ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

SYDNEY HEARING

OBERON VILLAGE CASE STUDY

SUBMISSIONS OF COUNSEL ASSISTING

Introduction

1. Mrs CA was born on 5 June 1936 and is currently 82 years old.[1] She is married and has five daughters and two sons.[2] Mrs CA was diagnosed with Alzheimer's disease in or around 2010.[3]

2. From 16 May 2018 until 27 June 2018, Mrs CA lived at Oberon Village, a residential aged care facility operated by Columbia Nursing Homes Pty Ltd. Oberon Village is located about three hours' drive west of Sydney.

3. Mrs CA entered Oberon Village on a respite basis when her husband had knee replacement surgery.[4] At the time of entering Oberon Village, she was mobile and had a history of wandering.[5] She required assistance with the general activities of daily living.[6]

The dementia unit at the facility

4. Mrs CA was admitted to a specific dementia unit of the facility.[7] Columbia Village has supplied a plan of the dementia unit.[8]

5. The dementia unit had 12 resident rooms, two of which had two beds. Each resident room was accessed by a door off a central hallway.

6. The unit also had a communal space, used as a dining room and a sitting room, and a nurses station/quiet room that was adjacent to the communal space.[9]

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[1] Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0001 [5].

[2] Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0001 [5].

[3] Transcript, DF, 8 May 2019, T1435.9; Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0001 [5].

[4] Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0002 [8].

[5] Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0001 [6] and .0003 [16].

[6] Transcript, DF, 8 May 2019, T1435.10-35; Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0001 [6].

[7] Exhibit 3-33, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at .0009 [52].

[8] Exhibit 3-29, Oberon Village tender bundle, tab 84, CAC.0005.0001.0001.

[9] Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0003 [20]. See also Transcript, DF, 8 May 2019, T1443.40-1444.7.

7. There were no windows between the nurses station/quiet room and the communal space.[10] The door between the nurses station/quiet room and the communal space was left open at times. Even with the door open, there was no line of sight between the nurses station/room down the corridors of the central hallway.[11] CCTV cameras monitored some common areas but not residents' rooms.[12]

8. In June 2018, one assistant in nursing and one enrolled nurse were rostered to work in the dementia unit.[13] A registered nurse would also attend the dementia unit from time-to-time.[14]

9. Oberon Village's policies promoted minimal use of physical and chemical restraints, and their use only as a last resort.[15] Under the procedures for the unit, residents were checked by care staff every 30 minutes, and observation might occur more frequently due to ordinary staff movement.[16]

10. On 27 March 2018, before Mrs CA was admitted to Oberon Village, a delegate of the Secretary of the Department of Health had issued a notice of non-compliance to Columbia Nursing Homes.[17] The notice referred to non-compliance by Oberon Village with various expected outcomes in the Accreditation Standards, including the expected outcome for behavioural management.

11. On 16 May 2018, around the time of Mrs CA's admission to Oberon Village, the Australian Aged Care Quality Agency (AACQA) had found that, with one exception relating to information systems, all non-compliance had been resolved.[18]

Residents in the dementia unit

12. When Mrs CA lived at Oberon Village, 12 of the 27 residents (including Mrs CA) resided in the dementia unit.[19] In the dementia unit, Mrs CA lived in room 2, at one end of the central

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10 Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0005 [30].

11 Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0005 [30]; Transcript, DF, 8 May 2019, T1444.27-1445.2. See also Exhibit 3-29, Oberon Village tender bundle, tab 84, CAC.0005.0001.0001.

12 Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0015 [104]; Exhibit 3-33, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at .0007 [43], .0011 [65]-[66] and .0013 [73]. See also Transcript, 8 May 2019, T1433.16-21.

13 Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0002 [15] and .0007 [44].

14 Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0007 [44].

15 Exhibit 3-33, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at .0012 [70]-[71], .0014-.0015 [81]-[86].

16 Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0006 [34] and .0008 [54]. See also Transcript, Marian Anderson, 8 May 2019, T1456.38-1457.10.

17 Exhibit 3-29, Oberon Village tender bundle, tab 21, CTH.1006.1000.0302.

18 Exhibit 3-29, Oberon Village tender bundle, tab 22, CTH.1006.1000.0121.

19 Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0007 [44].

hallway.[20] She regularly wandered about the unit and entered other residents' rooms and picked up their belongings.[21]

13. The room adjacent to Mrs CA's room, room 4, was occupied by a female resident, Mrs CC.[22] Mrs CC was involved in an incident with Mrs CA on 22 June 2018. That incident is described further below.

14. In the 11 months before that incident, Mrs CC was recorded in Oberon Village's "assaults" register as having been suspected of assaulting, or alleged to have assaulted, other residents on five occasions.[23] The "assaults" were recorded on 28 July 2017, 23 January 2018, 15 February 2018, 11 May 2018 and 17 May 2018. Ms Marian Anderson, the General Manager of Operations at Columbia Nursing Homes gave evidence that after each of these incidents, there was, follow-up by staff at Oberon Village on measures relating to Mrs CC's conduct.[24] However, any such follow-up did not prevent further incidents occurring.[25]

15. During an AACQA site visit on 13 February 2018, it was recorded that Oberon Village had referred Mrs CC to the Dementia Behaviour Management Advisory Service (DBMAS) on 12 January 2018. It was also noted that the DBMAS recommendations had not been incorporated into Mrs CC's care plan and that staff working with Mrs CC did not have access to the DBMAS report.[26] During a further AACQA visit on 15 May 2018, it was recorded that Mrs CC's challenging behaviour had improved and that a behaviour assessment was completed on 9 April 2018.[27]

16. The room across the hallway from Mrs CA's room, room 1, was occupied by a male resident, Mr CB.[28] During the day, he generally spent his time outside his room and the door to his room was usually locked. Mr CB was involved in an incident with Mrs CA on 27 June 2018. That incident is described further below.

17. In the 15 months before that incident, Mr CB was recorded in Oberon Village's "assaults" register as having been suspected of assaulting, or alleged to have assaulted, other

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20 Transcript, DF, 8 May 2019, T1442.37-1443.15.

21 Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0003 [16]; Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0005 [30].

22 Transcript, DF, 8 May 2019, T1443.17-24.

23 Exhibit 3-29, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001 at .0005-.0007.

24 See Transcript, Marian Anderson, 8 May 2019, T1452.20-1453.18.

25 See Transcript, Marian Anderson, 8 May 2019, T1452.20-1453.18.

26 Exhibit 3-29, Oberon Village tender bundle, tab 14, CTH.1006.1000.0078 at .0090.

27 Exhibit 3-29, Oberon Village tender bundle, tab 30, CTH.1006.1000.0121 at.0138.

28 Transcript, DF, 8 May 2019, T1443.26-38.

residents on three occasions.[29] The "assaults" were recorded on 4 April 2017, 9 May 2017 and 8 November 2017 Ms Anderson gave evidence that there was follow-up by staff at Oberon Village after each of these incidents on measures relating to Mrs CB's conduct.[30] However, any such follow-up did not prevent further incidents occurring.[31]

18. Mrs CA herself was recorded in Oberon Village's assaults register as having been suspected of assaulting, or alleged to have assaulted, a staff member on 3 June 2018.[32]

Mrs CA

19. Two weeks after Mrs CA's admission to Oberon Village, staff finished the preparation of her extended care plan dated 31 May 2018.[33] Pages 12 to 14 of that document related to behavioural management of Mrs CA.[34] In particular, it stated that:

> [Mrs CA] *shadows staff members caring for her and/or other residents. When this happens staff are to reassure* [Mrs CA] *and provide her with diversionary activity such as dusting.* [Mrs CA] *is intrusive at times and will enter other residents rooms and handle and remove other residents belongings causing distress to others and at times exposing herself to risk for injuries takes things that do not belong to her. When this occurs staff are to monitor for comfort or other needs such as toileting, thirst, hunger, pain etc. and address same. Staff are to reorientate* [Mrs CA] *to her room and her belongings.*
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> *…*
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> *When* [Mrs CA] *displays intrusive wandering Staff are to redirect* [Mrs CA] *to familar* [sic.] *surroundings and reorientate her to her bedroom/dinning* [sic.] *room where necessary* [sic.]*. Staff to encourage the residents famiy* [sic.] *to personalise her bedroom to create a sense of belonging and familiarity. Staff are to provide* [Mrs CA] *with purposeful activities to provide physical and social stimulation and ensure boredom is not a trigger for behaviours. When* [Mrs CA] *displays pacing behaviour staff are to monitor for evidence of pain (i.e. rubbing, grimacing, guarding, flinching moaning or other vocalisations etc.) and report any concerns to the RN for further assessment and management. When* [Mrs CA] *displays sleep disturbances staff are*

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[29] Exhibit 3-29, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001 at .0004-.0007.

[30] See Transcript, Marian Anderson, 8 May 2019, T1450.5-1452.18.

[31] See Transcript, Marian Anderson, 8 May 2019, T1450.5-1452.18.

[32] Exhibit 3-29, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001 at .0006.

[33] Exhibit 3-29, Oberon Village tender bundle, tab 38, CAC.0001.0009.0003.

[34] Exhibit 3-29, Oberon Village tender bundle, tab 38, CAC.0001.0009.0003 at .0014-.0016.

to assist her with toileting, monitor for pain and provide her with a snack and warm drink.

20. There were three behaviour assessments prepared for Mrs CA when she was at Oberon Village.[35] Those behaviour assessments were dated 5 June 2018, 22 June 2018 and 25 June 2018. The second behaviour assessment occurred after the incident on 22 June 2018, but it does not refer to that incident and is substantially the same as the first behaviour assessment.[36] The third behaviour assessment includes some additional information and was prepared after staff at Oberon Village had consulted with the DBMAS and an in-house dementia advisor.[37] However, much of the additional information in the third behaviour assessment was copied from the pre-existing extended care plan for Mrs CA dated 31 May 2018.

The incident on 22 June 2018

21. At or around 3.00 pm on 22 June 2018, Mrs CA and Mrs CC were unsupervised by staff for a short time in the communal area. There was an altercation between the two of them and Mrs CC hit Mrs CA on the face. Mrs CA sustained a cut to her mouth.

22. The residents' families were contacted. After the incident, a behaviour monitoring regime commenced for Mrs CA – it was reiterated that Mrs CA had a tendency to enter other residents' rooms.[38]

The incident on 27 June 2018

23. At around 8.15 pm on 27 June 2018, there was a second incident in which Mrs CA sustained a head injury causing bleeding on the brain and fractures to her pelvis and clavicle. Staff at Oberon Village prepared records in respect of that incident.[39]

24. In the early evening, Mrs CA was put to bed for the night. She then wandered into the communal area.[40] Staff either directed, escorted or partially directed or partially escorted Mrs

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[35] Exhibit 3-29, Oberon Village tender bundle: tab 50, CAC.0001.0010.0613; tab 56, CAC.0001.0010.0590; tab 60, CAC.0001.0010.0592.

[36] See Transcript, Marian Anderson, 8 May 2019, T1457.37-1458.26.

[37] Transcript, Marian Anderson, 8 May 2019, T1458.28-1459.24.

[38] Exhibit 3-29, Oberon Village tender bundle, tab 56, CAC.0001.0010.0590.

[39] Exhibit 3-29, Oberon Village tender bundle: tab 61, CAC.0001.0008.0003; tab 62, CAC.0001.0002.0088; tab 63, CAC.0002.0007.0378.

[40] Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0003 [15].

CA from the communal area to her room, and then left her unsupervised.[41] At this time, there were two staff on duty in the dementia unit.[42]

25. Mrs CA subsequently entered Mr CB's room, room 1, while he was present in the room. There was no supervision of them by staff at this time.[43]

26. Inside Mr CB's room, Mrs CA's head and body made forceful contact with the floor, but it is not clear whether this was the result of a push or blow by Mr CB (as Mrs CA alleged) or a fall (as Mr CB alleged).[44] No staff observed the events in Mr CB's room.

27. Mr CB was then observed by staff to drag Mrs CA out of his room by her arms into the hallway.[45]

28. At around 8.25 pm, staff contacted the families of Mrs CA and Mr CB about the incident and reported the matter to the police. Although the police attended the facility at around 9.30 pm, the matter was not pursued.[46]

29. On the night of the incident, Mrs CA was taken by ambulance to hospital with a five centimetre laceration to her head.[47] On 29 June 2018, Mrs CA was transferred to a larger hospital where investigations showed a brain bleed and haematoma as well as a fractured left clavicle and a fractured pelvic rami.[48]

30. Mrs CA was kept in the medical ward of the hospital for three and a half weeks before being transferred to the rehabilitation ward briefly and then moving to a new aged care facility.[49] In the rehabilitation ward, little or no physiotherapy was provided to Mrs CA, and the reason given for this was her inability to communicate.[50]

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41 Exhibit 3-29, Oberon Village tender bundle, tab 63, CAC.0002.0007.0378; Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0008 [58]. See also Transcript, 8 May 2019, T1426.15-19.

42 Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0007 [47].

43 Transcript, Marian Anderson, 8 May 2019, T1459.26-30.

44 Exhibit 3-29, Oberon Village tender bundle, tab 62, CAC.0001.0002.0088 and tab 65, CAC.0001.0008.0002.

45 Exhibit 3-29, Oberon Village tender bundle, tab 62, CAC.0001.0002.0088 and tab 63, CAC.0002.0007.0378. See also Exhibit 3-33, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at .0007 [43].

46 Exhibit 3-33, Statement of Marian Anderson, 24 April 2019, WIT.0135.0001.0001 at .0007 [47].

47 Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019, WIT.0134.0001.0001 at .0014 [96(a)]; Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0003 [20]-[22].

48 Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0003 [22]; Transcript, DF, 8 May 2019, T1439.8-19.

49 Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0004 [26] and [28].

50 Exhibit 3-32, Statement of DF, 29 April 2019, WIT.0102.0001.0001 at .0004 [27]-[28]; Transcript, DF, 8 May 2019, T1441.12-41.

31. Mrs CA is now chairbound or bedbound, and she does not talk at all.[51]

Other matters

32. There were 82 assaults recorded in Oberon Village's assault register between 10 July 2015 and 6 February 2019.[52] Only 10 of those incidents were reported to the Commonwealth Department of Health. The remaining incidents were not reported because they involved one or more residents with "cognitive impairment".

33. The assaults by Mrs CC and Mr CB on other residents recorded in Oberon Village's "assaults" register before June 2018 were, for the purposes of s 63.1AA of the *Aged Care Act 1997* (Cth), alleged or suspected "reportable assaults".

34. There is no suggestion that those alleged or reportable assaults were reported by staff at Oberon Village to police and the Department of Health under s 63.1AA(2) of the *Aged Care Act 1997* (Cth).

35. Nor can there be any suggestion that staff of Oberon Village were required to report those incidents under s 63.1AA(2). That is because, pursuant to s 63.1AA(3), the reporting obligation in s 63.1AA(2) does not apply "in the circumstances … specified in the Accountability Principles", in which circumstances the approved provider is "responsible for complying with the requirements that those Principles make of the provider in relation to any of those circumstances or the alleged or suspected reportable assault".

36. Subsection 53(1) of the *Accountability Principles 2014* (Cth) specifies the circumstances for the purposes of s 63.1AA(3) of the Aged Care Act and states that:

> *Subsection 63-1AA(2) of the Act does not apply to an approved provider in relation to an allegation or suspicion of a reportable assault if:*
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> *(a) within 24 hours after the receipt of the allegation, or the start of the suspicion, the approved provider forms an opinion that the assault was committed by a care recipient to whom the approved provider provides residential care; and*
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> *(b) before the receipt of the allegation or the start of the suspicion, the care recipient had been assessed by an appropriate health professional as suffering from a cognitive or mental impairment; and*

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[51] Transcript, DF, 8 May 2019, T1434.1-5 and T1442.20-30.

[52] Exhibit 3-29, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001.

(c) *within 24 hours after the receipt of the allegation or the start of the suspicion, the approved provider puts in place arrangements for management of the care recipient's behaviour; and*

(d) *the approved provider has:*

(i) *a copy of the assessment or other documents showing the care recipient's cognitive or mental impairment; and*

(ii) *a record of the arrangements put in place under paragraph (c).*

37. It appears from the entries in the right hand column of the register of reportable assaults that alleged or suspected reportable assaults by Mrs CC and Mr CB were not reported to police and the Department of Health on the basis that the requirements of s 53(1) of the Accountability Principles were met.

38. No evidence was obtained by the Royal Commission about what had been done by Columbia Nursing Homes to meet the requirements of s 53(1) of the Accountability Principles in respect of entries in the register relating to alleged or suspected assaults by Mrs CC or Mr CB. Whatever was done to meet those requirements, it did not prevent the incidents involving Mrs CA on 22 and 27 June 2018.

39. Residents with a history of aggressive behaviours, such as Mrs CC and Mr CB, should, where possible, be placed in rooms that are in the line of sight of a staff outpost. Residents with a history of intrusive behaviour, such as Mrs CA, should not be placed in rooms nearby rooms occupied by residents who have a history of suspected or alleged aggressive behaviour, especially in a location where the entries to such rooms are not in clear line of sight of staff.

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31 May 2019