The Senate

Community Affairs References Committee

Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

Interim report

February 2018

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45th Parliament

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ABBREVIATIONS

AHPRA	Australian Health Practitioner Regulation Agency
AHSSQA Scheme	Australian Health Service Safety and Quality Accreditation Scheme
ALRC	Australian Law Reform Commission
BPSD	Behavioural and psychological symptoms of dementia
Carnell Paterson review	*Review of National Aged Care Quality Regulatory Processes*
CEO	Chief Executive Officer
Committee	Senate Community Affairs References Committee
Complaints Commissioner	Aged Care Complaints Commissioner
CVS	Community Visitor Scheme
Elder abuse report	*Elder Abuse – A National Legal response*
ENs	Enrolled Nurses
ICAC	Independent Commission Against Corruption
ICBUs	Intensive Care Behavioural Units
MOC	Model of care
NALHN	Northern Adelaide Local Health Network
NGOs	Non-government organisations
NSQHS	National Safety and Quality Health Service
Oakden	Oakden Older Persons Mental Health Facility
Oakden committee	Oakden Response Plan Oversight Committee
Oakden report	*The Oakden Report*
OPMHS	Older Persons Mental Health Services
PCV	Principal Community Visitor

Quality Agency	Australian Aged Care Quality Agency
RACF	Residential aged care facility
the Repat	Repatriation General Hospital
SA	South Australia
SA Health	South Australian Department of Health
SA ICAC	SA Independent Commissioner Against Corruption
SA Minister	Minister for Mental Health and Substance Abuse
Single quality framework	Single Aged Care Quality Framework
SIRS	Serious incident response scheme
SOA	Schedule of Accommodation
TCUs	Transitional Care Units

LIST OF RECOMMENDATIONS

Recommendation 1

4.85 The committee recommends the extension of this inquiry into the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised.

Recommendation 2

4.88 The committee recommends that in the current aged care oversight reforms being undertaken, all dementia-related and other mental health services being delivered in an aged care context must be correctly classified as health services not aged care services, and must therefore be regulated by the appropriate health quality standards and accreditation processes.

Chapter 1

Introduction

> I witnessed so much bad culture in the place that was absolutely disgusting. It was disgusting. I would often think, 'Animals are treated better than these poor people.'[1]

1.1 This inquiry was established to review the effectiveness of aged care frameworks in ensuring vulnerable aged Australians receive quality care and are protected from abuse, with a focus in the first instance on the critical care failures in the Makk and McLeay wards of the Oakden Older Persons Mental Health Facility[2] (Oakden) in South Australia (SA). This facility has been the subject of a number of investigations, some of which are ongoing.

1.2 During the course of this inquiry, the Senate Community Affairs References Committee (committee) heard many personal accounts from family members regarding the poor care given to residents of Oakden. The committee is deeply concerned with the nature of the evidence presented to this inquiry which detailed the sub-standard, and in some cases abusive, treatment of highly vulnerable older Australians with cognitive or mental health impairments.

1.3 The committee is further concerned with evidence which points to systemic issues that negatively impact the quality of aged care services, not only at Oakden but throughout Australia.

1.4 This interim report is focused on the abject failures of the systems designed to provide oversight of care standards at Oakden. The committee's broader concerns regarding aged care quality frameworks, which the committee considers require review and consideration, are also outlined in this interim report.

Overview

1.5 In February 2016, Mr Bob Spriggs, a resident of Oakden, was admitted to the Royal Adelaide Hospital Emergency Department with unexplained significant bruising to his hip, a chest infection and severe dehydration. In June 2016, the Spriggs family made a complaint to the Principal Community Visitor (SA) who raised concerns with the Northern Adelaide Local Health Network (NALHN). After repeated unsuccessful attempts over four months to seek a response from NALHN and the Office of the Chief Psychiatrist (SA) regarding the complaint, the Principal

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1 Ms Deanna Stojanovic, Family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 71.

2 The Oakden Older Persons Mental Health Facility (Oakden) is comprised of three wards. The Makk and McLeay wards are long term Commonwealth subsidised Residential Aged Care for older people with neurocognitive disorders with severe and extreme behavioural and psychosocial symptoms of dementia (BPSD). The Clements ward provides transitional care for older people with complex, severe and enduring mental illness, while their clinical presentation is stabilised and appropriate longer term care options are identified.

Community Visitor noted the inaction in his annual report which was sent to the SA Minister for Mental Health and Substance Abuse (SA Minister) on 30 September 2016. The Principal Community Visitor also wrote to the SA Minister on 14 October 2016 to formally request a review of service delivery at Oakden and that NALHN meet with the Spriggs family regarding their complaint. The annual report was tabled in the SA Parliament on 7 December 2016 and generated media interest for the issues it contained. Subsequently, the Chief Executive Officer (CEO) of NALHN agreed to meet with the Spriggs family in December 2016 and after this meeting requested the Chief Psychiatrist undertake a review into Oakden.[3]

1.6 The Chief Psychiatrist's review *Oakden Report – Report of the Oakden Review* (Oakden report) was highly critical of the services provided at Oakden and found 'a system that gave all members of the Review little comfort. For each of us, we saw aspects of a mental health system that we had thought confined to history.'[4]

1.7 The Chief Psychiatrist made six recommendations regarding the quality and provision of clinical care at Oakden in his review, and ultimately recommended the facility be closed. The SA Government undertook to implement all six recommendations and subsequently decommissioned the Makk and McLeay wards at Oakden and relocated all residents into the Northgate Aged Care facility and the residential aged care sector.[5]

1.8 In order to implement the six recommendations of the Oakden Report, the SA Government established the Oakden Response Plan Oversight Committee and is providing $14.7 million to construct a new facility for older persons with mental health issues. This amount includes $1 million to develop a new contemporary model of care as recommended in the Oakden report.[6]

1.9 The Australian Government also took action in response to the incidents at Oakden. On 1 May 2017, the Federal Aged Care Minister, the Hon. Ken Wyatt AM MP, announced a review into aged care quality regulatory processes to be conducted by Ms Kate Carnell AO and Professor Ron Paterson ONZM.[7] The review's report, *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson

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3 Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian (SA) Government), *Oakden Report – Report of the Oakden Review* (*Oakden report*), April 2017, p. 1, Mr Maurice Corcoran, Principal Community Visitor, *Committee Hansard*, 21 November 2017, p. 25-28, Principal Community Visitor, *Annual Report, Mental health Services 2015-16* and Mr Maurice Corcoran, *Letter to The Hon Leesa Vlahos MP, Minister for Mental Health and Substance Abuse, 14 October 2016*, (tabled 21 November 2017).

4 *Oakden report*, p. 115.

5 SA Government, *Submission 28*, p. 3.

6 SA Government, *Submission 28*, p. 3.

7 The Hon. Ken Wyatt AM, MP, Minister for Aged Care, 'Federal Aged Care Minister to Commission Review of Aged Care Quality Regulatory Processes ', Media Release 1 May 2017 and 'Appointment of Panel to review National Aged Care Quality Regulatory Processes', Media Release 11 May 2017.

review), was published in October 2017 and made ten recommendations.[8] The Australian Government immediately moved to implement recommendation 8, unannounced audit visits, while it considered the entire review in detail, a process still underway at the time of drafting this interim report.[9] It is expected that a response to the other recommendations of the review will be included in the 2018–19 Federal Budget.[10]

1.10 The Australian Aged Care Quality Agency (Quality Agency) also took action, commissioning Nous Group to undertake a review of Quality Agency accreditation and quality monitoring processes. The Nous Group report was released on 31 July 2017 and made four key recommendations, each with short term and long term steps to improve Quality Agency processes.[11] The Quality Agency accepted all recommendations, and moved immediately to implement key recommendations such as revising their risk framework and expanding their case management. A small number of recommendations were referred to the Department of Health (Australian Government) or the Aged Care Regulation Review for further consideration.[12]

1.11 A more detailed discussion of the responses of the SA and Australian Governments to the systemic failures of relevant aged care oversight frameworks is contained in Chapter 3.

Key events

1.12 The following table provides a summary of the key events in the history of service delivery at Oakden.

8 Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report*, October 2017, pp. xi-xiii.

9 The Hon. Ken Wyatt AM, MP, Minister for Aged Care, 'Quality review released: Aged care assessment visits to be unannounced', Media Release 25 October 2017.

10 Ms Catherine Rule, First Assistant Secretary, Department of Health, *Committee Hansard*, 5 February 2018, pp. 17, 20.

11 Nous Group, *External independent advice: Australian Aged Care Quality Agency*, 31 July 2017.

12 Australian Aged Care Quality Agency, *Quality Agency Response to Nous*, available at https://www.aacqa.gov.au/about-us/response-to-nous-report, accessed 3 January 2018.

Table 1.1–Timeline of Oakden

November 1982	Oakden facility opened as a psychogeriatric unit for older people with a history of mental illness. At the time of the Oakden report, the service had expanded to also cater for older people with neurocognitive disorders with severe and extreme behavioural and psychosocial symptoms of dementia (BPSD). Staff consisted of Mental Health Nurses and Enrolled Nurses (ENs) as well as other specialist and allied health staff.
1998	SA Health gained Commonwealth Quality Agency accreditation to change classification of Makk and McLeay wards from an SA Health funded mental health facility to a Commonwealth-funded Residential Aged Care Facility (RACF) – which applies lower funding per bed. Consistent with other RACFs, Personal Care Assistants were introduced and ENs encouraged to undertake medication training to allow them to perform tasks previously allocated to Registered Nurses.
1999	A series of concerns led to Acting CEO of North West Adelaide Health Service to organise an external review of the Quality of Care for Older Persons Mental Health Services at Oakden. The review made a number of recommendations about the organisation and funding of services at Oakden.
2001	Initial privatisation discussions undertaken between SA Government and a not for profit organisation.
2001–2007	During this period, Oakden was only granted Commonwealth aged care accreditation for 12 month periods (with one 2-year period). Oakden report later concluded these shorter than usual periods of accreditation should have raised attention regarding quality of care issues.
February – July 2007	Quality Agency accreditation audit of Oakden found facility failed 6 expected outcomes and recommended sanctions, which were not enacted by the Department of Health (Australian Government). Department of Health issued a notice of non-compliance for one unmet outcome.
October 2007	Quality Agency accreditation audit found Oakden met all expected outcomes.
December 2007	Failed Quality Agency accreditation audit – facility did not meet 26 of Commonwealth's 44 expected outcomes and sanctions were imposed. ACH Group entered into a joint partnership with SA Health to assist with the operations of the services.
January – April 2008	After a series of unannounced visits and audits, a non-compliance notice was issued by the Department of Health.

August 2008	Standards deemed improved and Quality Agency accreditation audit once again found Oakden met all expected outcomes. Accreditation extended to April 2009.
February 2009	Site visit conducted and Oakden found to have met all standards. Accreditation granted for another 12 months.
2010	ACH Group ended partnership and Oakden returned to the full management responsibility of SA Health local Mental Health Services with continued Commonwealth funding for Makk and McLeay wards. At that time Oakden was found by the Quality Agency to have met all 44 standards and accreditation granted for three years.
July 2011	SA Community Visitor Scheme commenced operations. Visits to Oakden began. Oakden staff reported feelings of job uncertainty over future of the facility and that many allied health service positions were left vacant for long periods when staff were on leave or resigned.
March 2013	Quality Agency grants accreditation for a further three years.
2013	Community Visitor Scheme reported four residents passed away and that a doctor at Oakden requested a visiting geriatrician for complex medical conditions but did not receive a response to this request.
May 2014	Community Visitor Scheme reported Oakden staff concerned there was not a psychologist at the facility.
July 2014	Community Visitor Scheme reported another three residents died due to pneumonia within the facility. Staff commented that the need to document use of restraints was time consuming.
2015	Community Visitor Scheme reported staff dismayed by discontinuation of funding for a social worker at the facility. Community Visitor Scheme wrote to the Executive Director of Mental Health about allied health staff levels.
13 January 2016	Mr Bob Spriggs admitted to hospital after receiving 10 times the prescribed amount of antipsychotic medication.
February 2016	Mr Spriggs referred to the Royal Adelaide Hospital Emergency Department with significant bruising to his hip for which there was no satisfactory explanation. Mr Spriggs also had a chest infection and was highly dehydrated.
February – March 2016	Quality Agency audit was conducted and accreditation granted for a further three years.

1 June 2016	Spriggs family made complaint to Principal Community Visitor.
7 June 2016	Principal Community Visitor forwarded complaint to Director of Nursing at Oakden. Reached agreement to have consumer liaison officer carry out an investigation.
9 June 2016	Principal Community Visitor forwarded complaint to Chief Psychiatrist and asked for investigation.
20 July, 25 July, 30 August, 2 September 2016	Principal Community Visitor unsuccessfully sought response from NALHN and Chief Psychiatrist on request for Oakden investigation.
September 2016	Community Visitor Scheme reported staff raised concerns there was no occupational therapist or social worker available on site.
30 September 2016	Principal Community Visitor included reference to lack of response to Spriggs' family complaint in annual report presented to Minister.
14 October 2016	Principal Community Visitor wrote to Minister regarding length of time to respond to Spriggs' family complaint and asked for a formal review of services.
November 2016	Quality Agency unannounced assessment contact visit – Oakden met all assessed expected outcomes.
7 December 2016	Principal Community Visitor annual report tabled in SA Parliament which generated media interest in issues.
Mid December 2016	CEO of NALHN met with Spriggs family.
20 December 2016	CEO of NALHN requested the Chief Psychiatrist conduct an external independent review of Oakden due to concerns about the level of clinical care being provided.
17 March 2017	Quality Agency audit – 15 of 44 standards not met – 3 sanctions were imposed and accreditation period reduced to October 2017.
20 April 2017	Chief Psychiatrist's Oakden report released containing 6 recommendations.
	SA Government response to Chief Psychiatrist's report released - accepted all 6 recommendations.
1 May 2017	Federal Aged Care Minister commissioned Carnell Paterson review.
25 May 2017	Independent Commission Against Corruption (ICAC) investigation announced into the management and delivery of services and care at Oakden. There was no specified reporting

	date.
9 May – 14 June 2017	Quality Agency made 31 audit visits, finding that 15 standards were still unmet up to the facility's closure.
14 June 2017	SA Government decommissioned Makk and McLeay wards. 14 residents relocated to Northgate Aged Care facility and 12 relocated into the residential aged care sector.
June 2017	Oakden Response Plan Oversight Committee established to provide oversight and guidance to SA Health in implementing the six recommendations outlined in the Oakden report.
July 2017	SA Health established six expert working groups to implement each of the Chief Psychiatrist's recommendations.
31 July 2017	The Nous Group report released on 31 July 2017 made four key recommendations, each with short term and long term steps to improve Quality Agency processes. The Quality Agency accepted all recommendations.
October 2017	Carnell Paterson review published. Made 10 key recommendations.
	Commonwealth Government revokes NALHN's approval as a Commonwealth-subsidised provider of aged care.

Source: SA Government, *Submission 28*; Oakden report; Carnell Paterson review; *Committee Hansard*, 21 November 2017 and 5 February 2018; Nous Group, *External independent advice: Australian Aged Care Quality Agency;* Department of Health (Australian Government), answers to questions on notice, 5 February 2018.

1.13 A full timeline of the Australian Government interactions with the Oakden facility, including audits, sanctions and various orders for compliance, for the ten years preceding the facility's closure, is included as Appendix 1 to this report.

Interim report structure

1.14 Following this introductory chapter, this report consists of three subsequent chapters:

- Chapter 2 outlines the evidence specific to incidents of poor care and abuse at Oakden;
- Chapter 3 details the responses to date from the Australian and SA Governments; and
- Chapter 4 outlines broader concerns raised beyond issues specific to Oakden, and contains the committee's conclusions and recommendations.

Conduct of inquiry

1.15 On 13 June 2017 the Senate referred this inquiry to the committee with a reporting date of 18 February 2018 and the following terms of reference:

(a) the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;

(b) the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;

(c) concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;

(d) the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;

(e) the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;

(f) the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and

(g) any related matters.[13]

1.16 To assist submitters and witnesses in focusing their evidence, the committee published the following clarification on the inquiry website:

> This inquiry was referred to the committee in response to the reported incidents in the Makk and McLeay Aged Mental Health Care Service at Oakden in South Australia, and will examine the current aged care quality assessment and accreditation framework in the context of these incidents.[14]

Submissions

1.17 The inquiry was advertised on the committee's website and the committee wrote to stakeholders inviting them to make submissions.

1.18 The committee also issued a media release to promote public awareness about ways individuals could engage with the inquiry. The media release was published on the committee's website and tweeted using the @AuSenate handle.

1.19 The committee invited submissions to be lodged by 3 August 2017. Submissions continued to be accepted after this date. The committee agreed that to

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13 *Journals of the Senate*, No. 42, 13 June 2017, pp. 1384-1385.

14 Community Affairs References Committee, *Inquiry webpage*, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality.

protect the privacy of individuals providing sensitive material, all submissions from individuals would be accepted as confidential, unless requested otherwise.

Public hearings

1.20 The committee held two public hearings, on 21 November 2017 in Adelaide and on 5 February 2018 in Canberra. The committee also held a confidential hearing in Adelaide on 22 November 2017.

Acknowledgments

1.21 The committee would like to thank all those who participated in this inquiry as submitters and witnesses. The committee would like to particularly acknowledge the family members of residents at Oakden who provided crucial evidence to the committee by revisiting very traumatic personal experiences. Without committed family members advocating for loved ones, issues such as the failure of care at Oakden would never come to light. In the words of one such family member:

> We will happily remain the Oakden families, if for one reason only, and that is to allow the state and country to never forget that their old way of treating our elderly is over. We will forever hold them to account and see a complete overhaul of the care received and expected.[15]

15 Mr Stewart Johnston, Family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 59.

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.

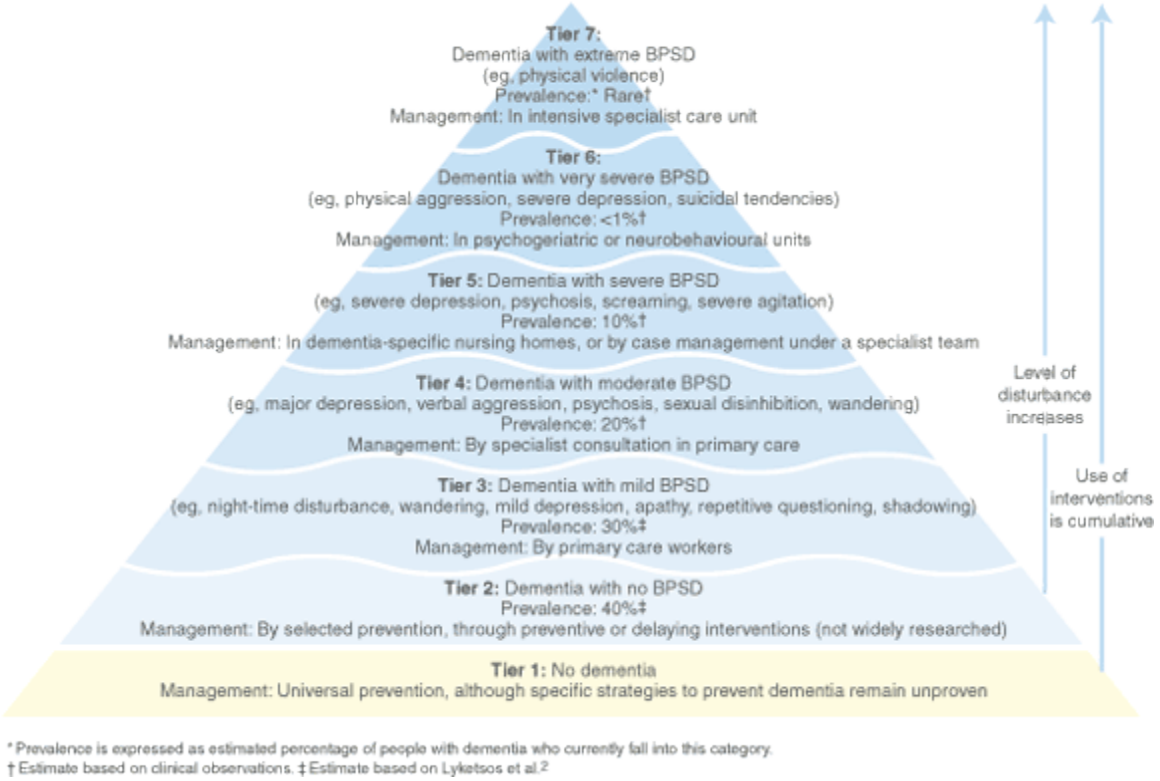
44 *Oakden report*, April 2017, p. 27.

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.

Chapter 3

Responses

> Once again, it was not the regulators, but a community visitor whose complaint about Oakden resulted in an independent outside report that exposed what had been happening at the regularly accredited Oakden.[1]

3.1 Chapter 1 provided an overview of the history of the Oakden Older Persons Mental Health Facility (Oakden), and a timeline of the key events that led to the exposure of the sub-standard care being provided. Chapter 2 has provided details about the treatment endured by residents of Oakden. This chapter will review the responses to date from the relevant government entities with management and oversight responsibilities for Oakden.

Regulatory responsibilities

3.2 In order to review the adequacy of the responses of the South Australian (SA) Government and the Australian Government, it is useful to establish a summary of the various funding, management and oversight responsibilities. While the Oakden facility was a SA Government owned and managed facility, the Australian Government Department of Health (Department of Health), Australian Aged Care Quality Agency (Quality Agency) and Aged Care Complaints Commissioner (Complaints Commissioner) all play a role in ensuring standards of care in aged care facilities, and in identifying issues of concern and responding to complaints. The following table provides a summary.

Table 3.1–Aged care responsibilities

Entity	Responsibilities
Australian Government	Funds the majority of aged care (around $17.5 billion in 2016–17) and regulates aged care service delivery to ensure that older Australians can access safe and quality care.
Department of Health	Australian Government department. Administers the *Aged Care Act 1997*, including funding for aged care providers. Based on information provided by Quality Agency, Complaints Commissioner and the public, determines if Accreditation Standards have been breached and can educate the provider, issue a notice of non-compliance or impose sanctions.
Complaints Commissioner	Australian Government agency. Reports to the

1 Aged Care Crisis Inc., *Submission 41*, p. 53.

	Australian Government Minister for Aged Care. Independently resolves complaints about Australian Government funded aged care services and educates providers about the best ways to handle complaints.
Quality Agency	Australian Government agency. Reports to the Australian Government Minister for Aged Care. Accredits residential care services in accordance with the Quality Agency Principles, and the Accreditation Standards made under the *Aged Care Act 1997*.
Northern Adelaide Local Health Network (NALHN), SA Department of Health (SA Health)	Approved provider of the Oakden Older Persons Mental Health Service (Oakden). At the time of critical care incidents, had full management responsibility.

Source: Aged Care Complaints Commissioner, *Submission 7* and Department of Health (Australian Government), *Submission 37.*

SA Government actions

3.3 The timeline of events provided in Chapter 1 indicates that there was not a swift response to the Spriggs family complaint from the SA Government. Evidence presented by the SA Principal Community Visitor shows the agreement from NALHN to meet with the Spriggs family came after there was media attention to the publication of details about the complaint, which was then six months old. This evidence also points to the SA Chief Psychiatrist not responding to initial requests from the SA Principal Community Visitor to investigate the Spriggs family complaint.

3.4 However, when action was finally taken by NALHN and the Chief Psychiatrist, it was comprehensive. After meeting with the family on 20 December 2016, the Chief Executive Officer (CEO) of NALHN commissioned the SA Chief Psychiatrist to formally investigate service delivery at Oakden, which ultimately resulted in the closure of the facility and the establishment of an oversight committee to advise on the development of contemporary older persons' mental health services.

3.5 Despite taking this action, the SA Government did not notify the Quality Agency that the review was taking place, or that SA Health had formed such a serious view on the quality of care being delivered at this Commonwealth-accredited aged care facility. The first time Australian Government agencies became aware of the review being undertaken by the SA Chief Psychiatrist was on 17 January 2017 via media reports.[2] NALHN also advised the Department of Health about the review at a

2 Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report (Carnell Paterson review)*, October 2017, p. 35.

meeting on 20 March 2017 regarding the sanctions that had been put in place by the Department.[3]

The Oakden report

3.6 The review of services at Oakden was conducted by the SA Chief Psychiatrist, Dr Aaron Groves, in the first quarter of 2017. The *Oakden Report – The report of the Oakden Review* (Oakden report) was released on 20 April 2017 and made the concerning finding that:

> …the Oakden facility is more like a mental institution from the middle of the last century than a modern Older Person's Mental Health Facility.[4]

3.7 The Oakden report found service and care deficiencies in the following areas:

- **Inappropriate Model of Care**: there was no satisfactory, specific Model of Care for the types of services provided at Oakden.[5]
- **Poor infrastructure**: Oakden was entirely unsuitable for its current purpose. The substandard quality of the infrastructure was likely to have led to considerable difficulty providing appropriate management of the most severe challenging behaviours of Dementia.[6]
- **Staffing concerns:** there was not an accurate staffing profile linked to an appropriate Model of Care, staff lacked training opportunities, staff lacked knowledge on reporting elder abuse and there was a shortage of trained mental health nurses and Allied Health staff.[7]
- **Governance failures:** there was a failure of governance, particularly across all components of a Clinical Governance Framework, leading to poor levels of clinical care across a broad range of areas.[8]
- **Toxic culture:** the dominant culture was characterised by: poor morale, disrespect and bickering, secrecy, an inwardly looking approach, control, a sense of entitlement and indifference.[9]
- **Restrictive practice:** staff working did not have the sufficient level of training in restrictive practices, leading staff to use restrictive practices beyond those outlined in the relevant legislation framework.[10]

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3 Department of Health, answers to questions on notice, 5 February 2018 (received 8 February 2018).

4 Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian (SA) Government), *Oakden Report – The report of the Oakden Review (Oakden report),* April 2017, p. 57.

5 *Oakden report*, pp. 31–32.

6 *Oakden report*, p. 57.

7 *Oakden report*, pp. 65–66.

8 *Oakden report*, pp. 89–90.

9 *Oakden report*, p. 100.

3.8 The Oakden report made six detailed recommendations around the issues of:

(i) developing a specialised contemporary model of care for people over 65 years of age who live with the most severe forms of disabling mental illness and/or extreme behavioural and psychological symptoms of dementia (BPSD);

(ii) provision of appropriate infrastructure to implement the model of care;

(iii) developing a staffing model that utilises the full range of members of a multi-disciplinary service;

(iv) developing a new and appropriate clinical governance system;

(v) ensuring there are people in senior leadership positions that can create a culture that values dignity, respect, care and kindness for both consumers and staff; and

(vi) developing an action plan based on Trauma Informed Principles and the six core strategies developed by the National Centre for Trauma Informed Care, with a goal of reducing the use of restrictive practice.

3.9 The Oakden report made the following key conclusion:

> At the very heart of the intent of this report's recommendations is that Oakden must close and that it must be replaced by a range of contemporary services that aspire to excellence in care to the most vulnerable people in South Australia. But more fundamental should be the lesson that the failings of Oakden should never happen again.[11]

3.10 In addition to findings on the sub-standard services provided at Oakden, the Oakden report also commented on regulatory oversight processes, finding that there were many practices at the facility 'that no accrediting body would ever endorse, if it was aware of its occurrence'.[12]

3.11 The Oakden report found that Oakden developed a culture of making periodic attempts to meet accreditation standards, that staff were trained in what to say during accreditation visits, and that service problems which were identified in 2007 were present throughout the last 10 years. The Oakden report concluded that:

> It is an important lesson for all involved in trying to ensure that the best care is provided that reliance only on periodic reviews, such as accreditation, leads to a sense of comfort that may not be meritorious.[13]

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10 *Oakden report*, pp. 113–114.

11 *Oakden report*, p. 115.

12 *Oakden report*, p. 78.

13 *Oakden report*, p. 77.

Response to Oakden report – SA Government

3.12 While the Oakden review by the SA Chief Psychiatrist was underway, NALHN undertook a number of immediate actions to improve the service at Oakden, including:

- employing a new clinical practice coordinator with extensive experience in aged care and dementia care to provide clinical and operational oversight at Oakden;
- an increase in hours of the consultant psychiatrist;
- the engagement of three after-hours registered nurses;
- the employment of a part-time social worker and occupational therapist;
- the employment of a nurse adviser to provide high-level regulatory independent advice to management; and
- the employment of a senior clinical pharmacist and part time clinical pharmacist.[14]

3.13 On the release of the Oakden report, the SA Government announced it would implement all six recommendations of that report.[15] SA Health established the Oakden Response Plan Oversight Committee (Oakden committee) in June 2017 'to provide oversight and guidance to SA Health in implementing the six recommendations outlined in the Oakden Report'.

3.14 The Oakden committee further established six expert working groups to implement each of the Oakden report recommendations.[16] The expert groups are made of 'a mixture of external people and internal people, experts in the particular field and in particular a lot of people with lived experience'.[17]

3.15 Below is the list of working groups, and their key outcomes as of 15 December 2017:

- **Model of Care Expert Working Group**: draft new model of care submitted to the Chief Executive, SA Health for endorsement.
- **New Facility Expert Working Group**: has developed a Schedule of Accommodation (SOA) which is based on the Models of Care Project.
- **Staffing Expert Working Group:** nearing completion of a recommended staffing profile for Neuro-behavioural Unit. In early 2018 will prepare a

14 *Oakden report*, p. 3.

15 SA Government, *Response to the Review of the Oakden Older Persons Mental Health Service*, April 2017.

16 SA Government, SA Health, *Oakden Response Plan Oversight Committee Communique – Issue 6*, 15 December 2017.

17 Dr Tom Stubbs, Chair, Oakden Response Oversight Committee, *Committee Hansard*, 21 November 2017, p. 3.

staffing profile for the Specialist Residential Units and the community-based Rapid Access Service.

- **Quality and Safety Expert Working Group**: draft Clinical Governance Framework under consideration and consultation.
- **Culture Expert Working Group:** focus groups will convene in January 2018 to guide the development of a culture framework that will address and promote respectful behaviours, values-based leadership, effective problem solving and positive communication.
- **Restrictive Practices Expert Working Group:** completed an implementation plan for a comprehensive program to reduce restrictive practices.[18]

3.16 The SA Government subsequently decommissioned the Makk and McLeay wards at Oakden and relocated all residents into the Northgate Aged Care facility and the residential aged care sector.[19] The SA Government has since allocated $14.7 million to construct a new older persons' mental health facility. This amount includes $1 million to develop the contemporary model of care and undertake longer term service planning, on which the new facility will be based.[20]

SA Independent Commissioner Against Corruption

3.17 The Oakden report and the Australian Government commissioned review, discussed later in this chapter, found that despite clear warnings signs, and in some cases formal complaints, there was a lack of action from all levels of the administrative and oversight systems within the SA Government and Australian Government. Evidence presented to this inquiry by a former staff member at Oakden concurs with those findings:

> It was so demoralising. We weren't sleeping and our health was being affected. We did try and see the Commonwealth department of ageing, and that just got us nowhere. There were commiserations with the ED, because they had a minister to report to…I said, 'We're not going to go anywhere. Let's go to the health rights commissioner,' …but were told that she didn't have the resources to help us, that we weren't really going to get anywhere and we should look after our own careers. So, with that, feeling totally demoralised, having failed at making the changes that I was to make—and I've never had this situation before—I left. I went back to my substantive position, because I knew I couldn't cope with it any longer.[21]

3.18 Family members of Oakden residents who have closely followed the various reviews have expressed similar views:

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18 SA Government, SA Health, *Oakden Response Plan Oversight Committee Communique – Issue 6*, 15 December 2017.

19 SA Government, *Submission 28*, p. 3.

20 SA Government, *Submission 28*, pp. 3–4.

21 Ms Sharon Olsson, *Committee Hansard*, 21 November 2017, p. 44.

> [T]here 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.[22]

3.19 In response to these issues, the SA Independent Commissioner Against Corruption (SA ICAC) is conducting an investigation into incidents at Oakden. In announcing the investigation on 25 May 2017, the SA ICAC stated:

> [The investigation] will focus on the extent to which all people in authority, from local management to executive leadership and Ministers, were aware of the conditions and sub-optimal care being delivered at the facility, when they became aware of such information, and what if any action was taken in response to that information. Alternatively, if information did not become known to appropriate persons in authority, my investigation will enquire as to why and how this may have occurred.[23]

3.20 The terms of reference for the investigation include whether appropriate complaints mechanisms were in place, whether complaints were brought to the attention of senior staff or SA or Australian Government officers and what actions were taken, whether anyone took steps to 'cover up' reports of poor care.[24] The SA ICAC stated the findings of the investigation would be published if it was 'in the public interest'. There is no set date for completion of the investigation or subsequent possible publication of the findings.

SA Police

3.21 As of September 2017, nine former Oakden staff were referred to SA Police for investigation, triggered by the SA Chief Psychiatrist's report.[25] In December 2017, a former Oakden staff member, working at the Northgate facility where many Oakden residents were transferred to, was reported to police for alleged assault relating to the use of restrictive practices. As part of the subsequent police investigation, it was

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22 Mr Stewart Johnston, Family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 58.

23 The Hon. Bruce Lander QC, SA Independent Commissioner Against Corruption, *Public Statement, 25 May 2017.*

24 The Hon. Bruce Lander QC, SA Independent Commissioner Against Corruption, *Terms of Reference: Oakden Maladministration Investigation*, 30 May 2017.

25 Adam Langenberg, 'First Oakden staffer to be charged by police since scandal began', *The Advertiser*, http://www.adelaidenow.com.au/news/south-australia/first-oakden-staffer-to-be-charged-by-police-since-scandal-began/news-story/d3433df9504bbe3cc8e8a90ba950dd65, (accessed 29 January 2018).

discovered that two other cases of assault occurred within six months, with one case taking five months before it was reported to police by the facility.[26]

Committee view

3.22 Whilst noting the findings of the SA ICAC investigation will be only published if it is in the public interest, the committee is of the view that these findings are likely to be pertinent to any broader recommendations this committee would wish to make on appropriate quality oversight and regulation of the aged care sector.

Australian Government responses

3.23 As outlined previously in this chapter, the Australian Government was not notified of the serious concerns with quality of care that the SA Government had formed regarding Oakden. In response to the care issues at Oakden coming to light via the media, the Australian Government took two key steps. First, the Minister for Aged Care, the Hon. Ken Wyatt AM, MP, announced an independent review on national aged care quality regulatory processes.[27] The outcomes of the review report, *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson review), was published in October 2017 and made ten recommendations. As a second step, the Australian Government immediately moved to implement recommendation 8, unannounced audit visits, while it considered the entire review in detail, a process still underway at the time of drafting this interim report. The findings of the report are discussed in greater detail later in this chapter.

Quality Agency actions

3.24 Concerns raised throughout this inquiry with Quality Agency processes in relation to Oakden centred on the Quality Agency audit of March 2016, where Oakden was found to have met all Accreditation Standards and was accredited for a further three years.[28] This was one month after Mr Spriggs had been admitted to hospital with unexplained bruising, dehydration and an untreated chest infection.

3.25 The committee heard evidence that consultants who were hired to improve services at Oakden also did not understand how Oakden was able to pass accreditation audits despite longstanding issues of concern with service delivery.[29] The same consultants told the committee of the serious consequences of Quality Agency failures to identify poor service outcomes at Oakden:

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26 Leah MacLennan, 'Oakden: Assault investigated at facility for patients moved from disgraced nursing home', ABC News Online, http://www.abc.net.au/news/2017-12-28/oakden-culture-transferred-to-northgate/9290354, (accessed 29 January 2018).

27 The Hon. Ken Wyatt, AM, MP, Minister for Aged Care, *Media release - Federal Aged Care Minister to Commission Review of Aged Care Quality Regulatory Processes*, 1 May 2017.

28 *Carnell Paterson review*, p. 34.

29 Mrs Carla Baron, Partner (Retired), N & C Baron & Associates, *Committee Hansard*, 21 November 2017, p. 44.

> Normally in an organisation those little things might not have been big. But in this case it actually supported institutionalised elder abuse. And that's what Makk and McLeay were, make no mistake.[30]

3.26 There is also evidence that the recommendations of auditors were not always taken on board by the Quality Agency in relation to Oakden. In January 2008, the Quality Agency considered whether to continue Oakden's accreditation following a December 2007 audit finding that 26 out of 44 expected outcomes were not met. The assessment team that had conducted the evaluation recommended that the facility not be accredited and the Quality Agency considered this along with other factors, such as NALHN's response to the assessment report and actions which had undertaken since. The Quality Agency set aside the audit team's recommendation, describing its decision in a letter to NALHN on 7 January 2008:

> The assessment team also recommended that the Agency revoke the home's accreditation. In making its decision, the Agency considered the home's level of noncompliance, compliance history and the home's remaining period of accreditation. While the home still has non-compliance, the Agency is satisfied that the home is continuing to make improvements to ensure the health, safety and well-being of residents. [31]

3.27 The CEO of NALHN pointed out that despite the failings at Oakden now being recognised as longstanding, Oakden received full Quality Agency accreditation in 2010 and at every subsequent audit a full three year accreditation cycle was granted. The CEO of NALHN told the committee:

> In fact, as recently as February 2016, Makk and McLeay passed all 44 expected outcomes under the Commonwealth Accreditation Standards and received a three-year accreditation period. Makk and McLeay also received an unannounced visit from the Commonwealth auditors in October 2016, and passed that assessment as well. At no time were concerns raised with NALHN in relation to systems and processes on any of these occasions until the audit conducted between 6 March 2017 and 17 March 2017, following the announcement of the Chief Psychiatrist's Oakden review.[32]

3.28 Of significant concern, is that the Quality Agency also conducted an assessment contact visit to Oakden as late as November 2016, and Oakden was found to have met all assessed expected outcomes.[33]

3.29 However the findings of the next audit were significantly different. After the Spriggs family complaint become public knowledge and the SA Chief Psychiatrist undertook an investigation into Oakden, the Quality Agency conducted another audit of the facility. On 28 February 2017, 12 months after the previous audit and a mere

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30 Mr Neil Baron, Partner (Retired), N & C Baron & Associates, *Committee Hansard*, 21 November 2017, p. 45.

31 *Carnell Paterson review*, p. 31.

32 Ms Jackie Hanson, Chief Executive Officer, Northern Adelaide Local Health Network, SA Health, *Committee Hansard*, 21 November 2017, p. 2.

33 *Carnell Paterson review*, p. 35.

four months after the unannounced contact visit, the Quality Agency undertook an audit which included examination of incident reports and medication charts. That audit used two assessors as distinct from the previous audit which used a single assessor. The report of the February 2017 audit raised a number of issues of concern which instigated a review audit in March, a rare occurrence that is indicative of potentially serious issues at a facility. The review audit was conducted by three assessors over a fortnight and found that residents were not being provided with adequate care and that the facility had failed 15 of the 44 Accreditation Standards.[34]

3.30 The Department of Health then determined an immediate and severe risk to residents and imposed the following sanctions:

> 1. The approved provider is not eligible to receive Commonwealth subsidies for any new care recipients for a period of three (3) months.
> 2. Revocation of approved provider status, unless an adviser, is appointed by the approved provider for a period of six (6) months, at its expense, to assist the approved provider to comply with its responsibilities in relation to care and services.
> 3. Revocation of approved provider status, unless the approved provider agrees to provide relevant training within six (6) months, at its expense, for its care staff, managers and key personnel to support it in meeting the needs of care recipients.
>
> Reason(s) for sanction:
>
> The department identified that there is an immediate and severe risk to the health, safety and wellbeing of care recipients at the service following information received from the Australian Aged Care Quality Agency (the Quality Agency). The department has serious concerns in relation to the following:
>
> - deficiencies in medication management,
> - failure to follow medical and allied health instructions and as a result placing care recipients at risk of injury or decline in health status,
> - care recipients not receiving correct medications, including overdose and significant delays in receiving medication, and
> - lack of clinical supervision and monitoring at the service.[35]

3.31 The Quality Agency subsequently undertook a series of actions to investigate why Oakden passed the March 2016 audit, when it later failed the March 2017 audit. The CEO of the Quality Agency told the committee:

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34 *Carnell Paterson review*, pp. 35–36.

35 Australian Government: myagedcare, *Makk and McLeay Nursing Home Sanction detail*, 17 March 2017, https://www.myagedcare.gov.au/compliance-information/summary/sanction-detail?tab=1&location-type=proximity&state=SA&location-action-type=AS&sp-id=1-DS-1103&sp-service-id=1-EI-8372&location-by-state=true&page=1&id=1-9FE1REP&status=Archive, (accessed 10 January 2017).

> [T]here is no doubt that the quality agency has some significant learnings to take away from the failures at Oakden.[36]

3.32 In discussing why the March 2016 Quality Agency audit did not identify concerns with the quality of care at Oakden, the Quality Agency told the committee that key information from previous audits was not adequately taken into account in later audits, and that there were improvements to be made in how the Quality Agency identifies service risk and ensures those risks are addressed.[37] This focus on identifying serious risk appears to now underlie the Quality Agency's approach to accreditation and assessment.[38]

3.33 The Quality Agency told the committee that in the case of Oakden, due to a 'culture of cover-up in that facility' it took a significant amount of time to uncover the extent of service problems:

> If I may, I might quote Dr Groves himself on radio here in Adelaide in April this year. He said that he visited the home for half a day in June of last year. That is four months after our re-accreditation audit. The quote was, 'There was nothing to see then.' The fact that he found nothing and that we did not find it in February of last year doesn't mean that it wasn't there. It did take Dr Groves, another psychiatrist, a chief psychiatric nurse and a health researcher who visited the facility for 10 straight weeks to uncover the rate of abuse going on. There was a culture of cover-up in that facility. We're determined to take the steps—we're already undertaking the steps—so that we will be much more alert systemically as well as with the training and available resources and times to pick that up were that to occur again.[39]

3.34 However, gerontologist Dr Anna Howe submitted that the failure was not in the information gathered during the audit process, but the subsequent Quality Agency decision making on what follow up or remediation actions were required:

> Rather than failures to identify poor quality care, the failures are clearly in decision-making by the Agency that over-rode recommendations made by assessors who had visited Oakden, had seen poor care, and had reported on the shortcomings, and done so repeatedly.[40]

3.35 The Quality Agency has maintained that, although they held responsibility for accreditation of the Oakden facility, they should not shoulder the blame for the failings of that facility due to the misinformation provided to, and information

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36 Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency (Quality Agency), *Committee Hansard*, 21 November 2017, p. 11.

37 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 13; Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, pp. 2–4.

38 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, pp. 2, 7.

39 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 13.

40 Dr Anna Howe, Gerontologist, *Submission 73*, p. 3.

withheld from, their accreditation staff.[41] The CEO told the committee that although there were lessons to be learned, their processes did find problems at Oakden:

> We did find noncompliance, and I think it's good to repeat it for the record. Whilst we think that based on better information we might have made a different decision 23 months ago—that's in February of 2016—before the Oakden report ever came out, we were aware of a serious medication error in late January of last year. We conducted an unannounced assessment contact. We were very concerned by what we found. We conducted a full review audit—that's a full audit against all 44 outcomes, not as part of the three-year cycle. We found [15] instances of outcomes not met. We reduced their accreditation to six months. Sanctions were applied by the department at that time. We were meeting then and were doing, in some instances, daily visits to the homes before Dr Groves and his colleagues had produced the Oakden report.
>
> So, yes, our system did work but, based on better information, strength and methodology, it may have been picked the year before.…Do I wish it had worked earlier? Yes. Were there lessons to be learnt? Yes. Did we publicly acknowledge that and undertake a review? Yes. Did we participate in all the reviews? We did.[42]

3.36 The Quality Agency denied that there was any culture of 'tick and flick' around assessment processes and noted that there are now processes in place to rotate accreditation staff through different facilities.[43]

3.37 The Quality Agency also told the committee of the requirement for hospitals to disclose negative findings from any other scrutiny to the health accreditation process, which is not required in the aged care sector. The Quality Agency admitted this non-disclosure may have impacted the ability of an audit process to uncover service concerns:

> Had we had access to the information available in the Clements wing, which is the hospital wing, not the residential aged care wing, we may have been better focused.[44]

3.38 The Quality Agency stated that the principal of open disclosure is replicated across the world, and the Quality Agency was keen to see that implemented into aged care audit processes in future.[45] The Quality Agency further told the committee that it had undertaken a co-accreditation sample with the Australian Council on Healthcare Standards for a hospital in Victoria which also provides aged care, and that the

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41 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, p. 2.

42 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, p. 6.

43 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, pp. 2, 3.

44 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, pp. 15-16.

45 Ms Ann Wunsch, Executive Director, Operations, Quality Agency, *Committee Hansard*, 21 November 2017, p. 13.

Quality Agency was 'interested in understanding how hospital accreditation and aged-care accreditation can better work together'.[46]

3.39 The CEO of the Quality Agency told the committee of processes it undertook once the Spriggs family complaint became known:

> Clearly, we had information in January of this year of a medication error at Oakden, at the Makk and McLeay wings of Oakden. We conducted an unannounced visit and a full review audit. Then, we did find failure against medication management as an outcome. The performance of a home can change in 12 months, by the way. The performance of homes can change over three months. But I was not satisfied that all of what ought to have been found in February 2016 was found, and that is why I commissioned Nous as a matter of urgency.

3.40 The Quality Agency told the committee that following the release of the Oakden report, the Quality Agency appointed Nous Group to provide external independent advice on any shortcomings in the Quality Agency aged care accreditation process.[47]

3.41 The Nous Group report was released in July 2017 and made four key recommendations, each with short term and long term steps to improve Quality Agency processes.[48] Broadly, the four key recommendations were:

(i) Use risk-based compliance monitoring.

(ii) Pre-plan audits.

(iii) Strengthen capability of auditors and provide specialist and clinical support.

(iv) Support decision-making functions for accreditation of high-risk facilities.

3.42 The Quality Agency accepted all recommendations and has begun to implement them, with a few of the underlying process recommendations referred to the Carnell Paterson review or the Department of Health for further consideration.[49] The Quality Agency also noted the complementary impact the Carnell Paterson review recommendation of unannounced audit visits would have to the Nous Group risk-based monitoring recommendation, telling the committee the 'move to unannounced visits presents an opportunity for the agency to strengthen our risk based approach, and we are working quickly to determine how to best implement this

46 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 13.

47 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 11.

48 Nous Group, *External independent advice: Australian Aged Care Quality Agency*, 31 July 2017.

49 Quality Agency, *Quality Agency Response to Nous*, available at https://www.aacqa.gov.au/about-us/response-to-nous-report, (accessed 10 January 2018).

change'.[50] In February 2018, the Quality Agency described the implemented changes to its assessment process:

> We now ask a series of key questions every time we conduct an unannounced assessment contact—that's not the re-accreditation audits—so we do want to understand risk. Where we find areas of concern, we thoroughly and quickly conduct review audits and we test to see whether there is serious risk to residents against the standards and if there is any failure against the standards.[51]

3.43 As part of the changes to its audit processes, the Quality Agency also told the committee it had adopted a new computer assisted audit tool which 'makes findings of compliance and noncompliance far more transparent'[52] and that recent improvements to risk-based monitoring has resulted in the Quality Agency being 'better placed to pick up regulatory failure where we find it; we test in a far more forensic sense the impact upon residents that is in any way linked to that failure'.[53]

3.44 The Quality Agency also described a 'strengthened relationship' with the Complaints Commissioner and Department of Health as part of the regulatory system to improve the consistency of accreditation.[54] Despite this close relationship with the Department of Health, the statutory nature of the Quality Agency means that the agency is accountable directly to the Minister and is not subject to any departmental oversight. As outlined by the Department of Health to the committee:

> We don't check the agency. They are accountable for the work that they do under the legislation that establishes them. They are accountable through to the minister and therefore the parliament in the same way that the department is.[55]

3.45 The Quality Agency also told the committee that, in future, a home with a history of non-compliance such as Oakden would always remain on the watch list for monitoring.[56] The CEO, reaffirming the responsibilities of the Quality Agency, explained to the committee:

> Any instance of poor care is unacceptable. Where there is an instance of poor care, and especially a pervasive culture of poor care as there was at Oakden, every single part of the system clearly has the opportunity to learn lessons. But do I or do my staff accept responsibility for the abuse or the neglect that occurred at Oakden? I don't. I don't believe that's a fair reckoning. I believe, and the law is very clear under the Aged Care Act, that

50 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 12.

51 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, p. 2.

52 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 16.

53 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 18.

54 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, p. 2.

55 Ms Catherine Rule, First Assistant Secretary, Department of Health, *Committee Hansard*, 5 February 2018, p. 21.

56 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 19.

> it's the provider who is responsible. But I'm not a spectator on this, Senator. I have a key responsibility and, wherever I come across, or my organisation comes across, not just poor care, we act vigilantly but, if we find that there was a pattern of misinformation, as was the case in Oakden, I need to know. I think it's absolutely clear and appropriate that I provide that publicly, if there are lessons to be learned about risk, especially historic risk, and how we better determine a long-term risk profile of a home that had historic noncompliance, serious non-compliance around 10 years ago that that home should never have fallen off our watchlist.[57]

3.46 However, while acknowledging that there are 'clearly learnings for us in terms of the way that we undertake our work,' the CEO of the Quality Agency told the committee that 'responsibility for what occurred at Oakden, under the *Aged Care Act 1997*, squarely falls with the provider.'[58]

Committee view

3.47 The committee notes that the Quality Agency has provided evidence that a single visit or accreditation process is sometimes not enough to uncover abusive treatment of aged care residents, where a facility seeks to hide that treatment. The committee is greatly concerned for the implications this evidence has on the adequacy of current processes for ensuing service quality and protecting aged care residents from abuse, given that many audits and site visits conducted by various oversight entities are conducted in a single day, as well as the ability of the Quality Agency to identify where information is being withheld or altered by providers. The committee is further concerned with evidence from the Quality Agency that processes required under health accreditation, which are very useful in uncovering service concerns, are not required under aged care accreditation processes. These are issues which have serious implications beyond Oakden, and impact the entire Australian aged care sector.

3.48 Although the Quality Agency has undertaken an external review of audit processes, the committee does not believe that review has addressed these issues.

3.49 The committee also wishes to express concerns about the Quality Agency's repeated refusal to take responsibility for what occurred at Oakden, despite renewing the facility's accreditation even after repeated non-compliance at audits over the course of a decade. This continued externalisation of blame onto the provider and dismissive attitude towards failure does not, in the view of the committee, show a genuine willingness to learn from the mistakes of the past.

Carnell Paterson review

3.50 As noted previously, in response to the issues experienced at Oakden, the Minister for Aged Care, the Hon. Ken Wyatt AM, MP, commissioned an independent review on national aged care quality regulatory processes. The review report, the Carnell Paterson review, was published in October 2017 and focused on why

57 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, p. 4.

58 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, p. 2.

'Commonwealth aged care regulatory processes did not adequately identify the systemic and longstanding failures of care at the Makk and McLeay wards'.[59]

3.51 In releasing the report, the Minister for Aged Care announced that the Carnell Paterson review recommendation for unannounced visits would be immediately implemented as the Australian Government continued to consider other details and recommendations of the review. [60]

3.52 The Carnell Paterson review made a number of disturbing findings in relation to regulatory oversight of Oakden. In responding to claims that the increased complexity of service delivery compared to other aged care facilities caused the poor care outcomes, the Carnell Paterson review found:

> [T]here were failures of care for consumers at Oakden that lay entirely within the scope of the Commonwealth's regulatory system, and were not caused by the extra layer of state health system regulation and control. They were issues that any service could experience.[61]

3.53 The Carnell Paterson review found three issues with accreditation that need to be addressed which, in summary, are:

(i) Some expected outcomes under the standards are inappropriate, particularly for leadership and restrictive practice.

(ii) Accreditation needs to look deeply into a service, by achieving more evenness in the examination of services and skills training of surveyors.

(iii) Services may prepare for accreditation cycles instead of focusing on continuous quality care.[62]

3.54 The Carnell Paterson review made six key recommendations:

- Establish an independent Aged Care Quality and Safety Commission to centralise accreditation, compliance and complaints handling (with an additional four recommendations relating to this new body).
- Enact a serious incident response scheme (SIRS) for aged care.
- Limit the use of restrictive practices.
- Implement unannounced accreditation visits.
- Strengthen assessment processes.
- Enhance powers of the complaints commissioner.

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59 *Carnell Paterson review*, p. 29.

60 The Hon. Ken Wyatt, AM, MP, Minister for Aged Care, *Media release - Quality review released: Aged care assessment visits to be unannounced*, 25 October 2017.

61 *Carnell Paterson review*, p. 39.

62 *Carnell Paterson review*, pp. 44–45.

3.55 As outlined above, the Minister for Aged Care has moved to implement unannounced accreditation visits, while the remainder of the Carnell Paterson review findings and recommendations are under review by the Australian Government.[63] The Department of Health have indicated that responses to further recommendations from the Carnell Paterson review will likely be included in the 2018–19 Federal Budget.[64]

Committee view

3.56 The recommendations of the Carnell Paterson review go well beyond issues occurring at Oakden, and call for a complete overhaul of the quality oversight and regulation framework, as well as the complaints investigation systems for the aged care sector nationally.

3.57 The committee agrees with the findings of that review, as the evidence to this inquiry received to date makes a compelling argument that the current system is out of date and is failing its duty of care to vulnerable older Australians.

3.58 Further the committee is not confident that there is not abuse elsewhere that the current compliance system has not identified.

Australian Health Practitioners Regulation Agency

3.59 The Australian Health Practitioner Regulation Agency (AHPRA) regulates 14 health professions, including all staff responsible for clinical assessment and medical care within an aged care context. They include doctors, registered and enrolled nurses, as well as physiotherapists, occupational therapists and certain other allied health staff. The Complaints Commissioner does not have jurisdiction in relation to the actions of individual registered health practitioners, and refers such complaints to AHPRA for investigation.[65]

3.60 As at 8 August 2017, a total of 34 registered health practitioner staff were referred to AHPRA for investigation in relation to Oakden.[66] To date, 13 practitioners have been issued with a caution or undertakings (which can range from requirements for education or professional monitoring or mentoring), one practitioner has been referred to a tribunal and subsequently disqualified from practice, and there are 12 open notifications under investigation.[67]

Concerns with response

3.61 Submitters and witnesses who discussed the effectiveness of government responses to quality of care issues at Oakden, were largely concerned that Oakden was not an isolated case and highlighted systemic problems with the overall aged care

63 The Hon. Ken Wyatt, AM, MP, Minister for Aged Care, *Media release - Quality review released: Aged care assessment visits to be unannounced*, 25 October 2017.

64 Ms Catherine Rule, Department of Health, *Committee Hansard*, 5 February 2018, pp. 17, 20.

65 *Carnell Paterson review*, p. 24.

66 SA Government, *Submission 28*, p, 4.

67 Australian Health Practitioners Regulation Agency, advice by phone received 18 January 2018.

quality and oversight systems nationally.[68] Evidence presented to the committee has suggested that there is no trend of aged care facilities being sanctioned or otherwise investigated in SA more than any other state or territory.[69]

3.62 Professor Joseph Ibrahim of Monash University told the committee of his strong concerns:

> My greatest concern, listening to the evidence today, is that you are focusing on a single episode rather than on the system as a whole. The research we've done indicates that bad things happen every year in every state that are potentially preventable. So what we have is a systems-wide issue in the same way that we had with patient safety in hospitals back in the nineties which we have tried to address.[70]

3.63 The Carnell Paterson review found that a view was regularly expressed that the Oakden case should be considered rare because the structure of Oakden was atypically complex, and that the residential aged care system as a whole is generally of high care. The Carnell Paterson review argued that both of these views 'risk understating the significance of the systemic issues that Oakden demonstrates'.[71] The Carnell Paterson review went further and found:

> [W]e know from Dr Groves' investigations at Oakden that the quality of care there was not accurately represented in the Agency's evaluations. If this is true at Oakden, it could well be the case elsewhere, a possibility raised with this Review by stakeholders. Accordingly, it is not possible to rely solely on the level of reported compliance with the Accreditation Standards as a robust indicator of quality in the residential care system.[72]

3.64 The Australian Medical Association expressed a similar view and submitted that Oakden should be viewed in context of the broader aged care system:

> Australia's aged care system is failing older people. The Oakden Report has shed light on a wide range of issues facing aged care. Our members are of the view that the occurrences at Oakden Older Mental Health Service (Oakden) were not isolated incidents, as they believe similar issues are seen throughout the entire aged care system.[73]

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68 Submitters and witnesses who cited Oakden as a symptom of wider systemic concerns include, but are not limited to: Aged Care Crisis Inc., Australian Law Reform Commission, Australian Medical Association, Alzheimer's Australia, Council on the Aging, Mental Health Commission of NSW, and Office of the Public Advocate Queensland.

69 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 5 February 2018, pp. 8–9; Ms Rae Lamb, Aged Care Complaints Commissioner, *Committee Hansard*, 5 February 2018, p. 15; Ms Catherine Rule, Department of Health, *Committee Hansard*, 5 February 2018, p. 21.

70 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Monash University, *Committee Hansard*, 21 November 2017, p. 30.

71 *Carnell Paterson review*, p. 38.

72 *Carnell Paterson review*, p. 40.

73 Australian Medical Association, *Submission 13*, p. 1.

3.65 Chapter 4 will discuss the broader concerns raised by witnesses and submitters to this inquiry, as well as detail some recent and ongoing actions being taken in relation to the regulation of the national aged care sector.

Committee view

3.66 It is clear from the evidence presented to this inquiry and from the reports of the two key external reviews into Oakden, that once action to address quality of care issues at Oakden was finally taken by the responsible government entities, it was extensive and effective. What is of deep concern to the committee is the length of time it took for the SA Government and Australian Government to respond to the concerns of residents, their families and whistleblower staff who had been raising issues for many years to no effect. Many subsequent instances of abuse and neglect occurred as a direct result of those with the oversight responsibility not acting earlier.

Chapter 4

A national concern

> [T]here is evidence to suggest that accreditation may not be adequate in delivering quality care outcomes for consumers.[1]

4.1 As outlined in Chapter 3, many of the submitters and witnesses to this inquiry have raised concerns that the oversight and regulation failures, which allowed the poor conditions at Oakden to continue for so long, are not isolated to the specialised type of service delivery at Oakden, and that the same regulatory failures can be seen more widely across the aged care sector.

4.2 Conversely, aged care sector providers and representative organisations have submitted that Oakden was a special case, and should not be seen as representative of the broader aged care sector or the quality oversight frameworks.[2]

4.3 Notwithstanding the views of aged care providers themselves, a significant body of evidence has been presented to this inquiry which highlights a broad range of problems with the quality oversight and regulation framework. Given the extensive evidence received of this nature and the terms of reference for this inquiry, this chapter will not seek to analyse or make recommendations on those sector-wide regulatory and oversight concerns. Instead, this chapter will highlight the key concerns raised within the scope of this inquiry, which go beyond the regulatory and oversight failures specific to Oakden and impact the aged care sector as a whole.

Concerns raised in evidence

Broad concerns with the accreditation system

4.4 Submitters and witnesses raised a number of broad criticisms of the current accreditation system.

4.5 Monash University Health Law and Ageing Research Unit submitted that the existing regulatory mechanisms are almost 20 years old, and there has been 'profound changes in the past 20 years about measuring, regulating and investigating quality of care'. The submission from Monash University further stated that the aged care regulatory mechanisms and legal systems are 'complex, fragmented and risk averse with divergent, discordant or contradictory approaches. This contributes to significant gaps in care, especially in [Residential Aged Care Facilities] (RACFs)'.[3]

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1 Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report (Carnell Paterson review)*, October 2017, p. 62.

2 This view that care concerns at Oakden were caused by issues specific to the circumstances at Oakden was raised in submissions from Aged and Community Services Australia, Aged Care Industry Association, BUPA, and Leading Age Services Australia.

3 Professor Joseph E Ibrahim and Associate Professor Lyndal Bugeja, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Submission 29*, p. 15.

4.6 The Victorian Government submitted that while the accreditation process has supported improvements in RACFs over the past two decades, the focus on compliance to minimum accreditation standards by individual providers does not support sector-wide capacity building or encourage improvements beyond the minimum benchmarks.[4]

4.7 The Victorian Government submitted it supports amending the Accreditation Standards to ensure they are clear, measurable and specifically applicable to residential aged care.[5] The Victorian Government further submitted that the monitoring approach should not focus only on individual providers, but should also monitor the performance of the aged care sector as a whole.[6]

Specialised dementia and mental health care

4.8 The committee heard that there is an increase in the prevalence of dementia and the increased demand for specialist beds is growing faster than supply.[7] Responding to this need, in the 2016–17 Mid-Year Economic and Fiscal Outlook the Australian Government announced the introduction of Specialist Dementia Care Units in residential aged care settings.[8]

4.9 However, there does not appear to be an Australian Aged Care Quality Agency (Quality Agency) accreditation process specific to aged care services with specialist elements of mental health or Behavioural or Psychological Symptoms of Dementia (BPSD) services. The South Australian (SA) Chief Psychiatrist argued the current aged care assessment and accreditation framework is not suitable for care settings for consumers with severe mental illness and dementia care needs.[9]

4.10 The Australian Commission on Safety and Quality in Health Care advised the *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson review) that all health services where patients have a severe form of dementia should be assessed against the National Safety and Quality Health Service (NSQHS) Standards. The Makk and McLeay wards were not assessed against the NSQHS Standards as they were rated as aged care facilities, despite the fact that the specialised aged care being delivered incorporated dementia and mental health services.

4 Victorian Government, *Submission 40*, p. 1.

5 Victorian Government, *Submission 40*, pp. 1–2.

6 Victorian Government, *Submission 40*, p. 2.

7 Alzheimer's Australia, *Submission 20*, p. 12. See also *Carnell Paterson review*, pp. 38–39.

8 The Hon Sussan Ley MP, Minister for Health and Aged Care, Media Release 19 December 2019, '*2016-17 MYEFO Drives Health Reform*', http://www.health.gov.au/internet/ministers/publishing.nsf/Content/E757065F44BAF304CA25808E0019AFB5/$File/SL109.pdf, (accessed 29 January 2018).

9 Chief Psychiatrist, Department for Health and Ageing (South Australian (SA) Government), SA Health, *Submission 27*, p. 7.

Conversely the Clements ward, which was not receiving Commonwealth aged care funding, was assessed against these higher health care standards.[10]

4.11 The Carnell Patterson review found that despite some stakeholders arguing Oakden does not represent the mainstream aged care sector, the issue of specialist dementia and mental health care in an aged care context is relevant to the broader aged care sector:

> We know from the Aged Care Funding Instrument, for example, that around half of residential care consumers have symptoms of mental illness. This group overlaps with the approximately half who have dementia. We know that frailty is increasing, and that the number of people in care with dementia (and therefore with severe dementia) is increasing. Oakden is not unique, because the characteristics and needs of its residents were not unique.[11]

4.12 The Carnell Paterson review found that regulation must include the capacity to review the full complexity of care being provided to aged care residents and wrote:

> The regulatory system must be designed to respond to the profile of consumers in a service. Had that been the case ten years ago, Oakden—and other facilities with more vulnerable consumers—could have been supported and monitored more closely.[12]

Consumer involvement

4.13 Multiple submitters and witnesses argued that the accreditation and audit processes do not adequately involve consumers and their families.[13] This view was also put forward by the Chief Executive Officer (CEO) of the Northern Adelaide Local Health Network (NALHN) in relation to accreditation audits conducted at Oakden:

> Take Oakden as an example: the residents of Oakden had little or no capacity themselves to speak to people who came for assessments. I don't believe that the carers or the families of the people who lived at Oakden were given an opportunity to share their perceptions with the accreditors. Certainly the past residents' families that I met with subsequent to the report being released, they all, without exception, reported observing the same issues, the same behaviours, the same treatment over many, many years. If they had been involved in the accreditation process, because the residents had no capacity, we would have seen a different outcome.[14]

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10 *Carnell Paterson review*, p. 37.

11 *Carnell Paterson review*, p. 39.

12 *Carnell Paterson review*, pp. 38–39.

13 See for example submissions from: Carers NSW, Council on the Ageing, Federation of Ethnic Communities' Councils of Australia, Mental Health Commission of NSW, Officer of the Public Advocate Queensland and Victorian Government.

14 Ms Jackie Hanson, Chief Executive Officer, Northern Adelaide Local Health Network, SA Health, *Committee Hansard*, 21 November 2017, p. 7.

4.14 The Quality Agency submitted the current audit process has been recently amended to ensure a minimum of 10 per cent of care recipients and their representatives are interviewed using a new structured interview process with standardised questions and that consumers' feedback is published in Consumer Experience Reports as part of a move to greater transparency.[15]

4.15 However Alzheimer's Australia submitted there needs to be greater involvement of consumers at the organisational level of the Quality Agency itself, to drive improvement in the quality assessment processes.[16]

4.16 Submitters also argued the Accreditation Standards only let consumers know which RACFs are failing, but do not let consumers know which facilities are providing high quality care.[17] Older Persons Advocacy Network also submitted that the accreditation process does not require consumers be informed when there are concerns in relation to a facility.[18]

4.17 The Federation of Ethnic Communities' Councils of Australia submitted that processes to accredit and monitor RACFs do not adequately cater for the needs of ageing Australians from a culturally and linguistically diverse background, particularly in the lack of independent translation services provided during accreditation and audit visits.[19]

Personal care vs medical care and clinical governance

4.18 Evidence to this committee shows there is a clear schism in how the aged care sector defines different levels of aged care services as personal care as opposed to health or medical care, and therefore the level of clinical governance required for that care.

4.19 HammondCare, which operates more than 1000 residential aged care places, submitted:

> [I]t is not appropriate for the accreditation framework for residential aged care services to monitor the appropriateness of medical care provided to residents, as aged care homes are not medical facilities. While approved providers of residential aged care under the Aged Care Act 1997 are required to provide residents with nursing services and to assist them with daily living activities, their responsibility when it comes to medical care is simply to assist in accessing the services of appropriate medical practitioners as required (Quality of Care Principles 2014, p.6)…
>
> As aged care homes are not responsible for the direct provision of medical care, they should not be held accountable for the manner in which it is

15 Australian Aged Care Quality Agency (Quality Agency), *Submission 42*, pp. 6, 13–14; Mr Nick Ryan, Chief Executive Officer, Quality Agency, *Committee Hansard*, 5 February 2018, p. 2.

16 Alzheimer's Australia, *Submission 20*, p. 14.

17 Alzheimer's Australia, *Submission 20*, p. 7 and Carers Australia NSW, *Submission 21*, p. 2.

18 Older Persons Advocacy Network, *Submission 23*, p. 3.

19 Federation of Ethnic Communities' Councils of Australia, *Submission 32*, p. 2.

> provided. Instead, the adequacy and appropriateness of the medical care provided to aged care residents should be overseen by the appropriate medical colleges.[20]

4.20 Despite arguing that aged care providers are not responsible for medical care, HammondCare also submitted evidence on the specialised health care services it provides, which includes services for people with severe behavioural and psychological symptoms of dementia and palliative care.[21]

4.21 However, the Productivity Commission 2001 report *Caring for Older Australians* defines the 'care' component of aged care as a 'mix of health (or medical care) and personal care services'.[22] Importantly, the Productivity Commission does not make a distinction between medical care and other forms of health care, such as mental health or nursing care.

4.22 Leading Age Services Australia, a national peak body representing aged care service providers, submitted that many providers have recommended that in order to properly assess the quality of clinical care being provided in individual RACFs, all Quality Agency auditors should have a background in clinical care.[23] BUPA similarly submitted that allied health service provision should be considered in the Quality Agency assessment process.[24]

4.23 However, Aged and Community Services Australia, another provider representative body, argued that individual clinical care was not an area that the Quality Agency should be assessing at all, and submitted that:

> Concerns about the standard of care provided by doctors and other health practitioners should be considered by the appropriate health practitioner body and is not something that an assessor from the Australian Aged Care Quality Agency would or should be able to make a decision about.[25]

4.24 The Quality Agency submitted that clinical issues, such as governance and practices, are currently incorporated into the Quality Agency's Accreditation Standards.[26]

4.25 However, Professor Craig Whitehead of Flinders University noted that clinical care oversight in the aged care sector was significantly less developed than in health care, and told the committee:

> One of the things that struck us is that the idea of quality or clinical governance in an aged care institution is very much in its infancy. Some

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20 HammondCare, *Submission 11*, pp. 4–5.

21 HammondCare, *Submission 11*, p. 2.

22 Productivity Commission, *Caring for Older Australians*, 8 August 2011, Volume 2, p. 12.

23 Leading Age Services, *Submission 4*, p. 4.

24 BUPA, *Submission 18*, p. 14.

25 Aged and Community Services, *Submission 12*, p. 5.

26 Quality Agency, *Submission 42*, pp. 12–13.

> aged care organisations are starting to look at risk and quality and managing adverse events, but, by and large, it is not mandated.[27]

4.26 The Victorian Government submitted it supported the development of a clinical governance framework for aged care providers, arguing 'the clinical needs of people living in residential aged care are increasing' and that clearly defining clinical care standards will facilitate workforce development.[28] The Victorian Government further submitted that this framework should include a definition of clinical risk as 'where action or inaction on the part of the organisation results in potential or actual adverse health impact' and goes on to list a number of personal care services such as hydration and nutrition, skin integrity and oral hygiene which, if done poorly or neglected, can result in adverse health outcomes for elderly people.[29]

4.27 The Law Council of Australia submitted that any changes to the oversight of clinical governance should include oversight of prescription medications, in particular the use of antipsychotic medications, which is linked to the practice of chemical restraint.[30]

Committee view

4.28 The lack of a defined model of care, coupled with appropriate clinical governance to deliver that model of care, was raised in Chapter 2 as a significant contributor to the substandard service delivery at Oakden.

4.29 The committee notes the evidence shows this issue is not isolated to Oakden. The evidence presented to this inquiry shows there is significant conflict within the aged care sector as to the definition of the care being provided, who is responsible for providing appropriate clinical care in RACFs, and which agencies should have quality oversight responsibility of that care.

4.30 The current impasse cannot continue and needs to be resolved.

Abuse and Restrictive practices

4.31 Investigations of care and practices at Oakden revealed an over-reliance on restrictive practice. The chair of the Oakden Oversight Committee stated it was one of the worst aspects of the abusive treatment found at Oakden.[31] The SA Chief Psychiatrist report found that:

> There has been ongoing, repeated use of restrictive practices at Oakden that has contravened legislation, national standards, state policy and local

27 Professor Craig Whitehead, Clinical Director, Rehabilitation, Aged Care and Palliative Care, Flinders University, *Committee Hansard,* 21 November 2017, p. 31.

28 Victorian Government, *Submission 40*, pp. 2–3.

29 Victorian Government, *Submission 40*, p. 5.

30 Law Council of Australia, *Submission 24*, p. 7.

31 Dr Tom Stubbs, Chair, Oakden Response Oversight Committee, *Committee Hansard*, 21 November 2017, p. 3.

> procedures and likely implemented for staff convenience and or used as punishment.[32]

4.32 Beyond Oakden, the unregulated use of restrictive practice across the broader aged care sector was raised by a number of submitters and witnesses as being a key concern. Alzheimer's Australia noted the use of chemical restraint, in the form of over-prescribing antipsychotic medication, was a continuing problem in the aged care sector.[33]

4.33 The Law Council of Australia also raised concerns with restrictive practice, and pointed to the Australian Law Reform Commission (ALRC) June 2017 report, *Elder Abuse – A National Legal response* (Elder abuse report), discussed in greater detail later in this chapter, which recommended regulating the use of restrictive practice in the aged care sector.[34]

Aged care workforce

4.34 A number of different workforce related issues were raised as matters of concern by submitters and witnesses, including training, staffing levels and regulation.[35]

4.35 Monash University submitted that the lack of gerontology-specific nursing training directly impacted the ability of nurses to monitor standards of care in aged care:

> [T]here is not a single tertiary nursing course on gerontology, let alone specific training for care of persons in [RACFs]. With such a large gap in the nursing workforce knowledge and training it is unreasonable to expect nurses to be able to monitor standards of care, advocate and challenge the status quo. This is very unlike the situation of health care in public hospitals.[36]

4.36 Staffing levels were raised in a number of submissions, with the majority being in favour of minimum nurse to patient ratios 'to ensure that skilled care can be provided to residents in a timely way'.[37] The Victorian Government pointed to the

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32 Dr Aaron Groves, Chief Psychiatrist, SA Health, *Oakden Report – Report of the Oakden Review*, p. 113.

33 Alzheimer's Australia, *Submission 20*, p. 20.

34 Law Council of Australia, *Submission 24*, pp. 9–10.

35 Workforce concerns, such as levels of staff and training, were raised in submissions from Australian Law Reform Commission, Bupa, Australian Nursing and Midwifery Federation, Law Council of Australia, Office of the Public Advocate Queensland, Mental Health Council of NSW, Monash University, NSW Nurses and Midwives Association and Victorian Government, among others.

36 Department of Forensic Medicine, Monash University, *Submission 29*, p. 16.

37 Victorian Government, *Submission 40*, p. 3. Staffing levels was also raised in submissions from Aged Care Crisis Inc., Australian Nursing and Midwifery Federation, NSW Nurses and Midwives Association, Occupational Therapy Australia, Office of the Public Advocate Queensland, Queensland Nurses and Midwives' Union and Victorian Government, among others.

ALRC Elder abuse report, which expressed concern that low staffing levels could lead to restrictive practises being used to manage patients, as well as lead to abuse or neglect.[38]

4.37 The heavy reliance of personal care attendants in the aged care workforce was also raised as a significant concern for quality care, given it is an unregulated workforce.[39] Submitters pointed to the recommendations of the ALRC Elder abuse report to increase the regulation of this section of the aged care workforce.[40] This recommendation was also made by the recent Senate inquiry into the *Future of Australia's Aged Care Workforce*.[41]

Data

4.38 The lack of data on quality of care was raised by multiple submitters as being a significant barrier to ensuring an appropriate quality framework for aged care services. Monash University discussed this at great length, and pointed to a recent study of coronial data which indicates there are a disturbing number of preventable deaths occurring in RACFs.[42]

4.39 Following on from the above study, Monash University have produced a report *Recommendations for prevention of injury-related deaths in residential aged care services,* which makes 104 recommendations on strategies to prevent similar deaths from choking, medication events, physical restraint, an unexplained absence 'while in respite care', suicide and, resident–resident aggression.[43]

4.40 Monash University further submitted there is a lack of empirical research into RACFs, regulatory mechanisms and quality of care, largely due to the lack of dedicated funding to support research, and that research is made all the more difficult by the lack of readily available, standardised national measures for quality of care.[44]

4.41 In relation to medication management data, the Department of Health have indicated that the government does not currently collect specific data on prescription rates or patterns of usage in aged care as many people who live within RACFs may not receive all of their medications through that facility. However national residential medication charts, where they are in use, offer an opportunity for data collection about

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38 Victorian Government, *Submission 40*, p. 4.

39 Department of Forensic Medicine, Monash University, *Submission 29*, p. 16. This issue was also raised by Alzheimer's Australia.

40 See submissions from Council on the Ageing, Law Council of Australia and Victorian Government, among others.

41 Senate Community Affairs References Committee, *Future of Australia's aged care sector workforce*, April 2017.

42 Department of Forensic Medicine, Monash University, *Submission 29*, pp. 13–14.

43 Department of Forensic Medicine, Monash University, *Submission 29*, p. 14.

44 Department of Forensic Medicine, Monash University, *Submission 29*, p. 16. The lack of appropriate data and the impact on quality of care was also raised in submissions from: Aged Care Crisis Inc., Aged Care Industry Association and Victorian Government, among others.

medications prescribed in particular facilities, and data under the PBS can be narrowed to the population aged over 65 years, so these could be areas for improvement in data research in the future.[45]

Critical, serious or reportable incidents

4.42 The Quality Agency told the committee 'no accreditation or compliance monitoring system can fully safeguard against individual instances of abuse or neglect'.[46] The Law Council of Australia similarly submitted that the accreditation looks at systemic issues, not individual serious incidents[47] and recommended a serious incidents response scheme.[48]

4.43 Monash University discussed the need for a 'national register which is comprehensive, coordinated and requires mandatory reporting of a suite of significant adverse events that include but are not limited to: physical restraint, elder abuse, resident–resident aggression, suicide, choking, unexplained absences that are occurring in [RACFs]'.[49]

4.44 The Victorian Government similarly raised the need for a reportable incident register and pointed to the ALRC Elder Abuse report recommendation for an independent body to oversee the investigating and monitoring of serious incidents.[50]

Complaints handling

4.45 In addition to the need for a serious incident reporting framework, submitters and witnesses discussed the need to improve the complaints handling systems, both within individual RACFs and systemically.[51]

4.46 Mr Stewart Johnston, a family member of a resident at Oakden, told the committee there is a range of serious problems with the complaints handling systems, both internal and external:

> Overwhelmingly, the consistent theme for all people who have come forward to me in the conversations I've had is the confusion experienced about where to lodge a complaint, how to lodge a complaint and whether it's safe to lodge a complaint. And after lodging a complaint via the many

45 Ms Catherine Rule and Mrs Lisa La Rance, Department of Health, *Committee Hansard*, 5 February 2018, pp. 22–23.

46 Mr Nick Ryan, Quality Agency, *Committee Hansard*, 21 November 2017, p. 11.

47 Law Council of Australia, *Submission 24*, p. 9.

48 Law Council of Australia, *Submission 24*, pp. 11–12.

49 Department of Forensic Medicine, Monash University, *Submission 29*, p. 19. The need for improvements to individual and systemic responses to critical, serious or reportable incidents was also raised in submissions from Australian Law Reform Commission, Council on the Aging, Office of the Pubic Advocate Queensland, Queensland Nurses and Midwives Union and Victorian Government.

50 Victorian Government, *Submission 40*, p. 4.

51 Attendant Care Industry Association, *Submission 19*, p. 7; Older Persons Advocacy Network, *Submission 23*, p. 3; Law Council of Australia, *Submission 24*, p. 11.

> channels, there are no clear avenues of independence and responsibility to follow up communication.[52]

4.47 The SA Principal Community Visitor told the committee of his concerns that complaints raised within facilities are investigated by a member of staff, raising conflict of interest issues as well as concerns regarding the complaints investigation skills of the person reviewing the complaint:

> The way that complaints are raised at facilities—say at NALHN at the moment—are investigated is by a consumer liaison officer, which is a member of staff who sits among staff that they're investigating. So it puts them in a very difficult situation. Again, I think it's really important to have a level of independence of anyone investigating any of these complaints and it's important that they have the skill sets—the investigative interviewing skills—and a background in enquiry and in making objective independent assessments.[53]

4.48 The CEO of NALHN told the committee that many complaints to relevant external agencies are never made, due to fears of repercussions or other intimidation:

> I asked them why they [family members of Oakden residents] didn't complain. They complained internally, to the management team. I'm not speculating when I say they were intimidated, in relation to using any of the external agencies to make further complaints…It is my view that people who could have complained were intimidated.[54]

4.49 The Aged Care Complaints Commissioner (Complaints Commissioner) agreed that there was work to be done around encouraging consumers to engage with complaints processes, particularly where they are conducted by a Commonwealth entity:

> …I do think there is some evidence that more people know about us and more people are coming to us, but I would be the first to admit that there's a lot more we have to do and particularly to help those people who are frightened to come to us or who are worried that there'll be repercussions.… If you're sitting in an aged-care facility and you're worried about involving the Commonwealth Aged Care Complaints Commissioner because that might lead to repercussions, a local advocate can be equally as effective with some complaints and seem a lot less scary. The provider's certainly likely to be perhaps a little less intimidated than if it's escalated to us. There's that opportunity.[55]

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52 Mr Stewart Johnston, Family member of Oakden resident, *Committee Hansard*, 21 November 2017, p. 58.

53 Mr Maurice Corcoran, SA Principal Community Visitor, *Committee Hansard*, 21 November 2017, p. 28.

54 Ms Jackie Hanson, Northern Adelaide Local Health Network, SA Health, *Committee Hansard*, 21 November 2017, p. 9.

55 Ms Rae Lamb, Aged Care Complaints Commissioner, *Committee Hansard*, 5 February 2018, p. 15.

4.50 The Complaints Commissioner echoed the evidence provided by other witnesses and submitters that consumers have problems with engaging with the complaints process as it stands for a number of reasons and described the work being done to change this, including:

- actively encouraging industry to be more open about complaints, with increased transparency in complaints processes;
- working with providers to improve complaints handling 'at the front door', as many complaints are made to the provider first;
- working with advocacy networks to help families and consumers through complaint processes either with a provider, a state or territory entity, or with the Complaints Commissioner; and
- raising the public profile of the Complaints Commissioner to ensure that consumers know this is an avenue for complaints.[56]

4.51 The Complaints Commissioner also provided evidence that the complaints resolution process in aged care does not have the same strength as similar processes for health care, submitting that all Australian hospitals are required to openly disclose adverse events to patients and their families and respond appropriately, but no such requirement exists in aged care. The Complaints Commissioner further submitted that '[r]equiring proactive and appropriate open disclosure of adverse events is one of the key steps to ensuring failures of care are acknowledged and appropriately and promptly remediated'.[57]

Broader actions

4.52 In addition to the Oakden-specific responses outlined in Chapter 3, the Australian Government is undertaking two key reforms of the aged care sector. These are discussed below.

Independent Aged Care Legislated Review

4.53 A critical input to future reform is the Independent Aged Care Legislated Review, undertaken by Mr David Tune AO PSM. This review assessed the impact of aged care reforms announced in 2012, how the system has changed and adapted, and where the Government could make further changes. The final report was provided to the Minister for Aged Care on 31 July 2017 and a response by the Australian Government has not yet been released.[58]

Single Aged Care Quality Framework

4.54 The Australian Government announced in the 2015–16 Budget it would work with the aged care sector to make changes to the Aged Care Accreditation Standards

56 Ms Rae Lamb, Aged Care Complaints Commissioner, *Committee Hansard*, 5 February 2018, pp. 11, 12, 15.

57 Aged Care Complaints Commission, *Submission 7*, p. 6.

58 Department of Health, *Submission 37*, pp. 23–24.

used by the Quality Agency, and proposed to establish a Single Aged Care Quality Framework (single quality framework) for all aged care services.[59]

4.55 The single quality framework has undergone a public consultation process on the two proposed components: a single set of quality standards and options for a streamlined approach for assessing provider performance against those quality standards.[60] It is important to note that while the single quality framework was announced in May 2015, the public consultation process was opened in March 2017, at a time when the Oakden complaints were public knowledge and the SA Chief Psychiatrist's investigation was underway.[61]

Single standards

4.56 The single set of standards, which is proposed to apply to all aged care services including residential care, home care and flexible care, were released in draft form on 30 January 2018 with a view to start the transition to these standards by mid-year.[62] These standards:

> …focus on quality outcomes for consumers rather than provider processes. This will make it easier for consumers, their families, carers and representatives to understand what they can expect from a service. It will also make regulation simpler for providers working across multiple aged care services, and encourage innovation, excellence and continuous improvement.[63]

4.57 The draft standards also include a draft explanatory document detailing the application of the standards, noting that they 'have been structured so that aged care providers will only have to meet those standards that are relevant to the type of care and services they provide and the environment in which services are delivered'.[64]

4.58 The consultation report on the single quality framework noted '[p]rior to implementation, the draft standards will be tested and piloted. This will provide

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59 Department of Social Services, *Aged Care Quality Agency: 2015 Budget*, available at https://www.dss.gov.au/sites/default/files/documents/05_2015/2015_budget_fact_sheet_-_aged_care_quality_agency.docx, (accessed 10 January 2018).

60 Department of Health, *Single quality framework: focus on consumers*, available at https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers, (accessed 10 January 2018).

61 Department of Health, *Report on the outcome of consultations on the single aged care quality framework*, July 2017, p. 3.

62 Ms Catherine Rule, Department of Health, *Committee Hansard*, 5 February 2018, p. 17.

63 Department of Health, *Single set of aged care quality standards*, available at https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards, (accessed 7 February 2018).

64 Department of Health, *Draft Aged Care Quality Standards and Draft Application of Draft Aged Care Quality Standards by service type*, available at https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards/draft-aged-care-quality-standards-and-draft-application-of-draft-aged-care-quality-standards-by-service-type (accessed 7 February 2018).

valuable insight into the application and assessment of the standards and guidelines to support their refinement'.[65] The Department of Health also described publishing the draft standards at this point as 'an important step in strengthening the standards and ensuring we're setting contemporary best practice benchmarks for providers to meet'.[66] The pilot phase will be undertaken from late January to April 2018 by the Quality Agency and will involve a number of service providers and consumers from around Australia.[67]

4.59 The Department of Health further noted the development of the single quality framework as part of an overall shift to 'a more market-based system where the consumer drives quality'.[68]

4.60 The Carnell Paterson review also made comments on the need for overhaul of the current regulatory system, writing that the system 'gives the impression of being the result of multiple incremental changes, rather than system-based design to achieve the most efficient and effective regulation of quality in aged care'.[69]

Streamlined provider assessment

4.61 The 2015–16 Budget also proposed privatising aged care accreditation services:

> The Government will also work with the sector to deliver private market provision of accreditation services as part of a single aged care quality regime across both community and residential care. Currently, the Government's Aged Care Quality Agency is the sole provider of aged care accreditation services.[70]

4.62 However, the March 2017 public consultation process on the single quality framework did not include privatisation of accreditation services in the three options for assessing performance it presented for comment. The consultation report found the majority of stakeholders supported the adoption of a single, risk-based assessment process for all aged care settings, combined with the use of a safety and quality declaration by organisations providing low-risk services.[71]

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65 Department of Health, *Report on the outcome of consultations on the single aged care quality framework*, July 2017, p. 9.

66 Ms Catherine Rule, Department of Health, *Committee Hansard*, 5 February 2018, p. 17.

67 Department of Health, *Single set of aged care quality standards*, available at https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards, (accessed 7 February 2018).

68 Department of Health, *Submission 37*, p. 24.

69 *Carnell Paterson review*, p. 28.

70 Department of Social Services, *Aged Care Quality Agency: 2015 Budget*, available at https://www.dss.gov.au/sites/default/files/documents/05_2015/2015_budget_fact_sheet_-_aged_care_quality_agency.docx, (accessed 10 January 2018).

71 Department of Health, *Report on the outcome of consultations on the single aged care quality framework*, July 2017, p. 10.

4.63 The Carnell Paterson review also made comment on external regulation, and wrote:

> In our view, the rationale for regulation of residential aged care quality is that the market is an inadequate mechanism to ensure the safety and well-being of highly vulnerable residents. Elderly citizens living in care facilities, many of whom suffer from disabilities and dementia associated with ageing, are especially in need of protection.[72]

Committee view

4.64 The committee notes the fundamental change to the aged care quality assessment framework and processes being brought about under the draft single quality framework. As this new framework has only just been published in a draft form, but is directly relevant to the terms of reference for this inquiry, it will be difficult for the committee to form a final view and set of recommendations for this inquiry.

4.65 Furthermore, the committee notes the Department of Health comments that the provision of aged care is moving to a more 'market-based system', which is similar to the change to disability services which resulted in the National Disability Insurance Scheme. While this move in disability services has been positive overall, there have also been significant unintended negative consequences for some service users as well as implementation difficulties, which should be studied and used to inform any such market-based reform of aged care services.

Recent inquiries

4.66 Perhaps the most compelling argument pointing to a regulatory system that is failing to provide adequate oversight of the aged care sector is the number of recent reviews and inquiries into various aspects of aged care service delivery. Many of the recommendations made in these inquiries remain unimplemented.

Productivity Commission

4.67 The Productivity Commission recommended an overhaul of the aged care regulatory system in its 2011 report *Caring for Older Australians*, finding 'the current regulatory framework is unsatisfactory and there is scope to improve its efficiency and effectiveness while ensuring an acceptable approved standard of care'.[73] Relevant to concerns raised in this inquiry, the Productivity Commission recommended the establishment of an Australian Aged Care Commission, with Commissioners for Care Quality and for Complaints and Reviews and to implement a national independent statutory Community Visitors Program and improvements to data collecting and sharing.[74]

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72 *Carnell Paterson review*, p. v.

73 Productivity Commission, *Caring for Older Australians*, 8 August 2011, Volume 2, p. 387.

74 Productivity Commission, *Summary of Proposals Caring for Older Australians Productivity Commission Inquiry Report*, 8 August 2011, pp. 8–10.

Australian Law Reform Commission

4.68 The ALRC June 2017 Elder abuse report looked at, among other things, the issue of abuse and neglect in residential aged care facilities. The Elder abuse report recommended the development of a National Plan to combat elder abuse, and specifically in the aged care context recommended establishing a serious incident response scheme, reforms relating to the regulation of care workers, regulating restrictive practices and developing national guidelines for community visitor schemes.[75] To date these recommendations have not been implemented, or agreed to by the Australian Government.[76]

Senate inquiry into Aged Care workforce

4.69 The Senate inquiry report *Future of Australia's aged care sector workforce*, released on 28 April 2017, made a series of recommendations regarding the regulation of residential aged care workforce, including a national employment screening or worker registration scheme.[77] The Minister for Aged Care, the Hon. Ken Wyatt AM, MP, responded to the report on 21 June 2017, announcing the Australian Government's intention to establish a taskforce to support an industry led workforce strategy.[78] The Minister for Aged Care subsequently announced the establishment of the taskforce on 1 November 2017, to be led by Professor John Pollaers to 'explore short, medium and longer term options to boost supply, address demand and improve productivity for the aged care workforce'.[79]

Concluding committee view

> Aged care is the only institution where the person who goes in dies—that is almost guaranteed—so there are no repercussions for society about how they've been treated. If you have a bad education system, a bad prison system or a bad hospital system, there are repercussions for society when those people leave those institutions. That's not the case in aged care.[80]

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75 Australian Law Reform Commission, *Elder Abuse - A National Legal Response*, 14 June 2017, pp. 8-12.

76 Attorney-General's Department, *Corporate Plan 2017-21*, p. 14, https://www.ag.gov.au/About/Documents/Attorney-Generals-Department-Corporate-Plan-2017-21.PDF.

77 Senate Community References Committee, *Future of Australia's aged care sector workforce*, April 2017.

78 The Hon Ken Wyatt AM, MP, Minister for Aged Care, *Media release* 'Report welcomed as Government works to strengthen aged care sector', http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt052.htm, (accessed 29 January 2018).

79 The Hon Ken Wyatt AM, MP, Minister for Aged Care, *Media release* ' New aged care workforce taskforce to focus on safety and quality, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt109.htm?OpenDocument&yr=2017&mth=11, (accessed 29 January 2018).

80 Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Monash University, *Committee Hansard*, 21 November 2017, p. 30.

4.70 The evidence presented to this inquiry, which includes the reports of two in-depth inquiries into the services provided at Oakden, shows that Oakden had a toxic culture of wilful negligence, cover-up and avoiding management and regulatory responsibilities, which resulted in a 'care' service which shocked the two external reviews tasked with making an in-depth investigation into Oakden.

4.71 Services at Oakden included appallingly sub-standard clinical and personal care, as well as abusive practices, some of which have been reported as criminal acts. Evidence of this sub-standard care was noticeable to anyone who cared to pay attention, but it seems that no-one in a position to effect change wanted to pay the required attention.

4.72 The committee commends the SA Government for the extensive actions taken to remediate the services at Oakden. However, the committee must also strongly condemn the length of time it took for the relevant SA authorities to take action after receiving serious complaints and clear warnings relating to Oakden. Some of the instances of abuse or neglect occurred well after the date of the Spriggs family complaint, and most likely would not have been possible had appropriate action been taken at the time of the complaint.

4.73 The committee is deeply concerned that the Quality Agency visited Oakden and had no concerns with the service as late as November 2016. This a mere month before the CEO of NALHN formed a serious view about the quality of service at Oakden, a view that was based on complaints made five months earlier. The Committee is not convinced by the Agency's explanation as to how this came about.

4.74 The committee believes that if a situation like that at Oakden can occur for many years under the eyes of the regulators, then there are serious concerns about the quality of oversight for the broader aged care sector, and the quality of care being provided to vulnerable aged Australians.

4.75 The committee cannot be confident that there are not other aged care facilities where abuse and neglect are occurring elsewhere in Australia.

4.76 The committee notes that while the two key inquiries into the standards of care at Oakden have concluded, investigations into individual instances at Oakden are ongoing. These investigations are by the Australian Health Practitioner Regulation Agency into the standards of professional care being given by individual registered health practitioners, by SA Police into assaults on residents under the guise of restrictive practice, and by SA Independent Commission Against Corruption into the appropriate actions of individual local, state and federal management personnel. This last investigation, when concluded, will be crucial in providing an assessment of any oversight failures, and whether those are systemic failures or the actions of individuals acting outside their mandated area of responsibility.

4.77 The committee strongly agrees with the views expressed by the majority of submitters that while Oakden is at the extreme end of sub-standard aged care services, it exemplifies broader concerns with the quality and oversight frameworks for the overall aged care sector.

4.78 Of particular concern to the committee is the body of evidence relating to model of care issues, definitions of personal versus medical care, and clinical governance within aged care facilities. The aged care sector appears divided in how it defines the provision of allied health or medical services, and who takes ultimate responsibility for the quality of service provision or the oversight and regulation of that health service.

4.79 The committee is concerned about the ongoing use of restrictive practice. We are aware that there are residential aged care facilities that have virtually eliminated use of chemical and physical restraints. The reform process needs to address this issue.

4.80 Additionally, aged care is experiencing an explosion of demand for dementia and mental health specialist services. Providers of those services are themselves divided as to whether these are health (or medical) services, and whether there needs to be specialist internal governance and external oversight mechanisms. It is clear the aged care sector needs better links to broader mental health and cognitive impairment service providers, to implement best practice of those specialisations within an aged care context.

4.81 The committee notes the views expressed above by aged care sector expert Professor Ibrahim. The committee firmly states that vulnerable aged Australians deserve the same level of personal and clinical care, the same level of oversight, regulation and protection from abuse that any other Australian deserves, regardless of their time of life.

Recommendations

4.82 The evidence presented to this inquiry clearly showed that many of the circumstances that led to the substandard level of care given to residents of Oakden were not unique to that facility. Not only are there similar models of care in other facilities, many of the failures in the quality oversight frameworks are universal, in that they could occur again in relation to any aged care facility, in any location, providing any kind of general or specialised aged care service.

4.83 The committee intends to extend this inquiry to further investigate aged care quality frameworks, with amended terms of reference to remove reference to Oakden, to ensure the inquiry can review the same issues without any restriction on location.

4.84 The committee anticipates that the Australian Government response to the recommendations of the Carnell Paterson review, due to be announced in the context of the Budget in May 2018, and the new Single Aged Care Quality Framework, due to be introduced in July 2018, will play major roles in the ongoing examination of the Aged Care Quality Assessment and accreditation framework. Continued inquiry by the committee will be directed by the outcomes of those external bodies of work.

Recommendation 1

4.85 The committee recommends the extension of this inquiry into the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised.

4.86 A primary cause of the failures at Oakden was due to the specialist mental health services being delivered in the context of being classified as an aged care service as opposed to a health service. This incorrect classification directly led to lower levels of service planning, workforce specialisation, oversight and regulation.

4.87 The committee strongly agrees with the views put forward to the Carnell Paterson review by the expert organisation in health safety, the Australian Commission on Safety and Quality in Health Care, which recommended that all services for severe dementia should be accredited under the Australian Health Service Safety and Quality Accreditation Scheme and must meet the National Safety and Quality Health Service Standards.

Recommendation 2

4.88 The committee recommends that in the current aged care oversight reforms being undertaken, all dementia-related and other mental health services being delivered in an aged care context must be correctly classified as health services not aged care services, and must therefore be regulated by the appropriate health quality standards and accreditation processes.

Senator Rachel Siewert

Chair

Coalition Senators' Additional Comments

1.1 Coalition Senators make the following additional comments on the interim report.

1.2 The Government is committed to ensuring effective aged care frameworks to protect vulnerable aged Australians, especially those with cognitive or mental health impairments.

1.3 In response to the service delivery failures at Oakden, the Coalition Government in May 2017 initiated a review into aged care quality regulatory processes. The review's report, *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson review) was published in October 2017 and made ten recommendations.

1.4 The Government took immediate action to adopt Recommendation 8, committing to implementing unannounced re-accreditation visits as soon as possible, to ensure continued safety and quality of residential aged care.

1.5 The Government has indicated its broad support for the other recommendations in the Carnell Paterson review and is currently considering these in detail.

1.6 Additionally, the Australian Aged Care Quality Agency (Quality Agency) also took action, commissioning a full review of Quality Agency accreditation and quality monitoring processes. The review (Nous Group report) released in July 2017 made four key recommendations, all of which the Quality Agency accepted and moved immediately to implement.

1.7 Noting that this is an interim report, Coalition Senators will provide further comments in the final report, if necessary.

Senator Slade Brockman **Senator Jonathon Duniam**

Additional Comments by the Nick Xenophon Team

An age-old problem – shamefully handled

1.1 We thank the committee for their work on this inquiry. The secretariat in particular has done a great job of distilling the evidence received and accurately identifying the issues. We support the findings of the report and the recommendation.

1.2 As the committee identifies, some blame must and should be directed at Australian Aged Care Quality Agency for their failure to detect and deal with what were systematic and life-threatening problems at Oakden. Ultimately, however, the primary responsibility for the disgrace that was Oakden lies with the South Australian (SA) Government.

1.3 The SA Government were directly responsible for the causes of the failed operations at Oakden including:

- **Inappropriate model of care**: Inexcusably, Oakden did not have an approved model of care. The effect of this was that there was no model in use appropriate for the types of services provided at Oakden and there was no articulation of who would be provided services at Oakden, or how those services would be achieved regarding staffing, resources and infrastructure. The SA Chief Psychiatrist summed up the effect of that very succinctly—'Oakden is not providing the right care, at the right time from the right team'.[1]
- **Poor infrastructure**: Oakden's facilities were entirely unsuitable for its purpose—a significant factor in the overall poor standard of care at the facility. The SA Government simply didn't fund the facility properly.
- **Staffing concerns**: There were not enough staff at the facility and those staff that were employed there were not trained properly on how to provide the care they were required to.
- **Governance failures**: The clinical governance framework was totally inadequate and led to poor clinical care across a broad range of areas.
- **Toxic culture**: The morale at Oakden was described as being poor. There was bickering and disrespect amongst staff in an atmosphere that could only be described as secretive and inward-looking.

1.4 It's not as though these problems arose in the immediate period prior to the facility's closure. These problems were the result of long-standing neglect by the SA Government.

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1 Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian Government), *The Oakden Report*, April 2017, p.31.

1.5 From 2007, five years after the current government came to power, some of the first issues started to arise and they persisted over the next decade. The state government simply turned a blind eye to those in need of acute mental care.

1.6 This contrasts to the situation in New South Wales, Victoria and Western Australia which properly supported and managed similar facilities in their jurisdictions.

1.7 Sharon Olsson, an experienced nursing administrator, summed up the state of affairs at this state-run facility in her evidence to the committee:

> There was a clear lack of nursing leadership and clinical supervision. No senior nurses were in the clinical area, from what I saw, at any time, unless you basically shamed them into being there. There were inappropriate resident-nurse interactions. They were handled. I couldn't even say they were fed and hydrated, because they weren't. So many of the meals went back to the kitchen because nurses couldn't be bothered to take the time that it took to feed some people. I don't know if you're aware, but people who have dementia and mental health problems often have difficulties during feeding and eating.
>
> There was an unsafe nursing environment with things everywhere. Things were broken. The chairs were all peeling apart. These were what the residents were expected to sit in. There were outdated and incompetent nursing practices. I noticed in the first few weeks that there were a lot of emaciated-looking residents, and that concerned me, so I went to look at their weight charts. What I found was that most of the residents—something like 65 to 67 per cent; I can't remember the exact figure—had lost at least 10 per cent of their body weight within six months of admission to the facility. When I talked to the nursing staff about this, the lack of education and knowledge was extremely clear, because I was told: 'These are people with dementia. Don't you know people with dementia lose weight? They don't eat properly and they lose weight.' I think that just reflects the lack of understanding and nursing ability.
>
> There was incompetent medication preparation and administration. That was mentioned earlier this morning, I note, but what I witnessed was nurses actually mixing one lot of medication in a mortar and pestle, giving it to one resident, and then mixing another lot of medication in the same mortar and pestle without washing or rinsing it, so the cross-contamination of medication was unbelievable.
>
> There was behavioural mismanagement, with high rates of restraint. That was of particular interest to me because there was a federally funded national project for reducing restraint across Australian mental health facilities, and I had done extremely well in that at Glenside, having closed down a restraint room and opened up a chill-out room. So I was very keen to see that restraint was addressed. However, that was a very difficult thing to do, because every time you said to the staff, 'Why don't you take this person for a walk?' the response was, 'No, they're aggressive, and if you're going to make us do things like that we're going to the union.' So it was very difficult. Then, if you enlisted the support of the service director or the executive director, you were told, 'Well, you're there to fix the problems

> that the Commonwealth have identified.' I said, 'Yes, that's what I'm trying to do.' 'Well, not if you're threatening staff.' I hadn't threatened anyone. So it became a very difficult situation, because, as Carla said, the environment was very toxic. There was a culture of cover-up, but I'd say that the cover-up was more at senior level than at base level.
>
> There were inappropriate rostering practices, where favours were done for mates and a whole lot of overseas general trained nurses were brought in. A lot of these people came from Asian cultures that had absolutely no background in looking after aged care. As one of them said to me, 'We don't have this facility in my country; I do the best I can.'
>
> The other thing that was particularly difficult to bear was that nurses were often sent to Oakden as punishment. If they hadn't performed or they got on the wrong side of someone or there was a personality clash at Glenside, then it was easy just to ship that nurse out to Oakden. There was minimal staff development for hands-on staff. The level 3s and above were sent on what I considered to be junkets. The real education was needed at the coalface. You had to do basic life support, because that's one of the legal requirements under the nurses act, and anything that was mandatory, that had been mandated by the Commonwealth, for example, and that's the physical handling aggression program. Those kinds of things were the only things that were really programmed. There was a very disenfranchised nursing and care division.[2]

1.8 All that was required was for the state government to turn its mind to the issue and to fund it correctly but they couldn't do that because the health budget was heading into crisis, haemorrhaging from the cost blowouts with new Royal Adelaide Hospital costs which eventually grew in size to $700 million. One can only imagine what a portion of that $700 million could have done to the lives of those that suffered at Oakden.

1.9 The story of Mr Bob Spriggs epitomises the situation at the facility. Mr Spriggs was first admitted to Oakden in January 2016. The committee report details the totally unacceptable treatment that he and his family experienced from admission until his death in June 2016:

> In June 2016, the Spriggs family made a complaint to the Principal Community Visitor (SA) who raised concerns with the Northern Adelaide Local Health Network (NALHN). After repeated unsuccessful attempts over four months to seek a response from NALHN and the Office of the Chief Psychiatrist (SA) regarding the complaint, the Principal Community Visitor noted the inaction in his annual report which was sent to the SA Minister for Mental Health and Substance Abuse (SA Minister) on 30 September 2016. The Principal Community Visitor also wrote to the SA Minister on 14 October 2016 to formally request a review of service

2 Ms Sharon Olsson, Private Capacity, *Committee Hansard*, 21 November 2017, p. 43.

> delivery at Oakden and that NALHN meet with the Spriggs family regarding their complaint.[3]

1.10 It was only after the annual report was tabled in the SA Parliament and media took interest that the family were finally given a meeting with NALHN. This epitomises the apathy that was present within the SA Government and total disregard the Weatherill Government had for the aged residents in their care.

1.11 As stated in the report, family members' accounts of Oakden featured consistent themes of feeling betrayed by and distrustful of the public aged care system. They felt let down by a system which was designed to help vulnerable people but, in their opinion, had failed to do so.

1.12 It was the SA Government that failed them. That failure can only be characterised as shameful.

Senator Rex Patrick **Senator Stirling Griff**

3 Community Affairs References Committee, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised—Interim report*, February 2018, pp. 1–2.

APPENDIX 1

Department of Health – Makk and McLeay Nursing Home
Key events timeline 2007–2017

This timeline was received from the Department of Health as part of an answer to a question on notice following the 5 February 2018 hearing.

Makk and McLeay Nursing Home - Key Events Timeline – 2007 to 2017

No	Date	Description	Comments
2007 – Aged Care Standard and Accreditation Agency, Aged Care Complaints Investigations Scheme, Department of Health and Ageing			
1	20-21 February 2007	Accreditation Agency: Site Audit Report • Recommend 3 unmet expected outcomes (2.12, 2.16, 3.7) Decision to Accredit Makk & McLeay Nursing Home • Decision 6 unmet expected outcomes (1.1, 1.4, 2.12, 2.16, 3.7, 4.1) • Timetable for improvement 5 July 2007	• 1 year accreditation until 9 May 2008
2	16 March 2007	Accreditation Agency: Support Contact Record	
3	4 May 2007	Accreditation Agency: Support Contact Record • 6 unmet expected outcomes (1.1, 1.4, 2.12, 2.16, 3.7, 4.1)	
4	23 May 2007	Accreditation Agency: Support Contact Record • 6 unmet outcomes (1.1, 1.4, 2.12, 2.16, 3.7, 4.1)	
5	22 June 2007	Accreditation Agency: Unannounced Support Contact Record • 6 unmet outcomes (1.1, 1.4, 2.12, 2.16, 3.7, 4.1)	
6	9 July 2007	Accreditation Agency: Advice letter to Department of Health • 1 unmet expected outcome remaining (2.16 Sensory Loss)	• Failed timetable for improvement • Accreditation Agency recommends sanctions be imposed
7	30 July 2007	Department of Health: Notice of Non-Compliance for unmet expected outcome 2.16 (Sensory Loss) • To be rectified by 5 October 2007	• Notice of Non-Compliance issued
8	27 September 2007	Department of Health: Notice to Remedy non-compliance	
	27 September 2007	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
9	5 October 2007	Accreditation Agency: Support Contact Record • Met timetable for improvement	• 2.16 rectified within timetable for improvement
10	12 October 2007	Department of Health: No Further Action • Compliance rectified	• No further action letter sent re Notice of Non-Compliance

No	Date	Description	Comments
	1 November 2007	Department of Health Complaints Investigations Scheme: Referral to Medical Practitioners Board • Board was satisfied with doctors management of care recipient	
	21 November 2007	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
	21 November 2007	Department of Health Complaints Investigations Scheme: Announced Site Visit	
	4 December 2007	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
11	6 December 2007	Department of Health Complaints Investigations Scheme: Type 4 referral to Accreditation Agency	
	7 December 2007	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
	9 December 2007	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
12	10-14 December 2007	Accreditation Agency: Review Audit Report to Revoke • 26 unmet expected outcomes and serious risk identified (12/12)	
13	12 December 2007	Accreditation Agency: Letter to Department advising of serious risk and recommending sanctions • Standard 4: Physical environment and safe systems	• Accreditation Agency recommends sanctions be imposed
14	12 December 2007	Department of Health: Sanctions Imposed Notice • Immediate and severe risk in relation to Standard 4: Physical environment and safe systems • Sanctions imposed restricting subsidy for six months (expires 11 June 2008)	• First sanctions imposed by department
15	14 December 2007	Accreditation Agency: Letter to Department advising of serious risk and recommending sanctions • 2.13 Behaviour Management	• Serious risk identified. • Accreditation Agency recommends sanctions be imposed
16	14 December 2007	Department of Health: Sanctions Imposed Notice • Immediate and severe risk in relation to 2.13 Behavioural Management • Sanctions imposed revoking, or appoint adviser for 6 months • Sanctions expire 13 June 2008	• Second sanctions imposed by department

No	Date	Description	Comments
17	15 December 2007	Accreditation Agency: Support Contact Record • 4.4 Physical Environment and Safe Systems	
18	16 December 2007	Accreditation Agency: Support Contract Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
19	17 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
20	19 December 2007	Accreditation Agency: Support Contract Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
	19 December 2007	Department receives phone call from Rebecca Graham, Director of Service Improvement, Central Northern Adelaide Health Service, advising Makk and McLeay had nominated a nurse adviser. Department requests the nomination be submitted in writing.	
	21 December 2007	Department of Health: Decision not to approve nominated nurse advisor (Ms Carla Baron)	
	21 December 2007	Department of Health: Decision to approve nominated nurse advisors (Ms Carla Baron and Ms Patricia McReynolds)	
21	20 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
22	21 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
23	22 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
24	23 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
25	24 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
26	25 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
27	26 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management	

No	Date	Description	Comments
		• 4.4 Physical Environment and Safe Systems	
28	27 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management • 4.4 Physical Environment and Safe Systems	
29	28 December 2007	Accreditation Agency: Letter to Department informing serious risk resolved for 4.4 Physical Environment and Safe Systems	• Serious risk rectified - 4.4 Physical Environment and Safe Systems
30	29 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management	
31	30 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management	
32	31 December 2007	Accreditation Agency: Support Contact Record • 2.13 Behaviour management	
2008			
33	1 January 2008	Accreditation Agency: Support Contact Record • 2.13 Behaviour management	
34	2 January 2008	Accreditation Agency: Support Contact Record • 2.13 Behaviour management	
35	3 January 2008	Accreditation Agency: Support Contact Record • 2.13 Behaviour management	
36	4 January 2008	Accreditation Agency: Letter to Department informing serious risk resolved for 2.13 Behaviour management	• Serious risk rectified - 2.13 Behaviour Management
37	7 January 2008	Accreditation Agency: Review Audit Report and Decision (for Review Audit visit on 10-18 December 2007) • 26 unmet expected outcomes (1.1, 1.3, 1.6, 1.8, 2.1, 2.2, 2.3, 2.4, 2.5, 2.8, 2.11, 2.12, 2.13, 2.15, 2.17, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6) • Timetable for improvement 28 February 2008 • Accreditation expiry 9 May 2008	
38	9 January 2008	Accreditation Agency: Support Contact Report • 26 unmet expected outcomes (1.1, 1.3, 1.6, 1.8, 2.1, 2.2, 2.3, 2.4, 2.5, 2.8, 2.11, 2.12, 2.13, 2.15, 2.17, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.2, 4.3, 4.4, 4.5, and 4.6)	
	14 January 2008	Department of Health: Advice from nurse adviser received. • Concern staff have entrenched attitudes and	

No	Date	Description	Comments
		they don't understand what is required to meet accreditation standards	
	16 January 2008	Department of Health: Letter of resignation from nurse advisers • Letter states residents are at serious risk, semantics over roles indicating disingenuous motives, political imperative is taking precedence over residents and they were ineffective to change. • No record of referral to Accreditation Agency or Complaints Investigations Scheme	• Nurse advisers (Ms Carla Baron, Mr Neil Baron and Ms Patricia McReyonlds) appointed under sanction resigns. • Mrs and Mr Baron has been in the media recently about her concerns when appointed and resignation. She has raised concerns about care recipients who are moved to another facility under the same provider.
39	22 January 2008	Accreditation Agency: Support Contact report • 26 unmet expected outcomes (1.1, 1.3, 1.6, 1.8, 2.1, 2.2, 2.3, 2.4, 2.5, 2.8, 2.11, 2.12, 2.13, 2.15, 2.17, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.2, 4.3, 4.4, 4.5, and 4.6)	
	7 February 2008	Department of Health: Letter to Central Northern Adelaide Health service approving new advisers' nomination.	• New nurse adviser appointed (Ms Margaret Onley)
40	7 February 2008	Accreditation Agency: Support Contact Report • 26 unmet expected outcomes (1.1, 1.3, 1.6, 1.8, 2.1, 2.2, 2.3, 2.4, 2.5, 2.8, 2.11, 2.12, 2.13, 2.15, 2.17, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6)	
41	19 February 2008	Accreditation Agency: Support Contact Report • 26 unmet expected outcomes (1.1, 1.3, 1.6, 1.8, 2.1, 2.2, 2.3, 2.4, 2.5, 2.8, 2.11, 2.12, 2.13, 2.15, 2.17, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.2, 4.3, 4.4, 4.5, and 4.6)	
42	26-28 February 2008	Accreditation Agency: Site Audit Report • 16 unmet expected outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 2.4, 2.13, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3) • Accreditation expires 18 October 2008 (Accreditation date revoked and revised to	

No	Date	Description	Comments
		9 May 2008 during 1-5 March visit) • Timetable for improvement 7 July 2008.	
	28 February 2008	Department of Health Complaints Investigations Scheme: Receives a Compulsory Report via fax in relation to a reportable assault that resulted in the death of a care recipient, Mr Graham Rollbusch following an alleged incident with another care recipient, Mr Peter Palmer. • Site Audit conducted by the department on 29 February 2008 (unannounced) • Site Audit conducted on 1 March 2008 (unannounced) • Site Audit 2 March 2008 (unannounced) Incident occurred: 28 February 2008 Fax received: 28 February 2008 Police aware: 28 February 2008	• Mr Graham Rollbusch killed. • Mr Peter Palmer changed with murder. • Mr Palmer died before the trial commenced. • No coronial inquest at this stage. • Provider met legislative timeframe for reporting assault.
43	29 February 2008	Department of Health Complaints Investigations Scheme: Type 4 referral to Accreditation Agency requesting Review Audit	
44	4 March 2008	Department of Health Complaints Investigations Scheme: Type 1 referral to Accreditation Agency	
45	1-5 March 2008	Accreditation Agency: Review Audit Report • 16 unmet expected outcomes (1.1, 1.3, 1.6, 1.8, 2.1, 2.2, 2.3, 2.4, 2.5, 2.8, 2.11, 2.12, 2.13, 2.15, 2.17, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.2, 4.3, 4.4, 4.5, and 4.6) • Accreditation expires 9 May 2008.	• Upheld original accreditation decision until 9 May 2008
46	7 March 2008	Accreditation Agency: Support Contact Report • 16 unmet expected outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 2.4, 2.13, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3)	
47	14 March 2008	Accreditation Agency: Support Contact Report • 16 unmet expected outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 2.4, 2.13, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3)	
48	19 March 2008	Accreditation Agency: Support Contact Report • 16 unmet expected outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 2.4, 2.13, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3)	
49	24 March 2008	Accreditation Agency: Support Contact Report	

No	Date	Description	Comments
		• 16 unmet expected outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 2.4, 2.13, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3)	
50	3 April 2008	Accreditation Agency: Support Contact Report • 16 unmet outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 2.4, 2.13, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3)	
51	10 April 2008	Department of Health: Notice of Non-Compliance. • 16 unmet expected outcomes (1.1, 2.1, 3.1, 4.1, 1.3, 2.3, 3.3, 4.3, 1.4, 1.6, 1.8, 2.4, 2.13, 3.5, 3.7, and 3.9)	• Notice of Non-Compliance issued
52	1 May 2008	Department of Health: Notice to Remedy Non-Compliance	
53	2 May 2008	Accreditation Agency: Support Contact Report • 14 unmet expected outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3)	
	12 May 2008	Department of Health Complaints Investigations Scheme: Announced Site Visit	
	15 May 2008	Department of Health Complaints Investigations Scheme: Announced Site Visit	
	26 May 2008	Department of Health Complaints Investigations Scheme: Announced Site Visit	
54	30 May 2008	Accreditation Agency: Support Contact Report • 14 unmet expected outcomes (1.1, 1.3, 1.4, 1.6, 1.8, 2.1, 2.3, 3.1, 3.3, 3.5, 3.7, 3.9, 4.1, 4.3)	
55	10 June 2008	Department of Health Complaints Investigations Scheme: Type 1 referral to Accreditation Agency (Case 071927) • Complaints Investigations Scheme site visit report and desk review report	
56	11 June 2008	Accreditation Agency: Support Contact Report • 6 unmet expected outcomes (1.4, 1.6, 1.8, 3.5, 3.7, 3.9)	
	11 June 2008	First sanctions expire	• First sanctions expire
	12 June 2008	Department of Health Complaints Investigations Scheme: Announced Site Visit	
	13 June 2008	Second sanctions expire	• Second sanctions expire
57	25 June 2008	Accreditation Agency: Announced Support Contact Report	

No	Date	Description	Comments
		• 6 unmet expected outcomes (1.4, 1.6, 1.8, 3.5, 3.7, 3.9)	
58	7 July 2008	Accreditation Agency Announced Support Contact Report • 6 unmet expected outcomes (1.4, 1.6, 1.8, 3.5, 3.7, 3.9)	
59	10 July 2008	Department of Health Complaints Investigations Scheme: Type 2 Referral to Accreditation Agency (Case 072243)	
	11 July 2008	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
	30 July 2008	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
60	4 -6 August 2008	Accreditation Agency: Site Audit Major Findings – Assessment Information Report • Full compliance with 44 out of 44 expected outcomes • Accreditation expires 30 April 2009	• Full compliance with 44 out of 44 expected outcomes of the Accreditation Standards • Accredited for 11 months expiry 30 April 2009
61	18 August 2008	Department of Health: No Further Action letter re Sanctions 12 and 14 December 2007	• No further action letter sent for both sanctions
	19 August 2008	Department of Health Complaints Investigations Scheme: Announced Site Visit	
62	26 August 2008	Department of Health Complaints Investigations Scheme: Type 2 referral to Accreditation Agency (Case 071672)	
63	28 August 2008	Department of Health Complaints Investigations Scheme: Type 2 referral to Accreditation Agency (Case 073520)	
64	29 August 2008	Department of Health Complaints Investigations Scheme: Type 2 referral to Accreditation Agency (Case 071760)	
65	26-28 August 2008	Accreditation Agency: Support Contact Report • Full compliance	
66	9 September 2008	Accreditation Agency: Site Audit Report Decision (from Review Audit visit of 4-6 August 2008) • Full compliance with 44 out of 44 expected outcomes • Accreditation expires 30 April 2009	

No	Date	Description	Comments
67	16 September 2008	Department of Health Complaints Investigations Scheme: Type 2 referral to Accreditation Agency (Case 073692)	
	24 October 2008	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
68	October 2008	Department of Health Complaints Investigations Scheme: Type 2 referral to Accreditation Agency (Case 078430)	
69	3 October 2008	Accreditation Agency: Support Contact Report • Full compliance with assessed outcomes	
2009			
	30 January 2009	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
70	16-18 February 2009	Accreditation Agency: Site Audit Major Findings – Assessment Information • Full compliance with 44 out of 44 expected outcomes	
71	13 March 2009	Department of Health Complaints Investigations Scheme: Type 1 referral to Accreditation Agency (Case 078430)	
72	23 March 2009	Department of Health: Disclosure of protected information to Accreditation Agency	
73	30 March 2009	Accreditation Agency: Site Audit and Accreditation Decision (from 16-17 February site audit visit) • Full compliance with 44 out of 44 expected outcomes • Accreditation period 30 April 2009 - 30 April 2010	• 1 year accreditation until 30 April 2010
	13 May 2009	Department of Health ACFI Review visit	ACFI Review Decision • 3 downgrades out of 6 appraisals reviewed
	14 May 2009	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
74	18 June 2009	Accreditation Agency: Support Contact Report • Full compliance	
	15 July 2009	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
75	11 August 2009	Department of Health Complaints Investigations Scheme: Type 2 referral to Accreditation Agency	

No	Date	Description	Comments
76	9 September 2009	Department of Health Complaints Investigations Scheme: Type 1 referral to Accreditation Agency (Case 084998)	
77	10 September 2009	Accreditation Agency: Support Contact Report • Full compliance	
	25 September 2009	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
	27 October 2009	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
2010			
78	1 -2 February 2010	Accreditation Agency: Site Audit Major Findings – Assessment Information • Full compliance with 44 out of 44 expected outcomes	
79	15 March 2010	Accreditation Agency: Site Audit and Accreditation Decision (for 1-2 February 2010 Site Audit Visit) • Full compliance with 44 out of 44 expected outcomes • Accreditation period 30 April 2010 – 30 April 2013	• 3 years accreditation until 30 April 2013
80	29 April 2010	Accreditation Agency: Support Contact Record • Full compliance	
	29 April 2010	Department of Health's Complaints Investigations Scheme: Compulsory Report received in relation to an alleged physical assault on Mr John Cartwright, by two staff members • Found by morning staff in a chair with two pelvic restraints tied through the chair to a wall rail behind Incident occurred: 28 April 2010 Departmental records indicate information received: 29 April 2010 Police aware: 29 April 2010	• Provider met legislative timeframe for reporting assault.
	30 April 2010	Department of Health ACFI Review Visit	ACFI Review Decision • 3 downgrades out of 11 appraisals reviewed
81	2 September 2010	Accreditation Agency: Support Contact Record • Full compliance with assessed outcomes	
	1 June 2010	Department of Health Complaints Investigations	

No	Date	Description	Comments
		Scheme: Unannounced Site Visit	
	15 November 2010	Department of Health's Complaints Investigations Scheme: Compulsory Report received in relation to alleged assault on a care recipient by a staff member who applied a pistol grip hold to the jaw to control care recipient and pulled the care recipient by twisting the bask of shirt and dragging him to a chair – the care recipient bled from the mouth. • Was referred to the Complaints Investigation Scheme for own motion investigation Incident occurred: 14 November 2010 AP aware: 15 November 2010 Departmental records indicate information received: 15 November 2010 Departmental records indicate police aware: 17 November 2010	• Provider did not meet legislative timeframe for reporting assault.
2011			
82	18 January 2011	Accreditation Agency: Support Contact Report • Full compliance	
	25 March 2011	Department of Health ACFI Review Visit	ACFI Review Decision • 6 downgrades out of 9 appraisals reviewed
	28 March 2011	Department of Health's Complaints Investigations Scheme: Compulsory Report received in relation to an incident that occurred in February. On 19 February the step son of a care recipient alleged that he felt his father's injuries from falls on both 13 February and 19 February were actually the result of abuse. Bruising was to jaw, chin and neck. • AP did not report on time because they had no suspicion of abuse and documentation indicated bruising from falls. Incident occurred: 13 February 2011 AP aware: 19 February 2011 Departmental records indicate information received: 28 March 2011 Departmental records indicate police aware: 28 March 2011	• Provider did not meet legislative timeframe for reporting assault
83	14 July 2011	Accreditation Agency: Assessment Contact Report • Full compliance with assessed outcomes	
	1 August 2011	Department of Health Complaints Investigations	• Provider met

No	Date	Description	Comments
	NF/114424	Scheme: Compulsory Report received in relation to a reportable sexual assault. Student staff member witnessed another staff member fondle a care recipient's breast. He then exposed her left breast making the comment "Oh! That's your boob" and then pulling her top down. Incident occurred: 28 July 2011 AP aware: 1 August 2011 Departmental records indicate information received: 1 August 2011 Departmental records indicate police aware: 2 August 2011	legislative timeframe for reporting assault.
2012			
84	31 January 2012	Accreditation Agency (unannounced visit): Assessment Contact Report • Full compliance with assessed outcomes	
	5 March 2012	Department of Health ACFI Review Visit	ACFI Review Decision • 0 downgrades out of 9 appraisals reviewed
85	22 May 2012	Accreditation Agency: Assessment Contact Report • Full compliance	
86	11 October 2012	Accreditation Agency (unannounced visit): Assessment Contact Report • Full compliance with outcomes assessed.	
2013			
87	11-12 February 2013	Accreditation Agency (Site Audit Visit): Audit Assessment Information • Recommends full compliance with 44 out of 44 expected outcomes	
	1 March 2013	Department of Health ACFI Review Visit	ACFI Review Decision • 1 downgrades out of 6 appraisals reviewed
88	4 March 2013	Accreditation Agency: Re-accreditation Audit Report and Decision (for site audit of 11-12 February 2013) • Full compliance with 44 out of 44 expected outcomes • Accreditation period 30 April 2013 – 30 April 2016	• 3 years accreditation until 30 April 2016

No	Date	Description	Comments
	April 2013	Department of Health: Sends letter to David Davies about request for conditions required in a SA Older Persons Mental Health Service - NGO partnership agreement for Makk and McLeay nursing home in terms of government interests letter.	
	8 May 2013 NF/101004	Department of Health Complaints Investigations Scheme: Compulsory Report received in relation to a reportable sexual assault. Staff member witnessed a resident fondle another care recipient breast. Both have cognitive impairment. Incident occurred: 7 May 2013 AP aware: 7 May 2013 Departmental records indicate information received: 8 May 2013 Departmental records indicate police aware: N/A	• No requirement to report assault under legislation.
	17 December 2013	Department of Health Complaints Investigations Scheme: Compulsory Report received in relation to a reportable assault. Care recipients wife raised an allegation of assault. She said that she saw the male agency nurse, who was unaware of her presence, grab her husband (Mr Serpo) from his shoulder of his shirt then throw him into a chair. When her husband attempted to kick him, the male nurse stated in a loud abusive voice 'don't you kick me'. The statement of the male agency nurse contradicts care recipient's wife's allegation. • No further action was taken as there was '*no serious consequences to care recipients*' and they reported within the legislated timeframes. Incident occurred: 16 December 2013 AP aware: 16 December 2013 Departmental records indicate information received: 17 December 2013 Departmental records indicate police aware: 17/12/13	• Provider met legislative timeframe for reporting assault. • Mr Serpo's family met with Minister Wyatt and Ms Kate Carnell on Tuesday 30 May 2017.
89	1 July 2013	Accreditation Agency (unannounced visit): Assessment Contact Report • Full compliance with outcomes assessed	
2014 – Aged Care Standards and Accreditation Agency transitioned to Australian Aged Care Quality Agency (1 January 2014)			

No	Date	Description	Comments
	3 May 2014 NF/156393	Department of Health Complaints Investigations Scheme: Compulsory Report received in relation to a sexual assault. A care recipient was naked from the waist down making gyrating movements over another care recipient whilst also trying to undress him - he remained fully clothed. Care recipient to care recipient both with cognitive impairments. Incident occurred: 2 May 2014 AP aware: 2 May 2014 Departmental records indicate information received: 3 May 2014 Departmental records indicate police aware: 3 May 2014	• No requirement to report assault under legislation.
	10 June 2014	Department of Health Complaints Investigations Scheme: Unannounced Site Visit	
90	30 September 2014	Quality Agency (unannounced visit): Assessment Contact Report • Full compliance	
	4 December 2014	Department of Health ACFI Review Visit	ACFI Review Decision • 1 downgrades out of 10 appraisals reviewed
2015			
91	22 January 2015	Quality Agency: Assessment Contact Report • Full compliance	
	11 May 2015	Department of Health: Places Management had conversation with Northern Adelaide Health about transferring places and subcontract	
92	8 October 2015	Quality Agency (unannounced visit): Assessment Contact Report • Full compliance	
2016 – Department of Health Aged Care Complaints Investigations Scheme transition to Aged Care Complaints Commissioner (1 January 2016). Compulsory Reporting stays with Department of Health			
93	1 -2 February 2016	Quality Agency (Re-accreditation Audit visit): Audit Assessment Information • Recommends full compliance with 44 out of 44 expected outcomes	
	2 February 2016	Northern Adelaide Local Health Network emails the Department about conditions on places and requests answers to questions regarding places.	

No	Date	Description	Comments
94	2 March 2016	Quality Agency: Re-accreditation Audit Report and Decision (for Re-accreditation Audit of 1-2 February 2016) • Full compliance with 44 out of 44 expected outcomes • Accreditation period 30 April 2016 – 30 April 2019	• 3 years accreditation until 30 April 2019
	11 May 2016	Department of Health: Places Management responds to Northern Adelaide Local Health Network email about places, state they have met with Julie Harrison on three occasions since 2013, and a meeting with Greg Adey in 2014.	
	10 August 2016	Department of Health commences sharing monthly data of Compulsory Reports received with the Quality Agency and the Complaints Commissioner.	
	13 September 2016	Department of Health: Compulsory Report received in relation to an unreasonable use of force. • nurse on night duty witness another nurse using excessive force, "pinning the resident down" on the bed by the hands • alleged perpetrator was trying to dress the resident / change their garment for ADL • incident also witnessed by a second nurse • a verbal altercation later took place between the alleged perpetrator and the original witness, after the above incident, that may be related to the incident. Departmental records indicate the incident occurred: 11 September 2016 AP aware: 12 September 2016 Departmental records indicate information received: 13 September 2016 Departmental records indicate police aware: 13 September 2016	• Provider met legislative timeframe for reporting assault. • Provided to the Quality Agency and Complaints Commissioner in monthly data sharing process.
	13 October 2016	Department of Health: Aged Care Places Management in SA Health State Network sent letter to Makk and McLeay about triennial Fire Inspection.	
95	1 November 2016	Quality Agency: Assessment Contact Report • Full compliance	
	1 November 2016	Northern Adelaide Local Heath Network send email to Department – application to vary conditions of allocation: Makk and McLeay Nursing Home	

No	Date	Description	Comments
2017			
	17 January 2017	Media: ABC Adelaide reports that Mr Spriggs was given 10 times the amount of prescribed medication and left with unexplained bruises in January 2016.	• First time Department became aware of Mr Spriggs' incident. • Mr Spriggs' family met with Minister Wyatt on Tuesday 30 May 2017
	28 February 2017	Department of Health: Advises Minister's Office of media in relation to Oakden and Mr Spriggs.	• Minister's Office and Executive were informed of media and issues at Makk and McLeay
96	28 February 2017	Quality Agency (assessment contract visit): Assessment Contact Report • Full compliance with assessed outcomes	
	February 2017 (undated)	Department of Health; Residential Programmes send letter to Northern Adelaide Local Health Network about variation of allocation for 40 residential care places at Makk and Mcleay Nursing Home	
97	6-17 March 2017	Quality Agency (Review Audit visit): Audit Assessment Information • Recommended 15 of 44 expected outcomes not met	
	16 March 2017	Quality Agency: Release of Information to Department of Health	
98	16 March 2017	Department of Health: Initial and Detailed Risk Assessment: Compliance Case Document • Information assessed and Department determined an immediate and severe risk to care recipients in relation to 2.7 Medication management	
	16 March 2017	Department of Health: Advice sent to Minister's Offices informing of possible imposition of sanctions	• Advice sent to Minister's Office and Executive of possible imposition of sanction
99	17 March 2017	Department of Health: Notice of Decision to Impose Sanctions • Expected outcome 2.7 Medication management	• Sanctions imposed – immediate and severe risk • Sanctions expired 17 September 2017
	17 March 2017	Department of Health: Sent email to Minister's Offices	• Advice sent to

No	Date	Description	Comments
		information of the imposition of sanctions	Minister's Office and Executive of imposition of sanction
100	23 March 2017	Quality Agency: Assessment Contact Report • 12 unmet expected outcomes assessed (1.6, 1.7, 2.7, 2.8, 2.11, 2.12, 2.13, 2.15, 3.6, 4.4, 4.7, 4.8)	
101	27 March 2017	Quality Agency: Decision of failure to comply with Accreditation Standards • Decision 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	• Decision of failure of 15 of 44 expected outcomes
102	27 March 2017	Quality Agency: Possible Serious Risk Report • Recommended 6 of 44 expected outcomes with possible serious risk (1.6, 1.8, 2.4, 2.7, 2.8, 2.13)	• Quality Agency recommends possible serious risk with 6 of 44 expected outcomes
103	27 March 2017	Department of Health: Initial and Detailed Risk Assessment: Compliance Case Document • Department assessed no further immediate and severe risk to care recipients identified	
104	28 March 2017	Quality Agency: Serious Risk Report Decision 6 of 44 expected outcomes with serious risk (1.6, 1.8, 2.4, 2.7, 2.8, 2.13)	
	28 March 2017	Department of Health: risk reassessment of Serious Risk information : (Compliance Case C17/000159) • Department assessed no further immediate and severe risk to care recipients identified	
105	31 March 2017	Quality Agency: Assessment Contact Report • 8 unmet expected outcomes assessed (1.7, 1.8, 2.13, 2.7, 3.6, 4.3, 4.7, 4.8)	
106	3 April 2017	Aged Care Complaints Commissioner: Receives anonymous complaint regarding two staff who allegedly verbally abused care recipients. • Type 1 referral to the Quality Agency	
	4 April 2017	Department of Health: Compulsory Report received in relation to a care recipient on care recipient assault. Both care recipients have a cognitive impairment. AP aware: 3 April 2017 Departmental records indicate information received: 4 April 2017	• No requirement to report assault under legislation.

No	Date	Description	Comments
		Departmental records indicate police aware: N/A	
107	5 April 2017	Quality Agency: Assessment Contact Report 1 unmet outcomes assessed (2.7)	
108	7 April 2017	Department of Health: Notice of Non-Compliance issued • 14 unmet outcomes (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	• Notice of Non-Compliance issued in relation to 14 unmet outcomes
109	7 April 2017	Quality Agency: Review Audit Report and Decision • Decision 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8) • Decision to vary accreditation period to 7 October 2017 • Timetable for improvement 7 July 2017	• Accreditation period varied to 7 October 2017
	7 April 2017	Department of Health: SA Health State Network – Places Management, compliance management meets with Northern Adelaide Local Health Network to discuss: Proposal to relocate 16 care recipients to Northgate facility • Varying conditions of allocations • Sanction process/ Nurse adviser • Security of tenure requirements of providers	
110	12 April 2017	Quality Agency: Assessment Contact Report • 1 expected outcome assessed (1.6)	
	18 April 2017	Department of Health: SA Heath State Network staff meet with Northern Adelaide Local Health Network to discuss: • Non-compliance with the Accreditation Standards • Quality Agency Reaccreditation • The Oakden report • Closing Makk and McLeay • Managing unused places – longer term considerations	
111	18 April 2017	Quality Agency: Assessment Contact Report • 1 expected outcome assessed (2.4)	
	20 April 2017	SA Chief Psychiatrist, Dr Aaron Groves, report published and closure of Oakden publically released and SA Government accepts six recommendations	• Dr Aaron Groves report released and closure of Oakden announced by SA Government.

No	Date	Description	Comments
112	26 April 2017	Quality Agency: Assessment Contact Report and Decision Report • 17 expected outcomes assessed (1.1, 1.4, 1.6, 1.7, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8) • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
113	26 April 2017	• Department of Health: Analysis of submission in respect of notice of non-compliance – Accreditation Standards	
114	28 April 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
115	29 April 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
116	30 April 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
	1 May 2017	Minister Wyatt announces review into the aged care quality regulatory processes. Review to report by 31 August 2017	• Minister Wyatt announces review
117	1 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
118	2 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
119	2 May 2017	Department of Health: Notice to Remedy Non-Compliance	
120	3 May 2017	Quality Agency: Assessment Contact Report and	

No	Date	Description	Comments
		Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
121	4 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
122	5 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
123	6 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
124	7 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
125	8 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
126	9 May 2017	Quality Agency: Assessment Contact Report and Decision Report • Decision of 15 of 44 expected outcomes not met (1.1, 1.4, 1.6, 1.8, 2.1, 2.4, 2.7, 2.8, 2.11, 2.13, 2.16, 3.6, 4.1, 4.7, 4.8)	
	9 May 2017 – 14 June 2017	Quality Agency made 31 visits to the Makk and McLeay wards and found that the 15 outcomes remained unmet until the service closed on 14 June 2017.	• The final Nurse Adviser Report dated 14 June 2017 recorded: • Activities toward compliance continue, however no outcomes have been met'

No	Date	Description	Comments
	11 May 2017	Minister Wyatt announces Ms Kate Carnell and Professor Ron Paterson as review panel to undertake the review into the aged care quality regulatory processes	• Minister Wyatt announces Ms Kate Carnell and Professor Ron Paterson to undertake review
	13 May 2017	Department of Health: Compulsory Report received in relation to an unreasonable use of force. A family member stated she had witnessed a male staff member hold the hand of a female care recipient who was sitting in a Princess Chair and then placed her hand on her forehead to push her back in the chair to avoid her falling out. Incident occurred: 8 or 9 May 2017 AP aware: 13 May 2017 Departmental records indicate information received: 13 May 2017 Departmental records indicate police aware: 13 May 2017	• Provider met legislative timeframe for reporting assault. Media 16 May 2017: http://www.news.com.au/national/south-australia/new-case-of-alleged-abuse-at-oakden-nursing-home/news-story/de0dd7f15f5d10c4d12b4e8812bbf8a5
	16 May 2017	Department of Health: Compulsory Report received in relation to an unreasonable use of force. A care recipient pushing a trolley was trying to exit through a door into another area of the service A male nurse, who was holding the door open to allow a different resident to exit through, attempted to stop the resident with the trolley by pushing the trolley back with force, causing the care recipient to stumble a step backwards, and the male nurse spoke “tersely” to the care recipient. Incident occurred: 16 May 2017 AP aware: 16 May 2017 Departmental records indicate information received: 16 May 2017 Departmental records indicate police aware: 17 May 2017	• Provider met legislative timeframe for reporting assault. Media 17 May 2017: http://indaily.com.au/news/local/2017/05/17/another-oakden-abuse-allegation-yesterday/
	17 May 2017	SA Health Minister Leesa Vlahos MP announced the closure of Oakden Older Persons Mental Health service will be closed in 20 days (6 June 2017).	• Department’s SA HSN advised on 26 May 2017, Oakden closure now 14 June 2017.
	29 May 2017	SA Coroner reopens inquest into the 2008 death of Mr Rollbusch.	

Makk and McLeay Nursing Home - Key Events Timeline – 2007 to 2017

No	Date	Description	Comments
	17 May 2017	SA Health Minister, Leesa Vlahos MP announced the closure of Oakden Older Persons Mental Health Service.	
	14 June 2017	Oakden Older Persons Mental Health Service closed following the relocation of all care recipients.	
	30 June 2017	NAHLN's operational places were transferred to another SA Health AP, Country Health SA.	
	1 to 10 July 2017	Department assesses NALHN's suitability to remain an approved provider of aged care services.	
	11 July 2017 to 4 August 2017	Department drafts and issues (4 August) a notice under subsection 10-3(3) of the Act proposing to revoke NALHN's approval as an approved provider. NALHN has a legislated 28 days to provide submissions to the notice.	
	31 August 2017	NALHN's submissions received by Department.	
	29 September 2017	Department issues revocation notice to NAHLN with an effective date of 6 October 2017.	
	6 October 2017	NALHN's approval as a provider of aged care service under the Act is revoked.	