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TRANSCRIPT OF PROCEEDINGS

O/N H-1037320

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

CAIRNS

10.05 AM, WEDNESDAY, 17 JULY 2019

Continued from 16.7.19

DAY 38

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

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Morning, Commissioners. This morning we're going to hear firstly from three witnesses from NewDirection, Bellmere. The first two witnesses are Ms Elsie Scott, who will be appearing today by a video link, in a panel with Ms Lisa Jones. And then following their evidence, we will hear from Ms Natasha Chadwick, who is the founder and CEO of NewDirection, Bellmere. So I call the first witness, Ms Elsie Marion Scott.

<ELSIE MARION SCOTT, SWORN [10.06 am]

MS HUTCHINS: I also call Mrs Lisa Jones.

<LISA JAYNE JONES, AFFIRMED [10.06 am]

MS HUTCHINS: Now, Ms Scott, could you please say for the record your full name.

MS SCOTT: Elsie Marion Scott.

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

MS SCOTT: Yes, I have.

MS HUTCHINS: Do you have a copy of that statement before you today?

MS SCOTT: Yes.

MS HUTCHINS: Do you wish to make any corrections or amendments to your statement?

MS SCOTT: No.

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

MS SCOTT: Absolutely.

MS HUTCHINS: I tender that statement of Ms Elsie Scott dated 5 July 2019.

COMMISSIONER TRACEY: Yes, the witness statement of Elsie Marion Scott dated 5 July 2019 will be Exhibit 6-51.

EXHIBIT #6-51 WITNESS STATEMENT OF ELSIE MARION SCOTT DATED 05/07/2019 (WIT.0266.0001.0001)

MS HUTCHINS: Thank you. Apologises, Commissioners, for the transcript, I note that that statement is WIT.0266.0001.0001. And, Ms Lisa Jones, you have also prepared a statement for the Commission?

MS JONES: Yes.

MS HUTCHINS: Could you please state your full name for the transcript.

MS JONES: Lisa Jayne Jones.

MS HUTCHINS: And the document reference number is WIT.0275.0001.0001. Did you have a copy of your statement before you - - -

MS JONES: I do.

MS HUTCHINS: - - - dated 2 July 2019?

MS JONES: Yes.

MS HUTCHINS: Have you had the opportunity to read over your statement before giving evidence today?

MS JONES: I have.

MS HUTCHINS: And do you wish to make any changes?

MS JONES: No.

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

MS JONES: Yes.

MS HUTCHINS: Thank you. I tender that statement.

COMMISSIONER TRACEY: Yes. The witness statement of Lisa Jayne Jones dated 2 July 2019 will be exhibit 6-52.

EXHIBIT #6-52 WITNESS STATEMENT OF LISA JAYNE JONES DATED 02/07/2019 (WIT.0275.0001.0001)

MS HUTCHINS: Now, Ms Scott, can you hear me okay?

MS SCOTT: Yes.

MS HUTCHINS: Thank you. So you're a resident at an aged care facility called NewDirection, Bellmere.

MS SCOTT: Yes, I am.

MS HUTCHINS: And is that where you are today?

MS SCOTT: Yes, it is.

MS HUTCHINS: And how old are you, Ms Scott?

MS SCOTT: 89.

MS HUTCHINS: And you've been in residential aged care for the last 26 years; is that correct?

MS SCOTT: That's right.

MS HUTCHINS: And where did you live prior to Bellmere?

MS SCOTT: I lived in Palmwoods Garden Village, Palmwoods, Queensland.

MS HUTCHINS: And was that a retirement village?

MS SCOTT: I beg your pardon?

MS HUTCHINS: Was that a retirement village?

MS SCOTT: Yes, it was.

MS HUTCHINS: And when was it that you moved to Bellmere?

MS SCOTT: On 4 January 2018.

MS HUTCHINS: And why was it that you moved from your retirement village to where you are now?

MS SCOTT: Because I was needing more care than I was able to get and I chose not to go into the residential care at Palmwoods.

MS HUTCHINS: Why was it that you chose not to go into that residential care?

MS SCOTT: Because I consider that NewDirection care is light years ahead of it.

MS HUTCHINS: In your witness statement, you note that you investigated a number of aged care facilities when you were making the decision about where to go. What were - - -

MS SCOTT: Yes, that - - -

MS HUTCHINS: - - - the types of things you were looking for?

MS SCOTT: I was looking for something that was one-on-one and really caring, not en masse but personal.

MS HUTCHINS: What were some of the features of the other facilities that you looked at, without naming any names of those facilities, but what were some of the features of the facilities that you saw that you did not like the look of?

MS SCOTT: A number of the facilities were like you had a hall and all the rooms were just off the hall, and often with a shared bathroom.

MS HUTCHINS: Thank you. Now, Mrs Jones, you are a carer at Bellmere.

MS JONES: I'm a House Companion leader.

MS HUTCHINS: A House Companion leader. And - - -

MS JONES: I was a carer.

MS HUTCHINS: You were previously a carer.

MS JONES: Yes.

MS HUTCHINS: And so do you see the role of a House Companion leader being different to that of a carer.

MS JONES: Absolutely, yes.

MS HUTCHINS: Yes. And why is that.

MS JONES: I organise all the other House Companions to go to certain houses to support our residents.

MS HUTCHINS: Yes. And you've been employed as a House Companion leader since May 2018?

MS JONES: No. I was a House Companion since May 2018.

MS HUTCHINS: Sorry, yes.

MS JONES: I've been a House Companion leader since January this year.

MS HUTCHINS: January this year. And prior to becoming a House Companion in May 2018, where did you work previously?

MS JONES: At a traditional aged care facility.

MS HUTCHINS: Yes. And what qualifications do you hold?

MS JONES: Just a Cert III in Aged Care.

MS HUTCHINS: And what was your experience like working in the more traditional aged care facilities you were at previously?

MS JONES: Well, I've worked in there for many years and it took a toll on me as a person because it was really sad and quite morbid to go there. And I felt that a lot of staff were there just for a wage; they didn't actually care.

MS HUTCHINS: And when you were in that previous role, were you encouraged to interact and get to know the residents?

MS JONES: No.

MS HUTCHINS: And why was that?

MS JONES: Not enough time.

MS HUTCHINS: Not enough time. As in not enough time to also fulfil the other duties?

MS JONES: Yes, because the staffing was quite tight and the timing, all of the duties that we had to do in the time allocated, there wasn't time and we were discouraged from developing relationships.

MS HUTCHINS: And so did you see, in your experience at the previous facilities, I guess, good care experiences being provided to the residents?

MS JONES: Some, yes, but a lot, no.

MS HUTCHINS: And what were some of the problems that you saw?

MS JONES: There's no genuine care in a lot of the staffing. And when there was issues and you took it to management, they just didn't address it.

MS HUTCHINS: When you took an issue to management, they wouldn't address it.

MS JONES: Yes.

MS HUTCHINS: And what were the type of issues that you might take to management?

MS JONES: Residents not being treated with respect and dignity.

MS HUTCHINS: Yes. And what were some of the ways you saw that occurring?

MS JONES: Rough handling, telling residents to wait because they were doing something else that was obviously not as important, not giving residents the time of day, really, like they didn't matter.

MS HUTCHINS: Yes. And these were the sorts of issues that, you have identified in your statement, made you want to leave the industry.

MS JONES: Yes, it took a toll on me as a person. Yes.

MS HUTCHINS: And so how was it that you came to be working at Bellmere?

MS JONES: Well, I decided that I would give up aged care once I had had enough. Then I saw an ad advertised by NewDirection and all their values were written down in the ad, five values that we go by. And they are my values as well, so I thought I would give it one last chance, and I was successful. And here I am.

MS HUTCHINS: Yes. And what were those values?

MS JONES: Respect, community, individuality – I've forgotten now, because – community, respect, individuality, relationships – I've forgotten the other one, sorry, on the spot.

MS HUTCHINS: It's okay. It's not a memory test. But you saw the ad and you thought they were in line with your values.

MS JONES: Yes, it was really person-centred care.

MS HUTCHINS: Yes.

MS JONES: And that is what I think it should be like.

MS HUTCHINS: Yes.

MS JONES: That's what attracted me to it.

MS HUTCHINS: And is it your experience that the facility has lived up to those values?

MS JONES: Yes. That's behind everything we do.

MS HUTCHINS: Yes. So, Ms Scott, at Bellmere, you've detailed in your witness statement that you live in individual houses; is that correct?

MS SCOTT: Yes. It's wonderful.

MS HUTCHINS: What's your house like?

MS SCOTT: We have seven residents and everyone has different problems. Like, the woman that lives next to me wouldn't know what day of the week it was. The man who lives the other side would sometimes know you and sometimes can't. And then there's Mary, who's in bed most of the time, but every week they get her out, take her out in the sunshine in her bed and make sure that she – if she can't eat, that she's fed. And then there's another two residents, a husband and wife. But in a house in Bellmere, NewDirection, a husband and wife must have two rooms: one as a bedroom and the other as a lounge room where they can still spend time together as a couple. It's just the loveliest place to live.

MS HUTCHINS: And is your house part of a bigger village?

MS SCOTT: Yes, there's 17 houses but all in the one facility and, like, we have a general store, we have a hairdresser, we have a craft centre, we have a café, we have a music studio complete with grand piano, and we have a wellness centre. And every aspect of caring is cared for personally.

MS HUTCHINS: And how do you find the staff at Bellmere?

MS SCOTT: Excellent. I've never had a problem with any of the staff, and it can depend on the day how some of the more dementia'd patients are. Sometimes they're really, really busy. But never once have I not had something that I needed – they would immediately help you.

MS HUTCHINS: What are the types of things that staff help you with?

MS SCOTT: Well, I'm vegetarian, and never once have I had a problem with food. I don't need help with much. It's just that I don't walk so well, and now I have a gopher that gets me around the place - - -

MS HUTCHINS: Yes.

MS SCOTT: - - - and into trouble sometimes. But, no, the staff are just so caring, and in the morning, there's usually one on and then another one at 7 – from 7 till 3, and then there's a second person comes on from 8 till 1.30. And then at 3 o'clock, the night staff come – the afternoon staff come on. But then overnight, the night staff, I've only ever had to ring my buzzer once, and within two minutes the night staff was in my room.

MS HUTCHINS: And so when you refer to the staff hours now, is that the House Companions?

MS SCOTT: Yes.

MS HUTCHINS: Yes. And so on a typical morning, Ms Scott, what would that involve for you? Do you have a set time that you wake up?

MS SCOTT: I do, because I like to be organised. But if you decide that you don't want to have breakfast until, say, 9 o'clock, that's no problem at all.

MS HUTCHINS: And how does the breakfast work? Do you choose what you want to eat yourself, or are there menus provided to you from which you can choose your food from?

MS SCOTT: You can choose what you want yourself.

MS HUTCHINS: And how do you – how does that work? Do you have a meeting with the House Companions where you discuss what it is that you're after or - - -

MS SCOTT: No, you just ask the House Companion what you want. Like, yesterday morning, one of the residents wanted scrambled eggs, and there's never a problem with anything with food.

MS HUTCHINS: And do the House Companions assist you with cooking?

MS SCOTT: I don't cook. I let them do that.

MS HUTCHINS: Yes. And then so after breakfast, say, what type of activities would you typically do in the facility?

MS SCOTT: I now work in the wellness centre as a receptionist – "work" in inverted commas – and get the residents up to have their treatments and things like that, which means it saves the physios and the podiatrists and that time, perhaps an hour a morning, which time is money.

MS HUTCHINS: Mrs Jones, what does a typical day look like in the life of a House Companion?

MS JONES: Every day is different. When you start a morning shift, you would go to the nurses' station and get handover from night House Companions and an RN if there's been a medical change or something. You would pick up your continence aid box and take it to the house with the medication folder, walk down to your house. Generally, there's residents waiting for you to arrive, waiting to start their day, see your face. Some residents have already made themselves a cup of tea. Some haven't; they wait for you to do it.

You would put the continence aids away in each resident's room and lock the box up in a storage room. We open the computer, see what's on the diary system for today and determine what resident needs to go where. They either have appointments outside or inside the facility. Then you would read progress notes to see what's happened. If you have been off for a couple of days on your weekend, you would update yourself to make sure you knew what was happening with each resident. You would go and check that each resident is safe right there and then, if they're having a sleep-in. Otherwise you would start breakfast for those that were up and ready for the day. And their routine is their routine. It's not up to a House Companion to determine that.

Some people like to have a shower at 10 o'clock. Some people like to have it at the crack of dawn. It's totally up to them, and their support plan will determine what level of support is required for each resident. So we go by that. The support plans that we have for each resident are very, very detailed. So if a resident is capable of still doing for themselves, they do for themselves and we support them when required. Once breakfast is over and all the morning cares are taken care of, we really just follow the residents, what they want to do. Some people would go to activities, some wouldn't.

MS HUTCHINS: Yes. And do the House Companions assist the residents with, say, showering and bathing - - -

MS JONES: Yes.

MS HUTCHINS: - - - if it's required?

MS JONES: Yes.

MS HUTCHINS: Yes. And what's the process in place if during the course of that care you notice an issue? How is it that, say, it might be escalated to a registered nurse?

MS JONES: Anything out of the ordinary or out of the normal for that resident is reported to the RN immediately.

MS HUTCHINS: And how many RNs are typically on duty?

MS JONES: Multiple RNs during the day; two on the floor and other RNs in different positions. There's always someone to call.

MS HUTCHINS: And do you receive any specific additional training when you become a staff member at Bellmere?

MS JONES: Lots of training. Lots of in-house training, and we have Dementia Training Australia come in and give training courses as well. Medication courses are done by an outside source. We have lots of other different training, continence

training. Our first day is our values. Our values is really important around everything we do, so that takes up a whole day of making sure that everyone has our values. We have manual handling. We have it – physically do manual handling. We have fire training and we have training on all our modern technology. Like, we wear Voceras. That's our communication device. We have training on how the bed sensors work and how the Sonata watches work that the residents wear and how ..... which is our mobile monitoring system, how to work all that and understand it.

MS HUTCHINS: And so you mentioned earlier today that you had previously done a certificate relating to care work in prior – you know, back before you worked here. How would you compare the level of knowledge that you have now after doing this additional training - - -

MS JONES: It's very - - -

MS HUTCHINS: - - - compared to what you knew previously?

MS JONES: Previously, it was mainly all online. At NewDirection Care it is mainly face-to-face, and we – there's always training available. We have our own training portal through Dementia Training Australia to help us understand more, and we've got training going on all the time.

MS HUTCHINS: And in terms of the subject matter of the training, are there things that you know now that, say, you can implement in the day-to-day care needs of the residents which, you know, you just weren't alive to before because - - -

MS JONES: Yes.

MS HUTCHINS: - - - of the lack of training?

MS JONES: NewDirection Care, we think outside the box, whereas traditional aged care, we – as a carer back then, we didn't have an input into the support plans for residents, whereas here it's a whole team that create the support plan which helps a House Companion support the resident the best they can.

MS HUTCHINS: Yes. And so what types of things will feed into that support plan?

MS JONES: Strategies. The level of care, the level of assistance that they need, any dietary requirements, any preferences, the history where they've come from, who they are as a person.

MS HUTCHINS: And is there any family involvement in that process?

MS JONES: Yes.

MS HUTCHINS: How is the family involved?

MS JONES: When they first come to NewDirection Care, they are given a history and that's part of the support plan.

MS HUTCHINS: And are family members able to visit residents when they want or - - -

MS JONES: Yes, absolutely.

MS HUTCHINS: Yes.

MS JONES: Anytime. The door is always open.

MS HUTCHINS: And, Ms Scott, you mentioned earlier some of the facilities that are available to you within the NewDirection village. What things are most important to you that you have access to that help you enjoy your day?

MS SCOTT: I think interacting with the carers and interacting with the staff generally.

MS HUTCHINS: And are you able to visit friends or have friends come and visit you?

MS SCOTT: Yes, I am. I have a gopher and I'm allowed to go out of the village on my gopher and I have – my next-of-kin lives just five minutes round the road, and I'm able to go round there and visit if I choose. And they're building a set of shops at the back of NewDirection Care, and when they're finished I will be able to go up there and do my own shopping, which is just so fabulous.

MS HUTCHINS: Yes. And what types of hobbies and interests do you have that you are able to do at the facility?

MS SCOTT: I love reading particularly, but I have always wanted to do calligraphy and I'm just in the process of taking that up again.

MS HUTCHINS: Thank you. And what do you think are some features of the care that you receive from the House Companions? I know you mentioned that you like that it's one-on-one. Have you noticed some differences in the way that they treat you which makes a difference to the enjoyment that you get in a day?

MS SCOTT: I think that the house carers treat everybody with respect and dignity. And no matter what level of dementia the residents are at, they are all treated fairly, equally, and the same amount of time is given to every resident.

MS HUTCHINS: Yes. And have you been able to make friends with other residents at the facility?

MS SCOTT: Yes, I have. There's currently another lady living in our house who is in her 50s and she has got Lewy Down syndrome, and we have become really good friends. She is going to be moving back to her home because now under the NDIS scheme you can get care there. But there will be somebody else come along, and it's the old adage: if you want a friend, be friendly.

MS HUTCHINS: Yes. Yes. And, Mrs Jones, what's the profile of Bellmere residents?

MS JONES: What – I don't understand that?

MS HUTCHINS: What type of people do you have living at Bellmere?

MS JONES: We have a big variety of people. We have people with dementia and people that don't have dementia. Some people are just ageing.

MS HUTCHINS: Yes. And do you have some younger people with disabilities?

MS JONES: We have quite a few of young onset dementia, yes.

MS HUTCHINS: Yes. And how are the clinical care needs of residents managed in the facility?

MS JONES: That would be up to the clinical team: RNs, physios, OTs.

MS HUTCHINS: Yes. And do you have services on-site which they can attend?

MS JONES: Yes, we've got a physio on-site and an OT on-site and – yes.

MS HUTCHINS: And are there any further activities in addition to the ones that Ms Scott has mentioned that are available for residents?

MS JONES: There's loads of activities every day. Sometimes I've seen on the activities calendar, there's sometimes nine a day. You can pick and choose what you want to attend, what you don't want to attend.

MS HUTCHINS: And what are some examples of the types of activities?

MS JONES: There's aqua classes. There's trivia in the cinema. There's outside gardening clubs. There is walking groups. Bingo is always a good one. There's so many. But there's also activities in the houses. Once you've done your morning cares as a House Companion, then you might have a bit of time before you start your lunch, you can sit down as a household around the dining table and do some activities.

MS HUTCHINS: Yes. In your witness statement, you note that, you know, some days there's challenges that you need to face. What are some examples of the types

of challenges that you face as a House Companion, and how is that you're able to work through those in your current environment?

MS JONES: Every day is different for a resident. So some days they find it more difficult, sometimes they don't. As a House Companion, you'll reach out for support. There's always support for extra staff to come and help you so you can dedicate more time to that person that's having a tough day, yes.

MS HUTCHINS: And what do you think are the key factors in your current workplace that make your role as a carer more enjoyable and more able to achieve better outcomes for the residents?

MS JONES: The relationships that we develop, very close relationships with our residents and their families. And as a team as well, we have good relationships with each other. So you don't feel like you're on your own. You – it's the whole community that you – support you to give the care that's required.

MS HUTCHINS: Yes. And how is it that you're able to, I guess, spend the time to make and build those relationships - - -

MS JONES: We have more time.

MS HUTCHINS: - - - amongst the demands of your job? Yes.

MS JONES: We have more time to develop those relationships, and we have a genuine desire to develop those relationships. And having a good relationship with a resident and having genuine empathy is – it always makes it easier for everyone.

MS HUTCHINS: Yes. And in your current role as a House Companion leader, you are involved in the hiring process; is that correct?

MS JONES: Yes.

MS HUTCHINS: And what are the types of things you look out for when you're hiring new staff?

MS JONES: Our five values must be behind everything that we do. It doesn't matter what qualifications you've got. We've got people working for us that are chefs. Some higher qualifications, but they want a more meaningful opportunity to give back. And if they meet our values, we go through a very detailed recruiting process and determine who's suitable to work for us.

MS HUTCHINS: Yes. So do I take it your evidence is that you find it more important the attitude of the person - - -

MS JONES: Yes.

MS HUTCHINS: - - - than the qualifications they come with? And have you had instances where you've had people that do have the qualifications but don't have the attitude that you're looking for?

MS JONES: Absolutely.

MS HUTCHINS: Yes. And what happens in those types of situations?

MS JONES: If you don't have our values, you can't remain working for NewDirection Care.

MS HUTCHINS: Yes. And do you find that people that have worked in previous aged care facilities might have particular habits or practices?

MS JONES: Yes. Yes. It's very difficult to change those habits if they've had experience in traditional aged care that they will be supported to change to NewDirection Care's way of thinking.

MS HUTCHINS: And what are some of the habits and practices that you see?

MS JONES: They don't take the time to sit down with residents and really get to know them. If you really get to know a resident, it's easier to look after them because you know how they work. It's very hard coming from traditional to NewDirection Care to change your way of thinking, but that's possible.

MS HUTCHINS: Ms Scott, in your witness statement, you detail your view that you think it's very important that there be a focus on individual needs. Is that correct? And what are the types of things that you would encourage aged care providers to focus on when they're looking after people in your position?

MS SCOTT: I think probably the answer is in current aged care, and I see two aspects of that: (1) that the present residential aged care is not relative and not functioning; and (2) may I respectfully suggest that the members of the Royal Commission personally visit NewDirection Care at Bellmere, Queensland. This facility is just an hour north of Brisbane. Here, you will see an aged care facility that takes aged care into the 21st century and beyond.

MS HUTCHINS: Thank you. And, Ms Jones, what do you think are some of the biggest areas that need improvement and change industry-wide in terms of better working conditions, both for carers and the experience for residents?

MS JONES: From a traditional point of view, once you've got your certificate III at a minimum, you can get a job anywhere. It's very evident that that doesn't work. At NewDirection Care, you don't need to have that certificate. You need to have our values and traditional care values – there's no such thing, in my experience. If you've got that certificate, you can get a job, and a lot of people, it is a wage for them and that's all they care about.

MS HUTCHINS: And in terms of the importance of leadership, clearly, you're in a situation now where you're, you know, happy with the state of the systems in place. How important do you think it is that attitude of leadership and the impact it has upon the workers, you know, from the top of the organisation down to the bottom?

MS JONES: It is extremely important because it does start from the top. If you feel listened to and supported to carry out your House Companion role, it makes it much easier and you feel valued and like you are actually making a positive difference.

MS HUTCHINS: Yes. And do you think the care needs of Bellmere residents are about the same as in other aged care facilities?

MS JONES: No. The care needs at NewDirection Care are far better quality than traditional aged care. Far better.

MS HUTCHINS: So you're saying the care provided to them is better quality?

MS JONES: Yes, absolutely, because we take - - -

MS HUTCHINS: Yes.

MS JONES: We've got the time.

MS HUTCHINS: Yes. And in terms of the acuity of the residents' needs, do you have a mix of high-needs or low-needs residents or - - -

MS JONES: Yes. Residents are placed in houses depending on their – who they are as a person and what they are used to.

MS HUTCHINS: And - - -

MS JONES: It doesn't matter what their diagnosis is.

MS HUTCHINS: Sure. And so when you compare the care needs of the residents you look after at the moment, is it a similar type of mix as what you've encountered in more traditional residential aged care facilities?

MS JONES: No. People with dementia in traditional aged care facilities are in a locked wing, whereas NewDirection Care, we all live together - - -

MS HUTCHINS: Yes.

MS JONES: - - - no matter what your diagnosis.

MS HUTCHINS: Yes. And in terms of how much care the residents are needing because, say, they might, you know, have a higher level of needs or a lower level of

needs, is that mix of needs of the resident similar at Bellmere to what it is in other residential aged care facilities you've worked in?

MS JONES: No, it's not. At NewDirection Care, we have a mix of any level of care in each house. It depends on who you are as a person. In traditional care, there's a lot of different wings. Like, one wing you would call high care and one wing you would call low care, whereas at NewDirection it's a mix of everything.

MS HUTCHINS: Yes. And do you observe that residents are able to mix well in that environment of different care needs of - - -

MS JONES: Yes.

MS HUTCHINS: - - - the residents they're in a house with?

MS JONES: Yes.

MS HUTCHINS: Yes. And because you said you organise houses by personality - - -

MS JONES: Yes.

MS HUTCHINS: Is that correct? How do you - - -

MS JONES: And their lifestyle.

MS HUTCHINS: And their lifestyle. So what are the types of things you look at to determine who might be well-suited - - -

MS JONES: Well - - -

MS HUTCHINS: - - - to be together in a house?

MS JONES: Who is that person? What have they done in their life? And what they're used to.

MS HUTCHINS: Yes, certainly. I have no further questions, Commissioners.

COMMISSIONER BRIGGS: Good morning, Ms Jones. I was wondering if I could go back to your evidence about the approaches and attitudes of staff in what you describe as the more traditional aged care setting, because we're particularly interested in how to assist staff move to a more Bellmere-like approach to working with residents. Have you got any suggestions about what might help them move from the older model to your newer model?

MS JONES: I think they need – a Certificate III is not the only qualification that you need. The attitude. We have a different attitude at NewDirection Care, and

you've either got it or you don't. And that's what we do when we recruit staff; we determine whether they are good enough to work for us or not.

COMMISSIONER BRIGGS: And that puts an onus on aged care providers to actually recruit effectively, doesn't it?

MS JONES: Yes.

COMMISSIONER BRIGGS: Yes, that's right. Thank you.

COMMISSIONER TRACEY: Ms Scott, it is wonderful to hear from a satisfied resident of an aged care facility. You have obviously chosen very well and you are very well looked after there. And we're very grateful to you for telling us your story. And no doubt Ms Jones is a major part of that happiness, and we thank her for her evidence and the way in which she caters for your needs on a one-to-one basis. It's very important. And we are looking, as Commissioner Briggs has just said, for models that will improve on the existing models of residential care, and this seems to be one that works very well. Thank you both for your evidence.

MS JONES: Thank you.

MS SCOTT: Thank you.

<THE WITNESSES WITHDREW [10.42 am]

COMMISSIONER TRACEY: The Commission will adjourn until 11.15.

ADJOURNED [10.42 am]

RESUMED [11.16 am]

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: I call the next witness, Ms Natasha Chadwick.

<NATASHA JANE CHADWICK, AFFIRMED [11.17 am]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Please state your full name for the transcript.

MS CHADWICK: My name is Natasha Jane Chadwick.

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

MS CHADWICK: I have, yes.

MS HUTCHINS: Operator, please bring up WIT.0172.0001.0001, the statement dated 17 June 2019. Have you had the opportunity to read your statement before giving your evidence today?

MS CHADWICK: Yes, I have.

MS HUTCHINS: And do you wish to make any changes?

MS CHADWICK: No.

MS HUTCHINS: To the best of your knowledge and belief are the statements true and correct?

MS CHADWICK: Yes, they are.

MS HUTCHINS: I tender that statement.

COMMISSIONER TRACEY: Yes. The witness statement of Natasha Jane Chadwick dated 17 June 2019 will be exhibit 6-53.

EXHIBIT #6-53 WITNESS STATEMENT OF NATASHA JANE CHADWICK DATED 17/06/2019 (WIT.0172.0001.0001)

MS HUTCHINS: Mrs Chadwick, you are the founder and CEO of NewDirection Bellmere Proprietary Limited.

MS CHADWICK: Yes, that's correct.

MS HUTCHINS: When was it founded?

MS CHADWICK: So I started the company itself in 2012 when we started the research but the operation of NewDirection Care at Bellmere didn't commence until 2017.

MS HUTCHINS: When you refer to the research what's that a reference to?

MS CHADWICK: So I've been in aged care for about 25 years now but 18 years into that career, I started research into what I thought, you know, was a change that we needed to make in aged care. And so I internationally researched what other people were doing and, you know, also what was happening here in Australia. I talked to a lot of residents and family members and that's pretty much the research that I refer to, as well as a lot of papers and – you know, from experts and so forth.

MS HUTCHINS: Yes. What was your prior experience working in the aged care industry.

MS CHADWICK: So my career started as a lobbyist, if you like, in the National Association of Nursing Homes and Private Hospitals and that was back in 1994. So as I said, I've been around for a while. And then I went on to create a consulting company. After the 1997 reforms I was heavily involved in the reforms back in 1997 and the new Aged Care Act. At one time I operated about 1500 aged care beds across Australia for church, charitable and private sector organisations. And then I founded a number of operations, if you like, in traditional aged care, and then my most recent is NewDirection Care.

MS HUTCHINS: And how many residents are at Bellmere?

MS CHADWICK: We have about 106 residents at the moment. There might be 107, yes.

MS HUTCHINS: Yes. And at your statement at paragraph 23, operator, if you could please pull out the table below that paragraph. Here you set out the profile of the residents that are at Bellmere. Could you describe for the Commission what is set out in this box and, you know, what the type of resident composition is.

MS CHADWICK: Yes, certainly. So in a traditional aged care environment you would typically see an average age of about 84 to 85. At NewDirection Care at Bellmere our average age is 77 and the reason for that is because we provide care and services, support services to older people who are frail, older people who are living with dementia, younger people living with young onset dementia as well as younger people with a disability.

MS HUTCHINS: Yes, Operator, please go to the next page. The box continues and there you see the figures in relation to the number of people with younger onset dementia being 19 per cent of the community.

MS CHADWICK: That's correct. So 19 per cent of the community and about a third of the people that are living with dementia in our community.

MS HUTCHINS: And what type of challenges do you face with this type of mix of people all living in one facility?

MS CHADWICK: Well, I mean, the point is they don't live in a facility, they live in a community. And so, you know, the challenges are quite different, I think, than what you have in traditional aged care. We are able to place residents based on their values. So younger people are living with younger people or they might be living with a mix of older and younger people. So the challenges aren't as extreme, I think, as what you might find in traditional aged care bringing a whole lot of people together from different ages.

MS HUTCHINS: Yes. Ms Jones just spoke briefly on the process in relation to determining the profile of residents that might be best placed together. Are you able to describe what that process is a bit further and how it is that you, I guess, match up residents who you think might be well suited to live with each other.

MS CHADWICK: Yes, sure. So some years ago when we first started and as part of our research, we developed a lifestyle survey. And that was done with one of the major research houses here in Australia and was tested widely across Australia. That survey is a 10-minute electronic survey that a resident or their family or someone close to them will complete if they're living with dementia, for example. And it really provides their world view, their base values, what matters to them in life.

You know, the kind of holidays that they might have gone on, the type of car they might have driven, whether they spend their money or they were savers, you know, what their political views were. And so out of that research we have identified that there are six lifestyles, if you like, here in Australia and that's across the board. It doesn't matter who you are, you fit into one of those lifestyles. And the life styles range from being a very traditional person, someone who follows the rules and right through to someone who is, you know, incredibly innovative or progressive and, you know, and is a breaker of rules, if you like.

MS HUTCHINS: You note in your witness statement that improving the quality of life and wellbeing of residents is the heart of what you seek to achieve at Bellmere. What are the features of Bellmere facility design that is directed at achieving this goal?

MS CHADWICK: So there are a number of factors but probably the biggest thing we have done and we talk about having turned aged care on its head. And we mean that in terms of pretty much everything that we do in aged care. So our building design, you know, instead of building a large nondescript institutional building or even an aged care hotel, if you like, what we have done is build a community. We call it a micro-town and the reason we use that descriptor, if you like, is because it's similar to, you know, a small town throughout Australia. We built all the services that would support a small community, you know, Elsie and Lisa spoke about them earlier. We have got a hairdressing salon, we've got a local shop, you know, a corner store, the wellness centre, the spa, you know, café and all of those services are available to the external community as well. They are not just for the people who live in the micro town.

And then, you know, the biggest difference is we then created homes. Houses for people to live in rather than a large building. So we have a main arterial road and off that arterial road we have six streets and on those six streets there are 17 houses and the houses operate like a mini care home. They only have seven people living in rather than 120 people under one roof, if you like. And they look just like your home or my home. You walk in the door, there's a front yard or a porch. You walk in the door; there's a lounge, dining room sitting areas, kitchen which is fully operational, a dining room and dining table for the residents to, you know, operate as a family, if you like. The biggest difference is probably there's seven bedrooms with an en suite. We don't have that typically in our homes. And then there's always a backyard, and on the backyard, there is a patio with a barbecue area and nice private places for people to be able to go to as well.

MS HUTCHINS: Yes. So you have described the home-like environment that you are able to provide for your residents. Do you find there is a tension between providing this home-like environment and being able to meet their individual clinical care needs?

MS CHADWICK: No, as I said, seven years of research went into this, you know, including piloting two homes, you know, well before we actually developed NewDirection Care at Bellmere. And so we dealt with all of those kinds of factors when we were developing the community. The reason I say no is because you can provide end-stage life in somebody's home. There's no reason why you can't do that, you know, in our homes and we do. We do it all the time. And, you know, one of the factors or the ways that we do that is by having a professional services team which is a clinical team that includes people like registered nurses, 24/7. We have occupational therapists, we have physiotherapists, we have allied health, GP, dental clinics and all of those people are available. And so we take the service into the home based on what that resident actually needs from us.

MS HUTCHINS: And at paragraph 49 of your statement, if you could please go to that, operator, you discuss the balancing of care needs while providing a home and you identify a number of factors at Bellmere that go towards achieving that balance. The first factor you point to is the use of what you call House Companions. Could you describe to us how you see the role of a House Companion and how you say it differs from, say, a care worker in the traditional residential aged care environment?

MS CHADWICK: Yes, look, the role is incredibly different. For one it's multi-factorial, if you like, it's multi-functional. So our House Companions, the whole part of their role is about building a relationship with their residents and gaining trust so that they can then provide individual services. House Companions are, you know, trained and provide services that pretty much run the household, if you like, in conjunction with the resident. So they menu plan, they've all been trained in nutrition and in balancing a diet if you like. So they menu plan with residents. They actually do the cooking. So they're trained in cooking as well and using equipment.

MS HUTCHINS: Who is that training provided by?

MS CHADWICK: It depends. We have a relationship with TAFE and they do some of our training and we also do training in-house. As Lisa mentioned, some of our staff include qualified chefs so we utilise their experience as well and our dietitian is involved in making sure that the House Companions understand nutritional requirements and what kind of meals over a week should be provided. So for example not too many pasta meals. You know, you have certain proteins and all of those things.

MS HUTCHINS: Yes. And are there any other qualifications that your House Companions will generally have?

MS CHADWICK: So they are all medication certified so they are all capable of providing or administering medication that is packed for residents. Any unpacked medication or schedule 8 drugs are provided by registered nurses so they're only giving the pack medication. They're also all food safety qualified. So, you know, even in traditional aged care people who work as a kitchen hand might have only done a few hours of training. Our team members do, you know, a full day and then they are constantly competency'd as well. So they are all food safety supervisor trained.

MS HUTCHINS: Generally, what clinical and personal care needs of the residents do the House Companions assist with?

MS CHADWICK: So their role is around personal care. We have a clinical team that look after the clinical care needs. However, you know, so it's the usual things around personal hygiene, you know, assisting someone to have a shower. It might be supervising, it might be, you know, assisting them to go to the toilet, making sure that they're eating their meals, you know, all of those personal requirements for residents. And from a clinical perspective it's about understanding what is happening with each of their residents that they're providing support to so that they can call on a registered nurse when they believe that something is changing with that person that someone needs to look at further.

MS HUTCHINS: Yes. And does the House Companion approach that you've implemented require higher numbers of staff than what is seen in a traditional model style residential aged care facility?

MS CHADWICK: It's a really interesting question and it's one that I get quite often. It really doesn't, you know, in a typical aged care environment of 120 places, you would see on the, you know, the numbers of staff – sorry – in that environment of about 120 to 130. And we have the same. We just use the staff – we utilise them in a different way. So in traditional aged care, everything is delineated. It's focused around the task. So I'm a kitchen hand, I'm a chef. I'm a cleaner. I work in the laundry. You know, I provide care. And it's very structured delineated task-focused role. As you can see with our House Companion, they do all of those things in a house with seven people only.

MS HUTCHINS: Back to the factors that you've identified for balancing the care needs or providing a home, the second factor that you identify is dignity of risk. And you say at Bellmere, "We believe in dignity of risk." What do you understand that term to mean?

MS CHADWICK: So for me it's about being able to continue to live the life that you've always lived, you know, and not have someone stopping you from taking the risks that you've always taken as an individual. So, you know, some of the things, I mean, Elsie herself spoke about how she goes outside on a gopher and that's five minutes down the road. That's near a main road, all of those sorts of things. We could take the view of, "No, Elsie, you are here. You are under our care. We don't want you to do that." But instead we look at how can we actually support you to continue to take those, you know, daily risks that you would have taken in your life anyhow.

So, you know, it might be as simple as someone who wants to continue smoking, you know. Many aged care facilities don't allow that. That's not up to us to judge. I believe, you know, if you are allowing someone to live their life, that's part of their life. And so it's important then how do we support that person to actually achieve that without putting the rest of the community at risk.

MS HUTCHINS: Yes. Another factor that you mention is the access to health services. You touched briefly before on the fact that you've got a whole clinical services team.

MS CHADWICK: Yes.

MS HUTCHINS: How does that work on site?

MS CHADWICK: So we have a wellness centre and in the wellness centre we have, you know, OT, physio, aides and exercise physiologist. We also have a dental clinic as well as a GP clinic. So we have rooms that are set up for those people. And then our clinical team of registered nurses work upstairs in the administration area so that they can oversight the whole community, if you like.

And they also have access to a bank of screens that have all the CCTV on them so that they're able to oversight residents from that perspective as well. In terms of health services, well, we operate on a diary system and I think that it was mentioned earlier. So if a resident has a doctor's appointment we are able to get them up to the GP clinic so that the GP can then be very effective in the way that they run their services.

MS HUTCHINS: In your facility, who is responsible for medication review?

MS CHADWICK: So medication review is undertaken in conjunction with the team, essentially. So it's a clinical team, GP, it might include our RMMR, the

people that actually review our medications separately is a separate pharmacist and also our pharmacy.

MS HUTCHINS: Yes, and what is the regular intervals of medication reviews?

MS CHADWICK: So, well, it depends on, you know, the resident. Everything is incredibly individualised. So a GP might – and one of the things we also do is we have a dedicated registered nurse for our GP clinic. So every time the GP makes changes to medication in conjunction with the resident or in discussion, all of those things are immediately acted upon that day following that clinic. And then if we're looking to review medications, then we will bring the whole team together to do that, at least on a monthly basis, but, you know, more often depending on the person.

MS HUTCHINS: Yes. And the Commission has heard, during the course of its hearings about evidence regarding challenges that many facilities face with the interface between hospitals and other parts of the health care system. How does Bellmere seek to address these types of issues?

MS CHADWICK: So we have a really strong working relationship with the local services, including Caboolture Hospital and also Prince Charles and the Redcliffe Hospital. So we have done that by working really hard to have access to the RADAR team that operates out of Caboolture Hospital. And it means that we are able to – you know, if someone – if we know that a particular resident has a particular behavioural increase, if you like, or an acute episode we know that they need to go to a CAM unit, for example.

We don't – we make sure that we contact the RADAR team and they take them through that process so that they're not languishing in a local hospital, if you like, where no one actually knows what to do with them. They're directed straight to the specialist service that they need. And part of that network, if you like, is because our professional services leader, Dr Judy McCrow, is very well recognised as a delirium and dementia expert and has access to many of those people as colleagues. And so we have made it really – you know, made sure that we manage that network.

MS HUTCHINS: And in terms of the staff at your community more broadly than just the House Companions who we have already spoken about, what observations can you make about the adequacy of training when staff first join your organisation?

MS CHADWICK: So I mean, it depends. We have, you know, people come to us, many of them that have never worked in aged care before, and so if you are talking about someone like that it's significant training, not just in the job but in actually our values and then understanding how to apply those values when they're carrying out their role. So, you know, we talked about the kind of training that our House Companions go through, but everyone goes through the same recruitment process no matter what their role, and everyone pretty much goes through the same orientation program as well.

MS HUTCHINS: Do you find that there's further specific training that you provide to nurses?

MS CHADWICK: Registered nurses?

MS HUTCHINS: Yes.

MS CHADWICK: We continue to encourage and provide them with additional education. So one of the things that we do in terms of a career pathway, if you like, for our registered nurses is a junior always works with a senior. So there's mentoring happening and then we specialise our registered nurses. So if someone is particularly interested in wound care, for example, we then provide them with the training and the support and the mentoring to actually become a specialist in that area so that they are the go-to registered nurse, if you like, for the other RNs or the clinical team when a chronic wound might come up.

MS HUTCHINS: Yes. And do you also have career pathway opportunities for other people within the organisation?

MS CHADWICK: Yes, sure. We have – you spoke to Lisa separately, she was a House Companion, and there's also then a House Companion mentor role. So there is a mentor in every single house. So there's 17 mentors. And their role is to, you know, to facilitate that relationship with the family and the resident as well as the clinical team. So making sure that our communication is, you know, getting through and that it's always, you know, everyone knows what's going on in the house. One of the things that the mentors do is if a family wants us to, we give them weekly updates. A little story about, you know, what might be happening for their loved one for that week and photos and things like that so that they can see that their partner is engaged, is doing something and is living a meaningful life.

MS HUTCHINS: Yes. And one further question in relation to staff training, in terms of the availability of training and education options generally in the community, do you think that what's available adequately reflects the needs of the types of things you would want for your staff to be able to be trained in?

MS CHADWICK: No. My experience has been that we have to provide significant training. Whether it's a registered nurse who has come out from a degree training or whether it is someone who has done a Certificate III or a lifestyle certificate, one of the failings, if you like, that you see is there is something as important as dementia care, for example. In our community, almost 70 per cent of our residents are living with dementia but typically in traditional aged care over 50 per cent of residents are living with dementia and yet it's an elective, you know, and it's something that a registered nurse may not even touch on when they're actually doing their training. So that's a pretty important aspect, I think, of training that needs to be looked at across all domains, if you like, of education for aged care. And we see the same with Certificate III, you know, it's an elective rather than something that is core to the training that's provided.

MS HUTCHINS: Turning now to the use of technology at your organisation, what are some technological – sorry, what is some things that you've been able to use in terms of technology to enhance the experience of residents?

MS CHADWICK: So our site is two hectares. It's a large site. And so we use a full suite of technology, if you like, that we have developed with a number of different providers to meet our needs. It's all based around mobile monitoring, if you like. It means that residents can continue to live an independent life where they are free to move in and out of their homes and around the community without people being on top of them, if you like. So they all have wearable technology and that wearable technology lets us know where they are at any time. There is sensors in bedrooms, in beds and things like that, so if someone is a high falls risk, for example, then we can respond to them very quickly; we are alerted to them attempting to get out of bed.

There is also communication through – I think Lisa mentioned Vocera badge. So every team member logs on as soon as they come into work, and we then have full access to communication at any time and across the whole site no matter where our staff are. So we also then use CCTV, and our CCTV is pretty much from the minute you walk into our main admin building right through the whole site so it's across perimeters so we can ensure a resident's safety and security. And, you know, it's also down our main streets, in the café, in all of the main areas.

MS HUTCHINS: Is it used in the resident's individual households?

MS CHADWICK: Yes, so it is in houses but only in, you know, the semi-public areas, if you like, the shared communal areas. We don't have CCTV in any resident's rooms and this has not been something that we've ever had a request of at this point.

MS HUTCHINS: Yes. Do you know what the organisation's attitude would be if you did have a request for CCTV in a room?

MS CHADWICK: Look, I would be concerned, first, that a family member felt that they needed that kind of added security, if you like, and it would be very individual-based. So we would want to understand what's going on, you know. Why have you potentially lost trust in us as an organisation, for example. You know, why – you know, issues should have been raised well before we get to, you know, that kind of request, that we could then deal with particularly if it's about a staff member.

You know, the other things that we need to take into account is other residents' privacy because they might go into that person's bedroom and they might chat, and so it could actually then impact on their privacy. You know, the way that we make decisions, if you like, is on an individual basis and then the house makes a decision. So we would look at it from that perspective, how does the house feel about this, and do they believe that it's a necessity as well. It's the kind of thing that we do even for

pets, for example, if someone wants to bring in a pet, they go through the same process.

MS HUTCHINS: Yes. And how is the Bellmere model of care funded?

MS CHADWICK: We are funded the same as any other aged care facility in Australia. I'm an approved provider, or we're an approved provider under the Aged Care Act '97, and, yes, we have the same funding mechanisms and requirements.

MS HUTCHINS: Yes. And we've heard from Elsie earlier today that she's able to freely come and go from the facility. Is that the situation for all residents, or is that – sometimes their care needs wouldn't facilitate that type of freedom of movement?

MS CHADWICK: Look, again, it's an individual basis. So, you know, if we have someone who is living with severe dementia, is not capable of, you know, crossing that threshold and, you know, being safe, it doesn't mean that they can't. It just means that we either need to have someone with them, you know, we make sure that a team member is with them, or, you know, we follow what the family requires of us in that situation. But, no, from our perspective, you know, if someone wants to go for a walk – for example, I think, you know, we talked about the walking group or Lisa talked about it earlier. Many of the people that are on that walking group are living with dementia and yet every morning they go for a walk around our external community, not just in the internal community.

MS HUTCHINS: Yes. And in terms of the individual units, do they need to be locked in the evening time or during the day or - - -

MS CHADWICK: So when we – you know, when we created NewDirection Care at Bellmere, it was all about trying to emulate as normal a life as possible for people. And so it's normal for us to lock our homes at night, but typically, you know, to be able to come freely and go freely during the day. And so, yes, there is a time frame when the doors are locked, but they're all, you know, on security release for fire and all of those kinds of things. And residents, you know, who are able to come and go are still able to. And, of course, we have all of our CCTV and our monitoring which allows us to monitor what is happening in that house, and our night team. We also have a night team which includes a 24/7 registered nurse.

MS HUTCHINS: Yes. And in terms of for residents that may be lacking capacity themselves to decide or, you know, have that freedom of movement, say, in and out of the facility, do you engage in a process of obtaining consent from family members or next-of-kin in relation to the restriction of that person's freedom of movement?

MS CHADWICK: Yes, look, we – again, everything is individualised. We'll sit down with the family and we'll talk them through. We are an organisation that does not believe in restraint and we don't have any restraints, you know, whether that's physical or chemical. And so it's a long conversation sometimes with families where they might think that, you know, a bed rail is not a restraint and so we'll talk to them

about how, you know, that could actually put their loved one in danger rather than be what they think it will be, which is, you know, to make them safe. And so we talk about other options and we look at, you know, how we can still enable a resident to live the life that they've always lived.

MS HUTCHINS: You note in your statement that you consider an appropriate indicator to gauge a resident's quality of life is positive wellbeing. What does this term mean, and how can you measure whether a person is enjoying their life?

MS CHADWICK: So I think particularly when you're talking about someone who is living with a cognitive impairment, observation is, you know, a real key to actually understanding what is happening for that person. We could have someone who, you know, might be asked a question with a smiley face, you know, and you think that you're going to get a response from them, but that response could be in absolute, you know, difference to their body language, to how they're actually behaving.

So, for example, to understand if someone feels safe in their environment, you know, we can see from their body language whether they're engaging, whether they're sitting around the dining room table and chatting, you know, with other residents and staff members. You know, we can see that if a person comes into close proximity to them whether or not they're reacting in a negative or a positive way. So there's a lot of observation, I think, that you can utilise and is better utilised than potentially a – you know, a survey or something like that.

MS HUTCHINS: And in your experience, what are some features of traditional-style residential aged care facilities that result in poor quality-of-life outcomes for the residents?

MS CHADWICK: Well one of the biggest ones I think, is restraint. You know, it amazes me that in, you know, today's society that we continue to restrain someone for what we think or tell ourselves is their safety. I think it's incredibly rare where you would actually need to restrain someone for their safety. You know, I tend to see in traditional aged care that it's used for other means rather than, you know, for the person's actual safety.

MS HUTCHINS: And separate from restraint, what are some other features of traditional aged care facilities that you think result in poor quality-of-life outcomes?

MS CHADWICK: Task. You know, as I said before, traditional aged care is based around delineated roles and function, you know, task. And what happens when you do that is you lose the person. And so the person themselves, you know, doesn't feel like they have any value because, you know, someone is doing something for them, they're taking away from them, they're taking their independence rather than, you know, trying to enhance that independence. Now, I'm not saying that people do that on purpose in traditional aged care, it's just that is what's occurred because we're focused on the task rather than the individual person.

MS HUTCHINS: Yes. And in your statement at paragraph 53 – if we could please turn to that, Operator – you note that the research you've undertaken and your own experience shows that there's a number of features of residential aged care that are important to aged care recipients and their families on this issue of enhancing their quality of life. Operator, if you could please go to 53 and pull out the subparagraphs (a) to (g). So some of these features we have spoken about already, the first being care delivery in a home-like setting. The second factor that you mention is the ability to remain engaged with the community. How important do you see that as being to a resident's quality of life?

MS CHADWICK: So for me, there is no hierarchy to these.

MS HUTCHINS: Yes.

MS CHADWICK: I think that they're all as important as each other.

MS HUTCHINS: Yes.

MS CHADWICK: And sometimes they might have a greater importance, you know, depending on the individual and where they're at in their life. So, for example, you know, a positive end-of-life journey and being able to palliate at home is important when you're at that point in your life. It's not necessarily, you know, important when you're socially isolated, for example, in your home and, therefore, are no longer engaged in community.

So one of the things that we believe that we're able to achieve at, you know, NewDirection Care at Bellmere is the ability for residents to – you know, to remain engaged in community, to have an active, you know, life, to still have purpose and meaning. I mean, Elsie talked about having a job. You know, that's a purposeful, meaningful thing for her, and many of other our other residents, you know, do the same things. They might do the garbage round, for example, or, you know, do the – answering telephones on a Sunday or, you know, whatever it might be. They might actually be helping with the cooking or cleaning up in the house.

So, you know, the ability to make those choices and to continue to do the things they've always done is incredibly important. And I think it's very hard to provide that in a traditional environment. You need a home-like setting and a communal setting to achieve that.

MS HUTCHINS: And one of the factors that you mentioned at 53, subpara (e) is the ability to make choices about their daily routines. And we heard evidence from Ms Scott earlier this morning about that she gets to choose what she wants for breakfast and she gets to choose what activities she does. Is it difficult to be able to create an environment for residents where they do get to choose things like food or activities or - - -

MS CHADWICK: I do think that the built environment is important to actually – you know, making it easier to provide those things, you know, than a traditional environment, if you like. And, you know, one of the reasons for that is if you have a scheduled breakfast time at 8, for example, and you're in traditional aged care and you've got, you know, so many residents that you have to make sure are, you know, awake, changed, you know, maybe showered before they can go down for breakfast, then someone is being woken at 6 o'clock in the morning, you know, and somebody else has been woken at 6.30 and that may not be their choice. You know, they may have always he slept in until 10 o'clock in the morning, and all of a sudden that's been taken away from them.

So by having a more flexible approach and a House Companion, you know, we're able to deal with that ebb and flow, you know, which is, "This resident wakes up at 7. They like to have a shower immediately that they've woken up, whereas, you know, this particular resident might not wake up until 9 and, you know, they might want scrambled eggs for breakfast rather than – or they might want, you know, jam and toast or a cup of tea, or they might actually want to turn the kettle on themselves for that cup of tea." So, yes.

MS HUTCHINS: You've touched on this just briefly now and also in your witness statement, the noting that it's important for residents to have purpose - - -

MS CHADWICK: Yes.

MS HUTCHINS: - - - and that you endeavour to provide them with meaningful tasks for them to do during the day. Could you explain a bit for the Commission, you know, the types of things that you're able to get residents involved in in that regard.

MS CHADWICK: Yes, sure. Again, it depends on the resident themselves, and it's really important that we learn about them and what their story is, you know, before they come into care with us. So, you know, for example we have a gentleman who is living with younger onset dementia. He recently came to our community, and he loves gardening. And so, you know, we worked with him to ensure that he can mow the lawns, but he does that under the supervision of our gardener. You know, he's involved in doing the pots and the planting and all of those things.

So even though he may forget exactly how to pot a plant, we're there to support him to actually, you know, continue to do that. And, you know, it changes, you know, the whole experience for a resident. I think they just – they continue to live their life. They look forward to tomorrow rather than thinking, you know, "I'm done on this earth. I'm just waiting to die", which, unfortunately, you know, we see quite often in traditional aged care.

MS HUTCHINS: Yes. And the final factor on your list here, and one you have touched on briefly earlier, is end-of-life journey. How important do you think it is to allow residents to have their end-of-life journey, you know, in the facility where

they've been living previously? And are there kind of any barriers or challenges to you being able to facilitate this for them?

MS CHADWICK: So I think it's incredibly important. You know, I myself supported my father to – you know, to die at home, and I was lucky to be able to do that but it was in a short-term care requirement, whereas, you know, someone who has come to live us – whether it's for, you know, a number of months or a number of years – it's really important that at the end of their life they're supported; they're surrounded by people that love them, that know them, you know; that they have relationships with and someone who also understands what's important to them, you know, at that end stage for them, you know, whether it's playing a particular type of music, whether it's actually getting in touch with someone that they haven't seen for some time and, you know, facilitating that to happen.

Whether it's supporting, you know, their family and the other residents that live in that house to – you know, spend time with them and even, you know, stay overnight or whatever it might be. You know, I just think it's an incredibly important, you know, thing that we can – that we can do, if you like, in aged care that allows someone to have a good death.

MS HUTCHINS: Yes. In relation to the care needs of residents generally, how important do you think family involvement is in that process?

MS CHADWICK: Well, it's key. You know, it's like anything. They know a person, you know, their loved one better than we do, and so it's really important that we, you know, engage them in that, and that we also take that burden from them, if you like. So many people when they come into aged care, their family members have been, you know, caring for them. They've become, you know, rather than the daughter, the carer for some time. And so for us it's really important that they can give us all of that information that we can develop a support plan that can support the – you know, the care of their loved one and then they can go back to having that original relationship, you know, being a daughter again, being a mother.

MS HUTCHINS: Turning now to some issues relating to the aged care system and your experience in that regard, you observe in your witness statement that when you commenced working on the Bellmere project in 2012 that you had – that the relationships between operators, government and the relevant quality agencies was largely a positive experience and collaborative. You have observed that you consider that the environment has now changed. Why do you think that is, and what do you think has changed?

MS CHADWICK: Look, I've been in aged care for, you know, as I said 25 years now, and I have never experienced the kind of, you know, punitive type of behaviour, if you like or regulation that we're currently seeing. You know, in the past if there was a problem with a facility, you know, the agencies and government would typically work with that organisation to either remove them from the industry, move them out if that was, you know, the right decision, or to encourage them and

work with them to actually, you know, increase the quality of care and then to provide a better service.

Whereas what we're seeing now is, you know, rather than recognition of – and I believe, you know, having been around for some time, that the government agencies and the department, they know who the organisations are or who the facilities are that are of concern. And instead of focusing on those, you know, of concern, there seems to be this, you know, approach across the whole industry now that we're not to be trusted in some respects, which is very difficult.

And, you know, the reason I say that is from our own personal experience, you know, when we were going through accreditation, for example, the assessors, you know, said to me and said to many of our team, you know, "I read about what you're doing in your handbook or, you know, I read about your policy, and then I look up and I see it happening."

So that's a really, you know, positive approach to the innovation and the change that we were making. A few short months later, you know, when we had an assessor come in for an unannounced, the comments were, you know, things like, "It's all smoke and mirrors. You know, this can't be real." And therefore, you know, we were being asked, if you like, to provide, you know, even greater and more evidence and to jump through a higher hoop, I think, than would typically be required.

MS HUTCHINS: Do you think that the current regulatory system encourages the development of innovative models?

MS CHADWICK: A few years ago, absolutely. I don't think I would have been able to, you know, do it without that. But right now, I would say no, and the reason I say that is because when you have shifting sands, you know, when the ground is moving beneath you, it is very hard to innovate. You need a certain level of sustainability and knowing what's going forward to be able to innovate. You know, we can't innovate as an industry on our own. We need, you know, financiers, we need funding bodies, we need, you know, all of those groups of people to come together to support innovation. And when you've got so much change happening in an industry and when a provider doesn't know, you know, next what's going to happen, it makes it very difficult.

MS HUTCHINS: And in terms of your experience with the Aged Care Quality and Safety Commission and its predecessor, the Aged Care Quality Agency, can you make any observations about whether you thought the process was working well or whether the staff was adequately trained.

MS CHADWICK: Look, I have actually offered to the Commission, to – you know, to assist them, if you like, in some of those processes because I've identified, you know, again through our own experience that in particular some assessors have no aged care background or residential aged care background. You know, it's pretty hard to assess something that you've not had any experience of. And then, you

know, one of the hardest thing to watch is an assessor that really, you know, doesn't have a good grounding or understanding or education around dementia care, trying to question a resident or, you know, impacting on their privacy, for example. You know, not listening to us as a provider when we say to them, you know, "It's probably best to not speak to that person, you know. You could actually trigger an event for them", and then to have that totally disregarded, you know, and go ahead and, you know, question that resident and then that poor resident, you know, is then put in a really difficult situation.

So I do think that greater training around dementia care and mental health, certainly around questioning, you know, of residents. And also one of the things that I have really, you know, experienced, if you like, is that as a provider we're required to ensure that our residents' privacy is met, that their dignity is maintained, and yet I don't see that same behaviour, if you like, you know, in the protocol coming out of the Commission for its own staff. You know, so, for example, you might have a resident sitting in a traditional aged care environment at the dining room table and because they're in a public area, you know, someone just comes up, sits down next to them and starts asking them questions. Where is their privacy? You know, where is their ability to engage?

MS HUTCHINS: Thank you. In terms of the Aged Care Quality Standards, what are your views about their standards and whether you think they will affect positive change?

MS CHADWICK: Look, I think that they're certainly headed in the right direction, you know, that there is a real focus around the individual, which I think is fantastic. I question whether or not it's possible to have a single, you know, instrument across the different levels of care. It's a very different relationship in home care or day care services than it is in residential aged care. You know, not everyone is lucky like Elsie to – you know, to have been able to make a decision and make that choice of where they want to live.

In residential aged care, the majority of people come to live with us because, you know, family can no longer provide that level of care. You know, it's not necessarily their choice. And, you know, so I think that that's quite a different relationship than home care where, you know, I might have someone coming in to provide cleaning or, you know, personal care for a few short hours a day, but I'm still living in my home. You know, I'm independent.

MS HUTCHINS: Is it apparent to you what your obligations are under the standards and what's going to be required to achieve compliance?

MS CHADWICK: Look, I would hope that we know, but it's not apparent, no. When I read through the standards, you know, when we completed the self-assessment as a team, you know, we have a lot of questions and we don't know how those are going to be addressed, how are we going to be, you know, questioned, what

kind of evidence, if you like, will provide, you know, the outcome that the assessors are looking for.

You know, and I will give you again, you know, just a little example. If we've got a resident who came to us, you know, was incredibly malnourished, underweight, and over a very short period of time we've been able to, you know, increase that person's weight substantially, you know, that's a great outcome. But to then be questioned on whether or not you have documented every single meal for that resident, to me, is, you know, not an effective way of looking at have we actually produced the right outcome for this person, have they put on weight, are they no longer malnourished.

MS HUTCHINS: So is there any suggestions or differences that you would advise to the Commission perhaps that might be appropriate changes to the current requirements in that regard?

MS CHADWICK: I think that there are some more objective measures that we can make, and I think that we need to have some, you know, greater guidelines that are consistent across assessors. It shouldn't matter who walks in that door, you know, as to what I provide or not. Whereas right now, you know, there is a lot of information that says, "Well, if this particular assessor walks in the door, this is the information that you need to have for them." That's ridiculous to me. You know, there should be – we should all be able to provide the same level of evidence or, you know, documentary evidence. The residents themselves should be able to tell their story, and that is, you know, how we should be measured, not based on my own personal, you know, belief system as an assessor.

MS HUTCHINS: And what are some of the objective measures you think might be appropriate?

MS CHADWICK: Look, you know, some of the things that are coming up in terms of the quality indicators, I think that's fantastic to – you know, to start seeing. But, you know, it's a better recognition as well of observation, as I've said, you know, some observational practice rather than, you know, a focus on doing a consumer experience report, for example. If you've got, you know, 70 or 80 or even 100 per cent people who are living with dementia, a consumer experience report may not have as much, you know, value as it's placed on in the current environment, so yes.

MS HUTCHINS: Turning to funding, in your statement, you note your view that the Aged Care Funding Industry – sorry, Instrument provides a disincentive for reablement processes in residential aged care. Why do you hold this view?

MS CHADWICK: Okay. So – and I think it's a widely held view. You know, it's not just my personal view. The Aged Care Funding Instrument in its current form is based around disability. So the more that I have to do for somebody, the more I get paid. Whereas, you know – and I talk about this quite often – it might take – if we have someone who's immobile, for example, and, you know, they're not able to move around freely on their own, they require assistance, to shower that person

because we're doing it for them, might only take, you know, 20 minutes or half an hour.

But if you've got someone who is living with severe dementia, you know, has a level of fear for the water or, you know, for the whole process, whatever it might be, it can take you an hour, an hour and a half to actually encourage and get that person to actually have a shower, you know, and the whole time you're prompting and supervising them rather than hands-on assisting, and, therefore, you know, you don't get anywhere near the same level of funding. It doesn't make sense to me.

MS HUTCHINS: Yes. And what do you think could be changed in this regard to encourage better outcomes for your residents?

MS CHADWICK: I think, you know, activity-based, something around time potentially. I mean, for me, you know, one of the most important factors I think needs to start being taken into consideration and, you know, true recognition is if someone is living with a mental health diagnosis or with dementia. You know, there typically is more work around that person, if you like, to encourage them and to support them to – you know, to do things for themselves.

One of the other things that I, you know, think is necessary in our funding system is if we don't get the front end right – so if we don't, you know, support someone when they move into a new environment, for example, then, you know, we're never going to have a good journey for them, if you like, through that process. And so, you know, when someone moves into residential aged care – and, you know, I tell – ask my team all the time, "How would they feel? You know, you've had your independence stripped away from you. You know, you are moving from your own home or, you know, your family's home into a community." And even though, you know, in our environment it's not 120 people you're living with, it's, you know, only six other people, that's still a big deal, you know, and that's a huge change for anyone to go through.

And I just don't think that we provide enough, you know, funding to actually recognise that there's a whole lot of work that's required at the beginning of that relationship to provide emotional support, you know, to provide debriefing and counselling and, you know, all of those things that actually allow a person to, you know, express their grief and then move on in their life.

MS HUTCHINS: And finally, do you think that the model you have at NewDirection is replicable?

MS CHADWICK: Absolutely. So one of the things that we always did when we, you know, were developing the model was look to changing an industry. It's not just been about us as an organisation. And the reason we've done that is because, you know, we recognise that the industry does need to change and, you know, needs to become more individualised. So, you know, we're actually licensing our model. It's almost a franchise, if you like. And we have a number of aged care operators that

we're currently in discussion with that are very interested in taking on our model and emulating that in their own organisation. So, absolutely, it does have, you know, that capacity to make a big change.

MS HUTCHINS: Thank you. No further questions from me, Commissioners.

COMMISSIONER TRACEY: Ms Chadwick, you're an invaluable resource for this Commission because one of the things that we are looking at very earnestly is alternative models to what you've described in your statement as traditional aged residential care. And you've seen how that type of care is provided. You have conducted years of research to develop an alternative model which you've now succeeded in doing, and from all accounts, including the evidence we've heard earlier today, it is working exceptionally well.

Could I get you to walk us through the process that you had to engage in with a view to setting up Bellmere, once you had got to the point of being satisfied that it was a good alternative to the traditional system and, in particular, how you funded it, where you turned to recruit staff – all those processes that led to the opening on day one.

MS CHADWICK: Okay. There's a lot in that.

COMMISSIONER TRACEY: There is.

MS CHADWICK: I will try and step through it. So, yes, the research and I think I mentioned we piloted, you know, our model, particularly the small house model for a number of years, including the House Companion role. So we, you know, kept working on that role, if you like. When we – how we funded it, we were – you know, I had been in the industry for some time as I said, and I think I was lucky that our bank, our financiers at the time were, you know – and they still of our financiers, were, you know, willing, if you like, to assist us to actually make that happen. And so, you know, we funded it through debt funding through the bank, through personal equity and equity that we had established from operating some traditional aged care.

COMMISSIONER TRACEY: And to that end, you incorporated the vehicle that was going to run the operation?

MS CHADWICK: Yes, that's correct.

COMMISSIONER TRACEY: And there would be shareholders?

MS CHADWICK: The only shareholder is myself.

COMMISSIONER TRACEY: And, therefore, it's a not-for-profit operation.

MS CHADWICK: It's a private, yes, profit – yes.

COMMISSIONER TRACEY: I'm sorry. I interrupted you. You were explaining how you got the funding from banks and - - -

MS CHADWICK: Yes, so pretty similar to, you know, how you would be funded or get financing from, you know, an institution for traditional care. You know, we were able to demonstrate, if you like, to our financiers that we could still provide a sustainable financially viable model that would, you know, pay them back that debt, if you like, just like you can with a traditional aged care environment. You know, the building of the community, even though, you know, it provides all of those services and it's a home and there are, you know, kitchens in every house and laundries and so forth, the cost, the capital cost was actually no more than actually building a traditional aged care environment. So, you know, again it's kind of like, well, why would you not do it this way.

So just stepping through those things, in terms of operations, nothing can ever be achieved on your own. I have an incredible team of people that have been on the journey with me and part of that process. And, you know, we just always come back to our values. And that's pretty much how we, you know, develop the recruitment process as well. So, you know, we recruit on the basis of attitude and value.

We put every single team member, no matter what their role, whether they're a manager, you know, whether they're in lifestyle, whatever they're doing, they go through the same process. So there is psychometric testing. There's a lot of processes and then we take them through an assessment centre. That assessment centre takes about three hours and during that time we do a lot of observation. You know, we actually set group tasks and individual tasks and things like that and out of that we can determine whether or not that person has the values that we require to provide services to an elder, you know, a vulnerable person.

COMMISSIONER TRACEY: You have a staffing model that differs from a number that we have heard about, and we've heard repeated evidence about people in need, particularly in the small hours of the morning, pressing buzzers and not getting any sort of response, any timely response, because there's simply not enough staff engaged to do it or they're otherwise tied up looking after somebody else, those sorts of things.

Compare that with the vignette from Ms Scott in her evidence this morning about the 2 am loud music being played in the next room, presses the buzzer, within 2 minutes there's a carer there. The music has gone and she has gone back to sleep. Now, your staffing model, obviously, is able to accommodate those sorts of things in a timely way. You have this institution of the Ms Jones' House Companions, which we've not heard of as a general feature within this industry. But all this has to be paid for.

MS CHADWICK: Yes.

COMMISSIONER TRACEY: Am I right in thinking you are able to budget all this within the normal government support payments that come in respect of the residents of your institution?

MS CHADWICK: So when we initially modelled our development and, you know, started the research, yes, certainly our feasibility showed that. In recent times because there has been, you know, quite a significant reduction in the level of funding to our industry, and, you know, as I explained before, the ACFI is based on disablement, not enablement, which is our model.

Our costs are pretty much the same but we do not get the same level of income because of the way that the ACFI is, you know, unfortunately a disincentive. We make that up through our other services, the local shop, the hairdressing salon, you know, the GP clinic, the dental clinic, the wellness centre and our café and all of those services are available to our external community.

So it's not something that could typically be funded standalone. It will be, I have absolute, you know, confidence that the industry will get through, you know, this crisis and the funding issue. As I said, I've been in aged care for 25 years, I've seen that ebb and flow and the change. But, you know, it does really need to look at the funding mechanisms because community expectations have changed dramatically in the last few years.

COMMISSIONER TRACEY: Could I ask you about another matter, and that is I think 22 per cent of your residents are younger than 65, and they are incorporated into the institution, it would seem, seamlessly. And as I understand your evidence, they're there as in most of these cases, because there is no alternative out there in the community to cater for young people with the range of disabilities that exist and are now catered for in the aged care area. Firstly, could you tell us whether all or some of those who you are looking after, whilst being appreciative of what you are doing for them, would rather be elsewhere and on the other hand whether there are others who, given their choice, would stay with you.

MS CHADWICK: Look, I think our model at least, you know, supports a younger person in a different way. So that they're more engaged with their community and the fact that we have a number of people, you know, around the same age also helps so that we can have, you know, the same interests and activity based around that. In real life, I think that, you know, probably the majority of the younger people that are living in an aged care environment would, you know, if they had the choice, live elsewhere. But their first choice would be live on their own in, you know, accommodation within their community.

And the NDIS is just not able to support that in many, many cases and that's why, you know, we have younger people living in aged care. I can, you know, say to you that having had that conversation with a number of our residents, you know, from their perspective, well, they're better off being where they are. They love living at

Bellmere. But, yes, absolutely, if they had a choice and could go home and live on their own with, you know, a carer, that would absolutely be what they want.

COMMISSIONER TRACEY: And are you seeing this sort of emerging with, as more and more of these young people become eligible for the NDIS?

MS CHADWICK: Look, our experience so far has been that the NDIS is not able to provide the level of accommodation that many people require, that have been moved into an aged care environment. You know, you are talking 24/7 care and, you know, independent accommodation; it's incredibly expensive. And so many of our residents they're now eligible. They, you know, currently have NDIS programs in place but none of those programs have moved to accommodation. They've been on the basis that they stay living with us.

COMMISSIONER BRIGGS: Thank you for your evidence today, Ms Chadwick. I just have one question around caring for people with high-end dementia. Virtually all of the evidence that we have had before us sees people with very high-end dementia placed in locked facilities and grouped together because we're advised that there needs to be a level of expertise and a level of safety used to protect those people. Your model is quite different.

MS CHADWICK: Yes.

COMMISSIONER BRIGGS: You blend those with dementia with other residents as part of the home environment. Why is your model better?

MS CHADWICK: Difficult – one thing, I think, is because we see people as individuals. We don't believe that, you know, a diagnosis is who you are. And by having a focus on individual, you know, the House Companions and all of our team, in fact it doesn't matter what your role is, you are trained in dementia care, and in responsive behaviours and in how to defuse a situation.

I think that's also, you know, incredibly important and something that isn't necessarily talked about a lot. Our residents live together, yes. You know, sometimes there might be an altercation between two residents. What we pride ourselves on is, you know, one, being able to diffuse that situation so that it doesn't escalate and become something bigger than it needs to be.

And, two, being able to identify a particular person's triggers, you know, what's – if we put them in this situation, you know, what is going to happen. So, for example, we know some of our houses where a resident might react if there's a lot of people that come into that house. Then we talked to all of the families that are visiting that house and they understand, you know, the kind of behaviour that is expected of them, if you like, knock on the door. Be respectful and all of those kind of normal things that we do when we move into somebody else's home.

And to the point where we might actually, if there is some big activity happening in a house, you know, take that person out of the house for that day and go somewhere else so that we're, you know, always mindful that a situation might put additional stress on that person. They can't express themselves in any other way than by, you know, potentially acting out, which might have an impact on somebody else. And so, you know, again it's up to that recognition, that training, that, you know, allows us to see that change in behaviour and get in front of it rather than be, you know, following an incident.

COMMISSIONER TRACEY: Ms Chadwick, thank you so much for your evidence. I should ask whether there's anything arising?

MS HUTCHINS: Nothing arising, Commissioner.

COMMISSIONER TRACEY: Thank you very much for your evidence and we will take what you have told us on board, because as I said to you a minute ago, we're anxious to look forward and improve the quality of care that's offered to elderly people, and the new system that you have developed would seem to be a very good example of how that care can be improved. And your evidence has been very helpful to us in understanding how, in practical terms, that can work. Thank you very much.

MS CHADWICK: Thank you.

COMMISSIONER TRACEY: And you are excused from further attendance.

<THE WITNESS WITHDREW [12.30 pm]

COMMISSIONER TRACEY: Mr Knowles, I think, has got a witness.

MR KNOWLES: Thank you, Commissioners. I now seek to call the next witness. The next witness is the subject of a pseudonym direction made by the Royal Commission on 1 July this year, such that the witness is to be referred to by the pseudonym "Ms FA".

<FA, SWORN [12.31 pm]

<EXAMINATION-IN-CHIEF BY MR KNOWLES

MR KNOWLES: Now, Ms FA, you have prepared a statement for the Royal Commission dated 4 July 2019?

MS FA: Yes.

MR KNOWLES: And that is document WIT.0208.0001.0001.

MS FA: Yes.

MR KNOWLES: Have you read your statement lately?

MS FA: Yes, I have.

MR KNOWLES: Yes. Are there any changes you wish to make to the statement?

MS FA: No.

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

MS FA: Yes, they are.

MR KNOWLES: I seek to tender the statement of Ms FA dated 4 July 2019.

COMMISSIONER TRACEY: Yes, the witness statement of FA dated 4 July 2019 will be Exhibit 6-54.

EXHIBIT #6-54 WITNESS STATEMENT OF FA DATED 04/07/2019 (WIT.0208.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR KNOWLES: Now, Ms FA, you have asked to read out your statement to the Royal Commission. You have referred to some photographs in your statement. They will be displayed as you read out your statement. Can I now ask you to proceed with the read out please.

MS FA: Yes.

I live in regional Queensland. My dad is 85 years old and has resided in a residential aged care facility since 2017. Dad was born in Nanango, Queensland and had two brothers. Dad was raised by his mother and stepfather on a farm in regional Queensland. In that time Dad and one of his brothers bought the farm from their mum. Dad share-farmed with his brother for many years. At different times there were dairy cows, pineapples, beans, tomatoes and beef cattle on the farm. Dad married Mum in 1957. Dad and his brothers and their wives had a dance band for a few years in the late fifties and they played at various local dances. Dad also did many other jobs. He was a contractor with his own dozer in the 1970s and he and his brother started a school bus run in 1967.

My mother and aunty mostly drove the bus until it was sold around 1980. Around that time a large portion of land nearby to the farm was subdivided and Mum and Dad gained a lot of new neighbours. Dad was very community minded and was often called upon for advice and assistance in community matters. Later in life, dad took some lessons and became a landscape artist and his very Australian art was quite popular locally. He also had his work in the Caloundra Art Gallery for some time. Mum and Dad sold the farm in 2004 and built a home on a portion of my property that had been subdivided for them.

Dad did maybe one or two paintings after moving to town but within a few years he started to forget how and it became very frustrating for him so he just pottered around the garden most of the time. He loved his grandkids and enjoyed having four of them living next door and visiting him every day. He was a great storyteller and the grandkids would always be asking him to tell his stories. In June 2014, my father received a formal diagnosis of Alzheimer's disease, however, my father's memory had been slowly deteriorating for several years before the formal diagnosis was received.

At that stage in 2014 my father was still living in his own home with Mum. Following Dad's diagnosis of Alzheimer's Mum held enduring power of attorney for Dad. Since March 2018 when my mother passed away I, along with my three sisters have held enduring power of attorney for our father. In July 2017 my father moved into residential aged care at a facility in regional Queensland.

Move to aged care.
Prior to his entry into residential aged care, my father was living with my mother in their own home next door to me. To the best of my knowledge, my father never had an age-related fall while he was living at home. This is despite the fact that he was always moving around, walking without an aid, doing little jobs like sweeping and chipping the garden. He rarely sat still as, in his mind, there was always work that had to be done.

Initially, my mother acted as my father's primary carer following his diagnosis. Dad had started receiving a home care package at a level 2 from October 2016. Prior to that, Dad was receiving assistance from Community Care from about January 2016 which entitled Dad to a carer for an hour once a week to provide respite and give Mum a break. From October 2016, under the level 2 HCP, Dad was having carers attend the house for showers three times per week as well as to assist with meal preparation. Lawn mowing and basic cleaning were also provided on a less frequent basis. The home care Dad received under the HCP was fantastic. The carers were great with Dad, and Mum loved having them around to help.

When my mother's health started to seriously deteriorate in around October 2016, my sister and her husband moved up from Brisbane to live in the family

home to help care for both Dad and Mum. In time, however, it became too difficult for my sister and her husband to continue in the primary carer role. Dad was declining mentally and really needed full-time care. Dad was very active. He loved being outdoors. And as a result, he had a tendency to wander.

I recall one time when my father was still living at home, he left his house and came into my house, into my bedroom at 3am in the morning and introduced himself to me. Eventually, Mum, along with my sisters and I, had to make the decision to place our father into residential aged care. Due to Dad's tendency to wander, my sisters and I knew that it was necessary for Dad to have a room in a facility that had a secure unit.

After waiting for close to a year for a place to become available in the facility of my family's choice, we ultimately accepted a place in a different residential aged care facility in July 2017. From my conversations with people since Dad entered residential aged care, it is apparent that in this town, and no doubt many other areas in Australia, there is a lack of places available in secure facilities for people with dementia.

Staff levels
My father was initially placed in the secure dementia unit of Facility 1. He remained there until he was moved to a less secure unit in June 2018. I would usually visit Dad about twice a week for about an hour or two in the midmorning. My sisters would also drop by to visit Dad a couple of times a week and on the weekends. Generally, between all of us, there was someone visiting Dad most days. Often when I went to visit Dad while he was in the secure dementia unit, I would not see any staff on the floor.

I recall one instance on 8 August 2017 when I went to visit Dad, I walked around the whole unit and could not find any staff member, nor could I hear any staff member in any residents' room. That day when I was leaving the facility, I approached an office staff member outside the unit and asked her if this time of day was staff changeover time. She very rudely replied words to the effect of, "Well, they're probably busy. We can't be expected to watch them 24/7." As I had not previously had much exposure to aged care facilities at this stage and it was all fairly new to me, I just thought I was expecting too much and this was just how it was.

Resident incidents
Shortly after my father's admission to Facility 1, another dementia patient, a woman, took a romantic interest in my father and would walk my father around the facility, both inside and out, holding his hand. The staff did not discourage this behaviour and indicated that this was the way she acted with all new male residents. My mother was still alive at the time, although, due to Mum's declining health, she was not very mobile so it was difficult for her to visit Dad at the facility. In any event, my sisters and I found the behaviour very

inappropriate and had to ask the staff to actively discourage the woman from approaching my father.

On or around 25 August 2017, I received a phone call from one of the staff to report to me an incident where my father had walked into another man's room and this man, who had been a boxer in his younger years, grabbed my father and pinned him against the wall, threatening to punch him.

Unwitnessed falls

On or around 31 August 2017, Dad had his first major fall at Facility 1. The fall was unwitnessed. I was advised via a phone call that staff found Dad on the floor and he seemed to be hurt. I was informed that staff had called an ambulance and had taken Dad to hospital. I recall being told by my sister, who was at the hospital with Dad, that he had broken ribs. At that time, Dad's Alzheimer's was at the stage where he couldn't communicate well and, of course, had no short-term memory. After a short stay in hospital, Dad returned to Facility 1. He was confined to a wheelchair and could not feed himself as he could not lift his arms. It was obvious to me that even small movements were painful for Dad.

On 4 September 2017, I phoned the facility to check on Dad and was advised that due to his pain, an urgent request had been made for stronger pain medication. I assumed Dad would receive the medication straightaway, however, was subsequently informed that the medication had to come from the facility's pharmacy located at a distance and Dad did not receive the medication until 7pm. After this incident, my sisters and I ordered all of Dad's medication was to come from a local pharmacy of our choice who actually delivered it to the facility for no extra charge. When I went to visit Dad, he was often still in bed with no stimulation. Dad was never a TV watcher, so there was not even a television in his room to entertain him.

On 6 September 2017, I received a phone call from a staff member at Facility 1 to inform me that although Dad's bed was as low as it could go, which was a distance of approximately 30 centimetres from the floor, Dad had been found on the floor. I was informed that Dad had no obvious injuries from the fall. Earlier that day when visiting Dad, one of my sisters had also been advised by staff at the facility that Dad had developed some 'watery blisters' on his heels.

On or around 10 September 2017, another of my sisters visited Dad and there was a thin mat that had been placed on one side of Dad's bed and a thicker mat placed on the other side. These mats had been set up as Dad was continuing to move off his bed on to the floor. Around this time, the staff at Facility 1 had also asked whether they could leave Dad on the mat on the floor beside the bed between meals and then give him pain relief before getting him back into bed to feed him. One of my sisters approved the request.

On 9 October 2017, around six weeks after his first fall, I received a phone call from a staff member at Facility 1 who told me that Dad had had another fall. I was told that the fall had been witnessed by a staff member and another visitor at the facility. I was told that Dad was seated in a wheelchair at a table with a carer. The carer left the room, and in her absence, Dad had stood up and attempted to walk. I was told that the staff member and visitor present witnessed by dad take a few steps from his chair, but they were too far away to prevent the fall and so Dad stumbled and fell.

Before this fall, one of my sisters had told me that she had alerted the staff that she had witnessed Dad standing up from the wheelchair and his legs were trapped between the footrest and the chair. The wheelchair footrests were a trip hazard and, in my father's case where he was known to wander or attempt to wander, the footrests on his chair should have been removed or swung on the side.

Due to this fall, Dad was admitted to hospital and X-rays taken at the hospital revealed Dad had a broken femur from the fall and he had damaged the hip replacement he had undergone years earlier. While at the hospital with my dad, one of my sisters was told that Dad had untreated or very poorly treated pressure sores on his heels. Neither I nor my sisters had been made aware that Dad's 'watery blisters' had deteriorated into pressure sores. When I visited Dad at the facility, Dad was usually covered by a sheet or blanket. Certainly, the matter of pressure sores had not been brought to our attention prior to Dad's hospital admission for his broken leg.

Upon Dad's return to Facility 1, I observed that the staff used cushioned booties on my father's feet. As far as I know, the facility acted promptly to treat the pressure sores on Dad's return from hospital and his pressure sores fully healed. One of my sisters was also told that by staff at the hospital that physiotherapy had been arranged to occur at the facility. My sisters and I understood that to mean that on his return to the residential facility, rehabilitation physio would be provided to Dad.

When Dad was finally assessed by a physiotherapist at Facility 1, I was told there would be limited point in Dad having physio as, at this stage of his Alzheimer's, he could not follow instruction well enough to make any worthwhile progress. Dad was now bedbound and had to be hoisted into a bed chair to get him out of bed. Within three months of being admitted to residential aged care, our dad had gone from being an active and able-bodied man to being bedridden and unable to even feed himself.

Personal care

On one occasion within the first month or two of Dad's entry into Facility 1, I visited my father at around 9.30 am. He was still in his night clothing and had a very full incontinence pad on. The room reeked of urine. The carers had just entered his room to get him ready for the day. From my observations of

visiting Dad at the aged care facility, it was common for my dad not to be attended to by staff until 9am or later.

I attended a case conference some time in late 2017/early 2018 with the facility's head nurse, Dad's doctor and family members. I recall Dad's doctor specifically requested that Dad be taken out of bed at least every second day. However, I continued to notice that Dad was often left in bed all day. Dad would try to get up himself and end up falling on to the floor beside the bed. I was concerned that my father could be left lying on the floor for hours. I am aware that my sister inquired with the staff about attaching bedrails to my father's bed so that the sides of his bed would be raised and he could not easily fall out. My sister was told that the facility was not allowed to use bedrails as the residents could get caught up in them.

It was not unusual for me to visit Dad and notes that his pants were soiled with faeces. On one occasion in about August 2017, one of my sisters told me that she had visited Dad and he had soiled pants on. She said that she found a carer and advised the carer of this and the carer said that Dad had just been changed and that he was only supposed to use three pads per day. My sister lodged a formal complaint with the head office of Facility 1 about that incident. My sister was subsequently advised by the head nurse in an email that if Dad needed to be changed, the facility would supply additional pads.

During another hospital stay in late 2018, when my father was admitted to hospital he seemed a lot brighter and could, at times, verbally communicate in a way that he could be understood. My sister told me that Dad one day said to her while she was visiting him at the hospital that he was sick of shitting in his own shit.

Dad's move out of the secure unit. In June 2018, my father moved to a different unit in Facility 1. I was told by staff that he no longer needed to be in a secure unit. I understood this to be because of his decreased mobility. One of the most distressing incidents that I witnessed occurred at the facility on 21 December 2018. I went to visit my father at around 9.15am and walking through the facility to his room I did not see any staff. Upon entering Dad's room, I found him half off the bed, his upper body on the floor, tilted downwards with his weight on his painful shoulder in which he had suffered chronic pain for many years.

The drop to the floor was about 30 centimetres. Dad was in his nightgown with a bib on and foul-smelling pants which looked to be very full of urine. Dad was lying on the floor in his own filth, unable to call out for help and looking very distressed. I knew I would not be able to get him up on my own, so I rushed out to find someone to help. There was a staff member at the sink washing up. When I asked if she was a carer and said that my father needed someone to attend to him urgently, she replied with words to the effect that, "I am new and I don't know what to do. The other carer is on her tea break."

The carer and I went back into the room and the carer rang the emergency buzzer for assistance and left the room. While she was out of the room, I took a photo of my father in this position. Four people then entered the room and the first thing the main carer said was, "Well, that was a short break." She told me that she had fed my dad around 9am and left him to go on her break and was going to come back to get him changed and dressed for the day. My father could have been left in that position for up to 20 minutes.

I spoke to a nurse at the facility shortly after I witnessed this incident and she informed me that she had found my father in the same position a couple of days prior, and it seemed that when he had soiled his pants he would try to get out of bed. Despite this observation, the facility did not make any changes to my father's care routine. I emailed the clinical nurse following this incident and requested that a sensor mat be put on Dad's bed. Eventually, a sensor mat was arranged for Dad's bed. However, one of my sisters told me that one time she was visiting dad, the sensor was malfunctioning and sounding the alarm repeatedly for no reason.

The head nurse from Facility 1 emailed me and apologised that I had to see my father like that and made the excuse that the staff must have been attending to another resident, which I pointed out to her in a reply email was not the case. I received no further communication from her about the incident. Personally, I found her comments extremely insensitive. It made me think that there had likely been other times that Dad had been found in similar situations that we hadn't seen or been informed of.

In February 2019, one of my sisters went to visit Dad at approximately 1.30pm. Dad was still in bed at that time, and my sister told me that she noticed that Dad's fingernails were very dirty and untrimmed and there was an accumulation of dried food around some of the quicks of his nails food. Dad was scratching at his incontinence pants and trying to lean forward, and when my sister went to assist him she found that the sheet behind his back was saturated and the pillow behind his lower back was wet and urine-stained.

His incontinence pants were still securely on him and should have been changed half an hour prior but obviously had not been changed for quite some time since they had leaked substantially. My sister was so upset she took a photo of my father's wet, urine-stained pillow. She also took a photograph of his fingernails that day. My sister told me that she asked staff to assist. However, I went to see Dad two days later and I had to again ask for Dad's nails to be trimmed and cleaned.

Move to a different aged care facility – Facility 2.
Due to what my sisters and I perceived was inadequate care being provided to our father at the facility he had resided in since July 2017, I was making attempts to a secure a place for our dad in the original facility of our choice. We applied on behalf of our father for admission to a facility, Facility 2, where

Dad had been in respite previously in early 2017. We were happy with Dad's care during his respite stay at Facility 2.

After I found Dad on the floor on 21 December 2018, that same day I approached Facility 2 and showed the admissions staff the photos as evidence of Dad's lack of care. The admissions person advised me to keep calling every week or two just to see whether anything was becoming available. From December 2018, I made regular phone calls to Facility 2 asking them to keep Dad in mind for a place. After approximately two months, we were offered a room for Dad and he was moved to Facility 2 within 10 days.

On 11 March 2019, our father was transferred to Facility 2, which has beautiful gardens and a large bird aviary for the residents to enjoy. As Facility 2 is closer to my home, I am usually there visiting about four times a week. I often pop in my way to or from somewhere. There are always staff available and often volunteers as well attending to the 46 residents. I specifically called the facility to ask about staffing and was told that on a morning there are 11 clinical staff on duty and eight in the afternoons. At Dad's previous facility, I would rarely see a nurse, usually just two or occasionally three carers for approximately 20 residents.

The registered nurse in charge of Dad's wing at Facility 2 is in an office at the entrance to the building and I have observed that her door is often left open. The staff offices in Dad's wing have glass fronts. The nurse told me that she occasionally wheels Dad outside the unit and she can watch him from her office through the glass doors. Dad loves being outside. The day that my father was moved to Facility 2, the registered nurse on duty asked me if Dad was always like this, referring to his semiconscious state, to which I replied, "Yes, mostly."

The staff at Facility 2 informed me that the care notes that came with Dad from the old facility indicated that he had been chemically restrained. The nurse at Facility 2 actually showed the notes to me. When I visited Dad the following day, the staff told me how much better he was than the previous day, and that he had called out my name and was asking about me. Instead of mumbling incoherently, which had become normal for him at the previous facility, Dad's speech has become much clearer and he is responding to questions and I often observe him interacting with staff. Dad's personality has started showing through the dementia. I see that staff take Dad out to the garden. The nurse told me recently that they took Dad to a show at the facility and he said, "Tell them I love it."

When I visit, Dad's face and fingernails are clean, he is shaved almost every day and never looks unkempt. Within the first week of Dad being in Facility 2, I visited him and I thought to myself, "He looks like Dad again. He looks relaxed and happy." I see that he often gives staff members a big smile. Dad can still say a few words and I see that he tries to have a joke with staff. He is

much more responsive to me when I visit him now as compared to how he was at the previous facility.

Physiotherapy. Along with the basic daily fee and means-tested fee, Dad pays an extra charge of $19 per day at Facility 2 which gives him access to extra services, including activities, entertainment, massage and allied health services. The admissions staff at Facility 2 explained all of this to us at the outset. My sisters and I were willing to pay extra if it meant better care for Dad. Facility 2 has an allied health department. I was told by the nursing staff that my father is receiving physiotherapy, including massage four times a week.

From my observations, Dad has significantly more movement in his limbs. Prior to residing in Facility 2, Dad had quite severe curling of his hands. However, Dad can now open his hands and they aren't clenched tightly like they used to be. Dad is able to lift his arms above his head now. Facility 2 has musical entertainment several days a week, which Dad attends and enjoys.

Prior to my father entering Facility 2, the nurse in charge asked me if we would like to have bedrails. This is a request that I and my sisters had made at the previous facility but were told that bedrails were not allowed for health and safety reasons. The nurse at Facility 2 told me that bedrails are quite standard. We agreed to the use of covered bedrails to reduce Dad's risk of falls. Dad has not had any issues with the covered bedrails since he has been residing in Facility 2.

Medication
I recently spoke with the nurse in charge of my father's wing at Facility 2 about medication. I commented that I had noticed that no sedatives had been ordered for Dad since he has been at Facility 2. The nurse replied to me words to the effect that, "He doesn't need them, and he won't be getting any at any time as they should not be used routinely."

Observations on Dad's care in residential aged care. It is unacceptable that an active, physically fit man could enter an aged care facility to be cared for in his last years and within three months be permanently bedridden from injuries sustained while unsupervised. The older generation deserves better than this, and my father, who is paying the maximum amount for his care, certainly deserved better. I believe that minimum staff-to-resident ratios, especially taking into account high-care areas like dementia units, is required.

MR KNOWLES: Thank you, Ms FA. Is there anything else that you would wish to tell the Royal Commission?

MS FA: No, that's all.

COMMISSIONER TRACEY: Ms FA, thank you very much for sharing that account with us. The Commission has been hearing good stories and bad stories

about the quality of care available to elderly citizens, and your evidence has covered both categories. It can be done well and it needs to be done well.

MS FA: Yes.

COMMISSIONER TRACEY: We thank you very much for sharing those experiences with us.

MS FA: Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until 1.30.

<THE WITNESS WITHDREW

ADJOURNED [12.56 pm]

RESUMED [1.32 pm]

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Commissioners, the last four witnesses that we will hear from in the Darwin/Cairns hearings, as we have dubbed these hearings, are a panel of four that the Commissioners can see, all of whom have nursing backgrounds. If the witnesses could please be sworn or affirmed.

<JENNIFER ANN ABBEY, AFFIRMED [1.33 pm]

<DREW DARREN DWYER, SWORN [1.33 pm]

<ANGELA RAGUZ, SWORN [1.33 pm]

<SANDY MARIE GREEN, SWORN [1.34 pm]

MR ROZEN: Thank you. If I could now reverse the order, if I may and start with you, Ms Green. Could you please state your full name for the transcript.

MS GREEN: Sandy Marie Green.

MR ROZEN: Ms Green, you are registered nurse and an endorsed nurse practitioner.

MS GREEN: Correct.

MR ROZEN: You work presently as a self-employed nurse practitioner in the aged care sector.

MS GREEN: I do.

MR ROZEN: You have in fact worked in the aged care sector since 1990 starting off as a laundry assistant.

MS GREEN: Correct.

MR ROZEN: You've worked as a personal care attendant - - -

MS GREEN: Yes.

MR ROZEN: - - - as a registered nurse - - -

MS GREEN: Yes.

MR ROZEN: - - - now as a nurse practitioner.

MS GREEN: Correct.

MR ROZEN: You are the living embodiment of the career path that we have been talking about these last six months.

MS GREEN: Yes.

MR ROZEN: You obtained your nursing practitioner qualification in 2010.

MS GREEN: Yes.

MR ROZEN: I will ask you a little bit more in a moment about the role of a nurse practitioner but it involved doing a Master's of Nursing.

MS GREEN: Ys.

MR ROZEN: A postgraduate qualification.

MS GREEN: A Master's of Nursing (Nurse Practitioner).

MR ROZEN: Yes. And where did you – at which institutions did you - - -

MS GREEN: Curtin University in Perth.

MR ROZEN: Right. Thank you. And you also have a postgraduate diploma in Nursing (Nurse Practitioner).

MS GREEN: Yes.

MR ROZEN: And for the Royal Commission you've made a witness statement dated 25 June 2019.

MS GREEN: And you have a copy of that in front of you, I see, and it will also appear on the screen to your left. It's WIT.0191.0001.0001. Have you had an opportunity to read through that before giving your evidence today?

MS GREEN: Yes.

MR ROZEN: Is there anything in it that you would like to change?

MS GREEN: No.

MR ROZEN: Are its contents true and correct?

MS GREEN: They are.

MR ROZEN: I tender the witness statement of Ms Green, Commissioners.

COMMISSIONER TRACEY: Yes, the witness statement of Sandy Marie Green dated 25 June 2019 will be exhibit 6-55.

EXHIBIT #6-55 WITNESS STATEMENT OF SANDY MARIE GREEN DATED 25/06/2019 (WIT.0191.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR ROZEN: Thank you, Commissioners. Turning to you, Ms Raguz, could you please state your full name for the transcript.

MS RAGUZ: Angela Raguz.

MR ROZEN: Thank you. And you are also a registered nurse by training.

MS RAGUZ: Yes.

MR ROZEN: Having completed a Bachelor of Applied Science in Nursing in 1993. You also have a Master's of Business Administration that you completed in 2007.

MS RAGUZ: That's correct.

MR ROZEN: And you have initially worked as a registered nurse in a hospital setting 1993 to 1994.

MS RAGUZ: That's correct.

MR ROZEN: For the transcript you have to answer. And you, since 1994, have been employed at HammondCare.

MS RAGUZ: Correct.

MR ROZEN: In various roles, both clinical, operational and leadership.

MS RAGUZ: That's correct.

MR ROZEN: And your present role is general manager residential aged care.

MS RAGUZ: Yes.

MR ROZEN: How many residents are there that you look after in that role; look after in the broad sense.

MS RAGUZ: Approximately 1300.

MR ROZEN: Right. You were also in 2017 and 2018 a member of the Department of Health special dementia care unit expert advisory group.

MS RAGUZ: That's correct.

MR ROZEN: You have also made a witness statement for the Royal Commission dated 14 June 2019.

MS RAGUZ: Yes.

MR ROZEN: Do you have a copy in front of you.

MS RAGUZ: I do.

MR ROZEN: And it's also on the WIT.0237.0001.0001. Is there anything in your statement that you would like to change?

MS RAGUZ: No.

MR ROZEN: Are its contents true and correct?

MS RAGUZ: Yes, they are.

MR ROZEN: I tender the statement of Ms Raguz.

COMMISSIONER TRACEY: Yes. The witness statement of Angela Raguz dated 14 June 2019 will be exhibit 6-56.

EXHIBIT #6-56 WITNESS STATEMENT OF ANGELA RAGUZ DATED 14/06/2019 (WIT.0237.0001.0001)

MR ROZEN: Dr Dwyer, if you could turn to you, please, and could you state your full name for transcript.

DR DWYER: Drew Darren Dwyer.

MR ROZEN: Thank you. Dr Dwyer, you're a consultant nursing gerontology.

DR DWYER: Correct.

MR ROZEN: You also have extensive experience in aged care dating back to 1986.

DR DWYER: Yes.

MR ROZEN: You hold a range of qualifications which I won't read out but they are listed in paragraph 3 of your witness statement.

DR DWYER: Yes.

MR ROZEN: And they include a nursing degree - - -

DR DWYER: Yes.

MR ROZEN: - - - various aged care certificates - - -

DR DWYER: Yes.

MR ROZEN: - - - and a PhD in evidence-based health care.

DR DWYER: Correct.

MR ROZEN: The PhD topic – the thesis topic; are you able to help us?

DR DWYER: My PhD topic was empowering and educating registered nurses to become clinical leaders in a residential aged care setting.

MR ROZEN: Thank you. You are fellow of the Australian College of Nursing.

DR DWYER: I am.

MR ROZEN: And you represent the college as a committee member on the Australian Industry Skills Council for enrolled nurse qualifications.

DR DWYER: Correct.

MR ROZEN: You are also an adjunct associate professor at the University of Queensland School of Nursing.

DR DWYER: Yes.

MR ROZEN: And for the Royal Commission you have made a witness statement dated 24 May 2019.

DR DWYER: Yes.

MR ROZEN: And that's WIT.0192.0001.0001. Is there anything in your statement you would like to change, Dr Dwyer?

DR DWYER: No, thank you.

MR ROZEN: Are its contents true and correct?

DR DWYER: They are.

MR ROZEN: I tender the statement of Dr Dwyer, Commissioners.

COMMISSIONER TRACEY: The witness statement of Dr Drew Darren Dwyer dated 24 May 2019 will be exhibit 6-57.

EXHIBIT #6-57 WITNESS STATEMENT OF DR DREW DARREN DWYER DATED 24/05/2019 (WIT.0192.0001.0001)

MR ROZEN: I should have added there, Dr Dwyer, that you were actually a student of our next witness to your left.

DR DWYER: I was.

MR ROZEN: Right. Which brings us to you, Dr Abbey. You are retired.

DR ABBEY: I am.

MR ROZEN: At least semi-retired anyway.

DR ABBEY: Yes, I suppose you could say that. Yes.

MR ROZEN: All right. You act a voluntary consultant to PainChek. Can you tell us what PainChek is.

DR ABBEY: PainChek is a phone app that has a facial recognition part of the app. So you take a photograph of a person and that can diagnose whether their face is showing pain and then all the other parts are the kind of questions we have in the Abbey Pain Scale which are filled in electronically so that they can all be recorded at the point of care.

MR ROZEN: Right. You also act as a volunteer onsite educator in aged care facilities.

DR ABBEY: Yes.

MR ROZEN: You are also by qualification a registered nurse.

DR ABBEY: Yes.

MR ROZEN: And you also have a PhD.

DR ABBEY: Yes.

MR ROZEN: You are also a fellow of the Australian College of Nursing.

DR ABBEY: Yes.

MR ROZEN: And you have worked in aged care in various roles since 1967.

DR ABBEY: Yes.

MR ROZEN: In both Australia and the United Kingdom.

DR ABBEY: Yes.

MR ROZEN: All right.

DR ABBEY: All the panel members inform me they weren't even born then.

MR ROZEN: Yes, it's disturbing, I suppose. And you are, and have been for some time, the first professor of nursing in aged care in Australia.

DR ABBEY: I was.

MR ROZEN: Where was that? What institution were you - - -

DR ABBEY: It was a joint appointment between Prince Charles Hospital and QUT.

MR ROZEN: Right. Thank you. And you are, of course, the author of the Abbey Pain Scale.

DR ABBEY: I am.

MR ROZEN: Used in many residential aged care facilities to assess pain for people with dementia who are unable to verbalise. Is the PainChek app that you told us about a moment ago a sort of modernised version of the Abbey Pain Scale.

DR ABBEY: Yes, it is.

MR ROZEN: I see.

DR ABBEY: It's not exactly a modernised version of the Abbey Pain Scale. We can't say that otherwise there are legal complications so it is – it stands alone but it is very similar to the Abbey Pain Scale.

MR ROZEN: All right. And you will be pleased to know that we have heard a lot of evidence about the Abbey Pain Scale in the course of the Royal Commission. And for the Commission, you made a witness statement dated 20 June 2019.

DR ABBEY: I did.

MR ROZEN: That is WIT.0193.0001.0001. Have you had a chance to read through your statement before giving evidence?

DR ABBEY: I have.

MR ROZEN: Is there anything you would like to change?

DR ABBEY: No, thank you.

MR ROZEN: Are its contents true and correct?

DR ABBEY: They are.

MR ROZEN: All right. I tender the statement of Dr Abbey, Commissioners.

COMMISSIONER TRACEY: Yes. The witness statement of Dr Jennifer Ann Abbey dated 20 June 2019 will be exhibit 6-58.

EXHIBIT #6-58 WITNESS STATEMENT OF DR JENNIFER ANN ABBEY DATED 20/06/2019 (WIT.0193.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR ROZEN: Now, you are, obviously, collectively, a very, very experienced panel and we are very grateful to have the opportunity to hear from you this afternoon. What I would like to start by doing is to relay to you a summary, hopefully a fair one, of some of the evidence the Commission has heard, some of the themes that have come through the evidence, and I will ask you to comment successively in general terms about that evidence. The evidence is to this effect: that Australians are entering residential aged care on average at an older age than was the case, say, 10 or 20 years ago. Generally speaking, they are more frail than their counterparts of that time, and they suffer from a range of comorbidities, and more and more often with an overlay of dementia. We have heard evidence from witnesses that high care has become the norm in the residential aged care sector.

At the same time we have heard evidence that the proportion of the care workforce in residential aged care has seen a decline in nursing staff as a proportion overall, with personal care workers performing and being expected to perform often more clinically complex work which is at the very least at the edges of their competence and we have heard that in a couple of the case studies that we have had in these hearings. We have also heard some evidence that the competency those nurses who are working in the aged care sector is perhaps not as high as it could be and may even be declining.

Those two bits of the evidence strike many people in the community, one would imagine, as somewhat counterintuitive that at the time when you have got increasing acuity you've got a declining proportion of the workforce as registered nurses. My question perhaps starting with you, Dr Abbey, if you accept that that is an accurate overview of what has happened to our aged care system in the past 20 years, then a question that arises is how has that been allowed to occur?

DR ABBEY: It's a very difficult question to answer. Since I've been in the business, so to speak, for many years, it has changed enormously from what was, if you like, a cottage industry, from small organisations often run by ex-nurses, converted houses, to complete corporatisation. And now we have got what seems to be, to many people, a profit-driven industry-driven organisation that is employing people on very low wages. The old – in the old days, we really had people who cared, who came to work because that was the job they wanted to do. Now, unfortunately, we seem to get people who come to work because they can't do anything else, and profit seems to be a motive rather than caring.

MR ROZEN: Thank you. Dr Dwyer, you have also extensive experience in the aged care sector, you've written widely, you have trained. You are regularly in residential aged care facilities. But that description I gave of the trends, is that something that resonates with you, that is an accurate description of what has been going on?

DR DWYER: Yes. Of course, my personal opinion is that slowly and gradually there has been an undertow to systematically just remove a majority of the clinical focus that was undertaken inside a traditional nursing home, predominantly run by

nurses and organised and managed by nurses, with distinct frameworks and sciences behind how they addressed the holistic practice to deliver care to frail and vulnerable and elderly people. And step by step, as Dr Abbey says, that more – as it became more a move and transition out of a cottage industry mentality and moved to corporatisation and, of course, expense plays a role.

And hand-in-hand with this is the social move towards people's choices, decisions, their rights and responsibilities, and they've negated themselves away from what is known as evidence-based health care and the decision-making or the clinical inference we use when looking after people who are chronically comorbid and frail and probably on a trajectory towards end of life. The nursing home as a tradition as its name, has now been formally changed to RACF and, of course, that has removed the term such as patient and such as nurse, and nursing home and it's now a residential care facility, which is more or less operating in different models of hotel services, and more rather than living in accommodation than general care and nursing responsibility.

MR ROZEN: Plenty for us to come back to in those observations, I think. Ms Raguz, your perspective is obviously somewhat different. Dr Abbey and Dr Dwyer are on the outside, in a sense, whereas you are very much within a particular approved provider and we have heard some evidence already in the Commission about HammondCare and have a general understanding of how it operates. From your perspective, is the summary of the evidence that I gave about the trends something that you've experienced or is your experience somewhat different to that?

MS RAGUZ: Yes, my personal experience is different to that. And it is fair to say that that comes from being within one provider. But as a registered nurse, my role started with HammondCare as a registered nurse, and I recall that I had sole responsibility for 41 people that were – I was caring for at that time. And since my time starting we have increased the number of registered nurse hours across those facilities and that goes to even in the last five years, it has been an increasing number. My view is that it's the role of the registered nurse that isn't as clear as what it should be.

And it's how our registered nurse staff are maximising their clinical potential rather than being all things to all people within a system, from roster managers, to budget controllers, to ordering stock, to deciding whether or not the care staff in the tea room need to be reprimanded for their behaviour. The role of the nurse, I believe, should focus on what that clinical expertise brings rather than doing it all.

MR ROZEN: If can I just follow up one aspect of that, those supervisory managerial-type roles, are they performed by registered nurses at HammondCare or are they a separate manager role?

MS RAGUZ: In some instances. So we have registered nurse managers in some instances. We have clinical care managers, which are those people that really focus on those clinical systems, the governance that comes with those clinical systems.

But in terms of leading and managing across those services, no, they're not all registered nurses and I think it is that idea that just because somebody is technically competent as a nurse – within this industry what I have seen is that that automatically leads people to believe that they are also good leaders, and that's not necessarily the case. And so it's about focusing on what does the business need but what do people need who are receiving care and where does the nurse's role fit best within that.

MR ROZEN: Thank you. We will come back to a couple of those points, too. Ms Green, you, like our first two speakers, are in a sense on the outside in that you are not embedded in a particular provider. You provide services to a range of providers.

MS GREEN: I provide services to 13 facilities but what I am seeing is that the qualified staff is very limited. So then now you've got trained staff that have just completed university, whether division 2 or division 1, be in charge of 30 people. They haven't got the knowledge or the training to deal with the staffing issues, the rostering issues and directing personal care workers to complete tasks. Yes, it's – they just haven't got the knowledge to do it and they've been put in that position.

MR ROZEN: Can I clarify you said you've got registered nurses looking after 30 people, do you mean 30 residents or 30 employees, care workers?

MS GREEN: Can I say that there's one RN that may look after 30 people but also in the afternoon they will look after 120. So if that one RN on an am shift that I've seen at facilities will look after 30 residents, plus the personal care workers and then if it's in the afternoon, one RN will look after three team leaders which is a registered nurse as division 2 then all the personal care workers.

MR ROZEN: All right. I should ask you just a little bit more about your experience. Do you do all your work in one particular state?

MS GREEN: In state?

MR ROZEN: Where is it that you are doing the work?

MS GREEN: In Victoria.

MR ROZEN: In Victoria.

MS GREEN: Yes.

MR ROZEN: The 13 facilities that you work for, how does that work? Are you on call or how does it work?

MS GREEN: I don't work for any particular facility. I am a subcontractor to a doctor, to 11 doctors. We have patients at 13 facilities that I provide service, together with the GP.

MR ROZEN: Thank you. You work, effectively, in a small team with the GPs.

MS GREEN: Correct.

MR ROZEN: Right. As a subcontractor, to the GPs or to the facilities?

MS GREEN: To the GPs.

MR ROZEN: Right. Thank you. I will ask you a little bit more about the role of GPs but before I do that, I would like to ask you, Ms Green, some questions about nurse practitioners because we have had a little bit of evidence in the Commission about, or from nurse practitioners but we have not really had much evidence about them and what they do and so on. So I thought it would be a good opportunity to ask you. Obviously, a nurse practitioner you have to be a registered nurse in the first place.

MS GREEN: Correct.

MR ROZEN: And you need to do postgraduate qualifications.

MS GREEN: A master's.

MR ROZEN: A master's. Is it demanding, in your experience?

MS GREEN: Very much so.

MR ROZEN: Right. Presumably, it's a practical-based – clinically based master's; is that right?

MS GREEN: Yes.

MR ROZEN: And what does that involve?

MS GREEN: In my role, I actually look at the acute and chronic illnesses of the residents. And then I often also – it's basically the acute and chronic and palliative care, education. It's a lot on education, families and staff and - - -

MR ROZEN: Do you have a specialty in gerontology or geriatric nurse practitioner?

MS GREEN: Yes.

MR ROZEN: Is that because of a particular qualification you have or is that experience-based?

MS GREEN: Experience-based.

MR ROZEN: How much experience have you had in working as a nurse practitioner specifically in aged care?

MS GREEN: As a nurse practitioner, nine years. In aged care, I've had 26.

MR ROZEN: And in your experience, is that model that you work in where you are subcontracting to general practitioners and doing rounds, effectively, seeing patients in particular facilities, I take it you don't see all of the residents at a given facility.

MS GREEN: No. Unless a doctor has asked me if I can review their patient, because I work with one doctor but if another clinic doctor has asked me, "Sandy, can you review my patient?", I will be happy to do that.

MR ROZEN: Okay. And that model of working as a nurse practitioner, is that common in the aged care sector?

MS GREEN: No.

MR ROZEN: It's not.

MS GREEN: No.

MR ROZEN: Are there other models? For example, we heard from Professor Gonski in the Darwin hearings about his geriatric flying squads in Sydney.

MS GREEN: Yes.

MR ROZEN: And he told us that part of the model he uses is to have a squad essentially headed by a geriatrician with a registrar and then a couple of nurse practitioners – and he spoke glowingly, I must say, about the nurse practitioners, you will be pleased to know – but he described that as being a terrific model for doing that sort of work. Have you had any experience of that in your work?

MS GREEN: I believe our model that we've put in place works very effectively because a resident – the staff can call me when there is a problem and then I can gather the assessment and implement the appropriate treatment or education or whatever it may be before they call the GP.

MR ROZEN: Are there, to your knowledge, nurse practitioners who are employed in a particular residential aged care facility?

MS GREEN: I believe that there is one.

MR ROZEN: In Victoria?

MS GREEN: In Victoria.

MR ROZEN: Okay. And we heard from a nurse practitioner in the Perth hearings, Mr Cohen, and he told us – he is based in Sydney – he told us he was part of a group of nurse practitioners particularly specialising in palliative care who had a network. Do you also network with other nurse practitioners?

MS GREEN: Yes.

MR ROZEN: And is that done formally or informally? How does that work?

MS GREEN: There is a formal meeting that they conduct every three months, and then there's also the nurse practitioner forum, the College of Nurse Practitioners as well that we communicate.

MR ROZEN: I should have asked you this at the outset, but the concept of a nurse practitioner is a relatively recent phenomenon.

MS GREEN: It has been – as I've been a nurse practitioner for nine years, and then also probably three years before there was another two nurse – or another three nurse practitioners. So we have been around but I think that there's just not enough education with staff, with nurses, with families, even with the residents. As I said, every day I am providing education on what a nurse practitioner does because I've got families that will say, "Are you capable of looking after my parents?" so I have to explain, "Yes, I am".

MR ROZEN: We all know what nurses do. We all know what doctors do, there's a lot of ignorance about the nurse practitioner.

MS GREEN: Definitely. And that's not just from families, that's from government bodies and from a lot of other people, so I think we need to get education out there on what a nurse practitioner does.

MR ROZEN: Yes. I can guess the answer to the next question which is do you think there are enough nurse practitioners in aged care?

MS GREEN: No, because they need to lift the restrictions. There's so many restrictions. If they're lifted, then we can act independently and provide the best possible care for our patients.

MR ROZEN: We have heard that some of the things that distinguish a nurse practitioner from a nurse are the ability to prescribe medicines, for example.

MS GREEN: Basically diagnose, prescribe, refer, follow up on diagnostics tests, implement treatment, educate families and other nurses.

MR ROZEN: Yes. You said refer; by that I take it you mean you can refer a patient to a specialist in the way that a GP would.

MS GREEN: Correct.

MR ROZEN: You mention in your statement that that is all well and good in theory but it doesn't work so well in practice.

MS GREEN: No, because when I refer a patient to a dermatologist or a cardiologist I put it under my name. I put my provider number down, and it doesn't come – the correspondence doesn't come back to me. It goes directly to the GP. So when I eventually find out, you know, if they've been to the appointment, what was the outcome, I have to look in that patient's file to see what their cardiologist has implemented.

MR ROZEN: Right. Have you had also the experience of specialists refusing referrals - - -

MS GREEN: Yes.

MR ROZEN: - - - from you because you're not a GP?

MS GREEN: Yes. I have had several phone calls that will ring me up and say that, "I can't accept your referral because you're not a doctor." And I – again providing them with education that, "Yes, I am a nurse practitioner. Yes, I am allowed to refer. I have got a provider number. My referrals are 12 months. They're valid." And sometimes they accept it, sometimes they don't.

MR ROZEN: The statement that you've made to the Commission also includes a description of some other legal and practical impediments that are in the way. For example, you inform us that whilst you are able to prescribe certain medicines - - -

MS GREEN: Correct.

MR ROZEN: - - - that prescription is not necessarily honoured by the PBS system in the sense that the subsidy that would be available if a GP prescribed those medicines - - -

MS GREEN: Correct.

MR ROZEN: - - - doesn't apply when you do it.

MS GREEN: Correct.

MR ROZEN: Yes.

MS GREEN: Because in – sorry, in Victoria, we've got medication formularies. We're the only state that has them. And on my medication formulary, it says, for instance, glaucoma preparation. So, yes, I'm not going to initiate. It would be the ophthalmologist. But for an aged care person, I should be allowed to continue and

maintain their medication charts and their pressures in their eyes, but the PBS won't allow me to do that.

MR ROZEN: Thank you, Ms Raguz, do you have any experience of nurse practitioners working at HammondCare?

MS RAGUZ: Well, HammondCare does actually benefit from the geriatric flying squads that were described by Dr Gonski.

MR ROZEN: Yes.

MS RAGUZ: So in that context - - -

MR ROZEN: Indirectly, yes.

MS RAGUZ: Indirectly.

MR ROZEN: Yes.

MS RAGUZ: We certainly have. But in terms of employing a nurse practitioner or having them attached to the local GP services, it hasn't been my experience that they've been available. I don't think there's enough of them in the system.

MR ROZEN: Yes.

MS RAGUZ: And I do concur that I think some of the barriers to the practice or misunderstanding of how the practice can work has meant that we don't have as many in aged care as what we perhaps could.

MR ROZEN: Do you think it would be more beneficial from HammondCare's point of view to have more nurse practitioners working in the sector?

MS RAGUZ: Absolutely. Be very happy to have nurse practitioners to come and provide services.

MR ROZEN: Yes. Dr Dwyer, from the point of view of career paths within aged care, do nurse practitioners have a place in your view?

DR DWYER: Absolutely. There's – quite a bit of evidence has been written and produced by several nursing professors are who are heavily involved in the identity and the structural framework for nurses to be structured. So nurse practitioner at the top, registered nurse with a degree, registered nurse general, enrolled nurse and then care workers in an aged care setting specifically. But I do, in my travels and work in every state, come across nurse practitioners in facilities that are established with organisations.

MR ROZEN: Yes.

DR DWYER: The difference between those organisations as far as multidisciplinary case management goes is completely different to those organisations that don't have them. And the essence of the role of that nurse practitioner in an organisation is to be the leading clinician of that multidisciplinary team, particularly to take on a lot of collaboration with the general practitioners when it's necessary but to try and educate the nurses underneath them specifically to facilitate the end-to-end care as a case management through a multidisciplinary team.

So they become quite essential. They become quite pinnacle at the top of food chain of nursing, and they do have a lot of influence over policy and practice because they ground themselves very strongly in evidence, and particularly around geriatric medicine which is a complex science.

MR ROZEN: I'll come back to that last observation in a moment. I wouldn't mind asking you a little bit more, though, about the role of the nurse practitioner in those facilities where, in your experience, they're part of the clinical governance arrangements, if I've understood your evidence correctly, what are the benefits from the point of view of the quality of clinical care that's provided in those facilities of having a nurse practitioner that is at that top of the food chain, as you described it?

DR DWYER: Yes. Well, what happens is – I mean, much like GPs, nurse practitioners do endless hours. It's a professional give to the industry and to the patient, the subservient leadership, but it makes a point of contact at all times for the different interdisciplines of the team. They've got someone to refer to immediately, someone who is directly allocated to the service and to the patient or the person, the resident's outcome.

And so there's no lacking in communication. There's less time wasted in prescriptions, in getting directives, getting diagnoses, setting up case conferencing and, more specifically, in taking transitions towards palliative approach and setting up the right care paradigm or platform to work in that makes everybody comfortable.

So having a nurse practitioner on-site or in a service, whether it be a group of service where they're sharing that practitioner, it gives very clear, direct lines of communication. It gives nice authority and directive. And it also establishes stronger trust with the person who is getting the care and the team who deliver the care. So that is very central to the clinical leadership of that nursing process.

MR ROZEN: We've – this week and last week, the Commission has heard some case studies where issues concerning clinical governance have arisen, that is, particularly board oversight within an approved provider of clinical decision-making. I take it from the evidence you've just given, if I've understood you correctly, that where nurse practitioners are either working full-time in a facility or, as you said, are shared amongst facilities, that they provide a good conduit, do they, between the on-the-floor care workers and the senior management and board-level of providers?

DR DWYER: Yes, not necessarily to a board level. I mean, if you look at clinical governance in an aged care setting across any of the sectors - - -

MR ROZEN: Yes.

DR DWYER: - - - of any of the business operations, the board – it should be a tiered approach. The board should be sitting at the top tier - - -

MR ROZEN: Yes.

DR DWYER: - - - looking at the governance, the legalities and integrated governance, and then you would have a second tier which is Clinical Governance Committee. It would be a number of people in the service that have specialty. Yes, a nurse practitioner would sit there as probably the chief clinician of the service.

MR ROZEN: Yes.

DR DWYER: Then there would be a chief WHS, a general management chief, a quality management chief, and that board of people or group of people as a committee. And more than likely, you would have a resident representative, an advocate sitting there as well looking at the governance, the integrated governance and the quality issues that sit within a service around its policies, procedures, its processes and its quality management of care. Then down on the front line you have the third tier, and that is the people who deliver the service, the multidiscipline, and they range from everything from carers and hospitality staff up into the nursing platforms and, of course, allied health professionals that sit.

Predominantly, the best practice of modelling for this is nurse-led model of clinical leadership, and that is evident in most of the evidence you read around it. When you look at evidence-based health care, particularly around geriatric or aged care settings, nurse-led clinical leadership is a best outcome. And when we look at about the role of the nurse, it's quite well defined that that's an issue that sits in aged care. Registered nurses are that. They're registered nurses in a clinical domain.

The unfortunate thing when they enter aged care, they then are given an automatic role of leadership. They're not trained in it. They do have clinical leadership training, but it's a complex for a RN to take over a shift with perhaps 50 to 100 residents with 20 to 30 staff, and in one context they are told to run the acumen and it's also performance manage and run a multidisciplinary team. So a nurse who doesn't have that qualification or expertise will fall down in those skill sets. The longer they're in the experienced platform of working, the more education, CPD and expertise they get in clinical leadership, which is competency-based set of qualifications - - -

MR ROZEN: Yes.

DR DWYER: - - - the more they get better at it. Nurse practitioners, by the time they reach that status, have got quite a bit of skill in this, they're quite good at performance managing interdisciplinary communication, talking to a number of different colleagues and organising and giving directive. So they're able to make – use heuristics to make clinical decisions, use clinical judgment very quickly and hold themselves to their directive that they're given. Whereas when you look at that tiered approach, some nurses are very resistant to doing it and don't have the skill. So that's where some of that communication falls down. Nurse practitioner has a very, I think, well-positioned role in – as a geriatric nurse practitioner, but we do not see enough of them.

MR ROZEN: You have some experience of that role, geriatric nurse practitioner or GNP as we see it abbreviated sometimes, overseas, particularly in North America.

DR DWYER: Yes. You'll see this very regularly through America - - -

MR ROZEN: Yes.

DR DWYER: - - - and through Canada, and now through the NHS within the English system. So it is a recognised – in some countries on their nurses' board, they are a speciality – recognised specialty. Generally, this is because those countries have already experienced the boom in their ageing populations, so they're already seeing the numbers. Australia, of course, only has 25 million people, although our numbers are now coming in the ageing population.

MR ROZEN: Yes.

DR DWYER: We will need to – and require – there's been many a recommendation written on it that we will need to establish for a period of time specialised geriatric nurse and geriatric nurse practitioners because it is a very specialised science even for a general registered nurse to build a clinical skill set to lead a multidisciplinary health care team and to case-manage the complexity of some of the elderly clients they deal with.

MR ROZEN: When you talk about building that capacity, the geriatric nurse practitioner capacity, it's something that the Commission is certainly very interested in for the future. What does that mean in a practical sense? In other words, do we need more tertiary institutions offering relevant courses, or do we need more support from the sector or the government? What is it that you would see as necessary?

DR DWYER: I would see it as three – I would say a three-pronged approach. A good example would be University of Queensland now has Re the Faculty of Nursing, Social Work and Midwifery. So they've combined a lot of their multi-disciplines into a single school because, as you will experience in the Commission, a lot of us are working interdisciplinary.

So people like myself, who are nurses who also have degrees – a bachelor's degree in psychology and social sciences, we adapt gerontologists to different skill sets so we can work with different disciplines. The University of Queensland currently has readjusted its postgraduate learning for nurses into a masters or a grad cert dip into matters of advanced nursing practice. This, of course, now consolidates the clinical leadership as a number of units across all nursing so that the – all nurses will develop a skill set in clinical leadership, management and giving direction and having that ability.

MR ROZEN: Yes.

DR DWYER: And then the rest of the course, they go on and learn their specific clinical skill, whether it be paediatrics, geriatrics, whether it be cardiac. So the master's degree component will be they have the full skills in clinical leadership and multidisciplinary case management and, of course, a specialty in their field. That has resulted in Queensland, I know, that nurses who elevate in the hospital system or in the Queensland Health system now, because of that skill set, cannot go for level 7-above jobs as nurses until they have that qualification - - -

MR ROZEN: Yes.

DR DWYER: - - - so they can manage people, services and multi-disciplines at the same time as be clinicians that give directives in care.

MR ROZEN: Yes.

DR DWYER: So the pathways are starting to be built. You see them through many universities. And what it does require is more funding from the government. Nurses are still on low wages, and to be able to commit to raising a family – which most of them are women, male nurses also parts participate in that – but to commit to a family, to get your CPD and continuously professionally develop to maintain your registration, your public insurance, your professional indemnity public liability is on the shoulders of the individual nurse, much as it is a doctor.

And now they require the support so they can continue to elevate and to get into this education that is not going to be a burden and still allow them to work and support their families at the same time. So in the aged care zone, we see – you won't see any of this. Aged care nurse in general will be paid $400 a week less than a nurse in a hospital system. So the deterrent to come into aged care for a nurse is not there. That continuing education is not there.

MR ROZEN: Yes.

DR DWYER: I will say, though, the disparity is that nurses in aged care have to have a great amount of discipline, multi-skills and a lot of science-based knowledge to be able to perform the fundamentals of looking after elderly people. It's much more complex work than people think.

MR ROZEN: Yes, and, therefore, deserving perhaps of higher remuneration rather than lower.

DR DWYER: Yes, without a doubt. The biggest argument you will get from a nurse in aged care setting is pay parity. And we're not attracting the right nurses or keeping the right nurses because we're not paying them and remunerating them. Part of my masters and PHD and the lived experience of registered nurses in aged care settings completely outlines this, and the nurses are isolated, they are structured poorly, they're not supported, they get very little education unless they're paying for it themselves, and so they're quite restricted. And yet the demand on them from the organisational perspective to govern the care is very demanding and very high.

MR ROZEN: Yes. Dr Abbey, it's been a while since we've heard from you. The Commission has heard a lot of evidence about general practitioners not wishing to, in general terms, attend residential aged care facilities, problems with the financial dimension of that, problems we've heard about concerns by general practitioners about the competence of staff, for example, to deliver subcutaneous medications having an impact on the relationship between general practitioners and residential aged care facilities. It occurs to me, maybe a bit naively, I don't know, that there's an opportunity for nurse practitioners to fill the breach a little there. Is that – are we on the right track if that's the thinking?

DR ABBEY: Absolutely. I agree with what everybody on the panel said, and I think that nurse practitioners could – if I say take over the role of GPs, I will get lynched on the way out, so I will just say that it would be very good for GPs to relinquish the work that they can't do and don't want to do in aged care to nurse practitioners. But, as the point has been made, they've got to have the proper funding. At the moment, it's so limited that it doesn't attract people to be independent nurse practitioners. So I think the role – I think it's absolutely imperative. I don't think there's any other alternative because the GPs just aren't there and not doing the work.

MR ROZEN: Does it necessarily have to be either/or? Is there more that can be done to encourage GPs to have more of a role in residential aged care facilities, do you think?

DR ABBEY: Yes, there can. When we were trying to encourage the use of case conferences - - -

MR ROZEN: Yes.

DR ABBEY: - - - for example, for the GP we had to make sure it was on the day he wasn't playing golf, that we have to have a car park right outside the front door, that we provided lunch during the case conference and it had to be the case conference that was the highest level of money he could get. So once we did all that, we were able to get a GP to attend the case conference. But you have to be able to do that

kind of thing to get them to come, because the payment for case conference was very minor.

MR ROZEN: Right.

DR ABBEY: So we had it ready to roll the second the GP walked in, and we did all the writing up and all the notes that allowed him to make the claim - - -

MR ROZEN: Right.

DR ABBEY: - - - and then they were willing to come.

MR ROZEN: Okay. That's a lot of work built around getting a general practitioner to visit an aged care facility.

DR ABBEY: Absolutely, a lot of work.

MR ROZEN: Yes.

DR ABBEY: Yes.

MR ROZEN: Are there structural changes that could be made that could mean that you could have a visitor on a non-golf day, for example?

DR ABBEY: Some of the structural changes are the kind of things that we talked about in the Teaching Nursing Homes work, and that would be, for example, having a GP facility co-located with a nursing home so that residents actually came to the GP - - -

MR ROZEN: Yes.

DR ABBEY: - - - rather than the GP going to residents - - -

MR ROZEN: Yes.

DR ABBEY: - - - or that there should be more facility for people to go from a residential care facility to a GP, like a normal person, if you like.

MR ROZEN: Yes.

DR ABBEY: So that's one thing that could be done, the co-location. Or the GPs could be paid more for visiting nursing homes.

MR ROZEN: Yes. Yes.

DR ABBEY: That's the old one.

MR ROZEN: Yes. The co-location idea, do we see any examples of that in your experience?

DR ABBEY: No. At one stage I thought it was really going to go ahead. There was going to be an awful lot of work about GPs living with community services, and then that was going to extend to aged care facilities being attached. But nothing came of it.

MR ROZEN: Right. Ms Raguz, if we could change tack here a little bit and explore another theme that we've heard quite a deal about in the Commission, and it's what has been described, at least by one witness, Dr Trigg, in our Perth hearings, as the HHH dilemma, that is, whether a residential aged care facility – an expression she is not overly fond of, I must say, probably for the same reason as Dr Dwyer doesn't like it – whether it's a hotel or a hospital or a home. And I know in your evidence, in your witness statement about HammondCare, you talked a lot about a homelike environment. I guess the question that arises that I'd like you to address first, if you wouldn't mind, is whether it's reasonable to expect hospital-level clinical care in a homelike environment?

MS RAGUZ: Well, I think the answer to that for me is no, because it's not a hospital.

MR ROZEN: Yes.

MS RAGUZ: And I think understanding that – and I think this has been said previously with the Commission – that older people, like every other Australian, are entitled to care through the public health system that sits within the states and territories.

MR ROZEN: Yes.

MS RAGUZ: So – but that doesn't mean that good clinical care cannot be delivered in a domestic and familiar environment. I think it is the genius of the end. I believe that a homelike environment is possible. I believe that relationship-focused care delivers good clinical care and good clinical results. I believe that knowing and understanding the person and then being able to tailor that care to meet those needs doesn't just come from – it comes from relationship as much as it comes from having clinical expertise. And it's bringing all of those ingredients, if you like, together and doing that effectively with a model that has evidence-based evidence behind it to say it works and it improves quality of life. It's really important to have all of those ingredients in place so you can provide good clinical care in a home for people.

And we know that older people want to stay at home. I think that's the other thing, that we're hearing people do not want to live in hospitals for the last three years of their life, if that's the average length of stay. People would prefer to stay in their own home surrounded by people that they love and who they trust. If we aren't able to provide that care for people in their own home any longer, how do you extrapolate

that model to provide it within a residential aged care setting? And that is through the domestic and familiar model.

MR ROZEN: You mentioned earlier the role of the geriatric flying squads in your experience, and one of the issues I would like to explore with you, which we did ask Professor Gonski about in Darwin, was the role played by the multidisciplinary teams that make up those flying squads in adding to the skill base of the employees in the aged care facility. And he told us that there is a training and educational function associated with the work, primarily through seeing rather than formal training. Would you comment on that. Is that something that you have experience of at HammondCare?

MS RAGUZ: Yes, I would totally agree with that, and that's what we've seen in – the service that that particular flying squad does visit - - -

MR ROZEN: Yes.

MS RAGUZ: - - - is small, domestic, familiar environments. We have four houses there of people who – where there's only eight people that live in the home.

MR ROZEN: Yes.

MS RAGUZ: It's care worker-led, so we have the frontline care staff who are empowered, who are involved in communications throughout the whole chain. So we don't just rely on the registered nurses to be the communicators. And when that flying squad does come in, the way that that care and the instructions that are provided, it's delivered to that whole care team and we do raise the bar.

MR ROZEN: Yes.

MS RAGUZ: People learn and, you know, nurses learn. But care workers also learn. Family members learn.

MR ROZEN: Yes.

MS RAGUZ: But having a small environment where people have an invested relationship with the person who they're caring for, people are far more likely to be receptive to that learning as opposed to, "I'm caring for X-number of people. It's a lot of different people with a lot of different needs." You're almost giving the people the learning in that context it's all theory. But how does it become real? It becomes real when there's a real human there - - -

MR ROZEN: Yes.

MS RAGUZ: - - - and you're providing care and you're getting that expertise that's being provided to you, you're hearing it, you're seeing it, you're able to be part of it.

Your experience, then, is richened and you're able to provide better care to the next person.

MR ROZEN: If I can come back to you, please, Dr Abbey. This dilemma – maybe that's overstating it, I don't know – but it's something that has arisen in a lot of the evidence that we have heard. Do you have a contribution to make in relation to this?

DR ABBEY: Yes. When normalisation first came in, I was very opposed.

MR ROZEN: Sorry. Can I just ask you to pause there for a moment and just get you to explain what you mean by "normalisation."

DR ABBEY: I'm sorry; normalisation, or social role valuation as it came to be, was this turning everything into a home, so we - - -

MR ROZEN: Yes.

DR ABBEY: - - - had medical trolleys turned into cabinets and we had dogs that the patients fell over, and we had all sorts of things. But it was to turn everything. Everything became focused on a homelike environment. And it was totally unsuitable for about at least 50 per cent of the residents. A homelike environment is perfect for somebody with physical frailty and cognitive total – full cognitive ability - - -

MR ROZEN: Yes.

DR ABBEY: - - - where they can enjoy – the perfect thing would be a room with a little balcony so that they can have their plants and they can have their cat and they could feel as if they were at home. Once you get into having dementia, then something like the dementia villages are marvellous for people, say, at stage 1 or 2 or 3 of the Brodaty triangle, which I think the Commission knows about.

MR ROZEN: It does.

DR ABBEY: Once you get – for people with dementia, once you get past that, a homelike environment is not suitable. Brodaty explains very clearly in his triangle the kind of specific facilities that are needed for people at stage 4 and 5, and certainly at 6 and 7 you need very specific facilities to care for those people who may be kicking, screaming, spitting. You can't have a homelike environment when you're caring for people like that. So it's got to be an environment that is fit for purpose – excuse me – not to use this generic homelike environment. It has to be an environment fit for purpose.

MR ROZEN: Can I just ask you about some evidence we heard just earlier today from Ms Chadwick, who was the previous witness. And in response to some questions from Commissioner Tracey, she was explaining that the model of care employed at the provider that she is in charge of doesn't support the notion of

segregating people suffering from dementia from others. That would seem – and perhaps the explanation is it's all about the stage that people are at. That may be the explanation.

DR ABBEY: Is this the butterfly model you're talking about?

MR ROZEN: Yes.

DR ABBEY: Yes.

MR ROZEN: Yes.

DR ABBEY: David Sheard's model. David's due out here very shortly, so we'll have another kind of burst about – I just don't think it's sustainable.

MR ROZEN: Right.

DR ABBEY: And it hasn't been shown to be sustainable. And it's – I've seen it rise up and then the – it all begins to fall apart. You've only got to have one or two of the residents within the group that start hitting, fitting – you know, something going wrong and the whole thing falls apart. So it's a great idea, but it's been around for quite a long time and I've never seen it sustained, I'm sorry to say. So I have a totally different view .....

DR DWYER: They're going to reach an end stage at some point.

DR ABBEY: The residents, yes.

MR ROZEN: Yes. Yes. Ms Green, if we can come back to you, you've been sitting there quietly for a while. We've had some evidence in case studies this week about the role of specialist wound consultants, but we - - -

MS GREEN: Yes.

MR ROZEN: - - - don't need to restrict ourselves to specialist wound consultants. I'm interested in exploring with you the relationship between the external expert. In a sense, you'll fall into that category but in a generaler sense rather than one specific care domain. What is your experience of the interrelationship between external consultants like wound consultants, for example, and the staff in aged care facilities, particularly in the sense of do they – do such external consultants complement the work, the clinical care work in aged care facilities or not?

MS GREEN: They do, but we've actually got a bigger issue because big organisations are dealing with so many external services, like nurse practitioners, wound consultants, geriatricians, they're only selecting a few people to attend their patients' wounds. So, look, I might not agree with that wound consultant's recommendations. They might not agree with mine. So I would like to bring

somebody else in. But that aged care facility will not pay them. And then it falls back on the family to have this person in. They will have to pay for it themselves. I think bringing in someone that is an expert in their field is a really good idea.

MR ROZEN: Yes. Is there a risk that bringing in such a person or the availability of such a person might potentially deskill the clinical skills within an aged care facility, or is that something that can be managed?

MS GREEN: I think it can complement - - -

MR ROZEN: Yes.

MS GREEN: - - - because they actually educate the RNs and the division 2s, because some of them can also do basic wound care. But, yes, I reckon they can complement them.

MR ROZEN: Right. If I can move to a new topic, and if I can come back to you, Dr Abbey, and ask you questions about the aged care workforce generally, which is a topic of great interest to the Commission. You, in your statement, make reference or use a phrase a couple of times "cognitive dissonance". I'm looking particularly at paragraph 11 of your statement, which perhaps if that could be brought up on the screen, it's page 2 of Dr Abbey's statement which is WIT.0193.0001.0001. And you very helpfully include a list of points for us in paragraph 11 and in case anyone missed it you repeat them at the end of your statement just to make sure we were paying attention, I think.

DR ABBEY: Slightly differently.

MR ROZEN: Yes, indeed. It's the second dot point I want to ask you about, presently. We will come back to the first one about the hospice function because I know you wish to address the Commission about that. You said:

> *The situation in aged care today generates cognitive dissonance for staff and family leading to burn-out, compassion fatigue, complicated grief, all of which can contribute to abuse.*

Would you like to expand on what you mean by cognitive dissonance, please.

DR ABBEY: It's when the staff aren't able to do what they feel they should do and only can do what they can do. So they are looking after people who, in many cases, for example, people with dementia, who are virtually living a life of hell. And the people who are looking after them know they're living a life of hell and they know there's very little they can do to help them, and they haven't got the time. Often they haven't got the expertise …

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DR ABBEY: … and she was probably a refugee or certainly from another country and the look of terror on her face, I will never forget it. It was so terrifying because she hadn't learned how to cope with this person before. The look of – as if we were miracle workers, this nurse and I, that we had managed to persuade this person to get out of bed and shower him and laugh. And I just thought how terrible it must be for that person to have to come to work every day, being so frightened, unsure what to do, and is it any wonder that they don't do a good job because they're terrified and they – and that's what cognitive dissonance is. They don't know what to do, they don't know how to do it. They know they're not doing it properly and they suffer for it – suffer for it.

MR ROZEN: The dissonance, I take it, arises from wanting to do one particular thing, and not being able to all at the same time.

DR ABBEY: That's right, yes. I mean, if someone is banging on the table screaming "help me, help me, help me" and you try to give them sedation and the family says, "No, you're sedating them too much" and then you try to give them some antipsychotics, and they might have a reaction to that, and so you go around in circles and the staff suffer.

MR ROZEN: Yes. Dr Dwyer, I know you are keen to make a contribution here. In your statement you discuss the notion of looking after the staff which seems to link to the point that Dr Abbey is making. Why is it important, from your perspective, that care staff get that sort of support from their employer to do their job?

DR DWYER: I mean, to support what Jenny is saying is very important and again it's the stuff that is not spoken about transparently and openly and yet it's very much a matter of everybody in aged care understands this. So the discourse is public and when you have people that are involved in the Dementia Alliance telling the community they're getting all the funding, telling everybody that people with dementia don't suffer with dementia, people with dementia don't do this and don't do that.

And yet when you are a person at $18 an hour with English as a second language, you're a second or first generation care worker, it's the only job you can get, you have got limited training, you are stuck in a room with somebody who you can physically see is a human being, compassionate enough to know that they are suffering, that there's something wrong. "I need to be able to do something. It's what I've been told is different to what I'm experiencing". And this extends through many layers of the work that care workers, nurses, clinicians have to deal with.

What we understand as a lived experience in the practice of working in aged care is not what's being taught and spoken about and it's almost a case of don't look behind the curtain. So when I teach – and I do a lot of teaching in aged care and particularly to many levels of staff, when I look at an organisation holistically, I often make the comment – because it's one of the uses of rhetoric they push and that is person-centred care – but at the end of the day we are never going to be able to deliver

person-centred care if we don't have person-centred staff. We treat our staff poorly as an industry. We don't look after them, we don't educate them and we give them very limited resources.

And then ask them to go into a room or into a facility or a service and do – or someone's home, and do a very important job that most of society have not got the courage, the ability or the confidence to do themselves. And this is the cognitive dissonance that the entire workforce has to live with every day. You speak about it, you are vilified.

MR ROZEN: Ms Raguz, I would anticipate that the HammondCare experience is somewhat different to that. What support mechanisms are in place at HammondCare for care staff picking up on the observations that Dr Dwyer and Dr Abbey have made.

MS RAGUZ: One of the things that – I don't disagree with what my colleagues have said, but I think that having some practical things in place enables the care staff layer, if you like, to achieve. And part of that does talk about – I mean we talk about specialisation in many different contexts. We talk about it with visiting specialists, we talk about it with all other things yet at the aged care workforce coalface we expect the frontline staff to be experts in all things. Be an expert in dementia care, be an expert in end of life care, be an expert in mild cognitive impairment and a person who may have a severe behaviour. Be an expert in depression, be an expert – you know, and this is at the frontline care worker workforce.

So thinking about how people live within that home-like environment, who lives together and then how are staff enabled to be expert enough for that group of people, I think is a really important component of not burning our staff out, not having staff who are unable to achieve and see different things when they're taught in a classroom to what they experience. I agree if you have only one of the ingredients or two of the ingredients, you will not deliver person-centred care and you will have a burnt out workforce that hears different things but experiences something entirely different in the workplace. So it is being able to say we need to be able to – and I actually think for residents themselves a social environment in which they live with people who have similar care needs enables people to function socially within the group, not be the one person with dementia who the other residents don't want to be around and we have heard about that.

And I heard that just 48 hours ago from, you know, a DSA consultant that was visiting the facility and saying, "How do we make sure that all these people get along?" Well, you really – you won't. So I do think that the experience is about providing frontline care workers with what they are able to achieve with a group of people that they then can truly become experts. Provide them with variety in the work. You know, being – I worked as an AIN alongside my colleague, that was where I started. It wasn't with HammondCare but it was as I was studying to be a nurse and I remember going into services and getting a list that said you've got 14 showers to do and you have to have that done by 9 am. Well, I was very young, I

was fit and so my back was fine, but just imagine our ageing, you know, frontline care worker workforce and that being the job.

And then you move from that to toileting people. Then you move from that to feeding people, then you move from that to – you know, and at the end of the day we get our care workers to fill in a bowel chart and we think that we've treated them well. I believe that our care workers are the key. I believe that that relationship and trust is built at that level and when you build it right there but in a number and scale that is achievable, with the supports in place, then you will get better outcomes for both your staff and for residents and I think that that's part of the answer. That's part of the solution.

MR ROZEN: Can I just follow up on that and ask you what strategies are in place at HammondCare to achieve those things.

MS RAGUZ: One thing is – and I've heard this a few times through the Commission – we recruit based on attitude. We don't recruit based on skills or experience because we can give you that but the attitude is paramount. We then provide people with training and we do have – it's compulsory training to look after people with dementia. But we also have a self-selection process. So in those houses where, you know, Dr Abbey described the fear that was on a care worker's face, we have houses where people do display behaviour that is found challenging and cannot be supported in the mainstream aged care system even in a dementia-specific system. People need to self-select.

So it needs a certain type of person who is able to make a connection with someone who has that level of distress or disturbance and then you need to be able to provide them with opportunities to come out of the workplace and to debrief and to be able to discuss what other things that they found, and use the information that they have learnt.

So we have what's called a case management model that runs at that frontline care worker being the key. We use simple tools to enable people to share the information that they've gathered learned and then you actually provide people the opportunity to use that. And I find that with that – you then recognise also when people – staff need to be able to tell you when it is becoming too much and they need to work in a different environment for a while and you have to listen.

MR ROZEN: Is there an element of empowerment there that the staff have to feel empowered to be able to do that?

MS RAGUZ: The staff have to be absolutely empowered, heard. Your systems needs to be transparent. So the staff have to be able to tell you when things aren't working the way that you think they are working and then you need to be able to say now we have to understand why and what are some of the responses. But having care workers who are expected to just be task-focused, racing through a series of actions that are decided or driven by somebody who is higher up in the food chain

means you've got a level of people who don't feel valued and who don't understand often why they're doing some of the things that they're doing but bringing staff along for the journey, developing relationship, getting people to be engaged in a home not just a set of tasks and a pay cheque means that you get people who are invested in the care of individual people, want to learn but are free to use what they learn and raise the issues and then you can work through them and address them.

MR ROZEN: Ms Green, on this topic based on your experience is there anything you would like to add to these issues particularly of supporting the workforce and promoting the sort of environment that we have been discussing?

MS GREEN: Well, definitely you need to support your personal care workers and especially with your dementia patients. I actually do want to say, and make it clear that medication is not the first line. It is your nursing interventions. And you try all that first. If that fails, then you might have to use your antipsychotic medication, you might have to redirect, or you will have to call family members in. So, yes, it's just that we do need support. The personal care workers and RNs.

MR ROZEN: You mentioned families and that happens to be the next the next topic I want to go on to.

MS GREEN: Yes.

MR ROZEN: We've had a lot of evidence in the Commission including this morning from or this afternoon from Ms Chadwick about the importance of involvement of families, the building of relationships between staff, residents and families. You obviously have a lot of exposure, no doubt on a daily basis to families.

MS GREEN: Yes.

MR ROZEN: You make a point in your witness statement which runs a little counter to that, that is that often one of the most challenging aspects of your work is dealing with families. Would you like to expand on that for us, please.

MS GREEN: Okay. I've been in the industry for a while. I've just noticed since the bonds have been introduced into aged care they're paying a bond. So they expect a service. So my mother needs a geriatrician or my mother needs a dietitian. I'm just finding families are getting angry. They're demanding services. They're demanding care. They're demanding treatment a lot quicker. And I don't see it as a home-like environment. It's supposed to be a home-like environment. I see it as a subacute hospital because family is driving this.

MR ROZEN: I might ask you to expand on that because that seems an important point. What is it about the family involvement that leads you to see residential aged care facilities as subacute hospitals?

MS GREEN: Because they want – when their mother or father is sick, they're not accepting that they've got multiple medical conditions and they're unstable. And they want us to fix it. And if we say, "I'm sorry, your mother or your father, they're dying" they don't want to accept that. They want us to get in outreach services. They want us to put everything in place so their parents can get better.

MR ROZEN: Dr Dwyer, I see you nodding there. I know in your witness statement you make is some similar observations. Would you like to add anything to what Ms Green has said about the challenges that can be presented by the families of residents in aged care settings?

DR DWYER: Yes, it's perhaps one of the most trained areas I educate in with clinical teams or multidisciplinary teams - - -

MR ROZEN: Yes.

DR DWYER: - - - primarily because the workforce are culturally diverse as much as some of their clients these days, if not more so, and they're very confronted when they've met a family who is highly emotive, living with guilt and grief in a grief cycle themselves as they watch the transition of their own loved one pass in front of them. Generally, it begins because a family has been poor – or ill-informed or not given a prognostic marker or a diagnostic space to work with, and the education that we provide to our communities and society around transitions and impacts of chronic disease and elderly and what we are experiencing as a society is not being educated.

So, therefore, many residents' families are coming into a service, even in community, and have such higher expectations of subacute services, when the reality is that it's probably met a point in the trajectory of the person who needs care is that they need to start developing a mindset around taking a palliative approach, getting further educated and emotionally stable about what they're about to experience and probably utilising what it is that the nursing home has to offer as a professional service, to nurture that and give to warmth and transition it so that the quality can give some longevity and some better outcomes to everyone involved.

It's a simple case in any home you go to, and as I go into many, that the families are extremely demanding and have a higher expectation for the fees and services they're paying but, unfortunately, when we – we need to understand that most facilities are not fit for purpose. If a person over a particular age is living with geriatric atrophy and comorbidity and we know that the pathophysiology of that human body is on a pathway towards end-stage, it should be picked up by a clinician, examined, categorised and then case-conferenced with the family to be educated so they understand, "What is in front of us is this pathway is well-known and established." And our responsibility as a team is to nurture that and give it warmth. But it's not usually the case.

It's a denial, it's a confrontation, it's, "You're not doing enough. You're not providing enough." And it's – you know, it causes a bit of discourse. So there's a

huge gap in what we're not telling or informing society about what they are about to experience, and that is the large – or the transition of a large number of our society who are going to move towards end-stage of life very soon as a cohort of older Australians.

MR ROZEN: Ms Raguz, I know that in your witness statement you address this topic of the importance of relationships. I think you've got a heading at one point, Relationships, Relationships, Relationships. We get it. Can I ask you about how HammondCare deals with this, because no doubt these challenges that are being described of high expectations by families are real. Is that also your experience?

MS RAGUZ: Look, I think there is definitely the expectation that when a service provider is promising care, that care is then delivered. I don't think that there's unreasonable expectations being placed. That's not been my experience.

MR ROZEN: Yes.

MS RAGUZ: What I experience is the start of that relationship, I believe, needs to be before entry into an aged care service.

MR ROZEN: Yes.

MS RAGUZ: So there are providers out there who will sort of pick up the phone and say, "Yep, this person needs a bed", the hospital will transfer and, sight unseen, a person will come into an aged care facility, and it's no wonder then that there's the scramble going around to say, well, you know, two days later, "Does the person need a pressure mattress? Does the person need – what assessment have we done? How do we know what the person's needs are?" Meeting a person and their significant – the others who are perhaps involved in the decision before entry into a facility and communicating effectively not just then but throughout the whole time that a person is in care develops that relationship.

MR ROZEN: Yes.

MS RAGUZ: And within that, you're setting up at the beginning what it is that you're able to do, what you're able to offer, how that person's care can be delivered within, you know, this service if and when they arrive. And that process, if you do that well, but also in a human sense – it isn't just about the care needs, it's pulling information the other way. "Tell me about what does this person want, what did this person want." How – you know, advanced care planning or advanced care directives have been discussed through this Commission. I think that's another issue that once somebody has a significant cognitive impairment, that's really difficult to do that well. It becomes, "What does everybody else know about what the person wants or doesn't want?"

Building the relationship, maintaining the relationship, being true to what you've promised, if you're – and understanding when it doesn't work, if something in the

relationship is broken, how do you repair that relationship, and how do you move from that point forward? But I have not experienced an overwhelming level of unrealistic or expectations or even – in fact, I haven't experienced people being in denial about the progression, and perhaps that's because I work in dementia-specific services. And there is a general understanding by people, when they come in, that dementia is a terminal illness - - -

MR ROZEN: Yes.

MS RAGUZ: - - - and that their parent or their loved one is on a trajectory, but it's not easy to define and identify what that might look like because it's so unique for each individual. But I haven't experienced the same level of pushback, if you like.

COMMISSIONER TRACEY: Perhaps, Dr Abbey, if I can come to you on this point. Specifically in relation to the importance of communication, because we've had a number of case studies where one of the themes that emerges from I think all of them that we've done has been a concern on the part of the family member, I think in every case the daughter, about concern as much about a lack of communication as about a lack of care. That communication seems to be so important about, you know, for example, what requires additional payment, what doesn't, what the likely trajectory of a condition is, and so on. Do you have any observations about that?

DR ABBEY: I think one thing that is missed is are we listening to the resident? We seem to feel, especially when someone has got dementia - - -

MR ROZEN: Yes.

DR ABBEY: - - - that they've lost their voice. Can I just quote to you – this is from my own research – and this is pseudonyms. They're not real.

MR ROZEN: Sure.

DR ABBEY:

> *Three weeks after her admission her notes record that Mrs Brown has been very aggressive throughout the day. She was throwing crockery, walking aids, etcetera. Anything that came to hand. When asked why she was doing these things, she simply stated that she wanted to die.*

Nobody takes – we just ignore it. We just take that as a – "she's demented, she doesn't know what she's saying", so we just ignore it. We mustn't ignore things like that. We mustn't ignore the voice of the resident when they're spitting food out. It's the last power a person with dementia has got. They're choking. They don't want this food. They want to spit it out. We go on feeding them. So we've got to listen to the voice of the resident as well as the voice of the family - - -

MR ROZEN: Yes.

DR ABBEY: - - - and everybody else. I think that that gets forgotten. Family communication is difficult, but it can be improved by all the things that we've talked about, setting up a good relationship in the beginning and regular family conferences.

MR ROZEN: Whilst I'm talking to you, I want to turn to another topic which I know you're keen to address the Commission about. It's at paragraph 38 of your witness statement, if that could perhaps be brought up, at page 7. You there refer to the issue of palliative care, and you say:

> *I expand on my earlier point about the need for a hospice function in residential aged care facilities.*

Now, that's not something we've heard a lot about in the Commission.

DR ABBEY: No.

MR ROZEN: Can you perhaps expand on what you have in mind there and the importance of it.

DR ABBEY: Certainly. Exactly the same thing as I was saying: fit for purpose.

MR ROZEN: Yes.

DR ABBEY: It's the elephant in the room, if you like. In actual fact, yes, everybody has got frailer, everyone is nearer to death when they come into nursing homes now than they were before.

MR ROZEN: Yes.

DR ABBEY: And we haven't got a good way of handling this. One of the known palliative care processes that's used for people with cancer, etcetera, is, for example, that towards the ends of life people might start not wanting to eat and drink. And about 65 per cent of people with dementia develop dysphagia. Their throats get loose, the muscles in their throat get loose, they can't swallow.

MR ROZEN: Yes.

DR ABBEY: And if you feed them, they choke. Very uncomfortable. And you're more likely if you go on feeding them to give them aspiration pneumonia, which is a terrible way to die.

MR ROZEN: Yes.

DR ABBEY: So you can order a no-food, no-fluid. And we know from people who've been on hunger strikes that that is a very peaceful way to die. Once you're having no food, no fluid, and if that's helped along with some painkillers, then the person will die within a couple of weeks. A very peaceful death, because as you

become dehydrated, endorphins kick in and that makes a very peaceful death. But that's very difficult for the family …

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MR ROZEN: Thank you, Commissioners. Commissioners, you've heard some disturbing evidence in the last eight days of hearings in northern Australia. You've been told about homes where nurses provide only seven minutes of care per day per resident, and other homes that only spend $7 per day per resident on food. What's more, Commissioners, expert witnesses have told us that these are not isolated examples.

Other key messages have emerged from the hearing over the last eight days in Darwin and Cairns, including that it is clear that quality care has multiple dimensions, namely, safety, various domains of clinical and personal, care and quality of life, including cultural, socioeconomic and geographical factors. Secondly, quality care is not being delivered at a systemic level in Australia's aged care system. This is despite the undoubted commitment and care offered by the overwhelming majority of those work is in the sector. Thirdly, aged care providers in rural and regional locations face particular challenges in providing quality care, including funding issues and access to skilled workers and specialist care.

At the end of our sittings in Darwin, I made some closing remarks about particular matters impacting quality care in the Northern Territory. Those matters include cultural factors, poverty and access to services. I don't propose to repeat what I said about those important matters at length in these closing remarks, although they will be referred to in passing at times. This afternoon I will focus, rather, on aspects of quality of care that has been explored in the hearing. I will focus on systemic nature of certain issues that contribute to or arise from a lack of quality care. In so doing, I wish to acknowledge the great work of the Commission staff who have prepared these submissions.

Commissioners, we've heard that safety is central to quality care, and an absence of safety, whether through a failure to undertake clinical assessments or to provide expert clinical care when needed, can lead to poor outcomes. What's more, we heard that some care may, in fact, be harming people. Evidence from continence expert Dr Joan Ostaszkiewicz suggests that care may be creating a situation of incontinence through the indiscriminate use of continence pads, resulting in which she termed "socially engineered incontinence." And as we heard on Monday of this week, this was the experience of the late Mrs Aalberts. Last week, we heard the late Ms Santoro was subjected to weight-bearing physiotherapy exercises while suffer pressure injury on her heel, that this would have been very painful for her and that the pressure may have contributed to the worsening of her injuries. Osteomyelitis associated with a terrible pressure wound in Mrs Santoro's heel was found to have contributed to her death.

Of course, safety extends beyond the delivery of appropriate care. In a particularly startling case, Lisa Backhouse told the Commission that she moved her mother, Christine, to a different residential care facility because of concerns about her mother's care, only to be told that her mother had been assaulted twice in the new facility. Commissioners, you'll recall that Ms Backhouse's distress was palpable as she lamented that she had moved her mother to guarantee her safety but, as she said, instead delivered her further into harm's way. To ensure her mother's safety, Ms Backhouse sought permission to install a motion-activated surveillance camera in her mother's room.

Yesterday, we heard from a Mr Hunt, Ms Lawrence and Dr Iuliano that malnutrition can have dire consequences for an older person's health. Such consequence include increased risk of falls; osteoporosis and fractures; slowed wound-healing; extended hospital stays; cognitive impairment; increased risk of infection; and, perhaps most alarmingly, increased morbidity and mortality. Yet the prevalence and risk of malnutrition are unacceptably high, and the levels of protein provided in residential aged care homes do not meet Australian guidelines. Ms Lawrence told us that approximately 1.14 million older Australians are at risk of malnutrition and 300,000 are malnourished. Commissioners will recall Dr Patterson's concerns about levels of malnutrition in aged care facilities during our Perth hearings, and the empirical evidence we heard yesterday would seem to provide a sound basis for those concerns.

Commissioners, three detailed case studies were presented in this hearing. In each of those case studies we heard from witnesses who were concerned about the nutrition and hydration of their parents, some of whom experienced alarming weight loss. In particular, Ms Fowler faced a continuing battle to achieve appropriate nutrition for Shirley, her lactose-intolerant mother, at William Beach Gardens, an issue that required constant advocacy. Commissioners will recall that Ms Ng told the Commission about how the extreme weight loss of her mother, the late Ms Santoro, was not regularly monitored.

You heard in earlier hearings about the importance of medication management and the poor outcomes that can result from inappropriate use of medications. Last week, we heard from experts in this area. Dr Sluggett from Monash University outlined how multiple factors related to medication use could contribute to risks such as falls, urinary tract infections, weight loss, infections, disease, and could undermine sound diabetes management. Professor Westbrook from Macquarie University described a study undertaken by her team which identified that general practitioners may be making medication decisions on records with an average of 10 discrepancies per resident compared to the aged care facility record.

Making medication decisions without accurate data could have serious consequences for a patient, she told us. The Royal Commission heard that aged care providers are at times not undertaking clinical assessments, not calling specialists when needed or calling them too late. We heard that the Assisi Aged Care missed crucial assessments for the clinical care needs of Mrs Santoro. Like Mrs Aalberts' case, Mrs

Santoro's wound was not assessed until too late, and the right professionals were not made aware of the wound, and her weight loss was not communicated to relevant specialists, nor to her family.

Evidence presented last week indicated deficiencies in the clinical and personal care provided to Mrs Shirley Fowler. There was no referral to a physio for preventative exercise. Shirley's contractures were not identified by the provider's staff. It was Lyndall Fowler, herself a trained nurse, who finally identified the contractures, by which time it was too late. And these flaws were in a facility, like those revealed at MiCare's Avondrust Lodge, that had met 44 of the expected 44 outcomes across the accreditation standards.

Many of the clinical experts involved in the hearing called for individualised assessments of older people across multiple clinical domains at the point of entry into care. And as Dr Batchelor of NARI explained yesterday, these assessments need to be ongoing and dynamic, particularly if people's conditions change. Dr Sluggett called for pharmacists to be involved when the ACAT assessment is undertaken, and Dr Ostaszkiewicz and Associate Professor Murray each emphasised the importance of continence assessments because the type of intervention is dependent on the type and cause of incontinence.

Associate Professor Sussman and Mrs Ryan of Wounds Australia noted in the Darwin hearing that good wound care starts with correct diagnosis and the use of appropriate wound management materials, and that misdiagnosis is a major problem. Both Dr Sluggett and Professor Westbrook called for the aged care sector to learn from hospital settings about patient safety, particularly in the use of medicines.

Evidence before the Commission says that aged care providers are not regularly providing evidence-based clinical care. Reflecting on her vast experience in aged care, Dr Ostaszkiewicz was astounded at the lack of understanding of incontinence in the community and among health professionals. Wound expert Ms Ryan observed that evidence-based guidelines, although in existence, are often not currently adopted by providers. Dr Sluggett explained that data could be pulled together and linked from a range of sources in order to better under and improve medication use in management, and Dr Batchelor yesterday made a similar point in relation to falls prevention.

Concerningly, Commissioners, you've heard that deficient personal care is impacting on both clinical and quality-of-life outcomes. Ms Fowler believes that the most likely causes of the skin tear on her mother's leg was the inappropriate use of a sling and a failure to regularly trim her mother's toenails. Ms Backhouse described the lack of care her mother received after breaking her leg in her first residential aged care facility. She described finding her mother in pain, agitated, lying half out of bed and soaking in urine while the care workers were, she told us, chatting in the nurses' office. Concerned about the level of care her mother was receiving, Ms Backhouse moved her to a different facility.

Few of us will forget the still images from the surveillance camera Ms Backhouse installed in her mother's room at that second facility. On one occasion her mother lay on the floor for over 45 minutes, and on another occasion she remained uncovered in bed on one of the coldest nights of the year. And Ms Backhouse described her feelings of overwhelming powerlessness to ensure basic humane care for her mother. She described this event as indicative of a much wider systemic issue that a failure of staff to attend in a timely way following sensor or call button alerts, a phenomenon that we have heard a great deal of evidence about. She called for response times to be monitored by the Aged Care Quality and Safety Commission as part of a facility's accreditation process.

Both Mrs Fowler and Ms Backhouse identified systemic issues that undermined the delivery the equality personal care. They spoke of their observations of pressures on staff to undertake administrative or indirect tasks reducing their ability to deliver personal care. The lack of access to sufficient aged care in the community is another systemic issue that warrants highlighting.

As we've regularly heard these last six months, waiting lists in aged care are a critical factor in restricting access to the right care at the right time. Ms Fowler, Ms Ng and Ms Backhouse talked about their experiences of no longer being able to care for their mothers at home. This led to them either taking leave or resigning from paid employment before eventually, and reluctantly, moving their mothers into residential aged care. Ms Aalberts-Henderson reflected on the joy of her mother being assessed for a level 4 home care package but that joy being quickly replaced by sadness when told it would be at least a year before funding would come through. And Ms Aalberts moved into residential aged care two months after the assessment.

Associate Professor Murray, a continence expert, noted that if we don't manage people in home and minimise their continence-related problems, they can become significant factors precipitating admission into residential care. We heard in Darwin about the impacts of long waiting times for community care resulting in increased hospital admissions and entering into residential aged care. Professor Westbrook observed that the right type and quantity of community care may delay entry into residential aged care and, in particular, care that provides social participation, supports delayed entry into residential care.

Over the course of the hearing, we've seen in graphic detail the result of failures to prevent and manage wounds. Wound experts Ms Ryan and Associate Professor Sussman called for a greater emphasis on wound prevention. Early intervention could mean that simple and relatively inexpensive treatments prevent problems. Wound care consultant Ms Sharp also referred to the importance of the right equipment. She explained the value of alternating pressure air mattresses for those at risk of pressure injuries.

The Dietitians Association of Australia have informed the Commission of the value of involving dietitians early to prevent malnutrition. Ms Maloney explained that a variety of allied health professionals can add a preventative and rehabilitative

dimension to care. Dr Batchelor spoke of the importance of focusing on the prevention of falls as well as the prevention of falls-related injury. Ms Ryan noted the impact of wound product supplies in some aged care facilities and explained that in her experience, some facilities restrict product selection because of the training provided by these suppliers.

Over the last eight days, numerous clinical experts have called for multidisciplinary teams in aged care, recognising that care involves multiple elements. Associate Professor Gonski explained the benefits of a multidisciplinary team at the acute end of the care spectrum, noting that his flying squad has geriatricians, a registrar and nurse practitioners. Commissioners, Associate Professor Gonski's evident optimism and what might be described as his glass-half-full approach to the many problems in the aged care sector are a reminder to the Commission that there are answers to many of the problems that are revealed by the evidence. Ms Maloney said that people receiving aged care services should have access to a full complement of allied health professionals as part of a multidisciplinary team-based care.

Many of the clinical experts we've heard from elucidated the need for clinical assessments and care plans to be undertaken by clinical care specialists and then implemented by aged care staff, that is, nurses and care workers. Wounds Australia called for multidisciplinary approaches when addressing wound care. And Ms Raguz, who we just heard from, Ms Hopkins and Ms Chadwick, who gave evidence earlier today, discussed the need for carers to form a relationship with clients so they could understand behaviour or identify significant changes in their needs. Equally, Dr Dwyer and Ms Green told us that this can be a complex process in a practical setting.

We've heard that good staff are responsive to the cues of a person with dementia and will know when they need to use the toilet, noting this can be more challenging when staff don't know residents well. Commissioners, this is yet another reminder of the importance and benefits of staff continuity in aged care and was echoed by Dr Batchelor's evidence yesterday in the context of falls prevention. And, of course, we have already heard, particularly in the Perth hearing, about the importance of relationship-based care.

In Darwin, I referred to the evidence Ms Ah Chee and Dr Boffa, both from the Central Australian Aboriginal Congress, who called for nurses providing level 4 home care to be embedded in primary health care organisations so they can benefit from the support of a professional clinical team. And just today, Dr Dwyer, Dr Abbey and Sandy Green – all trained registered nurses or nurse practitioners – called for an increased emphasis on clinical training and skills, clinical governance and the recognition of the role of the registered nurse and the nurse practitioner. This lack of clinical governance, particularly a clinical governance committee at the Assisi Aged Care Centre, would appear to have contributed to the plight of the late Mrs Santoro. Questions of governance also arose in the MiCare case that we heard earlier this week.

The availability of clinical expertise was a common theme explored in the hearing. It became clear from the case studies that there were risks associated with external consultants, as important as they be, particularly in the areas of wound care and incontinence care. And as we heard, the risk is magnified when such experts are excluded from organisational clinical governance structures, are too busy, don't have access to relevant records or are simply going on leave.

The Commission has heard that quality of life is a central tenet of care. Professor Westbrook and other experts opined that maintaining and improving quality of life is one of the most important outcomes that we should aspire to in aged care. For example, Adrienne Lewis of the South Australian Dental Service yesterday explained the quality-of-life impacts of oral hygiene and dental care. Ms Lewis noted that a healthy mouth is vital to an older person being able to enjoy food, to smile, to laugh and to socialise.

Ms Hopkins described the Eden alternative and called for a paradigm shift in the culture of aged care so there's a move away from institutionalised models of aged care. Ms Chadwick outlined the relationship-based focus of NewDirection Care at Bellmere, and the Commission also heard from Elsie Scott, a resident. Ms Raguz of HammondCare described the value of configuring services in small clusters in order to strengthen relationships and enhance familiarity.

Commissioners, dignity is a central element of quality of life which is often compromised. You'll recall the evidence of Shirley Fowler's food-covered clothes and other soiled clothing which, of course, diminishes a person's dignity. Ms Ng told us of the lack of privacy and sensitivity to her mother's dignity as she died. And Associate Professor Murray courageously and movingly explained that his personal experience of incontinence has provided valuable insight into the importance of continence and the maintenance of dignity in continence care.

Dignity can also be compromised in smaller ways which can still have a profound effect on personal wellbeing. Chef Ms Twyford described a resident crying with happiness when provided with aids which allowed him to feed himself. And who can forget yesterday's story of 90-year-old Mary, whose life was turned around and her dignity restored by the simple act of having her mouth cleaned.

It is clear from the evidence of this hearing that care encompasses clinical and personal elements as well as quality of life. These can be different sides of the same coin, so to speak. The point was illustrated yesterday with evidence that focused on food and nutrition, but it applies equally to any number of care domains. We heard from the Dietitians Association of Australia and Dr Iuliano about the impact food has on clinical outcomes. Indeed, Ms Lawrence told us that food service is part of clinical care. Mr Hunt described malnutrition as a silent, faceless abuser in aged care.

Adrienne Lewis has told us that poor dental health can impact a person's ability to eat, and that oral health can largely be supported by a personal care worker. Dr

Batchelor noted that incontinence and poor nutrition can be falls risks. Ms Maloney told the Commission that speech pathologists can treat the social and nutritional aspects of dysphagia, difficulty swallowing, which affects 50 per cent of residents in aged care facilities.

And celebrity cook and founder of the Maggie Beer Foundation, Maggie Beer, enthusiastically explained that food needs to be appetising for residents to want to eat it. Her evidence emphasised the centrality of food to a person's quality of life. She explained that nutrition is essential but not enough. Ms Beer also recognised the difficulty of making food seductive, as she memorably put it, when working with a budget of around $7 a day. She told us every meal, every bite of sustenance should be full of goodness but flavour first.

Yesterday, a panel of chefs explained there are really challenges in planning and providing adequate and appealing food in an aged care setting, particularly with limited funding which can lead to cutting corners, lower quality produce. Mr Deverell described seeing maggot-infested rubbish stored between serving trolleys.

Those responsible for aged care service provision must prioritise resourcing for adequate food and nutrition. When there is such a commitment, we've heard the results can be very positive. Like the rest of the population, those living in aged care have particular likes and dislikes, and you'll recall Ms Fowler explaining that her mother liked fresh fruit and vegetables, while the late Ms Santoro enjoyed Italian coffee.

Ms Raguz and Ms Chadwick talked about models of care assigning priority to learning the likes and dislikes of care recipients, and Dr Iuliano explained that more time needs to be spent assisting residents to eat, something that many of the direct-evidence witnesses have called for. For example, Ms Lovegrove noted it could take over an hour for her father to eat. Similarly, Ms Aalberts-Henderson recalled her mother's eating difficulties after her wrist was broken. We spent some time examining food and nutrition and, in and of itself, this is an essential domain of quality care and must be a priority for aged care providers across all levels of staff.

Commissioners, you'll recall that Ms Numamurdirdi in Darwin gave an account of her pain in having to leave country in order to access appropriate medical care. These challenges associated with accessing medical care arose in a number of the case studies that we've examined. On the expert side, multiple experts spoke of the importance of respecting the client or the residents wishes provided the consequence of their choices were explained. For example, Dr Batchelor gave evidence about the concept of informed choice. Dr Abbey, earlier today, called for a reconceptualisation of the notion of duty of care. In her statement, she talked about the application of that principle having gone too far in restricting people's choices.

Another tension that arises in the evidence concerns the different dimensions of care, as memorably expressed by Dr Trigg in Perth, the so-called HHH dilemma, whether a residential aged care facility should be like a hospital, like a home or like a hotel.

Professor Gonski described his flying squad providing acute care in residential aged care settings, and he described residential aged care facilities being reluctant at first to allow the flying squads or to embrace the flying squads but ultimately accepting that more clinically complex services could be provided in residential aged care with the support of a hospital-based team.

The panel that we heard from this afternoon, particularly Dr Dwyer, Dr Abbey and Sandy Green, called for increased emphasis on clinical training and skills, clinical governance and recognition of the role of the registered nurse and nurse practitioner. In something of a contrast to that, Ms Raguz spoke about the centrality of a homelike environment, whilst at the same time accepting that it was perfectly possible to deliver quality clinical care.

We've heard, Commissioners, that families' beliefs and expectations have a central role in the choice of aged care provider. Both Ms Ng and Ms Aalberts-Henderson were attracted to culturally focussed care for their mothers. Significantly, in Ms Ng's words, when choosing an aged care facility she had assumed a similar level of clinical care would be provided at any aged care facility.

This hearing again highlighted the role of advocacy by family members in the care received by older people. In this and previous hearings, we have heard from direct evidence witnesses of those receiving care, and these witnesses have advocated tirelessly for better care for their loved ones. The family members we have heard from are often well-educated and have high levels of health and aged care system literacy.

Like Ms Hausler and Ms Ruddock in Perth, the witnesses we've heard from in this hearing have the skills and confidence to deal directly with providers about their family members' care. Reflecting on the difficulty of these experiences leads us to contemplate the helplessness of older Australians who don't have someone advocating for them when faced with the failures of care the Commission has heard about over the last eight days.

The expert witnesses told the Royal Commission that poor care is systemic and they've also spoken about the high prevalence rates of often preventable or treatable clinical conditions. Dr Batchelor indicated that 50 per cent of residential aged care recipients experience at least one fall in any given year, and while we know less about the rates in the community, those receiving home care are also at significant risk of falling.

Dr Iuliano noted the high incidence of malnutrition or the risk of malnutrition amongst older people, noting that these could be reduced by providing increased protein to residents. These high rates of preventable clinical conditions suggest poor care at a system-wide level. The systemic issues identified in this eight day hearing include workforce challenges and deficiencies in information sharing, the use of technology, collection and application of data.

Other systemic issues relating to access to services, perverse incentives in funding and a lack of focus on prevention. Some of these have been addressed above and will not re-canvassed. Workforce issues were also a central theme with many witnesses calling for increased staffing levels, improved training, greater co-ordination and increased access to clinical support. While noting that in her experience the vast majority of care workers were good people and did care, Ms Backhouse called for the professionalisation of the workforce to improve quality of care, noting that this means regulation, appropriate funding and remuneration, and career pathways.

Associate Professor Sussman and Ms Ryan also call for increased training of staff in relation to wound care. Ms Lewis called for increased oral health training for nurses and personal care workers, and Dr Batchelor identified low staff levels and poor training as a contributor to poor falls management. The Commission also heard about the need for improved use of technology and data for quality and safe care. Professor Westbrook gave evidence that "Australia's aged care sector is data rich but information poor" and she called for a systematic approach, where the data required is planned for and collected. Startlingly, Professor Westbrook identified the multiple possible failure points in medicine use, with many providers still relying on paper records and fax machine.

We heard that an unexpected benefit of the surveillance camera installed by Ms Backhouse was the increased role that she could play in her mother's care, such as calling to ask the facility to hydrate her mother after seeing she had an exceptionally long sleep. Ms Maloney called for funding models that facilitate multidisciplinary care, encompassing allied health professionals, whether that is in a community or a residential aged care facility. Ms Beer and our panels of chefs and dietitians called for increased spending on food in aged care. Pointedly, Professor Westbrook called for investment in:

> *…improving the quality of data in … clinical record systems which should be used every day to support the care of clients.*

This would allow for improved clinical care for individual clients and for provider and population level improvements in care. Associate Professor Gonski called for an upskilling of residential aged care facilities to provide palliative care noting that 25 per cent of the people referred to their service are put on an end-of-life pathway. Questions remain for the Royal Commission including whether concerns about quality and safety in aged care will be addressed by current funding models. Issues arise about the current workforce, existing accreditation and standards, and the mandatory quality indicator program. Some of the witnesses we have heard from touched on these questions, and the Royal Commission will return to try to answer them in future hearings.

I will close, Commissioners, with the powerful and eloquently expressed observations by Ms Lisa Backhouse about what she called the national shame of aged care. She said this to the Royal Commission:

Older Australians like my mum have given of their bodies, minds and spirits to grow a future for their families and communities and have laid the foundations of the society we enjoy today. Growing old should be a dignified experience where self-respect can be maintained. The next generation must have confidence that their basic physical, psychological and human needs will be met and hopefully exceeded when they are at their most vulnerable. The current situation is heartbreaking at best, criminal at worst. When we look back in years to come, much like the orphanages of yesteryear, this will be our country's greatest shame.

Commissioners, it just remains for me to place on the record that the next hearing of the Royal Commission will commence in Mildura on Monday, 29 July. Over the course of three days in Mildura the Commission will inquire into the needs of family, informal and unpaid carers for older Australians including support services for carers and respite care. The following week, starting on Monday, 5 August, the Commission will move to Brisbane for a one week hearing in which the regulation of aged care will be examined. At that hearing there will be a focus on quality and safety and how aspects of the current regulatory system operate.

Commissioners, in conclusion, I should just raise one housekeeping matter and that is to make good on my promise to update the status of the general tender bundle which now has 149 documents. An additional 22 have been added since 8 July. Commissioners, it just remains for the hearing to be adjourned.

COMMISSIONER TRACEY: Thank you, Mr Rozen. I repeat what I said earlier by way of thanking staff for facilitating this hearing in Cairns. And the Commission will now adjourn until 10 am on 29 July in Mildura.

MATTER ADJOURNED UNTIL MONDAY, 29 JULY 2019

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