. You have to offer that language support. And you have to watch for changes in people’s preferences that you might not see if you’re not aware of the things that mean something to them culturally. So I would say that.

MR GRAY: Is that familiarity of cultural setting increasingly important as cognition declines?

5 PROF BEATTIE: Absolutely. I think so. And I think when you – when you look at, for example, older GBI – lesbian, gay, bisexual, transgender and intersex people, I think this is where, in the same way that it matters with people from different backgrounds, maybe of whom are immigrants and people ATSI backgrounds, history matters – yes – very much. These people have been visible, they’ve been marginalised, they may have been imprisoned, they’ve been treated as ill. And some people have had medical procedures imposed on them to change their sexual preferences. There’s a loss of family and friends and sometimes of employment relating to that.

15 And, you know, dementia doesn’t necessarily change sexual orientation. And when people come into care many people in this current generation that we’re looking after have been confronted with discrimination which was pervasive across their lives and they have not necessarily disclosed their sexuality and their sexual preference. And I think it’s also difficult for them to talk about intimate relationships. We’ve made some progress socially in Australia with the new marriage laws.

20 But social connection with community is typically very different for these people, because family for them may be identified differently than it is in heteronormative relationships. And once you lose access to that, you lose access to safe and affirming space that you can connect with. And it can get to the point in the experience of these older peoples where substitute decision-making isn’t as simple as it sounds, because there can be conflict and violation of people’s rights, because somebody who’s involved in the family of that person doesn’t respect the relationship that they may have with a person who has been a long-time partner. And I think there has been some very significant work in Australia, for example, by Kathryn Barrett, in relation to drawing attention to those specific concerns. But they would be a few of them.

MR GRAY: Thank you. Is that a convenient time, Commissioner?

35 COMMISSIONER TRACEY: Yes, it is. The Commission will adjourn until 2.15.

**ADJOURNED** [1.20 pm]

40 **RESUMED** [2.18 pm]

COMMISSIONER TRACEY: Yes, Mr Gray.

45 MR GRAY: Thank you, Commissioner. Members of the panel, I want to direct some questions to you concerning scenario four of which you’ve been apprised. That was the scenario that involved various ways in which instructions in hospital

discharge referrals didn't get carried through into care planning. Now, if I could direct my first question on this to Professor Pond. Professor, could you please comment on the importance of accurate communication in the context of transitions of various kinds between acute, primary aged care, allied health, even shift  
5 handovers, or perhaps that's better addressed by Professor Beattie, but in any of those contexts if you could express your views about the importance of accurate communication and how that's best achieved?

10 PROF POND: Yes, well, I think it's enormously important to have this communication between the hospital and the residential facility, between shift – between the nursing staff and the GPs, and between shifts within the nursing staff too, although I won't touch on that more. Part of the reason is that, of course, people with dementia don't know necessarily and can't convey what is going on. So we absolutely rely on good communication to know the details of what happened in the  
15 previous shift, or in the previous facility or in the hospital. And another thing is that medications are often changed between hospital and the facility, and we're not necessarily – the GPs aren't necessarily apprised of this except via a discharge summary which may or may not arrive on time and which has probably been written by a junior medical officer in the hospital and which therefore doesn't contain much  
20 in the way of reasons why a medication has been changed and so on.

And so we're left playing catch-up, recharting medications and so on. And that brings me to another problem issue which is that we might sit in our general practice recharting medications on our software in the general practice but then that has to be  
25 conveyed to the facility and there's very poor intra-operability between the practices and the facility. So that often has to happen via a handwritten or printed out note. That's not very satisfactory.

30 MR GRAY: Professor Beattie, anything you wish to add from a nurse's perspective?

35 PROF BEATTIE: I would agree with Professor Pond that this is absolutely essential to the continuity of care for a person, and that, historically, nurses were very good at this and they were trained extremely well to do this and to always sight people when they came onto a shift, and make sure they could see everybody during the day and report backwards and forwards. With the pressure that we now have on staffing and skills mix it's not always the case that these things occur, and that makes transfers in the way that you're talking about much more problematic potentially.

40 MR GRAY: Professor Goldberg, in scenario four there were some particular issues around speech pathology directions that had been generated within the hospital. Any comments you would care to add with specific reference to the assumptions raised in scenario four with respect to dysphagia and so forth?

45 ASSOC PROF GOLDBERG: Well, I'm looking at paragraph 8 where it talks about full assistance with activities of daily life including eating and drinking, and the evidence shows us that full assistance for eating and drinking is a predictor for

aspiration pneumonia, so this is an instance where this person was clearly at risk of aspiration pneumonia and that risk seems to have been missed which is very unfortunate.

5 MR GRAY: Could I go to another question for the panel. This is a big question and  
it's raised by three of the scenarios of which you've been apprised: scenarios one,  
two and three. And it's the question of appropriate responses to behaviours that  
might be generated by neuropsychiatric conditions, or they might be generated by  
environmental matters. How best should the RACF respond to those matters, and  
10 what, if anything, is the place of what's sometimes called restrictive practices, both  
in their potential manifestation as pharmaceutical prescription and in their potential  
manifestation as physical restraint. So look, I will start with Professor Pond and I  
will ask you to comment, as you see fit with respect to any aspects of scenarios one,  
two or three: what is the appropriate way to care for people showing those  
15 neuropsychiatric symptoms that might be regarded as challenging behaviours?

PROF POND: So I think the first thing that's always needed is a full assessment.  
So I – I quite like the A, B, C assessment which is the antecedents, what brought the  
behaviour on, what happened prior to the behaviour, the behaviour itself and the  
20 consequences, whether it be good or bad for the resident. Obviously, a behaviour  
that results in rewards for the resident will probably be reinforced so you need to  
know about that. If it's very dangerous for the resident you need to act quite quickly  
and often the antecedents will – there are some quite common things that cause  
people with dementia to exhibit distress. Too much sensory overload, bright lights,  
25 crowds. That sort of thing can make people distressed.

There can be internal things. There was one in one of these scenarios a person  
clearly had some sort of post-traumatic stress disorder, remembering things – very  
unhappy things from earlier in life, and when those memories surfaced as they often  
30 do in residential care and may have been triggered by the fact that you are now not  
able to look after yourself and you're being washed and so on, as you were when you  
were young, then – then you may well go back to the sort of feelings and be  
overwhelmed by the sort of feelings that you had when you were young and being  
abused in some way. So – and it might be possible, once you've analysed that, to  
35 make some changes. For example, sometimes female patients don't like being  
bathed by a male nurse if they've had some sort of sexual abuse as a child, and they  
will respond much better if they're just – if a female nurse is scheduled to do that  
personal care. So it might be a simple thing.

40 I'm not, though – I'm sometimes accused of being a Pollyanna; it's not always that  
simple. The disease itself makes people exhibit behaviours. The brain fires off  
randomly sometimes. It's hard to work out what's going on. And sometimes these  
behaviours are very challenging to understand and difficult to manage without  
medication, and there's a place for medication. And furthermore, I think a GP and a  
45 nurse has a role to look after the other residents as well, and the other staff, and if the  
particular behaviour is causing injury, then that really needs to be taken very  
seriously. So there's a tension then between the human rights of that person with the

dementia and the right of the people that are caring for them or surrounding them to be free from harassment or injury, and that's always difficult to resolve.

5 MR GRAY: You mention a place for medication; what's the appropriate approach to issues of informed consent if not of the person in care because they may not be capable of making decisions, then in that case on the part of authorised representatives such as guardians or powers of attorney?

10 PROF POND: Well, legally, as GPs, we are meant to get informed consent for certain classes of medications, psychotropics, That includes antidepressants. And I think that ethically it's best for us to do so. But having said that, it's quite difficult to track down family members sometimes. Sometimes I don't know who the person with the enduring guardianship might be. I might have to ask my nursing colleagues. I might rely on my nursing colleagues to remind me or to check with me, "Have you  
15 actually got informed consent before I start handing this out?" So I think once again the partnership comes out. We were discussing this at lunchtime. So there's definitely a role for informed consent and we should be pursuing it as best we can.

20 And I would add that we have been specifically instructed that we are not to charge for any communication with a relative. We are not to be paid for that, and it can – one of the problems with working as a GP in residential aged care is lengthy conversations with relatives. I mean, it – common humanity would say that we should have those lengthy conversations but we don't get paid for them and they have to somehow be slotted into the rest of our lives. So that's very difficult and I  
25 think that really does need to be looked at.

MR GRAY: You haven't mentioned in your response to my question anything about physical restraint. Scenario one that was given to you did raise that issue. What, if any, role does physical restraint have in this complex equation?

30 PROF POND: Well, in scenario one there was a very nice little extract that the relative signed saying it would be used as a matter of last resort and for as short a time as possible. And I think maybe there is a role for some sort of physical restraint for as short a time as possible in some circumstances. I don't think, as GPs, we have  
35 been trained at all in how to authorise that. I think we need to reinforce and check on the amount of time that – just having a look at that, that scenario, with all those lengthy periods of time the person was restrained for.

40 In the facilities I've visited, we tend not to use lap bands. There are other sorts of ways of dealing with it, with reclining beds and so on that – that very comfortably restrain the person. But it's still a restraint and we still should be authorising it only as a last resort and only for as short a time as possible. And we should be checking on that.

45 MR GRAY: Does the GP have a role in giving a clinical view about what the outer boundaries can be, because I want to ask you if you look at scenario one and the sorts

of times involved, are there some risks without having an outer boundary on the aggregate times of restraint?

5 PROF POND: Absolutely. And so one of the things that happened in scenario one was that the patient became quite deconditioned. So – and that doesn't take very long when you're old. If you can't move around, there's an adage that we say, if you don't use it, you will lose it. And if you can't move around, you get muscle atrophy very quickly and then you become incapable of moving around yourself. So that is a very important risk of physical restraint, whether it's a lap band or even the more comfortable types of restraint. And that's where having a facility where people are allowed to move around and the built environment is designed to accommodate that, and the staffing levels are – is much better for people.

15 MR GRAY: Professor Beattie, I want to go to you now and ask you, from the nursing perspective and the personal care perspective, as well, if I can add that, what are the appropriate approaches that should be attempted to address scenarios of the kind raised by scenarios one, two and three and what, if any, role would any sort of restrictive practice have, and, if so, what kind?

20 PROF BEATTIE: Well, I think that you have to go back and do you have think about the environment of care, for starters, and to what extent the environment of care actually helps people feel comfortable, feel safe. And this has to do with the way in which care is organised, as well as what effect physical environment looks like and the opportunities it has for people to have quiet spaces, to be able to  
25 congregate, to have access to pleasant safe outdoor spaces, those sorts of things, so that there's a general sense of wellbeing that's created by environment. I think it was unclear in these scenarios what sort of environment was actually happening.

30 The one scenario that we do have the map for, there's a small place where people can congregate centrally and another place where they can go outside. And it's unclear whether those doors were open or close or those sorts of things, so you don't know. In relation to that person-centred approach that I talked about before, I think, going back to what Professor Pond said, the assessment of whatever you are seeing in this person in terms of changed behaviours and understanding and responding to those  
35 changed behaviours is to think about, first, what extent some of these things might have to do with unmet need. And pain is the first thing that comes immediately to people's minds. And, also, hunger, thirst, needing to go to the toilet, being tired, needing to sleep more.

40 But unrecognised, unrelieved pain is a major identified reason for discomfort, particularly in those residents who aren't able to communicate well, which happened quite quickly in a number – several of these cases. So you've talked about the A, B, C approach. I think there are sever other models, like the need-driven behaviour model and the progressively lowered stress threshold model that we teach people  
45 about, where you can look at unmet needs and you can also look at what level of stress is created by this person's behaviour for them. This – the person has to be central here, not the impact that whatever the person is doing has on the staff, but

what impact does it have on the person to be as discomforted as they are by what's happenings to them.

MR GRAY: Can I just - - -

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PROF POND: So – yes.

MR GRAY: - - - at that point just ask you, with specific reference to the ambulatory behaviour, in each of these three - - -

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PROF POND: Yes.

MR GRAY: - - - scenarios. You will remember the first scenario involved a man who had day/night sleep pattern reversal.

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PROF BEATTIE: He did, yes.

MR GRAY: The second involved a woman who had, in effect, escaped or absconded at one point from the relevant facility. And the third involved also wandering, in the sense – or ambulatory behaviour, in the sense that she had been observed to be intrusive into other people's rooms. I'm not certain if that is encompassed by your learning on ambulatory behaviour or not. But with specific reference to the impact of those ambulatory behaviours, what's the appropriate response? Do you categorise that the same way as some other potentially challenging behaviours? It doesn't appear on its face to be a risk to other people, for example.

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PROF BEATTIE: Well, I think this is where you have to look extremely closely at what a person is doing. And there are people who exhibit behaviour which is characterised by a lot of ambulation and some of that ambulation leads them to cross over into the private spaces of others or to decide that they want to leave, for all sorts of reasons – yes – some of which are absolutely perfectly reasonable and they can explain those to you.

30

Or to have this sleep/wake pattern of reversal, which is a very frequent disturbance in Alzheimer's disease in the case of this person in scenario one. And you need to look at the intensity and the frequency and the duration of that behaviour, because for some people it's very intense. You know, most of us don't walk 14,000, 16,000 steps a day. And a pedometer can tell you a lot about this. And if you're an older person having this type of issue and you can't, for example, stop walking and you can't, therefore, sit down and eat or drink a meal, you can't rest, you are having issues with being able to find your way around, which are a piece of this, and the environment is very confusing to you, it's a question of protecting a person from overactivity and the fatigue and the risk of falls, potentially, associated with that, dehydration associated with that.

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And these are the things that often go unnoticed, because where a person is engaged in a lot of walking behaviour, unless they do tend to do this intrusive piece of it, they may not get noticed, because nobody else is really involved in that. Yes? So you have to be very clear eyed and say, “What is happening for this person that is  
5 experiencing this and what are those unmet needs. And how much of this are we going to actually improve by doing something like restricting their movement. You know, which bits of this are the pieces of what we’re seeing that are likely to result in something that is going to be negative for that person?”

10 And I think it’s, to my mind, reasonably rare that you need any level of restraint like we’ve seen in scenario one, which I would think of as excessive. And had there been assessment much, much earlier, a number of the things that happened to the person described here might have been able to be avoided. Yes? This excessive walking is not benign. That’s what I’m trying to get across. But there’s ways of working with  
15 that person to assist them to be more interactive. You know, this particular person in scenario one had this – like I said, this sleep/wake disturbance and so they were up a lot at night. I didn’t see anywhere that they were given a full sleep interview and an interview and physical assessment around their sleeping history, so that, together with the family, they could have worked out what typically happens with this person.

20 There’s no evidence in the case study of, for example, a sleep diary, the use of any scales that evaluate sleep or scales that evaluate walking, for example, the revised Algate Wandering Scale. And I didn’t see any mention of any sleep – what we call sleep hygiene interventions, which have to do with reducing things like stimulants,  
25 like coffee and that sort of thing; increasing, if you can, the activity – providing a person is not so active already in terms of their step counts that they’re already tired from doing things; exposing people to bright light and to the outdoors and to natural light. So you’ve got light falling on your eyes, which we know is going to help with improving the regularity of circadian rhythm in some people, not in all people.  
30 Avoiding napping during the day. Perhaps using a white noise machine, comfortable places, darkness, quiet, very, very hard in these environments. Perhaps cutting back on evening liquids a little bit. And perhaps some settling things like massage, there’s a whole range of things that could have been done here alongside or before or in consideration of this.

35 MR GRAY: Thank you. Now, I want to direct some panel questions on the issue of immobility and inability to communicate readily which are matters raised in respect of scenario two and scenario four. Firstly, with respect to scenario four in particular, focusing on the care of a person who is immobile and unable to communicate readily  
40 with cognitive impairment, Professor Goldberg, are you able to make some comments about the swallowing and feeding issues raised by scenario four and what might have been an appropriate response in that scenario having regard to the person’s immobility and inability to communicate readily?

45 ASSOC PROF GOLDBERG: Yes, can I just comment on the communication issue part of this because following along from what Elizabeth was saying I think, particularly in this scenario, this person had hearing aids which weren’t used, and

there's such a pivotal importance if people can't hear, you know, it can be a big piece of why they are not behaving the way that people might want them to behave. And for older people, hearing loss sometimes comes with ageing so it's a really important thing if a person has hearing loss or if a person is showing signs of hearing loss that that be really looked into because that can make a big difference in terms of communication.

Just in terms of swallowing, the really important thing is to make sure – the more dependent the person is the more at risk they are for swallowing difficulties, because they're being fed by other people and other people who may not know quite how to feed them well and to give them sufficient timing, and to feed them appropriate foods and to stay with them. I think this is a big problem that I see where carers might have the best intentions in the world but they're constrained by tasks that they're asked to do and time. We see that a lot. We hear that a lot from carers that they would love to sit and spend more time with somebody as depicted in these scenarios but they can't. So I think that's what we have to change around.

MR GRAY: Thank you. Just staying with scenario four and going back to Professor Beattie for a minute, with respect to the pain management and pressure area management issues in that scenario, is there anything you would care to add to the more general comments you've made about appropriate communication, person-centred care and so forth?

PROF BEATTIE: I think the communication around the assessment of pain, I noted that the Abbey Pain Scale, using that Abbey Pain Scale to work out what was going on in a nonverbal person with dementia in this case was discontinued after four days. There doesn't seem to have been the type of engagement with the palliative care nurse that you would want to see early on in this situation, given that what had happened to this person before would tend to indicate that this – a palliative approach to care was necessary. I'm sorry, I missed the second part of that, so that - - -

MR GRAY: Well, it was pressure area management as well.

PROF BEATTIE: And the pressure area care, you would want to see a person in this situation have a pressure mattress and have other contemporary care routines relating to the care of wounds in this situation so that that type of pressure area that's a pressure sore that's developed didn't happen in the first place. Now, this is difficult in deconditioned people, but what you want to see is that whatever nutrition that can be done to support this, and Lyn will talk about this, is given, that pain medication and that palliative approach to care is well embedded and that hopefully by the judicious turning and movement of a person without causing additional pain you can prevent the development, or the exacerbation of that type of changes to the skin that we've seen here.

MR GRAY: Dr Foltyn, I want to ask you to comment on scenario two if I may. In connection with that, might I ask the operator to put up the Better Oral Health in Residential Care 2009 report at RCD.9999.0055.0027. And while that's coming up,

Dr Foltyn, could you please comment on scenario two and the particular oral and dental health issues that appear to have arisen in that scenario?

5 DR FOLTYN: With denture care, clearly there's not been a protocol that's been abided by through the – that person's journey. What we have got in the same document – I've actually brought the booklet along which is from the Australian Government Better Oral Health in Residential Care, it's got five pages on denture care.

10 MR GRAY: Yes.

DR FOLTYN: And the problem I have is that this came out in 2009; most residential aged care facilities don't know it exists. So the information is available but it's not being provided and therefore not passed down the line to the assistants in  
15 nursing that are providing the daily management for their residents.

MR GRAY: What can be done about that? What are your observations over your experience in the area as to why that's occurring and what can be done about it?

20 DR FOLTYN: The program came about in 2009 and there was an allocation of \$3 million towards oral health in residential aged care facilities. With the number of facilities that were around at that time, that translated to no more than about \$1000 which went to education of one representative from each residential aged care facility. Unfortunately, in Australia we have one of the highest turnover rates of staff  
25 in RACFs and consequently within a few years most that had done the training were no longer at that facility and that knowledge was lost, and the relationship between oral health and deterioration of residents was missed.

I mean, the booklet and the program covers areas like how to observe dry lips, and  
30 observe the tongue, floor of mouth, a measure of xerostomia or dry mouth itself, denture care; so it covered most aspects of denture care. It also provided a traffic light check list which was supposed to be done, and it enabled whoever was providing that assessment within the aged care facility to then notify a dentist if there was something tangible that needed a dentist to attend to. But that's all lost.

35

MR GRAY: You've expressed some concern about the Single Quality Framework that's going to commence on 1 July in this regard.

40 DR FOLTYN: I have. Well, with that, the accreditation guidelines, it's consumer-driven, however, the wording doesn't provide any guidance to how to address oral health. So it was – I picked through the – those guidelines in my evidence, and it doesn't leave anybody in an aged care facility with any understanding of how to provide for a person's oral health needs. I think there needs to be prescriptive documents and rather than reinvent and spend more money, I mean, we should be  
45 resurrecting what already exists.

ASSOC PROF GOLDBERG: Could I add something to that?

MR GRAY: Yes, and Professor Goldberg, I was going to ask you about the better oral health in residential care – I beg your pardon, Australia’s National Oral Health Plan 2015 to 2026. Operator, please bring up RCD.9999 - - -

5 ASSOC PROF GOLDBERG: Can I just make a comment about this, what we call the OHAT affectionately. In the study that’s in the testimony I gave we have been using this tool as a part of our screening measures and it has been used well by carers, personal carers. So just completely support what you were saying before exactly. What the carers wanted was increased confidence by working with a dentist  
10 or with a speech pathologist. Once that was done, though, they were quite happy to continue and we have some good results as a result of them using the OHAT tool.

MR GRAY: Professor Goldberg, could you just enlarge on the indications from the study that you refer to in your statement making the connection between improved  
15 in oral hygiene and better health outcomes, for example, with respect to respiratory matters?

ASSOC PROF GOLDBERG: The project was designed to reduce aspiration pneumonia risk. And the measure we used was documentation of chest infections,  
20 because aspiration pneumonia is generally not diagnosed in residential care; it’s diagnosed when somebody has actually gone to hospital and had tests taken. So, over time, we had a three month period of intervention based on evidence, two minutes of teeth cleaning and removal of dentures for cleaning each day. And we documented the number of chest infections. So six months before the study, it was  
25 19, during the study it was 13 and six months after the study it was seven. So we had a nice reduction, as a result, I think. We can’t say it’s a cause, but certainly associated with this inter-professional approach we used in these residential centres. And that gets back to your other question about the – Australia’s national oral health plan.

30 MR GRAY: I will just ask for that to come up.

ASSOC PROF GOLDBERG: Okay.

35 MR GRAY: That’s - - -

DR FOLTYN: Can I just - - -

MR GRAY: - - - RCD.9999.0053.0001. Please go to page 0017.  
40

DR FOLTYN: Can I add to that, as well, that in the United States several hospitals were involved in studies which also addressed aspiration pneumonia, but in a different context. They were getting a high level of deaths in intensive care through aspiration pneumonia. The tubing that goes into the lungs becomes caked in a bio  
45 burden. And it was determined the bio burden is actually coming from the oral cavity. So what a lot of hospitals did in intensive care was staff to provide cleaning,

swabbing the teeth. And they found the patients in intensive care stayed for a shorter period of time, they saved money and saved lives.

5 The disease is exactly the same in aged care facilities. Aspiration pneumonia is one of the leading causes of death in aged care facilities. And it requires cleaning teeth, cleaning dentures, as well. We've not talked about the bio burden that accumulates on dentures. They need to be removed and cleaned.

10 MR GRAY: Thank you. And this is, no doubt, part of the learning that's behind the St Vincent's Hospital Darlinghurst initiative in the swabbing of mouths before certain surgeries. Is that a similar issue?

15 DR FOLTYN: Not – St Vincent's isn't involved in that program. My home in residential care is through the Montefiore home.

MR GRAY: In your statement you mention a protocol at the hospital at which you are a visiting dental officer concerning the swabbing of mouths before surgery. Is that - - -

20 DR FOLTYN: Certain surgeries. But, I mean, that's part of removal of teeth. I mean, we would be certainly using disinfectants, iodine and other materials, prior to certain extractions, but it's not a formal process in intensive care.

25 MR GRAY: Thank you. Professor Goldberg, in your statement you refer to Australia's national oral health plan 2015 to 2026. What's the state of progress in implementation of the plan? If I ask the operator to go to 0077. Thank you.

30 ASSOC PROF GOLDBERG: What I was particularly interested in in this plan was the advocacy of an inter-professional team approach. This is something that I had a lot of experience with in the United States and what we've been trying to do here with some success, and I know Elizabeth talked about this earlier today. And it's different than interdisciplinary approaches where multiple professionals might still work side by side but in their own particular sphere. So inter-professional has its own definition by the World Health Organisation. And the nuance is important, because it's when people are working with one another in different professions and so learning about what each other can contribute.

40 MR GRAY: Thank you. Could I, just before wrapping up, address a brief question firstly to Professor Pond on impediments to access to primary and, if you can fit in, allied – also allied services in the RAC setting. What do you see as the key impediments, particularly to access to GP services?

45 PROF POND: Sorry. Just to clarify, an impediment to stop residents being seen by a GP?

MR GRAY: If not to stop, to disincentivised or make it difficult.

PROF POND: Okay. So I would probably divide those into a few different levels. It's – there are – there are just practical impediments to going to a facility. They're often at a distance from one's practice. There may be parking difficulties. And then, when you arrive there, if you arrive after you've finished seeing patients, the  
5 facility's doors are often locked, quite rightly so, but it may be hard to actually get in. And then, having got in, it may be hard to find a nurse or the resident that you've been called to see.

10 So – and all of that takes time. And that lead me to the next impediment, which is the remuneration. And, at the risk of sounding greedy, we do need to be paid for what we're doing. We don't get a salary as GPs. I'm fortunate that I get a salary from the university, but most GPs rely entirely on their income from actually seeing patients. And until we've actually seen a patient in the facility, we're not getting  
15 paid at all. And there is a call-out fee now, so I will take that back. There is a call-out fee now, a single call-out fee for actually going to the facility, which is good. But after that we get \$37.60 for seeing a patient for up to 20 minutes.

And you can well imagine that it might – you might be inclined to see as many patients as possible for perhaps a little bit less than 20 minutes. You can – you can  
20 get the same \$37.60 for spending six minutes to 10 minutes with them. So why would you spend 20 minutes with someone, especially when there isn't – it's hard to find a nurse and you don't really know what's going on, and they can't communicate with you and you're not paid to see the relatives? So you tend to – so that's an impediment to proper care by the GPs in the facility. And then, further up the chain,  
25 I think, is the really important need for better education for GPs on really, really complex care and particularly dementia.

MR GRAY: How often do you see interdisciplinary planning conferences between GPs; possibly geriatricians; allied health, who might be needed for the holistic care  
30 of a person, and nursing staff?

PROF POND: Very rarely. And they are, in fact, funded for us GPs, if not for all the others. And I have been present at a number of those in my time in residential aged care. And they're enormously helpful. And so that – those planning services,  
35 the case conferencing item numbers, could be used to facilitate much better communication. However, they do pay the GP, but they don't pay the facility or the other – or the geriatrician or the other allied health or the pharmacist to attend. They will come in their own time and unremunerated, as well. So this needs to be sorted, I think.

40 MR GRAY: Dr Foltyn, I will throw the issue to you. From a dentist's point of view, are there some impediments to proper access?

DR FOLTYN: Well, there are. And I just have to – something that Professor Pond said. A couple of things. On rewards, unfortunately, a lot of the rewards are sweet – sweets, lollies. Getting somebody to take their medication very often we find mixed with jam and placed in the mouth with no oral care available. Again, the comment

made about speaking to family members; we're in the same position, having to track down a family member. And very often it's by email correspondence wanting them to call back, but that can be lengthy and delayed.

5 And, from a dental perspective, because we're not funded at all by Medicare, in a dental – apart from the few public facilities that have vans or dental services visiting maybe once a year – to utilise dental services means somebody has got to pay for it. It has to be the patient or the family. And a lot of dentists report that families are reluctant to even ring them back, because dental services can be costly and there may  
10 be a few that their inheritance is going to dwindle. So we have to tackle that. And, case conferencing, I would love to be involved, but, again, it's unfunded. And, I agree, it's terribly important. It would be very good to have oral health input into case conferencing with some of the difficult patients in residential care. It just doesn't happen.

15 My big area of concern is that oral health is not part of ACAT, the aged care assessment team that provides the residential aged care or home care package. There's no – that's the perfect time to do an oral health assessment. Additionally, our medical GPs get paid under Medicare to do an aged care assessment when  
20 somebody is 75. And the fine print of the descriptor for the item codes that doctors use clearly indicate that the assessment is there to pick up on any systemic issue, any issue that may impact systemically, and clearly oral health can impact systemically, but our GPs don't know enough about the mouth to provide the level of oral health assessment that the person needs, and we should be receiving referrals at that time.

25 MR GRAY: Professor Goldberg, from the speech pathology perspective, any comments you would wish to add on these issues of access to services in residential aged care?

30 ASSOC PROF GOLDBERG: Well, clearly I would love to see more involvement of speech pathology and speech pathology involving preventive care, and I would hope that that will come. But flipping it around, we want to empower people who are providing the direct care and that's the personal carers, right, so that's what we've tried to do in our project and they've risen to the task quite well. And I  
35 wanted just to say that in screening for swallowing difficulties there are some evidence-based strategies now that somebody like a personal carer can easily be educated to use. A study just came out from Japan showing that rinsing, somebody's ability to rinse and spit out may be a good predictor of upcoming swallowing problems, so things like that we can work with people who are providing direct care  
40 while we advocate for other professionals to get involved.

MR GRAY: Thank you. Professor Beattie, I know that the nurses are present the whole time or they're meant to be present the whole time providing the care. It often falls to them to in effect coordinate the visits of primary care allied health care, do  
45 you have perspectives that you can provide on this issue of access to those additional health and allied health services in the residential aged care context?

PROF BEATTIE: I would agree with everything that has been said by others thus far. I think it is very difficult to bring everybody together in the same space to look at the overall holistic care of a person. And typically what happens is there will be separate conversations here and there and the nurse is the person who has to be the person who brings all these things together. Now, depending on that person's exposure to people with dementia, their training, their education, these sorts of things, they are better or not so well prepared to do that. So I think the idea of inter-professional education, particularly for the workforce in residential aged care is – would be a major step forward.

MR GRAY: Thank you very much. Commissioner, we will have to leave it at that point.

COMMISSIONER TRACEY: On behalf of the Commission, may I thank each of you for giving us your valuable time and your professional insights have been enormously helpful in forming the views of the Commission. In due course we're going to have to make recommendations about best practice with a view to seeking to ensure that on an ongoing basis the aged people in care, both in institutions and at home, are going to receive the very best possible care, and you really have provided us with the benchmarks against which we can measure those standards, and we're most grateful. Thank you very much. You're free to leave at your discretion, if you wish to stay and listen to some evidence this afternoon, you will be more than welcome.

<THE WITNESSES WITHDREW [3.04 pm]

MR GRAY: Commissioner, our next witness is the Commonwealth Medical Officer, Professor Brendan Murphy. While Professor Murphy is moving to the witness box, might I tender some of the documents that have not yet been tendered but were traversed during the panel evidence?

COMMISSIONER TRACEY: Yes.

MR GRAY: Commissioner, the first of those documents is Better Oral Health in Residential Care, RCD.999.0055.0027. I tender that document.

COMMISSIONER TRACEY: Yes. I will ask that that be called up so that I've got its full title. The document prepared by South Australian Health entitled Better Oral Health in Residential Care will be exhibit 3-53.

**EXHIBIT #3-53 DOCUMENT PREPARED BY SOUTH AUSTRALIAN HEALTH ENTITLED BETTER ORAL HEALTH IN RESIDENTIAL CARE (RCD.999.0055.0027)**

MR GRAY: Thank you. And the next is RCD.9999.0053.0001.

COMMISSIONER TRACEY: The Australian Government's national oral health plan document entitled Healthy Mouths, Healthy Lives will be exhibit 3-54.

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**EXHIBIT #3-54 AUSTRALIAN GOVERNMENT'S NATIONAL ORAL HEALTH PLAN DOCUMENT ENTITLED HEALTHY MOUTHS, HEALTHY LIVES (RCD.9999.0053.0001)**

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MR GRAY: Thank you, Commissioner.

MS RICHARDSON SC: Commissioner, if I might announce my appearance, my name is Richardson. I appear for the Commonwealth with my learned junior, MR ARNOTT.

15

COMMISSIONER TRACEY: Thank you, Ms Richardson.

20

**<BRENDAN FRANCIS MURPHY, AFFIRMED [3.07 pm]**

**<EXAMINATION BY MR GRAY**

25

MR GRAY: What is your full name?

PROF MURPHY: Brendan Francis Murphy.

30

MR GRAY: Have you made a statement for the Royal Commission?

PROF MURPHY: I have.

MR GRAY: Bring up WIT.0129.0001.0001. Professor, is that your statement dated 24 April 2019?

35

PROF MURPHY: It is.

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

40

PROF MURPHY: No.

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

45

PROF MURPHY: Yes.

MR GRAY: Thank you. I tender the statement.

COMMISSIONER TRACEY: Yes, the statement of Professor Brendan Francis Murphy dated 24 April 2019 will be exhibit 3-55.

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**EXHIBIT #3-55 STATEMENT OF PROFESSOR BRENDAN FRANCIS MURPHY DATED 24/04/2019 (WIT.0129.0001.0001)**

10

MR GRAY: Professor, you refer in paragraph 4 in the statement to those matters over which you have direct responsibility, and they include the Department's Office of Health Protection and the Health Workforce Division. In respect of the Health Workforce, does that include the aged care workforce?

15

PROF MURPHY: It had some – the principal role of the Health Workforce Division is more in the direct registered health care workforce, doctors, particularly where we have major control, but we have certainly – are involved in the Aged Care Workforce Strategy that the – in Department – in conjunction with the aged care divisions in the Department. So we have some involvement in the aged care workforce, but I've had a long personal interest in workforce so I've had some experience from previous life but in the Department of Health I don't have direct responsibility of the aged care workforce.

20

25 MR GRAY: Thank you. And Professor, is it fair to say your clinical background is in acute care, not aged care; is that right?

PROF MURPHY: Correct.

30 MR GRAY: Can I just ask, in terms of access to clinical aged care knowledge, is there any in-house access to knowledge of that kind within the Department at present?

35 PROF MURPHY: Certainly, we have a range of medical officers in the Department, many of whom have had some experience in primary care, some of whom are still practicing GPs who have worked in aged care. We have currently a geriatrician who is working with the Safety and Quality Commission as the acting chief clinical adviser, and the Department, I believe, intends to continue an ongoing involvement with that geriatrician in the future. So there are a number of – and there are clearly a number of people from a nursing background who have had experience in aged care working in the Department as well.

40

MR GRAY: Thank you. Professor, there were a number of matters raised in evidence yesterday from Mr Glenn Rees, the chair of Alzheimer's Disease International, and I don't wish to ask you about all of those matters. I understand there are others representing the Commonwealth who can answer many of them.

45

PROF MURPHY: Correct.

MR GRAY: There is one. I'm not certain that you know about it and, if you don't, just say so, of course. But on the question of data in relation to diagnosis – diagnoses  
5 of dementia in Australia, the Commission has heard evidence to the effect that there isn't any direct national data on that matter at present. Is that right?

PROF MURPHY: I'm probably not competent to answer. The Australian Institute of Health and Welfare does collect a lot of disease-specific data. I'm not aware that  
10 there is any consistent comprehensive register of the diagnosis of dementia, so that that – there may be some truth in that statement, but I would not want to make a comment on that without referring to the Institute of Health and Welfare, which reports that national dataset.

MR GRAY: All right. If that is right, as CMO, is that within the scope of your area and you would be concerned about that and wish to remedy it?

PROF MURPHY: Again, not directly. The data collection through the Institute of Health and Welfare is the responsibility of other executives, but my role as CMO  
20 broadly includes clinical advice to the whole Department. So I have involvement in data collection, quality registries and the like. And clearly my view is that the better data we have generally about health conditions in the country, the more we are able to respond to that. But as you – I think you probably heard in other evidence, the diagnosis of dementia is sometimes difficult and getting clear definitions are tricky.  
25 So I think it would be better to have – the better data we have would inform us better, absolutely.

MR GRAY: Another point Mr Rees has made, and I think I can ask you about this with some confidence, it was concerning the recommendations of the ACSQHC in  
30 the third Atlas of Health Care Variation, a document with which I understand you're familiar. Is that right?

PROF MURPHY: Correct. Correct.

MR GRAY: And I will just ask the operator to put that up. That's the general  
35 tender bundle, tab 75. There's an infographic on recommendations of the council in the third atlas in respect of the topic of the overuse of antipsychotics, a matter which you address in some depth in your statement. Mr Rees' point is that, in his view, the recent 2019 amending principles to the quality of care principles 2014 will fall far  
40 short of the recommendations of the council in the third atlas. If we bring up native page 275, please, we see there's an infographic outlining the recommendations. Operator, please bring up native page 275.

PROF MURPHY: I'm familiar with infographic, so I'm happy to respond if you  
45 proceed.

MR GRAY: Do you remember the content of the infographic?

PROF MURPHY: Yes. The content of the infographic and the content of their written recommendations are far broader than the principles. The principles are one – but one part of the response to this issue. Those principles are the part that can be implemented in a regulatory environment by putting requirements on the providers.

5 It's very clear to me in my expert advisory committee, which I'm sure we will talk about later, that regulation is but a part of the response to this. Many of the other recommendations in that infographic and in the Commission's recommendations are dealt with in the options paper of the expert clinical adviser committee that I convened and are actively being reviewed and worked on in the Department for

10 implementation in other forums. You cannot fix this problem or the problem of residential aged care more generally by simply by regulation alone.

MR GRAY: With respect to the Commission's recommendation for seeking informed consent, is the position outlined in your statement and indeed the position

15 of the advisory committee which you, in effect, convened recently, was the position there that informed consent should be sought, but that's a matter for the medical practitioner. Is that the point?

PROF MURPHY: It's very clearly a responsibility of the prescribing practitioner

20 who is undertaking the intervention, in effect, initiating intervention to get the informed consent. As – this is a general principle of good medical practice. And, obviously, in the context of a competent person it's pretty easy: you have the discussion with the person in front of you and consent is implied. But in the situation of an incompetent person, there is an – for whom a material clinical intervention is

25 being planned, it is clearly a responsibility under good medical practice of that medical practitioner to inform and get the, at least implied, consent of the substitute decision-maker. It's very clearly our position. But, unfortunately, it doesn't happen as well as it should in this area of medical practice, as in many other areas of medical

30 practice.

MR GRAY: Well, I will come in due course to some questions about the nexus between that issue and the responsibilities of a residential aged care facility-approved provider. I understand there are some difficult issues that the committee had to

35 grapple with there.

PROF MURPHY: Correct.

MR GRAY: And I will have some questions about them. Before I do that, just before leaving Mr Rees' points, another one he raised was that there should be a

40 mandatory minimum dementia training requirement for personal care attendants or personal care workers in aged care as a condition of – in effect, as a condition of registration.

PROF MURPHY: Well, I think it's important to note that personal care workers are

45 not a registered health profession at the moment. They're - - -

MR GRAY: I took him to be saying that perhaps they should be.

PROF MURPHY: Well, they – that’s a big question. There may be steps short of full AHPRA registration, which is a very complex and expensive process. The various – the public health ministers have considered steps sort short of that, you know, some sort of less onerous register. But I think, whether or not these workers  
5 are registered in some form, I have – and my committee was of no doubt that there should be a nationally minimum set of standards for training for personal care workers working in aged care and that minimum standard of training should include training in dementia. I don’t think – I think that’s clearly an issue that the aged care workforce strategy that is being developed in partnership with the sector and the  
10 Department will need to address. And I think that is an important gap in the system at the moment.

MR GRAY: Just putting Mr Rees’ views to one side, because I’m not certain that he went that far. He was saying it was important to have minimum mandatory  
15 dementia training. But as to how one would impose that, do you have any views as to how that might be done without a registration system?

PROF MURPHY: Well, it could be a requirement on providers that they can only employ people with a certain standard of qualification. And, using the existing  
20 qualifications, registration processes we have in the country, you could define the registered courses that people would have to have had qualifications from to be able to be employed in the facilities. So it’s possible without registration. Registration would be another way of dealing with it.

MR GRAY: Thank you. I’m going to ask you some questions about whether there has been access to clinical expertise in aged care and dementia, in particular in the period prior to the convening of the Aged Care Clinical Advisory Committee in February 2019, a matter that you go into in some detail. During the time you’ve been CMO, at least, prior to the convening of that committee, has there been access  
30 in the Department to clinical expertise in dementia?

PROF MURPHY: Yes. There has been – primarily it’s been external access. We’ve used a lot of external experts. There has been a lot of action happening over the last few years in addressing the issue, particularly the issue of psychotropic drug,  
35 antipsychotic drug prescribing. We’ve engaged external experts, we’ve funded external experts to conduct research projects, we’ve funded NPS MedicineWise to do some work. The Department funds the Australian Commission on Safety and Quality, which has done a lot of good work. And that work has fed back into the Department. So it’s not necessary to have employed within the Department expert  
40 geriatricians. We’ve had good access to those. I think you’re hearing from Professor Brodaty later this week. And he has been a long term expert adviser to the Department.

MR GRAY: Going to one of the key issues in that field, and one you’ve already adverted to, on the use of antipsychotics in particular, but also extending to the use of  
45 anxiolytics and benzodiazepine, in particular - - -

PROF MURPHY: Correct.

MR GRAY: - - - the recently convened committee expressed the view that the rate of prescription of those pharmaceuticals is considered to be too high by reference, in effect, to benefit versus risk; is that right?

PROF MURPHY: Absolutely correct.

MR GRAY: And perhaps we will just bring up the options paper that was generated by the Aged Care Clinical Advisory Committee. That's general tender bundle tab 107, please, operator. On the very first page, if we go past the ministerial briefing paper to the options paper. If we go two pages into the document, please. Thank you. On the very first page of the options paper itself there, in the first paragraph, there's an estimate given that there's only a small proportion, estimated at 10 per cent, of the current use that's clearly justified. Was there any data underlying that? Was that, essentially, anecdotal? What was that?

PROF MURPHY: That was a pretty anecdotal assessment from a group of experts in the field. I don't think there was any data to support that. The sense was that in their clinical experience you know, probably eight to nine out of 10 cases you probably didn't need and shouldn't be using those drugs. So it was merely an estimate, a guesstimate.

MR GRAY: Nevertheless, there's a fair amount of experience - - -

PROF MURPHY: There is, correct.

MR GRAY: - - - around that table, was there?

PROF MURPHY: Correct.

MR GRAY: I'm not saying it was actually a physical table; I'm not sure how it was convened.

PROF MURPHY: Well, it was a physical table on at least one occasion. Yes.

MR GRAY: Now, with respect to the reasons why, in effect, that rate of overuse and over-administration might be occurring, was one of the factors considered to be that there's pressure from care staff requesting pharmacological intervention, because of perceived or real workload issues in managing behaviourally disturbed residents?

PROF MURPHY: I think it was the committee had the views that that was one of the factors that care staff – not necessarily because of workload, but that was part of it, but felt that the symptoms were causing sometimes distress to the resident or sometimes to other residents. Sometimes families of residents have asked for interventions when they've found the behaviours disturbing. So, yes, clearly

requests from the facility staff were mentioned as a common reason for GPs being asked to prescribe drugs to modify behaviour.

5 MR GRAY: And the Commonwealth has provided under notice some emails around the preparatory steps in relation to this work and probably related work. I will ask the operator to go to tab 63, which is an email exchange that you were involved in. It also included Dr Murray. Was he at the new Aged Care Commission?

10 PROF MURPHY: He's the current acting – or he was the clinical adviser. There has been a permanent one appointed, but he's still engaged by the Department as an adviser.

15 MR GRAY: Thank you. And was this an email chain that you were involved in and that also included - - -

PROF MURPHY: I believe so, yes.

20 MR GRAY: - - - Dr Murray?

PROF MURPHY: Yes.

25 MR GRAY: And if we go to the third page, there's reference to this topic of requests from care staff relating to perceived workload issues. Beg your pardon. If we just come back to the – beg your pardon. If we come back to the page before that, please. I might come back to that. I seem to have lost the precise reference.

PROF MURPHY: Sure. Sure.

30 MR GRAY: Now, the committee didn't go into the question of physical restraint; is that right?

35 PROF MURPHY: The committee's brief was to look at the issue of chemical restraints ..... chemical restraint. That was the specific request of the Minister.

40 MR GRAY: Yes. Now, in your statement at paragraph 42, you refer to four initiatives that you regard as key, and those are matters that – what you regard as key in addressing the overuse of and misuse of psychotropic medications in residential aged care. And the first of those is a clinical governance framework, and you say that this requirement for clinical governance frameworks meeting certain descriptions is, in fact, already slated and has for some time been slated to commence on 1 July by way of amendment to the Quality of Care Principles.

45 PROF MURPHY: Yes.

MR GRAY: And in particular the new single framework standard 8 will go to this issue. You refer also to the decision-making tool of 2012 supporting a restraint-free

environment. Now, apart from those measures, what precisely is the clinical research or any other – what was the clinical research that you adverted to a minute ago that the Department has obtained around the issue of dementia management, dementia care and intervention on this issue of over-prescription and overuse of psychotropics, apart from the Single Quality Framework and the decision-making tool and the convening of the advisory committee, are you able to tell the Royal Commission what the actual additional research or work that has been obtained by the Department on psychotropics.

10 PROF MURPHY: Mostly, there's a large body of published literature on this topic and that was provided to the committee. Most of the committee were appraised of that literature and some – I mean, Professor Brodaty was part of our committee and he had written a lot of the Australian literature on the stuff. He has developed the framework of dementia management and he certainly briefed us extensively on that.  
15 There's much other literature. This is a – it's very important to note this is an international problem. Every high income country that has residential aged care facilities has been grappling with this for the last 20 years.

20 There's lots of international literature on interventions in the reduced reduction of psychotropic drugs in the US, the UK and Europe. So there's a vast amount of scientific literature. One of the challenges is by getting the implementation of what's clearly good practice into the clinical practice in the field.

25 MR GRAY: And what is it that will achieve that around the use of the multidisciplinary teams that you mention; what is to be done to encourage the use of multidisciplinary teams?

30 PROF MURPHY: Well, a lot of that is culture. I mean, I think – I was pleased to hear this morning about some of the facilities that are dementia-specific that are being developed, that the culture of the provider, the leadership, particularly the clinical nursing leadership of the facility, the training and education of all of the people but including the general practitioner. I think they do – there does have to be some potential facilitation of involvement of GPs and we've heard, I think, from the previous witnesses that GPs are time poor and like to be remunerated for their time and that's why I think case conferencing item numbers have been introduced, why there are flag fall item numbers, and the Commonwealth is looking more broadly in general practice at providing models of remuneration for GPs that don't depend on – solely on fee for service remuneration such as enrolment models that have been talked about in the last budget context and are being considered by governments at  
40 the moment.

45 So there's a vast range of measures that can go to promote a clinical governance environment. One of the options we looked at in the committee was also the model of embedding part-time pharmacists in aged care facilities to promote the clinical governance around medication more broadly, not just psychotropic medication. But, you know, from my experience, as you probably saw from my statement, I spent 11 years as CEO of a very large health service. The most important thing that defines

the care culture in any facility, be it aged care and acute or other is the culture and leadership, not so much the regulatory environment around it.

5 So that is, I think, the biggest challenge in this space and that's why, you know, you heard this morning from some people where there was a fantastic culture, and I'm sure you've heard from other witnesses about the difference between a good and a bad facility and the experience that residents and their families have had from a facility that's well run and well led with the right culture.

10 MR GRAY: In respect to that idea of the embedding of pharmacists in residential aged care facilities, is that the ACT pilot program?

15 PROF MURPHY: Yes, the ACT pilot. It was announced by the previous government before caretaker, it's still subject to the processes of caretaker and the election, but that was a pilot that was announced. The Department funded trials previously in Tasmania and the RedUSE trial and they've funded trials in New South Wales and the RedUSE trial particularly in Tasmania showed pretty good benefit from that model and so the AC – the whole of ACT trial is the one that's currently proposed, if that goes ahead, and then that will be with a view to looking at, is it  
20 something that we should roll out nation-wide.

MR GRAY: Was it evaluated in Tasmania?

25 PROF MURPHY: It was evaluated very well in Tasmania in the RedUSE trial with very good benefit.

MR GRAY: Did they include reduction of prescription of antipsychotics?

30 PROF MURPHY: Absolutely. Yes. Yes.

MR GRAY: The concern about the overuse of psychotropics, not only antipsychotics but also the benzodiazepines, that has been a feature of the health and aged care landscape for many years now, hasn't it?

35 PROF MURPHY: Probably for as long as 20 years.

40 MR GRAY: Yes. It might be thought that it has taken government some time to get around to including in a delegated instrument in the nature of a regulation some clear statement disapproving of the effect of restrictive practices and putting limitations around those practices. It hasn't yet happened. It's going to come into effect on 1 July. Why the delay?

45 PROF MURPHY: Well I think the previous standards, you know, could be interpreted to provide proper safe quality evidence-based care so there probably was a regulatory environment that wasn't as highly specific as this one. But again, I come to the point that this is only part of a solution. You cannot – it's very difficult to regulate at the minute level medical clinical practice. The best way to influence

the prescribing behaviour of general practitioners working in aged care is education and making – and cultural change, getting – making them aware of the fact that the prescription of these drugs is not beneficial. Most of the inappropriate prescribing is not done with malicious intent to restrain someone. It's done because the general practitioner believes it might help in the management of the symptoms, and that they're not fully aware of the adverse consequences.

Now, you might say why, after 20 years, is that not the case? Well, it's very difficult. I mean, if you look at another example that I put in my witness statement, I'm struggling with the problem – it's very different and not nearly as material at an individual level – of antibiotic resistance. You know, GPs in Australia are prescribing a lot of antibiotics for people with viral infections. It's causing serious problems with their antibiotic resistance, where we are struggling with a range of measures to convince them of the evidence to change their practice. And it takes a lot of time and a lot of education and a lot of measures to do it. You couldn't do it by regulation.

MR GRAY: Can I ask you about the national residential medical chart. Is that a document you know? I will ask for it - - -

PROF MURPHY: I know of it. I know that it exists. I wasn't involved in its production.

MR GRAY: It's promulgated in 2012.

PROF MURPHY: Yes.

MR GRAY: It's RCD.9999.0049.0290. Now, was this proposed – just while we wait for it to come up, I will just ask you a general question. Was it proposed as a – in effect, uniform medical chart form and mode of communication between pharmacists, medical practitioners and residential aged care facilities?

PROF MURPHY: I wasn't in this role at the time when it was done and I wasn't involved in it but I believe that that's the case but that's – I can't say that with any confidence, yes.

MR GRAY: Is there any attention being given to this, do you know, within the Department as a potentially useful tool for capturing information about prescription practices in the RAC setting as well as assisting in communication of medication decisions?

PROF MURPHY: Sure. I think one of the conclusions of the committee was that we do need to get good data at an individual facility level on the prescribing of psychotropic drugs, benzodiazepines and antipsychotics. And in some facilities where they have very good medication charts, electronic ones, that information is easily obtainable. And our view is that this should be something that every facility should have knowledge of and should – should be able to be publicly displayed to

their staff and potentially to their residents and their families, and that – and it should be benchmarked.

5 So I think there is very – one of the most powerful drivers to change, particularly for  
doctors, is benchmarking data that shows that you’re an outlier. Now, the trouble  
with this concept is that, as you probably heard from other evidence, that there are  
huge variations in the types of facilities. Some will – some with a very high  
prevalence of severely psychotic psychogeriatric patients will, obviously, need a  
higher rate of prescription, so you’ve got to look at it in the context of the facility.  
10 But I think shining a light on this practice, probably at the facility level, subject to  
review by the Commission, it would be the best way to achieve it, and also to get  
national data.

15 MR GRAY: Commissioner, I tender that document.

COMMISSIONER TRACEY: Yes. The national residential medication chart will be exhibit 3-56.

20 **EXHIBIT #3-56 NATIONAL RESIDENTIAL MEDICATION CHART  
(RCD.9999.0049.0290)**

25 MR GRAY: Professor Murphy, there’s also mentioned in the work of the advisory  
committee a thing called the RACF ID.

PROF MURPHY: Correct.

30 MR GRAY: Now, am I correct in understanding this to be an ID that is supposed to  
be used, at least in certain circumstances, perhaps where this chart is used, to identify  
the location at which a particular patient resides, if that place is an RACF - - -

PROF MURPHY: Correct.

35 MR GRAY: - - - when a PBS claim is made?

PROF MURPHY: Correct.

40 MR GRAY: And what’s the status of utilisation of the RACF ID in PBA claims?  
Do you know?

45 PROF MURPHY: Incomplete. It was the assessment that the committee was  
advised that there was not good compliance with that. And that is another body of  
work that the Department is looking at, to work particularly with the pharmacy  
profession and the Pharmacy Guild around how we can make that much more  
completely used. Because the data, we are advised, if you look at the data that’s

tagged as being residential aged care, it clearly doesn't match with what we would otherwise know to be used in residential aged care, so it's clearly incomplete.

5 MR GRAY: So let's get this straight. At present, is it the case that you are unable to tell from PBS data what the precise rate of prescribing is in the RACF context?

PROF MURPHY: Correct.

10 MR GRAY: And that's because of underutilisation of the RACF ID?

PROF MURPHY: Correct.

MR GRAY: And is that woefully underutilised or just a little bit underutilised?

15 PROF MURPHY: It's substantially underutilised, to the point where we couldn't get useful information out of it.

MR GRAY: All right. So, in amongst the background paper and data information that was provided to the committee, there were some figures concerning PBS  
20 prescription, but they weren't confined to the - - -

PROF MURPHY: They were not.

MR GRAY: - - - RACF setting.  
25

PROF MURPHY: They were not.

MR GRAY: All right. Now, this absence of data about the rate of prescribing in an RAC setting is a significant obstacle to making good policy, isn't it?  
30

PROF MURPHY: Well, I think you need to be aware there are some data. There are point prevalence data. There have been a number of academic studies where people have gone out to a significant large sample of residential aged care facilities and looked in detail at the data. So we have – there are published data that generally  
35 shows, you know, rates of the use of antipsychotics of around the low 20 per cent level. And that's fairly consistently. And similar for benzodiazepines. So we do have data, but what we don't have is – and, by looking at the global PBS data, we can see that there has been a decline, for example, in the use of drugs like risperidone over the last five years, but across the whole community, and one would assume that  
40 that would include residential aged care. But it's true that there is an absence of comprehensive data that we can monitor on an annual basis. Yes.

MR GRAY: The third Atlas published by the Commission, that actually looks into health care variation from area to area within Australia.  
45

PROF MURPHY: Correct.

MR GRAY: And although that did note the decline you just mentioned, it also noted increasing volatility from area to area about prescription rates of antipsychotics.

5 PROF MURPHY: Yes.

MR GRAY: Yes. So it isn't safe to say that, because there's a general national decline, that's necessarily reflective of a good outcome in a particular area. Is that a fair comment?

10

PROF MURPHY: No, you couldn't make an assumption about a particular area. I think we can safely say that generally we're making some progress. But I don't think anyone would deny the fact that we haven't made sufficient progress and we need to – that's the reason for this committee that the minister asked me to convene was his personal frustration with the slow progress.

15

MR GRAY: And, of course, the data that you referred to which is – which is reflecting that aggregated national decline is, of course, community based, as well as residential aged care data, because - - -

20

PROF MURPHY: It is, yes.

MR GRAY: - - - you've just said we can't single out - - -

25 PROF MURPHY: Yes.

MR GRAY: - - - the residential aged care prescribing rates.

PROF MURPHY: Correct. But I think if we're talking particularly for drugs prescribed for the management of behavioural symptoms of dementia, it's likely that the majority of that is in the residential aged care setting, but it does occur in other settings, as well.

30

MR GRAY: All right. Those studies that you mentioned that have provided some data, they are, I assume, the studies that have been referred to of 44 nursing homes in Sydney and so forth.

35

PROF MURPHY: Yes.

40 MR GRAY: They're groups of nursing homes.

PROF MURPHY: Yes.

MR GRAY: And they have some statistical significance, but they are samples.

45

PROF MURPHY: They are not uniform dataset across the whole country, no, but they're probably statistically relevant samples.

MR GRAY: What is being done to improve the data, particularly with respect to somehow enforcing the identification of the particular RAC setting when a claim is made on the PBS?

5 PROF MURPHY: As I said, we're at the moment – the aged care division, the Department and the pharmaceutical benefits division will be undertaking some discussions with the pharmacy profession to work out how to do that. There isn't a clear plan to do that at the moment, but that is certainly on the long list of work plans for things to be addressed that have come out of our expert advisory committee.

10

MR GRAY: Will one of the options be to, in effect, flag a particular person's Medicare number with entry into a residential aged care facility so that you can data match when a claim is made for that person on the PBS?

15 PROF MURPHY: That would be one way of doing it. There is a problem with data matching between PBS and Medicare data at the moment, in that our – the Parliament has made that illegal. So you would have to change legislation to do that, but that certainly would be possible.

20 MR GRAY: Were these measures to include compliance with this PBS requirement – at least a requirement in certain circumstances, perhaps where that chart is used, that requirement around RACF ID – were these measures commenced before January 2019 or are they - - -

25 PROF MURPHY: Yes. Yes. There was some – I can't remember the exact date, but it has been in place for some years. Yes.

MR GRAY: What was the cause, if you know it, of the convening of the round table that you referred to on 24 January which then led to the convening of the  
30 advisory committee?

PROF MURPHY: So in January, Minister Wyatt asked me to convene a meeting of clinical leaders from the colleges, the AMA, at Parliament House, and he expressed his personal distress at hearing some of the stories that he had heard in various fora  
35 late last year, and that he asked, you know, what could be done to accelerate progress, noting that there had been a lot of things happening over many years, but he felt that progress wasn't quick enough. And he wanted to look at regulatory options.

40 The committee – the advice that I and others gave him was that regulation was only part of the solution and that we needed to get all the clinical experts together and to come up with a range of options for consideration by government. He said, "Go ahead and do that and report to me as quickly as possible because this is a great concern to me", and that was the basis of convening the committee.

45

MR GRAY: So you've said the cause is what the Minister required and you don't know why the Minister required it.

PROF MURPHY: The Minister expressed at the time that he was concerned about some of the stories he had heard of people's experience with inappropriate use of psychotropic medications and he – he wanted action, that he was aware – knew there was action happening but he wanted to accelerate it. And that was what he – I can't, other than state what he told us.

MR GRAY: Yes. Thank you. I just want to ask you now, in a little more detail about PBS requirements and indications in relation to the most commonly prescribed antipsychotics, and you probably have this front of mind - - -

PROF MURPHY: I do.

MR GRAY: - - - but I certainly need to either refer to a background paper or my notes. But the three most commonly prescribed antipsychotics are quetiapine, olanzapine and risperidone; risperidone coming in after the first two, however it's only risperidone that is in effect authorised under the PBS to be prescribed at a cost that can be claimed under PBS with no doubt substantial public subsidy to address behavioural disturbances arising from neuropsychiatric symptoms or dementia, specifically Alzheimer's disease. That's right, isn't it?

PROF MURPHY: Yes, I mean, the PBS – it's very important to remember that the PBS is simply a financing mechanism. It's not a mechanism upon which the safe and quality use of medicines is in any way regulated. Prescribers can prescribe outside of the PBS. They do not have to get a government subsidy and, in fact, prescribing risperidone as a private prescription might cost only \$25 rather than \$6 for a pensioner, so it is – but it is true that the risperidone is the only antipsychotic for which the Pharmaceutical Benefits Advisory Committee has felt that the evidence is there to warrant public subsidy for that indication.

MR GRAY: I want to go back to something you said a short time ago to the effect that regulation alone won't achieve the necessary change in respect of this problem of the overprescribing and overuse of psychotropics. You've mentioned in the course of elaborating on the other things that had to be done, as well as putting a lot of emphasis on education you did also mention incentives by the MBS, and I want to suggest to you that governments should be using all available levers of policy to head in the direction of curbing the recognised overuse and over-administration, over-prescription of these pharmaceuticals.

PROF MURPHY: Yes.

MR GRAY: So I want to now ask you about, albeit that the PBS might be a financing instrument as you say, whether it could also be used to add to the armoury available to government to attempt to put a curb, an appropriate curb on the prescribing of these items?

PROF MURPHY: Yes.

MR GRAY: Risperidone is under a streamlined authority requirement in the PBS.

PROF MURPHY: Correct.

5 MR GRAY: Which means it can only be prescribed in a manner that it will be claimed under the PBS if certain requirements are met, and the prescribing health practitioner is in effect warranting that those are met - - -

PROF MURPHY: Correct.

10

MR GRAY: - - - when the claim is made.

PROF MURPHY: Correct.

15

MR GRAY: And streamlined means it can be done via a code but it still - - -

PROF MURPHY: It has the same authority as any - - -

MR GRAY: It has the same authority.

20

PROF MURPHY: Yes, yes.

MR GRAY: Now, if we can just display, please, operator, a reference to one of the risperidone items and one of the requirements. It's item 1842Y,

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RCD.9999.0049.0014. This is just one of the dosages and packs - - -

PROF MURPHY: Yes.

MR GRAY: - - - for risperidone. Thank you. Now, when you access information about this item it says:

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*Authority required –*

It's streamlined, and then there's a way of accessing the details of what's required to obtain that authority; that's right, isn't it, Professor?

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PROF MURPHY: Yes. Correct.

MR GRAY: And if we could please - - -

40

PROF MURPHY: I'm happy to take as – if you tell me what the - - -

MR GRAY: Yes.

45 PROF MURPHY: I'm very happy, you don't have to display that. I understand the information that sits behind the indication.

MR GRAY: Yes.

PROF MURPHY: Yes.

5 MR GRAY: I'm not certain if I have that to display, but doing the best you can, to the best of your recollection, there's a requirement in relation to attempting non-pharmacological approaches before the conditions are met - - -

PROF MURPHY: Correct.

10

MR GRAY: - - - for the prescribing of risperidone under authority under the PBS, correct?

PROF MURPHY: Correct.

15

MR GRAY: Now, what I'm getting to is can't the government in effect ensure, to a greater degree than appears to currently be the case, that the non-pharmacological approaches are, in fact, tried and that it's only in cases where those non-pharmacological approaches have failed that the GP will prescribe risperidone under the PBS?

20

PROF MURPHY: I think that would be a completely impractical way of doing it. You would have to – you would be looking at the individual prescribing practices of each individual doctor. Certainly, you can use aggregate information from the PBS as we've done, for example, in that antibiotic space to identify really high prescribers, and we're planning to do that with risperidone. We're going to identify those people who are prescribing what we think is an abnormal amount and we're going to send them letters from me, which generally have a pretty significant impact, saying that they should reflect on their practice and provide them educational material. But I don't think it would be practical to – at an individual doctor prescriber level on a funding mechanism. Legally the doctor is still able, all we could do is say, well, you can't claim the PBS subsidy on this. It's not illegal to prescribe the drug without those conditions being met.

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The authority around the safe – the quality use of medicine sits with the States and Territories, Drugs and Poisons Act. All we have – all we could say is, well – the only intervention we can say is 'we won't let you have a PBS provider number if you're misusing the PBS' but we couldn't stop people prescribing. So I don't think it's a practical proposition to use the PBS funding mechanism other than to – as a prompt, a data section, so if another prompt thing we're looking at in that streamlined authority, at the moment there is no block to someone using it for a second time. You will note in the conditions it says it should only be used for 12 weeks. They can go in and use it again after 12 weeks. What we're now going to do is put a block so that you can't use it a second time.

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If you want to use it beyond 12 weeks you have to go to a different authority, and that will put up a lot of red letter warnings saying that this is seriously aberrant

behaviour and it is only in certain circumstances you should consider this, and you should probably be consulting a geriatrician or a psychiatrist. So we can use the PBS as a tool but it's not a regulatory mechanism to stop unsafe practice, and I think – I don't think we should pursue it in that way.

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MR GRAY: Two things arise out of what you said, thank you, Professor. Just taking the second one first, on the 12 week point, would it also be possible in addition to those red flags before a repeat prescription is made after 12 weeks - - -

10 PROF MURPHY: Yes.

MR GRAY: - - - to require a consultation involving review such as – I believe they're called an RRMR.

15 PROF MURPHY: Medication – Residential Medication Review or you could have a phone authority which is a much more rigorous thing where you have to phone up someone and make the case.

MR GRAY: Could that be in effect linked to the - - -

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PROF MURPHY: It could be.

MR GRAY: To the requirement - - -

25 PROF MURPHY: But again - - -

MR GRAY: - - - to consider whether to make a further prescription after 12 weeks.

30 PROF MURPHY: Yes. The trouble, again, would be that – particularly for a drug like risperidone which is actually not all that expensive, if it was – if the barrier was too difficult people might just make private prescriptions, and there's nothing to stop them from doing that; the PBS can only stop the funding of those things. So we want to continue to have people use the PBS and to influence their behaviour, not by putting big regulatory blocks in front of it.

35

MR GRAY: Well, I suggest, even though risperidone may itself be privately purchasable, it's still a significant – the fact that there is a price difference is still – would still be very - - -

40 PROF MURPHY: Yes.

MR GRAY: - - - significant disincentive to people doing that and would certainly make them think twice and three times - - -

45 PROF MURPHY: It would be. Yes. It would be. But we don't want to – and, look, those options are certainly worthy of consideration. I just think it's important

to recognise that what we – that the PBS hasn't got an absolute control over the safe quality use of medicines.

5 MR GRAY: The other thing that arose out of your answer was the suggestion, that you've also referred to in your statement, of, in effect, targeted mail-outs to people identified as prescribing at a certain rate or above a certain rate.

PROF MURPHY: Correct.

10 MR GRAY: What's the progress of that proposal?

PROF MURPHY: Well, our behavioural economics unit, who did – you've probably seen in my witness statement the work we did on antibiotics, where we got a 12 per cent reduction in prescribing from these high prescribers over a six month  
15 period. So that – it's very carefully targeted interventions. I have to say that we also did it in narcotic prescribing. And the GPs don't like getting those letters and they often respond to me in fairly colourful ways. The – so that's being planned at the moment, but it takes some months to do it properly, to actually make sure we get the data.

20

One of the things that we would like to do before that is to do an analysis of the Medicare claiming data to find out those GPs – the subset of GPs who have a big aged care practice, because not all GPs work in residential aged care. But the Medicare items that they use are specific for aged care, so we are planning an  
25 analysis of the Medicare data to say that this 60 per cent or whatever – or 40 per cent of GPs frequently use Medicare item numbers in aged care. This is the group we will then look at their PBS prescribing data, knowing that it's their global prescribing data that we're looking at, not just their residential aged care data, but assuming that that's a reflection of what's happening in aged care and then doing some statistical  
30 analysis to make sure we're identifying outliers and then crafting a letter which takes account for the fact that there might be some legitimate reasons for people being outlier prescribers, so that we don't cause serious offence. So it takes some time, but it's definitely in the planning phase at the moment.

35 MR GRAY: If the problem is as widespread as the expert committee suggested, that is, it's actually only about 10 per cent of prescribing of the antipsychotics and the anxiolytics that is justified or clearly effective, if it's that widespread, then isn't it important to have an initiative that doesn't just address outliers, but really grapples with the problem at a more fundamental level?

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PROF MURPHY: Absolutely. And the outliers is only one of the strategies. The broader strategy is, again, to identify all of the doctors who work in aged care and target them with educational material. Now, that's very hard to get educational material to GPs, and we're looking with the college and other people at how we do  
45 that. We're thinking of even targeting them with short, sharp video messages from me that point out to them that, you know, – if they are continuing to prescribe in a manner which is not based by the evidence and if they're not getting proper informed

consent, they are exposing themselves significantly to allegations of inappropriate and unprofessional practice. So we want to push that method out there.

5 But we also need to do that in a context of the cultural change across residential aged care to implement in those facilities that don't have alternative strategies to manage dementia, because you can't just take away the drugs from a facility that doesn't have alternative strategies. So I think it's a broad cultural approach across the whole industry. But the outliers is only one part of the strategy.

10 MR GRAY: You refer in your statement to the PPID and the role of the PPID.

PROF MURPHY: Yes.

15 MR GRAY: Now, does that body conduct audits of whether medical practitioners are prescribing in accordance with the PBS indications for those drugs that they're claiming under PBS?

20 PROF MURPHY: It can do. Yes. It certainly analyses data and contacts them, looks at global data and will contact a practitioner or send one of the – provided we have doctors employed in that division who might – who are working for the Department who might go and see that doctor and say, "We noticed you're prescribing a very large amount of X drug. Can you explain to us why you do it and what are the reasons." And if there's not a good explanation, we would counsel them to reduce or change their practice and keep an eye on it. Yes.

25 MR GRAY: Has that body got estimates of the over-prescription of antipsychotics and anxiolytics?

30 PROF MURPHY: There hasn't been any specific work in the provider benefits division. Again, the provider benefits division has largely been focussed on expensive drugs and where the financing risk to the Commonwealth. Great. But it has done some work in public health areas such as the antibiotics, so we did that – that was an initiative that we've done there. And it had done some work in narcotics, as well. And there has certainly been some interventions in narcotics.

35 I think it's certainly possible that we could do some work for the provider benefits division. Again, we would want to be able to identify those doctors who are working principally in aged care, so that we know where we're going. It's important – I think you mentioned quetiapine earlier on as an antipsychotics. That's probably not used  
40 so much in residential aged care; it's probably used in younger people, again, inappropriately, probably not incompetent people, as it took on a role as an alternative sedative. And it was used by – inappropriately by a lot of GPs and there was a lot of intervention that was done to try and change that practice. So we're not  
45 just talking about residential aged care.

I was – as I’ve said before, I was CEO of a big health service and there was quite a lot of inappropriate prescribing of risperidone and other drugs for people with dementia in our acute wards. So it’s a broader problem than residential aged care.

5 MR GRAY: Thank you. You mentioned that really – this is in your statement. You mention professional services review, but I don’t take you to be seriously propounding a role for professional services review in curbing the over-prescription of these drugs. Is that right?

10 PROF MURPHY: I think if there was an extreme outlier, that’s certainly possible. But, again, a sanction that is only employable is a removable of the PBS prescriber number. If we saw a really serious outlier, someone who was behaving in a way that was clearly not consistent with good medical practice, we would go to the medical board. The medical board is the appropriate body to investigate and sanction  
15 unprofessional practice. So we might – the provider benefits division has on many occasions made referrals to the medical board.

MR GRAY: So, taking the medical boards around the country, and they’re assisted by AHPRA, has there been a medical board matter during the aegis of the  
20 cooperative scheme and AHPRA that has looked into over-prescription of antipsychotics or anxiolytics in a residential aged care setting, to your knowledge?

PROF MURPHY: I’m not aware of in a residential aged care – I don’t know. I haven’t actually asked the medical board that question. There has been a lot of  
25 medical board activity in the area of over-prescription of anxiolytics, of benzodiazepines. There are a lot of doctors whose prescribing practices have been significantly aberrant in that space. So that’s probably more in the drug-addicted population. And they have certainly 0 when their prescribing practice has been identified and they’ve been referred to the medical board, the medical board has  
30 certainly taken action in that place. I’m not aware of any action specifically in residential aged care.

MR GRAY: So it’s really that regime that you’re, what, principally relying on as the ultimate curb on over-prescription?  
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PROF MURPHY: No. What we’re relying on is cultural change and education. That is going to make the biggest difference. Those regulatory measures will help and they will prompt and they will guide, but you will not make material change in this, as any other area of medical practice, without the doctors being involved in that  
40 cultural change.

MR GRAY: I want to go back now to the work of the Aged Care Clinical Advisory Committee and the work that has, essentially, been done from 24 January around restrictive practices - - -  
45

PROF MURPHY: Yes.

MR GRAY: - - - in particular the use of psychotropics. You referred to one of the key things that you see as important alongside the new amending principles to the clinical governance framework and the embedding of pharmacists. And you've explained that. Thank you, professor. You also – this is also at paragraph 42. This is one of your four key points. You also mention a strong focus on non-pharmacological and person-centred approach and training. So, just taking that item, what's the progress there? What, in concrete terms, has been done or at least is planned with some discernible timeline to be done?

10 PROF MURPHY: So I think that comes to a range of things. It comes to the workforce strategy which is around getting that training in, as part of the basic qualification for workers. The aged care division who has carriage of the recommendations of our expert panel is certainly doing – pulling together educational material, a lot of which already exists in there; a lot of this work has  
15 been done in the past but it just hasn't been properly promulgated. I think you heard earlier about some education around dental care that hasn't been promulgated. So I think they're pulling together all that information. One of the – if the embedded pharmacists model would be a clear path for providing education in facilities, and there is also exploration of a look at the idea of a nurse champion where each facility  
20 might have a registered nurse that might have four hours a week or something that was not – not allocated to clinical work or management work which was principally around education for all staff around non-pharmacological measures.

But again, I think the – none of that will be as successful as it could be without that cultural change at the top and, again, I was delighted to be here this morning hearing some of those facilities that have a whole different approach to care where they design their facilities, the whole – the whole idea of the care is person-centred. So you – education is fine but you've got to have the commitment from the leadership of the aged care provider to make it work.

30 MR GRAY: In terms of what the Commonwealth Government can do, those training initiatives you mentioned including the four hours per week on an indicative basis for a nurse champion, do you have in mind that that will be government funded; there will be specific grants?

35 PROF MURPHY: That would be a decision for government. At the moment the committee's view was that the highest priority was probably the embedded pharmacist because there is a – there is available pharmacy workforce now and the trial results showed the benefit and there's a benefit well beyond psychotropic medication. There's a whole range of medication issues in aged care. So that was  
40 the option that was put to government and the previous government before the election or the current government, sorry, now in caretaker agreed to do – expand that Canberra trial. That – a decision to fund anything more would be a decision of the future government. The Department hasn't put an option around the nurse  
45 champion or other measures to government yet. They are still being considered as a response to the work of the Aged Care Advisory Committee.

MR GRAY: The third point you mention in paragraph 32 I think you've already covered. It's targeted notifications and education particularly using PBS data to target medical practitioners - - -

5 PROF MURPHY: Yes.

MR GRAY: - - - who have higher rates of prescription.

PROF MURPHY: Yes.

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MR GRAY: And you've given evidence now about the progress - - -

PROF MURPHY: Yes.

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MR GRAY: - - - and the approach that you have in mind on that matter. You responded to a question I had asked about seeking to take extra steps, perhaps via the PBAC, to impose more rigorous conditions and enforceable conditions as preconditions of the prescribing of certain of these pharmaceuticals in an RAC context, and you were sceptical about any such proposal. You said it would be impractical.

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PROF MURPHY: No, I said it could be of assistance, and that's why we wanted to tighten the requirement for a subsequent prescription of risperidone, but there are other antipsychotics what we call general benefits at the moment. They've been around for a long time, they have no PBS restrictions on them at all. Some drugs, if they become cheap enough, drop off the PBS altogether, so I think it – the PBS is a useful measure to assist but it is not the regulatory solution to this problem.

25

MR GRAY: Yes. The fourth matter you mention in paragraph 42 is good documentation requirements that will inform clinical governance. Now, I just want to ask you about a specific item of the work of the committee and the interaction between the Department and the committee. When Ms Laffan first proposed background information and a briefing for the advisory committee, one of the matters that she raised was that government was looking at a requirement that RACFs obtain informed consent.

35

PROF MURPHY: Correct.

MR GRAY: And I raised this at the beginning of this oral examination and you referred to that as something that's really very much within the purview and duties of the medical practitioner and not the RACF.

40

PROF MURPHY: Correct.

MR GRAY: So was the dynamic involved in the work of the committee like this: that Ms Laffan said this was a suggestion from government and then you and the committee responded by pointing out - - -

45

PROF MURPHY: Correct.

MR GRAY: - - - the difficulties - - -

5 PROF MURPHY: Correct.

MR GRAY: - - - in imposing any such obligation on the - - -

PROF MURPHY: On providers.

10

MR GRAY: - - - facility.

PROF MURPHY: Yes.

15 MR GRAY: Couldn't the facility nevertheless be referred to document the giving of informed consent as conveyed by the medical practitioner; wouldn't that be a good idea?

20 PROF MURPHY: It would be a good idea and that was in the options paper that was mentioned but it wasn't included in the principles because, again, it would be – the facility would then have to be assured from the practitioner that they had obtained informed consent and the ability to – wouldn't always be there to get that information. So what the committee advised was in the short term, the important thing was that the substitute decision-maker was aware that the prescription had been  
25 made, and that would be so that the facility has a requirement for them to inform the substitute decision-maker, either before or as soon as practicable afterwards that the prescription had been made and if then they hadn't had a discussion with the prescribing doctor that would lead to a subsequent – that would likely lead to a discussion between the substitute decision-maker and the doctor.

30

So that was a way of pushing this issue, but ultimately it's not acceptable for these doctors not to get informed consent. We must work with the doctors to make sure they understand their obligations and that they are exposing themselves to risk and sooner or later, someone is going to take to the medical board a doctor who has  
35 prescribed a drug without informed consent with adverse consequences.

MR GRAY: The Royal Commission is, of course, about the aged care system, not about medical practitioners - - -

40 PROF MURPHY: Correct.

MR GRAY: - - - per se, although there are connections with what medical practitioners do. The amending principles have to be directed to the obligations of approved providers.

45

PROF MURPHY: Providers, correct.

MR GRAY: But you would accept, wouldn't you, that at least requiring approved providers to inquire of general – inquire of prescribing medical practitioners where the consent has been obtained and then documenting that would be an appropriate measure to impose on approved providers.

5

PROF MURPHY: It could be. The question is the practicality of that and there was debate about that in the committee. So – but I think it's certainly an option for the future.

10 MR GRAY: Yes. If we could bring up the amending principles – look, I will move on from there.

PROF MURPHY: Sure.

15 MR GRAY: If we could bring up Professor Murphy's statement, please, at paragraph 49, you there open the topic of the PBS providing the Department with access to information that could be used to provide some level of oversight.

PROF MURPHY: Yes.

20

MR GRAY: Potential influence over prescribing practices. And I've been asking you questions around the issue.

PROF MURPHY: Correct.

25

MR GRAY: At paragraph 68 on page 0021, you refer to a point that you've just covered in your evidence as well to the effect that prescribers are not audited with regard to whether they hold evidence of, in effect, the compliance with the conditions in streamlined authority requirements.

30

PROF MURPHY: Yes.

MR GRAY: And you go on to say in 69 that:

35

*In the context of the broader issue identified by the committee –*

*that's the Aged Care - - -*

PROF MURPHY: Yes.

40

MR GRAY: - - - Clinical Advisory Committee:

45

*...on the overuse of psychotropics, auditing prescribers in respect of their prescribing practices and benchmarking their rates of prescribing with other residential care facilities could be an effective tool in reducing over-prescription or mis-prescription of psychotropics.*

Then you say:

*Those best placed to undertake this work are residential aged care facilities.*

5 PROF MURPHY: So the intention there was, as I mentioned before, that facilities should document their prescribing of antipsychotics and benzodiazepines in their facility and put that information on a noticeboard and have it as something that they use as a facility, as a KPI. And then if they have a number of GPs, some of whom are prescribing very differently to others, to put that information up there, as well.  
10 So an audit in the sense of data gathering at a local level, where there's immediate feedback and there can be action and it's a practical thing to do.

MR GRAY: Should that be reported to the Department?

15 PROF MURPHY: Well, I think the Aged Care Safety and Quality Commission is now undertaking as part of their regular reviews they're asking facilities for their rates of prescribing. So it is something that they will expect facilities to know.

MR GRAY: Ms Bolger will be giving evidence from the commission and she has  
20 said there are screening questions and have been since about January - - -

PROF MURPHY: Yes.

MR GRAY: - - - which include that question.  
25

PROF MURPHY: Yes.

MR GRAY: Is that what you're referring to?

30 PROF MURPHY: Yes. Yes. Yes.

MR GRAY: With respect to the practice that you've outlined and proposed, I suppose, in a sense, in paragraph 69 of your statement which we just read, how far advanced is that idea? Is it yet a proposal? Is it in any concrete form?  
35

PROF MURPHY: I don't - - -

MR GRAY: And does it have any timeline?

40 PROF MURPHY: It's still – it has been – the aged care divisions in the Department have been given all of the work of the committee and – and the Minister has – Minister said he wants to progress the lot. And so they are working – the first one that was completed was the pharmacy – embedded pharmacist trial. Other research groups, like looking at the Medicare data, is underway. So these are all being  
45 worked up in the division at the moment. I haven't seen – I'm not directly responsible for this work. It's happening in the aged care division, but I don't believe it is at a concrete proposal stage yet.

MR GRAY: Can I please put up tab 104. That's the Quality of Care Amendment Minimising Use of Restraints Principles, 2019. Now, if we go, please, to the definition of chemical restraint.

5 PROF MURPHY: Yes.

MR GRAY: If you just pardon me for a moment. That is on page 5199. Page 5199:

10 *Chemical restraint means a restraint that is or that involves the use of a medication or a chemical substance for the purpose of influencing a person's behaviour, other than medication prescribed for the treatment of or to enable treatment of a diagnosed mental disorder, a physical illness or a physical condition.*

15

Now, Professor Murphy, I understand that this definition has been drawn from the disability legislation.

PROF MURPHY: Correct.

20

MR GRAY: And NDIS-related.

PROF MURPHY: That's probably the least worst definition that there is.

25 MR GRAY: I just want to raise for you a point that I understand has been raised in the preparatory materials in relation to the generation of these principles, which is that the definition is one that has a very broad carve out, commencing with the words:

30 *Other than medication prescribed –*

Etcetera. I want to suggest to you that it's possible that a medical practitioner would say that even if, take, for example, risperidone, even if, for example, risperidone were prescribed for a purpose which included restraining or influencing that person's  
35 – the aged care recipient's behaviour, if that behaviour was in any way associated with dementia, it would always come within the concept of being treatment of a physical illness or a physical condition.

PROF MURPHY: Yes. I don't think the intention is there. I think it's meant that a  
40 medication is prescribed to actively treat a physical condition. I think I – I have some problem with this definition, I think, because, example, is psychotic behaviour or very aberrant behaviour as part of dementia probably crosses over from dementia, which is normally classed as a neurodegenerative condition, into a diagnosed mental disorder, as well. So I think the intention is pretty clear that in that – and the  
45 interpretation of that definition would not suggest that dementia, a neurodegenerative condition, would be covered by physical illness.

I think the intention is to say that unless someone has overt psychotic behaviour, as in a mental disorder, that you shouldn't be using those drugs, and that you certainly shouldn't be using them just for the purpose of influencing behaviour. But I agree that that definition is not perfect. I have not seen a good definition of chemical  
5 restraint. But certainly that's – our intention is to say, "You should not be using these drugs for someone who's wandering or verbalising or – unless they have at risk psychotic behaviour at the severe end of dementia disorder."

10 MR GRAY: Thank you. So, notwithstanding that dementia involves physiological changes - - -

PROF MURPHY: It does, yes.

15 MR GRAY: - - - to the brain and has in that senses physiological manifestations, it's not - - -

PROF MURPHY: Yes.

20 MR GRAY: - - - the intention that it's within the - - -

PROF MURPHY: Yes.

MR GRAY: - - - intended meaning of physical illness or physical condition.

25 PROF MURPHY: But it could be interpreted that way. I accept that that definition is by no means perfect.

30 MR GRAY: And you've just said, on the other side of the coin, there might be some who would say, "It's a mental disorder, but it's not intended that it be characterised as a mental disorder either."

35 PROF MURPHY: Correct. Correct. Correct. I think the intent is do not use drugs to control behaviour which is troubling or disruptive; use drugs to control symptoms which are putting the person at risk or severely distressing. That's the implication. And that's probably better conveyed by education, rather than a definition in a regulation.

40 MR GRAY: And one of the points that has been raised is whether, given that the definition is subject to that broad exception, is there a fear that the principles won't actually result or contribute to the reduction in prescribing rates? They will just legitimise the current levels of prescription of these psychotropics.

45 PROF MURPHY: Well, I would have – anyone reading that would suggest, I think – well, it depends on how they're interpreted by those looking, but I think the clear intention for the quality agency is as I described it. And that would – that would – the way they would interpret that – those regulations, so I don't believe that that's true.

MR GRAY: All right. I want to raise another point about the amending principles, if I can call them that. And that is that you've just referred to the agency. I'm sorry. You might have said the commission, but the - - -

5 PROF MURPHY: The quality - - -

MR GRAY: - - - Aged Care Quality and Safety Commission - - -

PROF MURPHY: Commission. Yes. Yes.

10

MR GRAY: - - - the new regulatory body, being the one - - -

PROF MURPHY: Yes. Yes.

15 MR GRAY: Being the one body that will be, in effect, charged with some sort of function around the compliance by facilities with these principles. Do you have any visibility on the extent to which the information is geared up to actually undertake that task? Is that within your responsibilities?

20 PROF MURPHY: It's not within my direct knowledge or responsibility. I've certainly had many meetings with Jan Anderson and with the interim clinical adviser, Michael Murray, and I know that they are absolutely committed to that path but I can't comment on how geared up they are at the moment.

25 MR GRAY: I will take that up with other witnesses, probably including Ms Bolger. The other point, if we just have the operator put the principles back up on the screen and if we could please display – if we could please display the next page. We see there the beginning of section 15G at the bottom of the page. That's the provision to which the work of the committee related; is that right?

30

PROF MURPHY: Yes.

MR GRAY: And while we see an obligation in 15G subsection (2)(a) that there is an obligation:

35

*if the consumer's representative has not been informed of the use of restraint, inform the consumer's representative as soon as possible after the restraint starts to be used.*

40 While we see that, we don't see an obligation to ensure that the medical practitioner has obtained consent before the restraint is used.

PROF MURPHY: Yes.

45 MR GRAY: Wouldn't it be improved by having a prospective requirement?

PROF MURPHY: A prospective requirement?

MR GRAY: Well, an antecedent requirement to obtain consent before – to ensure that the medical practitioner or nurse practitioner has obtained the consent before the restraint is applied.

5 PROF MURPHY: In theory, that could be an improvement. The challenge, again, would be – you might be putting the provider in a very difficult position if a medical practitioner has legally prescribed a drug and instructed it to be given, I think the facility could legitimately say, well, you haven't even – if it's on the phone they could say you haven't assessed the patient, you've got to come in and assess it. But I think if they've come in, assessed the patient – a resident and prescribed the drug and there's no good evidence that they have obtained informed consent, it puts the facility in a very difficult position to disobey a legal prescription. They could certainly have a discussion with the doctor, and I think we felt that was probably a step that made things too difficult for the provider.

15 MR GRAY: The Commission has heard evidence to the effect that probably more frequently than one would imagine, the prescribing medical practitioner is actually relying on information from nursing staff of the facility.

20 PROF MURPHY: Yes, yes.

MR GRAY: So, in fact, if anybody has any visibility on whether informed consent has been provided or can be implied, it's probably the nursing staff just as often as the medical practitioner. Now, in those circumstances - - -

25 PROF MURPHY: It's still the obligation of the medical practitioner as a matter of good medical practice to get that informed consent. I agree that the medical practitioners do rely on the information from the nursing staff but no medical practitioner should be embarking on a material intervention such as the prescribing of a psychotropic without personally assessing the resident – the patient in some clinical detail. That would not be good medical practice.

30 MR GRAY: Finally, Professor, I just ask you to look down the page to paragraph (c) of subsection (2), so that additional obligation on the approved provider:

35 *while the consumer is subject to the restraint regularly monitor the consumer for signs of distress or harm and provide information to the practitioner regarding use of the restraint.*

40 Now, what's missing there is any time limit or requirement to put a time limit on the use of the restraint. There's an ongoing obligation to monitor while the restraint is in place, but there's nothing to the effect of, in effect, ensuring that the medical practitioner is putting some sort of limit on the use of the restraint. Can you comment on that omission?

45 PROF MURPHY: Yes, again, I think we felt that that was best dealt with in educational approaches to say that – and that was our message to doctors that 12

weeks would be a maximum trial period and after that, you know, you should seriously review with a view to stopping the drug, but you might – you would need to review people before that, to see whether they’re, you know, early on in the past, so I don’t think you could – it was felt that it was practical to determine a time in that  
5 and that every medical practitioner, if they’ve started a drug which could have significant adverse effects, they should be reviewing the person every time they see them to determine that.

MR GRAY: Wouldn’t it have been an improvement on this obligation to require,  
10 say, take 12 weeks, require the approved provider to contact the medical practitioner and raise the need for review - - -

PROF MURPHY: Well, they will have to - - -

15 MR GRAY: - - - of the appropriateness of the restraint at a 12 week interval.

PROF MURPHY: Well, they have to re-prescribe it anyway at 12 weeks, so that will be a formal stop point. If we’re talking about the most commonly used drug in this residential aged care, risperidone, we will be putting in, hopefully in reasonable  
20 time, this new streamlined authority process which will effectively do that. It will put a stop point to make the practitioner reflect before re-prescribing so that will be achieved in part by that mechanism.

MR GRAY: Aren’t you making the very assumption in saying that that you were  
25 really accusing me of making a little earlier, there may be private prescribing - - -

PROF MURPHY: That is true, that is true.

MR GRAY: - - - there may be prescribing of agents other than risperidone.  
30

PROF MURPHY: It’s not a perfect control. I absolutely agree. Absolutely agree.

MR GRAY: And they might not be subject to the 12 week flags.

35 PROF MURPHY: Sure. That’s certainly true.

MR GRAY: Commissioner, I have no further questions.

COMMISSIONER TRACEY: Thank you very much for your evidence, Professor  
40 Murphy. It’s been very good to learn something from the inside. I’m sorry that you’ve been detained longer than was planned but as you will have no doubt gathered the Commission has just been receiving so much evidence in the last session that we’ve run over, but we’re very grateful to you for having come and given your evidence. Thank you very much.

45 PROF MURPHY: Thank you.

**<THE WITNESS WITHDREW**

**[4.32 pm]**

5 COMMISSIONER TRACEY: The Commission will adjourn until 10 o'clock  
tomorrow morning.

**MATTER ADJOURNED at 4.32 pm UNTIL WEDNESDAY, 15 MAY 2019**

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