



Royal Commission
into Aged Care Quality and Safety

Statement of Jo-Ann Mayse Lovegrove

Name: Jo-Ann Mayse Lovegrove

Date of birth: [REDACTED]

Address: [REDACTED]

Date: 3 July 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 or any specific organisation.

Professional background



3. I am currently employed as a self-employed bookkeeper at Matters of the Mind and Soul in Darwin. I have been in this role since February 2016.
4. Prior to working at Matters of the Mind and Soul I worked for Building and Civil Construction Business from 2009 to 2015.

Background

5. My dad is 79 years of age.
6. I have acted as an attorney for my dad under an Enduring Power of Attorney since 31 August 2011.
7. My dad has been diagnosed with Alzheimer's and macular degeneration since approximately 2013 and requires full time care. My dad was on a level 4 package up until he was, as it is referred to, a respite in a permanent bed. I call it this, because I have to make an application for extension of dad's respite every 21 days because of proceedings before the Administrative Appeals Tribunal.
8. In 2016, due to my dad's Alzheimer's and macular degeneration becoming worse, I looked into permanent residency and full time care that he required. My dad then became respite in a permanent bed at a residential aged care facility in a regional location in the Northern Territory (**the Regional Facility**) on 24 February 2017.

Regional Facility

9. The Regional Facility was the best choice for my dad because of the following:
 - He was close to his immediate family, other than myself as I am based in Darwin,



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- He wanted his dog close by, and the facility allowed him to keep his dog with him,
- He was allowed to smoke.

Ultimately, the Regional Facility was set up for my dad's lifestyle and needs.

10. The Regional Facility is outdated and old with around 50-80 residents who require medium to high full time care and I have only seen hand rails in the bathroom.
11. As I lived 300kms away I was unable to visit my dad on a regular basis while he resided at the Regional Facility. Although I am aware that he would often be neglected while staff cared for other residents. Additionally I had requested from staff a weekly call to keep me updated on my dad's condition and time at the Regional Facility, however I never received a call. I therefore had to contact the Regional Facility for general updates and to see if he needed anything.
12. Even though my dad has Alzheimer's and macular degeneration, his room was not equipped with crash mats, motion sensors, bed rails, hand rails. I had continually asked the hostel if they had a plan in place to deal with my dad's condition as it progressively got worse. The Regional Facility's response was always "yes we are in touch with Dementia Support Australia regularly".
13. I also had to remind staff that my dad needed water frequently, as he doesn't always remember he needs it or asks for it. This should have been a regular task to give my dad water, but because the carers left him alone regularly, he wasn't getting it. We also tried giving him a water bottle but these were going missing.
14. My visits to the Regional Facility were limited to weekends due to the distance in travel. During my visits I would notice that his room and ensuite were not always clean. This had meant that there was constantly urine on the floor and around toilet area. There was also an incident where I found a roll of toilet paper soaked in some kind of fluid covered in mould behind his toilet.
15. There was less staff employed on weekends and even seemed as if no employees were there to clean. The 3 staff that were there on weekends (that I have seen) had to do everything for the residents such as giving medicine, smokes, washing, etc.
16. Dad would often share his meals with his dog by dropping food on the floor for him; this had encouraged flies in his room. There was also a water bubbler outside where dad spent most of his day, and we had to bring to the staff's attention, on more than one occasion, that it had mould growing in it.
17. While my dad was a respite resident of the Regional Facility, there were four occasions that I wish to raise;
 - 17.1. Dad slipped on, what was assumed to be, urine whilst getting out of bed;
 - 17.2. Dad collapsed and was rushed to hospital via ambulance, his blood pressure had fallen dramatically and his heart rate was extremely low. It was believed to have been caused by an internal bleed, however given his condition, it was decided that further investigation ran higher risk than benefits and so he was monitored via regular blood tests;



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- 17.3. Dad was constantly dehydrated and our family constantly had to remind staff to give dad water; and
- 17.4. Dad was involved in an altercation with another resident resulting in a wound on his back. We believe the altercation resulted from inappropriate words being said by my dad due to the era he grew up and thoughts that are not politically correct in this era pertaining to indigenous people. He therefore spoke badly to those that were indigenous of which resulted in an altercation. I had explained to staff of this when dad was admitted in the hope that the knowledge would prevent/minimise contact with indigenous residents.
18. I undoubtedly believe that the incidents mentioned could have been preventable had the staff members of the Regional Facility understood the severity of my dad's condition and taken appropriate care for him and subsequently other residents.
19. My dad had a fall while a resident at the Regional Facility in March 2018 and was rushed to the Regional Hospital. At this time I applied to have my dad transferred from the Regional Facility to the other facility near Darwin so that he can be closer to me.
20. My dad has had another fall on 16 September 2018 at the Regional Facility and broke his hip and was taken to the Royal Darwin Hospital ("RDH") on the same day. The staff members of the Regional Facility and I are unsure on what caused this fall. The staff at the Regional Facility had contacted me at approximately 1:30pm on the 16th of September 2018 to inform me that dad had a fall at around 9:30am that day and had been taken to the Regional Hospital. My dad was airlifted via 'care flight' from the Regional Hospital to the RDH at around 11:40pm.
21. On or about 13 December 2018 I was advised by the discharge planner at RDH that negotiations had taken place and my dad was to be moved to a residential aged care facility in the Darwin area (**the Darwin Facility**) on 14 December 2018.



The Darwin Facility

22. The Darwin Facility was not my choice of nursing home for dad, unfortunately due to the appeals tribunal process, no nursing homes would take dad. IWe had no choice but to accept this outcome. I wanted dad to go to another facility as they would allow him to smoke. However they refused to take him unless he paid the bed deposit in full. [REDACTED]
23. The Darwin Facility was enclosed and fully air-conditioned (dad has never used an air conditioner nor a fan) with a smallish outside area. The Darwin Facility, other than being in a metro area and being closer me, did not suit dad as he was not allowed to smoke or have his dog with him.
24. I attended a meeting on 17 December 2018 with a clinical manager at the Darwin Facility where I was informed that my dad has had a fall while in their care. From this information I requested that my dad's bed be fitted with side bars for his safety. I was informed that the Darwin Facility will not provide these bars as they were considered to be 'restraints' on the resident. The staff assured me that there were motion sensors below the bed, to inform staff that the resident was out of bed. On this occasion however, the sensors did not activate and my father had the fall.

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25. The clinical manager had explained to me that she was to assess the risks of residents on Monday of each week. She also claimed that there were only 10 falls over the weekend and none of which caused serious injury. It seemed as if she was proud of this number.
26. My dad was constantly cold and I provided the Darwin Facility with socks and shoes for this reason. Although staff would not always do this and I had to ask that they put his socks and shoes on for him. Again, this shouldn't be something that I have to ask for, especially considering I am not always there.
27. On 17 December 2018 I telephoned the Darwin Facility to request an update on the assessment and what steps will be taken to prevent my dad from falling again. I was informed that nothing had been done.
28. On 18 December 2018 I visited my dad at the Darwin Facility and was confronted by my dad covered in bandages all over his body and dried blood on his face. To my knowledge, these injuries occurred because of his attempt to get out of bed or his wheelchair. Injuries would also include skin tears to his arms and legs (which he has almost daily), injury to his cheek, nose, bruising to his arms, legs, feet and has a bedsore on his bottom. I do not know why my dad still had dried blood on his face prior to my visit and I am concerned as to the length of time it takes staff members to care for my dad after these incidents.
29. Days later it was agreed that dad's bed should be placed against the wall, so that he could only get out on one side of the bed and hopefully limit any potential falls. There were also crash mats and motion sensor mats placed on the floor and dad was given a 'low low' bed with a concave mattress to prevent him from getting up.
30. I believe that staff of the Darwin Facility notify me each and every time an incident occurs. For example when dad manages to get himself over the concave mattress and set of the motion mat. However, this is usually hours later, of which I assume is due to time to address dad's injuries and other pressing matters. I am usually advised of steps taken, which include cleaning and dressing the wound.
31. One of the calls from the Darwin Facility was to advise that dad had punched a carer who was wheeling him around; stopped and bent down to do something and he punched her. I believe because he cannot see very well, that she startled him.
32. I had advised the Darwin Facility as to my dad's politically incorrect communication with indigenous people that caused problems at the Regional Facility. However on one of my visits the Darwin Facility had placed dad at a table with an indigenous man who was playing the clap sticks and singing loudly. This had really aggravated dad and the staff at the Darwin Facility did nothing so I had to remove my dad from the situation.
33. I met with another staff member, as the clinical manager was on leave, regarding dad's want to walk and subsequent falls and thought that some intense physio might help him. The staff member advised me that the Darwin Facility do not offer intensive physio and that it would have to be done externally.
34. Dementia Support Australia ("DSA") were coming to see him and I wanted to be there for the meeting to find out how to get dad up and strengthen his legs so that he could

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- safely walk (therefore preventing further falls). My dad has not been able to walk since he broke his hip while at the Regional Facility.
35. I rang DSA regarding the intensive physio to try to get dad strong, but they suggested that only supported walks were required to achieve this.
 36. After my phone call with DSA I was advised by the Darwin Facility that the meeting with DSA had been cancelled because his want to walk was apparently not a dementia related issue. He can't remember that he can't walk; I believe that this is a dementia related issue.
 37. Doctors have prescribed Risperidone which was not effective and subsequently Lorazepam to try to calm dad. The Lorazepam keeps him calm for approx. two hours, of which they use this time in the mornings to wash and change dad.
 38. It is concerning that the doctor does not seek my authorisation as dad's Power of Attorney to issue/administer any medication. The Nurse rings me after the doctor's visit to advise me of the medication the doctor has decided to give my dad. I would ask why and they would explain it is to calm him, during these conversations I would google the drugs to see what they were. No I have not asked for the decision to be reversed. However, I have been advised that the dose of Lorazepam has been halved.
 39. I have noted that since the doctor prescribed Lorazepam, dad seems to spend more time in bed; this has led to a bedsore on his bottom. I am disturbed by the amount of time he now seems to spend in bed, I can't help but feel this suits the staff of the Darwin Facility more than it suits my dad.
 40. These drugs have put my dad into such a confused state and looks as though he isn't mentally present. Please see attached photos of my dad prior to entering the Darwin Facility (Doc ID: JML.0001.0001.0001, JML.0001.0001.0002), and also see attached photos of my dad after the Lorazepam was prescribed (Doc ID: JML.0001.0001.0003, JML.0001.0001.0004).
 41. On or around ANZAC day 25 April 2019, I received a phone call from the Darwin Facility advising that dad had an unwitnessed fall from his bed and, on consulting with the doctor, I was advised that he required stitches and was being taken to the RDH by ambulance. I asked if anyone from the Darwin Facility was going with Dad to the hospital and was advised "no", it was not policy for this to happen. I expressed my dissatisfaction with this, stating with dad's condition (dementia) it was a bad idea to send him alone. I expressed this at least five times during my call. Dad's cognitive function does not allow him to understand where he is, what is happening, what medication he is allergic to etc. I travelled immediately into the RDH (50 minute drive). Dad had not yet arrived. When he did arrive, I was taken to the bed he was being admitted into. During the examination and treatment process, the doctor asked a lot of questions that he clearly could not answer, i.e. what day it was, what injury he had sustained and where it was located on his body, what medication he was on, if he had any allergies (he is allergic to penicillin). They advised dad that they were going to put a local sedation on his wound so that they could treat it. It was going to be painful. I suggested to the doctor that dad would probably lash out if it hurt and therefore we should seek assistance from one of the nurses so that we could (the nurse and I) restrain dad's arms during this procedure. Dad was at the RDH all day and did not return to the nursing home until late.

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I don't think the doctor was aware of my dad's aggression. I am very concerned should this happen again and I am unable to go to the hospital with dad, what could potentially happen to him.

42. After the event, the following Monday 29 April 2019, I spoke with a staff member at the Darwin Facility. I understand from the staff member that a hand over note from the Darwin Facility was provided to the ambulance officers, which in turn is passed to the treating doctor at RDH. The staff member printed out a document and showed it to me, but I didn't get a chance to read it. I wasn't given a copy of this document. The staff member told me that it was standard practice to provide that note.
43. I do not know what was in the note or what happened with it on the day. All I know is that the doctors seemed unaware of my dad's aggression which led to myself and a nurse restraining him. This is a major issue as his carer was not with him to explain to staff his medical condition or attempt to keep him calm throughout the day. I have since asked the Darwin Facility for a copy of the document provided to the RDH. I was provided with a Hospital Transfer Form (JML.0001.0001.0005) from a staff member at the Darwin Facility. The Hospital Transfer Form refers to dad's diagnosis of Alzheimer's but does not refer to his behaviour risks.
44. I was told three different stories regarding this injury. The first call on the day was that staff said dad had hurt his arm while getting out of bed. I called the staff the following day, seeking what had happened to cause my dad's injury on his arm, but was told that it was in fact his shoulder. However, RDH did not treat his shoulder, they treated his arm. Finally, staff of the Darwin Facility told me that in fact it was an old skin tear on his arm that he had ripped open.
45. Dad has declined dramatically and it breaks my heart to see this once fit, active, kind gentleman left in his bed or princess chair, confused, lonely and fading fast. I want to see my dad cared for and looked after by the staff of the Darwin Facility the way he should be.
46. My other concern is with the staff training and knowledge of dementia residents. For example; one carer was unable to put socks on my dad's feet which lead to my dad getting aggressive. I had asked the carer to give my dad something to hold onto while I put his socks on. The carer then gave my dad a wooden block. Knowing my dad gets aggressive due to his dementia I was instantly concerned that the carer gave my father this block as it was very likely he would hit me or the carer with it. I quickly put the socks on with no problem at all.

Signed: _____

Date: _____

Witness: _____

Date: _____

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