AUSCRIPT AUSTRALASIA PTY LIMITED
ACN 110 028 825

T: 1800 AUSCRIPT (1800 287 274)
E: clientservices@auscript.com.au
W: www.auscript.com.au

TRANSCRIPT OF PROCEEDINGS

O/N H-1030608

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

PERTH

9.37 AM, FRIDAY, 28 June 2019

Continued from 27.6.19

DAY 30

MR P. ROZEN QC, counsel assisting, appears with MR P. BOLSTER, MS E. BERGIN and MS E. HILL
MR S. FREE SC appears for the Commonwealth

COMMISSIONER TRACEY: Please open the Commission. Yes, Mr Rozen.

MR ROZEN: Good morning, Commissioners. Commissioners, Bernard Cooney was a Victorian senator between 1984 and 2002. Barney, as he was known, died in February of this year after a long illness. At his funeral which was attended by over 2000 people Mr Cooney was lauded for his many years of public life, and his great contribution to Australia, both in the law and for his time in Parliament. Speakers at the funeral, all of them, spoke of his great humanity and his devotion to his family.

His last years were spent in a residential aged care facility in Melbourne. When this Royal Commission was announced in 2018 Mr Cooney prepared a written submission which he provided to the Royal Commission. The written submission is AWF.001.00519. This is what the late Mr Cooney wrote in his submission:

> *I applaud the announcement by Prime Minister Morrison of a Royal Commission into the aged care system and appreciate the opportunity to contribute to this extremely important process. It is entirely understandable that in view of the recent exposure of appalling incidents of noncompliance, with mistreatment of residents in aged care facilities, and the failure to maintain acceptable standards of care that he said 'we should brace ourselves for some pretty bruising information.'*
>
> *However, behaviours of the kind to which he was referring and have attracted publicity constitute only the most extreme manifestations of the mistreatment and deficiencies that are endemic to our system of aged care.*
>
> *Far more pernicious and difficult to identify are the largely unaddressed gaps in the provision of satisfactory personal support directed to the physical, emotional and psychological wellbeing of residents of aged care facilities. The pleasant physical surroundings and happy caring environments depicted in glossy corporate brochures in order to attract potential customers often conceal the real situation and experience of residents, particularly when they become disabled.*
>
> *The desire to maximise returns for shareholders is almost certainly the underlying explanation for these failures. It can be seen in minimum and often inadequate staffing levels, in the failure to ensure the adequate training and supervision of personnel, in the absence of serious endeavours to develop and conduct stimulatory programs and social interactions for residents and in the failure to take advantage of the technological aids that are now available to assist in all of these areas.*
>
> *Formal compliance with poorly described and limited formal standards appears to be the objective. The practical outcome of these deficiencies is, at minimum, the development of a sense of boredom and personal irrelevance for*

many residents and, at most, serious physical and mental suffering for others. This is of particular importance for those who are otherwise socially isolated. There are several reasons why this unfortunate state of affairs continues, including the reluctance and apprehension of elderly and fearful residents to lodge complaints against those upon whom they are so heavily dependent.

I am a resident in an aged care facility in Victoria, unable to perform the simplest acts to assist myself or even to adjust my position in the bed-style chair to which I am confined during my waking hours. If I become uncomfortable, thirsty or hungry I press the buzzer which is usually, but not always, placed close to my right hand. My voice is weak so I am unable to call for the assistance that may not be provided for up to an hour or so. In addition to what can be significant physical discomfort, this results in great frustration. I should add that the position has improved markedly since the Commission was announced. This is highly unlikely to be a coincidence and I doubt that I am being too cynical in asserting that there will be a quick reversion if pressure to comply in letter and spirit even with the present requirements is released.

A simple example of the tick box approach to the current formal standards in the operation of a facility can be seen in the provision of morning and afternoon tea. Each day, cups of coffee are brought to my room at the appropriate time by a kitchen staff member. The cup is then placed on a trolley or small table. I cannot move my chair to reach for it and even if I could do so I would be unable to hold the cup or drink without assistance. It does not seem to me to be unreasonable to expect, given that my physical condition is well known to the facility's administrators, that this assistance would be automatically provided. That does not happen and I find myself disinclined to press my buzzer for a cup of coffee, when it is difficult enough to secure a response at times when I am experiencing severe discomfort and require staff members to readjust my position. The coffee will usually remain on the trolley or table until the cup is removed or I am assisted to drink by a visitor.

Of course, whether or not I have a morning or afternoon cup of coffee is not of itself significant. I have chosen this example as a simple means of demonstrating the embedded culture and approach that is taken by the facility operators.

I make no complaint about the physical conditions of the facility, nor would it be reasonable to criticise staff members for their performance of demanding and underpaid roles but the absence of adequate training for them and the failure of our systems for the monitoring of standards of care in settings of this kind are evident. The objectives of the regulatory framework and the expectations of the Australian community with respect to the quality of care to be provided to some of its most vulnerable members are claimed to be satisfied by what is effectively little more than formal procedural compliance and too often this is unchallenged.

In addition to attention being directed to the staffing issues already mentioned, there must be substantial improvements made to ensure that the system of performance monitoring of providers operates effectively. Standing behind that must be the likelihood of the imposition of strong sanctions where proper standards are not met. The prospect of genuine and likely accountability of providers for failure to meet such standards is vital.

I am fortunate that I do not experience the social isolation of many others as I have a loving family and good friends to support me. I am in a far better position than many residents to make my concerns known, but I still experience these difficulties.

Even if you have them, friends and relatives cannot be present to monitor the day-to-day situation or assist with day-to-day issues. Of necessity, they must rely to some extent upon the integrity of the operators and may be hesitant about raising issues which could potentially create problems for their family member. It is apparent that residents like myself need an easily accessible and independent voice to assist them and ensure that their reasonable requests and expectations can be brought to the attention of the facility administrators and that proper standards of care are maintained. The more disabled the resident becomes, the greater is this need.

I recommend that this support be provided by qualified social workers who would be in regular attendance at the facilities, as they would possess the specialist knowledge and insights required to provide appropriate support and advocacy when needed to address both physical and emotional wellbeing.

The real values of a society as distinct from its stated claims can be measured by the way in which its most vulnerable members, and that certainly includes those in aged care facilities, are treated. Not much empathy is needed to appreciate that it is hard to retain a sense of personal dignity when, little by little, individual autonomy is lost. Viewed against that standard, our failures are apparent.

And Mr Cooney agreed to the submission being made public under his name. Commissioners, that brings us to the last witness that we intend to call as part of the Perth hearings. That witness is Dr Lisa Trigg and I call her to the witness stand.

<LISA JANE TRIGG, AFFIRMED [9.46 am]

<EXAMINATION-IN-CHIEF BY MR ROZEN

MR ROZEN: Morning Dr Trigg.

DR TRIGG: Morning.

MR ROZEN: Can you state for the transcript your full name, please.

DR TRIGG: Lisa Jane Trigg.

MR ROZEN: And, Dr Trigg, you have made, for the Royal Commission, a witness statement dated the 4th of June 2019.

DR TRIGG: That's right.

MR ROZEN: And the statement bears the code WIT.0156.0001.0001. Do you have a copy of your statement with you in the witness box?

DR TRIGG: I do.

MR ROZEN: There're a couple of amendments, three, in fact, that you wish to make.

DR TRIGG: Yes, please.

MR ROZEN: Is the first of those at paragraph 55 which can be found on page .0010.

DR TRIGG: Yes. There's an – and "is" in the first line that can be deleted.

MR ROZEN: So the first sentence:

> *In Australia, there is an emphasis –*

and that next word "is" should be deleted?

DR TRIGG: Yes.

MR ROZEN: So that the sentence will read:

> *In Australia, there is an emphasis on the ability of the baby boomer consumer to drive quality.*

That's how it should read; is that right?

DR TRIGG: That's right. Yep.

MR ROZEN: Okay. Is the next change in paragraph 124 on page .0022?

DR TRIGG: Yeah, that's right. The quotation should have a citation mark - - -

MR ROZEN: So the - - -

DR TRIGG: - - - and it's citation number 1.

MR ROZEN: Sorry, the quotation that concludes at the end of paragraph 124 should have a footnote at the end of it which is 1; is that right?

DR TRIGG: That's right, yeah.

MR ROZEN: Okay. And, finally, paragraph 146 which we can find on page .0026.

DR TRIGG: Yes, and in the third line from the bottom - - -

MR ROZEN: Yes.

DR TRIGG: - - - it should say:

> *Reinforced by a lobbying system which is more professionalised than in England –*

not Australia.

MR ROZEN: So you would delete the word "Australia" and insert the word "England".

DR TRIGG: That's right.

MR ROZEN: And the sentence should then read:

> *The centralisation of the system in Australia has made it more susceptible to capture by provider organisations and by policy entrepreneurs reinforced by a lobbying system which is more professionalised than in England.*

DR TRIGG: That's right.

MR ROZEN: All right.

DR TRIGG: Thank you.

MR ROZEN: With those changes made, are the contents of your statement, otherwise, true and correct?

DR TRIGG: Yes.

MR ROZEN: All right. I tender the statement of Dr Trigg dated the 4th of June 2019, Commissioners.

COMMISSIONER TRACEY: Yes, the witness statement of Lisa Jane Trigg dated the 4th of June 2019 will be exhibit 5-40.

EXHIBIT #5-40 WITNESS STATEMENT OF LISA JANE TRIGG DATED 04/06/2019 (WIT.0156.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR ROZEN: Commission pleases. Dr Trigg, your current role is as assistant director of research, data and intelligence at social care in Wales.

DR TRIGG: Social Care Wales.

MR ROZEN: Social Care Wales.

DR TRIGG: Yes. Yes.

MR ROZEN: And you've been in that role since February 2018.

DR TRIGG: That's right.

MR ROZEN: And what does Social Care Wales – what sort of an organisation is that?

DR TRIGG: Okay. Social Care Wales is an organisation funded by Welsh Government, and we have three purposes. So one is to improve public confidence in the social care sector. So social care in the UK is – is aged care, but also care for children in Wales.

MR ROZEN: Yes.

DR TRIGG: So our – so we have a remit to improve public confidence in the sector, to develop the workforce and also to support quality improvement in the sector. So one of our key roles is actually registering care workers so – which is quite different from Australia.

MR ROZEN: Yes.

DR TRIGG: So all care workers, by 2022 in Wales, will be registered whether they work in residential care, community care with children or with adults.

MR ROZEN: All right. We might come back - - -

DR TRIGG: Okay.

MR ROZEN: - - - to that topic, if we may. Make a note of that. So just so that I can understand that, is it actually part of government or is it a private organisation that's funded by government?

DR TRIGG: No, it's – it's part of government.

MR ROZEN: Okay.

DR TRIGG: Government sponsored.

MR ROZEN: Right. Okay. Thank you. You set out a bit more detail about it in paragraph 5 of your statement which I don't need to take you to in any detail. Prior to holding that role, between 2011 and 2018, you worked as a researcher at the London School of Economics and Political Science, LSE.

DR TRIGG: That's right.

MR ROZEN: And you continue to be a visiting fellow at the LSE.

DR TRIGG: Yes.

MR ROZEN: I will come, in a moment, to your research work that you did during that period. But significantly prior to that, earlier than that again, between 1989 and 2010, you worked in leadership project management and consulting roles in customer relationship management projects and operations in England and Australia.

DR TRIGG: That's right.

MR ROZEN: Can you give us an example of one of those roles during that period. What sort of organisations were you working for?

DR TRIGG: Okay. So I did a variety of roles, consulting roles, management operations myself, so I worked with companies like Telstra, Qantas, Aussie Home Loans, AMP. I – so, for example, at one point, in my career, I was actually – and please don't hold this against me. I was managing Big Pond technical support for Australia, but I did other projects working with, for example, Westpac to – how – how to improve the – the way they looked after their customers. So a variety of projects, a variety of sectors.

MR ROZEN: All right. I'm going to have to ask you to keep your voice up, if you could, please.

DR TRIGG: Sorry.

MR ROZEN: Only because you're competing with a rather noisy bit of machinery - - -

DR TRIGG: There you go.

MR ROZEN: - - - to my left here which is interfering. I should ask you about that. That seems a long way removed from aged care, or is it necessarily that far removed from aged care? Is there – are there any synergies between that previous life and the area that you now work in?

DR TRIGG: Well, the reason I changed careers is that I wanted to do something that was, I guess, more in the public good.

MR ROZEN: Yes.

DR TRIGG: So I – so I consciously changed sector and became involved in research. I suppose the thing that struck me is the opportunity to take some of that learning and apply it to this sector. So I think that there are – certainly, because the focus of my role before was around customers and relationships and customer loyalty, there are many parallel to how you try to manage operations to do those things.

MR ROZEN: Yes.

DR TRIGG: So some of the challenges are very different, but the – the importance of leadership and management and valuing staff, you know, if you want to provide good customer service, good – good sales, they're – they're also essential components. So I suppose one of the nice things is I have a bit of a unique opportunity to bring those skills and experience to this – to looking at this sector.

MR ROZEN: As you say in your statement at paragraph 9, your recent qualifications include a PhD in Social Policy awarded by the LSE and then various other - - -

DR TRIGG: Mmm.

MR ROZEN: - - - prior academic qualifications which I won't trouble you with, but are set out in paragraph 9. And you make the point that the witness statement you provided to us draws heavily on the research work that underlies – or underlay that PhD thesis and, in fact, the thesis itself; is that right?

DR TRIGG: That's right.

MR ROZEN: And the thesis title is, in paragraph 10 of your statement, Improving the Quality of Residential Care for Older People, a Study of Government Approaches in England and Australia. That's the title of your thesis, and I want to ask you a little bit about that, particularly the work – the research work that you did that led to the publication of the thesis. Firstly, the work involved research in both England and Australia; is that correct?

DR TRIGG: That's right, yes.

MR ROZEN: And in broad terms, what were you researching? What were you trying to find out?

DR TRIGG: Okay. So in my previous career, I worked with a number of organisations in various different sectors, and many of them were regulated. So I worked in Telecoms, financial services, and many of the organisations I worked with were trying to achieve accreditation around their quality. When I worked – when I started at the LSE, I was doing research into quality in aged care in many different countries and looking at how, particularly the European countries regulated for quality. And it occurred to me that there was this very strange kind of philosophy, belief, that inspection was a way to improve quality. So that, you know, whether announced, unannounced, whether it's a day, whether it's two days, this idea that an inspector could go – or a reviewer in Australia could go into an organisation, spend a day, two days, five days, whatever, and think that quality was going to be different for the other 360 days of the year.

MR ROZEN: Yes.

DR TRIGG: So it was this idea that regulation inspection could make a significant different to quality which, from my experience in other sectors, was, I suspected, misguided. And, at the time, I was also reading some really good work by some academics at ANU who did some great work comparing England and Australia and the US in the early nineties, and it just became clear that there was an opportunity to look at this again. And, obviously, with my history in Australia, I was naturally drawn to comparing those two countries, and the systems were, on the surface, anyway, quite similar. So it was a good opportunity to see whether there were any differences and what differences – what difference that made to quality of care. So that's kind of where it emerged from.

MR ROZEN: Thank you. And can you summarise for us the research work that you actually did. How did you go about this research?

DR TRIGG: So for the period of my research, I spent time in both England and Australia - - -

MR ROZEN: Yes.

DR TRIGG: - - - interviewing different individuals and also going to visit care organisations. So in England, I interviewed 32 people. So, in both countries, I interviewed people who were in the regulator. So, here, in the quality agency - - -

MR ROZEN: Yes.

DR TRIGG: - - - in the peak bodies, so I met with COTA, with LASA, with – with all of the peak bodies involved. Actually, not all, but most of the peak bodies

involved in care. I also talked to people in the Department of Health. I talked to people in the unions. I talked to consumer representatives, and the other thing I did while I was – so, in Australia, I talked to slightly more people. I think I talked to 32 in England, 47 in Australia.

MR ROZEN: Yes.

DR TRIGG: I also identified five care organisations that I could go and talk to about – we will come back to this, I suspect.

MR ROZEN: Yes.

DR TRIGG: But I tried to find five organisations that were delivering excellent care so I could go and talk to them about what was it that makes them provide excellent care and what did regulation necessarily have to do with that. So I came to Australia in 2015 and 2016, I spent five months here in total.

MR ROZEN: Yes.

DR TRIGG: I was – I was lucky enough to have visiting position at ANU while I did it, and so – yes, so 47 interviews in Australia and then additional visit to care providers and interviews with those people as well.

MR ROZEN: All right. You mentioned the five care providers and it might be an appropriate to time to ask you about that. How did you identify five care providers providing excellent quality?

DR TRIGG: So – so it was really important to me find five really good providers.

MR ROZEN: Yes.

DR TRIGG: So what – so what I wanted to do is talk to them about, "You provide excellent care. Where do you get the inspiration for that? What makes you an organisation that excels in this sector?" And I think the – one of the most striking things – and I mention this in my research is the difficulty I had in finding out who delivers good care in Australia. So we've seen this week that there are excellent providers out there. You know, there are excellent providers in England, there are excellent providers in Australia. But the difference was was that in England there was enough information out there that I could make a rough assessment of who I could talk to. Flawed, you know, not perfect information but enough information to makes some assessment of who I should go and talk to.

The difficulty in Australia is that there was absolutely no way of finding out. So there's no information in the public domain. 98 per cent of providers pass accreditation. So there's no differentiation between the people who've just passed and the people who are excellent. So I was really stuck with identifying those good

providers and, in fact, what happened in my research is I found myself in – I'm going to call them facilities which is a word I'm very uncomfortable with, but - - -

MR ROZEN: We might come back to that.

DR TRIGG: I thought you might. Facilities which were doing, you know, great people work in there and great had intentions but clearly hadn't grasped how to deliver good dementia care and good end of life care as well.

MR ROZEN: Did you speak to the Department in your efforts to identify these five providers?

DR TRIGG: That's right.

MR ROZEN: Yes. And what was the response from the Department?

DR TRIGG: Well, I talked to the Agency and the Department of Health both at the State level and the Federal level, and one of the things that was striking is – so there was some indication of who the really good people were and there were, you know, some names that come out again and again when you talk about Australian care. What was interesting to me is that good quality seemed to be conflated with who were the best known CEOs. So the, in fact – yes, so –there was no correlation in the care that I saw with that profile in some providers. So – I'm overcomplicating this but essentially I was given the name of five providers and within that was some really good care and some pretty ordinary care.

MR ROZEN: Thank you. And as you've already told us and as you say in your statement, you've distilled some of the key areas from your PhD thesis, slightly reduced the number of footnotes and that resulted in a very comprehensive witness statement for us.

DR TRIGG: Only slightly reduced the number of footnotes, sorry.

MR ROZEN: Yes, indeed. Now, in addition to the work that you've done, you've been in the hearing room for all five days of this hearing.

DR TRIGG: That's right.

MR ROZEN: You've sat through all of the evidence that has been led by the counsel team here in Perth and you've also been following proceedings in the Royal Commission in the earlier hearings.

DR TRIGG: Yes, some of it.

MR ROZEN: Some of it.

DR TRIGG: Yes.

MR ROZEN: I'm not suggesting you've watched all of it, not in the middle of the night in Wales, but you've been following it. We have also provided you with some transcripts and some other documents that we've asked you to read before coming along to give evidence here today.

DR TRIGG: That's right.

MR ROZEN: All right. Now, I want to ask you a bit about the hearing of this week and the way I want to do that is to identify three troubling aspects of the evidence and three parts of the evidence that we could describe as uplifting stories that we've heard, and then I will ask you some questions about that. So, firstly, the troubling part of the evidence. You were present in the hearing room when Noleen Hausler gave evidence on Monday of this week.

DR TRIGG: Yes.

MR ROZEN: And Ms Hausler told us about her experience of her 89 year old father who was assaulted three times in his bed, in a residential aged care facility operated by one of the largest providers of aged care in Australia. And she also told us about what happened after she raised a complaint about the facility and she was subjected to what appeared to be something of a David and Goliath battle with the management of that organisation. We heard yesterday from Shannon Ruddock who gave very moving evidence about the circumstances surrounding her father and she told the Commission that in his very final weeks she was wishing for him to die more quickly so that he didn't have to return to an aged care facility where he had previously been residing.

We also heard from Anna Urwin, an articulate and obviously intelligent young physiotherapist who described her experience working in aged care, and didn't want to return to work in aged care, largely because of the role that she had performed which she saw as a rather perfunctory pointless exercise of pain management – pain assessment and pain management and she told us that it provided no opportunity to her to exercise her professional judgment, her training which had taught her you can't take a one size fits all to physiotherapy and appeared to her to be driven by funding arrangements rather than the provision of quality care for recipients.

Counterbalanced by some uplifting stories, some truly uplifting stories. We heard from EA who spoke of the wonderful experience that she and her partner EB had had being cared for by Alzheimer's Western Australia, and we also heard from Jason Burton and we could see his obvious passion and joy, really, in the work that he does at Alzheimer's Western Australia. Secondly, we heard from Kevin Chester who spoke so movingly about his wife Marie and the care that she received from Whiddon and the way that he was embraced as part of her family, and we heard the carer, Ms Jubb, who told us about her role as a buddy for Marie Chester. And finally we saw that terrific video that was played when the managers from Wintringham were giving evidence and we saw the stories about the formerly homeless men and one woman, I think it was, who live and enjoy the warmth and the care that they get

from Wintringham and sometimes it's the first time in many years for them, they've had that sort of experience, that sort of human experience.

I suppose the question that arises from all of that is from the work you've done and your observations of the Australian aged care system, which provide us with a better guide overall about the system; is the good more typical or is the bad that's more typical, do you think?

DR TRIGG: It's very difficult to say because, well, one of the challenges you have with judging the quality of care is how do you compare it? What information do you take? So it would be very difficult for me to say with any degree of certainty that one is better than the other. I suspect – well, certainly in England, you get some outstanding provision and some very, very poor provision, and then most provision is either good or requires improvement. So there's this big chunk in the middle most of which errs towards the good. I suppose the thing I would say about what I've observed in Australia, one, is the good providers that were suggested to me didn't seem to be that good at all. So that was one issue, that it's hard to identify who they are.

But the – some of the things that I saw in Australia surprised me. Maybe the most tangible example is that there are still people who share rooms. So I visited some providers where there were people sharing rooms and that's something that hasn't happened in England for nearly 20 years. So in England, and the rest of the UK, rooms are only shared if it's a cohabiting couple or a married couple or if, for example, you might get, you know, sisters who want to share or best friends. So there are examples of things going on in Australia that I found quite surprising. You know, when I arrived here I had this idea, you know, having lived here and loved living here and having seen that 98 per cent of providers passed accreditation, I had this idea that, oh my goodness, it's going to be so much better. And that's not – that wasn't my perception by the end of my stay.

Like England, you know, there's – you know, we talk about different types of quality later but there seems to also have been quite a big emphasis driven by, you know, large amounts of money to have very flashy residential care. So it looks fantastic, you know, boutique hotel style, you know, chandeliers, tropical fruit, tropical flowers, you know, fantastic. But those places feel like hotels; they don't feel like the places where people want to live the last few years of their lives. So I couldn't say, you know, it would be unfair to say that care is much better in either place. We also have lots of problems with care quality in the UK, even though most care is acceptable or good. But certainly what I saw in Australia, I found slightly – I found it very disappointing. I came thinking, you know, I'm going to find out how it should be done, and I didn't.

MR ROZEN: One of the challenges for this Commission which is hearing the good stories and the bad stories through each of its hearings is to look at strategies, think about ways in which we can encourage more of the good and deter more of the bad, and I think some of the evidence that you will shortly be giving goes to that. But just

at a sort of high level, is that something that an aged care system can be designed to do?

DR TRIGG: Well, nobody has cracked it, so it's important to put that up there first.

MR ROZEN: Yes.

DR TRIGG: So you won't be able to go to a country and say, you know, it's breezy here, let's do what they do. I think there are some important principles though. One is quality is not something earned by the Quality and Safety Commission. Providers own quality and if they can't deliver quality they shouldn't be trying. So, you know, let's remember that whilst the government has a really, really important role here, providers have the responsibility to assure their own quality. So that, I think, is an important thing to say upfront. Regulation can't solve everything but what it can do is it can help to eradicate the really poor practice, so some of the things we've heard about this week. But equally it can help to shine the light on brilliant practice.

So how do you know, how do you inspire people to do things better? You have to show them how it's done. You know, it doesn't come naturally to everybody, but what you can find is that you will get providers who, given the information, can actually do wonderful things. And when we heard from, I think, Patti talked about the Butterfly Model which is a model of dementia care. In England we call it Marmite, so you either love it or hate it. You know, so there are other models of dementia care but you know, you could see how she had found this model and saw this way to improve quality. So there's definitely a role for regulators to shine a light on those wonderful bits of good practice.

But the other – two other things I would say: one is if you're going to have a system that looks after quality, it needs to have many people involved. So the other thing I would say is the government doesn't own quality, providers do, but I also think it's unacceptable for us as a society – that's difficult – us as the public to not support that. So some of the stories you've heard this week are about the best care being community-focused, bringing people in. So it's not acceptable for us to sit and judge providers without being committed to helping them provide better care because some of that is links to the community, is being involved with how those – you know, with the lives of homes – facilities.

The other thing that's important is that whatever system is designed has to have checks and balances. It has to have lots of organisations involved. So, for example, in the – in the UK – I will talk about England. So in Australia you have this system where the Federal Government owns everything, so it's the source of policy in aged care, it approves providers, it funds providers, the Quality and Safety Commission sits underneath that. There's something called the Community Visitors Scheme which has, I think, largely fallen into disrepair. There's the National Aged Care Advocacy Program. But they all sit in central government, in Federal Government. What's important – and if you look at some of the really good regulation theory is

that you have multiple stakeholders involved in the oversight of quality. So I will explain the English system very, very briefly.

MR ROZEN: Sure.

DR TRIGG: But it's not – as I was saying, it's not perfect. We haven't cracked it. But some of the things that are different are care in England has always been the responsibility of local authorities so here it would be the town councils and the other local councils and there are 152 of those which makes it very, very fragmented, but we have – so within those local authorities, they purchase care through government funded people and our funding structure is quite different. I don't – I won't go there just yet, but we have – so the Department of Health creates policy. The CQC is an arm's length body which – the Care Quality Commission which regulates quality. So it's part of the Department of Health, but arm's length. But then within local authorities, we have the bodies that buy care on behalf of people. We have organisations that are called Health Watch, so their job is to go and visit care homes and see – see how quality is going. So there's a much more – and we also have very strong legislation around mental capacity and consent and depriving of their liberty, and so all of these different bits of legislation and the different people involved, they all provide this kind of patchwork quilt - - -

MR ROZEN: Yes.

DR TRIGG: - - - of people who are caring about individuals in the care homes. So – so I think – as I say, nobody has cracked it, but there are some principles that you – that could be adopted to stop this kind of single, you know, huge monolithic body looking after care and everything associated with it because it becomes very difficult to make challenging decisions because if – let's take an example, if the Safety and Quality Commission was to say, you know, "We're going to crack down on psychotropic medication" - - -

MR ROZEN: Yes.

DR TRIGG: - - - which is something you've heard about - - -

MR ROZEN: Yes.

DR TRIGG: - - - then the Federal Government also has to foot the bill for what might be needed to do that. So I think there are just tensions within that – the way that's organised and not necessarily healthy challenging and checks and balances. So those are – those are some of the big tickets items, I would suggest. Can I just mention one more thing.

MR ROZEN: Of course.

DR TRIGG: It's about, also, something I think we will get onto about recognising that they – recognising the strength of different – Let's call them incentives.

MR ROZEN: Yes.

DR TRIGG: So you may be saying to providers, "We want you to do great relationship-centred care," but if the way they're paid is through the ACFI, which is really focused on clinical needs and activity based payments, then you will end up with a poor provider delivering that. So just to be clear. Good providers will deliver good care. You know, you've heard this week that they work around the ACFI, they will work with what they've got and they will find a way of delivering good care, but if you have providers that don't have either the competency or the values or the beliefs to do that, there are strong incentives in the Australian system that will – that will dominate how they manage their organisations.

MR ROZEN: Excuse me a moment. There's something in your statement I think I need to take you to about that. Yes. At paragraph 63 of your statement, if you have that handy - - -

DR TRIGG: Yep.

MR ROZEN: - - - it's on page .0012. Talking about relationship centred quality which we will come to in a moment, but I want to ask you about this paragraph because you just made a reference to good providers will always provide good quality care, and I was just wondering about this paragraph and what you're getting at here with – where you say:

> *Nothing, with the exception of inadequate funding, actively stops good providers delivering relationship centred quality.*

What are you getting at there, Dr Trigg?

DR TRIGG: Okay. So, clearly, if a provider doesn't have enough money to – to employ staff - - -

MR ROZEN: Yes.

DR TRIGG: - - - or pay their rent, you know, clearly, you have to be adequately funded. What I'm saying is that the good providers will do this come hell or high water.

MR ROZEN: Yes.

DR TRIGG: If you – one of the things that struck me is – so in my, you know, 15, 20 years of doing consulting, project management, you know, we've had had lots of conversations about leadership being an art or a science and, you know, which is it? And so, you know, there's this strong thing about, you know, well there's a science to leadership and management, what you have to think about. The thing that strikes me is – is – when you visit a really good provider is you inevitably meet people who – and managers who genuinely like their residents and their staff. So, you know, this

– this goes against everything I've ever talked about when I've worked with companies like Westpac.

They – you know, because we talk about, well, you don't need to like your staff. You just need to be able to manage them. But, actually, when you go to really good providers, when you find a little beacon of excellence, almost inevitably, it's run by somebody who just loves spending time with her staff – his or her, but it's often her staff, who, you know, comes in on a day, just – just goes the extra mile because they genuinely like the people in their home, whether they be staff or residents or relatives. So – so what I'm trying to get at there is that, you know, those are people who will do this anyway regardless of what the – you know, what – in – in academic terms, we call perverse incentives. So, you know, we talked – we had Anna earlier this week talk about the ACFI and how she can only administer tense or muscle – sorry, or therapeutic massage.

MR ROZEN: Massage. Yes.

DR TRIGG: You know, someone who's running a relationship centred good quality facility will find a way of doing of the things they need to do within those budgets. So what I'm trying to get at is, you know, you – the incentives in the system to deliver poor care exists, but the really good providers will do it, come what may. It's just part of their DNA. That's what they – they do day in, day out.

MR ROZEN: Dr Trigg, is there a bit of the evidence that jumped out at you during the week this week?

DR TRIGG: Well, poor or good or – I mean, the – what jumped out at me – two things. I will - - -

MR ROZEN: Yes.

DR TRIGG: - - - give two examples. One is that there is excellent care in Australia, and there is plenty of inspiration here, I think, to remodel the system. I think – you know, I was reflecting, the – I asked you to find the evidence from Andrew Sudholz from Japara.

MR ROZEN: Sudholz. Think we can - - -

DR TRIGG: I feel uncomfortable bringing this up, so - - -

MR ROZEN: That's all right. We can bring it up, and it's – it was on the 25th of June and it's transcript page 2391 at line 39.

DR TRIGG: So I - - -

MR ROZEN: Just a little context here. This – I had - - -

DR TRIGG: Yeah.

MR ROZEN: - - - asked Mr Sudholz about a reference to Ms Hausler as a person who was vexatious in some of the internal emails, and this was the response that he gave to that, if this is what you're referring to - - -

DR TRIGG: That's right.

MR ROZEN: - - - Dr Trigg.

DR TRIGG: So, you know, it's unfortunate to identify a single person, but I thought that this quote absolutely encapsulated where you can go wrong in aged care. So can I read it out.

MR ROZEN: Yes, please.

DR TRIGG: Yeah. So this is him talking about the meetings that he went to – a meeting he went to at the facility and he said:

> *And on the mid – I think it was mid-2016, we had a resident and relative meeting that I was attending, and in that meeting, there were a number of people who were very abusive, very aggressive towards me, shouted me down and showed little respect to me as the CEO of a big organisation, and I found that disappointing, and I was quite distraught about that.*

For me, that's the problem. The – you're not the most important person in the room, and if you don't recognise that the most important people in the room are the residents and the relatives and the people who work with them every day, then you have completely missed the point. So I – I feel slightly uncomfortable picking a – an individual, but I think that really sums up what the issue is, that if you don't believe those people, not just the residents, but their families, the – the people who work there every day, whether it be in the kitchen or the laundry or, you know, registered nurses, then you – you kind of missed the point.

MR ROZEN: So it brings us to a related point or a directly related point, and that is the importance of organisational commitment or leadership to the provision of quality care in aged care. The Commission has heard a lot of evidence about this. Perhaps I can just bring up one bit of the evidence from this week. This is Mr Mamarelis the CEO of Whiddon, and it's at transcript page 2431 from the 25th of June, and it's at line 31, if that perhaps could be highlighted, that passage. And you will see there that Mr Mamarelis was being asked about Whiddon and its approach and he said, I quote at line 31:

> *As CEO, I'm responsible for every aged care resident that we care for. I'm responsible for every home care client that we visit. I'm responsible for every retirement village resident as well. So as CEO, my focus and my leadership is very important in the organisation in setting the tone and setting the culture.*

As CEO, it has been really important, given the cultural shift, that we have to take to empower our people and give them licence to start thinking in this different context and to take them on that journey with us.

It's probably a rather obvious point, in light of what you've just said to us, but why is that sort of leadership and organisational commitment important, in your experience, in the delivery of quality aged care?

DR TRIGG: Yeah. It couldn't be more poles apart. So the thing about aged care, so – so, you know, I worked in customer service and sales, you know, managed operations. So something that is talked about for service and sales is the idea of emotional labour.

MR ROZEN: Yes.

DR TRIGG: So there's this idea that, you know, the people who are looking after customers through – you know, whether it be through customer service or sales, they have – they have this responsibility to put on a face. So no matter how they feel about the – about the person on the other end of the phone or standing in front of them, they have to put on this very professional and warm and friendly face, and that is incredibly taxing if you don't really believe it. I think for - - -

MR ROZEN: Taxing on the worker that has to - - -

DR TRIGG: On the worker. Yeah. I think they imagine putting on your face.

MR ROZEN: The smile.

DR TRIGG: Yeah.

MR ROZEN: Yeah.

DR TRIGG: You put on your happy face every day. So if you want to talk about the emotional labour in aged care, but, actually, people have gone much further, and I think this is really helpful, is that, actually, what we want in aged care is – so – one – an Australian academic called this banded emotionality. So what you want is people to be themselves. So, this week, we've heard about Tom Kitwood's idea of personhood.

MR ROZEN: Yes.

DR TRIGG: And something people forget about is that care workers also have that personhood. So to deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported. As, I think, Jason said – I'm not sure if it was Jason, but somebody said earlier in the week, if you try to lead an organisation where people care about the people they're caring for, they will also have really difficult times because people will die, people

will move away and they will find it very difficult. If you think about what it takes to lead an organisation which is full of people with, you know, their emotional hearts on their sleeves, but you're encouraging them to develop relationships, to be compassionate, to care, to be reciprocal, so, you know, the idea that – there – there's a great thing that I'm sure you've heard in the Commission that you heard it this week, I know for sure, is this idea that you're not doing to. You're doing with.

MR ROZEN: Yes.

DR TRIGG: But actually somebody, and I wish I could remember who it was, suggested it's not about doing with. It's about being with. So when you're with people in aged care, you know, it's not just about this one – you know, this kind of supportive relationship. It's about a genuine compassionate relationship. You have to be like Mr Mamarelis and understand that that's the sort of thing that you're supporting and – and that supporting those people to live with that sort of care is actually the lifeblood of aged care. So, yeah, I think – I think that it's – you know, it's back to that point, you know. You are not the most important person in the room. The people who are developing those relationships and supporting those relationships are the – absolutely, the most important people in the room.

MR ROZEN: Couple of things. We saw in the evidence of Carol Jubb, who was the buddy for Marie Chester.

DR TRIGG: Yes.

MR ROZEN: She was only here for a short time, of course, but one could sense the genuine joy she got from those celebrations of Marie Chester's life, the – as a resident of the week or resident of the month.

DR TRIGG: Yep.

MR ROZEN: Ms Hill will remind me, but that was – the Best Week, Marie's best week, and you could sense the genuine joy. Is that sort of what you're talking about? That true relationship between them.

DR TRIGG: Absolutely. I mean, I would say – because I have been aware through other channels about the Whiddon Group and their – one of the things that I think is very admirable about what Whiddon is doing, it's a large organisation that is trying to move towards a relationship-centred model. I mean, the best relationship-centred care I've seen is in very small providers because they feel like homes.

MR ROZEN: Yes.

DR TRIGG: You know, they feel like places of joy. I remember one home that I walked into in England, you know, you couldn't move for toddlers running around and the manager's dog was pottering about and there was any number of things and then some ducklings appears out of nowhere and, you know, so it was just a place of

– you could argue chaos but chaos in a very joyful and natural and enjoyable way. So Whiddon have got some really nice ways of trying to bring that into their very large – well, not all very large, but they're big organisations. So you know – with something like the Best Week, I think that the Best Week is a lovely idea, but what – but what's really impressive about the Best Week thing, is not the week that the resident has with the focus of attention on them; it's the fact that it means that they are known to the staff and to the other relatives and to the other residents as that individual.

And so it covers all sorts of – sorts of information and details about that person's past and so I, you know, I wouldn't say everybody should do that because, you know, one thing I would say, which I didn't, you know, the – the temptation when trying to reform this system will be more projectitis. Okay, so wow, that's a great model; let's take what Whiddon does and let's roll it out with every provider. And what you just brought up in terms of what Mr Mamarelis said is that it has to come from a leadership role. It's not something that you can instil into an organisation with that – without that top-down commitment that this is actually the way to go. So yes, that was a great example of a large organisation trying to move towards this more – a sense of a smaller kind of organisation.

MR ROZEN: Thank you. I would like to ask you a little bit about terminology because we've heard phrases bandied around during the week with different levels of enthusiasm for them. Person-centred care is the expression that's in our terms of reference, and you have introduced the notion of relationship-based care in your statement. What's the difference between those two notions?

DR TRIGG: I think it's arguably – well, the reason I've tried not to use the word person-centred, the reason why relationship-centred became, for me, more meaningful is the expression person-centred has become so abused.

MR ROZEN: Yes.

DR TRIGG: So, you know, you would – a care provider who may not be of an excellent standard who would say, well, having in your care plan that you prefer tea to coffee is person-centred, or that you prefer a bath or a shower, that's person-centred. And, you know, people who are delivering really good person-centred care know that's not what it's all about. But the temptation is that if you give people choice, if you, you know, write it down in their care plan, if you know a little bit about them, this could be, you know, this is person-centred. Relationship-centred care – it builds on all those principles so it's based on, like everything else that you will have heard of, it's based on Tom Kitwood's work. It's based on personhood, it's based on individuality. But what it's trying to do is distinguish – I'm trying to distinguish between that bandied-about term that people use so commonly without really understanding what it means, and emphasise how much that's about individuality but it's also about relationships.

So the best providers – and you will have seen this in the evidence this week, are all about treating the – their provision, they don't even call it provision – they're talking about families and communities and people being involved, and, you know, one of the – one of the most heart-breaking stories I heard this week was that couple in – Emma-Kaitlin mentioned. So she talked about the gentleman who was – who was living in one part of the facility, and his wife was living – and I will call it a secure dementia unit because I think that's what she called it, even though I struggle with that, and he just wanted to see his wife, and they couldn't make that happen. So he'd have an hour a day. That's not person-centred care. Relationships – so, you know, having a relationship with that person, you would make everything – every effort you could to make that happen, providing – somebody made the good point that, you know, the wife needed to want it too, but the – it's those sorts of things that people forget, the really important things and how can those people – how can everybody in the facility or home have those sorts of relationships is really important.

MR ROZEN: I think Emma Murphy might have been the nurse who gave that evidence.

DR TRIGG: Yes.

MR ROZEN: Yes. If I could just tease that out a bit more. So much of the evidence the Commission has heard from people who are working day to day, especially personal care workers – and we heard from two of them this week – is that they're rushed off their feet. They don't have the time even to attend to the tasks that they have to – the basic tasks of assisting the residents for whom they're caring. And at the same time, you and others have said that relationships are of central importance, they're crucial. And, of course, we all know that it takes time to build relationships, you know, literally the ability to sit down and have a cup of tea for 10 minutes and have a chat about a person's family. If that's distracting the already overworked care worker from doing the tasks that their employer requires them to do as their indicators of their performance, is there a sense of unreality about what you're saying, if I can be direct, about people putting time into relationships? Is that – is it feasible under our current arrangements in Australian aged care?

DR TRIGG: Yes, I will start with two things. One is we've seen people who are doing it. So you kind of think, well, there must be a way of doing it. The second thing is, I haven't done a huge amount of analysis about how much money there is in the sector compared to England so I would counter it with that. But what I would say is that – so if you work with, you know, a lot of people in our aged care system are living with dementia, and working with people with dementia can be very challenging but it can be very challenging if you do it in the wrong way. Because if you do it in the wrong way, aged care facilities can be very unpleasant places to be. So I was trying to think of a way of explaining this, so – in terms of how you work with people with dementia. So can I ask you a question?

MR ROZEN: You can.

DR TRIGG: So I'm going to ask you a question. If you got on a plane and you were flying to London and it's a pretty nasty flight, it's hot and stuffy and, you know, not very pleasant. You've had something to eat and it was pretty ropey. The person next to you is fidgeting and it's really annoying. You put your little eye mask on, you stick your earplugs in and you finally drop off to sleep. Suddenly your next – the next thing you realise is someone has shoved a toothbrush in your mouth and is trying to brush your teeth. What would you do?

MR ROZEN: You probably wouldn't be too thrilled, Dr Trigg.

DR TRIGG: You would probably smack them in the face. I think I would, or you'd try and get out of there pretty damn quickly, or even worse if they tried to take your pants off to change an incontinence pad. So you imagine, if people are given that sort of care just how unpleasant those places can be to work, because you haven't – you know, imagine people "kicking off" in inverted commas, they're not kicking off; they're reacting in a normal human way to things that are going on to them. But you think about those places and what they're like to work in. So you get less staff, they have more – less time to do – to provide good care. The place becomes more unpleasant.

They leave and then you're in this negative spiral where you're always trying to catch up. You're trying to employ expensive agency staff. You're recruiting and training new staff because they knew they don't have the relationships with people so – I think in my thesis I give the example of, you know, if you have somebody in an aged care facility and to some people they will know that Jenny, if you don't go to her straight when she rings her call bell she will have an accident, and that's what it is. To people who don't know her, she's just incontinent.

MR ROZEN: Yes.

DR TRIGG: So you imagine those sorts of places where you don't have the time to make relationships, you're just in a massive negative spiral. Because if you're not making the relationships, you're not providing good care. You don't know what good care looks like because you don't know the person. You leave, there's less staff. It gets worse. And without instilling good leadership and good practice you will never get out of that spiral. You know, it will always be about, you know, rationing incontinence pads and trying to find agency staff, and not being able to keep them.

You've seen this week, I think what was very striking is when you asked the people who were here talking about excellent care just how long they've been with their providers so, I mean, Bryan Lipmann from Wintringham, he had been here since I think the end of – in Wintringham since the late eighties. Kate, who was with him, she had been working in the organisation for 18 years. Patti and Gaye had been, you know, working in the industry sector for many, many years. So you can see that there's a common thread there.

MR ROZEN: Yes.

DR TRIGG: It's about if you have the right leadership and conditions, then you certainly seem to be able to do it within the current funding structure. I'm not – I couldn't, you know, I may be doing them a disservice. It may be very difficult for them but funding is not the whole answer. You know, for me – so one of the things that comes up a lot in Australia is the idea of staffing ratios.

MR ROZEN: Yes.

DR TRIGG: So, you know, there, I know, is a big move to try and convince that staffing ratios are the way forward. I would never argue that we need – don't need more staff in the sector but for many of the reasons that I just explained, that if you make somewhere an unpleasant place to work, it will be – and you do by not providing the right sort of care, then, you know, there is a need for more staff, and there is need to do something quickly because there are clearly very, very poor systemic issues in the sector. But the – the thing I would say is that what we're not trying to do here is run hospitals. You know, that's a low bar, you know, because the idea that nursing ratios are important plays into that poor model of care.

It's about, you know, having more nurses, not about nurturing your staff and keeping them for longer. So whilst I can see that they may be appealing, none of the evidence says that having a very granular calculation about how you staff aged care and you staff at, you know, X number of hours per person will deliver – you know, you have to have a safe level of clinical care.

MR ROZEN: Yes.

DR TRIGG: So I'm not arguing about "it's all warm and fluffy and everybody running around hugging each other". Within that you have to – people have very difficult complex conditions in aged care otherwise they wouldn't be there, they would be living at home in their communities. So I'm not arguing that you don't have to have sufficient staff to look after their clinical needs. But if you want to get past that basic level of safety and you want really good care for older Australians, then that certainly isn't all about nursing ratios. So it's – it's a chicken and egg thing, you know, you have to create an environment people want to work in.

MR ROZEN: Yes.

DR TRIGG: And then they will stay and then it becomes a better environment to work in and then they will stay, and you saw that with Bryan and Kate and all of the other people who have been doing this for many, many years.

MR ROZEN: I will read you a quote from Kate Rice, because I was going to do this – this appears on page 2465 of the transcript on 26 June. She, of course, told us about being a manager at Wintringham. There's a few things about her evidence that I would like to ask you about. This is at line 36, down the bottom of the page. She

was asked some questions about recruitment, staffing, the points you have just been talking about. She said in the first line:

> *I also look for people who might be interested in a pathway through aged care at Wintringham because I think that's what we offer people, too. I try and excite them about the job because I'm excited about working in aged care. I love it, so I think if I love it I want to find other people who are equally excited as me, yes.*

And then I asked Mr Lipmann about the same thing, and he described his amazing staff loyalty. He said he reads in the papers about aged care providers struggling to keep staff or get them, and he went on on the following page, and you remember he gave us those stats about how long his staff members had worked at Wintringham doing no doubt pretty difficult work with challenging residents on occasions. And so my question is what's – is that just down to the role of individual management in a given organisation to make a good and attractive place to work in aged care, or is there a role for the system? Is there a role for the regulator in relation to those matters? Or is it more really for the sector, as you say, to make it attractive?

DR TRIGG: It's – it's for the sector.

MR ROZEN: Yes.

DR TRIGG: But what you – what we need is a – a system that supports it and doesn't sabotage it. Doesn't put the wrong incentives in there to make money. So a couple of things – I've already mentioned the ACFI - - -

MR ROZEN: Yes.

DR TRIGG: - - - which will camp particularly in those really big providers who are really dependent on Commonwealth funded clients, people, residents. For them, the ACFI just focuses on all the wrong things. Well, it focuses on all the wrong things and it also has this issue that you can hit the target, hit all of the things the ACFI gets you to do, but completely miss the points about relationship-centred care. The other thing I would say, and this is in both countries, is you have the – you have the huge incentive to attract large amounts of money here through the DAPs and the RADs , so the deposits and the daily accommodation payments. And if we – if we go to the model of care, the model of quality that I tried to put together - - -

MR ROZEN: Yes.

DR TRIGG: - - - what that also seems to incentivise is a focus on swanky, gorgeous beautiful looking accommodation that appeals – normally because, you know, often, residents aren't making decisions for themselves. It appeals to relatives and – and – and that's – you know, often, you will have families in situations where they feel terribly, terribly guilty about putting mum or dad or moving mum or dad into a home, and – and that decision seems so much easier if they're in a really, really nice

looking place, even though the gorgeous, you know, beautifully designed accommodation may not be, in any way, in line with that person's tastes, but, even worse, may not be in lines with the needs of people living with complex conditions or dementia.

MR ROZEN: Yes.

DR TRIGG: So – so think about, you know, some of these beautiful buildings that have these long corridors. Think about you're an older person who's lived in a – a house your whole time and you need support and you just talked about Barney's – Barney's evidence.

MR ROZEN: Yes.

DR TRIGG: You know, think about how do you design places that aren't like hospitals and don't require call buttons, you know. They – they have a sense of community. So, yeah, I think it's important to – to try to provide a system that doesn't sabotage things, and – and I will come back to the thing that I said at the start is you – you need to shine a light on good practice and – and one – one of the things that was very difficult when I was in Australia, and I – during my field work.

So while I was doing my interviews, is I was really struck by the – the lack of appetite to say what good quality looked like. So wherever you go in the world, you will ask people about quality in aged care, what is it and it's really difficult because, you know, people say is it quality of care, is it quality of life. You know, arguably, you can't split the two because if you've got a pressure ulcer, your quality of life is going to be pretty awful. You know, people talk about, well, it's difficult for everyone, you know. One person will want to have wine with their meal, one person will want Foxtel, one person will want something different, you know. It's very subjective. So people want different things. People want different things on different days. Today, I want a curry. Tomorrow, I want a ham sandwich. You know, it's not difficult.

We're just human beings. So what I would ask people in both countries, well, what do you mean by good quality, and I was very struck in Australia that people really resisted being pinned down, to the extent that I remember having a conversation right at the end of my research with somebody in government where I – I just got very frustrated and ended up saying something incredibly inappropriate, like, Australia have a word with yourself. You need to decide what this looks like so people know what they can expect. So not my finest moment, I have to admit, but I was very, very frustrated with this idea that you can't put a – a – a nail in – you can't put a stake in the ground.

MR ROZEN: Yes.

DR TRIGG: And what I hope is that having heard these wonderful stories about relationship centred quality that – that not just government, but the public starts to

understand what that looks like. Something that was very striking for me from this week is – is just think about Shannon Ruddock and about Noleen Hausler, one thing that they have going for them, which just exacerbated their stress, but something that was very common between them is they knew what good care should look like.

MR ROZEN: Yes.

DR TRIGG: So if you look at Noleen's witness statement, when her dad first moved into the home that he was living in, he had brilliant care. She was so pleased. It was exactly where he needed to be, and then the care deteriorated after the home was bought. Same with Shannon. She knew what good care could look like. She cared for her mother in Calvary Hospital - - -

MR ROZEN: Yes.

DR TRIGG: - - - and she saw what it was like to have a good death. So she knew what it should look like. So she knew that when her dad Vincent was in hospital, the – in the – in the facility, he wasn't getting what he should be getting, but most people don't know that. They don't know what really good care looks like. They don't know that you can have something called a good death. That dying, you know, can be a very – you know, with all the stresses that go along with that, very peaceful and spiritual experience.

MR ROZEN: Yes.

DR TRIGG: Most people don't see that. So one of the challenges, I think as well, is to raise the expectations of the people working in the sector, the people who are using the services, the people who are families of the people using the services. But it's not acceptable not to say what really good care looks like, and I think that, for me, is one of the – was one of the biggest take outs from my research is that there is something about – so – so you know, as I said, the system in England is flawed in many ways, but the idea that the person is at the centre of care and they have rights and they have capacity to communicate. So the – the system in England, you – you have to assume that somebody has the capacity to consent unless you can prove otherwise.

So you can't fill them with psychotropic medication. You can't do any number of things without flagging it. I'm not saying it doesn't happen because bad things happen everywhere, but the system tries to work towards the point of, you know, quality and care being about the person and about their rights and about doing what matters to them in the way they want to live the rest of their lives. So I think there is something about – about stating what it should look like. And even in the act of doing that, that's helpful for other parts of the public to – to understand what they should be looking for, and to be excited about working in the sector. You know, it's very different, isn't it, to some of the behaviour we saw with Noleen Hausler's father, you know. Who would want that job if you're just manhandling – person handling individuals day in and day out. What a thankless task, you know.

MR ROZEN: Yes.

DR TRIGG: So let's – let's assume that the – there are good people doing bad things and the – you know, the stress of the job and the pressures, let's just assume that, but who would want to do that, you know? But then when you – you listen to Carolyn or you listen to Kate, so people, you know, who've been here talking about their care relationships, you know. Or Kate, the evidence that you just read out, those – those are lovely places to work, even under challenging circumstances. So I think, you know, one thing that can be done is to say, what does it look like? What do you want the experience to be like for older Australians

MR ROZEN: Yes. What I meant to raise with you a moment ago – I think this is where you were going with this. When you gave the example of the cost of staff turnover, for example, if it's not a pleasant place to work, people will leave. You will have to engage agency staff that will cost you more, and so on.

DR TRIGG: Mmm.

MR ROZEN: Is the point there the provision of relationship based care can actually ultimately save organisations money by retaining their staff, for example?

DR TRIGG: Absolutely. Absolutely, you know, you're – because if – you know, Jason said this much more articulately than I can, but if you – if you treat people like individuals and you work with them and, you know, the example I just gave you on the airline.

MR ROZEN: Yes.

DR TRIGG: You know, the tap you gently on the shoulder, the tell you, "What I'm going to do. I know this is going to be uncomfortable. I'm going to – you know, I'm going to help you do it," I think people underestimate. People lose their common sense, I think. You know, you can't ..... "Oh, they've got dementia. They're different. They – they don't know what's going on." And I – I have personal experience, so this is, you know, the power of an anecdote, but I – my father passed away a couple of years ago in a hospital in Cardiff, and he had some issues and I would sit with him overnight sometimes. Not through the night, but just to help the nurses given he had delirium, so I would help them while they gave him antibiotics.

And there was a – a – a guy, a – a gentleman in the bed next to him called Bob who was living with the late stages of dementia, and so he was in the foetal position. He was largely uncommunicative, and I just used to see what difference good and bad care came – did. So there were – there was one group of care assistants who would come in, and they would change his bed and they would turn him over, and they would change his incontinence pad without saying a thing, and he would yell. He would do what you would have done on that plane. When someone stuck a toothbrush, he would yell and it would be unpleasant for him, unpleasant for the

staff, woke the other patients up. So you've immediately got other things happening and just created a whole lot of work that didn't need to be done.

Because – and the reason I know this is because there were another – there was another crew that would come in and say – you know, to someone who's not communicating verbally with you, they would say, "Bob, we're going to change your bed, so what we'd like you to do is help us. So the first thing we're going to do is we're going to turn you on your right to face the wall and then we're going to take your incontinence pad off and put another one on." Not a word. He would do all of that without a whimper. He wasn't really helping physically, but he was helping in his own way because he had been engaged with. So – so there was no more work. They finish their task; they walk away. So, you know, you create chaos when you don't treat people in a respectful and engaged way, and I – I think the – you know, we – we – the people who work best with people with dementia are people who take, you know, the time to understand them. Can I give you another example?

MR ROZEN: Of course.

DR TRIGG: Sorry, I know we've got limited time. This is somebody I worked with in the UK who's worked with a lot of people with dementia and she trains care providers, and she had the example of a gentleman who would routinely strip in the care home living room, so he would just suddenly take his clothes off, and they had a woman there who had been raped, so every time this happened, there was consternation among everybody there, but, with one woman, it created really, really awful emotions for her.

And so someone spent time with him, and they realised that every time he was going to strip, he would say "Diesel, diesel, diesel," and so they looked into this, and they found out that he had worked in the merchant navy, and that he thought his clothes were suddenly filthy and covered in diesel. So what they would do is every time he mentioned diesel, someone would say, "Let's go to your cabin, Mark. Let's go to your cabin, and let's change your clothes." And, of course, as soon as they got out in the corridor, he would forget – he would forget what this diesel thing was about and the crisis would be over and – and, you know, the whole process of trying to get to know this guy meant that the environment for everybody was better. So I can't remember what your question was, Mr Rozen.

MR ROZEN: No. No, that's all right. I – we were talking about quality and, in particular, the monetary savings that could flow for an organisation from adopting a genuinely relationship based approach to - - -

DR TRIGG: Yep.

MR ROZEN: - - - a provision of care.

DR TRIGG: And I think those are two examples that just show you the difference between the chaos of not knowing how to support people - - -

MR ROZEN: Yes.

DR TRIGG: - - - versus the if you – if you apply some common sense and humanity and warmth, it becomes a much more – a much different challenge.

MR ROZEN: Stepping beyond the anecdotal, as - - -

DR TRIGG: Sorry.

MR ROZEN: No. No, that's all right. I was wondering if there's any ..... work that you can point the Commission to that has tried to measure those sorts of savings and the application of a relationship based approach in an aged care setting?

DR TRIGG: Yes, there is – there are some small-scale studies.

MR ROZEN: Yes.

DR TRIGG: But small studies that say, you know, if you – those sorts of cultures do encourage people to stay. It's – I'm trying to think of specific ones.

MR ROZEN: You can come back to us on it if you would like to.

DR TRIGG: Yes, I mean, I think the important thing is that when you look at the research around, so, for example, the question of staffing ratios that actually the factors that make the difference are experience and low turnover.

MR ROZEN: Yes.

DR TRIGG: Okay. So I think, you know, if you work your way backwards, the idea that you have a loyal workforce that is, you know, consistently working with people, rather than worrying about the ratio of nursing hours, that those are – there is much more compelling evidence about that model than there is about the quantity of staff.

MR ROZEN: Yes, quality rather than numbers.

DR TRIGG: Yes. Absolutely.

MR ROZEN: Can I ask you a little bit more about the definition of quality because you've touched on this. In your statement you talk about three types of quality. This is at paragraph 19 on page 3. You define three types of quality for residential care providers: organisation-focused, consumer-directed and relationship-centred. Can you briefly explain what organisation-focused quality is, and whether you've seen any example of that in Australia?

DR TRIGG: So yes, absolutely. So the – this model – because it's so difficult to define quality, what I was trying to do was think about, okay, if you're a provider

organisation, how can we come up with a model which describes what your different focus might be. So I came up with these three types of quality and it mirrors something another researcher has done which I may come back to. So what organisation-focused is about is – is this real focus on safety and quality of care. Now, you could argue that, you know, it's really hard to define what quality of care is because I would argue that if somebody is depressed and living with mental health issues and they're not being supported, that is poor quality of care. So it's not just about incontinence pads and avoiding pressure ulcers; it's about spiritual health as well.

So I'm not, you know – but mostly when I was talking about organisation-focused care it's about patient safety, about standardisation, about filling in documentation. It's about being task-centred, focusing on the routine, but it's also about thinking about the person as a patient. So if you think back to that example I just gave you about the chap in the bed, you know, Bob, then the organisation-focused is the, you know, do the task, don't worry too much about the individual that you're working with. Now, you could argue that that's pretty poor anyway, you know, but it is about the idea that the hospital-like nursing home where the emphasis is just pretty much keeping people alive, you know, if you think about some of the stories that you've heard.

So the focus is on clinical governance, keeping people "safe", but I'll give an example of that. You know, you could argue that story that we heard yesterday, you know, there were all sorts of issues with the quality of Vincent's care but, you know, the fact that he had had those falls, you know, they weren't keeping him safe. And, you know, if you go back to the more important forms of quality, you – so one of the issues you've got with good quality in aged care is that you have to take risks. Okay. So if somebody – if the quality of life of somebody living in your aged care facility – you know, if they're able to what people call "wander" which I find an uncomfortable term, but if they're allowed to do the things they want to, they might fall, okay. So you have to balance this idea that there may be a risk that they will fall because you want them to have the freedom to do what they want, to sit where they like, to go out into the garden.

What tends to happen with the organisation focus is that you want to avoid that, you know, so you want to avoid the falls. So you fill people with psychotropic medication or you, you know, you put them in a bed with bed rails, or more insidious things like, okay, the chair doesn't have a restraint on it but it's angled so it's really hard to get out of. So organisation is all about minimising risk, it's about clinical governance, it's about standardisation, it's about safety, it's about warehousing. And a nice guy in Australia that I met in a provider, he called – he referred to something called the triple H dilemma. Okay, so when you're designing an aged care facility, do you want it to be like a hospital because people are so sick; do you want it to be like a hotel because people are, you know, rich and you want them to come and stay in your hotel; or do you make it like a home? So the organisation focus is really about hospital, clinical governance, keeping people safe.

MR ROZEN: Yes. Go on. Sorry.

DR TRIGG: Would you like me to just talk about the other two?

MR ROZEN: Yes, absolutely. Please, yes.

DR TRIGG: Okay. So that was the first one, organisation focus. So then there's two other ones. One is – I call the second one consumer-directed. So - - -

MR ROZEN: Yes. And this is on page 5 of your statement, just so that we know where we're going; is that right? It should be consumer-directed quality.

DR TRIGG: That's right.

MR ROZEN: Yes.

DR TRIGG: So what we have here is that care is a service that you purchase. You choose it and I have – so a lot of the reform in Australia was focused on the idea that people can be consumers.

MR ROZEN: Yes, it's a language we see throughout a lot of the regulatory documents.

DR TRIGG: Absolutely.

MR ROZEN: Yes, standards.

DR TRIGG: And I remember I had – I can't remember how many interviews in both countries and I some – you know, I was bored one day and I just ran my interview transcripts through a thesis software and I was quite shocked by the fact that there had been one mention of a consumer in the English transcripts and in the Australian transcripts I found 250. So that's the difference in perception of what this person is. So the second type of quality is this service, is the hotel-like accommodation. And really it's talking to people being empowered consumers.

MR ROZEN: Yes.

DR TRIGG: Okay. So, and, you know, language – at the risk of sounding, I don't think it's pedantic but one of the issues with calling people consumers is if you think about what a consumer really is, then these people aren't consumers for a variety of reasons. So, you know, just think about it. Think about Shannon Ruddock yesterday who knew her father could get better care but I think the word she uses:

We were in a crisis situation, I couldn't do anything about it.

And that for many people is how they choose an aged care facility. You know, they've suddenly had a stroke, or a health crisis, their spouse has died and there's no

longer somebody to live with. So there are any number of reasons why when you are looking for this type of care it is not a typical experience. But also there are other things so, you know, many, many people don't choose their own care anyway because they're too frail or they're living with dementia and don't have the – the – I don't want to say skills but that's not an easy process for them to negotiate.

So if you think about the health status of individuals, think about – well, I mean, think about the people who don't have Shannon advocating for them or Noleen advocating for them. You know, you're 88, you've got dementia, you're living with dementia, you're doubly incontinent, you've had a stroke, you know; how are you a consumer. You know, you can't – even if you – even if you wanted to move, you're too ill. You're even too ill to tell people, so you don't have the ability to complain. And if you – if you do complain you fear retribution, you fear – and everybody has been in this process I'm sure in health and aged care, where I'm not sure I liked how that worked but, you know, you let it go. So there are some really unhelpful features of aged care that mean that mean that it's not really about being a consumer.

I think one of the things – so what I've said at the beginning about trying to find good providers, the information you need to process to work out what makes good provision, if it was available it can be very complicated. So, you know, in no world is a pressure ulcer acceptable, but if you gave that information – so let's say, for example, you give people information on pressure ulcers, pressure sores, you don't know whether, actually, this is a brilliant facility who would just take the very sickest people, you know, who come from hospital and had pressure ulcers. So the information that's – you know, the technical term is information asymmetry, you know, the provider knows so much more than you do and you will never uncover exactly what quality looks like.

And I think one thing that's really important about this idea about public information, there's something – there's something very specific about aged care that is important. So if you think about somebody being a consumer, if you see – so aged care has different bits to it. So if you think about it in terms of goods and services, there's a bit of aged care which you could argue has something that someone has called "search properties". So you can look up on the internet; does it – where is it, does everybody have an ensuite bathroom, can you have pets. There's stuff you can see that you can search for, you know, so you can see the basic information. But the problem with aged care is it's, as we all know, much more complicated than that.

So there's another thing which isn't searched, is experience. You can only – you can only tell the quality of something after you've experienced it. So the perfect thing is a haircut. You know, you can't go and say that is – that's what I'm buying. You know, until you've been through the process you don't know what that looks like and – or a meal in a restaurant or flying with a certain airline. So in aged care, one of the problems you have is that you – you don't know what it's like to live there until you live there. So the way that regulators around the world are trying to help with that is – so for example, in England the Care Quality Commission when it publishes inspection reports, what it tries to do is describe what it's like to live there, you

know, so whether people are in the kitchen chatting, you know, so little things but things that try to give you some flavour of what it's like to live there.

MR ROZEN: Would they descend to the level of what it smells like, for example?

DR TRIGG: Yes, absolutely. You know, we could smell warm bread, you know, they knew we were coming. I'm joking. But, you know, the – well, I think – and anyone who has worked in aged care for any amount of time, you know, you do know as soon as you walk in what sort of place you're by the smell and the noise or the lack of. So – so that's one complicating factor. But the other complicating factor is this idea that health and care is complicated and is something called a credence good, okay, so you might never know if you bought the right thing, and I will give you an example. So if you go to a car mechanic and there's something wrong with your car. If you're like me, I know nothing about cars. If that mechanic says, "You need a new clutch" I will say "Okay". I will never know if I did actually need a new clutch.

You go to the emergency department and you've got a pain. They say it's your appendix, they take it out; you might never know if it had to come out. You are completely in the hands of the doctor or the nurses. And the thing that people forget about aged care and you will have heard a lot about this week, is that a lot of it is about good dementia care and a lot of it is about good end of life care. And as I talked about with Shannon and Noleen, most people don't know what that should look like, okay. So the idea of being a consumer and having control and having choice is completely undermined by the fact that you will never know whether that is the right place for you or your mum or – so there are all these different aspects to the idea of consumer and aged care that I really struggle with.

And also in this – so in this model that's what we're grappling with. So what we're saying is the right, consumer – consumers have – are empowered and they can go and find things and what that means in both countries is that aged care providers design their services to attract these wealthy consumers. So that's where you get the beautiful – and even to the extent that if you go into a really good aged care facility, they may say to you – you may say, "I'd like to make muffins. I would like to make muffins today. That's what I would like to do." So you will go and make muffins. In this sort of consumer directed world, there will be a 3 o'clock slot for you to go and cook fruit cake because that's on the list, the schedule of activities.

MR ROZEN: Yes.

DR TRIGG: So it's all highly service, kind of, oriented, and one American author, I love this expression, referred to it as cruise ship living. So you're living in an environment where – you – you know, the cruise liner thing. You know, you've got lovely accommodation, the captain's dinner, and you've got, you know, all these other parts of the experience, but they're not real life. You know, it's great for a week, if you like that sort of thing, but they're not real life. It's not about living in a home. It's not about – you know, it's 3 o'clock in the morning, and I'd like to go

and pick courgettes – sorry, zucchini – I forgot where I was. You know, it's – it – it's about being very structured via offering services, and also within that – within that that model. It's kind of weird because you're saying, well, the consumer is paramount. They have sovereignty. So they're more important than the care workers. So it – it's kind of a weird model. Whereas, in the final model - - -

MR ROZEN: Yes.

DR TRIGG: - - - the relationship centred model, it's really about everybody being equal, everybody being – having their personhood respected and valued and – but also about the physical environment, about making it a home-like environment. That can be very challenging in some of these big places, but I think the Whiddon guys have given an insight into how you might go about – about perceiving that, but care then becomes a relationship. So in the first one, it's a process, a set of tasks. In the second model, it's a service.

MR ROZEN: Yes.

DR TRIGG: People are paying for it. In the third one, it's a relationship. It's about being with people, and it's two-way, and the other thing that's really important in that is the concept of human – of a rights based approach. That this person, no matter how frail they are, you – you always assume they have the capacity to consent to whatever is happening to them, and if you don't think they do, you have to work out with others what is in the best interest of that person. So if they don't have the capacity, you know, and it's – I can't remember who said – yesterday, I think. You know, consent fluctuates, especially with people with mental health issues. You know, you can have capacity and consent one day and not the other.

MR ROZEN: Yep.

DR TRIGG: But your presumed approach is that this is a person with rights and individuality, and you have relationships with them, and – and that – all – everything you do with them should be driven by – by their rights as a human being to participate, to be supported, to make decisions.

MR ROZEN: Thank you very much. Now, we are – as you know, we are in a bit of time pressure today.

DR TRIGG: Yep.

MR ROZEN: So what I would like to do to wrap up my questioning of you, subject to any questions the Commissioners might have, is to give you the opportunity we've given to others about a wish list, but with a particular slant, if I could, and that is what do we need to do to move to a more relationship based care approach where it's not happening in the Australian aged care system? So if you could sort of bear that in mind as a gloss, if you like, on the wish list that you might have for the Commissioners.

DR TRIGG: Okay. Are you sure you want me to do this?

MR ROZEN: Well, it's too late now. I've asked you.

DR TRIGG: I'll make it quick. Okay. So I – I've – I've talked about some of these. So, you know, if I – if I had your – your opportunity, I think is the right word, the first thing is set a vision for quality. Say what it looks like. Say – you know, it's about relationships. It's about rights. It's about putting the person at the centre. Say what it looks like and so that people know what it – what it looks like when it's there, and what it looks like when it isn't.

Something that is a personal thing, but I think many people in the sector would agree. Language matters. These are places where people live. They shouldn't be called facilities. They should be called homes. They shouldn't be called consumers. They should be called residents or people or individuals or citizens. But other things, "Abscond, wander, BPSD," you know, these are people who are reacting to what's going on around them. So those sorts of – that sort of language happens – matters. "The floor, feeding, toileting," you know. How would you feel if someone said they were going to toilet you, not help you go to the bathroom? "Palliating", all these words, the language matters, and it – and it's essentially very ageist and very – yeah, very inhumane.

Thirdly, clinical models won't deliver relationship-centred care, so think about how the structure, exactly, but also community care packages works. So, you know, if you – if you really believed in relationship centred care and outcomes and what matters to the person, looking at their capabilities today of – you've had a stroke, this is what you get. You know, what the care systems needs to be structured around is what matters to that individual. What do they want to achieve? What do they need help with? So that is a really important point.

Regulation won't fix everything. I've said that already. The Safety and Quality Commission doesn't deliver quality providers do. The Quality and Safety Commission can help eradicate bad practice, but everybody – we need to design a system where those responsibilities are more embedded in the way people work and in the way they – they support their own communities. Three things I'll – one of the things that I've talked about while I'm here is – so – so I know that the ACFI has been noted as being problematic for some time and that there were two reports written about it, and both of those reports suggested a new activity based model, rather than – okay. If good care – and we come back to the problem you have to say what good care looks like. How does that, in any way, help to you deliver the sort of care that needs to be delivered?

So I think there's something about thinking big and not tinkering – you know, not necessarily to throw the baby out with the bathwater, but, you know, think about new models of care, think about shifting away from these formal relationships, new model of ownership, thinking about shifting responsibility to local communities. You know, those are the people who know best what's going on in aged care

facilities. So involve those people, involve residents, involve relatives in designing new models of care and delivering new models of care, in overseeing quality, in supporting, you know, the various things that need to be done to ensure people have their rights protected.

And, finally – you will be pleased to know. Finally, something that's very easy to do in these sort of situations is go running round the world looking for the answer, and there are well publicised examples of – of – of things – of services that people go to, you know. In one – for example, in the Netherlands, everybody will go off to the – to Hogeweyk's dementia village and they'll also look at Buurtzorg which is the self-managed teams, and – and they are brilliant initiatives and they are worth going to see. But I think, for me, the biggest thing I would want the Commission to remember is the answers have been in this room. You know, there are people in this room who know what you need to do. There are people in this room who have the answers, who've been doing this stuff for 10, 20 years, and I suppose my biggest wish is that those people become the most important people in the system, and they're the people who will guide your work in what this needs to look like.

MR ROZEN: Thank you, Dr Trigg. Commissioners, that concludes my questions of Dr Trigg.

COMMISSIONER TRACEY: Well, you very modestly didn't refer to yourself as one of the people in this room, but you certainly are, and the way you have drawn together the threads of the evidence we've heard this week and fitted it into a – an overview of good quality care has been enormously helpful to us, and in the course of the Commission, we will be keeping up our conversation with you. Thank you very much for your evidence.

DR TRIGG: Thank you.

COMMISSIONER TRACEY: The Commission will adjourn for 10 minutes.

<THE WITNESS WITHDREW

ADJOURNED [11.24 am]

RESUMED [11.38 am]

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Commissioners, I propose, on behalf of the counsel assisting team, to make some brief closing remarks. Commissioners, the hearing this week has been focused on person-centred care and palliative care. I would like to close the hearing

with a reflection on the key themes that we've seen emerge from the evidence this week. The key themes are, firstly how social attitudes inform the delivery of aged care. Secondly, the importance of relationships in delivering person-centred care. Finally, the importance of organisational leadership.

We heard during the week about the broader societal context in which the aged cares system operates and the ways that that can affect the care that is provided. The Aged Discrimination Commissioner Dr Kay Patterson AO told the Commission about what she called the scourge of elder abuse and ageism that we see in our community. These beliefs can lead to assumptions that a person is incapable of making decisions for themselves or does not want to assume meaningful activity in personal growth. This can, in turn, lead to the balance between autonomy and protection being skewed so that older people's wishes are not respected.

Dr Mike Rungie of the Centre for Modern Ageing told the Royal Commission that these negative beliefs about older people can lead to complacency and a lack of innovation in aged care. He said you get positioned in a place where the world thinks it's okay to stick you in an aged care facility without trying really hard to see whether we could keep you at home with a package, and the world thinks it's all right for you to be doing nothing all day and bored and that you ought to be able to cope with that. Ms Houston a personal care worker shared her experience of this to the Commission. She said:

> *Well, we'll just stick them over there where we can't see them and we won't worry about that because it's all a bit yucky when people get old and, you know, they're just not themselves anymore.*

Dr Patterson emphasised the need for education to create a deep change in community attitudes towards older people. She made the point the culture set by younger people now is the culture they will inherit. In our exploration of the concept of person-centred care, we heard throughout the week from a number of witnesses about what they see as the fundamental components of person-centred care, and some consistent themes have emerged from this evidence. We heard that good relationships and really knowing the person you're caring for are critical to providing care. Commissioners, you heard about the importance of respectful, trusting and authentic relationships between the person receiving care, their carers, the aged care providers and care staff. About how important it is for a person's family and friends to be involved in care decisions as they have unique insights into the persons concerned. Carolyn Jubb a lifestyle and leisure officer with the Whiddon Group explained relationship based care as:

> *More about coming together as a family and being able to relate to each other as a friend, rather than just a person that you have to care for.*

Kevin Chester's wife Marie has Carolyn Jubb as her buddy. Mr Chester described his impression of the facility where his wife lives:

The home itself is just – it's a terrific atmosphere –

he said:

The vibes there were there for us. It felt good. It felt friendly. It felt it didn't take me long enough to get to know the admin staff, all the nursing staff, all the residents in the place. They all know me –

he told us:

I know all of them. That's the main reason why I wanted to be there.

Kate Rice the manager at Wintringham who provides aged care to the formerly homeless described the relationship of trust she built with the residents. She said:

That relationship with residents over a really long period of time has really stood us in good stead. I think because the people we look after actually know us and rely on us and trust that we will be looking after them.

Dr Trigg just now referred to that in the context of relationship-centred care, and she talked about the negative spiral associated with not providing relationship-centred care, important evidence about costs that can accrue to a provider that is not focusing on relationships in the provision of its care. Bryan Lipmann the CEO of Wintringham told the Commission that he actually didn't know what person-centred care was. He said he had never heard of the expression until we asked him about it, but he was focusing on the substance, rather than the label. He described the Wintringham approach to care as:

Treating people how you would like to be treated or, put it a slightly different way, how you'd like your parent or your grandparent treated, and so it's a matter of getting to know the person and spending time with them –

he told us. Ms Houston a personal care worker said that person-centred care for her involves working with people and their families to find the best ways to provide their care:

So this is a whole – looking at a person as a whole –

she said –

not just they need to be in a room, they need to be washed and clean. We need to be actually filling their needs as human beings, and so much time happens where people are sitting alone in a room or even sitting in a community room where they don't have any interaction one on one with people, and as a person working in dementia care, I find that really confronting and disturbing –

she said –

and I would like to see that changed.

We also heard how important it is for staff to know the person receiving care well. The Commission was told that this process is facilitated by consistency of staffing to build familiarity and genuine relationships. Another matter that Dr Trigg so eloquently referred to this morning. We heard about what it looks like when care relationships fail. On day 1 of the hearing, the Mitcham case study demonstrated for us to a devastating degree the awful consequences that can arise when relationships fail in aged care. The Commission heard evidence about the response of Japara the provider, to Noleen Hausler's report of abuse of her father. That evidence raises serious concerns.

It is open to you, Commissioners, to conclude, based on that evidence, that Japara management appeared to dedicate its staff time, including very senior managerial staff, to fuelling what appears to be a battle with Ms Hausler. In doing so, crucially, it appeared to lose sight of Clarence, the person in care. The evidence suggests that Japara management, to this day, rejects any real suggestion that its organisation may have handled those matters differently or better. The CEO Mr Sudholz referred to 100 per cent occupancy as an apparent measure of quality of care and denied that there was any systemic problem within the organisation. He gave evidence that, of the 298 mandatory reports made in the relevant period, the fact that fewer than 100 of them had been substantiated meant that there were no systemic issues:

It was not a big number –

he said. His report to the board regarding Mitcham reported on the 100 per cent occupancy and described Noleen Hausler and her group as making ongoing complaints and being vexatious. Although he did accept full responsibility for the criminal activity that occurred in his facility, he denied that there was a culture of impunity at Mitcham. There was no reference in his evidence to the need for greater scrutiny of allegations at a board level or improved transparency of reporting of abuse to the board. The evidence suggested that Mr Sudholz appears to leave those matters to be managed at a facility level. We consistently heard that leadership within an organisation is the key to providing person-centred care. Witnesses told the Royal Commission that person-centred care as a philosophy should start at the top and trickle down in the organisation. The CEO Mr Mamarelis of Whiddon told the Royal Commission that:

> *As CEO, it's been really important to empower our people. I have to work closely with the board and I have to take the board on this journey with us, and that also involves good reporting structures, good governance around the way things are done – sorry, the way we do things.*

The Commission heard that recruiting the right staff, supporting them in their role and fostering the right culture is important for person-centred care.

Jason Burton of Alzheimer's WA told the Royal Commission that at the heart of person-centred care is culture. It's the culture of the organisation, it's the culture of the leaders, it's the behaviour of the leaders in the organisation:

Without that –

he said –

care staff will find it very difficult to actually implement person-centred care at the coalface.

He told the Commission that if you do not attract and retain staff with the attributes that you're looking for to be able to deliver this care, then it's just not going to be possible. Mrs Whitford a registered nurse who works as an aged care coordinator described the difficulty she has with recruiting staff in a rural setting. The Commission, of course, heard evidence along those lines just last week in Broome and these issues will continue to be explored by the Royal Commission. Bryan Lipmann of Wintringham described how joyful it is working and living at Wintringham. He made that point that while their buildings are spectacular, that's not the point. He said:

I'm quite sure if we took over an institutional place, our staff would turn it into a home very quickly.

Some evidence that Dr Trigg gave this morning is significant in that respect. She made the point that there are people who are able to do this now in the current system. It shouldn't be accepted as being impossible or even particularly difficult with the right people and the right approach. We heard about how creating this culture of person-centred care can have positive outcomes for staff as well as residents and can lead to higher levels of job satisfaction and higher staff retention. The evidence demonstrated that the way that care is delivered, that is, the manner, warmth and flexibility with which care is delivered is important. The care should respect the person as an individual and treat them as a person, not just as a task to be completed. We heard that in a person-centred environment, we should look beyond a task-based tick-a-box focus and consider the experience of the person during the process when defining what successful care is. Jason Burton made the point that person-centred care is a philosophy of care, not a model of care.

That the two are oven confused –

he told us. Commissioners will recall Ms EA who told the Commission about how her partner EB was treated when she was receiving care here in Perth at Mary Chester House. She said:

When you walk through the door of Mary Chester House two mornings a week there were people all around saying good morning, good morning EB, good morning EA. They took the care and the time to make eye contact with me and

with EB, to show her into the room, offer her coffee, point out photos to us of her participating in activities which had been pinned up on the walls. It's certainly difficult and time-consuming to give people a lot of one-on-one time when there are 12 to 14 clients at once and limited resources –

she said –

...and just these small things and taking a minute or two to sit down and talk with someone is so important to most of us when we are needing reassurance in a world that is so complex and so confusing.

And of course, she's referring there to EB's experience of living with dementia. Mr O'Donnell who gave evidence by a video recording described how he sees the task-based culture play out in the residential care facility where he lives. He told us that:

What the carers are tasked with, they each have a list. They have to toilet and shower and feed A, B or C residents as soon as possible in the morning prior to breakfast and then soon after breakfast. And I'm saying –

he told us –

...that I don't think it's enough just to do that. That that doesn't meet the requirements of the residents. They need more than that. They need people that understand what they particularly want, those particular residents and it's different probably for each one. Someone who has some contact with them and has some understanding of what they require.

We heard about the importance of people having choice and control in how they live and the care they receive. The Commissioners will recall the evidence of Ms Urwin, a physiotherapist, who told the Commission that:

When a person in aged care does not have that sense of choice in what you do throughout the day or what treatment that you're given how can you expect to have any sense of independence or any improvement in quality of life.

The Commissioners will recall the evidence she gave about having to ask residents on more than one occasion whether they wanted a particular treatment, even when they had already said they didn't and they had no cognitive impairment. She found it belittling and inappropriate. Dr Sinclair told the Commission about the importance of advance care planning for facilitating person-centred care and choice and control, a message that was echoed by Dr Patterson. Dr Sinclair told the Commission that advance care planning should be seen as planning for the rest of your life, not just the end of your life. He told the Commission about supported decision-making which is a rights-based approach to decision-making that enables a person with a disability to make or communicate decisions about their personal or legal matters.

Dr Sinclair spoke about the importance of providing tailored supports to help a person to exercise their legal capacity even as their cognition declines. The Commission heard evidence about how providers managed the balance between autonomy and safety and how it could be done in a way that prioritises dignity of risk, and increases choice and control. Evidence was called from representatives at Wintringham, Whiddon and Alzheimer's WA, all of whom demonstrated that it is possible to allow for dignity of risk in a controlled and managed way. They are but three examples. There are, of course, others. Ms Murphy, a registered nurse, gave an example of where this had not been appropriately balanced. She spoke about a married couple living in the same residential aged care facility, both of whom have dementia. As she explained it, and I quote:

> *Because of restrictive restraint policies in aged care, he –*

the husband –

> *...cannot reside in the same wing as her because he doesn't have the tendency to wander. So he will come to the nurses and ask to be escorted to see her. He's allocated one hour twice a day to see his wife and he will come and ask us many times a day to come and see her, and often due to time constraints we have to let him know that he has already seen her twice today, he has to wait until tomorrow or it's not his time yet, or sometimes staff might be busy and he might only be able to see her once a day.*

Of course, Dr Trigg referred to that evidence in the evidence that she gave this morning. We've heard that people working in the sector want a care environment that supports them to provide person-centred care, and we've heard that a task-focused approach runs counter to providing person-centred care. This was a message that came through very clearly with the workers panel on Wednesday. Each of the workers spoke about their desire to deliver care that made lives better. Commissioners, we must consider how we can support the aged care workforce. Dr Trigg talk about that today, about the importance of a valued and supported workforce, what Tom Kitwood, who you've heard so much about, referred to as the caring organisation; the organisation caring for the staff, more likely to make it the case that the staff will care for the residents. Jason Burton put it this way. He said:

> *Practitioners will do their very best to be as person-centred as they can but if they're working in a care culture and a care environment of their organisation that doesn't support it, it's extremely difficult to sustain it.*

He said:

> *I think part of what we see in the high staff turnover we have in aged care is people just disenfranchised where – I mean, we've heard some, really, you know, distressing case studies of where it's gone wrong, but the majority of people working in aged care generally, and especially in dementia care, are very caring, compassionate, inspirational, passionate people who want to do*

their best for their clients and they're looking for care environments that will allow them to do that. So I think unless our culture is right as an organisation, the board support that culture in our policies and procedures, our decision-making, our senior management and our leaders at the ground and then our care staff actually with the hands-on role. If all of those pieces are not in place then it's very hard to see the end outcome of person-centred care take place.

This point was echoed in the experience of Mr O'Donnell. He said:

The residents themselves really want more in many cases and the carers want – they're very keen young people, many of them, many of them from overseas. They come here, they're trying to do their best to interact with the various residents in a way that applies to that particular resident and they get frustrated. If they can't do that, they feel they're not doing what they should be there to do which is to give care and the residents get frustrated. They're wandering up and down the corridor looking for someone to help them.

Of course, Commissioners, you heard the evidence of Ms Urwin which I took Dr Trigg to this morning, and one can't help but reflect on – tragedy might be too strong a word, but it is very unfortunate that a young professional motivated to exercise her professional skills is so quickly disillusioned in aged care, and disillusioned because of structural arrangements within aged care to do with the ACFI, and it's very unfortunate that a sector that so needs young, keen, professional workers can so quickly disillusion one as was the case with Ms Urwin.

Providers with good person-centred models of care explained that although there are significant barriers, they are determined to provide person-centred care and make it work. Chris Mamarelis from Whiddon told the Commission that it is financially challenging for Whiddon to provide this type of care but he said it works because they make it work. Wintringham gave evidence about the difficulty in providing person-centred care without the appropriate resourcing levels.

The Commission also this week has heard evidence where counsel have explored the provision of person-centred care in the context of palliative care. The Commission was told about the importance of palliative care in aged care being person-centred. You heard from Joshua Cohen, a nurse practitioner, a very inspiring worker in this area it must be said. He told the Commission:

The most important aspects of appropriate palliative care in aged care is adapting the care to the individual and the family and keeping the resident at the centre of that care.

This was echoed by Dale Fisher, the CEO of Silver Chain, who, when describing Silver Chain's model of person-centred palliative care, said:

Philosophically, we believe it's really important that we transfer the power and control of care to the person affected.

And clearly the family as well are important in that definition. One can't help reflecting on the powerlessness that Shannon Ruddock expressed yesterday as a counterpoint to that. Dr Jane Fischer of Palliative Care Australia emphasised the importance of palliative care being needs-based, holistic and responsive to a person's psychosocial situation. Professor Tieman of Flinders University expressed the view that:

> *We need to make sure that person-centredness permeates all planning at all levels: policy, service design, consumer engagement, planning and evaluation, and that will be the test of us actually being person-centred.*

We heard evidence suggesting an inability of residential aged care facilities to deliver quality palliative care with consistency or to support access to specialist palliative care when required, and a case study was a good example of some of those issues. Some of the possible explanations for this were advanced including workforce issues such as the lack of suitably skilled staff in aged care facilities, and funding issues, such as the narrow definition of end of life care within ACFI. Attention was also drawn to the challenges presented in managing the intersection between the health and aged care sectors, the Commonwealth and State responsibility which, of course, is a theme that we will be examining in further detail in later hearings.

The Commission was told about the need to normalise dying in what Dr Reymond, a palliative care physician, described as "our death denying society". She said that expected death can be planned for in a proactive way that can increase both the quality of life and the quality of death. The expert panel in palliative care agreed with the importance of timely and regular advance care planning conversations to guide treatment and care towards the end of life, another example of person-centredness.

The Alkira Gardens case study showed the desperate circumstances families can find themselves in when the system fails. At a time when families should be able to choose how they spend their final days with their loved ones, instead they must advocate for them. Commissioners, you will recall the evidence of Ms Ruddock only yesterday who described how she could not be satisfied that her father's palliative care needs were going to be met by Alkira Gardens. Ms Ruddock, in agonising detail, described the guilt she felt that hoping her father's health would deteriorate so that he wouldn't have to return to his aged care home. One need only contemplate that for a moment to appreciate the trauma that she went through.

The Alkira Gardens case study, amongst other things, demonstrated the importance of relationships between providers, care recipients and their families. That communication is critical to the success of relationships, the value of a trained workforce and the consequences of inadequate care. The Commission also received input from many witnesses about what needs to change in aged care. Some of those suggestions from quite a long list that we've heard this week included Mr Moore who gave evidence about the experience of aged care for Aboriginal and Torres

Strait Islanders and the Institute of Urban Indigenous Health's wraparound model of care. He told the Commission that he would like the Commission to recommend to COAG to refresh the Closing the Gap strategy to embed aged care targets.

Ms Whitford, a registered nurse working as an aged care coordinator in regional South Australia, described the difficulty in organising alternative therapies and allied health for residents:

> *Some of our resources are very limited. Our staffing is minimal. We have a very small volunteer base. Even access to allied health or geriatricians is very difficult, the logistical concerns. And even often the inability to organise contracted alternative therapies to come in and assist because of the financial regulations. So, you know, providing some people we've trialled before enjoy yoga and I've had a local girl come in to provide this for them voluntarily, and they've actually really enjoyed it but we haven't been able to have the funds to support this as an ongoing activity.*

Senator Cooney's submission, which I read out this morning, along with many submissions that we've received and the suggestions of witnesses this week can inform the work of the Royal Commission. The Royal Commission will shortly adjourn today until 8 July 2019 when hearings will resume in Darwin followed by hearings in Cairns. Briefly, the theme of the Darwin and Cairns hearings will be, firstly, aspects of care in residential home and flexible aged care programs, including access and availability, wound, medication and pain management, nutrition and hydration, continence care, mobility and social supports. Secondly, rural and regional issues; thirdly, quality of life for people receiving aged care.

The future hearing program continues the work of the Royal Commission around Australia. The Commission's attention will turn in the next few months to an examination of the necessary reforms to the current aged care system to address the systemic problems that have emerged in the evidence, including problems with regulatory oversight, sustainability and funding arrangements. The Commission is determined to hear as much evidence as it can to assist in meeting the requirements of its terms of reference and to design a better aged care system for Australia. To that end, we encourage the public to continue to engage with the Royal Commission to share their stories about the aged care system, both good and bad. Many of the witnesses that the public have heard from this week were identified on the basis of submissions that have been provided to the Royal Commission. Anyone can make a submission to the Commission by following the steps on our website which detail the various alternative ways.

In closing this Perth hearing, Commissioners, counsel assisting will prepare written submissions within seven days proposing that the Commissioners make certain findings arising in the evidence on the two case studies. We propose the usual directions for written submissions be made and a note that we have prepared can be handed up. It has been provided to parties with leave to appear. In summary, we propose a timeline for written submissions where counsel assisting will provide

written submissions within seven days; the parties will have the right to respond to those within a further seven days. I won't read out the detailed written submissions now. They follow a pattern which has been utilised in previous hearings and the final directions will appear on the Commission's website.

The only final matter I need to raise at this point is in the nature of a housekeeping matter,that is just to note that additional documents have been added to both the Mitcham and general tender bundles, and we raise this at this point for your assistance, Commissioners and for the assistance of parties with leave to appear. That concludes our closing remarks, Commissioners.

COMMISSIONER TRACEY: Thank you, Mr Rozen. There will be directions given in the terms proposed by counsel assisting. I won't read them because, as you've already indicated, they are lengthy but they will appear immediately on the Commission web site and be available to all those to whom they apply. We are indebted to counsel, solicitors and support staff for all the hard work that has gone with a view to facilitating this week of hearings in Perth. And we are very conscious of the long hours that have stood behind the calling of the evidence that we have heard and which has been of great assistance to us. The Commission will adjourn until 9.45 am on 8 July 2019 in Darwin.

MATTER ADJOURNED at 12.06 pm UNTIL MONDAY, 8 JULY 2019

Index of Witness Events

Index of Exhibits and MFIs