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THE HONOURABLE T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

MUDGEE

10.04 AM, MONDAY, 4 NOVEMBER 2019

Continued from 18.10.19

DAY 61

MR P.R.D. GRAY QC, counsel assisting, appears with MS Z. MAUD and MS E. HILL
MR T. BATEMAN appears for Pioneer House

COMMISSIONER PAGONE: I would like to start by acknowledging the Wurundjeri people, the traditional custodians of the land on which we meet today. I would also like to pay my respects to their elders past and present and extend that respect to other Aboriginal and Torres Strait Islander people who are present. Mr Gray.

MR GRAY: Thank you, Commissioner. Commissioners, I appear with Ms Maud and Ms Hill. I, too, would like to pay my respects to the Mowgee people of the Wurundjeri nation and I wish to acknowledge them as the traditional owners of the land on which we meet. I would also like to pay my respects to their elders past, present and emerging and Aboriginal elders of other communities who may be here today. I want to begin this hearing with a basic proposition: people living in rural, regional and remote communities in Australia ought to have the same levels of access to aged care as people living in metropolitan areas, and the aged care they receive must be safe and of high quality.

There's no doubt that rural and remote settings pose special challenges for the delivery of aged care. Much of this arises from immutable structural aspects of rural and remote living such as widespread dispersion of populations, transportation challenges, geographical isolation from large centres of economic activity and isolation between population catchments, and potentially insufficient population densities to support services that depend on scale to be viable. However, equity of access to quality aged care for Australians who live outside the big cities is a matter of simple fairness.

This hearing involves the same basic principle which guides the provision of aged care to groups with diverse backgrounds and needs, and this has not been ignored in the Aged Care Act. People who live in "rural or remote" areas are recognised in section 11(3) of the Act as having so-called "special needs" which are to be met by certain special measures set out under principles of the Act. One of the issues in the hearing is whether those measures and related grant and subsidy programs are sufficient and fit for purpose. The evidence indicates that these measures are not currently achieving their intended purpose to the extent they should.

In this regard, the hearing will build on evidence already received earlier this year by the Royal Commission in Broome, Darwin and Cairns and also with particular emphasis on the needs of informal carers in rural settings, the evidence in Mildura. If anything, the principle of equity of access according to need should mean that rural populations receive better care, better access on a per capita basis than the national average. That's because the need in rural Australia would appear to be greater. Reasons for this are as follows: the average age profile of the population in regional and remote areas is older than in urban areas.

Also, on average, older people in regional and remote areas generally have poorer health outcomes at the moment including higher rates of disability, disease and injury, and also there's a higher proportion of Aboriginal and Torres Strait Islander

people in regional and remote areas who generally require aged care services at a somewhat younger age. However, as with other social and health services, availability of aged care in regional and remote areas compares poorly to its availability in urban Australia. This remains the case in spite of several reviews over the years having drawn attention to the disparities. First, there are fewer residential aged care places per 1000 people in regional and remote areas when compared with major cities.

Next, there are fewer people using community aged care services per 1000 people in regional and remote areas when compared with major cities. Next, there are higher hospital patient days used by those eligible and waiting for residential aged care in regional and remote areas when compared with the general population. Next, few residential aged care facilities in regional, rural and remote settings can cater for diverse and complex needs such as the needs of people with advanced dementia creating complex behavioural management issues, for example.

And finally, people wait longer for home care packages and the services associated with those packages, especially for higher level packages. And particularly in remote areas , these services may not be available at all. There's a technical point I should make here. Throughout this hearing we will use the Australian Statistical Geography Standard Remoteness Structure to refer to what are commonly referred to as regional, rural and remote areas. This classification structure defines geographical locations in five categories: major cities, inner regional Australia, outer regional Australia, remote Australia, and very remote Australia. Mudgee, for example, is itself inner regional but it's surrounded by outer regional areas.

We acknowledge there are a number of other geographical classifications which have been or are currently used in Australia to describe and, in some cases, plan for services in regional and remote areas. Commissioners, at the end of the hearing we will be raising for your consideration 11 specific propositions about potential changes directed to improving the viability and sustainability of aged care in rural, regional and remote settings. We will be testing these propositions through the course of this hearing. A word of explanation is warranted here. Last week the Royal Commission submitted its interim report to the Governor-General. The work of the Royal Commission has now entered a new phase. In this new and final phase of the work, Commissioners, we intend to formulate and test propositions which we are considering for submission to you as potential recommendations for you to make in due course.

These propositions form part of the work the Commission will be doing to develop options for a fundamental redesign of the aged care system. There are four broad questions or areas for inquiry in this hearing and a number of potential recommendations that might arise in due course from each of them. Each area of inquiry has been chosen because of its potential for improvement of the aged care available for older Australians in regional and remote areas. Rural and remote Australians make a huge contribution to the nation and deserve a first class aged care

system. Regrettably, the evidence suggests that they are not getting that first-class system at present and we intend to use this hearing to find ways to remedy this.

The first question the hearing will consider is whether the mainstream model of service delivery is sustainable in regional and remote areas. In this regard, sustainability encompasses financial sustainability but extends to other aspects of the viability of safe and quality service delivery. We will examine funding and financing of the aged care system in detail next year. Ahead of that, we know that a number of recently published reports have suggested that providers in all geographical areas are experiencing a decline in financial performance. It's reported that regional and remote providers are performing particularly poorly and the viability of many such providers might be questioned.

Operator, please display the Aged Care Financing Authority's seventh report, July 2019. Thank you. If we go to page 9, please, operator, we call out the text beginning "44 per cent of residential care providers". ACFA has reported, Commissioners, that 44 per cent of residential care providers reported a loss compared with 32 per cent in 2016/17. That 44 per cent relates to the financial year 2017 to '18. They've reported that there was a very significant decline in the financial performance of regional residential care providers in 2017/18 and on average the performance of not-for-profit providers dropped significantly more than for profit providers. Not-for-profit providers are prevalent in regional and rural areas.

The issue of whether and to what extent mainstream providers can operate sustainably under the current funding and financing framework is not a new issue. In 2016 the Aged Care Financing Authority published its report 'Financial Issues Affecting Rural and Remote Aged Care Providers'. Operator, please display RCD.9999.0075.0058. Now, in this report at page 0063, ACFA found that in spite of the potential availability of supplementary funding known as the viability supplement rural providers face higher costs and their other sources of income are lower leaving them worse off overall. In light of this, perhaps it's unsurprising that residential aged care facilities in regional and remote areas are overwhelmingly owned and operated by not-for-profit organisations and also by government.

In the case of not-for-profit organisations, providers tend to own fewer facilities each compared with those in metropolitan areas and the organisations and facilities are smaller, and these factors raise potential scale and professionalism issues. We will explore potential mechanisms for capacity building and interventions that might support these organisations to deliver quality aged care services or to safeguard the welfare of care recipients where services might be at risk of failing. As to the issue of financial sustainability, in this hearing we will ask you, Commissioners, to consider the proposition that aged care services delivered in regional and remote areas should be funded to a level that accords with the additional costs incurred in supplying the services in these areas.

The Australian Government, we'll be considering submitting to you, should establish an independent authority charged with (a) conducting a costs study to determine the

appropriate level of subsidies in these contexts, and (b) updating required subsidy levels annually. The Independent Hospital Pricing Authority could be used as a model for the form, structure and work of such an authority. Commissioners, with regard to the viability and continuity of safe and high-quality care, we will test a series of further potential proposals relating to capacity building of small rural not-for-profit services in communities where supply is scarce, that is, supply of labour and aged care services is scarce, and improvement of governance of such services.

We will also consider the potential benefits of a mechanism by which the Australian Government could intervene when providers encounter extreme cases of challenging care needs which the provider has become unable to meet. Mechanisms for intervention in other circumstances will also be considered, such as the Australian Government taking over management of services in exceptional circumstances. I will articulate those in detail in my closing address on Wednesday afternoon. The second broad issue for inquiry in the hearing, closely related to the first, is whether the Australian Government's existing policy approaches to supporting the provision of aged care in regional and remote areas sufficiently acknowledges the unique circumstances of those areas. Are those measures sufficient to close the gap and remove inequalities? If not, what other approaches are needed.

There are four major pillars to the Australian Government's current policy to support regional and remote aged care. The first is the viability supplement I've just mentioned which is available in different forms to residential care providers and home care providers. The second is the availability of capital grants directed predominantly to residential and home care providers in regional and remote locations for infrastructure investment. The third is a set of arrangements under the Allocation Principles 2014 by which priority may be given to special needs, that statutory term, in the course of assessments and decision-making as part of the aged care approvals rounds processes that results in the allocation of places to residential care providers.

And the fourth is the prevalence in regional and remote settings of two flexible programs for the provision of aged care, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, sometimes called NATSIFlex or NATSIFAC program, and this was a focus of evidence in Broome, in particular. And, secondly the Multi-Purpose Service Program which will be a focus in this hearing in Mudgee. The Multi-Purpose Service Program or MPS is a partnership between the Australian and State and Territory governments with the aim of providing health and aged care services in regional and remote communities that couldn't support standalone hospitals or residential aged care services sustainably.

The program was developed in the 1990s at a time when regional hospitals were struggling to deliver acute health services sustainably and the ageing regional population meant that the aged care hostels and nursing homes in those regions were no longer meeting demand. Flexibility of funding and infrastructure to meet community need is a key tenet of the model. For example, multi-purpose services receive Australian Government funding to deliver aged care services and State or

Territory funds for the delivery of health services and capital infrastructure. A pooled funding arrangement thereby provides for flexibility to allocate resources where required.

There's no requirement for the Australian Government contribution to be applied only to aged care, nor for the States or Territories' contribution to be applied only to health care. As at 30 June 2018 there were 178 multi-purpose service facilities in Australia funded to provide 3152 residential aged care places and 472 home care places. The number of multipurpose services has increased from 117 in 2008 with growth in every jurisdiction except Tasmania and the Northern Territory.

What can be done to improve the delivery of aged care through the multipurpose service program? A centre for Health Economics Research and Evaluation at the University of Technology Sydney, UTS, recently completed a review of the aged care component of the multipurpose service program at the request of the Australian Government's Department of Health. The report was prepared by a team led by Professor Mike Woods, who was the presiding Productivity Commissioner who had responsibility for the 2011 Productivity Commission report of which you, Commissioners, have heard so much.

I will refer to the new report from Professor Woods and his team as the UTS report. Operator, please display general tender bundle tab 13. We will examine some of the findings and the recommendations of the UTS reports with representatives of the New South Wales, Western Australia and Australian Governments later in this hearing. Commissioners, we expect to submit for your consideration a series of detailed proposals in relation to improvement based largely on the recommendations in the UTS report and for its targeted expansion into areas that are not served by sufficient levels of privately operated services. We will articulate the proposals we draw from the UTS report in detail in my closing.

As to the potential for expansion of the MPS program where needed, we're considering advancing a proposal to the effect that the Australian Government, together with relevant states and territories, should agree upon and implement a joint approach to expand the MPS program into new outer regional and remote locations, including those where there is currently another approved provider with demographic projections and demand forecasts warranted. The Australian Government should consider MPS as one of the mechanisms to address the issue of thin or non-functioning aged care service markets, including in the delivery of home care packages as identified in one of the other recommendations.

The third broad issue for inquiry in this hearing is whether the changes to allocate home care packages to consumers instead of allocation to providers, as was previously the case, have had undesirable consequences for access to services in what I've just referred to as thin markets in some regional and remote areas. In this regard, we will inquire whether the Department of Health has paid sufficient attention to the monitoring and development of the market in regional and remote areas.

Evidence before the Royal Commission to date suggests that without an active approach from the Department of Health to mark development and stewardship, a market-driven approach that relies solely on competition between providers may not in some areas be fit for purpose where there's no working competitive market for such services. Providers face poor economies of scale in these contexts and care subsidies are not meeting the differential costs of service provision, it seems. There's a broad consensus apparent on the evidence that collaborative approaches, rather than competitive ones, might yield better results in such condition.

There are often fewer providers willing to offer services and aged care recipients receive less care, as the value of their package might be eroded by high travel costs. The data shows that since 2016 when the increasing consumer choice reforms were rolled out and home care packages were allocated nationally on the basis of priority need directly to aged care recipients, no consideration of regional distribution – the percentage of home care package received by people in outer regional, remote and very remote areas has decreased. With respect to outer regional, it's decreased as a proportion of all packages. And with respect to remote and very remote areas, it's decreased in raw terms, as well as in percentages.

In this regard, we're considering advancing the following proposition, Commissioners. The Department of Health should assess the markets for the services covered by the home care package program in outer regional and remote areas. In the absence of compelling evidence that there is a working competitive market for the entire suite of home care package services in each such area, the Department of Health should vary and augment the home care allocation model in that area to ensure a sufficient supply of services to meet demand in that area.

In my closing address I will outline the potential mechanisms for variation or augmentation of the current home care allocation model which we presently have under consideration for submissions. This is part of our broader work on options for system redesign. And we will also have it front and centre when we're considering what's needed to provide effective solutions in regional and remote areas as work on that very important issue progresses.

The fourth and final broad issue for inquiry is the depth and quality of the aged care workforce in regional and rural and remote areas. For the purposes of this week's hearing we will put to one side the question of accessibility to health and allied health practitioners. And that's a matter to which attention will turn in a hearing to be held in Canberra in December. This week we will focus on potential measures for ameliorating workforce and skills shortages and shortfalls in regional and remote areas. This, of course, feeds back into other lines of inquiry hearing, in that a sufficient and sufficiently skilled workforce is critical to the sustainability of aged care provision in regional Australia.

The Aged Care Workforce 2016 report highlighted a number of variations between the aged care workforce in metropolitan areas and the aged care workforce in regional and remote areas. Providers of both home and residential care in regional

and remote areas report skill shortages attributable to a lack of suitable applicants, skills and qualifications and geographical location.

Access to health services is also challenging. There's a marked decline in the full-time equivalent rate, based on total weekly hours worked, of most types of health care professionals per 100,000 population as remoteness increases. We will highlight two grass roots approaches tomorrow that will help inform future broader policy solutions to the issue of aged care workforce in regional and remote areas. In my closing address, I intend to articulate proposals for improvements in the depth and skills of the rural aged care workforce, one involving funding for a proposed conditional scholarship program and the other to foster the establishment of registered training organisations, RTOs, within or with links to rural aged care providers.

In Melbourne hearing 3, you heard evidence from Ms Kerri Rivett, CEO of Shepparton Village, about a proposal for a traineeship program venture between her organisation and a local TAFE. Ms Rivett told you that the proposal failed to attract funding from the Australian Government.

I turn now to the place where we're holding this hearing, Mudgee. We meet here today in the centre of mid-west regional New South Wales in the township of Mudgee. And Mudgee is home to around 11,700 people. It has a high percentage of people over the age of 65 and a high percentage of people aged over 85 when compared with national data. Given these figures, aged care is an important issue in Mudgee. 2.4 per cent of jobs in the town are in aged care, higher than the national two per cent. Three aged care residential facilities are located in Mudgee, which each offer distinct examples and experiences to draw on. Mudgee, therefore, presents a good opportunity for the Royal Commission to examine the provision of aged care services in a regional context.

The scope and depth of concern in rural communities about aged care has featured in submissions received by the Royal Commission. We propose to tender one of those submissions. It comes from a community forum recently convened by members of the Three Rivers University Department of Rural Health at Charles Sturt University and was cosponsored by the Dubbo Regional Council. It's entitled the Voice of a Rural Community, a Submission to the Aged Care Royal Commission from Dubbo and Surrounds. Operator, please display first page. Thank you. We then go to page 0004, please, Operator.

The level of concern expressed in this submission about workforce levels and skills was particularly acute. Restrictions in available services, a lack of coordination of services and pathways, the difficulties of isolation and transport and access to palliative care and specialists also feature prominently in the submission. But there was also much said that's positive about the experience of ageing in a rural setting. Operator, please go to page 0002. The submission places great emphasis – great emphasis – on the social connections in small rural community, a sense of belonging and also volunteerism in rural communities.

The Office of the Royal Commission experienced the depth of concern about aged care in the region firsthand when our staff were warmly welcomed at community meetings held in Mudgee and Dubbo in September. The community came out in higher than expected numbers, some in challenging weather conditions, to meet with Royal Commission staff and share their stories, knowledge and experience in accessing and delivering aged care in the region. These generous insights formed the basis of the preparation of what you will hear over the coming three days. Some of those community members will appear before you this week as witnesses.

The first witness this morning will be Ms Ruth Hamilton, who will speak to you about her experience caring for her mother in a regional residential facility. Ms Hamilton will provide evidence about quality and safety from a family member's perspective and her experience of quality assessment and accreditation audits undertaken by the Aged Care Quality and Safety Commission.

The rest of the day today will be taken up with a limited case study examining the experiences since the commencement of 2018 through to September 2019 of Pioneer House Aged Care, a local residential aged care facility here in Mudgee. I will open the case study following the evidence of Ms Hamilton. Tomorrow, the Commission will open with direct experience accounts given by Mr Phillip Dunlop and Mrs Sue Dunlop. Mr Dunlop cares for Mrs Dunlop on a rural property in New South Wales. Mrs Dunlop is the recipient of a homecare package. Together they will explain to you the challenges of accessing home care and some of the specific barriers that they've encountered living in a rural area.

Commissioners, you will then hear another perspective, a panel of approved home care providers comprising representatives from Australian Unity, Uniting and Live Better Community Services will give evidence about the practical and systemic challenges associated with delivering home care services in regional and remote areas. They will be asked what is needed to ensure that people in regional and remote areas of access to quality aged care in their homes. Dr Rachel Winterton is an academic at La Trobe University and also the convenor of the Australian Association of Gerontology special interest group for Rural, Regional and Remote aged care.

She will give evidence about some of the innovative approaches that are needed to overcome the challenges associated with service delivery in these regions. Specifically, Dr Winterton will describe the rural workforce centre model and how it can be adopted and implemented to facilitate greater access and higher quality services to older people in regional and remote communities.

Tomorrow afternoon we will continue the theme of exploring innovative approaches to overcoming the inherit challenges of service provision. Mr Lyndon Seys, chief executive officer of Alpine Health Victoria, will share with you his knowledge and experiences in delivering services through the multipurpose service program. Mr Seys explains how Alpine Health has strived to meet broader needs of the community, establishing a service as an employer and service provider in the region

across health, aged and disability care. Alpine Health also became a registered training organisation to train, attract and retain a local workforce.

Ms Sally Goode, chair of the Loxton and Districts Health Advisory Council in South Australia, will then give evidence about her own experience of addressing workforce challenges for aged care in the South Australian Riverland. The advisory council worked to establish a scholarship program in the region to encourage locals to gain skills, knowledge and experience in the aged care sector. The scholarship program is in its second year and has successfully provided a pool of qualified workers, many of whom have gone on to secure employment in the aged care sector in the region.

Finally, on Tuesday, Ms Sue Hood will share her experience of caring for her husband who's living with dementia and the difficult path seeking formal support services in regional Dubbo. On the final day of the hearing, Wednesday, we intend to hear evidence from Julian Krieg, chair of the York Health Advisory Group, who will outline his views on the benefits associated with flexible funding through the multipurpose service program and the barriers to delivering services with individualised funding packages.

We will then hear from representatives of the New South Wales and Western Australian governments on their participation in the multipurpose service program and their operation of several MPS facilities in regional and outlying areas. On Wednesday afternoon, we will hear from Mr Graeme Barden, Assistant Secretary of the Residential and Flexible Care Division in the Department of Health of the Australian Government; and also Mr David Hallinan, Acting Deputy Secretary for Aging and Aged Care, Department of Health.

In this evidence, we will examine many of the issues I've canvassed in this opening and will seek the Department's response to the emerging evidence. The final witness to appear in the Mudgee hearings will be Mr Peter Harris. Mr Harris is a carer for his wife, who lives in a multipurpose service in New South Wales. Mr Harris will tell you the value of the multipurpose service in keeping his wife nearby and how important the service is to the community. Operator, please display Mudgee hearing general tender bundle index. Commissioners, I tender the 37 documents constituting the general tender bundle for the Mudgee hearing set out in the index which is currently on display.

COMMISSIONER PAGONE: Yes. Thank you. That tender bundle will be exhibit 12-1.

EXHIBIT #12-1 GENERAL TENDER BUNDLE

MR GRAY: Thank you, Commissioner. Ms Hill will now call our first witness.

COMMISSIONER PAGONE: Ms Hill.

MS HILL: If the Commission pleases, I call Ruth Hamilton.

<RUTH MAREE HAMILTON, AFFIRMED [10.36 am]

<EXAMINATION BY MS HILL

MS HILL: Good morning, Ruth.

MS HAMILTON: Good morning.

MS HILL: Ruth, could I please ask you to state your full name?

MS HAMILTON: Ruth Maree Hamilton.

MS HILL: And how old are you?

MS HAMILTON: 53.

MS HILL: And, Ruth, you've prepared a statement for the Royal Commission.

MS HAMILTON: Yes.

MS HILL: And in that statement, you talk about your mum's experience of residential care, don't you?

MS HAMILTON: Yes.

MS HILL: And your mum receives residential care in a country town.

MS HAMILTON: Yes.

MS HILL: You've expressed a preference to the Commission that you would rather not identify the place where your mum receives care.

MS HAMILTON: Yes, please.

MS HILL: And you've asked me to call you Ruth.

MS HAMILTON: Yes.

MS HILL: And to refer to your mother as just that.

MS HAMILTON: Mum, yes.

MS HILL: Operators, could I ask you to please to you display document ID WIT.0597.0001.0001. Ruth, do you see a copy of your statement in front of you there?

MS HAMILTON: Yes.

MS HILL: And also on the monitor.

MS HAMILTON: Yes.

MS HILL: Are there any changes you would seek to make to that statement?

MS HAMILTON: No.

MS HILL: And are the contents of that statement true and correct?

MS HAMILTON: Yes.

MS HILL: Commissioner, I tender the statement of Ruth Hamilton.

COMMISSIONER PAGONE: Yes, the statement of Ruth Hamilton will exhibit 12-2.

EXHIBIT #12-2 STATEMENT OF RUTH HAMILTON DATED 24/10/2019 (WIT.0597.0001.0001)

MS HILL: As the Commission pleases. Ruth, I would like to start by asking you to share with the Commission a bit about your mum. Can you tell me what your parents did for work when you were growing up.

MS HAMILTON: My father was a race horse trainer and my mother had a cafe and did catering.

MS HILL: And did you have any siblings?

MS HAMILTON: I have a brother – older sister and brother.

MS HILL: What was family life like growing up?

MS HAMILTON: It was wonderful. Mum and Dad were very supportive, yes, a great family environment.

MS HILL: And, Ruth, you work in Dubbo.

MS HAMILTON: Yes.

MS HILL: What do you do for work?

MS HAMILTON: I work as a diabetes educator.

MS HILL: And, in fact, you're a registered nurse.

MS HAMILTON: I'm a registered nurse, yes.

MS HILL: What do you like about living in the country?

MS HAMILTON: Not much traffic, it's quiet. Yes, you mostly know most of the people, so great friends, yes.

MS HILL: Two of those friends have joined you - - -

MS HAMILTON: Yes, they have.

MS HILL: - - - today, haven't they?

MS HAMILTON: Yes.

MS HILL: Can I take you to the beginning of 2012.

MS HAMILTON: Yes.

MS HILL: Where were your mum and dad living at that time?

MS HAMILTON: They were living in the central west slopes and plains.

MS HILL: And were they living independently?

MS HAMILTON: Yes.

MS HILL: And it wasn't too far from where you were.

MS HAMILTON: No, I lived in the same town.

MS HILL: In 1991 your mum had been diagnosed with a brain tumour.

MS HAMILTON: Yes.

MS HILL: What did that mean for your mother's care in 2012?

MS HAMILTON: Prior to that in the home Mum and Dad were independent. Dad was Mum's carer, and he provided the care for her. She had a PEG tube – a gastrostomy tube in and she had feeds which he did all that, he cared for her dressing. That's – yes, and Mum did – like, she was independent. She was

gardening, a cook. Even though she couldn't eat she still cooked, yes, so they were independent. But then in 2012 Dad passed away.

MS HILL: That was in March, wasn't it?

MS HAMILTON: Yes.

MS HILL: What did that mean for your mum's ability to stay at home?

MS HAMILTON: It made it very hard. She wanted to stay at home, and I tried to keep her at home for at least, I think, five months.

MS HILL: How did you try and do that?

MS HAMILTON: I – well, I worked full time and so I would go there every evening to see how she was and sometimes I would check before I would go to work. She was lucky; she had a good neighbour across the road that would keep an eye on her as well, but it just became too much.

MS HILL: How old was your mum at that time?

MS HAMILTON: She would have been in her early 80s.

MS HILL: What did you and your mum decide to do?

MS HAMILTON: It became hard for me to look after her because she did have a couple of falls and then I realised she just couldn't cope at home by herself. So we talked about it and I said, "Look, I just can't do this any longer, Mum. We're going to have to do something." And she said, "Well, put me away if you have to". But she then came around and decided that it was the best thing.

MS HILL: When you were looking for somewhere with your mum, what were you looking for in a home?

MS HAMILTON: I was looking for something that still maintained her independence and that she could probably have a room of her own, her own bathroom, and that had activities. Yes, I didn't think she was high-level care at that stage.

MS HILL: So your mum ultimately moved into residential aged care.

MS HAMILTON: Yes, in the August, yes.

MS HILL: At the beginning, what observations do you recall of the care that you mum received when she was in residential care?

MS HAMILTON: I found it was – I was quite happy with it in the beginning. The staff did their best that they could. Probably their knowledge on the gastrostomy tube that Mum had wasn't – I didn't feel was enough, but on the overall thing, I felt the care was fairly good.

MS HILL: What was important to you for the type of care you wanted your mum to receive?

MS HAMILTON: Well, I wanted them to, you know, maintain her independence, ensure that the gastrostomy tube was adequately cared for and that she was happy to be there, yes, and that she enjoyed quality of life.

MS HILL: And were you very involved in the delivery of care for your mum?

MS HAMILTON: Yes. I go there every Monday and Wednesday evening to check on her after work, and I stay there for about an hour and a half to two hours. And then I go on Saturdays; we go to get flowers and go for a drive. And Sundays, we go and get the Sunday paper and a coffee – or I have a coffee, she doesn't.

MS HILL: Can I take you to the beginning of this year, January 2019. What was happening at that point in time with the care your mum received?

MS HAMILTON: The lady that was looking after Mum – January, yes, was it the gastrostomy tube?

MS HILL: Yes, thank you.

MS HAMILTON: Okay. Mum has a gastrostomy tube which – the beginning – or the end of 2018 had changed and what was happening with the staff when they were feeding Mum, unfortunately, it was getting broken. And I spoke to the manager about that and she said the staff – they had new staff and that they were being trained. But – and then what happened was I got a call – no, I didn't get a call, sorry, get my straight, yes. And I was concerned about that getting broken, and I spoke to her about it. She said maybe I could help with some training for them.

MS HILL: What did you say when that was suggested to you?

MS HAMILTON: To me, I said, "That's fine but I have to do it when a day – that I was a day off work to be able to do that". Yes, and then I – sorry, I've lost my train of thought.

MS HILL: You were talking about how you had had a conversation with the manager at your mum's facility.

MS HAMILTON: Yes.

MS HILL: And you had had a conversation with her about you were prepared to offer training to – about the changing of the PEG tube.

MS HAMILTON: Tube, yes. But I didn't want anyone to do it until I had seen them – supervised them, just them watching me do it and then me supervising them doing it.

MS HILL: What did the manager say to you?

MS HAMILTON: She said that – you know, they had – some of them were employed in their country as registered nurses but they were employed as PCs here and they had those – they were registered nurses and had the skills to do it. But I said I still wanted to watch them do it, so I knew that they were competent.

MS HILL: And then what happened?

MS HAMILTON: Then one – in February I think, the 11th, one of the team leaders told me that they were doing an education session but there was no mention of me actually being involved in that. So I asked to see what information they were going to give and I made suggestions to that information.

MS HILL: At paragraph 13 of your statement you describe visiting your mum on 13 February, a few days after that training session.

MS HAMILTON: Yes.

MS HILL: What happened on that day?

MS HAMILTON: When I got there, Mum said "My tube had been changed". I thought that's really odd, I haven't been contacted about that. And so then the PC that was on, he came down to tell me that he had changed Mum's tube and I asked why I hadn't been contacted and he said, you know, "You would have been". And I said, well, "No, I haven't. I haven't received any messages" and he – I said, "Why did you change it?" And he said it was broken and the RN had told him to change it.

MS HILL: And what did you do?

MS HAMILTON: I explained that I wasn't very happy about it, and I spoke to the team leader that was in on that evening and told her that I wasn't happy about it and that I would be speaking to the CEO in the morning.

MS HILL: Did you then have a conversation with the CEO?

MS HAMILTON: Yes, I rang her the following day and asked her why I hadn't been contacted about it and – and then my concerns about it being done and that she knew – I said, "You knew that I didn't want it done until I had supervised someone doing it" and she said to me, "What is your problem? Nothing happened – nothing

went wrong and your mother wasn't hurt." And then I tried to explain to her why I was upset about it and she just said to me that, "You're nothing but a bully and no one wants to look after your mother because of you".

MS HILL: How did that make you feel?

MS HAMILTON: Insignificant, yes, as if my concerns – like, yes, I know things happen and if it was just, look, apologise to you for that, it won't happen again, but it was just that my concerns weren't listened to and they didn't mean anything.

MS HILL: And what did you do, then?

MS HAMILTON: Well, I didn't really do anything then, yes. I just thought, yes, not good.

MS HILL: And then in March your mum tells us that there was a meeting held at the facility; is that right?

MS HAMILTON: No, Mum, they get a – the minutes of the residents' meeting, yes, and I – Mum leaves them there for me to have a read so I was reading those minutes, and I was quite concerned by something that was in those minutes.

MS HILL: What were you concerned by?

MS HAMILTON: It was stated that some residents – the CEO had been at the meeting and she said:

> *...some residents evidently telling officers they are not getting the care needed. The CEO advising it is very important and disappointing if residents do not report to management, CEO or the emotional and spiritual support team members or the residents meeting before going to the department. Any complaints cannot be fixed if not reported and discussed.*

MS HILL: And you're reading there from your statement at paragraph 15.

MS HAMILTON: Yes.

MS HILL: And you've also provided the - - -

MS HAMILTON: Minutes.

MS HILL: - - - Royal Commission staff with a copy of those minutes.

MS HAMILTON: Yes.

MS HILL: Can I turn then to April 2019.

MS HAMILTON: Yes.

MS HILL: In April 2019 there was an audit at your mum's facility, wasn't there?

MS HAMILTON: Yes.

MS HILL: How did you find out about that?

MS HAMILTON: I was contacted by one of the auditors.

MS HILL: Where were the auditors from?

MS HAMILTON: The Aged Care Commission.

MS HILL: Were you involved in the audit?

MS HAMILTON: No, just that phone call from her.

MS HILL: And what was the phone call?

MS HAMILTON: She wanted to see how I felt about Mum's care and if I was happy with the care and if I thought that the staff had the skills and if the RNs were – had the skills as well to be caring for my mum.

MS HILL: What did you say to that person?

MS HAMILTON: I said that I was concerned about Mum's care; I did have issues with it because since January two thousand – this year, Mum had a carer that looked after her five of the seven days for two years, the same carer. And she had recently been moved and I had noticed Mum's care had declined since then, and so I mentioned that to her. And I mentioned the issue that I had about the gastrostomy tube and she said she was actually a clinical person and I said I had – there was a folder in Mum's room that I could write in the family notes, and I – and I used to write things in there if a dressing wasn't done properly or certain things I wanted to leave, and she said she had been in there but hadn't seen those notes.

MS HILL: What observation did you make of the audit process?

MS HAMILTON: That audit I think was very concise and very good, because I heard later on that they actually did not pass that .....

MS HILL: .....

MS HAMILTON: That re-accreditation, yes. I think they were quite thorough.

MS HILL: Did you have any contact with the staff at your mum's facility about that audit in April?

MS HAMILTON: I did have to make a phone call about an issue. And I spoke to one RN there. And she told me that that – the – because after that audit mum's folder had then been locked away in a cupboard and I said I don't have access to that anymore. And she said, "Yes. That came from the audit. They went through us like a fine toothcomb. It was really awful."

MS HILL: You've referred to the April audit as "that audit". There was another audit in August of 2019, this year, wasn't there?

MS HAMILTON: Yes. Yes.

MS HILL: How did you become aware of the August audit?

MS HAMILTON: I was sent an email that had a release saying that they were going to be doing an audit and if you wanted to make an appointment you could. So I did make an appointment.

MS HILL: And you attended that appointment?

MS HAMILTON: Yes.

MS HILL: And what happened at that time?

MS HAMILTON: That appointment with that lady, she told me that she didn't have a clinical background. And I didn't feel that it was as – an effective audit. She asked my mum questions and then I said things after and those questions, I didn't feel – I thought they were fluffy questions and they're not questions that people – if that's what the questions they were asking the facility, I don't think the resident would tell the actual truth.

MS HILL: Can I ask you to expand on what you mean by "fluffy questions".

MS HAMILTON: Well, "Are you happy here? If you had an issue, would you feel comfortable saying something about it?" Yes. "If you had pain, would you tell the staff?"

MS HILL: What observations did you make of your mum in answering those sorts of questions?

MS HAMILTON: She would just go, "Yes. Yes. Yes."

MS HILL: And why do you think that was?

MS HAMILTON: I think her generation, they don't like to make waves, because, you know, of the repercussions that may happen to them. And they just like to keep people happy.

MS HILL: What would you have liked to have seen in that audit process in August?

MS HAMILTON: I would have liked it to have been another clinical audit, because I felt that majority of the issues that they may fail were clinical issues. And I don't see how they could have in that period fixed all those issues. And if the person wasn't clinical, how would they know if they were actually fixed?

MS HILL: Did you become aware of the outcome of the August audit?

MS HAMILTON: Yes. I was talking to staff and I asked whether they had failed or passed and they had passed. And the comment that had been said to the staff that it was an easier audit or it was much better.

MS HILL: And did you have any discussions with staff about their work and what they were doing at that facility after that audit?

MS HAMILTON: The first one or the second one?

MS HILL: The second one?

MS HAMILTON: Yes. The staff were pretty disappointed themselves and they didn't think many changes had taken place.

MS HILL: Can I ask you how, with someone – someone with a background – a clinical background as a registered nurse and also being the daughter, how do you balance – or is there a balance to your professional background as a nurse and being a daughter?

MS HAMILTON: It's hard, because I probably – being a nurse I have certain expectations and they're probably more than what people can probably provide there, so it is hard. But most of the staff are very good and if they're not sure about some of the things for mum, they will ask me to help them – yes – with that. But it is hard balances that in being the daughter and not being pushy as a nurse.

MS HILL: And how do you balance that with the communication that you've described needing from your mum's facility?

MS HAMILTON: I find it hard. I don't feel that I can go to management about my concerns, so I do talk to the staff about some of the issues and they try and fix them. But then sometimes they've had repercussions from trying to do that.

MS HILL: What do you mean by "repercussions"?

MS HAMILTON: They've – one of the issues that we had, they said that they would – I asked them about and they said they would leave a note in the book about it. And that person the next week got a disciplinary action for that, following that up.

MS HILL: And how is your mum going now?

MS HAMILTON: She's not too bad, yes. She's 89 this year and – yeah, she has her moments. She gets – often she will go there and say, "Can I not go home with you? I don't like being here," which makes it very hard for me. Yes. And she's a little bit happier now, but she did have an issue before whereas they employ a lot of male people, male PCs, and she wasn't happy with being showered by a male. So that was an issue I had to - - -

MS HILL: And when you refer to PCs, you're describing personal carers?

MS HAMILTON: Carers, yes.

MS HILL: And how did you manage that issue?

MS HAMILTON: Well, I went there on a Saturday to take her to the library and I got there at 11.30 and she hadn't been showered. And so I went to find someone and they said no, she hadn't been showered. So I had to actually just go to the library, take her books, came back at 12 o'clock and she still hadn't been showered. So I went and found the PC that was looking after her and he said she wouldn't let him shower her and he was waiting for one of the female PCs to do it, which I found out they hadn't been informed. So I don't – so I actually went and showered my mother that day.

And I said to Mum, "Why do you not like the male showering you?" And she said, "Would you like a male showering you?" I said, "No, I probably wouldn't. " And so I went in on the Monday and spoke to the team leader that was on that day. And she stated that she showers Mum during the week. And I said, "Well, why is it different on the weekend? If you know that she doesn't like a male, why are you rostering a male on on the weekend to shower her?" So, actually, Mum had said to them she didn't like it, but they didn't follow through with that. It actually took me saying something for that to be changed.

MS HILL: Ruth, perhaps drawing on your clinical background, but also drawing on being your mother's daughter, you've prepared a list of recommendations that you've considered and have shared with the Royal Commission at paragraph 35 of your statement.

MS HAMILTON: Yes.

MS HILL: Could I ask to you read them to the Commissioners.

MS HAMILTON: Yes. I feel that a RN should be rostered on every shift, not just on-call, because at present they only have an RN during the day shift. RNs to have compulsory training in wound care and diabetes care. All Aged Care Quality and Safety Commission auditors to have a clinical background, so that a thorough audit is done. Residents and family to be notified of the outcomes of audits. Areas that they

have failed and any changes that are being implemented. The facilities need to be more open. Residents and family be notified of audits. This was the first time I have been informed of an audit and invited to have a meeting.

Aged Care and Safety Commission to send residents and family a survey prior to an audit to get a background of the issue that are there. If a facility fails an audit and then passes the audit, they should have regular spot audits for six to 12 months to ensure that they are complying and not going back to old habits. Support for staff to be able to speak up about issues at facilities without the risk of losing their jobs or having their shifts reduced. The facility to conduct 12 to – six to 12 monthly case plan reviews with the residents and family. This would provide a formal way for feedback from both sides that should be signed off like a contract that both parties agree to.

MS HILL: With those recommendations in mind, Ruth, what motivated you to come and tell you and your Mum's story to the Commission this morning?

MS HAMILTON: Just from having Mum in a facility, it's actually opened my eyes to what actually goes on. And because I am there quite often, I see a lot of things that happen. And I just feel that changes need to be made and I find some of the – as I said, "The staff are very good and they try the best that they can, but when they try to make recommendations, it doesn't always – their recommendations aren't listened to." And I just – I think we just need changes and I just wanted to be part of trying to help change things for the future.

MS HILL: And how did you feel about coming along and giving evidence this morning?

MS HAMILTON: I felt very nervous, because I was worried because I live in a small – it is a small town that I live in and for the repercussions to my mother and myself and also to the staff that I thought I just had to speak up.

MS HILL: Commissioners, they are the questions I have for - - -

COMMISSIONER PAGONE: Yes. Thank you.

COMMISSIONER BRIGGS: Might I ask you, Ms Hamilton. The issue about staffs' comments and residents' wishes not being respected or listened to, how do you think that might best be addressed? I'm really asking how you change the approach to that in the management or the leadership of the organisation, I think.

MS HAMILTON: Leadership being more open and being supportive and listening to those recommendations and not saying that it won't be done this way. Yes. Just more listening and that coming from that management path that they're more open and willing to make changes. And not – not the residents or the family feeling that there's no point saying anything, because nothing's – you know, a lot of the residents

won't say anything, because they are frightened of the repercussions and that there's no change anyway.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Ms Hamilton, thank you very much for coming to give evidence. It's very important that the Commission hears evidence like yours. Well, I think we're all conscious of the vulnerability that not only people like your mother, but also you feel. And it's very important that you've said what you said to us. Thank you.

<THE WITNESS WITHDREW [11.01 am]

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Commissioners, we're a little ahead of schedule. We could break now or I could proceed to an opening of the case study.

COMMISSIONER PAGONE: What's your preference, Mr Gray?

MR GRAY: I'm indifferent. The opening will take about 20 minutes.

COMMISSIONER PAGONE: I think we might do the opening, Mr Gray.

MR GRAY: Thank you, Commissioners. Commissioners, at the close of this hearing, as I mentioned in my opening of the hearing, we will be raising recommendations for potential consideration with a view to assisting rural not for profits to remain sustainable. I mentioned that there were going to be 11 proposals at the end of the hearing. The Pioneer House limited case study relates to three of them, which are numbered 3, 6 and 10.

Recommendation 3 relates to targeted assistance or small standalone rural not-for-profit aged care providers in circumstances where upskilling of board governance capability, management capability and the like are warranted in areas where there's shortages of supply of aged care services. And, Commissioners, that recommendation in many respects mirrors the criteria of the existing service development assistance program, which in the main relates to services directed to Aboriginal and Torres Strait Islander people in remote areas and it would represent, in effect, a tailored expansion of that program so as to make it available more widely and perhaps in a way that is capable of being custom tailored to different settings relating to rural not-for-profit residential aged care services.

Number 6 is a proposal for an intervention power on the part of government, probably the Department of Health, in relation to very challenging and complex needs where it appears that a small rural standalone not for profit is no longer able to

meet complex care needs of, say, a resident who is showing very difficult and challenging behaviours and that circumstance is threatening the viability of the service and the services in an area where there's a shortage of supply of aged care services.

And number 10 is a suggestion in relation to initiatives that would encourage the training, attraction and retention of local rural workforce, in particular via scholarship programs and establishment of a linked RTO programs.

Now, the Pioneer House case study is intended to test the workability and advisability of those proposals. Pioneer House is a not-for-profit residential aged care service operated by a community organisation which was originally established in 1964 after concerned citizens in the Mudgee area identified the need for an aged care facility in the district. There was a major refurbishment of the facility operated by that organisation commencing in June 2007. And the facility was reopened in 2008 with services available for 81 residents, divided into four wings, two of which are for general care and two of which are for dementia care.

The directors of Pioneer House Living Limited are voluntary members of the local community. And, as I said in the opening, it's a rural community here in Mudgee. Albeit classified as inner regional, it's surrounded by outer regional areas. The board at the relevant period that we're concerned with, Commissioners, commencement of 2018 through September 2019, had no member with any clinical expertise or experience. And, furthermore, we will be asking Mr Codrington, the chair of the board, about this, but we understand that the board didn't have risk management or legal experience either.

The case study today will present evidence about the challenges faced by Pioneer House in that period of January 2018 through to September 2019 and the causes of what became its noncompliance with expected outcomes under the applicable accreditation standard. The case study will explore what changes to practices and to the aged care system itself might avoid these kinds of failures recurring in the future in providers of this kind facing similar operating environments and challenges.

Like other residential aged care facilities, Pioneer House was, essentially, operating on three shifts a day, with a blend of skills and clinical experience represented in each of the shifts, consisting of registered nurses, enrolled nurses and assistants in nursing, who are sometimes called personal carers or personal care workers or personal care attendants. The terminology differs, but, in essence, the role is very similar and in the case of Pioneer House the care workers were referred to as AINs or assistants in nursing.

There will be evidence that by about early 2018 if not earlier, Pioneer House was experiencing difficulties with staffing its shifts and keeping up with the work required to provide quality care. In early 2018, towards the end of its three-year cycle of accreditation, Pioneer House received a visit from the then Quality Agency, now the Quality Commission. The Quality Agency conducted a re-accreditation

audit at Pioneer House in early 2018. The Quality Agency's assessment team recommended to its delegate, back at the agency, that Pioneer House was not complying with the expected outcome applicable for human resource management.

On 13 March 2018, the Quality Agency decided to reaccredit Pioneer House, but for a truncated period of two years of accreditation, rather than the usual three, because of non-compliance not only with outcome 1.6, human resource management, but also with what the delegate regarded as non-compliance with outcome 1.1, continuous improvement.

Steps were pursued in 2018 by Pioneer House to address these matters raised by the quality agency. And amongst those measures an extra staff member was added to two of the shifts. The evidence indicates that there were deeper underlying workplace managerial and governance issues affecting Pioneer House's important work of caring for its residents. And, compounding this situation, in late 2018 Pioneer House accepted admission after a period of respite of a resident on a permanent basis whose pseudonym is Mr UI. And Mr UI was living with dementia.

Mr UI was unsettled at Pioneer House and there were numerous incidents involving Mr UI and other residents and sometimes other staff, involving physical force and other behaviour. Now, Pioneer House staff tried to give Mr UI sufficient special care to avoid these incidents, but this was very resource intensive and there was a limit to what could be done, apparently.

This evidence, I think you will be able to see, Commissioners, links through to the recommendation I just identified as recommendation 6 about the possibility of the counsel assisting team, in due course, proposing to you the conferral of power on the department or possibly the Quality Commission to intervene to support the care of people with complex needs arising from the effects of dementia and environmental triggers if it appears that a provider in a rural context where supply of services is short is just not able to cope and to meet the requisite standard of care for that person.

Returning to, in effect, my chronological opening, at the same time by early 2019 Pioneer House's management considered that in light of Pioneer House's poor financial performance which had been a matter of increasing concern over the preceding financial year and into the financial year 2018/19, in light of that, there should be a reduction of the additional staff who had been added in 2018 so that the level of the staff on the morning and night shifts would be decreased again to the early 2018 level. Now, on closer inquiry the evidence suggests that Pioneer House's volunteer board may not have well understood the implications of doing this for the care of residents in the circumstances Pioneer House faced.

In February 2019 – so very shortly after that decision was taken and at about the time it was being implemented, the Quality Commission, on a visit to Pioneer House, found that Pioneer House's care had deteriorated, and Pioneer House was found to be noncompliant with almost half of the expected outcomes under the accreditation

standards at the time. Shortly after that, the Department, under its separate sanctions function, imposed sanctions on Pioneer House requiring Pioneer House to appoint a nurse adviser and to conduct a program of training at its expense if it was to save its status as an approved provider.

And also at the same time Pioneer House was precluded from receiving subsidies for newly admitted residents, save – but this was later varied for some respite residents. The effect of that element of the conditions imposed in the sanctions was that Pioneer House while it was under sanction, which was to run until 27 August 2019, would be in effect prevented from taking new residents until it had achieved compliance. That's the policy behind a condition of that kind.

The chair of Pioneer House, Mr Allan Codrington, will be our first witness in the case study after the break. He has, over many years, generously given his time to serving Pioneer House in a voluntary capacity. He has been doing so for 16 years. He has been chair for the last four years and he was vice chair for nine years before that. He has made a witness statement for the Royal Commission and I will also be asking him questions so that he will give some supplementary oral evidence about the events I've described, including the board's decision-making, and he will also be invited to outline recommendations he makes in his statement for avoiding the sorts of problems which can be encountered by small rural not-for-profits and which were encountered by Pioneer House in the relevant period.

Next, one of Pioneer House's clinical staff, Ms Tania Sargent, registered nurse, will also give evidence. Apart from a brief period in May and June this year when Ms Sargent was acting DON, director of nursing, she was essentially a deputy DON throughout the entirety of the relevant period. Pioneer House has produced a number of its business record to the Royal Commission from the relevant period. Out of these, we on the counsel assisting team, with the assistance of other staff of the Royal Commission including the solicitors, have compiled a selection of the most relevant documents and they are in an index for the case study. Operator, please display the Pioneer House tender bundle index. Commissioners, I tender the documents in accordance with the index.

COMMISSIONER PAGONE: That tender bundle will be exhibit 12-4.

EXHIBIT #12-4 PIONEER HOUSE TENDER BUNDLE INDEX

MR GRAY: Thank you, Commissioner. Returning to the chronological opening, on 3 and 4 May 2018 a series of focus groups and interviews were conducted by an organisation called in Insync Surveys at Pioneer House in which staff identified areas for improvement in relation to clarity of staff roles, values for actions and behaviour, staffing levels and training, communication between management and staff, and respect and recognition. Operator, please display tab 8 of the general tender bundle – I beg your pardon, of the case study tender bundle. A report of these matters was

provided by Insync to Pioneer House in about May 2018, and some aspects of this document will be raised in the course of the examination of the witnesses.

Insync recommended six actions which included planning workshops to agree on actions and initiatives to deal with the issues in the report, and implementation in accordance with agreed timelines and a governance process, for monitoring implementation with regular updates to be provided to staff and, finally, with a re-run of the survey. Operator, please display tab – perhaps there's no need to display it. I will just refer on the transcript to tab 73 as evidence in support of this point, Commissioners. On 16 July 2018 Mr UI commenced as a respite resident. On 27 August 2018, Dementia Support Australia received a referral from Pioneer House about Mr UI. Dementia Support Australia is the organisation you've heard a lot of evidence about, particularly in the Sydney hearing.

Dementia Support Australia is a joint venture of HammondCare supported by the government, and so it is available to provide advisory services and, in some cases, concrete physical presence and intervention to assist providers to help – to assist providers to care for people living with dementia who are showing challenging behaviours as a result of their dementia and environmental triggers. Dementia Support Australia ventured – I beg your pardon, Commissioners. Dementia Support Australia actually visited Pioneer House on 30 August 2018 and gave a report which included suggested strategies for managing the care of Mr UI. That's at tab 9.

At about this time in August 2018 there's evidence from the papers submitted to the board that the financial performance of Pioneer House was not tracking as the board wished. The finance manager reported that occupancy was lower than planned and the level of Aged Care Funding Instrument, ACFI claims, was below the level planned and advised by a consultant group, which had been retained by Pioneer House. On 1 September 2018 – this is tab 74 – Pioneer House and Mr UI's wife signed a permanent resident agreement for Mr UI. I'll ask you, operator, to please display tab 11 now.

On 9 January 2019, an all-staff meeting was held at Pioneer House. The finance manager and the CEO/DON – CEO/DON refers to one person who held both the position of CEO and director of nursing. Both of those people, the finance manager and the CEO/DON, spoke to staff about the financial pressures that Pioneer House was facing, and the minutes of the meeting which are on display report that the CEO/DON spoke to the inability to sustain rosters as they are. And the minutes record – if we go to page 29, please, operator – that staff were informed that it was proposed to make changes to the roster to reduce one AIN on the morning and evening shift.

Now, we interpolate, on our understanding it appears in the document that that meant that the numbers of AINs on those shifts would go from nine to eight AINs and to have two enrolled nurses on the morning shift. In addition, there would be a one B shift or a B stream shift, of which Ms Sargent will give some explanatory evidence later. The minutes record that staff were told that:

...no one would lose hours as we believe in our commitment to staff, however, we will not be recruiting to positions that are no longer on the roster.

So it was intended by those management executives to be an attrition which would eventually result in the fact that the shifts were staffed at a lower level, not resulting in remaining staff losing hours. That's as we understand the gist of the point made in that evidence and the aim of the efficiencies was reported as being to decrease wage expenses by a forecast $350,000 per annum. On 14 January 2019 the evidence in the tender bundle shows that the finance manager submitted the January finance report which reported that on current trends a ratio known as the liquidity ratio would be deteriorating on current financial performance trends.

The liquidity ratio – as we understand it, and we will ask Mr Codrington, but as we understand it the liquidity ratio represents, in effect, the cash at bank, compared with liabilities represented by RADs or refundable accommodation deposits. The finance manager reported that Pioneer House was providing 3.37 care hours per resident per day, close to a benchmark mean care hours for not-for-profits of 3.30 and we will ask the witnesses to explain where these means come from, but it appears evident that the decision-making at board level was based on not exceeding a mean or an average number of hours for not-for-profits providing care to their residents.

The main issue identified in the report was that ACFI was below the level at which the consultants said it should be. The finance manager warned that:

Pioneer House needed to make a profit in order to have the likelihood of positive cash flow without which we will eventually run below our policy 50 per cent liquidity ratio.

On 20 and 21 February this year the Quality Commission conducted an assessment contact and at that assessment contact it was found that at least five expected outcomes were not being met, including, again, 1.6 human resource management, and also including behavioural management which was outcome 2.13. In the assessment contact report which is at tab 31 – can you please display that, operator – there's a list which shows unfilled shifts on nearly every day, or unfilled positions for AINs on shifts on nearly every day from 15 January 2019 to 21 February 2019. That's at page 93 to 4. Operator, if you're able to bring up tab 21, go to page 93 and 4 and display them both. Thank you, operator. So this is a list of unfilled positions on the shifts displayed on the roster is of serious concern. It shows the lengths to which the problems at Pioneer House regarding staffing had gone.

Now, the case study will examine the way in which information available to management was filtered through or conveyed to the board and the purpose for that is to pose a question about whether something needs to be done to tighten up the governance structures that providers of this kind have, or perhaps that all providers have in the future to ensure that boards can be in a position to and do properly exercise their governance functions in relation to management of these facilities. There seems to have been a disconnection between what management must have

known and proposed to do on the one hand, and what the board seemed to know on the other in this case.

Now, the CEO/DON was reporting to the board on continual behavioural management challenges posed in the dementia care area of Pioneer House and those concerns and challenges focused quite largely on Mr UI. There were attempts by management of Pioneer House to negotiate with the family of Mr UI about the transfer of Mr UI to other facilities that might have been better able to care for Mr UI in a way that would be safe for other residents. There are significant points of uncertainty that arise in circumstances of that kind. The User Rights Principles 2014 under the Act don't include a clear mechanism for resolution of an impasse which can exist when a provider thinks it can no longer provide safe care but the resident or his representative refuses to relinquish tenure under the resident agreement.

Now, there is a section of the User Rights Principles that deals with this issue. It's section 6, CTH.0001.1000.4726 at page 4735. Thank you, operator. However, formal existence of a mechanism is one thing; how to practically apply it in circumstances where there's a disagreement on the part of family members about such a transfer is quite another and this leads, as you will have guessed, Commissioners, to the point we make about the recommendation I numbered as recommendation 6 concerning a proposal for an intervention by the department, or perhaps by the Quality Commission to facilitate transfers where the criteria in this section are met.

Now, as I mentioned at the outset, on 27 February 2019 the Department of Health imposed sanctions. They're at tab 26. And the conditions imposed by the sanctions were as I described them, including appointment of a nurse adviser. To comply with the sanction conditions, on about 6 March 2019 Pioneer House appointed Harcourt Aged Care Advisors Proprietary Limited led by Ms Michelle Harcourt RN as its nurse adviser. Ms Harcourt was engaged as nurse adviser until the sanctions expired on 27 August 2019. During the term of the engagement Ms Harcourt spent about 27 days on-site at Pioneer House but Ms Harcourt made it clear from the outset that she had limited ability to be physically present and this is, of course, one of the issuers raised by the imposition of sanctions of this kind in a rural setting.

There are going to be logistical and practical difficulties in getting the requisite expertise in on site. I will come to what the solution was to that when I speak about the evidence of Ms Prudence Dear in a minute. But just staying with Ms Harcourt, Ms Harcourt is not able to give oral evidence, Commissioners, but she has made a statement. Operator, please display WIT.0524.0001.0001. Now, I will be asking Mr Codrington about aspects of this statement so that there will be a fair opportunity for Mr Codrington to comment on it and, indeed, he has been apprised of it. Having said that, I seek to tender the statement.

COMMISSIONER PAGONE: Yes. All right. The statement of Ms Harcourt dated 14 October 2019 is exhibit 12-4.

MR GRAY: Commissioner, we might be up to 12-5, I think.

COMMISSIONER PAGONE: Actually, I think you're right. I didn't make a note of the last one. You're quite correct; 12-5. Yes.

EXHIBIT #12-5 STATEMENT OF MS HARCOURT DATED 14/10/2019 (WIT.0524.0001.0001)

MR GRAY: Thank you. Commissioners, I probably have another five to 10 minutes to go with the opening. Should we break now?

COMMISSIONER PAGONE: Yes. I think that's a good idea. We will break now. You might recalibrate the length of time you think you might need on the opening. Presumably, a lot of this you will go through in greater detail when you've got the evidence. You might be able to shorten it a bit.

MR GRAY: I was seeking to short-circuit having to spend some time on some of this material in evidence by including it in the opening.

COMMISSIONER PAGONE: All right. Well, as long as you make up time somewhere, Mr Gray. All right. We will adjourn until 20 to.

MR GRAY: Thank you.

ADJOURNED **[11.31 am]**

RESUMED **[11.47 am]**

COMMISSIONER PAGONE: Mr Gray, we just need to renumber some of these exhibit. The – I think I had been correct originally. It was 12.4, the witness statement of Ms Harcourt. So that will be that, 12-4. The Pioneer House tender bundle is 12-3. The next one will be 12-5.

MR GRAY: Thank you, Commissioner. Commissioners, it's been brought to our attention some there are some sound difficulties and also some glare difficulties. We've tried to remedy them as best we can. We've been told that there are people, particularly towards the rear of the public seating, who can't hear. We can't raise the PA system beyond a certain point, because it will create feedback, and I don't think it's so much the level of people – people's voices into the microphone, but the level of amplification that's a problem.

COMMISSIONER PAGONE: Yes. But if you do speak a little bit louder, that might solve part of the problem.

MR GRAY: Yes. I will certainly do that.

COMMISSIONER PAGONE: So you might want to get the microphone a bit closer to your mouth, as I have just done and shown.

MR GRAY: Yes. So with respect to Ms Harcourt's statement, which is now exhibit 12-4 – I wonder if it's on. Perhaps this one is.

COMMISSIONER BRIGGS: That's it.

MR GRAY: Right. I will try this one. Excellent. With respect to exhibit 12-4, I will ask the operator to go to page 0002, please. At paragraph 6, Ms Harcourt outlines her experience as a nurse adviser of not for profits. At page 0006, paragraph 20, Ms Harcourt recounts how it was agreed with Pioneer House that Ms Prue Dear RN would also be retained to provide nurse adviser services on-site. At page 0009 at paragraph 44, Ms Harcourt summarises the root causes of the key safety and quality issues as she saw them relating them to workforce difficulties and problems with leadership and governance.

Ms Harcourt formed conclusions about Pioneer House in the paragraphs that follow. And I'll now, in effect, paraphrase what appears at paragraphs 45 to 49 and 53 to 58. Staff were burnt out and disengaged, frustrated and in some cases distressed. Clinical leadership roles of registered nurses, including those from overseas, were not respected by AINs, making it difficult for the registered nurses to fulfil their roles of leadership and their obligations of supervision and delegation.

There was limited education and training for staff, with no training on challenging behaviour management. There was resistance to the provision of training, likely because of cost and challenges of arranging it in a rural location. There was a disengaged senior leadership team who did not have knowledge of contemporary aged care. There was limited knowledge of quality at the DON and board levels. No structured governance systems were in place. There was a focus on financial data at board level, with very little data provided to the board about clinical service level.

From early 2018, the issue with short staffing and lack of policies and processes to guide quality were deficient. There was high turnover of staff. Remaining staff reported that a lot of good staff had left out of frustration. And the ongoing issues continued to get worse over 2018, with a lack of attention to ensuring that human resources were sufficient to enable staff to perform their roles. And this had an adverse impact on care. There were ineffective mechanisms to ensure proper reporting to the board and to ensure that they understood their role of governing and organisation delivering complex services to a very complex group of vulnerable residents.

There was no indication, says Ms Harcourt, that accreditation had been limited to two years as a result of the re-accreditation process in early 2018. I will ask Mr Codrington about that. There was ongoing conflict between the CEO/DON on the one hand and the chair on the other. The chair was concerned about ongoing staff issues raised with him about lack of support from management. And the DON regarded this as interference. And, finally, board reports focused on financial management with very little information about comments, complaints, clinical indicators, staff performances, recruitment and retention or policies and procedures.

Now, as I foreshadowed a minute ago, Ms Harcourt retained Ms Prue Dear RN as a nurse consultant to assist her to perform the role of nurse adviser. Ms Dear commenced on-site at Pioneer House on 11 March 2019. And from that time until 26 June 2019, Ms Dear was generally present at Pioneer House four days per week. And Ms Prue Dear will be giving evidence in the case study later in the afternoon.

Two further witnesses have made statements. And it's unnecessary to call them to call oral evidence. The first of these is Ms Daskein RN, who was acting DON from 9 September 2019 to about 14 October 2019. And she gives a brief statement about the staff pool available to Pioneer House and the composition of its four wings and their occupancy levels in February 2019. Operator, please display WIT.0469.0001.0001. I tender that statement.

COMMISSIONER PAGONE: Yes. Well, that now is exhibit 12-5, statement of Robyn Daskein, dated 11 October 2019.

EXHIBIT #12-5 STATEMENT OF ROBYN DASKEIN DATED 11/10/2019 (WIT.0469.0001.0001)

MR GRAY: The second of the witnesses who have made a witness statement but whom we don't seek to call to give oral evidence is Ms Kathryn Brown RN, who's a nurse practitioner, who was sent to Pioneer House in a role facilitated by the industry association ACSA to assess and assist in dementia care and management at Pioneer House and ultimately to provide training on two days in each of April, May, June, July and August 2019. Operator, please display WIT.0523.0001.0001. Commissioners, I tender that statement.

COMMISSIONER PAGONE: Yes, the statement of Catherine Brown dated 3 October 2019 will be exhibit 12-6.

EXHIBIT #12-6 STATEMENT OF CATHERINE BROWN DATED 03/10/2019 (WIT.0523.0001.0001)

MR GRAY: Commissioners, in the tender bundle – I don't ask you to turn to it now, but it's at tab 16 – there's an assessment report conducted by – or authored by Ms Brown finding that the relevant dementia wing – dementia care wing of Pioneer House was inappropriate for caring for resident with very high behavioural needs, although she did identify certain improvements that could be made reasonably easily, such as converting some available space into a space used for diversional activities.

Ms Brown identified gaps in services to dementia support in services for dementia support in rural areas more generally. And in her statement towards the end at pages 10 and 11, please, Operator, back in the statement, 12-6, pages 10 and 11, Ms Brown makes recommendations for improvement of services for dementia support, in particular in rural areas. That's under the heading Question 12:

> *What services or supports do you consider would be useful –*

etcetera, on page 11. Towards the end of the sanction period on 12 August 2019 the nurses adviser, Ms Harcourt, wrote to the board in relation to the likely status of Pioneer House when sanctions were due to expire, noting that two outcomes remained still unmet. This is tab 70, Commissioners. Ms Harcourt reported that:

> *With respect to key personnel and recruitment of a CEO/DON, we've now had a company on board since mid-May without great outcomes.*

Ms Harcourt expressed confidence that Pioneer House would be compliant with the old accreditation standards, although she was not necessarily so confident that Pioneer House would be compliant if required to meet the new policy standards that had came into effect on 1 July 2019 and to which residential aged care facilities would have to be assessed in future accreditations.

Ms Harcourt's engagement as nurse adviser ceased when the period of the sanctions expired and she provided a handover of information to the incoming interim CEO of Pioneer House on 8 September 2019. Mr Codrington gives evidence that the sanctions caused Pioneer House a loss of $934,000, comprising $482,000 in lost revenue, because of an inability to accept new residents, and $452,000 for the actual moneys paid to the various people who assisted the adviser and the adviser's company herself. Commissioners, I will now call Mr Codrington.

COMMISSIONER PAGONE: Yes. Thank you.

MR GRAY: Mr Bateman will announce his appearance.

MR BATEMAN: May it please the Commission, Bateman on behalf of Pioneer House Living Limited.

COMMISSIONER PAGONE: Yes. Thank you.

<ALLAN JOHN CODRINGTON, SWORN [11.59 am]

<EXAMINATION BY MR GRAY

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Mr Codrington, please take a seat.

MR CODRINGTON: Thank you.

MR GRAY: Mr Codrington, what is your full name.

MR CODRINGTON: Allan John Codrington.

MR GRAY: Thank you. And, Mr Codrington, you've made a statement for the Royal Commission, haven't you?

MR CODRINGTON: I have.

MR GRAY: The operator is now displaying on the screen in front of you WIT.0522.0001.0001, statement of Allan Codrington, dated 11 October 2019. Do you recognise that as the first page of the statement you've made for the Royal Commission?

MR CODRINGTON: Yes.

MR GRAY: And do you have any amendments you wish to make to the statement?

MR CODRINGTON: No.

MR GRAY: To the best of your knowledge and belief, are the contents of the statement true and correct?

MR CODRINGTON: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes. Thank you. The statement of Mr Codrington, dated 11 October 2019, will be exhibit 12-7.

EXHIBIT #12-7 STATEMENT OF MR CODRINGTON DATED 11/10/2019 (WIT.0522.0001.0001)

MR GRAY: Thank you. Mr Codrington, towards the end of your statement on page 0019, under question 16 and question 17, you identify lessons learned by the board and you make various recommendations, if I could use that expression, for improvement for support for small regional aged care providers, don't you?

MR CODRINGTON: I do.

MR GRAY: Could you please outline for the Commissioners what the key lessons that you've learnt from .....

MR CODRINGTON: Do you want those from my statement or - - -

MR GRAY: In your own words, from the statement, as you choose.

MR CODRINGTON: I can't see that page, so I will have to read it off this. So we're on 0009, you said?

MR GRAY: Page 0019, question 16. There's a heading:

> *What lessons have you or Pioneer House, including the board, learnt from the above processes?*

And the processes are the processes that led to imposition of sanctions and appointment of nurse adviser and a path – a path back to compliance by Pioneer House.

MR CODRINGTON: So that relates to question 17?

MR GRAY: Question 16.

MR CODRINGTON: Question 16. To have a strong governance structure and accountability requirements for the management team was one point. To appoint external independent auditors and advisers to verify and interrogate on behalf of the board the quality of the organisation's systems and processes to ensure in its meeting it complies and accreditation standards.

MR GRAY: So, just stopping you there, that first point you've mentioned about stronger governance structure and accountability requirements of the management team, just putting your statement aside for the moment, what do you mean by that? What was the problem that you identified there that needed to be fixed?

MR CODRINGTON: I believe that the 1st of July standards will correct a lot of what we didn't have as a board previously. I believe as of 1 July we will get a lot more clinical and a lot more targeted advice to the board. And I think that's probably been taken into account with those new standards as of 1 July. Previous to that, there was no requirement for the CEO/DON to indicate anything that she didn't think was necessary or that she didn't think was important.

The board – boards in these types of facilities rely heavily on their CEO/DON or general manager, whichever the case may be, to make sure that we meet all accreditation standards, that we meet all the standards' requirements. In those days there were 44. And the requirement to meet all 44 standards was a minimum. We thought we were doing that. We passed accreditation for the first four years of our CEO/DON's tenure. When I say that, there were behavioural managements which you have indicated and have been indicated right throughout the statements that we had a lot of difficulty filling our base roster. That was recognised by the board. The board was always given to understand that the base roster was adequately filled.

We certainly put measures in place towards – after the sanctions, to make sure that the board were reported any rosters that weren't filled on a regular basis. And we brought that forward to make sure we knew prior to the board meetings. So that's where I come from with – with that, because I believe that all the boards will now receive better and more accurate recordings – information that will reflect the residents more than it used.

MR GRAY: Is it the case that the board didn't have anybody on it over the relevant period of 2018 to September 2019 with clinical expertise or experience?

MR CODRINGTON: Not necessarily. We've got a physio on the board that would be quite confident to identify any of these things, but very few of those things were ever reported to the board that we needed someone to identify it. We have put in place now with the board ongoing that that physio, we feel, is competent. She feels she's competent enough to actually decipher the clinical reports that will come to the board. And we will take notice of that.

MR GRAY: What's the point you make in 93.2 about external and independent auditors and advisers to verify and interrogate?

MR CODRINGTON: Well, as previously mentioned, we went through a period where we passed all accreditations except 1-1 and 1-6 in early January with that assessment. All the rest of them we went through. There were previous mentions about human resources which always related back to difficulty filling shifts, but, other than that, we passed all our accreditation. So we were led to believe that the person we employed in that role was competent and capable of doing the job. In light of that, if you had an audit at least every six months reporting to the board, whether our policies and whether the work that we believed was being done was actually being done, I think is very important. And that's why it's there.

MR GRAY: Okay. Well, perhaps we will come back to the recommendations you make under question 17 a little later, but I might just ask you now about some of the events of the relevant period of 2018 to September 2019 and seek your clarification of some of the facts. Now, you will have heard in my opening that there is evidence about unfilled rosters for the shifts at Pioneer House in the period probably commencing some time in 2018 and going through to 2019.

MR CODRINGTON: Yes.

MR GRAY: Was the management of Pioneer House reporting to the board on that problem?

MR CODRINGTON: Yes. Yes. The board was aware. When our accreditation came up we were completely aware that our accreditation had been reduced from three years to two years. Our CEO/DON indicated that she expected that and that's what they do – were her term – her comments. In hindsight, should it have raised bigger awareness that it was a potential problem? In all probability it should have been. But, as I previous said, our accreditation standard was – was in pretty good condition prior to that.

MR GRAY: So I will just ask you about the point you've made about the board knowing that, the period of accreditation had been reduced - - -

MR CODRINGTON: Yes.

MR GRAY: - - - from the usual three years to only two years.

MR CODRINGTON: Yes.

MR GRAY: So, Mr Codrington, the board knew, did it, in February 2018?

MR CODRINGTON: The board was certainly made aware that we had reduced accreditation time, yes.

MR GRAY: Okay. And what were the steps, if any, that the board took to address the non-compliance with human resources – human resource management?

MR CODRINGTON: With – with the CEO/DON, who was entirely responsible for everything regarding the criteria we had to work under, so we spoke at length with her. I spoke at length with the fact that there – was there a disconnect between her and our staff and she indicated there wasn't. I started a policy then to make sure I was always – and there was always two board members present at any of those meetings in an endeavour to make sure that the board was entirely across any of these situations that arose which started early January '18 and continued on through the sanction.

MR GRAY: All right. So there's evidence that there were staff surveys conducted in March 2018. Do you know anything about the staff surveys conducted - - -

MR CODRINGTON: Yes.

MR GRAY: Yes. So was that an action that the board took on the question of the need to bring Pioneer House into compliance with the expected outcome around human resource management?

MR CODRINGTON: Look, that was certainly part of it. Because we appeared to have ongoing shifts not filled and like I just mentioned, a disconnect – an apparent disconnect with staff, all those things were put in place in an endeavour to make sure that we could bring our staff together as one and to try and improve late ring-ins of not being able to attend shifts and the potential problems that causes.

MR GRAY: All right. Now, when a year later Ms Harcourt came on board as the nurse adviser under the sanctions imposed in 2019 she formed the conclusion that:

> *Key safety and quality issues arose from workforce difficulties and problems with leadership and governance.*

That was a phrase I read out - - -

MR CODRINGTON: Yes, I heard you read it out before, yes.

MR GRAY: What's your response to that?

MR CODRINGTON: With – with Ms Harcourt's statement, it was difficult to get a grip on it because of the fact that she brought Prue Dear in. Prue was there for the first three months. A lot of that time evolved around Prue being instructed from a distance as to what was expected. Some of Ms Harcourt's statement, which I've got in front of me, part of which I've made comments on and I'm more than happy to comment later; I don't agree with the lot and I've actually marked what I agree and what I do agree but if you want to ask a specific question I will try to cover it.

MR GRAY: Well, the specific question at present is do you agree with her overall conclusion that key safety and quality issue arose from workforce difficulties and problems with leadership and governance?

MR CODRINGTON: Because she doesn't clarify what she means by "governance" or whatever, I think the board was equipped to handle the governance and have policies in place to cover what was necessary and what we expected our staff to do. So I disagree with that, but a lot of what she says is very true.

MR GRAY: All right. Well, let's go to the detail. Before we go to the detailed conclusions she reached and set out in her statement, I just want to ask you about a document I referred to in the opening which is a report of Insync Surveys.

MR CODRINGTON: Yes.

MR GRAY: Have you had a chance to familiarise yourself with that in preparation for giving your evidence? It's at tab 8, please, operator.

MR CODRINGTON: I – no, I didn't read it again but I was fully aware of it when it was put forward and then when the board authorised it to be put forward.

MR GRAY: Okay. What if anything was the action taken by the board in response to this Insync report? There were six recommendations that appear on 0678 and 0679; we can have them displayed, Mr Codrington. Perhaps, operator, if you could call out the text at the bottom of 0678 and you see there – thank you – you see there, there are six recommendations:

Accordingly, we recommend that –

and then there's (a), (b), (c), (d), (e) (f).

MR CODRINGTON: Yes.

MR GRAY: Did the board consider putting in place those steps?

MR CODRINGTON: We certainly put in place that there had to be workshops and we had to have meetings with our staff, all the staff which was – Insync said they could come up and do it but our CEO/DON decided that it was better to use our deputy DONs to run those meetings. So those meetings were put into and we agreed to put those initiatives in place. We did agree with the time that we would try to do that, have regular updates back to the staff. It was chosen by our senior staff that rather than try to have meetings with all the staff at any given time, they chose to do it with staff from each area, maintenance, kitchen, laundry and the nursing criteria.

We took minutes of that. It was a pretty damning – there was a lot of fairly damning information come out in that Insync report. The board took it very seriously to the point that we were pretty dismayed that some of our staff would consider it necessary to make those comments. So yes, we did.

MR GRAY: I think if we go, please, to page 0686, just under the heading Staffing and Rostering Discussion Notes, we see, the first point is:

We are all just rushing. There is no acknowledgement that we are in this situation. Everyone is under pressure, resentment, frustration, rudeness, accusing other shifts of not doing such and such.

And there are further bullet points in a similar vein. There's a fourth bullet point:

No one has come up with strategies to help us manage being so short-staffed. We are just managing to cover it, but it's so pressured and stressful –

etcetera. Did you, as a board, take note of those comments about, in effect, short staffing at the time, that is, in May 2018, Mr Codrington?

MR CODRINGTON: Everything that – everything that was raised in that meeting including that, were read by the entire board. So the board was aware of that and quite concerned about a lot of those comments, so yes.

MR GRAY: In 2018 there were a series of financial reports to the board about the financial performance of Pioneer House not tracking in accordance with a plan set by consultants called Mirus; is that right? M-i-r - - -

MR CODRINGTON: Mirus, yes. I call it Mirus, whatever. It's all the same.

MR GRAY: M-i-r-u-s.

MR CODRINGTON: Yes.

MR GRAY: What were those consultants retained to help Pioneer House to do?

MR CODRINGTON: Because ACFI virtually pays for most of the stuff that goes on or most of the kitchen, laundry, front office staff - - -

MR GRAY: That's ACFI.

MR CODRINGTON: - - - are paid by ACFI. So ACFI is an amount of money that the government will allow you to claim over and above the standard rates into a nursing home. Our ACFI was down between 130 and 140. The average ACFI was, I think, 175 at that stage. Some of the for-profit organisations run above 180. So the fact that our management team couldn't get our ACFI anywhere near the level that would make us viable, it was necessary to look to bring Mirus in to try and train our staff, review how we handled ACFI and put systems in place to make sure we could claim the full entitlement that was available to us under the government regulations.

MR GRAY: And when did Mirus commence that process of assisting your staff to raise the ACFI level?

MR CODRINGTON: Exact dates, I don't know. We had Mirus prior to the CEO/DON that was there for the four and a half years because we identified it back as far as then. They made considerable improvements then. Our – the current CEO or the CEO that's under this criteria indicated that they knew what to do and there was no need to have Mirus and we went down that track for the first two years and found what was previously put in place was deteriorating. So we then brought Mirus back to initially look at what we were doing and bring it up.

MR GRAY: Was that in late 2017?

MR CODRINGTON: It would have probably been, yes, in all probability. And we maintained them – at the current time we've got them under a contract just to review our claims and to do training of our staff and we're still – I think at the moment we're running around about 160. That's still a lot lower than the state average and where we need to be.

MR GRAY: Where do you get that information about the state averages; is that a benchmarking service?

MR CODRINGTON: It's benchmarking and it's quite available to most people. It comes to us via our accountant who is on the top of that sort of thing and that's his expertise.

MR GRAY: At some point in this relevant period of 2018 through to September 2019 was that through QBP, that information?

MR CODRINGTON: I can't tell you that.

MR GRAY: Okay. Now, so there's reference to the CEO/DON outlining the focus groups in one of the minutes of the board meetings. That's on 18 June. I will just ask the operator to bring that up, please. It's tab 1, operator, at page 0197. And this is a familiar format, Mr Codrington, for the board minutes, isn't it?

MR CODRINGTON: Yes.

MR GRAY: There was usually a CEO/DON report; that was item 4 in this document, and a finance report, that was item 5?

MR CODRINGTON: Yes.

MR GRAY: And if we look at the end of item 4, we see somebody asked re staff survey progress, and then there's a reference to the name of the CEO/DON who's now left the employ of Pioneer House as of mid this year.

MR CODRINGTON: Yes.

MR GRAY: And it says she outlined the focus groups.

MR CODRINGTON: Yes.

MR GRAY: Is that a reference to this process referred to in the Insync report?

MR CODRINGTON: Yes.

MR GRAY: Right. But there doesn't seem to have been detailed decision-making by the board minuted at any time about specifically what should be done in relation to the matters in the Insync report. Do you agree with that?

MR CODRINGTON: In all probability, I – I would have thought there would have been some things minuted but it was certainly discussed and as that board member asked the question that was a regular general business question or if it didn't come up in general business it would come in if mentioned as a dot point in the CEO/DONs report.

MR GRAY: Now, Mr Codrington, one of the things Pioneer House seems to have done after being found by the assessment team back in early 2018 to be

noncompliant with human resource management was to put on extra staff on two of the shifts; is that right?

MR CODRINGTON: Just to clarify that, our CEO/DON asked the board to put extra staff on to endeavour her to correct what she thought were a couple of inefficiencies before that accreditation period. So we – the board put forward and allowed those extra staff immediately to be put on.

MR GRAY: All right. Now, when did that happen? When did those extra staff - - -

MR CODRINGTON: Prior to the - - -

MR GRAY: When were they added?

MR CODRINGTON: Prior to the – to the re-accreditation period that started early '18.

MR GRAY: So about the beginning of 2018?

MR CODRINGTON: Either that or a little bit before, yes, I can't recollect exactly, but yes.

MR GRAY: All right. And this Insync report which I've read from - - -

MR CODRINGTON: Yes.

MR GRAY: - - - was referring to, in effect, pressures from short staffing in about May 2018. Do you agree with that?

MR CODRINGTON: Yes, that would be right.

MR GRAY: So wasn't the feedback from the Insync process, which you've said was read by the board at the time, showing the board that there were staffing pressures and staffing level shortages even though there had been additional staff put on in early 2018?

MR CODRINGTON: These people – the extra staff were put on for specific reasons which was what the board was told. Our base roster, we always expected it be fulfilled. So I – your statement is correct, I guess.

MR GRAY: So even with the additional AINs on the morning and evening shift, the feedback from staff was that Pioneer House was under staffing level pressure as at May 2018; agreed?

MR CODRINGTON: Other than to make a comment, without seeing the exact figures which you're talking about at the exact shift, I can't give you a positive answer to that.

MR GRAY: Well, it's just plain commonsense, isn't it, from the document, that's what the feedback seems to be.

MR CODRINGTON: Yes, but I still don't see the figures. I don't know whether they were or they weren't, but you are probably right.

MR GRAY: Well, did you ask to see the figures at the time - - -

MR CODRINGTON: At that particular stage, probably not.

MR GRAY: And why not?

MR CODRINGTON: I guess the board had to have trust in its management team and that was the case of the board. To have policies in place and try and make sure that we had done everything we could do. We weren't involved in direct management of staff, ever.

MR GRAY: Ms Harcourt referred to there being conflicts between the CEO/DON on the one hand and yourself on the other concerning issues that were being raised by staff.

MR CODRINGTON: Yes.

MR GRAY: What was the nature of that conflict?

MR CODRINGTON: There wasn't a conflict.

MR GRAY: So you say she's wrong about that, do you?

MR CODRINGTON: Yes.

MR GRAY: So as at May 2018, having read this Insync report, that didn't cause you to have any concern that - - -

MR CODRINGTON: Look - - -

MR GRAY: - - - the DON might not be managing ..... - - -

MR CODRINGTON: I have answered that - - -

MR GRAY: - - - properly.

MR GRAY: - - - and it did cause a concern, it caused considerable concern. It was a system that the board requested to try and make that pointed, and it was expressed to our CEO/DON what was expected, and she reported back what was done on a regular weekly or fortnightly basis with these focus meetings.

MR GRAY: Now, remember at the start of your evidence I asked you about a comment you had made about the lessons learned.

MR CODRINGTON: Yes.

MR GRAY: And you said one of the lessons learned – this was at paragraph 93.1 – was to have a stronger governance structure and accountability requirements of the management team.

MR CODRINGTON: Yes.

MR GRAY: So are you saying that during 2018 you didn't have a strong enough governance structure?

MR CODRINGTON: Not necessarily. I thought we did have. The board had a fairly strong governance. The board had in place what we needed from – what we thought we needed from clinical. Certainly, as I previously mentioned, not up to the standard that will be expected after 1 July. Could there have been improvement; yes, there certainly could but it wasn't recognised by us as a board at that stage.

MR GRAY: Right. Because it seems that actually on your evidence that the board knew about this feedback from staff but just, what, trusted the DON to respond to it without supervising precisely what was being done in response to that concern, the concern in the feedback from staff; is that - - -

MR CODRINGTON: I can't hear you at the moment. You're speaking very softly.

MR GRAY: Sorry, I will say it again. It seems from what you said about the board having received and considered the Insync report that the board knew about the feedback about short-staffing levels but simply left it to the DON to respond to that feedback; is that right?

MR CODRINGTON: Other than the questions asked at the board meeting and the board level as to why, yes.

MR GRAY: And the board didn't have a governance structure in place to follow up on what the DON did in that respect; is that right? Apart from - - -

MR CODRINGTON: If governance was necessary to do that, no, but I wouldn't have thought that was part of governance.

MR GRAY: In a situation where you're getting feedback of the kind in this Insync report, why wouldn't the board's role extend to taking a closer look at what management was doing on staffing issues?

MR CODRINGTON: I can't answer that.

MR GRAY: Well, I suggest that the board should have done more.

MR CODRINGTON: I take your suggestion but it's not really the role of the board when we've got appropriate staff employed, which is why I identified there quite clearly that I think we needed audits or an auditor to do that, and I've made other information in my report regarding what I think the government should do to help that. So we have identified it but I don't know what you expect me to say. You are making suggestions from where you stand. I hear the suggestions. You are probably right.

MR GRAY: Now, I was asking you about the financial performance that was reported to you by the finance manager in the latter part of 2018. And I had asked you whether it was the case that Pioneer House wasn't performing as planned on either ACFI level or indeed on occupancy levels. I beg your pardon. I will ask that again. I had asked you about whether Pioneer House was tracking as planned on ACFI levels and you said Pioneer House wasn't tracking as had been planned with Mirus' help with respect to planned ACFI levels. Is that right?

MR CODRINGTON: That's right.

MR GRAY: Was occupancy also a concern of the board in late 2018?

MR CODRINGTON: Yes.

MR GRAY: And was it the case that Pioneer House wasn't tracking as planned with respect to occupancy levels?

MR CODRINGTON: Obviously, that was part of it.

MR GRAY: So were they the two main drivers of financial performance that was of concern to you on the board in late 2018?

MR CODRINGTON: Yes. It – it was identified by the board where we – with the aid of our local member, Andrew Dree went to see Ken Wyatt, the Minister of Health and Ageing, with our full balance sheets, our finances, the fact that we were forced to employ Mirus to try and lift our ACFI in an endeavour to point out that the board recognised that we weren't tracking at a level where we were going to end up financially stable.

So myself; my vice-chairman, Mr Ross Mayberry; and our CEO/DON, who has been blacked out, so I won't mention anymore, drove to Canberra to see the Minister, had a meeting with him, which was at the last sitting of Parliament where there was quite a conflict going on between the relevant parties. He didn't make that meeting, but we had – we conducted that meeting with his adviser. And present were myself, the two people I just mentioned, and Andrew Gee, our local member.

MR GRAY: So, Mr Codrington, when was this?

MR CODRINGTON: Late December.

MR GRAY: 2018?

MR CODRINGTON: Yes.

MR GRAY: All right. So this was the extent of the concern at Pioneer – sorry. If this was the extent of the concern at Pioneer at board and management level about the deterioration in Pioneer's financial performance; is that right?

MR CODRINGTON: It's probably not fair to say "the extent". There was considerable concern in lots of areas. I don't see why we can minimise it to one statement like you've just made.

MR GRAY: Okay. So did you go to Canberra because you were concerned about the financial performance of Pioneer House?

MR CODRINGTON: Certainly.

MR GRAY: Yes. And, under those conditions, you also were concerned about the liquidity ratio of Pioneer House was deteriorating; is that right?

MR CODRINGTON: Certainly.

MR GRAY: And what is the liquidity ratio? Did I summarise it correctly in my opening, that it's a comparison of – or a ratio of cash at bank compared with liabilities owed under refundable accommodation deposits?

MR CODRINGTON: Accommodation deposits have little to do with your ongoing credibility, your wages, whatever. Your ongoing – your bonds that are paid – or your recoverable deposits as you call it are there that we can gain interest on. That entire money goes back to the people that paid it. The interest rate on that is very minimal. Our cash in bank is, obviously, where we need to run with the positive cash flow. We look at those reports on an ongoing basis. And if you wish more exacting information on that, then our accountant should be here.

MR GRAY: So is the liquidity ratio a ratio of cash at bank versus liability to - - -

MR CODRINGTON: Probably would be, but I don't know.

MR GRAY: - - - residents for refundable accommodation deposits?

MR CODRINGTON: I don't know where refundable accommodation bonds would come in to what you just said. I don't understand your statement.

MR GRAY: So what is the liquidity ratio?

MR CODRINGTON: Look, I'm not 100 per cent aware of that, so I can't answer that.

MR GRAY: At a meeting on 9 January, the finance manager and the CEO/DON announced to all staff a reduction in staff levels for the morning and evening rosters and certain other changes to the roster. Are you aware of that, having at least heard me refer to it in the opening?

MR CODRINGTON: We were aware that it was going to happen, but we were asked not to attend ..... that as a management matter.

MR GRAY: Okay. That was going to be my next question. So when did you first hear that the finance manager and the CEO/DON were going to announce that to all staff on 9 January - - -

MR CODRINGTON: I would assume it would have come up at the previous board meeting. If not, it would have been told to me to reflect it to the board.

MR GRAY: Do you know whether it was minuted in any board minutes or did you find any - - -

MR CODRINGTON: No, I'm not sure. I was aware that it took place and I was aware of the statements. I was – I was away when some of that happened and when I returned my able 2IC or vice-chairman had asked these questions and was made aware what was happening. So I presume it would have come up at that particular board meeting that I wasn't present at. But no, I can't answer it definitively.

MR GRAY: So when do you say that board meeting took place that you weren't present at, at which this might have been raised?

MR CODRINGTON: I think it was around about June, but I'm not 100 per cent sure of that. You would have those records there. They're not in front of me at the moment.

MR GRAY: Do you think it was June 2018?

MR CODRINGTON: Probably. I don't know.

MR GRAY: Well, the reduction in the rosters was announced on the 9th of January 2019 to take place at the beginning of February 2019. Does that cause you to reconsider?

MR CODRINGTON: Yes, probably. Like I said, I was unsure of when that took place.

MR GRAY: Well, you've had an opportunity to look over the board minutes in preparation for giving your evidence, I suggest.

MR CODRINGTON: Yes, you suggest correctly. We were given hundreds of pages to look over and – and I didn't think it was a memory test. So I don't recall.

MR GRAY: All right. It doesn't appear that there's any decision by the board prior to 9 January 2019 to reduce staff levels in the relevant shifts with effect in early 2019, does it?

MR CODRINGTON: With respect, you appear to be asking me questions you know the answers to that I'm not aware of. And I've indicated that.

MR GRAY: Okay. Now, there was a board meeting on 29 January, so after 9 January, at which there was a financial report referring to the reduction in staffing levels in the rosters.

MR CODRINGTON: Yes.

MR GRAY: Have you had a chance to read the minute of that board meeting?

MR CODRINGTON: I would have. I would have over the last several weeks.

MR GRAY: Okay. And there was also – I will just ask the operator to bring that up. Operator, please go to tab 1 at page 0221. Sorry – zero – yes, 221. So if we just stop there for a second at 0220, do you see there, Mr Codrington, that's the cover sheet for the minutes of the backpack board meetings on 29 January 2019? Are you able to see that at the top?

MR CODRINGTON: I can see the cover sheet and the date, yes.

MR GRAY: Yes. Thank you. And then, over to the next page, 0221 there's a finance report.

MR CODRINGTON: Yes.

MR GRAY: And there's a reference to a review of a monthly report, finance report package reviewed, financial report and payments and reconciliations for the previous month approved. Now, if we go to another document, we can see what appears to be that report. It's at tab 19, please, Operator. Now, this report bears the date – I beg your pardon – yes. Thank you. PAC.0002.0001.0351. If we just go over the page to 000 – beg your pardon – 0353. Do you see there there's, under Summary:

> *Our main problem is in care where we're now forecasting a contribution before depreciation.*

Then there are some figures mentioned:

> *QPS benchmarking data for the December quarter shows that for NFPs.*

Is that not for profits?

MR CODRINGTON: Presumably, yes.

MR GRAY:

> *The mean care hours per day per resident was 3.30 and our new rosters are very close to this at 3.37.*

And then the issue is in the ACFI level. So there's a reference there to the new rosters. And this is approved in the meeting of January, it appears. Is that – beg your pardon. I think I've misspoken, because the date of this document postdates the 29 January meeting. Please do excuse me, Mr Codrington. I will ask the operator to go to page – beg your pardon – tab 14. If we go to tab 14, we see a November/December finance report. And if we go, please, Operator, to page 0589, this document bears a date 16 January 2019. Is it safe to assume that this must have been the finance report that was tabled at the board meeting of 29 January 2019?

MR CODRINGTON: Certainly would appear so.

MR GRAY: Thank you. And if we go, please, to page 0588, Operator, of this document, at .3 of that page we have:

> *Nursing wages are 50k below planned for the rest of the year. This assumes the introduction of new care rosters from February, which have the reduction of two AINs and one EN –*

is that enrolled nurse?

MR CODRINGTON: Sorry?

MR GRAY: EN, is that enrolled nurse?

MR CODRINGTON: EN is an enrolled nurse, yes.

MR GRAY: Yes:

> *…from the current rosters. This is not a reduction of three staff from the actual December staffing, as some shifts were not filled in December due to lack of staff, but this will ensure that staffing does not increase back to the previous peak levels.*

So is this a reference to the reduction of staffing that was announced – or the reduction of staffing levels announced on 9 January 2019?

MR CODRINGTON: Yes. I would assume that was what it referred to.

MR GRAY: Yes. And this report seems to be the report that is approved at the board meeting of 29 January 2019; is that right?

MR CODRINGTON: Yes.

MR GRAY: So, in effect, there's a retrospective approval of the reduction of the rosters; is that right? That is, retrospective in the sense that it comes after the announcement of 9 January.

MR CODRINGTON: I would be very, very surprised if we weren't aware of that prior to that, but yes, you're right.

MR GRAY: Okay. And you were present at this meeting, weren't you?

MR CODRINGTON: As far as I know, my name should be on the front of it, if I was. I missed very few meetings, probably only one, maybe two.

MR GRAY: If we go back, please, Operator, to page – to tab 1, page 0220, we see in the template table at the top that you were present - - -

MR CODRINGTON: Yes.

MR GRAY: - - - and chairing.

MR CODRINGTON: Yes.

MR GRAY: Is that a convenient time, Commissioners?

COMMISSIONER PAGONE: Resume at 2 o'clock.

ADJOURNED **[12.44 am]**

RESUMED **[2.00 pm]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioners. Mr Codrington, I want to ask you about the supports that you consider would have been required to address the underlying issues that resulted in Pioneer House falling into non-compliance. In your statement, at paragraph 0014, you were asked for your opinion about what supports would have been required to address the issues which resulted in the events in question and if there are obstacles to obtaining that support, what were they. That's towards the bottom of page 0014. You see that?

MR CODRINGTON: Yes.

MR GRAY: And you've identified a number of factors. Could I ask you about your opinions referred to at 76.2:

> *Inability to access nursing staff with aged care-specific experience, particularly in a rural setting.*

Could you elaborate on your views on that topic by reference to your experience position as chair of Pioneer House?

MR CODRINGTON: Yes, I would like to. Thank you, Mr Gray. The difficulty in country areas of getting people that are competent in aged care nursing. There are a lot of nurses available that are competent in lots of areas, but we've identified to have someone that's competent in aged care with clinical knowledge, with knowledge going forward, the fact that they're dealing with people that are entering the last phase of their life, the demands are a lot greater than they are in the hospital regime.

And I – we've just had a lot of difficulty getting registered nurses, enrolled nurses with particular experience in aged care with good clinical knowledge. It's very difficult. I have mentioned further down there that any incentive to bring people to the country areas might be an advantage. We, obviously, pay to the standard, but aged care – aged care nursing is a lot more demanding, with incontinent people, people with dementia, people with very serious – and vulnerable people. So that's my thoughts about that.

MR GRAY: Thank you. You next, in 76.3, refer to the lack of options in respect of managing the behaviour of a particular resident. If we can just take it away from the specifics - - -

MR CODRINGTON: Yes.

MR GRAY: - - - concerning that particular resident and pose the question in a generalised way, what are your views on the ability of rural not for profits such as Pioneer House to be able to deal with the very challenging end of behavioural spectrum for people living with dementia?

MR CODRINGTON: If it goes to the maximum, particularly with dementia patients that have been recognised as front lobe dementia, which often results in very bad behavioural management, sometimes tending on violence, sometimes, because their inability to – their body to react with their brain, sometimes they get into other people's spaces, where you've got relatively small dementia wings and you haven't got individual areas where people can be guided to – to try and calm them down, if that's necessary, depending on your facility, the layout of your facility and – and the type of difficult behaviours.

And if you happen to get two in the one area where they interact with one another, the demand on the staff is considerably high for your staff to understand that – to understand how to do it, to understand that you can't make these people do things; you've got to try and guide them, you've got to try and comfort them. It's the most challenging thing I think anyone in a rural nursing home can do, if you've got someone that's very, very difficult with behavioural management with dementia.

MR GRAY: And has Pioneer House reached, in effect, the point at which on occasion it hasn't been able to adequately care for somebody and - - -

MR CODRINGTON: Certainly.

MR GRAY: Yes.

MR CODRINGTON: We have.

MR GRAY: And what have been the options available? We see some evidence here, quite extensive evidence, of attempts to contact Dementia Support Australia and obtain assistance. What are the options that are available to Pioneer House and at what point are they exhausted?

MR CODRINGTON: We endeavour to go through all the options. We went to Dementia Care Australia. We went through the dementia care group that HammondCare have been subsidised by the government to make available to us. We got a nurse practitioner in. We changed the layout of our facility. We implemented a lot of plans, a lot of photos, a lot of different things on the walls, a lot of identifying features, a lot of different chairs to encourage people to relax and try to get them to relax.

We identified things that they last remembered and tried to have photos of different things on their door. We've done considerable things with that. We got people in to give us specific dementia training. We got people in to go through the exercise of making our staff recognise what dementia was and how – try to get your staff to understand how that dementia person felt. We've done all of that. And, basically, we reached the end of our tether, because we still had the same problem that we started with, with the start of the sanction, which we received on 27 February. That was mentioned then.

And we still experience the same thing now after Michelle Harcourt come forward with four different advisers and everything else I've just mentioned. We have still got the same problem. We endeavoured to put this person in another facility. We endeavoured to have Bloomfield accept him to see if they could come up with a better way to medicate this person without chemically restraining him that he become a zombie, because no one ever wants to do that, including us. But we tried to control it. He was a – this particular case was a walker. And I would like to finish it, because it's very important.

MR GRAY: I was just trying to make the question a general one so - - -

MR CODRINGTON: Yes. I know you were, but it's very difficult to make a general question, because all this trouble started with us when this particular person that you're trying to avoid talking about – or would rather not – first come to the facility, because if he got into someone's face – and he didn't know he was doing it. He'd just enter someone's personal space. And the reaction from everybody, demented or not, is, "Go away." And I won't use the terminology that was used with that go away.

But it become the stage that it put enormous pressure on our staff and enormous pressure on our CEO/DON, who had to control, educate the staff, and continually told us he had a tenure that we had to recognise, a security of tenure, which made it difficult to move him. We did arrange to go to another bed. And his family, rightfully so, said that they didn't want to do that. It didn't help us, but everyone seems to have their rights except the facility to do something that makes this better for us and makes it better for our residents and staff.

MR GRAY: Do you have any recommendation for the Commission as to how that might be addressed?

MR CODRINGTON: I would like to think the Commission could put in place somewhere where the government realised how difficult this was to manage. I've mentioned in my report that even a flying squad to come in before it got to the extent that it was, or someone to help us go to the next step with a resident like this. We asked questions regarding what we could do. What – what's in place at the moment – and don't get me wrong. people from the safety Commission and people from the health department endeavour to do the right thing by everybody, but they won't give advice, whether they're not allowed or they won't.

No one wants to expose themselves to giving advice that doesn't work, which is why I said I think someone should be able to give us advice as to what we can do and how we can do it. Our CEO/DON asked this question and reported back to the board. She was told to read the Act, which isn't very satisfactory when that particular Act says that he has got tenure, security of tenure, and we should keep him and try to manage him.

But I brought up to the board, as did some of my other board members – brought up in front of the CEO/DON – if we go to the next step and look at occupational health and safety. That Act also says we must protect our staff and our other residents. We weren't protecting them to the letter of the law. But one Act counteracts the other Act and there's nowhere for someone like us or our management team to go to and say, "These two Acts conflict. What can we do to remedy this situation?"

MR GRAY: There's a lot in what you've just said. Can I just take two aspects of it .....

MR CODRINGTON: You can.

MR GRAY: The flying squads.

MR CODRINGTON: Yes.

MR GRAY: You have referred to them in your statement. Can you please expand on what you have in mind with flying squads.

MR CODRINGTON: Well, we expanded that to a flying squad from an advisory group. It's one and the same thing, but to try and get everybody's mind around the fact that we were sanctioned. The amount of money that we were sanctioned for, you've already mentioned in your report, and it's in mine. That has got the potential to virtually break facilities like us. We were forced to employ Bentleys, which are a group of people to make sure we protect all our staff, our senior staff and our board that we don't trade insolvent. So we have to pay for that on top of what we paid the advisers and what we lost by not bringing people in.

And probably to be specific with that, having spent all that money, if the flying squad or advisory squad come through the door and recognise what the problem is and have the power to say two things. With this particular thing we've got to be able to find somewhere that you can place this resident for his safety and the safety of everybody else and allow you to run the place without this considerable loss you've had. That's the second part of the question.

The first part, before the sanction was imposed, as I said to you in an earlier statement, we went through four years and the unmets we've met were 1.1 and 1.6, continuous improvement and behavioural management and human resources. So the previous four years to the start of '18 we passed all accreditation, which led the board to believe that the management team we had in place were doing an adequate job. And we seen matters to roll with the board to do that.

If the flying squad could come in and identify and say, "Well, you've had those couple of unmets; you've been reduced to two years instead of three years. Why don't we go through your systems and make sure what the board is being told is actually being done." So as part of the flying squad and part of an audit team, because I've mentioned the audit team, as well. And whether the government class it as an audit team that they do in an endeavour to help, rather than send in the police force and endeavour to put you in jail, two completely different things. And I'd like – that's what I'd like uppermost in my mind to get before the Commissioners.

MR GRAY: I think you've covered both of the strands I wanted to pick up, because the second strand I was going to ask about was should the government have a role in trying to facilitate the transfer of a person that - - -

MR CODRINGTON: 100 per cent.

MR GRAY: - - - a rural aged care provider can't care for anymore?

MR CODRINGTON: Sorry, I spoke over the top of you. But 100 per cent. 100 per cent I agree with that.

MR GRAY: And what about the funding of those two measures? That is, the flying squads with the advisory role, if some initial non-compliance is picked up; and, also, the facilitation of transfers of people for whom a rural provider can't care anymore?

MR CODRINGTON: From where I sit as chairman, having dealt with – and I've got a couple of previous chairmen back on the board, because it's difficult to get people to come on to your board. And I'm grateful that I've had their knowledge behind everything we've done. But it's a situation that – look, I would be silly if I sat here and said we should pay for it, because I've just told you how much money that we lost. So, yes, I think the government should pay for it.

When you're stretched and when we went through the exercise to go and see the Minister and showing what we had lost the previous year and then have this dumped on you the second year, you don't have to be a mathematician to work out how much money this facility has lost in two years. And I just think the advisory or flying squad could avoid all that wasted expenditure. Look, it's not wasted. Did we need to do extra training? Did we need do a lot of things? But they're the things I think the flying squad would pick up before they become crucial. You shouldn't have to be slammed with a sledgehammer to know you've got to tidy things up. So that's where I come from with that. Thank you.

MR GRAY: All right. Now, next we've got in – beg your pardon, I've just lost my place.

COMMISSIONER PAGONE: Whilst Mr Gray is finding his place, Mr Codrington, just so that I can understand the point of what you just said, the idea seems to be that it would be useful for places like yours to have somebody from, as it were, the government or externally, to come in, having a look at you from time to time, and saying to you, "Well, here are some things that you need to do to be viable or to deal with some problems that at the moment you're not dealing with adequately"; is that the general idea of the audit/flying squad?

MR CODRINGTON: 100 per cent. 100 per cent, to avoid that massive lot of money, Commissioner. If someone came through – and it can't be that costly, just to come through, check your process, check what you've done, make sure what's being reported to the board is accurate. We're all lay people doing our very best as volunteers in trying to employ the right person to do the job.

COMMISSIONER PAGONE: Yes.

MR CODRINGTON: And when you think you've got that, as we did, and we failed, it was – it come as a hell of a shock and a hell of a lot of embarrassment, to both Pioneer House and Mudgee locally.

COMMISSIONER PAGONE: Yes.

MR GRAY: Thank you, Commissioner. I've found my place. Operator, please go to 0019 in Mr Codrington's statement. And, Mr Codrington, this is another question in a similar vein which was posed to you and which you answered on this page of the statement. The question was question 17:

> *How could small regional aged care providers be better supported to provide quality and safe aged care services?*

And you then list five ideas. The first is having more qualified and better paid workers, and I know that's easy to say; it's probably very hard to achieve. Do you have proposals in mind which could help to achieve that outcome?

MR CODRINGTON: This is something that myself and the board thought about for a long time and it's happened in other areas where trying to attract, as I said before about registered nurses being qualified to work in aged care and enrolled nurses the same, if we could offer them more money, more incentive – more incentives to move from somewhere else to Mudgee, make them feel more secure that they were being well paid, and we think the government could do that.

I heard mention about more training, but most people in this room would assume that a registered nurse is a 100 per cent qualified to work in any facet, whether it be hospital, aged care or whatever. We've got to try and attract nurses and enrolled nurses from – and probably an easier or higher elevated position back to aged care, and we need people that want to dedicate themselves to looking after the aged and to get that is not easy.

You've got to bring them from places where they probably were – where they're comfortable. We've got a lot of – and so everyone can understand, visa nurses where we've joined in the government policy to bring visa nurses in that have been trained elsewhere, upskilled to a certain extent, but we don't know how much, in Australia. We found we've had to put a buddy system in with other registered nurses to take those around and pre-train them to work to the standard that we want them to work, but you're relying on other registered nurses or our deputy DONs to try and upskill those people to aged care.

If something was put in place to train specific aged care nurses, because the clinical care and the clinical knowledge and the expertise needed for that is far greater than, I think, in to other factors where people can go in and be in charge of different areas and they never come into that sort of situation. And I know that's a bit longwinded but I'm a bit passionate about some of these things. Sorry.

MR GRAY: So just taking that idea a little further and scrutinising it about RNs and ENs and the visa staff, there's downtime involved in training them up in your workplace. That's the gist of what you're saying, I take it, and that means you really need additional resources, does it, to have additional RNs on to provide that training as well as providing care on the floor on a day-to-day basis. Is that the issue?

MR CODRINGTON: We – we – when we done that we weren't allowed to put those visa nurses into our system on the base roster until we were satisfied that the buddy system and pre-training was done. Was it done for as long as we probably should have; probably not. But those people come on board. Most of them are very passionate and they want to learn, but no, we don't put them on the base roster until we're satisfied that the buddy system with other registered nurses actually works.

MR GRAY: I see, so you have to absorb the cost, do you, of the buddy system - - -

MR CODRINGTON: Definitely.

MR GRAY: - - - until the visa nurse, as you've described that person, is sufficiently skilled to take over on a standalone basis?

MR CODRINGTON: Yes, and look, that's not the least of the cost but the cost has never come into anything with us. Any staff that we've been asked to provide, we've never ever taken cost into account. The board has always given permission on any request from our DON. If we wanted staff from an agency, and they were available we would bring them in. I know there's mentions here about agency staff being often difficult to get but if we knew we had someone going on an overseas holiday for a month or having a baby and out for two months, we would apply to the agency if we couldn't get our own registered nurse to supply one for a block. But you obviously have to know that in advance and when you apply for them for a block they would be able to provide that to us. And we've done that on several occasions to make sure we maintain 24/7 registered nurses in our facility.

MR GRAY: So what can or should be done to the system to assist rural providers like yourselves in training up the RNs if it's necessary under a buddy system? Is anything further required from government on that?

MR CODRINGTON: Every time you ask me a question like that I say money. The more money that the government can put forward to our facility to endeavour to do that, we – we actually pay the facility where these people come from. We've got to pay 10 grand, we've got to guarantee them; sometimes we've got to find accommodation until they settle. We've been through all that on a number of occasions and never ever questioned the fact that if we couldn't get someone that had been pre-trained in Australia for that job we were prepared to take what we had to take to meet what we considered were our requirements as a board. So we've always done that. So it's always about money. The higher the ACFI – I think ACFI should be scrapped, and I think they do something like they do for people on respite.

If you've got someone there on respite that's considered a high-care person, then they put the money in your hand; you don't have to claim it. Why should you have to claim it for all the rest of the high-care people where you can't get what you're entitled to and you've got to employ people like Mirus that cost over a period of time several hundred thousand dollars to do what the government could put in your hand and say, "Here it is. We want you to run the place, effectively."

MR GRAY: And do you say it should be scrapped in essence because of those high transactional costs, not just Mirus but having to make claims all the time; is that - - -

MR CODRINGTON: You mentioned earlier, and I thought the figure was fairly reduced, that 44 per cent of places were losing money. I think it's more than that but I can't quote figures so I won't, but of all those people, a majority of those who employed Mirus or someone like Mirus and people to try and help us get our ACFI claim up to a reasonable level, why should people looking after the aged have to throw money in someone else's bucket and take it out of our bucket to do it to make it harder? So that's why I say it should be scrapped. Part of the questions I asked in front of Ken Wyatt's adviser was that she thinks that will happen and good things are coming in two years, but I'm not convinced that a lot of places like us will survive another two years while they make their mind up.

MR GRAY: Can I just ask you about a point you made in 94.1 which might still be available on the screen, at the touch of a button. You refer to a regional allowance or loading that could be provided, and I think that's with reference to RNs and ENs.

MR CODRINGTON: Yes.

MR GRAY: Could you explain that?

MR CODRINGTON: Well, I thought I had explained it previously. If there was more assistance and a regional loading and, look, do I know that that's going to work? No. But the suggestion we need is we need some way of when we advertise for an EN or a registered nurse we want them to come to Mudgee and we want to be able to offer them something more than where they want to be, if that be the city or near the beach or whatever. So if there was a regional allowance and it helped to get people, that may prove a failure but coming up with ideas that will work is very difficult.

MR GRAY: Thank you. So that's a reference to the extra funding that's needed to meet these additional costs of recruiting in regional areas.

MR CODRINGTON: Part of it, yes. There's a lot more on top of that that I thought - - -

MR GRAY: And should that money go to the approved provider or directly into the pockets of the RN or EN concerned?

MR CODRINGTON: Just to make it clear to the Commissioners, us as a board, we are the approved provider, not Pioneer House or not the nursing staff or whatever. So the board is the approved provider so the demands are put on us to make sure that the facility runs effectively, profitably and etcetera. So if – as the approved provider we don't want the money. We want the money to be in the system to allow our DONs, deputy DONs, general managers, registered nurses to do their job and have the funds to do it. So we don't want it in a separate bank account. It's got to go to the facility, not necessarily the approved provider.

MR GRAY: So it goes into the pool of funds available to operate the approved provider.

MR CODRINGTON: Definitely. Definitely. Yes.

MR GRAY: Yes.

MR CODRINGTON: It goes where ACFI goes and that's into the general fund to pay everything that the government doesn't fund. So the government doesn't fund any front office, it doesn't fund any kitchen, it doesn't fund any maintenance, it doesn't fund any laundry. So other than the money we get as a standard basis which is if they pay a bond we've got the little bit interest on that that you get, we get a daily fee if they go in as a supported resident. We get in excess of two-thirds of their pension which everyone that comes in pays that. The ACFI on top of that is what tops you up to pay for all those things I've just mentioned that the government doesn't give you a cent for.

MR GRAY: And while we're on money, can I ask you about 94.3, which I think is separate to what you're making. You're speaking there about specifically raising funding for high-care residents. Are you saying that if a high enough amount of funding had been provided, say, in the circumstances Pioneer House has found itself in recently, there might have been enough money to support special measures for caring for that resident?

MR CODRINGTON: The more – it still relates back to ACFI which I said they should scrap and give you a bulk amount. If our ACFI run between 175 and 180, which some of the for profits and some of the bigger not-for-profits who employ special people who just deal with maximising ACFI claim, nothing illegal, just get everything they're entitled to; if it was changed so we had that money, the more money in the pool, the more staff you can employ and the rest of the costs you can pay. I suppose a simple yes would have been sufficient but, as you can see, I'm passionate about this side of my report.

MR GRAY: We've also, as you might have heard in my opening, floated the potential proposal for some workforce attraction and retention initiatives in the nature of linkages with RTOs in rural locations, so that people can be trained and may then stay in that particular location, and we've also raised a potential proposal for rural scholarships. Do you have any views on those ideas?

MR CODRINGTON: I thought – I thought your opening statement to the Commission was very, very good. I thought a lot of what you said I agreed with 100 per cent. I won't say I agreed with the rest of it you've put me though, but I did agree with that.

MR GRAY: And does that include those measures, Mr Codrington?

MR CODRINGTON: Yes, yes.

MR GRAY: Do you have any other thoughts about the point you've made in several places in your statement of evidence about the difficulty of recruiting staff in the regions? Any other ideas?

MR CODRINGTON: I would like the Commissioners to understand that when our CEO/DON – before we employed the CEO/DON that's just resigned, we went through an exercise of advertising widely. We got two applicants. She certainly had worked in aged care. She didn't report to a board. She reported to a general manager because they had two facilities, not one. She sounded and interviewed extremely well, so we employed her. The same applied to when we wanted an additional DDON, so when we got – sorry; our assistant or a deputy DON, DDON. We got one applicant in the country town and she came out of the hospital system. Since they've both resigned, myself and my board put together and used a company in Sydney to try and bring people to the country area.

We interviewed three prospective general manager/deputy DONs. A lot of the newer people liked the terminology general manager encompassing deputy DON and CEO but they liked the title of general manager. We interviewed three of those; two of those would have been approved – we definitely would have approved them. One we didn't; we put them through a psych test and it didn't come up to measure. We offered both those people jobs and they indicated they were coming back. One apologised that she couldn't because her husband had a good job somewhere else but she said she was prepared to come and help me because at that stage we never had a DON or general manager sitting in the chair. We didn't take that up.

The other one said she wanted the job. She brought her mother with her from down the coast. I met her mother, and offered to show them around, very genuine, and to this day she hasn't picked up the phone and said why I'm not coming. So going on from that, I employed Robyn Daskein and she came up and gave a statement. Robyn is going to be with us for three months; been extremely good and done a great job for us. We're very appreciative of her.

In the meantime, I've just appointed a guy by the name of Dean Saxby as our general manager. He is a registered nurse. He has signed a two-year contract and he appears to have the people skills that myself and the board think are essential for trying to bring the board together as a group and not have a them and us attitude, and I think that did exist with our previous DON.

And I had several conversations with her and I put in place, given the way you can be challenged nowadays for bullying, that every conversation I had, I had another board member with me, more often than not my vice-chairman. And we had several conversations about how we thought that it would be better to bring the staff forward and encompass the staff and respect the staff and gain respect for ourselves, and we went through a lot of series of things which is where Michelle Harcourt's comment was, there was conflict.

You can have a reasonable discussion with people without being inferred to as conflict. There was never a conflict. I have spoken to the lady since she left us. If I met her down the street tomorrow I would have a cup of coffee with her. So there's no conflict. But did we have a series of fairly hard discussions about what we thought we needed to lift? Yes, we did.

MR GRAY: Thank you. Before I let you go I had better just go through those paragraphs. We haven't been able to have Ms Harcourt give oral evidence so it's important that you indicate where you disagree with those conclusions that she's expressed and if you agree with them, you should indicate that, too. Could we please have Ms Harcourt's statement up on the screen, operator. That's WIT.0524.0001.0001.

And if we go to paragraph 58 which begins at the foot of page 0012 we will bring that – perhaps if we call out paragraph 58, yes, including the foot of the preceding page. Thank you, operator. Now, I take it from your evidence, Mr Codrington, that you disagree with 58.1? You were aware that there was a reduced period of accreditation in 2018 after – that was after a decision of the Quality Agency in March 2018. You were aware of that. That's right, isn't it?

MR CODRINGTON: Yes. Yes. Sorry. Yes, I should answer clearly.

MR GRAY: Yes. Earlier, before lunch, you had said that in your evidence.

MR CODRINGTON: Yes, that's true.

MR GRAY: 58.2 you disagreed with the word "conflict", and you've explained your perspective and why it differs from Ms Harcourt's.

MR CODRINGTON: Yes, I have.

MR GRAY: 58.3, what do you say to that – BoM is board of management:

> *Board of management reports focused on financial performance, and there was very limited information about comments and complaints, clinical indicators.*

MR CODRINGTON: I disagreed with that because she's inferred there, and I take offence to the inference, that we concentrated on finance more than anything else. We got two reports. We treated them both equally. They both read their report. We

certainly have to concentrate and consider our finances to the uppermost level, but to make a statement that we concentrated on more of that than the residents that are there – and I would like to add to that, I know one-word answers are better, but I've got a vice-chairman with his mum in Pioneer House. I've got a deputy DON with a mum and two other family members in Pioneer House.

I've got an accountant that had his mum and dad – sorry; his wife's mum and dad and their dad has passed. I've had my secretary; her mum is in another nursing home. So my board is all over the respect that our residents should be given and to make a statement that we consider finance more than those people, I would take definite offence at it.

MR GRAY: Okay. And just while you've mentioned that point about the membership of the board having those connections, is that a feature of not-for-profits in the regions, generally, that you have that ability or opportunity to have real connection between the community, the people in the relevant facility, and the board itself when you have a volunteer board?

MR CODRINGTON: Look, I don't think it's essential, but I think it was worth mentioning that that's what we've got. It didn't stop us being sanctioned. And there was an inference earlier that the board probably should have done more but – which is why the Commissioners have received my statements about how I think we should have been able to avoid that sanction in the first place. But it needs to be said because it hasn't been asked yet, we were sanctioned on four to five matters originally, and a severe problem.

So when we were sanctioned, it didn't include 21 unmets. You made a statement for everyone here to hear that we had 21 unmets. When we were sanctioned they've got it listed as five unmets; two of those were regularly compliant so we've condensed that – you can't – to four and then they say immediate and severe risk.

And in my statement I mention that I challenged that. We were never given due right to reply to that. The Health Department, even though they rang and spoke to our staff and were satisfied there was no immediate risk, it still ended up in the sanction as an immediate risk. And I'm pretty concerned that if they were satisfied it wasn't an immediate risk, why it still appeared in the sanction.

MR GRAY: And, Mr Codrington, there's a list of points that Ms Harcourt identified in paragraph 53, and you were – your attention was drawn to these in the course of helping you to prepare for giving your evidence, and have you had an opportunity to reflect on those points at paragraph 53? Are there any you dispute?

MR CODRINGTON: I was given a list of questions out of Ms Harcourt. You might just have to raise that because it doesn't appear to be here in front of me.

MR GRAY: Okay. In paragraph 53 – I'm sorry if I got that wrong – in paragraph 53 there's a list of matters that Ms Harcourt regarded as clear from the assessment

contact and review audit as having not been met for a period of 12 months, and she gave some examples.

MR CODRINGTON: Yes, I've got paragraph 54 to 55 so it may even be included in that so - - -

MR GRAY: Okay. No, well, I withdraw that question.

MR CODRINGTON: It's probably just listed differently. But she did mention, and I – I've just made a note here that any request put to the board by the CEO/DON for staff – was put to the board by the CEO/DON or staff was always addressed. I always told all the staff that anything that came outside I would address it with the CEO/DON as I considered that the proper procedure. I also made it very clear at those meetings that if it was a complaint about the CEO/DON I would address it at a board meeting without the CEO/DON. So if that answers the question, that's what was put in place.

MR GRAY: All right. Just give me a moment.

COMMISSIONER BRIGGS: Mr Codrington - - -

MR CODRINGTON: Sorry. Yes, Commissioner.

COMMISSIONER PAGONE: I'm sorry, Mr Codrington. While counsel is consulting his notes, it might be worthwhile after this discussion if you and your own counsel go through the items in paragraph 53. I think that will help our discovery as we go forward.

MR GRAY: Yes.

COMMISSIONER BRIGGS: But I wanted to ask you a specific question about your board, and we're quite conscious of the challenge of recruiting boards in country districts. And I wanted to ask you whether, as a board, you've been through a process of looking at the skills of your board members since the problems with the sanctions and so on, and what you might need as you go forward as a board?

MR CODRINGTON: Yes. Look, we have. We've put in place – one of our board members is a physio and after speaking extensively with Dr Robyn Daskein who is our acting general manager until the end of November, we believe she's got adequate skills to look at the clinical side of things as a physio. We have got an honorary solicitor. It's been brought to our attention that before we get involved with writing anything for the government we should take legal advice and it would be nice to be able to get legal advice on the board. Because we're a small community area, having risk management has been raised and it's been raised at a board level. It was raised at a governance session that I organised from our association which was held together with Pioneer House and Kanandah.

So we've tried to reduce the cost of things where we think it's beneficial. We haven't done anything about risk management. We have had a long discussion with our new CEO/DON who is now a general manager; that's his term. Dean was a manager of – and travelled amongst nine other facilities so he was quite well-versed with – with what was done and has probably seen risk management literature and we will certainly put risk management literature before the board and in front of Dean. I would love to be able to employ someone, but we probably can't afford to have a specific risk management person, but we need someone to take adequate training that's already there that can identify risks because 1 July this year, residents can pretty much do in our facility what they can do in their own home.

That's the theory of the new standards, as long as we tell them what the risks are and we counsel them and even if they say, we don't want help walking, we can't just walk away and let them fall over. We've got to try and avoid that, and we've got to have risk management in place that is seen adequate when the assessors come around and say, "Why did that person fall, why did you do this, why did you do that?" So, Commissioner, we've identified the need. We've certainly addressed the clinical side of it. We've spoken about the risk management side of it and it's got to continue on. That was made very clear to us as a board at that governance training we done.

I would love to have a doctor, a solicitor and a risk manager on the board but I'm flat out keeping the guys I've got. As I just said, I brought back three people that resigned. They've got heaps of experience. And I'm glad they come on board with me, because they've been a tower of strength to me, given through what you can see has been a pretty stressful time. So thanks for your question.

COMMISSIONER BRIGGS: No. Well, I suppose I've got another one that draws on what you've just said. Are the issues for retention and recruitment of board members as pressing as the issues to do with retention and recruitment of nurses?

MR CODRINGTON: Look, I think it would be more so. People sitting here today and seeing what I went through as a board member have said, "Why would anyone volunteer to be on a board if you're going to be put through that sort of scrutiny?" And I can understand that question. I've tried to be truthful. It's very, very difficult not to be. I've agreed under oath to say that. So yes, it is. And I think it's going to get harder.

As the finances roll in, unless the government do something with money to ease the burden on boards having to make sure you covered everything, then the viability is going to be harder and harder. And I can assure you, by people that I've learnt and spoken to over the last few years, the number of facilities that have been taken over by bigger providers is scary. And we're going to lose small community-run facilities that were actually put in place by the community for the community, simply because of what I've already said through Mr Gray to yourselves about keeping a board together, keeping volunteers that want to give up their time.

We've all got lives. I would rather be down visit my kids at Nelson Bay than sitting here, I can assure you. But it's going to get harder and harder and harder, Commissioner. And I shouldn't treat that question lightly, because it is a very serious matter to continually encourage people to come onto a board when Mr Gray has already identified – and I think his numbers are on the low side – of boards that are losing money – well, facilities that are losing money.

COMMISSIONER BRIGGS: If I might reassure you, I think Commissioner Pagone and I well and truly understand the challenges of these issues. And I think what counsel was trying to do before lunch was expose the challenge of the situation you operate in. And you've helped us understand that very well. So thank you very much and I will hand back to senior counsel.

MR CODRINGTON: Thank you, Commissioner.

MR GRAY: Thank you, Commissioner. Mr Codrington, there is a list at paragraph 53 which Ms Harcourt states that she has drawn from an assessment contact report and a review audit report. In a way those documents will just speak for themselves, so I won't take Mr Codrington through that list of matters.

Mr Codrington, you say – and I will return to where we began the examination – you say that one of the lessons learned – and this is towards the end of your statement at page 0019. One of the lessons learned by the board, 93.1, is to have a stronger governance structure and accountability requirement to the management team. And when I asked you about that at the outset you referred to the new standards that now apply. And there is an aspect of those standards, standard 8, which relates to governance.

MR CODRINGTON: Yes, true.

MR GRAY: And you were adverting to that, I take it?

MR CODRINGTON: Yes, look, I was. The new reporting to the board on clinical matters is going to be a lot more extensive, the requirements of the board to get their head around it. I would like some of my board – whether we can all do it is another matter to do clinical governance, as well as our staff. That was recommended by Michelle. We haven't done it.

It's – I guess to help the Commissioner – and she said – or they've both said I've helped them. To some extent after we were reduced in our accreditation from three years to two years, then we were sanctioned, which was still three years to two years, which supposed to expire in April – 8 April this year. When they've come in and found those other 17 unmets, which you've initially mentioned as 21, which was the total, the health department tacked that onto the sanction that was already there. We weren't sanctioned, because of those; that was tacked onto the initial sanction which I said I had some concerns about.

When that was tacked on, they reduced the 8 April back to, basically, 8 January. So we lose another three months. So in that time we've been under full sanction. We've been under not bringing people in. We've had the cost of the adviser, the cost of not bringing people in. On Tuesday of this week the safety committee arrived unannounced, which they're entitled to, on our doorstep and said, "We're going to do a new accreditation."

MR GRAY: The quality - - -

MR CODRINGTON: The Quality Safety ..... Commission lobbied on Tuesday. They left us on Friday. I was going through my statement and trying to read that stuff during that week. The amount of pressure that's been piled on myself and my board during that six months has been enormous, because, as I said, reducing from April to January – and they've got to do their accreditation, I think it says, 56 days in advance of that time, basically meant, before I could get anyone on board as adequate general manager and try and fill those roles, we were back under complete accreditation rules. So there was no respect shown to the board of Pioneer House as the approved provider at all.

And I know that's longwinded, but I think it's important, if we're going to help this situation going forward, I think people have got to be 100 per cent aware of what I just said, because without my wife, who has probably broken down in tears a couple of times because of the stress, there's no credibility given to us as the approved provider. We've been, in blunt terms, screwed.

MR GRAY: Just on that lesson learnt at 93.1, is it the case that you do see the appropriateness of having the board more closely involved in clinical governance framework, for example, endorsing its implementation and testing that it has been implemented each year?

MR CODRINGTON: 100 per cent. 100 per cent. But that's part of governance; that's not hands on.

MR GRAY: Yes.

MR CODRINGTON: And we've got to do that. That's part of it. That's why I've said to you the reports that come to us from now on will be more adequate and we will make sure we understand it. And the person we've got in the seat now as our general manager has had that spelled out in very, very blunt terms, that we feel let down by what we previously had. So I make no secret of that.

MR GRAY: I have no further questions, Mr Codrington.

COMMISSIONER PAGONE: Mr Codrington, you've been very open with us. We've learned a great deal and we really thank you very sincerely for the way in which you've given your evidence. Thank you very much.

MR CODRINGTON: Thanks Commissioners. I appreciate that. Thanks Mr Gray.

MR GRAY: Thanks, Mr Codrington. Ms Maud will call our next witness.

COMMISSIONER PAGONE: Yes, Ms Maud.

MR CODRINGTON: Can I ask one question. Does that mean I'm excused completely, if I wish to be?

COMMISSIONER PAGONE: Yes. That's always a defect of mine. I never formally do that. I apologise to you. You are formally excused. You may go home and do other things.

MR CODRINGTON: Thank you. I appreciate it. Thank you very much for listening.

<THE WITNESS WITHDREW [1.53 pm]

MS MAUD: Commissioners, I call Tania Elizabeth Sargent.

COMMISSIONER PAGONE: Yes. Is Ms Sargent in the hearing room?

MS MAUD: She's coming.

<TANIA ELIZABETH SARGENT, SWORN [1.54 pm]

<EXAMINATION BY MS MAUD

MS MAUD: Have a seat, Ms Sargent. And come in nice and close to the microphone. Can you state your full name for the transcript, please.

MS SARGENT: Tania Elizabeth Sargent.

MS MAUD: And, Ms Sargent, have you prepared a statement for the Royal Commission?

MS SARGENT: Yes, I have.

MS MAUD: Do you have a copy of it there?

MS SARGENT: Yes.

MS MAUD: Does it have the code in the top right corner WIT.0598.0001.0001?

MS SARGENT: Yes, it does.

MS MAUD: Yes. And it's dated 28 October 2019.

MS SARGENT: Yes.

MS MAUD: And have you had an opportunity to read it recently?

MS SARGENT: Yes.

MS MAUD: And – can you just speak up, sorry, Ms Sargent.

MS SARGENT: Yes, I have.

MS MAUD: To the best of your recollection , are its contents true and correct?

MS SARGENT: Yes, they are.

MS MAUD: I tender that, Commissioners.

COMMISSIONER PAGONE: Yes, Ms Maud. That statement of Ms Sargent of 28 October 2019 will be exhibit 12-8.

EXHIBIT #12-8 STATEMENT OF MS SARGENT DATED 28/10/2019 (WIT.0598.0001.0001)

COMMISSIONER PAGONE: We might need to get you a bit closer to the microphone, because I think we're finding it a bit difficult to hear you.

MS SARGENT: Okay. Is that better? Yes?

MS MAUD: Now, Ms Sargent, you're a registered nurse and you're currently employed as the Deputy Director of Nursing at Pioneer House; is that correct?

MS SARGENT: Yes, that's correct.

MS MAUD: And you've worked in aged care for about 30 years.

MS SARGENT: Yes, approximately.

MS MAUD: Yes. You've worked as an RN and then the Deputy Director of Nursing at Pioneer House from 1989 to 2002?

MS SARGENT: Yes.

MS MAUD: And then you had a period of some years working for another residential aged care provider in the Mudgee from 2003 to 2011.

MS SARGENT: Yes.

MS MAUD: And then you returned from February 2011 at Pioneer House as a registered nurse and then in your current role as Deputy Director of Nursing.

MS SARGENT: Yes, that's correct.

MS MAUD: And you were acting in the role of director of nursing for a short period of about a month in May/June this year; is that right?

MS SARGENT: Yes.

MS MAUD: And the role of the Deputy Director of Nursing at Pioneer House is in a general sense to support the CEO/DON as it's referred to; is that right?

MS SARGENT: Yes. Yes, that's correct.

MS MAUD: And part of the role includes responsibility for the supervision of the clinical care of residents.

MS SARGENT: Yes.

MS MAUD: And rostering of new staff, compliance, ACFI submissions, all of those tasks.

MS SARGENT: Yes ..... all part of the role.

MS MAUD: Yes. And since July 2011 have you been employed part time in your current role?

MS SARGENT: Yes.

MS MAUD: And you share the role with another person; is that right?

MS SARGENT: Yes. Initially, well, I do share the DDON role. And the other person was working part – part-time as the DDON and then a couple of days focusing on something else, but yes. So .....

MS MAUD: It's a shared – job sharing.

MS SARGENT: It's a job sharing-type, yes.

MS MAUD: And since August last year your role has primarily been responsibility for Pioneer House's ACFI documentation.

MS SARGENT: Yes.

MS MAUD: Yes. So does that take the full amount of your role of the time that you spend in the role?

MS SARGENT: It takes a fair portion of it, but I was also involved in assisting with admissions and other things that the other DDON needed. We assisted each other as required.

MS MAUD: I see. And you're employed three days a week; is that right?

MS SARGENT: Yes, that's correct.

MS MAUD: Now, I want to ask you about the filling of rosters at Pioneer House, which you say in your statement has always been an issue. Is the difficulty that you encounter both filling the rostered positions in relation to assistance in nursing, AINs and RNs?

MS SARGENT: Yes.

MS MAUD: And does Pioneer House have minimum qualification requirements for the AINs that it employs?

MS SARGENT: Yes. We do like, where possible, for them to have a certificate III. We will employ them if they're willing to be working towards or willing to work towards one at times, because at times you do get people that have experience, but don't actually have the qualifications.

MS MAUD: So you will take people who don't necessarily have a certificate III, if they're undertaking study and they've also got prior experience in aged care.

MS SARGENT: Yes.

MS MAUD: And you say in your statement that you have concerns about the lack of consistency of skilled – of the newly recruited AINs that you've seen at Pioneer House. What's the explanation for the inconsistency in skills that you've observed?

MS SARGENT: What I've observed is, like, particularly – so they're coming from TAFE. Some of them will come, for example, they can do basic observations like a blood pressure, pulse, temperature, respiration, others have never been taught how to do that. So they're coming to us with different skills right from the start.

MS MAUD: And the RNs that Pioneer House employs, have you always been able to recruit RNs that have got specific experience in aged care?

MS SARGENT: No. More recently, like, Pioneer House applied to become a facility that can take visa holders, because we just couldn't recruit RNs. And so they – they may not necessarily have worked in aged care.

MS MAUD: So the RNs that might work at Pioneer House on a visa come from overseas might not necessarily have aged care experience?

MS SARGENT: Yes. Some may do, but not all of them.

MS MAUD: Yes. And if you didn't have access to those, I think Mr Codrington referred to them as, visa nurses, how would that affect your ability to fill your rostered positions of RNs?

MS SARGENT: There would be positions on the roster that would not be filled.

MS MAUD: So you're dependent on the overseas trained nurses to fill your RN positions.

MS SARGENT: Yes. Certainly, at present and, you know, for a while now. Yes.

MS MAUD: Yes. And on the occasions when staff call in sick at the last minute when you have unplanned leave, is there an agency in the Mudgee area that you're able to obtain staff from?

MS SARGENT: There's one agency that we can try and obtain staff from. They rarely have RNs or ENs, but they – they do have assistants in nursing, but because they do other roles, as well, like, you know, they might go to people in their own homes and that sort of thing. They are not always available when we need them or for a full shift.

MS MAUD: You refer in your statement to Pioneer House having given consideration to building an association with an RTO, a registered training organisation, to help address the staff shortages that you've experienced, but you say that that's not been possible, because of Pioneer House's regional setting and a lack of access to RTOs. Are you able to explain that? Is there – are there RTOs in the local area?

MS SARGENT: That sort of came about from a discussion with the previous CEO/DON and we were – her previous employer had access to an RTO, but it was in conjunction with a university, so they were able to get registered nurses through that. So we haven't got a university here, so we can't do that side of things. We haven't got – there's limited in what would be available. There are some training organisations that could do apprenticeship for assistants in nursing or that sort of thing, but you – with an apprenticeship you also have to have so many available shifts for that person once they've completed it. But often on our roster it's – it's someone's actual line that we can't give away. They might be on maternity leave or

they might be on unplanned sick leave. So, even though the roster is not filled, they may not necessarily be an actual position on it.

MS MAUD: So is that really the reason that you've not gone down that path, rather than the availability of an RTO?

MS SARGENT: It's probably part of the reason.

MS MAUD: Yes.

MS SARGENT: And the other part is, you know, actually having enough staff on board to think about looking at that focus, as well, you know, because - - -

MS MAUD: Because having somebody in a trainee role takes time for other staff as buddies. Is that what you're .....

MS SARGENT: Yes, they would have to be, you know, supervising them and helping them, yes.

MS MAUD: So when you're already short-staffed, it makes it difficult then to undertake those workforce building programs for the future, because you've got an immediate short staff issue that you're trying to deal with?

MS SARGENT: Yes, that's correct.

MS MAUD: You've lived in the Mudgee area for a long time. Do you have a sense of whether a program such as exists at the moment for medical practitioners, a bonded scholarship program, might be useful or successful in this area, so a program whereby people would receive a scholarship to do a nursing degree but on the – on the condition that they would then return to the regional area to work for a period of time? Is that something that you think would be useful or might be successful in this area?

MS SARGENT: It could be successful. I think anything that will get people to the regional areas to work would help.

MS MAUD: All right. In paragraph 37 of your statement you identify changes to the roster at Pioneer House over a period of time from January 2018. And you say that in paragraph (a) there was an increase to the rostered AINs by one shift in around January 2018. Does that mean that one AIN was added to the morning or evening or night shift at that time?

MS SARGENT: Yes. And I believe – I – if I'm correct in remembering, I think it was to the evening shift.

MS MAUD: The evening shift. And then in February 2018, so a month later, there was a further increase to the roster to add an AIN to both the morning and night shift.

MS SARGENT: Yes.

MS MAUD: Do you recall, was that in response to an accreditation audit conducted by the Quality Agency at the end of January 2018 which had found that Pioneer House did not meet expected outcome 1.6?

MS SARGENT: I think it was probably partly in response to that, but I think possibly also in response to what our staff were telling us, like that our, you know, our assistants in nursing, say, for example, on night shift, it was difficult without the extra night shift AIN, the RN was caught up, you know, manning one of the rings, for a better word, while they had their breaks and that sort of thing. So it allowed a floater to – to go around and help in the different areas. So – but I think it was probably partly in response to the audit and partly just in response to what the staff were telling us anyway.

MS MAUD: Because Pioneer House was found to not meet standard 1.6 in January 2018; but then an assessment contact in May 2018, they were then found to be meeting standard 1.6. Is that your recollection?

MS SARGENT: Yes, that's my recollection.

MS MAUD: Then in paragraph 37(c) through to (e), you talk about changes that were made in January this year. And just so that it's clear what that is; there was a reduction of one AIN on both the morning and the evening shift - - -

MS SARGENT: Ys.

MS MAUD: - - - and a reduction of one endorsed enrolled nurse in the morning and evening shift.

MS SARGENT: Yes.

MS MAUD: And introduction of a B stream, EEN shift. Can you just explain to the Commission what a B stream EEN shift is.

MS SARGENT: So that shift that's referred to as the B stream, it was just a title given to the endorsed enrolled nurse shift that started at a different time. It started later, like, I think it was 10 o'clock through to 6.30 pm to help sort of cover things at either end of the day.

MS MAUD: All right. Could we bring up a document, please. It's tab 11 of the Pioneer House tender bundle. You see there, there's minutes of a meeting held on 9 January; it's described as an all care staff special meeting.

MS SARGENT: Yes.

MS MAUD: And the minutes are taken by the DDON, I'm not sure if that's you, but you are referred to later on. Do you recall being at this meeting?

MS SARGENT: Yes, I do.

MS MAUD: Yes. Could we turn, please, to page 29 and the section in the middle of the page, if we could bring that forward, commencing:

Helen Harwood then spoke to the rosters –

so this is describing the roster changes that we've just been through; is that right?

MS SARGENT: Yes, that is correct.

MS MAUD: Yes. And then underneath that paragraph there's a paragraph:

No-one will lose hours as we believe in our commitment to staff, however, we will not be recruiting to positions that are no longer on the roster.

The statement that "no-one will lose hours"; is that reflecting the fact that prior to the reductions to the roster in January 2019 the higher roster in December was not being filled?

MS SARGENT: Yes.

MS MAUD: So, in effect, although the roster was reduced in January 2019, the actual number of staff present may not have substantially changed because you had already been working short-staffed.

MS SARGENT: That's correct.

MS MAUD: So the difference, really, was that Pioneer House was from that time not going to recruit to try to enable it to fill the higher roster, so the lower position would become the default position; is that correct?

MS SARGENT: Yes. Yes. I mean, we were still recruiting all the time, really, just to try and maintain – to cover what was on the master roster.

MS MAUD: Even on the reduced master roster?

MS SARGENT: Yes.

MS MAUD: Yes. So the position after the changes in January 2019 was that on the morning shift there were two RNs, two EENs and eight AINs, plus one EEN on the B stream shift, and that was until May 2018; is that right?

MS SARGENT: Yes. That would be correct.

MS MAUD: And then from May the B stream shift was phased out?

MS SARGENT: Yes, it was phased out and they actually went back to the three EENs on the morning - - -

MS MAUD: Okay. Increased the number of EENs again.

MS SARGENT: Well, the staff time, really, effectively and added the evening EN back on as well so - - -

MS MAUD: And the evening shift from this point in time from January 2019 was one RN, one EN and eight AINs?

MS SARGENT: Yes, I think that's correct.

MS MAUD: And the night shift was one RN and five AINs. You say in your statement that from the start of January 2018 through till September this year you had raised with the CEO/DON on a number of occasions your concern that Pioneer House didn't have sufficient staff to meet the care needs of the residents. Was your concern at that time that the base roster was insufficient or that there were insufficient staff to fill the roster?

MS SARGENT: My concern has been both at varied times throughout the period.

MS MAUD: So at the time when the roster was reduced in January 2019, did you have a concern that it was then not providing for a sufficient number of staff?

MS SARGENT: Probably not so much then because the – the finance – before the reduction happened, the finance manager had had meetings with us to try and explain, you know, what he found, how our ACFI was tracking and where we benchmarked against other facilities and we did have – I think we had some empty beds as well, so occupancy wasn't 100 per cent.

MS MAUD: So in January 2019, is your evidence that you didn't have concerns that those reductions to the roster was going to affect the care?

MS SARGENT: My concerns at that time were still that we were having trouble filling the roster as it stood anyway. We weren't getting the full complement.

MS MAUD: Right. So could we bring up another document, please, which is tab 21 in the bundle.

COMMISSIONER BRIGGS: Might I ask, Ms Sargent, whether there's a generalised problem in Mudgee with availability of nurses, including at the hospital?

MS SARGENT: I'm not sure about the hospital, but I do know the other aged care facilities do advertise – you know, I see advertisements for staff, care staff for their

facilities on – in the local paper or on, you know, such places such as Indeed and Seek.

COMMISSIONER BRIGGS: Yes. It's the case, isn't it, that RNs who work in aged care are paid less than RNs who work in the hospital system?

MS SARGENT: Yes, I believe so.

COMMISSIONER BRIGGS: Yes. So there's an issue there about, might I suggest, equalising at least the salaries between the RNs in the aged care sector and the RNs in the state hospital system.

MS SARGENT: Yes, I think that also impacts us as well.

COMMISSIONER BRIGGS: Thank you.

MS MAUD: I'm just waiting for tab 21, and can you show pages 93 and 94 side by side. So from the first page there, you saw that that was an assessment report of the Quality Agency in February 2019. And here on the page you can see the assessors are reporting the number of unfilled shifts since 15 January, and they've identified there almost every day or every second day shifts that have been unfilled for AINs and also for, on some occasions, EENs. Does that look to you like the kind of short-staffing that you were experiencing at this time in January/February 2019?

MS SARGENT: Yes, unfortunately it does.

MS MAUD: And so when it says that these are unfilled shifts, this means even on the reduced roster from January 2019 you were still having this extent of a problem of filling even that reduced roster?

MS SARGENT: Yes.

MS MAUD: Now, I want to ask you some questions about a resident at Pioneer House in the dementia wing who I'm going to refer to as Mr UI, and you know who I'm talking about.

MS SARGENT: Yes, I do.

MS MAUD: Mr UI commenced as a respite resident at Pioneer House on 16 July 2018. Does that sound correct to you?

MS SARGENT: Yes, I'm not sure of the exact date but it was July 2018.

MS MAUD: Yes. Can you describe Mr UIs behaviour when he first arrived as a respite resident?

MS SARGENT: He did – during his time as a respite resident he did have some challenging aggressive behaviours. Some of those behaviours did impact other residents. He – he also wandered, you know, excessively into other people's spaces, personal space.

MS MAUD: Are those kind of behaviours common when a resident with dementia first comes to a facility like Pioneer House?

MS SARGENT: Yes, it's not uncommon for someone with dementia to be very unsettled initially in a new environment. So often you do consider that there would be a settling-in period, but everyone is an individual as well, so there can be different behaviours with different residents.

MS MAUD: In late August 2018 Pioneer House arranged for a consultant from Dementia Support Australia to attend the service to assist in the care of Mr UI, and if we could bring up, please, tab 9, and just highlight the box at the bottom there, Reason for Referral; that's probably enough. If you could just read that to yourself, the box Reason for Referral. Does that accord with your recollection of Mr UIs behaviour at that time?

MS SARGENT: Yes.

MS MAUD: Notwithstanding those issues, Mr UI became a permanent resident on 1 September. Did his behaviour settle down after that?

MS SARGENT: He – not immediately I don't think it was, but he did actually have – there were a couple of months where his behaviour did settle to what it had been. There were not as many reportable incidents.

MS MAUD: Do you recall when that was?

MS SARGENT: No, not exactly. No. I don't exactly.

MS MAUD: When Mr UI became a permanent resident did you have concerns about Pioneer House's capacity to care for him, based on what you had seen during the period of respite?

MS SARGENT: No, not initially because as I said I thought it – you know, it may – he may just need a settling-in period and his GP to review him, you know, while there were, you know, care staff around to – to care for him and follow the recommendations from the GP.

MS MAUD: Well, Pioneer House did then seek further support from DSA, including in February 2019. Was the assistance that you got from Dementia Support Australia enough to enable Pioneer House to adequately care for Mr UI, in your observation?

MS SARGENT: No. I don't think fully. I think they certainly provided us with strategies to try with him and some helped some of his behaviours at times, but not fully.

MS MAUD: Was one of the proposals that DSA fund a short period of one-on-one care for Mr UI?

MS SARGENT: Yes. That's – that's usually before they come on site, so that they can have a one-to-one doing assessments on that person and that – that sort of thing. However, there's difficulty there when you're already short-staffed because we had to provide that one-to-one person. So when you're already having challenges with your roster that's difficult, too.

MS MAUD: So as a practical matter, at this time in late 2018, early 2019, even if Pioneer House had had funding for one-on-one care for Mr UI, is your evidence that you wouldn't have been able to find the staff to provide that care?

MS SARGENT: I think because he was such a priority in the challenging behaviours that needed to be addressed, staff – we would have put someone one-to-one there but it may have meant somebody else in the facility – another area did not have as many staff as they should have.

MS MAUD: All right. After sanctions were imposed on Pioneer House in February 2019, a nurse practitioner consultant called Catherine Brown attended at Pioneer House two days each month from April through to August. Do you recall that?

MS SARGENT: Yes.

MS MAUD: And if we could bring up, please, tab 16 of the tender bundle. One of the things that Ms Brown did was to undertake an environmental audit, and you see there in the paragraph at the bottom that the aim of that audit was to identify strengths and weaknesses of the physical environment in the dementia care setting. Do you recall that audit taking place?

MS SARGENT: Yes.

MS MAUD: And Pioneer House was provided with a report of Ms Brown's findings which is this document that we're looking at. Do you recall, would this have been something that you saw at the time?

MS SARGENT: Yes, I believe I did.

MS MAUD: I just want to briefly take you through some of the observations that Ms Brown made. One of them, which is on page 59 under the heading 2, Provide a Human Scale; do you see in the middle of the paragraph there's a reference to:

The large common room is currently not conducive to emotional support or feelings of being in control and creates entrapment.

Is that an issue that you had observed in the dementia wing at Pioneer House?

MS SARGENT: I don't – well, I personally hadn't thought of it in that way, you know, creating entrapment. But possibly because – the way – there weren't so many areas – individual areas set into it, like – like with the chairs and things, the way things were set out, it possibly, yes, did. It wasn't something I'd thought of prior to seeing her report.

MS MAUD: Well, some of the other things that Ms Brown noted were lower on the same page under the heading number 3 in the middle of the paragraph. Do you see:

There are few landmarks for residents throughout the unit, (wayfinding signs, colour cues, landmarks).

So those are things, I take it, that Pioneer House might have been able to do something about, whereas the layout of rooms not necessarily could be so easily fixed.

MS SARGENT: Yes.

MS MAUD: After receiving this report or in the course of Ms Brown assisting Pioneer House, did Pioneer House undertake changes of this kind, including landmarks to assist with wayfinding?

MS SARGENT: Yes. Yes. Signs were purchased like that pointed to with an arrow the direction of the dining room, and that sort of thing. There were some boards with scenery put in certain areas and if it was scenery with a lake or something, in a country setting, there might be a board put with scarves and hats next to it just to sort of help them associate that, you know, they might be thinking about going for a walk. Yes. So there were certainly – certainly – large clocks, easy to read clocks with the date on it and, yes, there were a number of things that were put in place from Catherine's report.

MS MAUD: So, based on the report, you did make some changes. At some stage, though, did you form a view that Pioneer House was just not able to care for Mr UI adequately?

MS SARGENT: Yes. I think there were ongoing – ongoing incidents that were not keeping the other residents and staff safe.

MS MAUD: What – did you take steps – did Pioneer House take steps that you were aware of to try to find alternative accommodation?

MS SARGENT: Yes, I wasn't directly involved and – but I do know – because I was away for part of this period of time, but I do know that his GP also tried to – to actually get him somewhere to actually be assessed a bit more to see that, if with, you know, certain changes with medication or – or something, that we might still be able to manage him, but that was even unsuccessful because the doctor tried a mental health unit in Orange and was told, "No, you need to ring Dubbo."

So he did and then he's told "No, you need to ring the other place again" so, you know, he couldn't even access anywhere for a good assessment. And then I believe when I was away – I was on carer's leave for a period of time here – that they had found an alternate accommodation, however, I believe the family refused because it was going to be too difficult for a particular member of the family - - -

MS MAUD: All right.

MS SARGENT: - - - to get to visit the gentleman.

MS MAUD: I just want to move on to July 2019 when the commission conducted another assessment, an assessment contact at Pioneer House. And Pioneer House was found to still not meet standard 2.13 which is the behaviour management standard and there was a response from Pioneer House to the commission in relation to that; and if we could bring up, please, tab 66, and highlight, see there, just before I highlight it, it's a letter from Pioneer House and you can see over the page if necessary it's from the other director of – deputy director of nursing, and you see at the bottom there under the heading Overview:

> *While we believe we have done everything possible in relation to the care of UI, we have exhausted all our options of seeking alternative accommodation and assessment.*

Did you agree with that assessment at that time that Pioneer House had done everything possible in relation to the care of Mr UI?

MS SARGENT: I believe that would have been correct. As I said, I was away for a period of this time but in what had been tried prior I certainly think – expect that, I agree with that.

MS MAUD: When was the period of leave that you - - -

MS SARGENT: 17 June through to August.

MS MAUD: So up until 17 June when you went on leave.

MS SARGENT: No, I went on leave on the 17th - - -

MS MAUD: Yes, but until then - - -

MS SARGENT: Until then, yes. Yes.

MS MAUD: Is that your assessment, too, that Pioneer House had done everything possible?

MS SARGENT: Yes, and still we weren't achieving what we needed to.

MS MAUD: Do you have views that you formed over your time at Pioneer House as to further support that would be useful for you in dealing with dementia residents displaying complex behaviour?

MS SARGENT: Well, I think this is an example where you felt if there was somewhere that they could go to be assessed and that – and then, you know, if possible, then you might be able to manage them once they've been fully assessed under, you know, supervision of specialists. You know, there's possibilities then that you might be able to manage them when they come back. And, if not, then there needs to be alternative accommodation that you can just access that - - -

MS MAUD: So, just to understand that a bit more, Dementia Support Australia did attend Pioneer House and did conduct some assessment, but is it your view that that's not sufficient?

MS SARGENT: Yes.

MS MAUD: And why is that? What else would be required?

MS SARGENT: Well, for example, when they come the psychiatrist does not attend in person. They go off of the assessments that the person that does come provides them. But, also, it may – it may be that that person needs to be reviewed for a number of weeks to really get a full understanding of what's going on with them, which, I mean, they're coming in from Victoria at times was the person that – that came.

MS MAUD: And the people that come from Dementia Support Australia, are they nurses?

MS SARGENT: I'm not 100 per cent sure, sorry.

MS MAUD: Okay.

MS SARGENT: I think - - -

MS MAUD: But it's specialist psychiatric - - -

MS SARGENT: Yes.

MS MAUD: - - - care and advice that you're specifically looking for?

MS SARGENT: Yes. Well, we weren't – with the information that DSA was giving us we still weren't achieving, so he needed to be reviewed even further. So – and I do know the GP did try to get him reviewed by the mental – older persons mental health team, but was told, "No. Because he has dementia, you know, you can't access that.-" The GP was told no.

MS MAUD: And the mental health team, is that a team that comes to you or does that require being admitted somewhere else?

MS SARGENT: They come – the registered nurse comes first and then at times the psychiatrist comes.

MS MAUD: Right.

MS SARGENT: But we could not access that.

MS MAUD: So that's a mental health-specific service that they wouldn't provide because it was a dementia case.

MS SARGENT: Yes.

MS MAUD: I see. Commissioners, I have no further questions for this witness.

COMMISSIONER PAGONE: Ms Sargent, thank you for giving evidence. You're free to go.

MS SARGENT: Thank you.

<THE WITNESS WITHDREW [3.33 pm]

MR GRAY: Commissioners, I call Prudence Dear.

COMMISSIONER PAGONE: Yes.

MR GRAY: Commissioners, I fear we may be about 10 minutes behind the run sheet and, consequently, I seek your indulgence for an extra 10 minutes until about 10 past 4.

COMMISSIONER PAGONE: Sure.

MR GRAY: Thank you.

<PRUDENCE MARGARET DEAR, SWORN [3.34 pm]

<EXAMINATION BY MR GRAY

MR GRAY: Ms Dear, make yourself comfortable. What's your full name?

MS DEAR: Prudence Margaret Dear.

MR GRAY: And you're a registered nurse.

MS DEAR: Yes.

MR GRAY: And you've get a graduate diploma in human resources and industrial relations.

MS DEAR: Yes.

MR GRAY: And you've got quite extensive experience in being a nurse adviser going into aged care facilities to help them to change management; is that right?

MS DEAR: Probably more as a nurse consultant than an adviser. Yes. I've recently done a nurse adviser position as a secondary – as a second nurse adviser, but, yes, I would say nurse consultant.

MR GRAY: Thank you, Ms Dear. Could you, please, see if you can just pull the microphone a little closer to you. And we will just - - -

MS DEAR: Is that better?

MR GRAY: Yes. Thank you. You were selected by Ms Harcourt to assist her in providing services, nurse adviser-type services to Pioneer House from 11 March 2019; is that right?

MS DEAR: Yes.

MR GRAY: And you provided those services on the ground four days a week up until past mid-June; is that right?

MS DEAR: Yes.

MR GRAY: So you spent a lot of time at Pioneer House?

MS DEAR: There were a couple of – two or three weeks that I wasn't able to be there, but yes.

MR GRAY: Yes. And you were under the supervision of Ms Harcourt, but Ms Harcourt wasn't always there when you were there; is that right?

MS DEAR: Correct.

MR GRAY: And when you got to Pioneer House you were briefed with certain materials that you referred to in your statement. And you also, what, conducted interviews to try to understand what the situation was?

MS DEAR: Yes.

MR GRAY: Yes. And in your statement you refer to some conclusions that you drew about the key safety and quality issues at Pioneer House; is that right?

MS DEAR: Yes.

MR GRAY: Your statement is – I will ask for it to be displayed for you. It's WIT.0525.0001.0001. This is a statement of Prudence Margaret Dear, dated 11 October 2019. Do you see that appearing before you with some redactions of personal details?

MS DEAR: Yes.

MR GRAY: And that's just the first page, but do you recognise that to be your statement?

MS DEAR: Yes.

MR GRAY: Are there any amendments you wish to make to the statement?

MS DEAR: No.

MR GRAY: To the best of your knowledge and belief, are its contents true and correct and are the opinions you state in it opinions which you truly do hold?

MS DEAR: Yes.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes. Well, the statement of Prudence Dear of 11 October will be exhibit 12-9.

EXHIBIT #12-9 STATEMENT OF PRUDENCE MARGARET DEAR DATED 11/10/2019 (WIT.0525.0001.0001)

MR GRAY: Thank you Commissioner. Just for completeness, Ms Dear, at paragraph 5 there was a reference to your attached résumé. And thank you for providing that, but that is not attached to the exhibit.

MS DEAR: Thank you.

MR GRAY: Now, when you got to Pioneer House and you formed some views about key quality and safety issues – sorry – I withdraw that and I will rephrase it. In your statement you were asked the question at page 0008:

As a result of your time as an adviser appointed by –

Or, as you've said, a consultant to Pioneer House:

(a), what do you consider to be the key safety and quality issues at Pioneer House during the relevant period?

Now, the relevant period is from the beginning of 2018, before you actually got there. But you formed some views, did you, about what had probably been the case before you got there?

MS DEAR: Yes, I did.

MR GRAY: Okay. And then you deal with that question under several headings. Can we just start with the first heading, Human Resource Management.

MS DEAR: Yes.

MR GRAY: In relation to human resource management, there seem to be two themes that you pick up in these points. At paragraph 112, 113 and 114 and then 116, 117 and 118, 119 and 120, you refer to the rostering system and the roster. And at 121 you refer to unplanned sick leave and leave at short notice. What were the issues around the roster, unplanned leave and gaps in shifts as you saw them?

MS DEAR: There were a number of gaps in the roster anyway and – which means that the shifts weren't able to be filled or weren't filled. And it seemed that there were insufficient staff to be able to fill those shifts. There was – there was a complexity of issues, staff were also suffering – experiencing some burnout because, the, as has been identified previously, their hours had been cut back. But they hadn't actually worked to a full baseline roster for, my understanding would be, a few months at least in 2018, anyway, because of possibly the inability to recruit staff.

MR GRAY: So just before getting to that recruitment issue - - -

MS DEAR: Yes.

MR GRAY: - - - can you just explain how that creates burnout? Perhaps it's obvious, but can you explain what the burdens on staff are, particularly if there's a short shift?

MS DEAR: When they're short staffed, they would go home feeling very frustrated, because of their inability to provide the care required. And as we move towards, or, ideally, have already moved towards a person-centred approach to care, the first thing that tends to happen as a generalisation is that people go back to task focus and task, because that's the best way of being able to get through their work. And so the person-centred care is not able to be achieved. And they also are not always able to complete the requirements that are needed on a day-to-day basis of providing care for the residents.

MR GRAY: And did you observe this when you got to Pioneer House in March 2019 to be occurring in the workforce of Pioneer House?

MS DEAR: Yes. It was observed, due to the fact that there were also a number of tasks that were not able to be completed a daily basis, as well. So that might be part of the clinical side that you want to move on to later, but, for example, weights that hadn't been done for a number of months. So, therefore, I was able to identify weight – monitor weights and weight loss or weight gain was not able to happen.

MR GRAY: Right.

MS DEAR: Observations. Yes.

MR GRAY: Thank you. You refer to – in that heading Human Resource Management, you also refer to lack of clinical expertise and then you have a separate heading, Clinical, with a number of references to clinical matters beginning at paragraph 127. In addition to those points, at 122 to 126 you make the following points:

> *Need for clinical supervisors to manage staff allocation to areas to ensure skill mix and staff acceptance of this. Staff confidence.*

This is at 123:

> *Staff confidence in management and decision-making.*

124:

> *No proactive leadership.*

125:

> *Overcoming a reactive style of management.*

And 126:

> *An AIN-dominated culture and fragmented teamwork.*

Are you able to explain those issues? If you want to take them separately, that's fine. If you want to deal with them together, that's fine as well.

MS DEAR: So the shortage of staffing was across both the AINs or assistants in nursing, as well as the enrolled nursing, as well as the registered nursing. There was the senior management – or the key management were in place. Everyone was trying to do their role, but, because of the stress that everybody was under and the increase in the roster not being filled, it was very reactive. And so, therefore, while people were trying to do their best, they were just not – they were in a non-coping framework. And – sorry. I'm, obviously, quite nervous here and not explaining myself well at the moment.

There was also – there was a need to bring staff – this probably is going back to the roster. There was a need to be able to be creative in managing the roster. So, as well as trying to bring on staff to fill those shifts, it was also a matter that when there was a short – short staff in any of those positions that you would try to be creative in bringing staff on earlier, working them for longer periods and, of course, bringing agency staff in. So there were a number of strategies that needed to be undertaken there.

Part of that clinical leadership, which – sorry – you were focusing on before was that the DDON that was responsible for that, which was the full-time DDON at that stage when I arrived, was responsible for the filling of the roster, the development of the roster and – and then the day-to-day shift replacement. And while it is only a small facility, because of the amount of unplanned sick leave, both – and particularly the short notice unplanned sick leave, that became a really full-time job for someone to be doing.

They hadn't been – when I arrived at least, they hadn't been in the habit, because – quite possibly because of financial constraints or concerns of using the agency. When they did use agency staff, it – they would – didn't always have success with bringing on agency staff. The agency in the town only has AINs, not ENs or RNs. So it – the clinical expertise wasn't there either. And so it was about trying to free up the key clinicians so that they could do their role of managing and having clinical oversight, so that the administration staff could be trained to do the roster replacement and then try to get to be to a proactive state where the roster was coming out in advance, rather than only a few days before the shifts were due to start.

MR GRAY: One of the points you make about the roster is that it's important to get that roster out a month in advance so that any clash – clashes and so forth can be identified and those positions filled - - -

MS DEAR: Yes.

MR GRAY: - - - well before time. But that wasn't happening. Is that the case?

MS DEAR: No. That's right. And, I'm sorry, I'm going back to the roster now. But the issues were that, because the roster wasn't coming, there was a number of issues with the roster and with the HR. So there was a tendency for particularly AINs to own their shifts, rather than owning hours. And there were a number of different contracts there, so that there was some staff that were on monthly contracts – sorry – monthly rostered hours, rather than fortnightly. Any of the new staff that was starting, a decision had been made to try and change that framework. A decision had been made by management to put them onto a flexible staffing hours. But then, of course, they were picking up the shifts that not necessarily anyone else wanted, so they also became quite dissatisfied in a short period of time.

MR GRAY: Yes.

MS DEAR: So, to be able to streamline that, that just seemed, in spite of all the clinical issues that were identified, if you didn't have the staff on the floor to be able to manage the day-to-day, you weren't going to get on top of those clinical issues. So it was a need that was the highest priority of a number of areas that needed to be focused on. So to be able to pull that roster towards a proactive roster – so it was out a month in advance. And so then we had some strategies that still took probably just over a month or six weeks to be able to really format into that.

So then it was happening with some timelines in advance, so that staff were then able to – we had it clearly identified that at four weeks they could – the roster would go out and any unfilled shifts that the permanent part-time staff could pick up. And then at two weeks out the casual staff could pick up. And one week out it would go to the agency. So it was a complete different framework to what they were used to working in.

Also, to be able to have staff work overtime and pay staff for overtime. And I know that that's not a financially – a good financial decision, but in this situation it's necessary so that you're appeasing and meeting the residents' needs and you're also building up that trust in the staff again, so that they are feeling that they are being heard and able to do their job.

MR GRAY: Thank you. You – thank you for going back to human resources.

MS DEAR: Yes. I'm sorry.

MR GRAY: No, not at all. In explaining how that's the necessary minimum criterion before you can go on and deal with the clinical issues. Could you now please explain the changes that were made in clinical management or clinical leadership. And you have some references to clinical leadership under the Human Resource Management heading which I read out a short time ago. And then you've got an entire heading devoted to Clinical, which deals – under which there are a number of points beginning at paragraph 127. One of those I see is insufficient – this is 134 on page 0009:

Insufficient support with management of behavioural and psychological symptoms of dementia.

But there are a number of other matters raised as well. What were the measures that you regarded as necessary to address failings or deficits in clinical leadership issues?

MS DEAR: There were a number of areas and, as I said, weights was an example, but there were a number of areas that needed to be focused on again. And the staff needed some leadership with that and my role, I saw, was to be there as a support and mentor for the key personnel so that together we could get on top of these issues. While there were two RNs rostered, for example, in the mornings on shifts, quite often there was only one RN available or there may not be an RN, so I'm going back to the staffing issue again. But it was a matter of being able to be flexible so that sometimes the key personnel, the key staff needed to be out on the floor to also do those – those shifts.

The medication rounds were another area; the medications were quite a complex area there and the medication rounds were quite long because of the number of residents that the ENs were doing – were administering medications to in the morning. So we tried to free that up by rearranging those shifts and that came a few weeks later when we put on an extra EN in the morning, but I'm jumping there. Initially, it was – it was just about just getting on top of some of those basic clinical indicators of the weights, the diabetic management, BGL ranges, managing of Parkinson's medication so that there was some timeliness in the medications that they were needing to take, observations, of course, wound management and looking at some best practice around wound management and a lot of those clinical issues.

MR GRAY: Thank you. Now, I'm just going to skip over question – questions (b) and (c) on page 0009 for the moment and go to question (d) on 0010. At that point in your statement you recite the question asked of you:

To what extent do you consider those safety and quality issues to be related to Pioneer House's location in a regional area?

And it's not surprising, given the emphasis you've repeatedly put on the staffing levels and the need to obtain staff that that's one of the issues that you've identified here. What is the situation in Mudgee with respect to the labour force, both AINs on the one hand and also clinically trained RNs and ENs on the other?

MS DEAR: It seemed to me from the evidence that I was given when I got there that, and because they had gone through this – the 12 months before as well, with staff shortages over Christmas and New Year that in particular around that holiday period that, when the mines slow down, that people who are employed in human services or in nursing positions if they don't have the shifts that they want, and that are satisfying to them, then they would take off as we would do and go on holidays with their families, knowing that really when they come back to work when the

season starts up again, they would get work again. So you're left really short-staffed over that period.

So perhaps a focus on some – an HR strategy. Some forward planning was really necessary and that was just another of the balls in the air as well because you need to start is that out months from when that situation was going to be in place. There was difficulty also not just from a clinical perspective and AIN perspective but there was difficulty in accessing allied health services, including dietitian, and while there was a physio there was most supportive, she was really also quite stretched in trying to recruit other physios to the area to support her in the services to be provided. The dietitian was extreme because, of course, we were wanting to get on top of those weights and the weight management as a priority.

And so that ended up being a – done remotely, so we gave her access to the system to be able to do that because she'd just had a baby so she wasn't able to come in. So initially that was how we managed the assessment of the nutrition from the dietitian. Podiatrists were very busy and stretched as well, and the speech pathology came in later. As well as that, just to be able to manage behaviour management, some wound expertise, palliative care, any of those areas where there's, in aged care these days, so many comorbidities, you're needing access to those specialist services.

MR GRAY: What thoughts do you have, from your experience, particularly in providing consultant services in regional areas, on the question of improving the availability of the AIN workforce and the clinically trained workforce in rural areas and just providing a greater pool of workforce supply in those respects?

MS DEAR: If I start with the oversight and guidance that you need from specialist services, the access to, certainly, nurse practitioners has worked well in my experience in a couple of other rural and remote regional areas. Of course, the GPs need to be on board for that, so if you don't have all the GPs on board or there's GPs that aren't on board with nurse practitioners, but it is a great model and they've provided great comfort to facilities. As well as that, there's – telehealth has worked well as well. That's not something that we had looked into doing at Mudgee - - -

MR GRAY: You're talking now about bringing in specialist expertise as opposed to day-to-day hands-on workforce.

MS DEAR: Yes.

MR GRAY: Okay. Thank you.

MS DEAR: Yes.

MR GRAY: With respect to the day-to-day hands-on workforce, do you have any thoughts as to how the position might be improved in regional areas, that is, how workforce supply of AINs and RNs and ENs might be improved. It's not a matter you've addressed in your statement but - - -

MS DEAR: No. You are needing to try and attract people to the regional areas and while people would generally tend to say in the surveys that remuneration is not of the highest priority, but to be able to have some remuneration for work in regional areas or even just in aged care across Australia that's equitable to the acute sector at least, or even compensation for rural and remote services, would be one option. Some additional training and support that – and so they would perhaps acquire some additional skills that – without having to pay for that out of their own pocket.

MR GRAY: I don't know if you were present when I was making opening submissions to the Commissioners, but one proposal that the counsel assisting team are considering putting to the Commissioners is for funding to be available for bonded scholarships or linked scholarships by which people can get training locally, one would hope, on the condition that they stay on in the relevant region and work as AINs or RNs or ENs in that region for a time after the training. Do you think that idea is workable?

MS DEAR: I think that's an excellent idea. All of those opportunities need to be explored.

MR GRAY: And another proposition that the team is considering advancing is that funding should be made available more readily for aged care providers to make arrangements with local RTOs or, indeed, to if they're large enough become themselves RTOs to provide training in situ, right in the location, in the regional location, in an attempt to attract a ready-made workforce that can be trained on the spot and who may have a greater likelihood therefore of being retained in the region. Do you think that idea is workable?

MS DEAR: Yes. I've also worked with a couple of organisations where they have had RTOs so my caution there is that they need to have really strong practices and best practices and currency of practices at that – at those aged care – within those aged care organisations, and a staff mix that is prepared to be able to take that on as well.

MR GRAY: Do you have any other recommendations that you would like to advance to the Commissioners around the training of health - - -

MS DEAR: It is about – it is about that career pathway. And to a certain extent that exists quite nicely at the moment from an AIN to an EN to an RN and progression but perhaps with some financial compensation and support and assistance with that for the rural and remote, and for added certificates, of course, in clinical expertise.

MR GRAY: Yes. Did you have any thoughts about the training of health professionals in those categories more generally and whether there should be greater linkages with aged care as a career pathway?

MS DEAR: I haven't given this a lot of thought as far as putting it into operation. However, I have often thought that a transformational aspect could be that all health-

related disciplines do have a closer alignment with aged care. Now, how that would look or how that would be played out, I haven't been able to put into the operational context. However, it's probably also about normalising the ageing process and aged care. There is a lot of – and bring in some stream – alignment between hospitals and State health primary – primary health doctors and then all the specialists, etcetera, etcetera, but to be able to have aged care as part of that mix so that it's not just seen out as a separate area and it is the baseline of core skills and care and services.

MR GRAY: Thank you. Could I return to a strand underneath the heading of the clinical quality and safety issues that you identified at Pioneer House once you got there in March this year. You referred amongst those matters to difficulties in managing residents with challenging behaviours and, in particular:

> *Insufficient support with management of behavioural and psychological symptoms of dementia.*

That last point is at paragraph 134 on page 0009. Then when you address under heading (d) on page 0010 which is the linkage of those issues to being in a regional area, you say – at 159 you actually begin by referring to:

> *Difficulty in accessing local support for specialist services including –*

and one of them is behaviour management. And then at 160 you say:

> *Limited options for placement of residents with extreme behaviours, either for permanent placement or for assessment.*

And at 161 you say:

> *Limited availability for specialists for on-site support for residents with extreme behavioural issues.*

Without commenting on any particular individual case, can I just ask you about those topics, Ms Dear, the behaviour management for residents who may be exhibiting behaviours that are challenging because they're living with dementia? What – what view did you form about the capacity of Pioneer House to deal with its cohort of residents who might have been showing challenging behaviour?

MS DEAR: Certainly, there was more training needed and that's increasingly the case in aged care with managing challenging behaviours. And so – and that became just another of the training exercises that needed to happen on top of mandatory training requirements there as well. So from – with regard to the behaviour management in itself, it is about being able to have – have expertise on the ground to be able to assist and support the staff and guide the staff.

So whether you also have an approach of well, every staff needs training in that area, perhaps to have some leaders of that field as AINs who have got some extra expertise

and understanding and who are passionate about it, because not everybody has the desire or the skill to work with people with dementia or with challenging behaviours. We all have different strengths.

So to be able to have some people trained so that when you do have extreme episodes of behaviour, you are able to rely on some local resources that have done some training either here or actually gone away to do some training, but also to be able to – the difficulty with bringing in services as was identified before is that they're there for a period of time but Sod's Law says that often the extreme behaviours start – occur after hours and at weekends and so you're needing to have that support and be able to lead by example and – and have the staff support there at those times.

MR GRAY: Thank you. Help yourself to some water if you need to.

MS DEAR: Thank you.

MR GRAY: Yes. Now, could I just ask you about a point you make at paragraph 147 on page 0009. You refer to this reactive – a short time ago you mentioned the word "reactive" and a reactive approach to management, and you referred to the reasons why it appeared to you that management had become reactive because of gaps in the roster when you arrived. At 147 you say:

> *While management and staff were trying to rectify issues as they arose, time constraints became a greater challenge as the negative effects of system and process breakdown compounded with flow-on effects.*

What do you mean by the negative effects of system and process breakdown compounded with flow-on effects?

MS DEAR: I think from the start – I'm going back to the vacancy and the inability to fill the shifts in the roster, and then particularly in January when the staff cutbacks happened and staff felt that they weren't being heard, that they weren't being listened to, they felt that they weren't able to do their jobs, they did have some – a number of residents with some challenging behaviours there as well.

So then the ability to be able to continue with – if you're in an ideal – there's the ideal world and the real world, and so in the ideal world you're getting through all your assessments and observations on a daily basis and all the expectations of wound reviews, etcetera.

However, when you're short-staffed and when there's challenging behaviours that need to be addressed or incidents that need to be followed through on and managed, so the systems fall apart, the processes fall apart and you're in a reactive phase of trying to manage those rather than looking at things proactively and so therefore it implodes as such.

MR GRAY: I want to raise with you what might be done to prevent or at least to give a better chance to providers of preventing that situation entering that compounding vicious cycle which you've just described. Now, Mr Codrington in his evidence used the expression "flying squads" and in my opening I referred to consideration by counsel assisting of a proposal whereby there be targeted assistance to help rural and regional providers who might be beginning to face difficulties of this kind to increase their governance capabilities and their managerial capabilities to the extent necessary to address this problem before it becomes too bad. What are your thoughts on a proposal of that kind?

MS DEAR: Certainly, from both a governance perspective and an operational perspective, for rural and remote, they're often standalone facilities. They often don't have the same structure in place as a larger organisation and even, for example, in recruiting and then training with the expectations of responsibilities and day-to-day expectations and the role say, for example, as a DDON or in one of those key leadership roles. In a larger organisation they will usually have an orientation program that those staff go through and they're given clear responsibilities and expectations but often in these small standalone organisations you don't have the capacity to be able to do that. So to be able to have some assistance with that and to have some support from the government; I think that was a great idea of – of them being able to come in to assist in regional areas.

MR GRAY: What about Mr Codrington's point about the Quality Commission – or previously the Quality Agency having a more advisory mode than it currently has, or at least having the discretion to adopt a more advisory or mentoring posture than a policing posture? What are your thoughts on that matter?

MS DEAR: It would be good to – whether that's the Commission or whether that's going to be in conflict with their role as a regulatory body as such, it would be good to have some support there. And, I mean, they are the people that are as auditors identifying areas.

One thing that does come up – there's several, but one thing that does come up is when they do come to do an audit over a few days and they're looking back on retrospective information that perhaps it's good if an organisation has moved mountains in really tough situations to overcome all the hurdle that they've been facing, if they assess them today or over those three days as being compliant, in spite of the fact that there's been ructions in the past, perhaps that they acknowledge where they are today and then have a support visit in another three months.

So that they're coming back in another three months to check on their continuous improvement and ensure that the CI plan, the continuous improvement plan, is active in a living document that – you know, checking on some of that clinical indicator stuff that is fairly evident when that can also be done from a – as they used to be desktop audits, but from remotely, as well, really, in checking on how people are going with addressing incidents, mandatory reporting. And now you've got the clinical indicator data that the government's starting to collect, as well. So - - -

MR GRAY: Thank you. Finally, can I ask you about an intervention that might be available in the case of there being very challenging behaviours arising from the progression of dementia in a person living with dementia. Is there a point at which, in your experience, in particular, standalone approved providers in rural areas are just not going to be able to cope and shouldn't be expected to cope with very challenging situations and behaviours and in which it would be warranted that the government should have an intervening role to be able to facilitate perhaps transfer of residents? What do you think of that proposition?

MS DEAR: I think, to go through it out loudly, it's a difficult one, because you've got the quality of care principles and the security of tenure situation, you've got the family, you've got advocates and advocacy groups. I don't think it would be a popular determinant to be making. However, the other side of that is if you think about the number of – you've got to care for all the residents, so, therefore, if you're reducing the number of physical aggressive episodes with other residents and staff, then perhaps it is necessary.

I mean, in an ideal situation, you would have an environment, you would have the training, you would have support in place. But that's not always the case even in a larger town or city, let alone in rural or remote. So it would be as a last resort and I guess it would have to be specific each time. It would need to be specific on the individual situation.

MR GRAY: Thank you.

MS DEAR: Yes.

MR GRAY: I don't - - -

MS DEAR: And – sorry – also with some support for the family and their – or their representatives to be able to compensate them or to visit their loved one, wherever that person may be, on a short-term basis, but all with flexibility for them to be able to return once the situation has settled or the person has – behaviour has changed.

MR GRAY: Thank you, Ms Dear. I have no further questions.

COMMISSIONER BRIGGS: Ms Dear, thank you for your evidence today. One of the things in my career I've been conscious of, that people want to grow up in a place, live and work there. So they want to stay locally. And this is been an issue with country GPs, as well. So one of the strategies that has been tried there some years ago was to recruit kids from the country to go to medical schools in the country and do their placements in the country.

We know that the workforce supply issues in aged care are so significant that we're going to have to find lots and lots of new people to work in this sector, country, city, remote, no matter what. Do you see the possibility for a genuine focus on country recruitment of people and proper training in the country supported through the VET

sector for personal care workers, but also the university sector in the country to massively increase at least the initial intake from country areas?

MS DEAR: Yes. So that would be in the – in the – the regional areas - - -

COMMISSIONER BRIGGS: Yes.

MS DEAR: - - - where the training is happening. And I was reflecting the other day. I guess they do it across the states with teachers when they first come out of training. And I imagine it happens in all states, where they accrue points for working in country areas, etcetera, etcetera, and then to be able to go on to other teaching. And I know that this is very different for aged, care because it's a lot more of a deregulated industry than state education. But, yes, that would be a good idea to be able to incorporate aged care into, as we were saying before, everything to do with health-related disciplines.

COMMISSIONER BRIGGS: Is the vocational education training framework sufficient to – of sufficient quality and availability to be able to support the kind of career paths you were talking about earlier?

MS DEAR: I think, as someone identified earlier, you do see a variety of training and trainees come through. So it would be good to have some consistency with that. And it is such a complex area. So there are so many areas to be across now in specialised services. And so, therefore, perhaps that needs to be in certain certificates, as I'm thinking it through - - -

COMMISSIONER BRIGGS: Yes.

MS DEAR: - - - rather than - - -

COMMISSIONER BRIGGS: Yes. That's kind of what I've been thinking about, as well. So in other areas, if you do a particular training course that might build up your skills, then some money flows with that through salaries and so on. There's not a lot of evidence of that in this sector.

MS DEAR: No. No. It's – and, of course, it has such a poor representation, really, amongst the – in the media. I mean, and there are some good news stories, there are some good things happening in aged care. But – and I guess the excitement is often towards the home care, which is fantastic and that's what we all want, but residential care still needs to exist, as well. And to be able to recruit, we've got an ageing workforce, but, also, to be able to see the – there are some good clinical governance and management aspects of it, as well.

COMMISSIONER BRIGGS: Yes. I certainly think there are lots of great career opportunities for country kids here. And we will be looking at that as we go forward.

MS DEAR: Yes. Yes.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: I think I would like to try to ask a question that Mr Gray asked you before, but in a slightly broader, compendious way, if I may. So I know that I'm repeating, and forgive me for that. But in the context of – this particular session is about a case study. And, in the context of case studies like that – namely, assuming an aged care facility in the rural regional area such as we have here, relatively small, trying to do the right thing, trying to make ends meet, trying to provide good care for the people within the system, and then balancing all of the other things like security of tenure and staffing needs and requirements and so on – with some suggestions that we've had from Mr Codrington about flying squads and interventions and things like that, but bearing in mind all of these factors, what would you like to see us recommend?

MS DEAR: Thank you. From an accreditation perspective, if I could start with that, the focus on, at the moment – and it's for all the right reasons, and I've identified in my statement as well the benefits of an accreditation visit and the accreditation process, every person's – all key personnel, their roles, a day – a day-to-day job is at least 10 to 12 hours in a day and even if you're competent and have all your teams in place, etcetera, you still need to do some long hours, at least a couple of days a week. And then to have the agency come in for the right reasons and spend two or three or four days there, to then have them come in on an – without notice and your day is already filled in whatever capacity you're working in aged care as a – as – so it would be great to think that you could just leave and go through and see everything and perhaps with technology in the future that will happen.

But it's quite difficult to juggle because all of that work will still have to happen at some stage which, of course, just gets added to the burden. And I think it would be interesting to track – I don't know if this is happening but I haven't seen it – track the managers or key personnel positions across Australia in aged care and the number of vacancies and the – the tenure, the length of time they stay in those positions because people burn out in those positions very quickly because of the workload there. From also the commission's perspective as in the age – accreditation agency's perspective, Quality Agency, it used to be that when they came in, they would look – the terminology that was put to me is multi-dimensional, so they would look for evidence that the needs were being met and that services were being given in accordance with what they should be – how they should be provided.

So they would look at the policy processes paperwork, but then they would go and consult with the residents, their relatives, the representatives, the staff and validate that information. It seems increasingly at the moment that the one-dimensional focus – and if it's not documented, it hasn't been done. And so therefore, there's this absolute focus on spending more and more time on documenting which, of course, is less and less time. Now, I know with tablets and everything else, portable tablets, you can be at the bedside – in the resident's room and wherever the resident is. And I'm sure that our technology will change in the next five years radically to where it is

at the moment, but it is still taking away from that person-centred care, so that's from an accreditation perspective.

Certainly, from a funding perspective, my subjective thought from the interim report is that there's going to be more money put into aged care. That's great in theory, and it will necessarily be in the home environment but we're really critically needing that extra money as well for clinical support and care support in the residential facilities as well. And I'm not sure that I can see that coming across to residential at this stage. Perhaps they will be waiting till the end of the report. But there's – I guess with the change in the last decade at least of increasing comorbidities and the complexities of care, it's a dynamic industry, it's a dynamic environment that you work in, and there is so much more that is needing to be addressed to meet residents' needs, and the expectations, let alone when we come through.

Another area is probably from a behaviour – managing challenging behaviours and also mental health. We haven't really even started to see a lot of the post-traumatic stress disorders come through from war-weary veterans, etcetera, etcetera yet, let alone the next generations after that of the mental health issues that we will see coming through as well. So behaviour management will, in whatever form that looks, will need to be a larger part of services provided, and perhaps needs to be a bit more of a focus or a different focus or a specific focus with even the expected outcomes with the accreditation process as well, because the expected outcomes at the moment – my understanding, when I've been working with them is that they really – we all identify triggers and you have responses to those triggers and strategies, and then auditors want to see that those strategies have been implemented and then when there's been, for example, a monthly report or a discretion not to report that those strategies are reviewed and updated.

And there's only so – so much – so far you can go with really fleshing out more strategies, even for the – the most creative or the people with the greatest experience in behaviour management. So perhaps that's – needs some greater consideration as well. It's a really challenging area. And to support staff because increasingly there's the aggression in the workplace that's coming in.

COMMISSIONER PAGONE: Thank you.

MR GRAY: Nothing arising. Thank you, Commissioner.

COMMISSIONER PAGONE: Thank you. Ms Dear, I think I may formally excuse you from further attendance.

MS DEAR: Thank you.

<THE WITNESS WITHDREW [3.26 pm]

MR GRAY: Commissioners, we will prepare written submissions in accordance with a timetable we'll propose on Wednesday afternoon in relation to this case study.

COMMISSIONER PAGONE: Thank you. Adjourn the hearing until tomorrow morning.

MATTER ADJOURNED at 4.27 pm UNTIL TUESDAY, 5 NOVEMBER 2019

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