# Chapter 2

# What happened at Oakden

> I would say that Oakden was a perfect marriage of chaos and maladministration.[1]

2.1 This chapter will detail what occurred at the Oakden Older Persons Mental Health Facility (Oakden) in the lead-up to the closure of the facility. In particular, this chapter will focus on concerns about the quality of care provided to residents in the facility. The chapter will extensively rely on evidence from family statements from the Adelaide hearing, evidence from staff and external advisors, and evidence detailed in the investigation by the South Australian (SA) Chief Psychiatrist.

## Complaints from the families of Oakden residents

### *Case study – Mr Bob Spriggs*

2.2 In January 2016, Mr Bob Spriggs was admitted to Oakden after 4 months' hospitalisation in the acute ward at the Repatriation General Hospital (the Repat). While it was originally intended that Mr Spriggs would be moved to a secure area in a private residential aged care centre, due to the severity of his symptoms he only lasted one day in private care before being returned to the Repat acute ward. At this point, his family were informed that he would need to be moved to Oakden. Mr Spriggs was relocated to Oakden, accompanied by staff from the Repat who had prepared a written care plan.[2]

2.3 The family did not know anything about the Oakden facility before Mr Spriggs arrived, but his wife, Mrs Barbara Spriggs, described her first impressions to the committee:

> As a family, we were out there to greet him when he came. It didn't feel good right from the word go. We didn't appreciate the way that we were treated when we got there. We didn't appreciate the fact that they were asking us so many questions about Bob's care and what he needed, because we knew that there had been a good handover from the Repat. But, that aside, we just tried to embrace the fact that Bob had to be there, because we were told at the first meeting how we were very fortunate to get Bob in there, because it was the only place in South Australia that would take somebody like him, so we should feel very lucky that he was able to get a place there. They said, 'You have to tick lots of boxes to get in here, and you've ticked all the boxes,' so we thought, 'Well, we're probably lucky that he's in here.' But we didn't feel good about it.[3]

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1 Mrs Natasha Glowick, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 71.

2 Mrs Barbara Spriggs, family member of Oakden resident, *Committee Hansard*, 21 November 2017, pp. 62–63.

3 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 63.

2.4 Mrs Spriggs explained how after her husband had been at Oakden one week, the facility's psychiatrist recommended that Mr Spriggs be returned to the Repat acute ward '…because things aren't working out here. It's a bit hard to handle him…he needs a lot more care'. However, when Mrs Spriggs contacted the Repat, she was told that her husband could not stay there as it was an acute facility, not an aged care home. This situation left her feeling devastated about what to do for her husband's care.[4]

2.5 The next day, Mr Spriggs was taken by ambulance from Oakden and readmitted to the Repat acute ward, where Mrs Spriggs was told that her husband would have to return to Oakden. There was some question of whether there was a deficiency in the handover between the two facilities, so the family held meetings with Oakden to address their concerns and try to improve things before a second transfer. Mrs Spriggs described how the Repat to put together a care plan and coordinated her husband's second transfer to Oakden some weeks later, but that alarm bells had begun to ring:

> I can't give the Repat high enough marks as to how hard they worked to put together a package for him to go out there with lots of backup. They assured me that they would ring every day and offer help. They stayed out there the whole day the first day that Bob went out there. There were two staff members that went out with them. I saw them putting information into the computer. I saw them talking to the whole staff about how to look after him. They would ring me nearly every day to ask how things were going, and I could see there were a few things wrong. They said: 'Well, we've rung up and we've asked, "Can we help you?" but no; they're okay. They were managing.'[5]

2.6 During his second stay at Oakden, Mr Spriggs' health and function rapidly declined. In February 2016, Mr Spriggs was found to have very significant bruising to one hip and was sent to the Emergency Department of the Royal Adelaide Hospital to investigate whether this hip was broken. On arrival, it was discovered that he was dehydrated, was suffering from pneumonia, and had been overmedicated. He did not return to Oakden following this incident.[6]

2.7 Mr Spriggs passed away in July 2016, six months after his first admission to Oakden.

2.8 The Spriggs family has detailed a number of instances of neglect or failure of care which occurred while Mr Spriggs was a resident of Oakden. These included:

(a) unexplained bruising, including the bruising to his hip which necessitated emergency admission to Royal Adelaide Hospital;

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4 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 63.

5 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 63.

6 Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian Government), *Oakden Report – The report of the Oakden Review (Oakden report)*, p. 2; Mrs Spriggs, *Committee Hansard*, 21 November 2017, pp. 64–65.

(b) severe dehydration and undernourishment; and

(c) being placed/left on the floor when he was 'too difficult to handle', with a nurse on either side to prevent him from standing.[7]

2.9 In addition to these, there was one very serious instance of medication mismanagement. Mr Spriggs received 10 times the dose of an antipsychotic drug on at least three occasions, over three sequential midday doses.[8] Mrs Spriggs explained that she had not realised the implications of this at the time she was informed:

> It went over my head, to be honest, and my heart went out to the doctor, because we all make mistakes. Looking back, I should have really jumped up and down, but I just said, 'Okay, well, mistakes happen.'[9]

2.10 However, the Spriggs family believes that this medication overdose was a major contributing factor to Mr Spriggs' rapid decline in function and may have contributed to his death.[10]

2.11 It was noted by the Spriggs family that, as far as they were aware, neither staff from the Repat nor the Royal Adelaide Hospital made any formal complaint or report about Mr Spriggs' condition following his admissions from Oakden.

2.12 The Spriggs family first contacted the Community Visitor Scheme (CVS) on 1 June 2016 to raise their concerns about the care environment at Oakden. The CVS response to the Spriggs family's complaint is discussed later in this chapter. Mrs Spriggs had kept detailed notes and photographs of her husband's time in care and expressed a motivation:

> … to pursue this matter… because she wanted to ensure that other families would not have to go through what she and [her family] had gone through.[11]

### *Evidence from the families of other residents*

2.13 There have been many more instances of neglect and failure of care at Oakden raised by the families of former residents. The committee heard from two panels of family members during the hearing on 21 November 2017 in Adelaide, and received 26 submissions from individuals, many of whom are family members of former Oakden residents. Family members' accounts have featured consistent themes of feeling betrayed by and distrustful of the public aged care system following their

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7 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, pp. 62–65; Mr Clive Spriggs, family member of Oakden resident, *Committee Hansard*, 21 November 2017, pp.64–65.

8 *Oakden report*, p. 85; *Principal Community Visitor Annual Report Mental Health Services 2016–17*, p. 16; Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 64; Mr Maurice Corcoran, Principal Community Visitor (PCV), *Committee Hansard*, 21 November 2017, p. 25.

9 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 64.

10 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, pp. 64–65; *Principal Community Visitor Annual Report Mental Health Services 2016–17*, p. 16.

11 *Principal Community Visitor Annual Report Mental Health Services 2016–17*, p. 17.

experience with Oakden; they felt let down by a system which was designed to help vulnerable people but, in their opinion, had failed to do so.

2.14 As was the case for the Spriggs family, other families reported that they often had no choice in sending family to Oakden as it was only facility in South Australia able to care for their family member's needs. Families explained that private facilities that can accommodate dementia residents, particularly where there are concerns about violent behaviour, are extremely limited, and this is supported by evidence from the Oakden report.[12]

2.15 Residents were shunted between hospitals or acute care and Oakden, with neither facility really being suitable for the needs of the resident. There were some issues around the difference between the acute and long-term care their family members were receiving across the public health sector, which reflects the concerns held by CVS about the classification of Oakden as sub-acute. [13]

2.16 Many family members reported impacts on their own mental health and a significant burden to continue to provide care for the resident due to the lack of appropriate personal care provided to residents at Oakden.[14] Others questioned how staff would feel if it were their parent or loved one in that centre receiving similar poor quality of care.[15]

*Personal care*

2.17 The committee was presented with overwhelming reports from families of the poor quality of personal care at Oakden.

2.18 Resident's clothing in the facility often went missing or was put on other people, and residents were dressed poorly and haphazardly, but staff did not appear to care.[16] Despite labelling, clothes would still go missing or be placed on different

12 Mrs Patrina Cole, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 60; Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 62; *Oakden report*, pp. 29–33.

13 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, pp. 64-65; Mrs Patrina Cole, *Committee Hansard*, 21 November 2017, pp. 59–60; see also Mrs Alma Krecu, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 61.

14 Ms Christine Blakely, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 61; Mr Stewart Johnston, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 57; Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 61; Mr Mark Martin, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 73.

15 Ms Christine Blakely, *Committee Hansard*, 21 November 2017, p. 61; Ms Deanna Stojanovic, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 74.

16 Ms Deanna Stojanovic, *Committee Hansard*, 21 November 2017, p. 70; Mrs Natasha Glowik, *Committee Hansard*, 21 November 2017, p. 72.

residents.[17] Residents were also left in soiled clothing for long periods of time[18] and were not washed.[19]

2.19 Residents were not being fed properly and '[t]he quality of food was just disgraceful'.[20] Some residents were not being given opportunity to actually swallow their food[21] and staff force-fed sleeping residents or residents with known swallowing issues.[22] One choking incident required emergency hospitalisation for a resident.[23]

2.20 Residents were also being restrained for significant portions of the day and not being walked, resulting in bedsores and worsening health outcomes.[24]

*Medication mismanagement and clinical care*

2.21 Medication mismanagement was common, and this is also detailed in the Oakden and CVS reports. Many family members reported over-sedation and/or overdose, leading directly or indirectly to the death of their loved one in care.[25] There was a belief that sedation was used as chemical restraint to minimise the need for care from staff:

> That's where, as a culture, everyone just seems to think: 'Oh, they've got mental health issues, so dose them up, overmedicate them'—which they did for my father—'and just leave them to be. Strap them in a chair for the daylight hours and then just put them to bed at night.'[26]

2.22 In one instance recounted to the committee, an overmedicated resident was unresponsive for 12 hours before staff called an ambulance. However, following this adverse event, the resident's family were not sure if there was any change in staff behaviour at Oakden nor, in an echo of the Spriggs' case, if the overmedication was ever reported by Royal Adelaide Hospital:

> We actually told Royal Adelaide that we felt that dad was being overmedicated—we know for sure he was being overmedicated. They

17 Mrs Petrina Cole, *Committee Hansard*, 21 November 2017, p. 59; Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 61; Ms Maria Costa, family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 68; Mr Mark Martin, *Committee Hansard*, 21 November 2017, p. 73.

18 Ms Maria Costa, *Committee Hansard*, 21 November 2017, p. 69.

19 Mr Mark Martin, *Committee Hansard*, 21 November 2017, p. 73.

20 Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 61.

21 Ms Christine Blakely, *Committee Hansard*, 21 November 2017, p. 60.

22 Ms Maria Costa, *Committee Hansard*, 21 November 2017, p. 68; Ms Deanna Stojanovic, *Committee Hansard*, 21 November 2017, p. 70.

23 Ms Deanna Stojanovic, Committee Hansard, 21 November 2017, p. 70.

24 Mr Mark Martin, *Committee Hansard*, 21 November 2017, p. 73.

25 Mrs Petrina Cole, *Committee Hansard*, 21 November 2017, p. 60; Ms Maria Costa, *Committee Hansard*, 21 November 2017, pp. 68–69; Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, pp. 64–65.

26 Mrs Petrina Cole, *Committee Hansard*, 21 November 2017, p. 60.

> agreed with that and they told us that they were going to write a letter to Oakden because they questioned all the medication. My dad was still on antipsychotic drugs three years later, and they wanted to know why he was on such high dosages of all those drugs. We had that family meeting two days later and were reprimanded, because we overreacted when we walked in and saw my dad completely unresponsive and we scared the nursing staff at Oakden. We were reprimanded on that first up, and in the next breath we were told that dad was ready to go to mainstream—all after Royal Adelaide, supposedly, and I don't know if they ever did, send a letter about my father's medication.[27]

2.23 Families noted that staff often did not have explanations for residents' unwitnessed falls or bruising,[28] and in one instance failed to identify a major injury after a fall.[29] Other families also questioned why hospitals did not report apparent abuse of residents at Oakden[30] when comments suggest that the issues at the facility were known to hospital staff:

> When my mother was admitted to the [Royal Adelaide Hospital], the first question was, 'I bet you're from a nursing home and I bet we know which one.'[31]

*Abuse of residents*

2.24 There have been accusations of staff perpetrating physical and verbal abuse against residents, some witnessed and some suspected. There is no CCTV footage of the centre, so staff explanations for injuries and incidents, such as unwitnessed falls or bruising, could not be corroborated,[32] and families reported that complaints were 'brushed off' when made to the relevant authorities.[33]

2.25 One family reported verbal and physical abuse of a resident by a staff member in front of the family. In this situation, the registered nurse on duty did not step in to stop the staff member concerned, and the family were unhappy with the response:

> The police were called; however, no charges were ever laid against this carer, because the registered nurse that was on duty downplayed the incident and said that my father had actually provoked the attack. I don't know how a patient with Lewy body dementia—and yes, my father was aggressive, but at that point his medication was stable enough that he

27 Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 65.

28 Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 62; Ms Deanna Stojanovic, *Committee Hansard*, 21 November 2017, p. 70; Mr Mark Martin, *Committee Hansard*, 21 November 2017, p. 73.

29 Mr Mark Martin, *Committee Hansard*, 21 November 2017, p. 73.

30 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, p. 65; Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, pp. 65–66.

31 Mrs Natasha Glowik, *Committee Hansard*, 21 November 2017, p. 72.

32 Mrs Petrina Cole, *Committee Hansard*, 21 November 2017, p. 59.

33 Ms Maria Costa, *Committee Hansard*, 21 November 2017, p. 69.

> wasn't. So nothing ever happened to that carer or to the registered nurse that witnessed the whole thing and did nothing to intervene.[34]

*Administrative concerns, responsibilities and incident reporting*

2.26 Many families noted major issues with the administration of Oakden, particularly in the handover of resident information, which is an area of significant importance for a facility that was intended to act as a transitory stage and not long-term care. The committee heard that handover of resident information and medical history to new doctors or other health professionals was left to the responsibility of family members[35] or, even where a full handover had occurred, family were called upon to provide missing information.[36]

2.27 In one situation, a family member had to intervene to instruct ambulance staff because Oakden staff would not direct them to a particular hospital for the resident's emergency treatment. The same family also found they had the opposite problem, with the facility not contacting them in other situations for power of attorney issues or to make decisions about medical procedures.[37]

2.28 Even when Oakden was closing, there were administrative errors which nearly saw one female resident transferred to a men's ward at Northgate due to miscalculation of resident numbers.[38]

2.29 Families reported that they were given insufficient information in their first contact with Oakden, so they did not know who to approach when they had concerns.[39] When they did raise issues or make complaints with management, some families reported feeling 'fobbed off' or dismissed.[40] In one case, the family found that after they made complaints, the facility staff moved to contest their guardianship of the resident.[41]

2.30 Additionally, a lack of accountability and shifting of blame between levels of management and levels of government has left families feeling ignored, excluded and helpless in their quest to find answers to their questions and closure in their grief.[42] One witness told the committee about his concerns about the failure of clinical

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34 Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 62.

35 Mrs Petrina Cole, *Committee Hansard*, 21 November 2017, p. 59.

36 Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 63.

37 Ms Deanna Stojanovic, *Committee Hansard*, 21 November 2017, p. 70.

38 Ms Deanna Stojanovic, *Committee Hansard*, 21 November 2017, p. 71.

39 Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 67; Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, p. 58; Mrs Natasha Glowik, *Committee Hansard*, 21 November 2017, pp. 71–72.

40 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, pp. 57–58.

41 Mr Mark Martin, *Committee Hansard*, 21 November 2017, pp. 73–74.

42 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, pp. 58–59.

governance at Oakden and his fear that reviews, if conducted by the same system which implemented the model of care in the facility, will not achieve anything:

> Nothing will make up for what mum and others went through, but our expectation is accountability, and the evidence, with exposed time lines and reported failings have been uncovered thus far throughout many inquiries, shows without doubt that there were identifiable and culpable people who either in the past or still currently do via the position they held or hold either actively sought to cover up, encourage or, at the very least, fail to execute their duties. This facilitated and allowed a systematic abuse of procedure and through inaction and maladministration actively and successfully created and continued to develop a culture of bullying, intimidation and corruption with outright, blatant criminality. This also allowed blame shifting and zero accountability to become the norm at all levels of SA Health and other industry overseers. These individual people, including ministers of government, CEOs and senior bureaucracy within departments, whether in a past appointment or tenure or a current one, were and are responsible through the position they held, and it is already unequivocally clear where and with whom the chain of command started and finished…Inquiries and investigations ordered politically as a result of adverse events being exposed are legendary. So are the resulting actions in administering and implementing findings. Why? Generally those at the top commission the very same negligent framework of people and personalities to implement the findings, or be seen to, with a large implementation window of years.[43]

2.31 The concerns raised by family members raise fundamental questions regarding the model of care under which services at Oakden were delivered.

## The model of care at Oakden

> …Model of Care is defined as the way that health services are delivered, drawing on best practice care and services for a person, population group or patient cohort as they progress through the stages of managing a healthcare condition. A Model of Care articulates how people can access the right care, at the right time, from the right team in the right place.[44]

2.32 Oakden was originally established in 1982 by the SA Government as a state government funded health facility, delivering a specialist mental health service for older people with severe mental illness, including mental illness arising in the context of dementia. From 1998 onwards, although the service remained the same, part of the facility was reclassified as an aged care service so that it became eligible for Commonwealth aged care funding. This lead to confusion in the health system about resident eligibility, regulatory responsibilities,[45] and the complex arrangements for

43 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, pp. 57, 59.

44 *Oakden report*, April 2017, p. 27.

45 A breakdown of the regulatory responsibilities of relevant aged care agencies is detailed in Chapter 3.

resourcing and funding between the State and the Commonwealth.[46] Additionally, classification as an aged care facility rather than a special mental health service meant a lower staff to resident ratio was required by the relevant accreditation process.[47]

2.33 Oakden primarily provided care for older people with enduring or severe mental illness in need of transitional care and people with severe Behavioural and Psychological Symptoms of Dementia (BPSD) rated at Brodaty Tier 6 (Dementia with very severe BPSD) or Brodaty Tier 7 (Dementia with extreme BPSD), and who were unable to receive care in non-government dementia-specific aged care environments.[48]

**Figure 2.1–Seven-tiered model of management of behavioural and psychological symptoms of dementia (BPSD)**


Source: Medical Journal of Australia.[49]

46 *Oakden report*, p. 31; One critical issue for this arrangement is what funding is available from the Commonwealth and what 'top-up' funding is needed from the state government to provide appropriate and quality services to avoid insufficient resourcing of a facility. The Oakden report found that this funding issue is not captured by any model of care in South Australia.

47 South Australia Community Visitor Scheme, *Principal Community Visitor Annual Report 2014–15*, p. 62.

48 *Oakden report*, p. 14.

49 Henry Brodaty, Brian M Draper and Lee-Fay Low, 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery', *Medical Journal of Australia*, vol. 178, no. 5, 2003, pp. 231–234.

2.34 Evidence received by the committee has shown that the model of care in place at Oakden was out of date and not updated to reflect modern approaches to dementia and other ageing-related cognitive and mental health issues.[50]

***Older persons mental health in SA***

2.35 Prior to 2012, there was no model of care developed for the care of older people with severe mental illness in SA, although project teams and reference groups tasked with developing such a service model had been established in 2007. A draft model, designed to respond to national policy changes, mental health reform and state initiatives, was endorsed by the SA Older Persons Mental Health Services (OPMHS) in 2012 but was not endorsed or progressed by SA Health.[51] That draft model of care:

> …articulated a number of underpinning principles including; the uniqueness of the individual; having real choices; fostering recovery oriented attitudes and rights; dignity and respect; partnership and communication and evaluating recovery.[52]

2.36 This draft model set out two types of mental health units of relevance to Oakden, each designed to deliver 'high-dependency but recovery-focused specialist care' before transition to mainstream care:

(a) Transitional Care Units (TCUs), which would act as transitory care (average length of stay 3–6 months) for step-up/step-down between acute facilities and mainstream aged care; and

(b) Intensive Care Behavioural Units (ICBUs), which would act as slow-stream units (average length of stay 18 months) for residents whose behavioural and psychological symptoms could not be managed in mainstream aged care, even with specialist support.[53]

2.37 The model of care recommended that TCU and ICBU beds be available in all local health networks to ensure service proximity to families, carers and communities.[54]

2.38 It also proposed contractual arrangements between state government and non-government organisations (NGOs), wherein a NGO would host the service and OPMHS would manage admission/discharge and 'provide extensive control over assessment, care planning, therapy, medication management, research and education

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50 *Oakden report*, p. 31-32; Ms Sharon Olsson, private capacity, *Committee Hansard,* 21 November 2017, p. 43; Ms Ann Wunsch, Executive Director, Operations, Australian Aged Care Quality Agency, *Committee Hansard,* 21 November 2017, p. 18; Ms Jackie Hanson, CEO, North Adelaide Local Health Network (NALHN), SA Health, *Committee Hansard,* 21 November 2017, p. 4.

51 *Oakden report*, pp. 27–30.

52 *Oakden report*, p. 28.

53 *Oakden report*, p. 28.

54 *Oakden report*, p. 28.

through an in-reach model led by the Community Mental Health Team'.[55] This proposal was consistent with the SA initiative *Stepping Up: A social inclusion action plan for mental health reform 2007–2012* recommendation that TCU and ICBU beds be outsourced to the non-government residential aged care sector.[56]

***The Oakden report findings on model of care***

2.39 While the 2012 OPMHS draft model of care holds similarities with other states' approaches to TCU and ICBU bed classification, the proposal to transfer these services to NGOs was specifically addressed as a major concern in the SA Chief Psychiatrist's *Oakden Report – The report of the Oakden Review* (Oakden report). It was unclear why the NGO outsourcing of these services was proposed, beyond an overall push within the OPMHS to reform the sector in SA.

2.40 The Oakden report detailed evidence from New South Wales, Victoria and Western Australia which suggests that Tier 7 BPSD beds should only be supported by state services to ensure consistent access to specialised, highly-trained staff. Furthermore, there are no specific Tier 7-only services provided by the residential aged care facilities in Australia. Additionally, where Tier 6 BPSD beds are provided in private facilities:

> …these are heavily subsidised by the State Government (in addition to the Commonwealth subsidy that is received) to ensure the person…has access to the full range of highly trained multi-disciplinary staff needed to ensure safe, high quality care.[57]

2.41 The SA Chief Psychiatrist noted that a lack of an endorsed model of care was a significant factor in the decline of services at Oakden:

> As a result of no endorsed system wide Model for OPMHS there has been understandably, little done to define a Model that is specific for Oakden. This has led to a resultant further decline in services at Oakden Campus, which remains unclear what its purpose is within a State-wide system of OPMH services.
>
> As such Oakden has continued to provide services that should be consistent with TCUs and ICBUs, on behalf of the State, without a plan that supports the level of resources it needs to provide such a service.
>
> This is compounded by a widespread view, held by the staff, which the Review heard repeatedly, that Oakden (in particular Makk and McLeay Nursing Home), is a place for the rest of the consumer's life. This resulted in an attitude among staff that there was less effort and emphasis that needed to be placed on managing the consumer's challenging behaviours as there was little prospect that any improvement would help facilitate their discharge. This became a self-fulfilling prophecy for many in Oakden.[58]

55 *Oakden report*, p. 28.

56 *Oakden report*, p. 29.

57 *Oakden report*, p. 29.

58 *Oakden report*, p. 30.

2.42 The SA Chief Psychiatrist also made a number of significant findings in the Oakden report in relation to the model of care in place at the facility, concluding that 'Oakden is not providing the right care, at the right time from the right team'.[59] The Oakden report found that at the time of the review:

(a) there was no specific, satisfactory model of care that had been developed for the types of services provided at Oakden;

(b) there was no articulation of who would be provided services at Oakden or how those services would be achieved regarding staffing, resources and infrastructure;

(c) that local health networks across SA relied on Oakden to provide services for sub-acute and acute BPSD services and transitional care, rather than making arrangements for these services in their own catchment areas;

(d) that the unendorsed model of care proposed by the executive leadership of the SA OPMHS in 2012 was not supported by 'the degree of commensurate change within…resources; skills and capacity; or changes in practice…if the changes aspired to…were to be achieved' and was therefore 'unable to prevent ongoing deterioration in the Oakden service';

(e) that this unendorsed model had been relied upon by OPMHS and that the disconnect between 'an unfunded aspirational document and the real-world challenges of the service' had contributed to deficits in service at Oakden;

(f) that this unendorsed model did not reflect international or national best practice in the provision of care for Tier 6 and 7 BPSD; and

(g) that the model of care provided at Oakden did not reflect best practice for people with functional mental illness and had 'no relationship' with best practice for people with Tier 6 and 7 BPSD.[60]

2.43 Another significant concern with the model of care in place at Oakden was the physical environment and infrastructure of the facility. The Oakden report found that the facility itself was 'not well designed or modern for the time it was built' and, at the time of reporting, was 'entirely unsuitable' as a facility for management of Tier 6 and 7 BPSD. Furthermore, the substandard quality of the facility's infrastructure was identified as a cause of low morale for staff, distress for the families of residents, and had likely caused 'considerable difficulty' in providing appropriate care for the challenges associated with managing the more severe behaviours of BPSD.[61]

59 *Oakden report*, p. 31.

60 *Oakden report*, pp. 31–32.

61 *Oakden report*, p. 57.

## Concerns about the care provided by staff at Oakden

2.44 The longstanding push to outsource Oakden's services to NGOs, a culture of under-resourcing within the facility and a model of care which was inappropriate, unendorsed and poorly implemented were significant contributing factors to the quality of care provided in the facility. Evidence received by the committee in particular shows ongoing concerns, detailed below, about appropriate levels for staffing and resourcing at Oakden in the years leading to its closure and the impact of these on the care and treatment of residents.

### *The Community Visitor Scheme reports*

2.45 The CVS was established in 2011 with a role to visit and inspect acute mental health facilities in SA, including the Oakden facility, every month. Two community visitors conduct each visit and provide a written report to the mental health coordinator and the Principal Community Visitor (PCV), which are then assessed for any issues or concerns.[62] The PCV, Mr Maurice Corcoran, explained the visiting process to the committee:

> We say to all our visitors when we're preparing and going through our training that when they're visiting and inspecting units that they run the mum test over it, which is basically that if they are going to look at the facility, the key part of it is a human service. So it is looking at the observations between staff, patients and family members, and how they're being cared for and being treated, but also to look deeply into such things as individual care and treatment plans.[63]

2.46 Where issues or concerns were identified, CVS collate these and forward copies of reports to the senior executive or directors responsible for the services in question to seek their response. Recurrent issues are tracked through a register and raised with an advisory committee, and significant matters are ultimately included in the CVS annual report, which is provided to the relevant minister.[64]

2.47 Mr Corcoran told the committee that CVS had held concerns about Oakden since beginning visits in July 2011, particularly in relation to a perceived 'streamlined and trimmed down' workforce 'in readiness for a possible tendering out to the non-government sector':

> That was made clear to us in the very early days. That had an impact on staff and the uncertainty for staff. And that affected the number of agency staff that were brought in on a regular basis to work at Oakden. That is very relevant. That placed enormous pressure on a number of other staff we met with—regular and permanent staff—who were responsible for a lot of the data entry and the recording of incidence and issues on their Safety and Learning System.[65]

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62 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, p. 23.

63 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, p. 23.

64 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, p. 23.

65 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, pp. 23, 24.

2.48 In 2013, CVS visitors reported shortages of mental health nurses, including positions not being backfilled while other staff were on leave, and the impact of this on resident care: '[t]hey tried to avoid toileting patients if some staff were at meetings or meal breaks or not available to help'.[66] It was also reported that staff did not have time to engage with patients except to provide tea and fruit.[67]

2.49 These concerns about staff and resources were reflected in a number of visitor reports to the PCV[68] and raised across a series of CVS annual reports in the lead-up to the Oakden closure.

2.50 The CVS annual report for 2014–15 noted that key allied health staff positions at Oakden were vacant, including the psychologist, who had responsibility for behavioural plans, and the social worker, who had responsibility for finding appropriate accommodation for residents. CVS also identified that Oakden was classified as a sub-acute facility and was therefore using a ratio of 1 staff member to 4 residents, while acute units would use 1 staff member to 3 residents.[69] At the hearing on 21 November 2017, the PCV told the committee:

> They were getting some of the most complex and challenging clients from acute wards, which have staffing ratios higher than what Oakden had as a subacute ward, yet it was expected to cope with and manage and support people with some of the most challenging behaviours of all. It was classified as a subacute model of care, a longer term subacute model of care. It was something that, again, I failed to understand why it was so when we were dealing with some of the most challenging clients. It was certainly something we tried to seek answers to.[70]

2.51 The committee notes that at the time of the 2014–15 annual report, CVS had received concerns from three families about the care and treatment of their family members at Oakden, reporting falls, bruising, medication errors, sleepiness and drowsiness, and decline of daily function.[71]

2.52 In 2015–16, CVS reported that the psychologist and social worker positions were still vacant. CVS commended the dedication of senior leaders and managers working at the facility, but held concerns for the pressure placed on them to cover the responsibilities which the allied health staff had managed. Concerns received about the care of residents in the previous year were restated and it does not appear that they received any new complaints in 2015–16. However, the report also made specific reference to complaints raised with the Minister about the care of a resident, now

66 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, p. 24.

67 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, p. 24.

68 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, pp. 24, 25.

69 *Principal Community Visitor Annual Report 2014–15*, p. 62.

70 Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, p. 26.

71 *Principal Community Visitor Annual Report 2014–15*, p. 62.

understood to be Mr Bob Spriggs, in an older persons' mental health facility.[72] Additionally, the report made a recommendation that a review be conducted 'of the clinical hours in contrast to resident acuity at…Oakden to ensure the provision of quality and safe care to residents residing in this facility'.[73]

2.53 The CVS annual report for 2016–17 presented a worsening situation for allied health in the facility. At the time of the annual report, the only allied health professional working at Oakden was a part-time dietitian. An extract from a visitor report stated that there was no occupational therapist, physiotherapist, psychologist, speech pathologist, or social worker employed by Oakden and that while these services were available on call from another centre, staff had 'been told to call on these only in exceptional circumstances…and only two referrals [had] been made in…18 months (one forensic)'. The report also reiterated CVS' ongoing concerns about the classification of the facility as sub-acute and impact of this on staffing levels and funding, despite most residents entering the facility from acute wards.[74]

2.54 The CVS annual report for 2016–17 also included the first reference by name to the Spriggs family and their complaints about the treatment of Mr Bob Spriggs at Oakden. The report detailed how CVS had facilitated a formal complaint process regarding this case to the management of Oakden, before escalating the matter to the Minister for Mental Health. As discussed in Chapter 1, this sparked the series of events which led to the SA Chief Psychiatrist's Oakden report and the subsequent closure of the facility.

***The Oakden report findings on quality and safety of care***

2.55 The SA Chief Psychiatrist outlined a number of serious failures across all components of the clinical governance framework at Oakden and reported a number of very concerning findings about the quality and safety of care provided, including but not limited to:

(a) warning signs, such as rate of injuries, medication errors, poor documentation, clinical deterioration etc., were not heeded;

(b) there was no ownership of responsibility for clinical outcomes and no one was clearly in charge;

(c) there was poor leadership and poor understanding of what was expected of leadership;

(d) education, training and professional development was 'seriously deficient and focussed in areas that [were] out of date and irrelevant';

72 South Australia Community Visitor Scheme, *Principal Community Visitor Annual Report Mental Health Services 2015–16,* p. 24.

73 *Principal Community Visitor Annual Report Mental Health Services 2015–16,* p. 62.

74 South Australia Community Visitor Scheme, *Principal Community Visitor Annual Report Mental Health Services 2016–17,* pp. 13, 16.

(e) staff were unclear of priorities and focus was on compliance and accreditation, not on improvement or on high quality and safe care;

(f) staff were afraid to report errors due to fear of blame and because senior staff 'thought it better not to know';

(g) staff continued to make mistakes because the culture of the facility did not support learning from mistakes;

(h) clinical risk was not appropriately resolved on the rare occasions it was raised, leading to staff reluctance to raise concerns again in the future;

(i) external scrutiny was discouraged, open disclosure was rare, professional accountability was weak and inconsistent;

(j) standards of care were poor and not closely monitored;

(k) safety Learning System data was treated 'as a chore' rather than as a tool for learning and change; and

(l) information about residents was not actively gathered from families and carers and complaints were not used as 'a source of important information to aid improvement' but as seen as part of the nature of the work.[75]

***Other concerns about staffing and care quality***

2.56 The committee also heard evidence from staff, external advisors and family members of residents about the quality and safety of care at Oakden which echoed the accounts in the CVS and Oakden reports.

2.57 A significant amount of evidence points to consistent understaffing of the Oakden facility, both in relation to its classification as sub-acute and due to the perceived streamlining of positions.[76] This was also noticed by residents' families.[77] Ms Jackie Hanson, CEO of the North Adelaide Local Health Network (NALHN), of which Oakden was part, told the committee:

> Retrospectively, I would accept, with the contemporary model we now have, that the nursing hours per patient day that were negotiated and approved by the ANMF don't deliver the model of care that we now have in place, which is that of dealing with older people with severe behavioural disorders and/or enduring mental illness.[78]

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75 *Oakden report*, pp. 89–90.

76 *Principal Community Visitor Annual Report 2014–15*, p. 26; *Principal Community Visitor Annual Report Mental Health Services 2015–16*, p. 62; *Principal Community Visitor Annual Report Mental Health Services 2016–17*, p. 13; Mr Maurice Corcoran, PCV, *Committee Hansard*, 21 November 2017, p. 24; Ms Jackie Hanson, NALHN, *Committee Hansard*, 21 November 2017, p. 4; Ms Sharon Olsson, *Committee Hansard*, 21 November 2017, p. 43; *Oakden report*, p. 30.

77 Ms Maria Costa, *Committee Hansard*, 21 November 2017, p. 69.

78 Ms Jackie Hanson, NALHN, *Committee Hansard*, 21 November 2017, p. 4.

*Training*

2.58 Many people also reported that the nursing staff employed by Oakden were not adequately or appropriately trained for the kind of work they were doing. Historically, Oakden had been predominately staffed by mental health trained nurses, not aged care nurses.[79]

2.59 The committee heard that a contributing factor towards the lack of available, qualified staff is that people aren't interested in working in this dementia-specific area of aged care,[80] nor are they generally trained in it through a standard nursing degree or other qualification.[81]

2.60 The CEO of NALHN told the committee that while NALHN had delivered some training programs to staff at Oakden about resident behaviour and de-escalation of violent situations, that training was of a 'baseline' nature and was not reflective of contemporary best practice.[82]

2.61 Family members noted how little training was required for some carer positions at Oakden. Families noted that staff often have no training in dealing with dementia patients[83] and are immediately placed 'on the front line' in the dementia ward.[84] One person noted that it takes just four weeks in a classroom and three weeks' placement in a facility to achieve a Certificate III level qualification as a personal care assistant.[85]

*Culture and attitudes*

2.62 As also discussed in the Oakden report, there was a serious concern about the attitudes of many staff members and the culture created by the view that the facility was 'for life' and was the only option available to residents:

> It was accepted that if somebody was admitted to Makk and McLeay it was because no other facility would take them due to behavioural issues. Therein lies part of the problem. Staff had this view that the relatives should be grateful that we had them because nobody else wanted them.[86]

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79 Ms Jackie Hanson, NALHN, *Committee Hansard*, 21 November 2017, p. 9.

80 Professor Craig Whitehead, Clinical Director, Rehabilitation, Aged Care and Palliative Care, Flinders University, *Committee Hansard,* 21 November 2017, p. 40.

81 Professor Craig Whitehead, Flinders University, *Committee Hansard*, 21 November 2017, pp. 38–40; Professor Joseph E Ibrahim, Head, Health Law and Ageing Research Unit, Monash University, *Committee Hansard*, 21 November 2017, pp. 38–40.

82 Ms Jackie Hanson, NALHN, *Committee Hansard*, 21 November 2017, p. 9.

83 Mrs Patrina Cole, *Committee Hansard*, 21 November 2017, p. 60; Mrs Natasha Glowik, *Committee Hansard*, 21 November 2017, p. 74.

84 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, p. 58.

85 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, p. 58; Mr Mark Martin, *Committee Hansard*, 21 November 2017, p. 74.

86 Ms Sharon Olsson, *Committee Hansard*, 21 November 2017, p. 48.

2.63 The committee heard from a former staff member of Oakden, Ms Sharon Olsson, who detailed many toxic aspects of the nursing and management culture in the facility, including:

(a) lack of leadership/support from leaders;

(b) lack of understanding among staff about dementia;

(c) 'cover-up' when concerns were raised by staff, although this was 'more at the senior level than the base level';

(d) inappropriate rostering of staff with no background in aged care; and

(e) staff being sent to Oakden as 'punishment' when they had caused problems at other facilities.[87]

2.64 Ms Olsson also described how the facility was a physically unsafe nursing environment due to broken and run-down furniture, equipment and rooms,[88] and these comments were also reflected in descriptions of the facility from family members[89] and in the Oakden report.[90] This is likely to have contributed to frustration.

2.65 Ms Olsson's comments about Oakden being used as a place of punishment for bad staff was also reflected in evidence presented to the committee that there was a large concentration of problem staff at Oakden. One family member described Oakden as a 'dumping ground', stating that staff were 'unexperienced and short of patience, and…most of them would never, ever be employed anywhere else'.[91]

2.66 Family members of residents stated that staff displayed abusive behaviour towards each other,[92] or would blame each other for mistakes.[93] There appeared to be a culture of lying openly to family members.[94] Families also told stories of staff 'slacking off' on the job, such as staff members using a mobile phone for a personal call during medication dispensing[95] or sitting around smoking outside rather than answering the door or caring for residents.[96]

2.67 However, the committee also heard evidence that not all staff at Oakden were problems for the facility. Some individual staff members offered small glimmers of hope for family members, who described how they would feel most comfortable

87 Ms Sharon Olsson, *Committee Hansard,* 21 November 2017, pp. 43–44.

88 Ms Sharon Olsson, *Committee Hansard,* 21 November 2017, p. 43.

89 Mrs Alma Krecu, *Committee Hansard,* 21 November 2017, p. 61.

90 *Oakden report*, pp. 33–57.

91 Mrs Natasha Glowik, *Committee Hansard,* 21 November 2017, p. 71.

92 Mrs Petrina Cole, *Committee Hansard,* 21 November 2017, p. 60.

93 Ms Maria Costa, *Committee Hansard,* 21 November 2017, p. 68.

94 Ms Christine Blakely, *Committee Hansard,* 21 November 2017, p. 60.

95 Mrs Natasha Glowik, *Committee Hansard,* 21 November 2017, p. 72.

96 Ms Christine Blakely, *Committee Hansard*, 21 November 2017, p. 61.

leaving their loved ones behind when those staff were on duty.[97] Dr Thomas Stubbs, Chair of the Oakden Response Oversight Committee, also affirmed that:

> …we should not forget that despite all the horrors of Oakden there are a lot of very dedicated and very good staff who did a great job. That needs to be remembered in all of this.[98]

## The one thing I would change…

2.68 During the course of the hearing on 21 November 2017, members of the committee asked the witnesses appearing in the family member panels to outline the one thing they wished they could change about aged care following what had happened at Oakden. Recommendations and suggestions from families included:

(a) independent reviews of aged care facilities;[99]

(b) sufficient funding for appropriate mental health aged care facilities, including funding for sufficient beds in more than one location;[100]

(c) a reporting hotline for the aged care sector;[101]

(d) appropriate training for staff, including on-the-job training in dementia care;[102]

(e) fixing the culture of mental health and aged care, particularly in relation to respect for residents;[103]

(f) more information for families about advocates, complaints mechanisms, and consumer rights;[104] and

(g) encouraging a greater understanding of dementia and related issues.[105]

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97 Ms Maria Costa, *Committee Hansard*, 21 November 2017, pp. 68–69; Mrs Natasha Glowik, *Committee Hansard*, 21 November 2017, p. 71; Ms Deanna Stojanovic, *Committee Hansard*, 21 November 2017, p. 71.

98 Dr Thomas Stubbs, Chair, Oakden Response Oversight Committee, *Committee Hansard*, 21 November 2017, p. 1.

99 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, p. 66.

100 Mrs Petrina Cole, *Committee Hansard*, 21 November 2017, p. 66; Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 67.

101 Mr Stewart Johnston, *Committee Hansard*, 21 November 2017, p. 66.

102 Ms Christine Blakeley, *Committee Hansard*, 21 November 2017, p. 66; Mrs Barbara Spriggs, *Committee Hansard*, 21 November 2017, p. 67; Mr Mark Martin, *Committee Hansard*, 21 November 2017, p. 74; Ms Maria Costa, *Committee Hansard*, 21 November 2017, p. 74.

103 Ms Deanna Stojanovic, *Committee Hansard*, 21 November 2017, p. 74.

104 Mrs Alma Krecu, *Committee Hansard*, 21 November 2017, p. 67.

105 Mrs Natasha Glowik, *Committee Hansard*, 21 November 2017, p. 74; Ms Maria Costa, *Committee Hansard*, 21 November 2017, p. 74.

2.69 The committee notes that many of these recommendations from family members reflect those found in reviews and responses from the Commonwealth and SA governments, detailed in the next chapter.

***Committee view***

2.70 Evidence presented to the committee shows that the Oakden facility failed to provide an appropriate model of care: it was not the right care at the right time from the right team in the right place. This was manifest in facilities and attitudes of decades earlier, care that did not reflect national or international best practice and the total lack of an endorsed model of care for older person's mental health in SA.

2.71 The committee wishes to note that while this inquiry has not delved deeply into the appropriateness of mental health services provided at Oakden, it must be considered that the model of care issues found at Oakden will become increasingly relevant to aged care service delivery around Australia, with the increasing rates of dementia in our ageing population, and the increasing use of mixed-model services, where specialist mental health and dementia services are provided within the context of a mainstream aged care service.

2.72 The committee agrees with evidence from submitters and witnesses that poor or inappropriate training and a culture of fear, silence and cover-up among staff were major contributors to the inadequate care provided to residents at Oakden. In addition, perceptions that the Oakden facility would be outsourced to an NGO and categorisation of the facility as sub-acute meant there were too few staff to manage care in accordance with modern standards.

2.73 Most of all, the committee is deeply concerned that warning signs in relation to resident health were not heeded, such as unexplained bruising, medication mismanagement and falls, and that complaints from family members and community advocates were ignored.