Royal Commission
into Aged Care Quality and Safety

Statement of A/Prof Peter Gonski

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Address: [redacted]

Date: 27th May 2019

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

2. The views I express in this statement are my own based on my education, training and experience. They are not intended to represent any views of my employer .

Professional background

3. I am currently employed as a Senior Staff Specialist Geriatrician at South Eastern Sydney Local Health District(SESLHD),NSW. I have been in this role since 1991. I am a geriatrician and general physician and hold MBBS BMed Sci FRACP.I am clinical stream director,Aged Care and Rehabilitation SESLHD.I am a Conjoint Associate Professor,Faculty of Medicine,UNSW,Sydney.I have experience in acute ,subacute and chronic care of the elderly.I see patients in acute hospitals,rehabilitation services,at home and in aged care facilities.I work within a very integrated model of care with good communication and working relationships with local general practitioners,allied health and staff of aged care facilities.Our service works closely with other non-governemnt organisations.

   Prior to working at SESLHD I worked for South Eastern Sydney and Illawarra Area health Service in the same roles.

Care

4. The care of aged care people residing in the community and aged care facilities varies from district to district.In our district we have formulated a model ,trying to assist the elderly in their journey of care wherever they are:home in the community,home in their aged care facility or in hospital(public or private).There need to be good working relationships between all these systems.The model is a multi-disciplinary team which provides expertise in many areas of aged care wherever the person is.

   With regard to aged care clients living in the community it is important to provide comprehensive assessment and services and healthcare.We have good relationships

with our ACATs.The Commonwealth's My Aged Care innovation has slowed assessments but our ACATs are within benchmark.The greatest challenge is that clients are assessed for services ,but the services are not available or too expensive.Many are assessed at level 3 and 4 packages but then have to wait 6-12 months to get these services.This can mean that deterioration occurs and then hospitalisation and/or more premature admission to an aged care facility is required.

From an assessment point of view this needs to be medical,functional,cognitive and social and multy-disciplinary.It needs to be in a timely manner.The person's home is the ideal place for assessment and should be preferred.Many medical aged care departments offer outpatient clinics as well.This is appropriate particularly for patients who are not functionally impaired.

Residents of aged care facilities are cared for by nursing and allied health staff of the facilities with medical back-up from GPs.

Our services provide significant support to aged care facilities.Please see attached synopsis under section 21 below.

The level of care is very dependent on nursing leadership and education of junior staff.The level of acuity of residents and the challenges associated with behavioural disturbance of dementia are the two major areas where education of staff are so important.

Behavioural disturbances need to be managed in the optimal environment,by experienced staff.This certainly varies amongst aged care facilities.

5. There are many people responsible for care in aged care facilities;primarily nursing staff,allied health and GPs.There are many team supports eg palliative care teams,,DBMAS,ACAT,Aged care departments associated with Local Health districts.

Volunteers are an important group who provide a lot of help and support.

Information is shared via telephone,fax,email.Unfortunately each group has different IT databases which do not communicate.

We share information effectively but there can be problems when the older person moves from one location to another eg aged care facility to hospital.We have worked hard on these communication relationships and put in methods to improve them.

6.The barriers depend on the databases used and the accuracy of records.

Aged care resident needs have markedly increased over the last 10-15 years.The acuity has increased as hospitals are discharging patients earlier.The level of care requirements has increased as those people with lesser needs are more likely to stay at home.The number of chronic diseases for many residents has increased as the age of residents entering aged care facilities has increased every year.

The level of difficult behaviour is more common as more dementia sufferers with lesser behaviours are being managed at home.The prevalence of dementia increases as our lifespan increases in duration.

The aged care facility should be the residents home.It needs to be managed as a home.The residents individual needs need to be managed at a personal basis.Although a "home" environment is the way to provide best care to residents, there needs to be an understanding that medical deterioration can occur acutely and is common and medical needs also require addressing in the facility .Again there is variable achievement in this aspect of care.

Veterans

8 They deserve care to keep them at home.The major aspect that is currently lacking is overnight care or 24 care at home for the veterans with significant functional ,cognitive or both impairment.I do not believe that Veterans require different care to non-veterans in aged care facilities.

Rural

9 The major problem in rural settings is availability of aged care workers and in the community, distance to services.The latter severely affects availability of assessment and services.In aged care facilities ,having sufficient experienced staff including registered nurses is a real challenge.

Teleconferencing can provide a means to assessment issues.We have provided aged care consultations to Norfolk Island very successfully via teleconferencing.

The benefit of local care is that older people are cared for by staff who understand the community.Travel is not such a great problem if workers are local.

There is little doubt that if staffing is lacking ,there will be worse outcomes in the community and aged care facilities.

Furthermore people are more likely to be sent to local hospitals rather than being more appropriately looked after at homes or aged care facilities.

Hospital avoidance is so important for older patients to avoid the complications of hospitalisation,especially delirium,falls,infections,medication errors.

Often rural inhabitants have to go to hospital for assessment,which would be better done in their own homes.

ATSI

13. Aboriginal and Torres Straight Islanders often have problems related to older people at younger ages than other communities.

They also often do not accept support and care that is provided to other communities.

It is essential to have Aboriginal and Torres Straight Islander workers working side by side medical,nursing and allied health workers .Training staff from these communities would be the ideal outcome on workforce issues.

They are more reluctant to accept usual medical care and also very reluctant to go into aged care facilities.These principles need to be understood and taken into account when assessments and management plans are constructed.

Quality of life

14. The most important aspects of quality care is to provide individual/personal care to residents.Staff need to understand their interests,likes,dislikes and cultures.There needs to be flexibility in provision of care.The environment needs to be conducive to comfortable living.Sound and colour ambience,comfortable furnitiure,Individuals should have their own personal effects with them and in their room.There must be socialisation and activities which must be tailored to the interests of the residents.This requires diversional therapy expertise.Nutrition is very important which again is tailored to the desires and cultures of the residents.Exercise also must be provided to residents who are mobile even if functionally and cognitively impaired.

The most important aspects are to allow residents to feel they are living in their home.

Providing exercise,nutrition,socialisation/activities in a comfortable,safe environment allows improvement in quality of life.Activities and entertainment should be mixed,aimed at the clientelle and should be in-house as well as via outings.These care requirements will also promote wellbeing.

Medical care also needs to be available in a timely manner to address chronic problems and acute deterioration.This is essential for each resident and also reduces complications.Residents will need less care rather than more care if they are enjoying their later years more.There will be slowing of deterioration,less falls, less anxiety and depression,less pain,less use of medications and therefore less side effects from medications(anti-depressants,anti-psychotics,sedatives,analgesics)

15. It is up to the approved provider to ensure that all the above requirements are fulfilled and provided.It is part of the necessary care .

16. Most people prefer to live in their own home.The balance of care at home(family/carer and community) versus the needs of the individual results in people having to go into aged care facilities.They often lose some independence and individual needs and desires and this is why it is so important for aged care facilities to provide for individual needs.

17. Aged care facilities need to respect individual's privacy which is not always easy given the number of residents that need looking after and also the staff to resident ratio.

18. Facilities should provide areas where families and friends can go and be with the resident privately.

Unfortunately some facilities are run to allow for the staff to cope with the workload at the expense of supporting individual's personal needs.Clearly aged care organisations need to have excellent governance and policies and procedures but they also must provide some individual flexibility.

20. Family and friends are paramount to contributing to good outcomes.They need to be embraced in the facility,they can help with care and provide socialisation.They can be most important as decision makers if the resident is unable to make decisions independently.They must have a positive attitude to the facility,and that is why the facility needs to include them in planning and decision making.

21. Other information

The care of the Elderly requires the client to be at the centre.General practitioners must be integral to their care.Services must work in an integrated fashion to support older people at home in the community and in aged care facilities.

Support and services provided to all older people should include marketing the concept of "positive living" which includes keeping active physically and cognitively,socialising,eating well,avoiding cigarette and excess alcohol consumption,reviewing medications,vaccinations.These need to be provided in the community and in aged care facilities.

Health services need to provide comprehensive assessments,medication review,programmes reducing falls and osteoporosis assessment to reduce fractures,continence and wound education and management.Discussion and formulation of advance care directives and planning ,nominating enduring power of attorney and guardian allow for improved quality of life for older people as they age.

Older people most commonly live in the community but often require the care of aged care facilities and people greater than 70 years old have a 25% chance of using hospital services per year . It is for this reason that community services,GPs,aged care facilities,state financed services need to work closely together,communicate and share care.These relationships need to be established in all the places older people need care ie.community,aged care facilities,hospitals.We provide a fully integrated service to support older people wherever they are.

Models of care that encourage such relationships and partnerships should be supported financially.

Relationships between aged care facilities and NSW Health services in SouthEastern Sydney Local Health District

SESLHD has developed significant partnerships with Sydney aged care facilities.The relationships are throughout the District and target different resident groups depending on their requirements .We provide care of residents with chronic problems and very acute problems in a timely fashion and in close communication with general practitioners.We help manage all residents requirements and provide education and training to staff in the facilities.We have also provided written documentation to support them.

Where possible residents are seen and assessed and managed in the residential aged care facility which is their home.
If residents are transported to hospital there will be continuing attempts to return residents back to their home in the Aged care facilities with optimal communication to the facilty,to the general practitioner and with organised follow-up and support as required.

1.residents having chronic medical problems-geriatrician/registrar consultation.
most residents have multiple medical problems and will be under the medical care of a general practitioner.
Our hospital/community services provide geriatrician liaison/consultation services.However the GP may want specialist support in behavioural disturbance exhibited by dementia sufferers,wound care,pain management,fall review etc.This is through referral from the GP.We have set up consultation services either through direct referral from GP to a specific geriatrician or as in the St George district specific geriatricians are allocated to specific aged care facilities where they attend regularly.Both models work well.Data on number of visits are available.
Good relationships with GPs allows optimal service with communication being documented by letter and returned to GP and facility.
Other services through NSW Health support the facilities such as wound and continence care.

2.acutely deteriorating residents-Geriatric flying squads
Prior to the advent of our Geriatric squads ,residents who acutely deteriorated in aged care facilities were sent to acute emergency departments if GPs could not attend rapidly which is/was often the case.
Referral to emergency departments requires ambulance transport,a lengthy stay in the emergency department for assessment and often subsequent acute hospital inpatient admission for 4-5 days.This was very unsettling for the resident,often increasing adverse events such as delirium,falls,medication errors.often the resident is confused and is very unaware why they are transferred.The families need to be contacted and need to attend .
In our district we have 4 Geriatric flying squads allocated to assess these residents in aged care facilities before transporting them to the hospital.

Members of the team including specialised nurses and aged care specialists receive referral from the Aged care facility staff(where possible after liaison /communication with GP) when the resident has deteriorated.There are specific inclusion and exclusion criteria.Within 4 hours of referral the squad attend the Aged care facility to assess the resident.The squad carry equipment for diagnosis and treatment.The assessment is carried out and in consultation with aged care facility staff,family of the resident and GP ,a management plan is put into place.In 90 per cent of cases the resident will remain in the Aged care facility(their home)and receive appropriate care.The resident will be followed up by the flying squad in consultation with the GP until the acute deterioration has stabilised.25 per cent of residents will be placed on a palliative care pathway due to their previous chronic conditions as a result of which their conditions had been previously deteriorating and at a level where quality of life was deemed minimal.The flying squad will support the aged care facility staff with this palliative care pathway.If there is an outbreak of gastroenteritis in an Aged care facility,the flying squads will actively assist in rehydration and symptomatic support.This has seen a marked reduction of transfer to hospital.Staffing is financed via the District(NSW Health) and the Primary Health Network.The latter has been very supportive ,particularly boosting after hours so that the services can be provided for extended hours ,seven days per week.

3.*Residents of Aged care facilities who are transported to the hospital.*If seen by the Geriatric flying squad or the GP before transfer and admission to hospital is required there will be an attempt to find an inpatient bed so the resident does not have to go through emergency departments.This can be through liaison of the geriatrician on-call,bed manager ,aged care registrar.

*4.residents going straight from aged care facility to emergency department.*In an acute emergency ,residents may be transported directly to emergency where the flying squad inclusion criteria are not met eg head injury,suspected fractured hip or if the resident deteriorate outside flying squad hours.During assessment of an aged care resident by emergency department nursing ,allied health and medical staff there is communication with the Aged care facility staff through direct discussion via phone and through documentation that accompanies the resident.Medication conciliation is performed by viewing medication charts directly.Advanced care directives are viewed if they are sent by the facility.Family members and GPs are contacted.If residents are discharged home from Emergency ,a discharge summary will accompany the patient and a copy is sent to the general practitioner.Management plans,medication changes and follow-up are recorded.

5.residents that are admitted as an inpatient to the hospital are managed by the inpatient medical team.Liaison with nursing staff in the Aged care facility is made with regard to medical and nursing information,advanced care directives,medications,other treatments.On discharge all residents return with a discharge summary indicating management plan,medication change ,follow-up.This may suggest a referral to the Geriatric flying squad if the aged care facility needs ongoing help with managing the acute medical condition.It may also include referral to palliative care services.There is

liaison with the facilities about when the patient is expected to return back to the facility.

6.video and teleconferencing.

There was a trial of using Tele/video conferencing instead of direct attendance at the facility.As travel in our district is not excessive,Assessment generally is performed at the facility.Tele/video conferencing has been set-up as a service to Norfolk Island in our district.This may include seeing residents of the Aged care facility or community on the island.

7.phone call communication is available to all Aged care facility 24hours a day every day in each part of the District via emergency doctors,aged care registrars and geriatricians on-call .

8.Garrawarra Aged Care
This district provides geriatrician,clinical nurse consultant and aged care registrar services to this State owned aged care facility.The Southcare Flying Squad is also available.

9.combined aged care committees-meetings with local LHD staff and staff from individual aged care facilities.This is invaluable in communication,developing new initiatives and resolving general issues.NUMs of facilities meet with social workers,discharge planners,patient flow,flying squads etc.

10.regional medication advisory meetings-meetings between aged care facilities,local health district staff and PHN discussing medication use,policies and pathways around medications.

11.Research.Aged care facilities are excellent places to conduct research.There are very formal relationships set up eg.Montefiore Aged Care and UNSW.Furthermore there are other relationships where research has been established eg Macquarie University and Southcare and all the Aged care facilities in the Sutherland Shire are doing a research study on wound incidence and management.
The flying squad data and outcomes have been published.

12.Palliative care support and education-provided by nurse practitioner from Calvery palliative care.

13.Education.This is multi-factorial.Includes Geriatric flying squad education at aged care facilities,provision of education information,pathways etc and also specific topic meetings eg wound care

Conclusion:

The older person needs to be seen and helped as an individual, supported by integrated services with a direction of positive living.Older people should be encouraged to do what they can do and be supported in what they cannot do.Where possible people should be managed at home or close to home with the intent to maintain people in their own homes.If this is not possible the person may move to an aged care facility which should provide a homely environment with personalised care.

Signed: _____

Date: 30/5/19

Witness: _____

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