Columbia Aged Care Response to Oberon Village Case Study Submissions of Counsel Assisting dated 31 May 2019

1 Columbia Aged Care (**Columbia**) makes this submission in response to the submissions of Counsel Assisting on the Oberon Village Case Study (**Submissions**).

2 Columbia has provided substantial information and evidence to assist the Commission. This includes the documents provided pursuant to Notice to Produce 0077 on 1 April 2019, Columbia's response to Notice to Give 0095 on 1 April 2019, the witness statement of Cheryl Anne O'Connell registered nurse of Oberon Village dated 24 April 2019, the witness statement of Marian Anderson General Operations Manager of Columbia dated 24 April 2019 and Ms Anderson's appearance at the Sydney hearings on 8 May 2019.

3 Columbia is grateful for this further opportunity to assist the Commission in improving the quality and safety of the Australian aged care system.

The Oberon Village Case Study

4 The Commission's media release dated 6 May 2019 announced that the hearings commencing 6 May 2019 involved inquiring into the quality and safety of residential aged care, with a focus on care for people living with dementia.

5 The media release went on to say:

"*In the first four days of the hearing (commencing on the afternoon of 6 May and covering 7, 8 and 13 May), the Commission will inquire into allegations of poor care and mistreatment by certain providers, and will hear evidence from those providers. These case studies are expected to shed light on particular issues relevant to the quality and safety of care provided to residents living with dementia.…*

The Commission is aware of significant public and professional concern about the use of physical restraints and over-use of psychotropic drugs (in particular anti-psychotics and benzodiazepines) in residential aged care to manage behaviour of people living with dementia. Clinical evidence about these practices will be a focus of the hearing. The evidence is expected to be overwhelmingly against them….

The hearing will also involve a consideration of the exposure of residents with dementia to substandard clinical and personal care."

6 The Oberon Village Case Study has provided a useful counterpoint to the case studies involving the use of restraints. As Counsel Assisting noted in paragraph 9 of their Submissions, Columbia's policies promote minimal use of physical and chemical restraints, and they are used only as a last resort. In that regard, Columbia's practices are consistent with the overwhelming evidence to which the media release referred.

7 The Commission was interested in two particular incidents which involved Mrs CA, a female resident diagnosed with dementia who was in Columbia's care at its Oberon facility from 16 May 2018 to 27 June 2018. Upon admission, Mrs CA's dementia was causing various behaviours which needed to be managed as part of her ongoing care. The behaviours and associated triggers were not unusual for a person living with dementia, but did require special care and attention to manage which is why Mrs CA was located in Columbia's specialist dementia unit. This response seeks to address key facts and recommendations raised by Counsel Assisting in the Oberon Village Case Study, which Columbia believes illustrates the deep complexity associated with caring for persons with dementia in residential aged care and the nuanced solutions this complexity demands.

8 As Counsel Assisting fairly acknowledged in opening remarks in connection with the Oberon Village Case Study:

> *"In particular, it raises a host of difficult issues concerning how the facility is to deal in a way that balances freedom of movement of people who may have challenging behaviours and may even have risky behaviours. On the one hand, compared with the undesirability of allowing them to be in peril and sustain injury, these are crucial issues and it may be that there are no easy answers on any of these issues, the balance of the dignity of risk*

with safety from potential interactions that may be aggressive interactions with other residents is a real dilemma and a conundrum in the management of aged care residential services":[1]

9 Counsel Assisting went on to outline the "*tension between the imperative of dignity of risk and freedom of movement on the one hand, and direct impacts on the physical safety of residents on the other*" and the difficulties for management in dealing with those issues.[2]

10 Consequently, it appears that Counsel Assisting has approached the Oberon Village Case Study as one that highlights the challenges involved and the difficult management issues that are faced in circumstances where preference is given to the dignity of the resident with the risk that there may be physical interaction with other residents. Those risks are, however, preferable to the loss of dignity and quality of life involved in physically or chemically restraining a resident who may from time to time exhibit dementia behaviours such as wandering.

11 Counsel Assisting did not seek, either in cross-examination or the Submissions, to advance a case that there was substandard care at Oberon Village. Instead Counsel Assisting's Submissions focus on the possibility of recommendations for dealing with the challenges identified.

12 Columbia approaches these submissions in a similarly constructive way, the focus being on the particular recommendations made by Counsel Assisting, particularly those at paragraph 39 of the Submissions. Those recommendations are that residents with a history of:

(a) aggressive behaviour should, where possible be placed in rooms that are in line of sight of a staff outpost; and

(b) intrusive behaviour should not be placed in rooms near those 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.

13 Whilst each of those recommendations have been put forward, they have not been the subject of any thorough investigation in the case study and Columbia wishes to draw attention to some issues which they raise.

14 Before doing so it is necessary to note two features of the Submissions; first, the issue of supervision and secondly, the associated implication that interactions of the type experienced are necessarily capable of being avoided or minimised by the recommendations made.

The Issue of Supervision

15 Once a decision is made to prefer resident dignity to physical or chemical restraints, the possibility of adverse interactions between residents living with dementia is a risk.

16 Ideally if it were possible to provide one-on-one line of sight care, it may be that adverse interactions between residents (involving wandering, intrusiveness or aggression) might be able to be minimised, but not removed.

17 On a number of occasions in the Submissions Counsel Assisting refers to Mrs CA being *"unsupervised"*: see, eg at paragraphs 21 and 25 of the Submissions. If this is intended to mean that at those particular instances Mrs CA was not in the line of sight of a staff member at the particular relevant time that may be readily accepted. With the current funding framework it is difficult to have all residents in line of sight at all times. In that context, Columbia believes that the supervision provided at Oberon Village through the nursing and other staff and CCTV monitoring was appropriate and in compliance with aged care legislation.

18 As Ms Anderson said of the supervision regimen, that does not just involve a check every 30 minutes or so on residents. The nurses on duty are continually walking around and observing

[1] See Transcript, Mr P. Gray, 8 May 2019 T1428.19-26.
[2] See Transcript, Mr. P. Gray, 8 May 2019 T1429.6-15.

because they are looking for triggers, for changes in behaviour and they would be monitoring those residents frequently.[3]

19 As Ms Anderson said in relation to a question of whether there was a need for greater supervision of Mrs CA: "*It is regrettable that this has occurred. We – I believe the supervision was adequate with two nurses in the unit at all times. I think it's the unpredictability of people living with dementia when their triggers for behaviours occur spontaneously, as I had said, and without notice*".[4]

20 The evidence is that episodes of aggression are frequently spontaneous, unexpected and random,[5] and as Ms Anderson has aptly described it, *"wandering is a part of living with dementia"*:[6]

21 The second recurring theme in the Submissions is that whatever follow-up occurred in relation to alleged or suspected assaults by Mrs CC or Mr CB did not prevent any further instances occurring (see paragraphs 14 and 38 of the Submissions).

22 These observations, whilst no doubt factually correct should not be regarded in a pejorative way. Once a decision is made not to chemically or physically restrain residents, there is a risk that there will be interactions between residents from time to time.

23 For example, there is no evidence, nor is it logical to believe, that even if the recommendations made by Counsel Assisting in this case were followed, that that would operate so as to prevent any further instances occurring. There is a danger in oversimplifying the solutions to the challenges associated with the complex set of behaviours that accompany dementia.

Response to factual matters

24 In response to paragraph 7 of the Submissions, it is not correct there is no window between the nurse's station and the communal space as there is a glass window pane in the door of the nurse's station. This door is nearly always left open and as such there is always a line of sight between the nurse's station and the common area.[7] In addition, nurses are rarely in the station whilst on duty.[8]

25 In further response to paragraph 7 of the Submissions, CCTV covered *all* common areas of the dementia unit and were live streamed to monitors in the nurse's station.[9] The design and placement of the nurse's station, common areas and rooms was purposeful to encourage residents' independence without exacerbating triggers or behaviours. To create such a conducive environment, Columbia engaged integratedDESIGNgroup, architects on HammondCare's panel of experts who are experienced in designing care facilities for persons living with dementia.[10]

26 With respect to paragraph 8 of the submissions, two assistants in nursing were dedicated solely to the dementia unit as well as other staff in the unit at various times. In addition there was a dementia adviser stationed in the unit three days per week as well as the care manager and the facility manager who had supervisory responsibility.[11]

27 Columbia wishes to clarify that Oberon Village is a 70 bed facility. The 27 residents referred to in paragraph 12 of the Submissions are those 27 residents who had a diagnosis of dementia on 27 June 2018. There were more than 27 residents in total in Oberon Village at 27 June 2018.

28 In response to paragraph 20 of the Submission, it is not correct to say that the additional information in the third behaviour assessment was copied from the pre-existing extended care plan for Mrs CA of 31 May 2018. The extended care plan is dated at the time it is first prepared. However, the care plan is constantly updated. When a behaviour assessment is conducted, the

[3] See Transcript, Marian Anderson, 8 May 2019 T1456.36-46.
[4] See Transcript, Marian Anderson, 8 May 2019 T1459.42-46.
[5] See Transcript, Marian Anderson, 8 May 2019 T1450.34-35; T1452.18 and T1453.25.
[6] See Transcript, Marian Anderson, 8 May 2019 T1456.5.
[7] Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019 WIT.0134.0001.0001 at 0.0015 [107].
[8] Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019 WIT.0134.0001.0001 at 0.0015 to 0.0016 [107] to [109].
[9] Exhibit 3-33, Statement of Marian Anderson, 24 April 2019 WIT.0135.0001.0001 at 0.0011 at [65] and 0.0013 [73].
[10] Exhibit 3-33, Statement of Marian Anderson, 24 April 2019 WIT.0135.0001.0001 at 0.0012 [72].
[11] Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019 WIT.0134.0001.0001 at 0.0002 [15]. As well as Transcript, Marian Anderson, 8 May 2019, T1466.6- T1466.10.

software Columbia uses automatically updates to the extended care-plan, so that all information is caught in the one document. As a result, the information that is said to be "copied" from the extended care plan into the third behaviour assessment rather originates from the third behaviour assessment itself.[12]

29 In response to paragraph 22, the reference to Mrs CA's tendency to enter other residents' rooms is irrelevant to the 22 June 2018 incident as it occurred in a common area.

30 In respect of the injuries suffered by Mrs CA referred to at paragraph 23 and 29 of the Submissions, Oberon Village is unable to make any submission in respect of those injuries as there has been no admissible evidence put forward in respect of those injuries. There has been no medical or hospital records tendered or otherwise made available to Oberon Village.

Oberon Village Assault Register

31 The Submissions refer on a number of occasions to Oberon Village's assault register[13] (see paragraph 14, 17 and 32 of the Submissions).

32 The register of assaults maintained by Oberon Village captures all incidents or suspected incidents involving residents and staff. It records all instances of resident on staff assault.[14] For example, it includes instances where cordial was thrown on to a staff member by a resident, as well as more serious incidents.

33 There is no obligation on Oberon Village to maintain such a comprehensive register of assaults. Paragraph 3435 of this response explains why Columbia chooses to maintain a register over and above the strict requirements of the aged care legislation. The information in the register is also consistently reviewed as a part of the regular review and audit process undertaken by the Aged Care Quality and Safety Commission.

Reporting Framework

34 In relation to paragraphs 32 to 38 of the Submissions Columbia agrees with Counsel Assisting's summation of the existing reporting framework.

35 Responding to paragraph 37 in particular, Counsel Assisting is correct. In Columbia's view, the requirements of section 51 of the *Accountability Principles 2014* were met. Columbia believes in the importance of retaining a record of this information and the importance of investigating each allegation so that staff can better understand the underlying cause and the best clinical response. As a result, even in the absence of any legal obligation to do so, Columbia records and documents all incidents in its assaults register and Critical Incident / Injury Reports, respectively.

36 Responding to paragraph 38 in particular, Columbia is thankful for the opportunity to co-operate with Counsel Assisting in delivering its response to notices, providing the witness statements and in its appearance before the Commission, throughout which Columbia believes it has provided detailed documentation which met Counsel Assisting's requirements.

Response to recommendations

37 With respect to paragraph 39, Columbia agrees room placement can impact the interactions between residents, however it would like to bring the Commission's attention to key matters which inhibit Columbia's ability to meet Counsel Assisting's recommendations.

Complexity of behaviours

38 Columbia believes both Mrs CA's behavioural and psychological symptoms of dementia and Mr CB's "history of aggression" is a strong example of the oversimplification of Counsel Assisting's recommendation which recommend residents with a "history of aggression" be kept within line of sight and away from those with a "history of intrusive behaviour".

[12]See Transcript, Marian Anderson, 8 May 2019 T1459.17-T1459.24.
[13] Exhibit 3-29, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001.
[14] See Transcript, Marian Anderson, 8 May 2019 T1454.45-T1455.10.

39 Mrs CA's dementia symptoms meant that she was a person who exhibited **both** aggressive and intrusive behaviour at different times.[15] As the Commission has heard, these are characteristics that are not uncommon in people living with dementia. It is important to understand that dementia does not manifest in discrete behaviours such that a person is either "aggressive" or "intrusive". Its inherent complexity means dementia cannot be managed by keeping those with aggressive behaviours away from those with intrusive behaviours.

40 With regards to Mr CB's "history of aggression", prior to the 27 June 2018 incident, the register documents an incident on 8 November 2017, as well as April and May of 2017. Between the 27 June 2018 incident to 24 April 2019, Mr CB appeared on the register once more in December 2018. Mr CB had therefore appeared on the register only once in the 12 months prior to the incident of concern in the case study. This shows the incidents are unpredictable, at times at least 6 months apart and without any discernible pattern. Residents who appear on the register are not diagnosed with aggression, but dementia with certain triggers which manifest in different ways at different times.

Security of Tenure

41 Section 10 of the *User Rights Principles 2014*, which together with the *Accountability Principles 2014* form a part of the relevant aged care legislation, prohibits providers from moving a care recipient to another room or part of a room unless the move is:

(a) at the resident's request;

(b) with the resident's consent after being fully consulted without being subject to any pressure;

(c) necessary on genuine medical grounds as assessed by various professionals; or

(d) required as the place occupied by the resident has become an extra service place and the resident elects not to pay the extra service fee; or

(e) necessary to carry out improvements and repairs, and if so only temporarily.

42 Accordingly, moving a resident to prevent resident aggression is likely to be in breach of current aged care legislation. In particular, Columbia notes that:

(a) encouraging a resident to move on the grounds that failure to do so may result in that resident being harmed or harming others is likely to constitute a form of pressure in contravention of section 10(1)(b) of the *User Rights Principles 2014*;

(b) requiring a resident to move on the grounds that failure to do so may result in them being harmed could lead the provider to infringe residents' rights to dignity of risk which are protected under the *User Rights Principles 2014*; and

(c) moving a resident to another room may not be effective or sufficiently effective to justify the move for the reasons set out below in paragraphs 43 to 47.

Practical difficulty

43 Security of tenure obligations aside, there are various factors which make it difficult, if not at times impossible, to relocate residents:

(a) **Entry on the register** - due to the inherent unpredictability of dementia which can manifest in aggressive behaviour and Columbia's policy of recording all incidents regardless of whether they are substantiated or if they constitute a reportable assault, many residents within the dementia unit may appear in the register.[16] Accordingly there could be a significant number of people who would be required to be placed within line of sight and away from residents displaying intrusive behaviours.

[15] Exhibit 3-29, Oberon Village tender bundle, tab 82, CAC.0001.0007.0001.
[16] See Transcript, Marian Anderson, 8 May 2019 T1454.45 - T1455.2.

(b) **Meaning of "history of aggressive behaviour"** – it can be difficult to define what constitutes a history of aggressive behaviour, as incidents on the register do not mean that the allegations were substantiated, it does not take into consideration the significance of the incident nor does it acknowledge the circumstances of the incident which may be unlikely to eventuate in future or resolved effectively after the incident.

(c) **Limitations of the physical environment** – there is limited space and opportunity to move and relocate residents. The dementia unit is a 12 bedroom facility consisting of 10 single rooms and 2 double rooms. At the time of the incidents no two residents shared a room.

Limited effectiveness

44 Due to the inherent unpredictability of dementia which can manifest in aggressive behaviour, Columbia does not believe placing residents with a "history of aggressive behaviour" within line of sight and away from those with intrusive behaviour would necessarily prevent harm coming to any residents (see also paragraphs 38 and 40 of this response).

45 As detailed in paragraph 24 and 25 of this response, Ms O'Connell's witness statement[17] and Ms Anderson's witness statement,[18] care staff spend their time on the floor and outside the nurse's station. Therefore in the environment encouraged in the dementia unit where staff are not in the nurse's station but closely interacting with residents and the residents are supported to be ambulant with a restraints as a last resort policy, the rationale of keeping residents within line of sight of the station does not appear to have evidentiary support.

46 For example, although the residents in room 11 and room 5 were separated by three rooms and the entry lobby, allegations of physical assault was made by the room 5 resident against the room 11 resident in February and May of 2018. Furthermore, the resident who came to occupy room 8, was alleged to have assaulted the residents in room 5 (Mrs CC) and room 3.

Lack of familiarity with rooms / disorientating

47 We believe relocating residents from time to time and primarily on the basis of keeping them within line of sight or away from residents with intrusive behaviours may be disruptive and negatively impact the care they receive. It could also lead to incidents between a person who was recently moved and the person who occupies their former room. Addressing the issues in the way Counsel Assisting suggests could aggravate matters and is not always possible depending on the behaviour profile of other residents.[19]

48 Paragraph 39 of the Submissions contains a recommendation that *"[r]esidents with a history of aggressive behaviours … 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 … should not be placed in rooms nearby rooms occupied by residents who have a history of suspected or alleged aggressive behaviour.*" Columbia submits that there is no evidence to support such a recommendation, and the submissions made in the preceding paragraphs support that there is no basis for these recommendations.

49 Mrs CA had many complex needs which Columbia sought to care for to the best of its ability. As a result, Columbia believes the issues raised in the Oberon Village Case Study highlight very important matters the Commission needs to consider as they are relevant to the broader discussion on the quality and safety of services received by people living with dementia. Columbia is pleased to see that as the focus of the Sydney hearings, and Counsel Assisting's consequent submissions on this issue, and welcomes the sector wide focus this brings to dementia care.

[17] Exhibit 3-30, Statement of Cheryl Anne O'Connell, 24 April 2019 WIT.0134.0001.0001 at 0.0015 [108].
[18] Exhibit 3-33, Statement of Marian Anderson, 24 April 2019 WIT.0135.0001.0001 at 0.0013 [73].
[19] See Transcript, Professor Macfarlane, 15 May 2019 T1758.45-1759.3.