Royal Commission into Aged Care Quality and Safety

Final Report: Care, Dignity and Respect

Volume 4B

Hearing overviews and case studies

Mildura Hearing to Canberra Hearing

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Introduction to Volume 4

Introduction

This volume of the Final Report details some of what the Royal Commissioners heard in public hearings. It also contains the conclusions that Commissioners have reached about the case studies that have been examined at some of those hearings.

Volume 4A contains the hearing overviews and case studies that were first published in the Interim Report. The accounts in that part of this volume represent the views of Commissioners Tracey and Briggs. The text in Volume 4A, apart from the Introduction and the redaction of a name, is an exact reproduction of the Interim Report text, including page numbers.

Volumes 4B and 4C contain the hearing overviews and case studies from the Mildura Hearing, in July 2019, to our final hearing, in October 2020. The accounts of the hearings held in Brisbane and Mildura were finalised after Commissioner Tracey's death and represent Commissioner Briggs's account of, and findings in, those hearings. Commissioner Briggs presided alone at Melbourne Hearing 1 and the account of that hearing represents her views. The accounts of the hearings from Melbourne Hearing 2 onwards are those of Commissioners Pagone and Briggs.

This volume is not intended to be a comprehensive record of all evidence received at hearings. Some of the evidence has been drawn upon in Volumes 1 to 3 of this report. Whether or not summarised here, or in other volumes of this report, we have considered and been informed by all the evidence which has been received.

Hearings: overview

As set out in Volume 1, there are many ways in which we have conducted our inquiries, including through public hearings. This volume contains an outline of some of the evidence received at our hearings.

Public hearings and hearings in the form of workshops were held between 11 February 2019 and 23 October 2020.[1] There were 99 hearing days in total. Witnesses included people receiving aged care, family members and friends of people receiving care, experts, advocates, volunteers, researchers, service providers, and representatives from government departments and agencies.

Counsel and Solicitors Assisting the Royal Commission selected witnesses to give evidence based on their connection to the matters being examined in a case study or based on their expertise or experience in connection with the themes being focused on at the particular hearing. In addition, many people gave accounts of their experiences with aged care. In most cases, providers are not identified in these direct accounts. The purpose of direct accounts was to allow Commissioners and the public to bear witness to individual experiences. These valuable accounts assisted us in understanding the range of issues relevant to our Terms of Reference.

Our Terms of Reference required us to consider appropriate arrangements for evidence and information to be shared by people about their experiences, recognising that some people need special support to share their experiences.[2] In most cases, witnesses gave evidence in person. However, in some cases it was necessary to take evidence remotely or by pre-recorded video.

In Volume 1, we explained that early in the Royal Commission's operation, the Commissioners decided that each hearing would focus on a particular theme or themes associated with our Terms of Reference.

Public hearings

Public hearings were conducted in courtrooms or in courtroom-like settings. They were conducted formally with witnesses summonsed to appear before the Royal Commissioners. Witnesses were generally being required to provide written statements in advance of giving oral evidence directed to the theme of the public hearing.

Counsel and Solicitors Assisting determined that, where appropriate, case studies would be used to illustrate the themes to be examined at public hearings.

Case studies

Case studies that had the potential to expose the themes being explored at a particular hearing were selected for investigation. Solicitors and Counsel Assisting investigated many more case studies than ultimately proceeded to examination at public hearings. These investigations involved:

- detailed review of submissions from the public
- interviewing potential witnesses
- issuing notices to relevant entities and comprehensively reviewing the material returned.

Following this process, Counsel and Solicitors Assisting decided which case studies would proceed to examination at a hearing. Following the conclusion of our hearing in Hobart in November 2019, we decided it was unnecessary to hear further case studies. This was because our focus shifted to the recommendations we might make in our Final Report.

Case studies at Royal Commission hearings focused on the experiences of individuals with particular approved providers of aged care. They involved some consideration of approved providers' responsibilities and obligations, as well as the regulatory environment within which they operated.

Leave to appear and post-hearing submissions

In the weeks before public hearings, details of the hearings were announced on the Royal Commission's website. These announcements included details of the scope of matters that would be examined. People or organisations with a direct and substantial interest in matters being examined were invited to apply for leave to appear at the hearing. These applications were considered, with leave usually granted to those being called as witnesses or those with an interest in the factual matters being examined in a case study, especially when their interests may have been adversely affected.

After most hearings, Counsel Assisting provided written submissions. These written submissions generally concerned the case studies. Where Counsel Assisting considered it appropriate, they invited us to make findings about facts and issues arising in case studies. Counsel Assisting's submissions were provided to parties with leave to appear whose interests were affected by those submissions. Those parties had the opportunity to respond in writing, making submissions in reply. We have considered all the submissions. Where appropriate, we have reached conclusions based on the evidence and submissions before us.

Standard of proof

Our hearings were conducted differently to trials conducted in courts; they were inquisitorial rather than adversarial in nature. Royal Commissions are not bound by the rules of evidence but we have been guided by them and we have applied a civil standard of proof. Findings are made and conclusions reached only where we have 'reasonable satisfaction' of the fact or issue in question. We have been guided by the principles discussed by Dixon J in *Briginshaw v Briginshaw*:

> it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing

> from a particular findings are consideration which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal…the nature of the issue necessarily affects the process by which reasonable satisfaction is attained.[3]

While not binding or enforceable, the conclusions or findings we made can have significant impact upon those who are the subject of them. We have not reached conclusions or made findings lightly.

Hearings in the form of workshops

Hearings in the form of workshops were conducted in early 2020 to allow us to gather evidence in a less formal setting than public hearings. They were not conducted in courtrooms or in a courtroom-like environment. Hearings in the form of workshops were used to test propositions and ideas with panels of witnesses and were focused on specific issues or topics.

Virtual hearings

On 20 March 2020, we suspended all hearings and workshops as a consequence of the evolving coronavirus (COVID-19) pandemic. We resumed our hearing program in August 2020. To ensure public health advice related to the ongoing pandemic was followed, we elected to conduct our remaining public hearings using a virtual model. This model allowed witnesses and parties with leave to appear to participate in the hearings using a real-time video link.

Submissions

At various points during our schedule of hearings, Counsel Assisting made submissions about recommendations that they considered we could make. In addition, Counsel Assisting made various calls for submissions directed at particular matters. The process of submissions in response culminated in a hearing held over two days on 22 and 23 October 2020, when Counsel Assisting made their final submissions to us. We have considered Counsel Assisting's submissions and responses to them in making the recommendations contained in Volume 3 of this report.

Endnotes

1 A full list of public hearings and hearings in the form of a workshop is set out in Volume 1 of this report.
2 Commonwealth of Australia, *Letters Patent*, 6 December 2018, paragraph (r).
3 (1938) 60 CLR 336 at 362–3.

7. Mildura Hearing: Carers for Older Australians

7.1 Hearing overview

7.1.1 Introduction

Commissioners Richard Tracey and Lynelle Briggs held a public hearing in Mildura, Victoria, on 29 and 31 July 2019. The hearing focused on the role of informal and unpaid carers in the aged care system and challenges experienced by carers. Informal and unpaid carers are generally partners, family members, friends and neighbours who provide care to older people. Due to Commissioner Tracey's death, what follows represents the observations of Commissioner Briggs.

The hearing provided an opportunity to receive evidence from a number of informal carers, as well as experts whose research has focused on informal carers, and on rural health and aged care. This evidence illustrated that informal carers do vital work. They may do so for many years, in increasingly difficult circumstances as they and their loved ones get older. In many cases, they do so with inadequate support and little respite. The carer's role can be socially isolating and potentially harmful to their own health and wellbeing, not to mention their working life and finances.

Some of these issues, such as social isolation and lack of access to respite, can be exacerbated in rural settings. The choice of Mildura as the location for this major inquiry into the role and circumstances of informal carers was therefore appropriate.

Mildura is located on the Murray River, 542km from Melbourne and 395km from Adelaide. Mildura is a regional centre in the Sunraysia region of north-western Victoria and south-western New South Wales.

The main topics examined at the hearing were:

- needs of informal carers, and information and outreach about available support and services
- experiences of informal carers
- availability and suitability of services to support informal carers, particularly in rural areas
- funding arrangements supporting access to respite services for informal carers.

The Royal Commission received 126 documents into evidence and heard oral testimony from 23 witnesses during the hearing. We heard from eight people who were caring for a relative or friend, or who had recent experience of doing so. We heard from four representatives of locally active support organisations, two of whom also gave evidence about their informal carer roles. We also received evidence from six academics and experts—hearing oral testimony from four of them—representatives of four approved providers, and a panel of three witnesses from the Australian Department of Health and the Australian Department of Social Services. A number of the witnesses were from the Sunraysia region.

The importance of the role of informal carers in sustaining the aged care system should not be underestimated. In 2015, Deloitte Access Economics estimated that the commercial value of all informal care in Australia was more than $60.3 billion per year.[1] The role, typically performed by older women, can be rewarding but may also come at a personal and financial cost. Support for informal carers has been the subject of a number of reviews in recent years, including a report by the Aged Care Financing Authority, published in October 2018, into respite for older people.[2]

The *Carer Recognition Act 2010* (Cth) states that carers should be considered partners with other care providers in providing care, and acknowledge the carer's unique knowledge and experience. It also contains non-binding declaratory statements of support for carers to enjoy optimum health and social wellbeing, and social and economic participation.[3] However, the Act does not establish a particular framework to sustain carers in their role, or to ensure that their own needs are assessed or addressed.[4]

Several key themes emerged from the evidence:

- The system is marked by an absence of proper referral pathways, inadequate information and assistance for informal carers in navigating the aged care system, and inadequate amounts and types of available respite and support.[5]
- Informal carers experience difficulties in aligning support services, such as respite services, with other support services, like education and training opportunities for themselves, because of the Australian Government's disconnected arrangements regarding access to these.[6]
- The aged care system does not adequately assess the needs of informal carers.[7]
- Some community-based support organisations have been fulfilling an unmet need by providing a social support and 'navigation' role for informal carers.[8]

The following is an outline of the evidence received.

7.1.2 Pathways, information and navigation

Ms Barbara McPhee AM, a physiotherapist and direct experience witness who cared for her mother, said there is a lack of accessible information for informal carers, including about pathways through the aged care system for carers and the people they are caring for.[9] There was also evidence at this hearing that there is a lack of planned pathways for

carers to follow to find much-needed support and respite.[10] Nearly every carer who gave evidence spoke about difficulties faced in navigating the aged care system.[11] These were stories of hardship and fortitude. Many of the witnesses conveyed the sense that they had struggled alone, advocating for the person they cared for, without adequate support from government services.[12]

For many, the caring role is unfamiliar and involves complex skills and knowledge that they may not have. Dr Lyn Phillipson, public health academic at the University of Wollongong, said that when providing care for people living with dementia, even health professionals and paid care workers 'really benefit from training around this'.[13] She said that the National Dementia Support Program provides a limited amount of education about the initial stages of dementia for people living with the condition and their carers. However, there is little education to help carers meet the needs of a person living with dementia as their condition changes and deteriorates.[14] A program designed to help informal and family carers provide care for people living with dementia who are living at home could meet this need for information.

Carer Ms Rosemary Cameron said that there was no pathway or educational resource available to her when her husband Mr Cameron was diagnosed with Lewy body dementia.[15] Ms Cameron said that after her husband's diagnosis, she walked out of a clinic without any information or guidance about what to do next or where to find support:

> You walked out of there thinking, 'Well, I now know what we have to deal with', as in that it's a diagnosis, but there was no referrals, there was no pamphlets, there wasn't anything to help me to know. You're out the front door. And they did explain that's the reason they were there, for diagnosis, and they didn't have any further reason to contact after that. But there was really nothing to know where to head. I had no idea what to do from there.[16]

This had a real impact on Ms Cameron's ability to care for Mr Cameron and herself. She struggled with a constant and ongoing inability to find suitable respite for her husband. In time, Ms Cameron was pushed to the brink of despair and completely exhausted.[17] As a consequence, she was left feeling alone, rejected, and as if she had to fend for herself in caring her husband.[18]

Ms Danijela Hlis also told us how she was pushed to the brink by being an informal carer for her parents before her mother moved into residential care.[19] When describing her own experience as her mother's carer, Ms Elaine Gregory said:

> The worst thing with the aged care system is that you're constantly reaching out for support or guidance without anyone asking if you need a hand. It wears you down.[20]

Ms McPhee said that she did not know where to go to seek help for her mother and father as their health declined:

> I think we had the exact same problems that everybody else here has described. …We were trying to find information from Veterans' Affairs, Social Services, local government, local hospitals, anybody who could give us information, and there was nothing—there was nothing—there were lots of brochures but nothing that actually met our particular needs, which were quite minor for most of their lives, most of [their] later lives.[21]

Ms McPhee said that one of the main difficulties she and her sister faced was arranging suitable care at home, while also having to deal with 'over a dozen state and federal government departments'. She described how each service used a different form of assessment and, in her experience, none shared information.[22]

Ms Nicole Dunn, who cared for her elderly grandmother, told us about getting the 'run around' on the phone and having to constantly repeat the same information to different services.[23] She agreed that it would relieve the burden if people were more informed and were able to 'tick a box', easily indicating that their carer had the authority to make decisions for them.[24]

Ms Shontia Saluja-Honeysett is a Wiradjuri woman from Leeton, New South Wales and the Vice Chair of the Victorian Committee for Aboriginal Aged Care and Disability. Ms Salufa-Honeysett told of her experiences working, since 2015, as an Aboriginal Access and Support Officer for the City of Whittlesea in Victoria. She explained how her clients and their carers can often 'fall through the gaps' if they do not have an Aboriginal Access and Support Officer to help them access aged care support services. Ms Saluja-Honeysett said that this is because of factors such as a lack of cultural competency and awareness within services such as My Aged Care.[25]

Ms Saluja-Honeysett said that her 'Clients need to feel supported and safe' and that 'Services that are culturally aware ask the right questions.'[26] She stated that 'Elders and community members can sometimes feel shame about asking for support' and retelling their story over and over can be traumatic for them.[27] Ms Saluja-Honeysett referred to intergenerational trauma, including the ongoing effects of the Stolen Generations. She said that for Elders and their families, 'having someone come into their house can be nerve-racking because they don't know if they are going to be judged on it'.[28]

7.1.3 Systems of support

The primary programs funded by the Australian Government that provide support for carers are the Australian Department of Social Services' Carer Gateway and the Integrated Carer Support Service.[29] The Carer Gateway is a website which started in December 2015. The Australian Department of Social Services was, at the time of the hearing, in the process of implementing the Integrated Carer Support Service, and was considering tenders from regional service delivery partners to provide this.

After the Mildura Hearing, on 21 August 2019, the Minister for Families and Social Services, Senator the Honourable Anne Ruston, announced the outcome of the tender process. The Australian Department of Social Services website states, 'The department has selected 10 organisations with the strongest claims and supporting evidence to become the new network of Carer Gateway service providers in 16 service areas across Australia.'[30]

Ms Fiona Buffinton, First Assistant Secretary of In Home Aged Care at the Australian Department of Health, and Mr George Sotiropoulos, Group Manager for Disability and Employment and Carers Group at the Australian Department of Social Services, agreed that the primary focus of the Australian Department of Health is the person receiving aged

care services, whereas the focus of the Australian Department of Social Services is the carer.[31] Ms Buffinton said that 'the My Aged Care gateway and the Carer Gateway are closely linked'.[32] While acknowledging that 'it doesn't always work as well as it could', Ms Buffinton did not 'want to leave the impression that the system is broken'. She stated:

> we are actually all working to the one—to the one purpose, which is to make sure that the person being cared for and the carer is well looked after.[33]

The carers who gave evidence described circumstances in which services had not met their needs. Mrs Gregory said that when she was her mother's carer, she had no knowledge of services that were available to carers.[34] For carers living in rural, regional and remote areas, challenges in finding support services can be exacerbated. According to Associate Professor Suzanne Hodgkin, Deputy Director of the John Richards Centre for Rural Ageing Research at La Trobe University, the market for service delivery is very limited in rural areas.[35] This can mean that carers and older people need to travel large distances to access support, which results in greater costs and increased fatigue.[36]

Ms Catherine Thomson, a research fellow at the Social Policy Research Centre at the University of New South Wales, whose research includes the cost of care for Australian carers, gave evidence about the importance of considering both the carer and the person receiving care in determining the support needed:

> a focus on the carer and the older person is important because they both have needs and one should not be prioritised over the other…and what's happened with carers and respite is that it's assumed that the person accessing support…through the package, those services will give the carer a break, but that isn't necessarily the way that carers need or want to have a break from their caring role.[37]

The evidence in this hearing suggests that there is considerable work for the Australian Government to do to align the systems that support carers and the systems providing aged care services. It also suggests that the Government could do more to ensure that services such as respite, counselling and education are available to carers, and that carers are informed of these services and given information about them after a dementia diagnosis. This would help sustain carers in their important role, while assisting the sustainability of the aged care system as a whole.

7.1.4 Assessment of carer needs

Aged care assessment is the process by which older people are approved as eligible for subsidised aged care services under the *Aged Care Act 1997* (Cth). Assessment is conducted by an Aged Care Assessment Team or, as they are called in Victoria, the Aged Care Assessment Service. An aged care assessment is often the first point of contact people have with formal support services. It offers a critical opportunity to understand the support and care needs of the older person, and usually includes an interview conducted in their own home. This can and should occur in the presence of any family member or friend who may be providing support to the older person.

One of the questions raised in the hearing was whether aged care assessments adequately take into account the needs of the carer, and whether a holistic approach which allows for the needs of both the carer and person receiving care is warranted. The expression 'care dyad' was sometimes used to refer to the two people in the care relationship.

Informal carers gave evidence that the assessments did not adequately consider their needs as carers. Ms Dorothy Holt described the aged care assessment process as having 'very little interest' in what it was like for her to look after her mother.[38] Ms Hlis, a carer for her brother-in-law and her mother, now deceased, suggested that carer needs should be considered more comprehensively during aged care assessments.[39] Ms Holt's words echoed this suggestion. She said that the aged care assessment was focused solely on her mother and lacked any consideration as to what would support her as a carer.[40] Ms Holt explained she learned about carer services through word-of-mouth. She said that she did not access respite until she was already in need of a break from caring for her mother.[41]

Ms Cameron said that she did not recall being offered anything during her husband's aged care assessment.[42] She stated that due to Mr Cameron's anxiety, conducting the aged care assessment with him present would not have been an appropriate situation for her to express her needs.[43]

All the experts who gave evidence spoke of the importance of early engagement with carer services to prepare and support the care relationship. Dr Meredith Gresham, Post-Doctoral Research Fellow at University of New South Wales, said that the assessment of carer needs should occur early in a person's caring role.[44] This point was also emphasised in the joint paper of Ms Thomson, Dr Trish Hill and Dr Myra Hamilton, of the Social Policy Research Centre at the University of New South Wales. They said that carers require improved access to preventative respite.[45]

Associate Professor Hodgkin also listed the timeliness of access to respite care and continuity of care as critically important to the needs of carers living in rural, regional and remote areas.[46] Dr Phillipson described the consideration of carer needs in an aged care assessment for a Home Care Package:

> At the commencement of the new HCP [Home Care Package] program it was not mandatory for ACATs [Aged Care Assessment Teams] to conduct an assessment of carer need in their own right. As a result, the needs of carers have frequently gone unacknowledged or been viewed as secondary to the needs of the package recipient. Since October 2018, the carer screen in the National Screening and Assessment Form became mandatory, which is a welcome improvement in carer recognition. The focus however remains on carer assessment to determine the 'sustainability' of the caring relationship. As such the assessment still runs the risk of identifying carer needs, only at a time of crisis.[47]

Dr Phillipson also said 'the needs of one can't be seen without…looking through the lens of the other as well'.[48]

Senior Counsel Assisting suggested to Ms Buffinton that informal carers do not feel that their needs are properly considered in the Aged Care Assessment Team assessment process.[49] Ms Buffinton acknowledged that the focal point of the My Aged Care assessment process is the person receiving the care.[50] She added that the needs of the carer were considered in the assessment and the assessor could refer the carer to programs run by the Australian Department of Social Services.[51]

Dr Phillipson expressed her concern about the current Aged Care Assessment Team process in understanding the needs of carers only to ask if the carer has reached a moment of crisis:

> really does show a problem with the system if our goal is to be maintaining people to live well at home, and also to maintaining the wellbeing of carers as part of that situation.[52]

Dr Gresham described an assessment framework she has used in her research to identify the needs of carers. This framework identifies where the carer sits on a spectrum from 'care provider' through to 'care manager':

> Understanding caring style provides important information about how carers will interact with both formal services and informal supports and in my experience is a useful framework for analysing the needs of carers. In my clinical practice it has helped my understanding of why some carers readily utilise services and supports, while others do not.[53]

The evidence from direct experience witnesses in the Mildura Hearing suggests that the needs of carers are not adequately taken into consideration at the time of any Aged Care Assessment Team assessment, or before or after any such assessment.

A further problem facing carers in rural areas is that often younger generations will move to major cities, leaving older relatives in smaller regional areas. Associate Professor Hodgkin said that this means older spousal carers, with no adult children available to help, bear the totality of the caring responsibility.[54]

7.1.5 Community-based support

A number of witnesses discussed how community-based support activities and services, such as carer groups, provide an invaluable support service. There was evidence that these organisations help fill gaps, such as information gaps about support services that are available for carers. Obtaining respite may be necessary for the carer to have sufficient free time to receive other services, such as education and training. These community supports can provide crucial information to carers to assist them in navigating the aged care system.

Carer Mr Don Laity, a member of the Mildura Carer Blue Print steering group and Treasurer of the Sunraysia Carers Support Group, said that it can be harder being a carer when living in a regional area, because of the physical and social isolation.[55] He told us that support groups and face-to-face support are important for carers to feel connected.[56] He said that the Mildura Carers Hub 'was formed to provide an information centre and…a venue for carers where they could come and gather together'.[57] The Carers Hub had evolved into an education facility, a meeting place and a drop-in centre for carers.[58]

Mr Laity said that the Carers Hub is a success. It has 'an average attendance of 30 people per day, which is a big demand on the facility and certainly justifies its existence'.[59] We agree. The evidence received was that the Carers Hub gives carers the chance to look after themselves, debrief, and share their experience of caring, as well as exchange important information. The Mildura Carers Hub is a critical resource for carers in the region.

The need for community support services is particularly acute for those caring for people living with dementia, because of its progressive nature and its effect on cognition and behaviour. This can have indirect effects on the carer, who may feel trapped and isolated. Mrs Cameron said that:

> Dementia is a very isolating disease. The carer and the person with dementia become disconnected from 'normality' in many ways. Slowly over time, friends and sometimes family members move on with their lives and contact is lost. …I felt immense release when I first attended the Woodend Lifestyle Carers' Group because I could discuss issues I was dealing with, and by also listening to others, I felt that I was not the only one to go through this.[60]

Mrs Gregory said that when she first started caring for her mother, she felt that there was no pathway she could follow, and that she feels like she was 'thrown in the deep end' and had to work everything out herself.[61] She told us about the support she received from the Carers Hub, and the important role it plays in the community:

> the carers pop in and touch base and see how each other are coping. You might be good, but then there's someone else that is in there that needs a bit of a pick-up and encouragement.[62]

These peer-based carer support groups, particularly in rural, regional and remote areas, play an important role in supporting carers. Governments should support these organisations where they exist and encourage the development of similar peer support models elsewhere.

7.1.6 Respite

Overview

'Respite care' is defined in the Aged Care Act as:

> residential care or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. However, it does not include residential care provided through a residential care service while the care recipient in question is on leave under section 42-2 from another residential care service.[63]

The most common form of respite is residential respite care provided by residential aged care facilities, which is available to individuals following an Aged Care Assessment Team assessment. This service provides up to 63 days of residential respite per year, with an additional 21 days if approved by the Aged Care Assessment Team. This is funded by the Australian Government in the form of subsidies and supplements paid directly to providers approved to offer respite accommodation. In 2017–18, funding of $349.6 million was paid to providers of residential respite care. This funding was accessed by 61,933 people.[64]

The other forms of respite services available are funded through the Commonwealth Home Support Programme and can be purchased by an individual through their Home Care Program. In her statement, Ms Buffinton said that the respite services available through the Commonwealth Home Support Programme and Home Care Program are:

> (a) Social support group services that cover group-based activities held in centres of community settings;
>
> (b) Centre-based respite, which covers day-time respite in group based settings, including a centre or residential facility;
>
> (c) Cottage respite, which covers overnight community respite delivered in a cottage-style facility other than the home of the carer, care recipient or host family; and
>
> (d) Flexible respite, which covers day and overnight respite in varied settings, including the client's home (In-Home Respite), a host family's home and respite delivered as an outing.[65]

In 2017–18, there were 556 services providing respite care through the Commonwealth Home Support Programme. The Australian Government paid $262 million to services providing respite through the program, which was accessed by 46,098 people.[66] Despite this funding, there was evidence that there continues to be issues with the availability, type and accessibility of respite.

Witnesses said that the current funding arrangements do not ordinarily support more flexible forms of respite or a preventative, reabling approach such as short-term and regular cottage respite. These issues are described in more detail in the following sections.

The Aged Care Financing Authority reached a number of conclusions in its October 2018 report on respite for people receiving aged care.[67] The report noted that a recent increase in the use of residential respite care can be partly attributed to the use of respite for purposes other than supporting older people to remain living at home. Submissions to this review identified key concerns about:

- difficulties in finding respite services and navigating My Aged Care, inadequate consideration of carers' needs in assessments for aged care and difficulties faced by people with special needs, including dementia care
- funding being inadequate to meet the cost of care and accommodation, high administration costs associated with short-term respite care compared with permanent residents, and greater financial risk incurred by respite compared with permanent residential care
- concerns about the availability of respite care under the Commonwealth Home Support Programme, including availability and funding of 'cottage respite', and in residential aged care facilities. These concerns include the use of respite as a 'try before you buy' model impacting the availability of respite care.[68]

The need for respite

Many witnesses gave evidence about the physical and emotional toll that caring takes. Ms Thompson said:

> the difference between caring for a child and caring for somebody with a disability or who's ageing is that caring for a child usually follows a natural progression and they will, in the end, become more independent and go on and have their own lives…Whereas caring for somebody who—who's declining in their cognitive ability or who's becoming more frail…the nature of the relationship changes and so there's this, like, a decline…But also the needs of those people and the support that you give is often unpredictable so you can't…know exactly what's going to happen in terms of the types of support you're going to provide.[69]

This change in relationship between the person receiving care and their carer, combined with the unpredictability, can place significant strain on carers. Ms Bonney Dietrich, carer for her mother and coordinator of the Mildura Carer Blueprint, said that for some carers, the frustration that can come from this new role can impact negatively on their relationship with the person receiving care.[70] For some, they are also forced to give up work to provide full-time care to their loved one.[71]

Witnesses also said that they could feel angry and frustrated at times by the lack of support available to them.[72] Mrs Gregory said that when reflecting on caring for her mother 'you feel like a bit of a failure because you're not coping with what you're doing.'[73] Mr Laity stated that for carers, 'Isolation is part of the deal'.[74] He said:

> Stress has a huge emotional cost to the carer. It builds up and very quietly drags the carer down…they go through a stress of grief, a sense of loss, frustration, and even failure at recognising their inability to achieve anything for the person that they're caring for, that they can't cure or restore the health or the normality of the person for whom they are caring.[75]

Mrs Cameron shared her struggle with exhaustion and despair. She told how her husband would often try to strangle her or throw her against the wall because he did not recognise who she was.[76] When it came to learning survival techniques for dealing with these behaviours and calming Mr Cameron, Mrs Cameron said, 'I just learnt that I was on my own, you know, and I couldn't rely on anyone else to get me through that'.[77] She said she was struggling to cope by herself and had a desperate need for meaningful respite, for both her and her husband. After waiting for four months on a waiting list, Ms Cameron described how she felt when her husband was refused care after just a few days into a respite stay:

> I cried silently all of the way home. That was the closest I have ever felt to ending it all for both of us. I was exhausted and didn't know how much longer I could stay on my feet to look after Don, and I couldn't trust anyone else to care for him and not mistreat him.[78]

Ms Holt also described the emotional and physical strain she experienced while caring for her mother:

> I mean, I had the skills to support her, but you needed someone to support you because it is hard work, and it's emotionally hard work and physically hard work.[79]

Ms Nicole Dunn, a physiotherapist, explained how she took on caring for her grandmother while also working full-time. She said that 'it wasn't a good experience when I was still working. It was just too hard'.[80] As her grandmother's health deteriorated, she reduced her hours of employment to meet the demands of her caring role:

> I guess there came a point where I knew something was going to give and a change had to be made…I really needed to reduce work because I couldn't be a full-time carer, which is what it was turning into, and also work full-time. So work had to reduce.[81]

Ms Thomson said that carers often need to work part-time, or are in precarious work arrangements.[82] She said that as well as the financial impact of giving up work for a caring role, being a carer can lead to reduced support networks for the carer and exacerbate feelings of social isolation.[83]

Ms Holt told us about feeling guilty and of the dilemma she felt when she needed a break. She described how the difficult decision to access respite was made harder because of the impossible task of organising respite in Mildura. Ms Holt said she was told by facilities '"You can take it when it's available but, really, basically, unless somebody dies, you won't get any"'.[84]

Witnesses gave evidence about the positive impact that high quality, appropriate respite can have on carers and people receiving care. Mr Laity and his wife Sherilyn were able to find regular respite for one weekend every six weeks for Aileen, his mother-in-law, in Horsham. Aileen considered that going to respite care was like a holiday.[85] The staff-to-care recipient ratio was very high, at 2:1, and they only took four people at any one time. Mr and Mrs Laity had a standard booking for respite in Horsham, but would also take any free spaces that became available. Mr Laity said he and his wife were able to enjoy the break because they knew Aileen was well cared for.

Ms Saluja-Honeysett spoke of the importance of culturally appropriate respite. She gave examples of the ways in which facilities can provide culturally safe and appropriate care. This includes being respectful and aware of Aboriginal culture and being non-judgmental, having a greater involvement with Aboriginal communities, and celebrating Aboriginal and Torres Strait Islander culture and events, including NAIDOC Week and Sorry Day.[86] She said that in Melbourne there are only two culturally appropriate respite facilities for older Aboriginal people.[87]

Ms Lynette Bishop, Chair of the Victorian Committee for Aboriginal Aged Care and Disability, and an Aboriginal Access and Support worker, agreed with Ms Saluja-Honeysett and repeated that culturally appropriate respite is important. She said that Aboriginal people:

> are suspicious of institutions and being 'locked in'. Their families don't like it either, and say things like 'they will not be going into residential care while I'm still breathing'.[88]

Respite—a missed opportunity

In Mildura, there was evidence that respite did not provide effective reablement and rehabilitation tailored to the needs of the person receiving care. Instead, respite was typically provided in a basic and uniform way, as a one-size-fits-all model. Witnesses gave evidence that this approach neglects the care needs of residents, and can result in some very poor health outcomes for the individuals in care. This can be particularly bad for people living with dementia.

Mrs Cameron gave evidence that the staff providing respite care for her husband were unable to manage his behavioural symptoms from Lewy body dementia. She said she decided to remove him from respite care after a staff member told her that 'she refused to have him there unless he had a PRN [as needed medication]…to settle him down' and 'the locum would prescribe what he felt possible and if I didn't like that, then I could come and get him'.[89] Mrs Cameron was aware that there are a large number of medications that people with Lewy body dementia cannot have due to 'very adverse reactions'. She said that she was not going to risk her husband's life by allowing a locum to prescribe medication for him without first talking with the locum.[90]

Mrs Kay Gray told of how, in 2018, she organised two weeks of respite care at a residential aged care facility for her husband, Mr Clive Gray. She gave a day-by-day account of the poor care he received during the respite period. The poor care and rapid decline in her husband's health led to her decision to withdraw him from respite early.[91] Mrs Gray said that Mr Gray walked into the facility in good health.[92] However, after 10 days his health had deteriorated so significantly that he left the facility in a wheelchair.[93]

Mrs Gray said that on the first day of the respite stay she explained to the care staff that due to Mr Gray's dementia, he would need 24-hour care, regular prompts to drink water, and assistance with meals and personal care. In her statement, she wrote that the facility requested that she would not visit Mr Gray for the first three days to allow him to adjust.[94] Two days later, when Mrs Gray visited, she found him:

> sitting in the dining room quite confused. His meal had not been cut up and he was just given a knife and fork, and he was just sitting there not knowing what to do.[95]

Although Mrs Gray continued to remind care staff of Mr Gray's care needs, she said she found him thirsty, unshaved or unshowered, in dirty clothes and with his food not prepared properly on many occasions during the rest of his time in respite. Mrs Gray's daughter and her husband visited Mr Gray at one point and Mrs Gray said that 'they were so concerned at how he had deteriorated in the short time that they said to me that if I didn't…get him out of there…"He will either end up in hospital or he will pass away"'.[96]

Mrs Gray decided to remove Mr Gray from respite care and organised an emergency visit to the general practitioner. She stated that the doctor was 'just shocked' at Mr Gray's condition and immediately diagnosed him as dehydrated and suffering from a urinary tract infection. [97] This experience was very difficult for Mrs Gray:

> I felt really bad about it, and I kept saying—I thought it was my fault, but the family kept saying to me, 'No, Mum, it wasn't your fault.' But it made me feel that no way would I ever, you know, put him in another facility.[98]

From her experience of being her grandmother's carer, Ms Dunn said that the aged care system is 'very reactive' and 'really needs to be flipped on its head'. She argued that 'we need to be more proactive in the way we respond to aged care'.[99] This view was expressed by Dr Meredith Gresham, Senior Consultant to Hammond Care's Dementia Centre and Post-Doctoral Research Fellow at the University of New South Wales:

> we need to start thinking about not reactive services for the older person themselves but looking at proactive reablement type of services to help lessen the impact of chronic disease on family caregivers. I think I would like to finish with an old adage that an ounce of prevention is worth a pound of cure and I think in this instance it's highly relevant.[100]

Mr Darren Midgley, Chief Executive Officer of Chaffey Aged Care, an approved provider of residential aged care in the Sunraysia region, described the challenges that regional and rural residential aged care providers face in delivering respite care that is restorative:

> there is much that could be done in residential aged care around supporting the needs and working with a restorative health focus for care recipients coming in for respite care, as for permanent care recipients. However, the funding model is a very big constraint and there just are not the resources to enable…a high level of restorative care to be provided for care recipients. And also compounding that is the skills shortage, particularly in regional areas where we struggle to recruit and retain, for example, allied health staff, physiotherapists, occupational therapists.[101]

Some of these funding issues are considered in the following section.

Residential respite—distortions in funding

The evidence received indicates that funding arrangements for residential respite do not encourage the provision, or use of, this service in ways that best support informal carers seeking to care for their loved ones at home for as long as possible.

Providers of residential respite are funded through a Daily Respite Care Basic Subsidy and a Daily Respite Care Supplement with different rates for low and high level needs. There is also an additional funding incentive for high level respite when a provider has at least 70% occupancy of allocated respite places. As at 1 July 2018, the total paid per day to a provider was $85.20 for low-level respite care, $184.96 for high-level respite care and $222.78 for high-level care when a provider has at least 70% occupancy of their respite care allocation.[102]

Funding for permanent residents is provided through the Aged Care Funding Instrument basic daily subsidy, along with two types of supplements, and is determined by appraising the care needs of residents. Other sources of revenue for permanent residents include accommodation payments, extra services fees and additional services fees.

The Aged Care Financing Authority's 2018 review of respite paid close attention to funding arrangements of residential respite, and compared it to that for permanent residential care. The analysis indicated that for a number of reasons, funding for respite is unfavourable compared with that for permanent residential care, and is inadequate to meet costs.

The review also observed that permanent residential care for people with higher needs was better funded than residential respite for people with higher needs, once accommodation funding is taken into account. The review also indicated that residential respite funding was inadequate in addressing the additional costs incurred by caring for people with special needs, and the proportionally high costs associated with frequent admissions for short stays.[103] The review identified trends indicating:

> that the availability of residential respite care to support those seeking to live at home for as long as possible and their carers is not increasing, and that residential respite subsidy is increasingly being paid to providers for care that is not short-term respite care.[104]

Mr Midgley said that Chaffey Aged Care had provided 1009 low care respite bed days over the previous 12 months and the cost of doing so was greater than the funding provided.[105] This equated to a loss of $68,077.[106] He also discussed the significant administrative burden and cost associated with admitting a resident into respite care.[107]

Mrs Cameron talked about the same issue from the perspective of an informal carer:

> So sometimes I would book it [respite] in and it would be three months ahead and then I would get a few weeks just prior to going in and you're hanging on thinking, well, if I just hang on a little longer I'll get that respite. And then they would ring me to say, 'I'm sorry, that bed's not available now, we've filled it with a permanent resident so I'm sorry, you know, you can't have that'.
>
> So then you've got to ring again and wait longer…again, so you're put to the back of the list. A lot of the facilities were closing down their respite beds and it was told to me by one facility that [it] really wasn't worth them doing all that paperwork every two weeks. If they did two-week slots for respite, then it was far too much paperwork. If they put a permanent resident into that bed it was easier. So they were stopping their respite beds.[108]

Mr Nigel Murray, Assistant Secretary of the Funding Policy and Prudential Branch at the Australian Department of Health, agreed that the average Aged Care Funding Instrument funding amount was higher than the maximum possible funding amount available for providing respite accommodation.[109] He also agreed that this difference had been identified by the Aged Care Financing Authority as worthy of further consideration, and the Department agreed with this view.[110]

However, at the time of this hearing, there were no immediate or current plans by the Australian Department of Health to address this distortion in funding. In response to a series of questions from Senior Counsel Assisting, Mr Murray said that respite funding reform should be considered together with proposed reforms to the residential care

funding system arising out of work by the University of Wollongong, which is to determine the characteristics of aged care residents that drive residential care costs (the Resource Utilisation and Classification Study process).[111] He conceded that because of this process, it may take years before the distortion is corrected.[112]

Respite—a lack of options

Residential respite is provided in residential aged care facilities that are typically large, have an institutional atmosphere and accommodate many permanent residents. The evidence suggests that residential respite is more likely to be available in quite large blocks of time, but it is unsuited to frequent, short duration respite.

Flexible, overnight and short duration respite in a less institutional environment is often called 'cottage' respite. Dr Gresham spoke about the research she had undertaken which identified that 'carers overwhelmingly preferred cottage respite'.[113] This research quantified the impact that access to cottage respite had on the sustainability of the care relationship. Dr Gresham said that the carers in the study:

> kept their person at home for 12 months longer than they otherwise would because they had that flexibility of having various lengths of breaks when they needed it. Key to that for me is that again it's proactive. It's not about having respite when you are overwhelmed and exhausted and then somebody says we will give you a month's respite or two week's respite.[114]

Dr Phillipson told of studies she had done, both during her PhD and subsequently, that had produced results that were consistent with Dr Gresham's research regarding carers' preference for cottage respite. However, Dr Philipson also said that 'cottage respite is often not very available for people', adding 'there are real issues with access to both cottage respite and to residential respite in aged care facilities'.[115]

This is consistent with other evidence. Mrs Cameron described the great need for home-like day respite for people caring for people living with dementia. She said this need is so great in her regional area that the Woodend Lifestyle Carers Group was planning on building a day respite centre to service their semi-rural area.[116] Mrs McPhee said that cottage or day respite would have been 'marvellous' and 'wonderful' had it been available to her.[117]

Ms Buffinton agreed with a suggestion by Senior Counsel Assisting that, due to providers' preference for offering respite in blocks of at least two weeks, residential respite in a residential aged care facility is not well adapted to regular and ongoing short bursts of overnight respite.[118]

There was also evidence about the benefits associated with 'in-home' respite. According to Dr Phillipson, 'in-home' respite means having somebody come into the older person's home and having meaningful interaction with them while the carer attends to their own needs or other responsibilities. She said that when a person starts to deteriorate, 'getting out can be a burden in and of itself, so services in the home can make a big difference to a carer being able…to have a break'.[119]

Ms Dunn said she was able to seek in-home respite and support with caring for her nanna through Carers Victoria. She considered this to be 'wonderful, and of great assistance'. Ms Dunn was able to qualify for four hours of in-home respite per fortnight through Carers Victoria. She supplemented this by paying privately so that she could have more of a break.[120] Dr Phillipson explained how flexible respite options such as in-home support, which is available to allow carers to go to work or to an appointment, can make a real difference to both the person receiving care and the carer.[121]

Ms Hlis spoke about how residential respite at an aged care facility can make people from culturally and linguistically diverse backgrounds feel that they are 'no longer loved, that they are abandoned, that they are not wanted'.[122] She said that this was the case for her brother-in-law, for whom the only appropriate respite was in-home. Ms Hlis said this was not available under his Level 4 Home Care Package, and had cost the family between $6000 and $7000 for just one week. She said that the 63 days available for respite at a residential aged care facility was 'wasted money' for people who couldn't use this. She added that it 'would only be fair' if this money was added to a Home Care Package so individuals can use the money for in-home respite when needed.[123]

There was evidence in the Mildura Hearing about the need for specialist respite services to cater for people with higher or different needs. Initially, when Mrs Cameron needed day respite for her husband, she said he would be placed in the dementia unit of the local residential aged care facility, and during these times he would beg not to go and become distressed. Mrs Cameron said that more home-like offerings should be available for people living with the early stages of dementia. She said that 'Unfortunately there is so little on offer' and that there is only one program in her area that meets these needs. But according to Mrs Cameron, that program 'cannot cater for the vast number of people with dementia in our area'.[124]

As her husband's Lewy body dementia progressed, Mrs Cameron said she needed different respite options to better suit his needs. She was able to secure one week of respite at a local residential aged care facility after months of waiting, and Mr Cameron was assessed on entry. However, Mrs Cameron said she received a call after three days from a nurse to say that they wouldn't tolerate his 'bad behaviour' any longer. Mrs Cameron said:

> Don wasn't a criminal. He wasn't choosing to do this. This was his illness…And Don had no choice in this whatsoever. So to be told that he was behaving badly, or to be, you know—you know, there were times when I felt that I had the naughtiest boy at school and that he just wouldn't conform—well, he couldn't conform and I felt that she was trained to know better. She was part of the dementia specialised part of the nursing home. So it's hurtful. It's hurtful to see Don treated that way. It's disrespectful.[125]

Mr Cameron was taken to a mental health facility where he was medicated. Mrs Cameron said that when she visited him:

> Don was really just knocked out. He was in a chair, he was unshaven, he was smelly and he was non-coherent, really. He was just so heavily sedated.[126]

She said that when he came out of the mental health facility, he was in a far worse condition than he had been when he had begun his planned respite. When Mrs Cameron tried to get respite on another occasion, she was again told that he was not welcome to stay after spending one night there. Mrs Cameron described these incidents as having an enormous impact on her wellbeing and state of mind.[127]

7.1.7 Conclusion

This hearing focused on the important role of informal carers within the aged care system. A number of current and former carers gave evidence about the significant challenges involved in caring, advocating and supporting an older person. This evidence was compelling.

Witnesses spoke about how the lack of good information and clear pathways through the aged care system left them feeling lost, alone and having to fend for themselves. Several spoke of the difficulties of having to deal with an overwhelming number of different agencies and bodies. There is work for the Australian Government to do to improve the availability of information and better assist carers in navigating the aged care system.

There was evidence about how the systems in place to support carers are poorly aligned with the systems in place to provide aged care services. This highlighted the inadequacy of the assessment of carer needs. There is work to be done to improve the alignment of systems of support for carers and the older people they care for. Proper assessment of carer needs is critical to supporting the carer and helping them to continue to provide care.

Witnesses also spoke about how community-based, peer support networks had been established by carers. There was clear evidence of the benefits of these services for carers and the older people they care for.

Some of the evidence about the quality of some respite care and, in particular, respite care for people living with dementia, was appalling. Improving the quality, variety and availability of respite care is essential to support these carers and the people they care for, and to improve the sustainability of the caring relationship.

It is shameful for a respite facility to reject a person with dementia within two or three days of entry to respite. That this should occur reflects poorly on the respite care options available for people with dementia and the level of dementia training available to nurses and personal care workers.

This hearing provided an opportunity to hear directly from carers about the challenges they face and the impacts of some of the systemic issues based on the experience of carers. Providers of respite services and a number of expert witnesses provided very useful evidence on the problems within the system and offered their views on how these problems could be addressed. Addressing these issues and properly supporting people in their caring role should be a priority for Government.

Endnotes

1 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 17, RCD.9999.0003.0001 at 0006.
2 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 26, RCD.9999.0124.0102.
3 *Carer Recognition Act 2010* (Cth), sch 1, cl 4, 7, 9.
4 Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3990.34–3991.4.
5 See, for example, Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3893.1–8; Transcript, Barbara McPhee, Mildura Hearing, 29 July 2019 at T3916.5–22.
6 See, for example, Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3850.43–3852.45; Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3860.29–3862.41.
7 See, for example, Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3879.4–28; Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3860.26–43.
8 See, for example, Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3962.44–3963.13; Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3846.35–3847.39; Exhibit 7-4, Statement of Rosemary Cameron, 26 July 2019, WIT.0309.0001.0001 at 0021 [126]–[139].
9 Transcript, Mildura Hearing, Barbara McPhee, 29 July 2019 at T3916.1–22.
10 Transcript, Mildura Hearing, Meredith Gresham, 30 July 2019 at T4037.22–25.
11 See, for example, Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3983.37–41.
12 Transcript, Dorothy Holt, Mildura Hearing, 29 July 2019 at T3868.1–3; Transcript, Mildura Hearing, 30 July 2019 at T3975.41–45; Transcript, Danijela Hlis, 31 July 2019 at T4067.46–4068.10.
13 Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2019 at T4008.22–27.
14 Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2019 at T4008.29–39.
15 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3875.10–21.
16 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3876.16–21.
17 Exhibit 7-4, Mildura Hearing, Statement of Rosemary Cameron, WIT.0309.0001.0001 at 0007 [43]–[44].
18 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3887.30–3888.36.
19 Transcript, Mildura Hearing, Danijela Hlis, 31 July 2019 at T4068.6–10.
20 Exhibit 7-2, Mildura Hearing, Statement of Elaine Gregory, WIT.0315.0001.0001 at 0003 [23].
21 Transcript, Mildura Hearing, Barbara McPhee, 29 July 2019 at T3916.5–12.
22 Exhibit 7-6, Mildura Hearing, Statement of Barbara McPhee, WIT.0311.0001.0001 at 0003 [17].
23 Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3981.41–43.
24 Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3983.37–41; T3985.8–19.
25 Exhibit 7-7, Mildura Hearing, Statement of Shontia Saluja-Honeysett, WIT.0317.0001.0001 at 0002 [9]–0003 [14].
26 Exhibit 7-7, Mildura Hearing, Statement of Shontia Saluja-Honeysett, WIT.0317.0001.0001 at 0004 [17], [19].
27 Exhibit 7-7, Mildura Hearing, Statement of Shontia Saluja-Honeysett, WIT.0317.0001.0001 at 0004 [17]–[19].
28 Exhibit 7-7, Mildura Hearing, Statement of Shontia Saluja-Honeysett, WIT.0317.0001.0001 at 0005 [23].
29 Exhibit 7-2, Mildura Hearing, Statement of Emma McGuirk, WIT.0298.0001.0001 at 0009 [44].
30 Australian Department of Social Services, *Integrated Carer Support Service – Implementation Updates and Information*, 2020, https://www.dss.gov.au/disability-and-carers-carers/integrated-carer-support-service-implementation-updates-and-information#uoi, viewed on 17 November 2020.
31 Transcript, Mildura Hearing, Fiona Buffington and George Sotiropoulos, 31 July 2019 at T4118.6–20.
32 Transcript, Mildura Hearing, Fiona Buffington, 31 July 2019 at T4138.38–39.
33 Transcript, Mildura Hearing, Fiona Buffington, 31 July 2019 at T4139.19–23.
34 Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3850.46–3851.10.
35 Transcript, Mildura Hearing, Suzanne Hodgkin, 30 July 2019 at T4010.31–38.
36 Transcript, Mildura Hearing, Suzanne Hodgkin, 30 July 2019 at T4010.40–4011.3.
37 Transcript, Mildura Hearing, Mary Thomson, 30 July 2019 at T3991.15–20.
38 Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3860.29–33.
39 Transcript, Mildura Hearing, Danijela Hlis, 31 July 2019 at T4070.24–38.
40 Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3860.29–43.
41 Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3864.18–24.
42 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3879.22–25.
43 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3879.25–28.
44 Exhibit 7-13, Mildura Hearing, Statement of Meredith Gresham, WIT.0284.0001.0001 at 0010 [55].
45 Exhibit 7-12, Mildura Hearing, Joint Paper of Catherine Thomson, Trish Hill and Myra Hamilton, WIT.0286.0001.0001 at 0025 [15]–0027 [16].
46 Exhibit 7-15, Mildura Hearing, Statement of Suzanne Hodgkin, WIT.0285.0001.0001 at 0004 [15].
47 Exhibit 7-14, Mildura Hearing, Statement of Lyn Phillipson, WIT.0287.0001.0001 at 0008 [36].
48 Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2019 at T4031.23–24.
49 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 44, CTH.0001.1000.7587; tab 45, CTH.0001.1000.7588; tab 46, CTH.0001.1000.7589; tab 47, CTH.0001.1000.7708.
50 Transcript, Mildura Hearing, Fiona Buffington, 31 July 2019 at T4128.44–4129.2; T4131.35.

51 Transcript, Mildura Hearing, Fiona Buffington, 31 July 2019 at T4132.15–18; T4135.1–4.
52 Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2019 at T4010–4.
53 Exhibit 7-13, Mildura Hearing, Statement of Meredith Gresham, WIT.0284.0001.0001 at 0004 [23].
54 Transcript, Mildura Hearing, Suzanne Hodgkin, 30 July 2019 at T4012.12–15.
55 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3966.13–28.
56 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3968.41–46.
57 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3958.22–23.
58 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3958.41–46.
59 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3959.1.
60 Exhibit 7-4, Mildura Hearing, Statement of Rosemary Cameron, WIT.0309.0001.0001 at 0021 [131].
61 Exhibit 7-2, Mildura Hearing, Statement of Elaine Gregory, WIT.0315.0001.0001 at 0003 [18].
62 Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3847.37–39.
63 *Aged Care Act 1997* (Cth), sch 1, cl 1.
64 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 39, CTH.0001.1000.7255 at 7256–7257.
65 Exhibit 7-22, Mildura Hearing, Statement of Fiona Buffinton, WIT.0299.0001.0001 at 0003–0004 [15].
66 Exhibit 1-37 Adelaide Hearing 1, RCD.9999.0011.0001 at 0055–0056.
67 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 26, RCD.9999.0124.0102.
68 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 26, RCD.9999.0124.0102 at 0104.
69 Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3988.10–24.
70 Transcript, Mildura Hearing, Bonney Dietrich, 30 July 2019 at T3965.24–29.
71 Transcript, Mildura Hearing, Bonney Dietrich, 30 July 2019 at T3965.25–26.
72 Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3844.18–19.
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74 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3966.13.
75 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3965.39–43.
76 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3878.4–5.
77 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3878.22–25.
78 Exhibit 7-4, Mildura Hearing, Statement of Rosemary Cameron, 26 July 2019, WIT.0309.0001.0001 at 0007 [43].
79 Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3868.1–3.
80 Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3860.12–14.
81 Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3977.37–41.
82 Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3988.40–47.
83 Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3993.26–35.
84 Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3868.31–32.
85 Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3954.3–5.
86 Exhibit 7-7, Mildura Hearing, Statement of Shontia Saluja-Honeysett, WIT.0317.0001.0001 at 0007 [31].
87 Transcript, Mildura Hearing, Shontia Saluja-Honeysett, 29 July 2019 at T3932.1–9.
88 Exhibit 7-8, Statement of Lynette Bishop, WIT.0316.0001.0001 at 0004 [33].
89 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3881.15–39.
90 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3881.17–20.
91 Exhibit 7-16, Mildura Hearing, Statement of Kay Gray, WIT.0310.0001.0001 at 0005 [33]–0008 [61].
92 Exhibit 7-16, Mildura Hearing, Statement of Kay Gray, WIT.0310.0001.0001 at 0005 [33].
93 Exhibit 7-16, Mildura Hearing, Statement of Kay Gray, WIT.0310.0001.0001 at 0009 [63].
94 Exhibit 7-16, Mildura Hearing, Statement of Kay Gray, WIT.0310.0001.0001 at 0005 [35].
95 Transcript, Mildura Hearing, Kay Gray, 31 July 2019 at T4053.27–29.
96 Transcript, Mildura Hearing, Kay Gray, 31 July 2019 at T4056.31–4057.4.
97 Transcript, Mildura Hearing, Kay Gray, 31 July 2019 at T4058.42–4059.2.
98 Transcript, Mildura Hearing, Kay Gray, 31 July 2019 at T4059.31–33.
99 Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3983.26–33.
100 Transcript, Mildura Hearing, Meredith Gresham, 30 July 2019 at T4037.32–37.
101 Transcript, Mildura Hearing, Darren Midgley, 31 July 2019 at T4097.3–10.
102 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 39, CTH.0001.1000.7255 at 7261.
103 Exhibit 7-1, Mildura Hearing, general tender bundle, tab 26, RCD.9999.0124.0102 at 0025–0028.
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105 Transcript, Mildura Hearing, Darren Midgley, 31 July 2019 at T4100.41–42.
106 Transcript, Mildura Hearing, Darren Midgley, 31 July 2019 at T4100.36–42.
107 Transcript, Mildura Hearing, Darren Midgley, 31 July 2019 at T4087.26–31.
108 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3882.26–38.
109 Transcript, Mildura Hearing, Nigel Murray, 31 July 2019 at T4149.24.
110 Transcript, Mildura Hearing, Nigel Murray, 31 July 2019 at T4150.4–7.
111 Transcript, Mildura Hearing, Nigel Murray, 31 July 2019 at T4150.18–4152.15.
112 Transcript, Mildura Hearing, Nigel Murray, 31 July 2019 at T4151.14–17.
113 Transcript, Mildura Hearing, Meredith Gresham, 30 July 2019 at T4019.23–28.

114 Transcript, Mildura Hearing, Meredith Gresham, 30 July 2019 at T4019.37–41.
115 Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2019 at T4020.33–4021.8.
116 Exhibit 7-4, Mildura Hearing, Statement of Rosemary Cameron, WIT.0309.0001.0001 at 0024 [144].
117 Transcript, Mildura Hearing, Barbara McPhee, 29 July 2019 at T3923.29.
118 Transcript, Mildura Hearing, Fiona Buffington, 31 July 2019 at T4142.6–17.
119 Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2019 at T4020.33–46.
120 Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3979.13–21.
121 Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2019 at T4020.20–29.
122 Transcript, Mildura Hearing, Danijela Hlis, 31 July 2019 at T4072.33–38.
123 Transcript, Mildura Hearing, Danijela Hlis, 31 July 2019 at T4073.14–23.
124 Exhibit 7-4, Mildura Hearing, Statement of Rosemary Cameron, WIT.0309.0001.0001 at 0023 [143]–[144].
125 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3884.23–31.
126 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3885.17–21.
127 Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3887.5–9; T3888.35–42.

8. Brisbane Hearing: Regulation of Aged Care

8.1 Hearing overview

8.1.1 Introduction

Commissioner Richard Tracey and Commissioner Lynelle Briggs held a public hearing in Brisbane, Queensland, from 5 to 9 August 2019. This hearing examined:

- regulation of quality and safety in aged care, including complaints handling and oversight of reportable serious incidents
- how aspects of the regulatory system operate, including the extent of any connection with prudential regulation and oversight, and the adequacy of advocacy services
- different approaches to regulation, including in other sectors
- how regulation and oversight of quality and safety in aged care, complaints handling and serious incident oversight could be improved.

Thirty-three witnesses gave oral testimony. A total of 690 documents, including 32 witness statements, were received into evidence.

Several witnesses gave direct evidence about their experiences when interacting with the aged care regulatory system—in particular its complaints system. Two shared their experiences of receiving aged care services.

A number of representatives of the Australian Government, from the Australian Department of Health and the Aged Care Quality and Safety Commission, also gave evidence. Representatives of other related sectors and policy experts in the field of regulation also spoke.

Due to Commissioner Tracey's death in October 2019, findings in this overview are made by Commissioner Briggs.

The evidence exposed a number of deficiencies in the aged care regulatory system and areas for improvement. These were identified in detail in three case studies which focus on the operation of the regulatory system in relation to: the Earle Haven facilities, Queensland; MiCare Ltd, Victoria; and Japara Healthcare Limited, Victoria.

This hearing took place during a period of rearrangement and reform of aged care regulatory functions that started on 1 January 2019 with the establishment of the Aged Care Quality and Safety Commission.[1] This replaced the existing Australian Aged Care

Quality Agency and the office of the Aged Care Complaints Commissioner which were abolished on 1 January 2019.[2] The quality and safety regulatory functions of the Australian Aged Care Quality Agency and complaints handling functions of the Aged Care Complaints Commissioner became the responsibility of the newly-established Aged Care Quality and Safety Commission.

At the time of this hearing, responsibility for quality and safety regulation of aged care was shared by the Australian Department of Health and the Aged Care Quality and Safety Commission. Responsibility for accreditation of residential aged care services and for quality reviews of aged care services, and certain related functions, rested with the Aged Care Quality and Safety Commission. The Australian Department of Health had responsibility for the approval of aged care providers, prudential regulatory oversight, and the imposition of sanctions. On 1 January 2020, all the Department's regulatory functions relating to quality and safety, and most aspects of prudential oversight, were transferred to the Aged Care Quality and Safety Commission.[3]

8.1.2 A system of 'ritualistic regulation'

Commissioners Tracey and Briggs heard that many aspects of the aged care regulatory system could be characterised as one of 'ritualistic regulation', focused on processes and systems at the expense of curiosity and intellectual rigour.[4]

Professors John Braithwaite and Valerie Braithwaite, and Emeritus Professor Toni Makkai, all of the Australian National University, describe ritualistic regulation in the aged care context as follows:

> Ritualism means obsession with means for attaining outcomes that are encouraged by regulators while losing sight of the outcomes themselves. Mostly it means focus on inputs rather than outcomes…all too often attention shifts in regulatory encounters from getting good care to getting good paperwork.[5]

In his evidence, Professor Ron Paterson ONZM, a co-author of the *Review of National Aged Care Quality Regulatory Processes*, widely known as the Carnell-Paterson Review, characterised the system as having a 'total lack of curiosity' and a 'mechanistic approach' to its regulatory functions.[6] Professor Paterson referred to evidence in the Earle Haven Case Study as 'alarming' and said it highlights a regulatory framework that holds a range of information but does not put each of the sources together.[7] He said that:

> often, the information is sitting there if people will just look at it. So then you have to ask, "Why aren't they looking at it?…how is it being presented? And what sort of dashboards do we have so that it becomes readily visible that we have a problem?"[8]

A lack of curiosity by the regulator in relation to audits and assessments was apparent in the MiCare Case Study. The evidence showed a reliance by the Aged Care Quality and Safety Commission on routine and mechanistic assessment processes. The Royal Commission heard evidence about the use of computer-generated assessment reports, including 'template reasons' for findings that a service had met, or not met, expected outcomes.[9] When asked by Counsel Assisting about the content of one re-accreditation

audit assessment regarding the MiCare Avondrust service, quality assessor Ms Gilda D'Rozario agreed that a 'large proportion' of the content was 'template reasoning'.[10] This is particularly concerning because the information in these assessment reports ultimately underpins decision-making about accreditation and re-accreditation.

The Japara Case Study, which examined the system of compulsory reporting of suspected or alleged assaults in residential aged care facilities, also illustrated regulatory ritualism. The evidence indicated that the system operated by the Australian Department of Health appeared to be focused on documentation and a 'tick box' approach to assessing reports, rather than on what the process is presumably intended to achieve—ensuring the safety of residents. The Royal Commission heard that information given to the Department by providers was accepted at face value, without investigation, and that compulsory reports were routinely finalised without the Department being notified of the outcome of investigations conducted by approved providers into allegations concerning staff members.[11]

8.1.3 Fragmentation within the regulatory system

One of the issues explored was whether the regulatory system lacked effective information sharing processes and coordination, both within and between the Australian Department of Health and the Aged Care Quality and Safety Commission. At the time of this hearing, regulatory functions were split between the Australian Department of Health and the Aged Care Quality and Safety Commission.

Ms Elsy Brammesan PSM, then Director, Compliance Centre East, Compliance Branch of the Australian Department of Health, acknowledged that there could be disadvantages with this arrangement. One disadvantage was that providers may be required to respond to both agencies on regulatory matters, which could cause issues in achieving timely outcomes for people receiving care.[12] Ms Brammesan acknowledged that, while the two agencies had different regulatory processes and focus, the system could result in both agencies 'prosecuting the same issue in two different ways'.[13]

The Earle Haven Case Study illustrates that deficiencies in sharing and integrating information affected the ability of the regulatory agencies to recognise and respond to what Counsel Assisting characterised as 'clear and present risks'.[14] Counsel Assisting submitted that the Earle Haven Case Study demonstrated a 'failure to appreciate risks raised in the course of different functions being exercised by different officials'.[15] Findings in the Earle Haven Case Study are set out later in this chapter.

The Earle Haven Case Study demonstrates a lack of integration of information from different sources and information about risk held by the Aged Care Quality and Safety Commission and the Australian Department of Health. When asked about the evidence heard in this case study, Professor Paterson said he found it 'alarming' and that it highlighted that 'the left hand didn't talk to the right hand', even where particular functions existed within a single regulator.[16]

The issue of fragmentation was also highlighted by the evidence about the Homes of Interest list, maintained by the Aged Care Quality and Safety Commission, and the Service Providers of Concern lists, maintained by the Australian Department of Health. The operation of the separate lists as risk analysis tools, and as a way to facilitate information sharing between the two agencies, was examined with Australian Government witnesses, and during the Earle Haven and MiCare case studies.

Residential aged care services were included in the Homes of Interest list, where they were under sanction or found to be non-compliant with a certain number of expected outcomes or requirements of the relevant aged care standards.[17] Inclusion of a service in the list did not change the Aged Care Quality and Safety Commission's regulatory approach to a service, but allowed the Commission to 'track, review and share actions taken to manage risks, support regulatory case management and business management of regulatory operations'.[18]

The Service Providers of Concern list, maintained by the Australian Department of Health, included certain approved providers of concern where non-compliance had been identified.[19] It was updated from time to time in response to nominations and updates by the Service Providers of Concern Committee, comprised of Australian Department of Health staff members who attended meetings to discuss the list.[20] Mr Anthony Speed, Acting Assistant Secretary of the Aged Care Compliance Branch in the Department, confirmed the Service Providers of Concern list was intended to list the highest risk providers known to the Australian Department of Health.[21] Despite this, Mr Speed stated that the inclusion of an approved provider on the list did not change the regulatory approach taken by the Australian Department of Health to the provider.[22] However the Service Providers of Concern Committee would apply a risk rating to an approved provider and this was used to determine the committee's regulatory stance and response.[23]

Following a streamlining of the operations of the Service Providers of Concern Committee in April 2019, the Committee ceased referring specifically to a list of factors relevant to its determination.[24] As a result, there were no explicit criteria for inclusion on the list. Inclusion of a provider was not automatic, but rather a matter of discretion for the Committee and its Chair.[25] Ms Brammesan, a member of the Committee, said that the Service Providers of Concern list was 'about having knowledge of a provider with multiple areas of non-compliance'.[26] She said that, when nominating an approved provider to the Service Providers of Concern list, she looked at systemic issues across all the services of a provider.[27]

The Service Providers of Concern list was circulated to regulatory staff members in the Australian Department of Health, and a copy was provided to the Aged Care Quality and Safety Commission.[28] Meetings of the Committee were held monthly to discuss service providers identified on the list, and staff from the Aged Care Quality and Safety Commission attended these meetings.[29] The Homes of Interest list was also provided to the Department by the Commission for discussion at the meetings.[30]

Ms Shona Reid, Executive Director in charge of complaints at the Aged Care Quality and Safety Commission, said the meetings 'facilitate an end-to-end compliance response' by the Aged Care Quality and Safety Commission and the Australian Department of Health.[31] Ms Brammesan said that the focus of each list differed to the other, which reflected the

different regulatory focus of each agency. One supported the regulation of services' accreditation by the Aged Care Quality and Safety Commission and the other supported the regulation of approved providers, including through sanctions, by the Secretary of the Department.[32]

Evidence in the MiCare Case Study showed that in August 2018, the MiCare Avondrust service appeared on the Homes of Interest list maintained by the Aged Care Quality and Safety Commission. This was as a result of a finding that the service had failed to meet a number of expected outcomes. However, the approved provider, MiCare Ltd, was not included on a Service Providers of Concern list. Ms Brammesan explained that the two lists were considered in the same meeting. Ms Brammesan stated that she decided not to nominate MiCare Ltd for the Service Providers of Concern list due to its ongoing process towards compliance and the fact that, on her assessment, it did not have widespread non-compliance.[33]

8.1.4 Deficiencies in complaints handling

There was evidence about the importance of aged care providers being held accountable by the regulatory system, particularly in the context of complaints made to the Aged Care Quality and Safety Commission or previously to the Aged Care Complaints Commissioner. The evidence emphasised the role of effective complaints handling, along with sanctions and enforcement powers, in a strong regulatory system.

A number of direct experience witnesses said they felt there had been a lack of transparency and accountability where things had gone wrong for their family member, particularly in relation to the outcome of complaints processes. Ms Sarah Holland-Batt spoke about her experience pursuing a complaint of an alleged assault on her father by a staff member in his residential aged care facility. She said:

> I got the impression that the ACCC [Aged Care Complaints Commissioner] was inclined to work with the facility and accept its assurances, and did not really intervene in the process and make suggestions about what measures might be appropriate.
>
> …
>
> I would also like to see greater transparency regarding provider responses to complaints. I would have like[d] to see a response to my complaint in writing from the provider, rather than just their promises being relayed to me by the complaints operator. I did not feel empowered during the process.[34]

Ms Holland-Batt detailed her frustrations with the complaints process, especially the amount and quality of information provided to her by the Aged Care Complaints Commissioner regarding the process. This included options at its disposal and the outcome of her complaint.[35] Similarly, Ms Debra Barnes, another direct experience witness who described the complaints process in relation to her mother's care, stated that she was disappointed with the process. She could not understand how her complaint could be resolved without any acknowledgement or accountability of what actually happened to her mother.[36]

Ms Gwenda Darling, an Aboriginal woman, who spoke of her experience of raising complaints about her home care services, said:

> In that interaction with the woman at the ACCC [Aged Care Complaints Commissioner], I didn't feel like there was any compassion for me or concern about my experience. It felt like the woman I spoke to had a script to read and there was no personalisation.[37]

Ms Darling explained that her experience made her feel like it was useless to complain so it was not worth the bother.[38] It ultimately left her feeling like no-one cared.[39]

Ms Holland Batt and Ms Barnes said they felt as though providers paid lip service to their complaints about the care received by their loved ones.[40] They described feeling as though the complaints system did not extend empathy or concern and that the priority was to resolve cases rather than address concerns.

Although a focus of the complaint handlers appeared to be on timely resolution, Ms Holland-Batt described her disappointment to learn that her complaint had been marked for early resolution, rather than her preference for 'a more robust process' with evidence in writing and investigation of documents.[41]

Mr Geoffrey Rowe, Chief Executive Officer at Aged and Disability Advocacy Australia, said that he could understand why people were left unsatisfied by complaints processes because communication was not face-to-face and the Aged Care Quality and Safety Commission, and its predecessors, often seemed to be guided by the provider's version of events.[42] Mr Rowe spoke of the frustration that the resolution of complaints did not always translate to actual change.[43] He said that a provider might pledge to change following a complaint, but the regulator did not follow-up to ensure that changes had been implemented.[44]

In response to concerns that Ms Holland-Batt raised in evidence, Ms Reid of the Aged Care Quality and Safety Commission agreed that complainants should be made aware of the options that the Commission has for dealing with complaints beyond early resolution. However, she did not agree that complainants should have an opportunity to make some sort of submission as to their preference.[45] Further, Ms Reid said that the *Aged Care Act 1997* (Cth) did not allow the Aged Care Quality and Safety Commission to forward a provider's response to a complainant without the provider's permission.[46]

Ms Reid agreed that early resolution of complaints is encouraged and that the vast majority of complaints are finalised at early resolution. She did not agree that quick resolution is favoured at the expense of proper process.[47]

8.1.5 Failing to hear the voices of older people receiving care

The evidence highlighted the importance of placing those receiving care and their supporters at the centre of the aged care regulatory regime. It suggested that the regulatory system did not seek out, consider adequately, or act upon the views of the person receiving care and their families in relation to the care that they receive.

Mr Rowe said that 'currently the Act reads as an overarching funding mechanism rather than a system of care based on the rights of the care recipient'.[48] He said that the legislative focus on providers' funding entitlements, and the statutory secrecy of their affairs, gives the appearance that the rights of people receiving care are relegated to a subordinate place. Mr Rowe described the system as lacking a human rights framework to underpin the delivery of aged care. He said that:

> I frequently talk about older people…being asked to check in their rights when they check into aged care. There's nothing in the legislation that talks about human rights. It's not part of the language, it's not part of the culture. You know, even moving to a customer basis, we don't have empowered customers. We have disempowered customers. And we have customers who are subject to chemical restraint, without even sort of agreement to such.[49]

Ms Beverley Johnson described the difficulties she has experienced in having her voice heard and respected in the aged care facility where she lives. When asked about representation of residents in aged care facilities, Ms Johnson said:

> Well, I would say, 'What representation?' There seems to be very little of it. And, like anyone in the community, [residents] should have a right as to how you're treated. And residents, it would appear, once they pass through the front door of the facility, give up that right.[50]

In addition to evidence about the difficulties those receiving care, and their supporters, experience in interacting with the regulatory system, there was also evidence given about the importance of the voice of those receiving care and the role of advocacy. Professor Paterson considered that in Australia, the voice of the provider is heard 'far too much', and the voices of recipients heard 'not nearly enough'.[51] Professor Paterson spoke about the importance of an advocacy body to ensure that the 'consumer voice' is heard. He said:

> The absence of strong consumer voice in the aged care system is a notable feature of aged care in Australia. The voices of providers are prominent in the Australian system—and appear to be highly influential in policy debates, with Ministers, departments, agencies and officials—but the voices of consumers, families and consumer advocates are relatively weak.[52]

Mr Rowe also said that in the Australian aged care system, the consumer's voice was not being represented. He highlighted, as an example, his experience of consultations during the development of the Aged Care Quality Standards, where providers and other interest groups were in the majority and discussions focused on standards as a tool for fee payment rather than ensuring safety and quality.[53]

Mr Rowe spoke of the need for greater support for advocacy. He said that in Queensland:

> despite best efforts, we are only supporting less than one per cent of aged care users. To me that's extraordinarily frustrating and what we're seeing is a real growth in demand for advocacy services.[54]

Mr Rowe described his frustration that, as a consequence, the wait list for advocacy services is up to six weeks.[55] Mr Rowe recommended that the accreditation process for aged care services include consideration of people's access to advocacy services and education about their rights.[56]

8.1.6 Home care

Evidence pointed to weaknesses in the regulation of quality and safety of home care services. Ms Darling, who described her experience receiving home care services from numerous providers, said that, in her opinion, 'the home care system is broken and it seems totally unregulated'.[57]

Ms Amy Laffan, Assistant Secretary of the Aged Care Quality Regulatory Design and Implementation Branch in the Australian Department of Health, and Ms Ann Wunsch, Executive Director of Quality Assessment and Monitoring Operations in the Aged Care Quality and Safety Commission, gave evidence about the regulation of home care services. Ms Laffan listed, in her statement, what she considered to be the current weaknesses in the regulation of quality and safety of home care as follows:

(a) Nature of approval

(b) Conduct of reviews

(c) Reporting requirements

(d) Transparency

(e) Intelligence sharing.[58]

Ms Wunsch and Ms Laffan agreed that home care providers are able to commence providing services prior to being subjected to a quality review.[59] Ms Wunsch said that in 2017–18, the median time for the first quality review was 324 days.[60] In the year ending 30 June 2019, this was reduced to 201 days.[61] Ms Wunsch stated that in 'understanding an acceptable timeframe' for a first quality review, information is reviewed to 'understand… the acuity of the needs of the consumers of that service'.[62] She said that quality review visits are prioritised 'according to the best regulatory intelligence that we have available to us in the Commission'.[63] When asked by Senior Counsel Assisting whether the current system should change to expand accreditation to home care, Ms Laffan agreed that 'some sort of assessment prior to delivering care would be a sensible one for home care', stating that such assessment is 'potentially…a scalable thing depending on the risk and the services provided'.[64]

Evidence revealed that the home care regulatory framework is less transparent than the framework that applies to residential aged care services. Ms Laffan acknowledged that quality assessment information regarding home care is not published, in contrast to the

publication of accreditation outcomes for residential aged care services.[65] Ms Laffan said that she understands this distinction exists as quality reviews do not 'have the same outcome in a sense that accreditation does'.[66] She agreed that, due to the implementation of a 'consumer directed care' approach in home care, this 'information is really important, particularly to people seeking that information prior to receiving care'.[67] Ms Laffan was of the opinion that quality reviews should be published.[68]

Ms Laffan stated that following the introduction of the *Aged Care Quality and Safety Commission Rules 2018* (Cth) in relation to home care monitoring, the Aged Care Quality and Safety Commission can now 'go into care recipient's homes to ask about care experiences of home care'.[69] Ms Laffan was unable to state whether this is being implemented in practice.[70] She stated that some privacy issues still exist as consumer groups had raised concerns that people receiving home care services do not feel that they are required to let assessors into their house.[71]

8.1.7 Features of good regulation

The Royal Commission heard evidence from a number of witnesses about features of effective quality and safety regulation in the aged care and related sectors. The evidence on this topic has been drawn upon in Volume 3 of this Final Report.

Professors John and Valerie Braithwaite and Emeritus Professor Toni Makkai developed the model of 'responsive regulation' in the aged care system. They explained 'responsive' regulation in this way:

> To a considerable extent, the industry plays games with some of the words…When it suits them to say that regulators are inflexible, they say that; when it suits to say regulators are inconsistent, they say that. It is hard to be flexible and consistent! What we actually want regulators to be is responsive in ways that follow principles that the industry commits to after participating in their formulation. A principles based approach necessarily will result in what on first blush looks like 'inconsistency'; the key issue is the ability and willingness of service providers, the regulator and policy makers to move beyond a rules based enforcement approach to an outcome oriented responsive approach to achieve the best that is possible for residents. Then it is imperative to keep raising the bar on that best possible quality of care that is delivered by re-energizing the continuous improvement approach, and motivating innovation in care delivery.[72]

Professor Paterson considered that responsive regulation in the aged care system can help improve the quality and safety of services, in addition to the primary regulatory purpose of protecting users of aged care services.[73]

Professors John and Valerie Braithwaite and Emeritus Professor Makkai also described the approach they call 'relational regulation', which focuses on interactions between assessors, the approved provider and facility management and staff.[74] They gave as an example the approach of the Care Quality Commission in the United Kingdom, referring to its balance between 'the drive for relational care and relational regulation with basics of safety, effectiveness and professionalization of leadership'. They explained that the Care Quality Commission's assessment of services against its fundamental standards includes questioning whether a service is caring, responsive and well-led.[75]

8.1.8 Gathering and using information in undertaking risk assessment

A number of the witnesses emphasised the importance of the regulator using information and data obtained from a range of sources, in particular complaints, for effective compliance monitoring. Professor Paterson stated, 'A responsive regulator needs to be an intelligent regulator. And to be an intelligent regulator, you need intelligence…You actually need to be looking at all the source[s] of information.'[76] Professor Paterson described the importance of compiling a range of sensible inputs, including complaints data, serious incident reporting data, prudential and financial analysis data, and assessment audit and inspection information.[77]

Professor John Braithwaite agreed with the evidence of Professor Paterson about the need for 'pulling complaints together in an agile way with other sources of information'.[78] He considered that risk management is the 'bread and butter' of good regulation.[79] He explained that it is important for the regulator to fulfil a more 'detective-oriented approach…taking the initiative to seek out evidence from complainants, to seek out evidence from advocacy organisations, from community visitors, looking diagnostically at the quality indicators'.[80]

The regulatory framework used by the National Disability Insurance Scheme Quality and Safeguards Commission was the subject of evidence. Mr Graeme Head, the Commissioner of the National Disability Insurance Scheme Quality and Safeguards Commission, observed that complaints can inform the regulator about both the unique experience of an individual consumer but also provide a window to more systemic issues and present insights about things like the culture of an organisation, workforce training issues and provider systems. He said that it is 'important to ensure that individual complaints are resolved, but also to provide those insights into wider problems'.[81]

Mr Head considered that a central factor to the ability of the National Disability Insurance Scheme Quality and Safeguards Commission to succeed in its regulatory role is 'the fact that we have the key functions in one organisation and we'll be able to connect the dots in a way that has…historically been atypical'.[82]

8.1.9 A role for regulators in continuous improvement

Witnesses spoke about the role that regulation should play in encouraging and facilitating continuous improvement of aged care services. Professor Paterson said that one of the ways to encourage improvement is to 'shine a light on what works well, so that other providers are encouraged to say, "We need to lift our game".'[83] The existing accreditation process is not well designed to achieve this. In the Carnell-Paterson Review, Ms Kate Carnell AO and Professor Paterson said:

> accreditation audit reports should include graduated scores against all outcome measures. This approach will provide richer data on provider performance that differentiates high-performing providers and incentivises quality improvement.[84]

The Carnell-Paterson Review explained that this information should be made available to the public to support informed decision-making about choice of providers, alongside a 'star-rating' performance indicator reporting system. At the hearing, Professor Paterson described the progress in implementing these measures as disappointing and said that the current aged care accreditation and assessment system is inadequate, because it merely provides for binary outcomes of 'met' or 'not met', and 'doesn't even meet the minimum standards' of providing sufficient information to the aged care sector to facilitate quality improvement.[85]

Professors Braithwaite and Emeritus Professor Makkai stated that the notion of continuous improvement has not been well implemented in the aged care regulatory system to date. They described it as 'good in theory but disappointing in practice in some important respects'.[86] They explained that, in their view, continuous improvement has taken the path of ritualism, where more time is put into documentation than devoted to care.[87]

Professor John Braithwaite emphasised the importance of seizing opportunities such as developing capacity in the industry through identification of excellence and encouraging providers to seize the opportunity to emulate that excellence.[88] He suggested that the regulatory system can make better use of industry awards by using them to 'convey strategic lessons by explaining with more precision what it is that is excellent, that others in the industry should be following'. Professors John and Valerie Braithwaite also highlighted informal praise from regulatory assessors as one of the simplest ways to lead and motivate staff in facilities to 'improve the situation in a sustainable and continuous way', rather than restricting the role of assessors to 'calling out inappropriate behaviour or breaches'.[89]

8.1.10 Transparency and accountability

The importance of transparency as an element of good regulation was a theme throughout the hearing. A number of direct experience witnesses gave evidence about their interactions with the aged care regulatory system and described their frustrations at the lack of transparency they experienced, particularly in the handling of, and responses to, complaints.[90] Professor Paterson stated that that one of the primary purposes of quality regulation is to 'help reduce the information asymmetry between providers and recipients', which in turn facilitates continuous quality improvement.[91] He used the example of mandated publication of comparative quality information as one way of achieving this.[92]

Adjunct Professor Debora Picone AO, Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care, talked about the regulatory framework used by her organisation in regulating health services. She stated that, in the Australian Commission on Safety and Quality in Health Care framework, 'transparency is absolutely critical to the operation of the system and to the accountability that we give to members of the community, that these care facilities are doing what they're meant to be doing'.[93]

Adjunct Professor Picone explained the importance of collecting clinical data in promoting transparency and accountability in the Australian Commission on Safety and Quality in Health Care's regulation of the National Safety and Quality Health Service Standards.[94] She described the clinical incident mandatory reporting system regulated by the Australian

Commission on Safety and Quality in Health Care as very broad, very detailed and, in her opinion, 'one of the best developed internationally'.[95] She said that the Australian Commission on Safety and Quality in Health Care collects data about a range of adverse events and that it is able to analyse it to identify trends within clinical indicators.[96] She stated that the system is linked to a funding arrangement so 'if a health service has a higher than accepted rate, say of pressure injuries…they will actually lose funding based on that'.[97] However, she acknowledged that, despite significant progress in transparent reporting and analysis accessible to hospitals, relevant medical practitioners and State departments of health, the extent of public disclosure and transparent reporting, in a way that is accessible to patients and their relatives, is 'very little'.[98]

Witnesses emphasised the importance of information about quality of care being made available to older people receiving care and their families and representatives. Among other things, it was observed that the aged care regulatory regime 'is not providing information of a kind that helps families to choose the best quality of care for their loved one'.[99] Professor Paterson stated that the Australian system 'is lagging behind international trends in transparency of comparative healthcare quality information'.[100] He drew particular comparison to the approaches to information availability regarding aged care services in the United States and United Kingdom.

Adjunct Professor Picone also spoke about the importance of 'open disclosure' in both the health and aged care context. She explained the concept of open disclosure and its importance to the continuous improvement process as follows:

> Open disclosure and discussions of clinical incidents resulting in harm with patients, their families and carers is important. It entails an apology, explaining what occurred; discussing the experience and consequences; and describing what steps are being taken to manage the incident and prevent recurrence.[101]

Adjunct Professor Picone described open disclosure as meeting the need for 'a just culture committed to transparency and continuous improvement to be built within organisations'.[102] She explained that open disclosure can 'allay feelings of anxiety and abandonment after harm' on the part of families and carers.[103]

Adjunct Professor Picone identified differences between open disclosure provisions in the Health Standards and those currently in operation in aged care. The open disclosure provisions in Standard 1.12 of the National Safety and Quality Health Service Standards mandate an open disclosure program that is consistent with the Australian Open Disclosure Framework.[104] This may be contrasted with Aged Care Quality Standards 6 and 8, which refer to open disclosure in generic terms, without identifying the scope of the open disclosure obligation and without referring to any specific open disclosure framework. The Aged Care Quality and Safety Commission has published a framework and guidance document to assist providers, but it is not mandatory.[105]

Adjunct Professor Picone also explained that the National Safety and Quality Health Service Standards include mandatory governance requirements in relation to quality and safety. An organisation's governing body is required to sign a detailed attestation to say that it is satisfied that measures are in place relating to safety and quality.[106]

8.1.11 Tailored enforcement

Professors John and Valerie Braithwaite spoke of the importance of 'regulatory agility' and explained that one of the factors that drives regulatory effectiveness is 'the deployment and use of a varied mix of enforcement tools'.[107]

Mr Head stated that the National Disability Insurance Scheme Quality and Safeguards Commission has 'a wide variety of tools to enable it to respond to non-compliance in a responsive and proportionate manner, on a case-by-case basis based on the surrounding circumstances and nature of the non-compliance'.[108] The regulatory responses available to the National Disability Insurance Scheme Quality and Safeguards Commission include enforceable undertakings, infringement notices, injunctions and banning orders imposed on providers or employees.[109]

During her evidence, Ms Brammesan was asked about the regulatory tools available to decision-makers in aged care regulation within the Australian Department of Health. She said that they were 'adequate', but that the ability to impose sanctions on directors or others involved in the management of approved providers 'would be amazing'.[110]

Adjunct Professor Picone gave evidence that the Australian Commission on Safety and Quality in Health Care 'wanted to make safety and quality as important as finance and as general performance' and that 'there would be significant response from the regulator' if an individual was found to have been misleading in their governing body attestation.[111]

8.1.12 The voices of older people receiving care

It was clear that the regulatory system must respond effectively to the voices and experiences of people who receive aged care services, and their families or representatives. Professor Paterson considered that there is 'nothing more important' than hearing the voice of older people receiving care, and their families, as part of the regulatory system.[112]

Mr Head emphasised the person-centred focus of the National Disability Insurance Scheme regulatory regime. He said that:

> central to design of everything to do with the National Disability Insurance Scheme is the idea of choice and control by participants and that the person with disability is at the centre of what is happening in an NDIS [National Disability Insurance Scheme] arrangement. And that includes the quality and safeguarding arrangements.[113]

Professors John and Valerie Braithwaite were critical of the reliance within the aged care regulatory framework on 'volunteered complaints' to uncover deficiencies in care.[114] Professor Valerie Braithwaite suggested that to remove this reliance, the aged care system needs to involve 'using the eyes and ears of residents'.[115] She and Professor John Braithwaite referred to the approach of the United States regulatory system which requires mandatory care planning meetings, involving people receiving care,

their representatives and care staff, as an important form of resident and relative input, and the early recognition of issues which may otherwise result in complaints.[116] Professor Valerie Braithwaite explained that:

> I think care-planning meetings…are under-utilised. They can be used to sort out all sorts of problems…the relationship is better, if problems are solved in…care-planning meetings for example, at the time that they occur. I think if that was working more efficiently, then the number of complaints that would actually be made to government would be fewer. It's the fact that they're not being resolved at the time locally that I think is part of the problem here.[117]

Professor John Braithwaite said that to hear the voice of people receiving home care services:

> it's necessary to actually have more conversations with those who use home care services rather than send them a letter to say 'If you've got any complaints, write in now'. That's not going to work.[118]

A number of witnesses highlighted the role that formal advocacy services or consumer representatives can play in promoting the voice of those receiving care and their representatives as part of the regulatory system. Ms Darling suggested that 'it would be good to have people in a role like a guardian when someone commences with home care, as a contact and advocate for them if they experience problems with their care'.[119] Mr Rowe emphasised the distinct role of advocates, saying that their role is not to 'be a member' of the complaints process but to ensure 'the voice of the older person is taken into consideration within that process'.[120] Mr Rowe added that advocates can have a greater role in monitoring the resolution of complaints.[121]

Professor Paterson referred to the role of publicly funded advocates in regulatory systems in New Zealand, the United Kingdom and Canada.[122] He said that 'the availability of publicly funded advocates in…the aged care sector is a strength in the New Zealand system'.[123] He described the role of the advocates as follows:

> whereas people handling complaints in a commission are there on the phone or they're looking at the papers, advocates are out there in the community. They stand alongside…they meet with the family member, they meet with the resident…they are ears and eyes on the ground.[124]

Professor Paterson described the advocacy service that operates in relation to the *Health and Disability Commissioner Act 1994* (NZ):

> in the Health and Disability Commissioner Act, there is provision for a statutory independence of the advocacy service…that's essential, because you can't be both advocate and judge. So that's one model, that you provide it within the statutory umbrella, but you say it must be independent. Otherwise, you need to ensure that it's through some other, you know, funding arrangements that you are funding those sort of community visitors or advocates or whatever we call them, and they are able to funnel information to the commission.[125]

The Australian Government submitted that the role of the Aged Care Quality and Safety Commission is impartial and that it also funds consumer advocates through the Older Persons Advocacy Network. Professor Paterson said that at the time of the Carnell-Paterson Review, the Older Persons Advocacy Network was 'pretty loose and…it seemed

as if a lot more could be done to strengthen' it.[126] He stated that advocacy services need to be properly resourced by government to be effective.[127]

Adjunct Professor Picone said that consumer representatives are increasingly involved in the process of assessing a health organisation's adherence to the National Safety and Quality Health Service Standards. She stated that it is very important for consumer or community representatives to be involved as 'that person brings that patient-centred perspective, which is critical'.[128]

Adjunct Professor Picone also spoke about other ways in which the voice of the person receiving care can be discerned. She referred to patient reported outcome measures and patient reported experience measures in the health context. According to Adjunct Professor Picone, patient reported outcome measures 'address the disconnection between what the clinician sees as a good outcome and what the patient wants from their healthcare', focusing on the results of treatment that the patient cares most about.[129] Patient reported experience measures, on the other hand, seek to identify the experience of the patient while receiving care.[130] According to Adjunct Professor Picone, both measures are 'a particularly rich source of information, having been linked to care quality improvements and identifying safety issues'.[131]

Some witnesses who gave evidence about the operation of regulatory schemes in other related sectors described the role of community visitor schemes in those sectors. Mr Head said that the National Disability Insurance Scheme Quality and Safeguards Commission recognises the importance of State and Territory based community visitor schemes and engages in information sharing arrangements with those entities.[132] Ms Natalie Siegel-Brown, Queensland's Public Guardian, explained the roles of advocates and visitors' schemes in Queensland for people with disability. These roles and schemes are underpinned by rights of entry, incident reporting and unannounced visits.[133] She described the community visitor scheme that operates under the *Public Guardian Act 2014* (Qld) as 'a bridge to the major complaints, disciplinary and other bodies'.[134] Ms Siegel-Brown highlighted the importance of independence from government, saying that it gives community visitors 'real teeth'.[135] Independence from government also means industry lobbyists, who have influence with government, have no power over her office.[136]

Ms Siegel-Brown called for a system, with 'legislative teeth', of paid aged care community visitors.[137] She said that, in relation to community visitors, the aged care sector is where the disability sector was 20 to 30 years ago, when there was recognition of a need for 'eyes and ears monitoring of the rights of people who lack the cognitive capacity or self-efficacy to act on their own behalf'.[138] Ms Siegel-Brown said that a role for community visitors in aged care is to monitor complaints, ensuring that a provider had rectified a fault as agreed.[139] She also proposed a possible role for community visitors specifically in improved legislated oversight of restrictive practices.[140] When taken to Ms Siegel-Brown's evidence by Counsel Assisting, Ms Reid, of the Aged Care Quality and Safety Commission, agreed that there is a need for a professional and fully-funded community visitor scheme.[141]

8.1.13 Implementation of previously recommended reforms

A number of reviews have made recommendations about the regulation of aged care. Most relevant to this hearing was the Carnell-Paterson Review, which made 10 recommendations.[142] At the time of the hearing, the recommendations from this review had been with the Australian Government for almost two years. A number of witnesses gave evidence about the progress of the implementation of the recommendations. This included evidence from Professor Paterson.

The Carnell-Paterson Review was presented to the Minister for Aged Care in October 2017. In closing submissions, Senior Counsel Assisting referred to the failure of the Australian Government to reach decisions in relation to the recommendations made by Ms Carnell and Professor Paterson by that time. He submitted that this failure is an example of the Australian Government's tardiness in implementing recommended reforms.[143] In response, the Australian Government submitted that:

> Although the timeframe to implement a number of the measures may appear protracted, the Commonwealth submits that progress should be considered against the complete reform agenda and the additional work required to operationalise a number of the complex measures.[144]

In his evidence, Professor Paterson described the progress of implementation as 'disappointing'. He said:

> The Review recommended a major overhaul of national aged care quality regulatory processes in Australia. Given the supportive statements about the Review, from the then Minister for Aged Care, the Hon Ken Wyatt AM MP on 25 October 2017 and 18 April 2018, it is disappointing that the pace of change has apparently been so slow. Although the recommended changes are complex, the directives of the Minister and the strength of community feeling about the need for improvements…should have led to urgent implementation.[145]

Ms Laffan gave evidence about her role with the Australian Department of Health overseeing reforms to quality and safety regulation of aged care, including implementation of the recommendations of the Carnell-Paterson Review which have been approved by the Government.[146] Ms Laffan stated that 'all ten recommendations of the Carnell-Paterson Review have been adopted in whole or in part by the government' with funding initially through the 2018–19 Budget *More Choices for a Longer Life Package*.[147] She said there are still decisions pending to be made by the Government as to if and whether particular actions, recommended by the review, may be implemented.[148]

The sections that follow set out evidence about some of the key recommendations made by the Carnell-Paterson Review, and the Australian Government's actions in response. Issues raised by these recommendations are considered further in Chapter 14 on quality and safety regulation, in Volume 3 of this Final Report.

Carnell-Paterson Review Recommendation 1—independent Commission and Commissioners

The Carnell-Paterson Review recommended the establishment of an independent Aged Care Quality and Safety Commission comprising a number of independent commissioners and overseen by a governing board.[149] The Australian Government supported, in principle, the recommendation, but concluded that the model of multiple commissioners and a board is not cost effective.[150]

The Australian Government's response to the review, dated 20 September 2018, stated in relation to Recommendation 1 that a taskforce within the Australian Department of Health is vested with establishing a new Commission.[151] The Australian Government said that a new Chief Clinical Advisor would be appointed and, supported by a new clinical expert panel, would provide advice to the Commission. Additionally, an Advisory Council would be established to provide support to the Commission's engagement with consumers and the sector. The response stated that:

> This is a more cost effective governance model than establishing a board with multiple commissioners and facilitates greater information exchange within the Aged Care Commission, mitigates the risk of creating silos and ensures comprehensive responses to consumer needs.[152]

In response to questions from Senior Counsel Assisting, Ms Laffan agreed that a governing board, as proposed by the recommendation, is a completely different proposition to an advisory council.[153] She agreed that, unlike an advisory council, a governing board can direct the Commission and 'exert far more direct governance capability'.[154] In post-hearing submissions, the Australian Government stated that the establishment of the Aged Care Quality and Safety Commission, with an advisory council, rather than a governing board as recommended by the Carnell-Paterson Review, is 'consistent with government policy regarding governance of Commonwealth entities of the nature of the Aged Care Quality and Safety Commission'.[155]

Professor Paterson stated the intention of proposing a governance board was that in 'setting up a new entity', it is important to ensure good governance and this was a different model from the advisory council.[156] He said that 'there's always a valuable place for advisory councils, but a governance board is something different'.[157] While Ms Laffan acknowledged the evidence of Professor Paterson regarding the importance of a governing board and the hope that there would be a consumer voice within that board, she said that she believes those things 'can be achieved through…the model that's been adopted'.[158]

Carnell-Paterson Review Recommendation 2—centralised database and information sharing

The second recommendation made by Ms Carnell and Professor Paterson was the development of a centralised database for real-time information sharing, to be managed by the Commission, and associated actions related to intelligence gathering and risk profiling.[159] The Australian Government supported the recommendation in principle.[160]

At the time of this hearing, the Australian Government had not made a decision on the proposal to improve information sharing between State operated health and mental health services, and the Australian Government-supervised aged care sector.[161] Ms Laffan stated that from her perspective, it is a good idea but that it has yet to be put to government. [162] She stated that the Australian Department of Health will 'develop the risk profiling system, have that bedded down and then…look at potentially ways to increase that information sharing and risk profiling systems that we have.'[163] Ms Laffan indicated that no discussion has yet occurred with State and Territory Governments because it had not been a priority.[164] She agreed that the Australian Department of Health is under-resourced to deal with a reform program of this kind, resulting in the need to outsource such projects to consultants.[165]

Recommendation 2 also proposed that 'assessment contact visits seek the view of 20 per cent of consumers and their representatives'.[166] This would be an increase from the 10% of those receiving care spoken to during assessment contacts at the time of the hearing. Ms Laffan stated that such implementation would be 'undesirable', making the work of the Aged Care Quality and Safety Commission 'more prescriptive and potentially less risk-based'. She stated that:

> The reason for this is that mandating a fixed 20% sample of consumers and representatives who must be surveyed on all occasions could mean that the gathering of this information is prioritised above the collection of other information that may more appropriately address the particular risks.[167]

Professor Paterson did not agree with this opinion but accepted that it might be more difficult. Professor Paterson considered that providers and agencies would 'come up with all sorts of reasons why it's too difficult' but that ultimately, it is 'a way in which we end up diminishing the voices of the people who we need to hear from'.[168]

Ms Laffan agreed that gathering the views of residents and their families is very important.[169] However, she reiterated her view that 20% is too prescriptive with respect to current assessment contacts. Ms Laffan agreed that her concern is that the requirement to survey 20% of residents on every assessment contact would divert resources.[170] She stated that this is because assessment contacts are very frequent and used for a variety of purposes.[171] She agreed that she supports this level of prescription for review audits and accreditation site audits, but noted that there may be 'resource implications' for the Aged Care Quality and Safety Commission.[172]

Ms Laffan stated that, to her knowledge, there is no Government position with regard to the 20% proposition, nor has the Australian Department of Health provided advice to the Australian Government on it.[173] She said that consideration of this proposition will occur in relation to consideration of Recommendation 8, which sets out ongoing accreditation requirements, including the replacement of re-accreditation visits with unannounced visits.[174]

Recommendation 2 also proposed that the Aged Care Quality and Safety Commission 'develop options to capture the views of residents, families and staff all year round'.[175] At the time of this hearing, that proposal had not been the subject of any recommendation

from the Australian Department of Health to the Australian Government.[176] Professor Paterson said that this is a 'very important recommendation'.[177] Ms Laffan agreed that this can be done very easily 'from a technological perspective' but stated that there 'may be issues with statistical analysis' and she would 'have to seek advice from experts'.[178] She agreed that an 'interactive' interface to allow individuals to 'fill out a consumer experience report' is not yet happening but would be a 'very useful tool'.[179]

Carnell-Paterson Review Recommendation 6—serious incident response scheme

Recommendation 6 proposed that a serious incident response scheme be enacted.[180] This recommendation endorsed one made by the Australian Law Reform Commission in its May 2017 report entitled *Elder Abuse—A National Legal Response*, referred to as the Elder Abuse Report.[181] This report recommended a new serious incident response scheme to replace the system in section 63-1AA of the Aged Care Act, including an independent oversight body, reporting of abuse of one person receiving care by another person receiving care, and reporting of neglect.[182]

Ms Laffan spoke of the Australian Department of Health's progress in implementing a serious incident response scheme since May 2017. She explained that work on a serious incident response scheme did not begin immediately after the Elder Abuse Report was tabled in Parliament because the Carnell-Paterson Review was commissioned shortly afterwards and the Australian Department of Health determined that 'it was appropriate to consider the SIRS [Serious Incident Response Scheme] in the context of that broader aged care reform'.[183]

In May 2019, as part of the 2018–19 Budget, the Australian Government announced 'the development of options for a SIRS [Serious Incident Response Scheme] in consultation with the aged care sector'.[184] The Australian Department of Health subsequently engaged accounting firm KPMG to develop model options.[185] A consultation paper was developed by KPMG in October 2018 for consultation with stakeholders in workshops in late 2018.[186]

KPMG produced a report following the consultations in February 2019 entitled *Strengthening Protections for Older Australians*. This report sets out five options:

> **Option 1:** involves no change to the current arrangements.
>
> **Option 2:** involves developing guidance material to better enforce the current arrangements.
>
> **Option 3:** involves introducing a reportable conduct scheme which would require all aged care service providers to report abuse or neglect by a staff member against a consumer to the Aged Care Quality and Safety Commission (the Commission).
>
> **Option 4:** involves expanding Option 3 to include unexplained serious injury in residential aged care as a serious incident.
>
> **Option 5:** involves expanding Option 3 to include aggression and abuse between consumers in residential aged care settings as a serious incident.[187]

In its report, KPMG acknowledged the Elder Abuse Report recommended Options 4 and 5 but noted that each is a 'complex issue' which 'warrants further consideration'.[188] Ms Laffan stated that, as part of KPMG's modelling of the costs of the options for a serious incident response scheme, KPMG estimated that each year 10,500 incidents of aggression by one resident against another resident, occur where the aggressor has a mental impairment.[189] At the time of the hearing, incidents of this nature were not required to be reported.[190]

As part of the 2019–20 Budget, the Australian Government committed $1.5 million to introduce a serious incident response scheme for residential aged care providers.[191] Ms Laffan said that preparatory work would require further stakeholder consultation until late 2019.[192] Further preparatory work also involved seeking a consultant to 'conduct additional research into the incidences of resident on resident aggression in residential aged care'.[193]

A further KPMG consultation paper, dated August 2019, and entitled *Serious Incident Response Scheme for Commonwealth funded residential aged care – Finer details of operation – Consultation Paper,* was provided to the Royal Commission at the hearing.[194] Ms Laffan was unable to provide a further update due to concerns about Cabinet confidentiality.[195]

Senior Counsel Assisting suggested to Ms Laffan that the Australian Government should just proceed to the serious incident response scheme recommended by the Carnell-Paterson Review and the Elder Abuse Report. Ms Laffan stated that there is some stakeholder resistance on the basis of the perceived regulatory burden of compliance with the serious incident response scheme and that the 'devil was in the detail' in a large complex scheme.[196] In his closing address, Senior Counsel Assisting submitted that 'Critical urgent reform tasks have been outsourced to consultants and appear to be mired in protracted and multi-staged industry consultation processes'.[197] In post-hearing submissions, the Australian Government submitted in response that:

> the SIRS [Serious Incident Response Scheme] is a complex reform, which will impose additional obligations on approved providers and require the commitment of significant resources on the part of Government to administer effectively. As a consequence, it has been the subject of a range of consultations by the Department and advice to Government. This has included identifying appropriate models of reporting, including through a report from KPMG and assessing community and expert feedback on the proposed details of a SIRS. Public consultation is underway on the finer details of operation for a SIRS for Commonwealth funded residential aged care, concluding on 4 October 2019. Other preparatory work has included research into the prevalence and nature of resident on resident incidents that are exempt from reporting under current arrangements. The Department's current proposal is to remove this exemption.[198]

The issue of a serious incident response scheme is considered further in Chapter 14 on quality and safety regulation, in Volume 3 of this Final Report.

Carnell-Paterson Review Recommendation 7—limit use of restrictive practices

Recommendation 7 proposed that 'aged care standards will limit the use of restrictive practices in residential aged care'.[199] The recommendation included requirements for approved providers to record and report the use of restrictive practices, and for review of their use as part of accreditation requirements.

During Sydney Hearing 1, there was a focus on amendments to the *Quality of Care Principles 2014* (Cth), which inserted Part 4A. That part was initially entitled *Minimising the use of physical and chemical restraint* and has since been retitled *Physical or chemical restraint to be used only as a last resort*.[200] Consequently, the subject matter of Recommendation 7 was only indirectly addressed during this hearing. The focus of this hearing was on reporting the use of restraints, rather than the regulation of restrictive practices itself.

Professor Paterson spoke of the importance of reporting the use of chemical restraints. He stated that in undertaking the Carnell-Paterson Review, he and Ms Carnell noticed the prevalence of the use of chemical restraints, associated 'harms' and 'frankly, lack of evidence of efficacy'.[201] Professor Paterson stated that the importance of recording and reporting on their use was to incentivise change.[202]

Ms Laffan agreed that it is important to draw attention to the use of chemical restraints in aged care. She acknowledged that the Australian Law Reform Commission had, in May 2014, recommended a national approach to regulating restrictive practices covering all sectors.[203] However, Ms Laffan agreed that it is unknown whether there will be any mandatory requirement to report the use of chemical restraint to the Aged Care Quality and Safety Commission. She stated that the Australian Department of Health has not advocated to the Australian Government that mandatory reporting be extended to the use of chemical restraint.[204] Ms Laffan noted that the Australian Government is committed to extending the Quality Indicator Program to include medication management 'so it may be captured under that' but explained that no decision has been made as to what 'medication management' would cover.[205]

8.2 Case studies

8.2.1 Earle Haven

Introduction

The Royal Commission examined the circumstances leading to the closure of the aged care facilities of Orchid House and Hibiscus House at the Earle Haven Retirement Village, referred to as Earle Haven, and located on Queensland's Gold Coast. This resulted in the evacuation of 68 aged care residents, by emergency services, on 11–12 July 2019. This case study considered the regulatory and other monitoring of the approved provider, People Care Pty Ltd, referred to as People Care.[206]

The following parties and individuals were granted leave to appear at the public hearing and were represented by counsel and/or solicitors: People Care and its employees—Mr Arthur Miller, Director of People Care, Mr Bruce Lang, Finance Manager, and Ms Karen Heard, Facility Manager at Earle Haven; HelpStreet and its employees—Mr Kristofer Bunker, founder and Global Chief Executive Officer of HelpStreet; Ms Karen Parsons, Executive Director at Earle Haven; Ms Telecia Tuccori, Clinical Care Coordinator at Earle Haven; the State of Queensland; and the Australian Government.

Counsel Assisting provided written submissions setting out the findings they considered should be made arising from this case study.[207] In response to those submissions, the Royal Commission received submissions from Ms Tuccori, the Australian Government and the State of Queensland.[208]

In making the findings below, I have considered Counsel Assisting's submissions, as well as the submissions of the Australian Government, Queensland and Ms Tuccori, and all the evidence in this case study.

At the outset of this case study, Senior Counsel Assisting explained the purpose of the case study as follows:

> The focus of our inquiry today is on the regulatory system, whether all was done by regulators that should have been done and whether the system is appropriately designed to address risks of the kind that eventuated at Earle Haven.
>
> From its approval in 2006 as a provider of community, flexible and residential care, People Care appears to have had a poor compliance record, raising potential red flags about governance and management capacity.[209]

The purpose of this case study was not to adjudicate the dispute between People Care and HelpStreet that precipitated the evacuation of Earle Haven. However, it was necessary to receive evidence and understand something of the dealings between People Care and HelpStreet which led to the events of 11 July 2019.

This case study highlights a number of regulatory failings, in particular a failure to share information, make proactive inquiries, and consider the suitability of People Care to continue to provide aged care services in light of concerning information. The Australian Government, in its submissions, agreed that there were deficiencies in the regulatory response to Earle Haven. I address these submissions in the context of the evidence below.

I use 'Commonwealth regulators' or 'regulators' in this case study to refer to the Australian Department of Health and the Aged Care Quality and Safety Commission and its predecessors, the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.

Background

The evacuation, in July 2019, of Hibiscus House and Orchid House, co-located facilities in the precinct of Earle Haven, occurred when a contractor, HelpStreet, ceased to provide care and management services due to a dispute with the approved provider, People Care.

The focus of this case study was on the regulatory oversight of People Care. The hearing began with an examination of the circumstances surrounding the events at Earle Haven on 11 July 2019, including dealings between People Care and HelpStreet. It then examined missed opportunities for regulatory intervention.

The relevant people and entities

People Care and Arthur Miller

Mr Arthur Miller said that he owned several nursing homes in New South Wales from 1985 until the late 1990s.[210] He managed them but did not provide care services as he did not have clinical experience.[211]

Mr Miller was director and owner of People Care Pty Ltd. Mr Miller made an application, on 14 November 2005, for People Care to become an approved provider.[212] This application appears to have been made because of the Australian Department of Health's refusal to issue a 'licence' to another of Mr Miller's companies to operate Hibiscus House and Orchid House. Mr Miller and his wife stated in People Care's application for approval as a provider that the refusal was due to sanctions imposed on an aged care facility in New South Wales that Mr Miller and his wife were trying to sell.[213]

The application indicated that Mr Miller had provided aged care services at Hibiscus House and Orchid House since February 2002.[214] In 2016, Hibiscus House and Orchid House were merged into one aged care service with 89 allocated places.[215]

The Finance Manager of People Care was Mr Bruce Lang. Mr Lang identified himself as the main contact person for the Australian Government.[216]

HelpStreet

There are several HelpStreet companies in the group. They are all managed by Mr Kristofer Bunker and for the purposes of this case study are all referred to as 'HelpStreet'.

On 23 March 2018, Bruce Lang, of People Care, advised the Australian Aged Care and Quality Agency that from 1 April 2018 'Help Street Partnership will be contracted to manage' the facility for People Care and that People Care 'will continue to hold the bed licences and Approved Provider Status'.[217]

In April 2018, People Care and HelpStreet negotiated an interim agreement whereby HelpStreet would pay rent to lease the premises at Earle Haven, and People Care would pass on the Commonwealth aged care subsidies received as approved provider. It was intended that HelpStreet would eventually purchase the aged care business from People Care.[218] It appears that HelpStreet paid rent as envisaged by the April 2018 agreement.[219]

However, the business sale did not proceed and no 'formal documentation' was ever entered into.[220] Mr Lang said that he did not provide a copy of any agreement between HelpStreet and People Care to either the Australian Department of Health or the Australian Aged Care and Quality Agency.[221]

The regulators' knowledge of and response to this arrangement is considered later in this section.

Kristofer Bunker (HelpStreet)

Mr Kristofer Bunker was born in the United Kingdom but resided in Australia between 2009 and 2016.[222] He worked in the aged care industry in recruitment between 2009 and 2011.[223] He founded HelpStreet in or around 2012. HelpStreet provides allied health specialist services to the aged care industry. Mr Bunker returned permanently to the United Kingdom in 2016. He says he 'generally' managed HelpStreet and had ongoing involvement with the company.[224] Mr Bunker spoke to the Royal Commission by video-link with the hearing from the United Kingdom, having returned there after the events of 11 July 2019.

Mr Bunker was the principal representative of HelpStreet in negotiations with People Care.[225] Mr Bunker described himself as the 'founder and Global Chief Executive Officer of the HelpStreet Group, which includes HelpStreet Villages (Qld) Pty Ltd'.[226] Mr David Lamb was described as the HelpStreet Australia and New Zealand Chief Executive Officer.[227] Mr Bunker was involved in communications with People Care on behalf of HelpStreet from 2018 to 2019, including in relation to the payment of invoices.[228]

Mr Bunker was disqualified from managing corporations pursuant to section 206F of the *Corporations Act 2001* (Cth) during the period of his involvement with People Care. The disqualification is for a period of three years, commencing on 27 June 2018 when the notice of disqualification was given.[229] That notice was in effect during Mr Bunker's dispute with Mr Miller, including on 10 and 11 July 2019.[230] A notice requiring Mr Bunker to demonstrate why such disqualification should not occur was issued to Mr Bunker in December 2017. Mr Bunker's evidence was that he disclosed the prospect of the disqualification to People Care from the start.[231] There is no evidence to suggest that either the Australian Department of Health or Aged Care Quality and Safety Commission were made aware of Mr Bunker's disqualification before 11 July 2019.

Events leading to the emergency evacuation

Deterioration of the relationship between People Care and HelpStreet

Following the agreement with People Care, HelpStreet replaced the management personnel of the Earle Haven aged care facilities. Ms Karen Heard, who had a background in nursing, had been employed by People Care as Facility Manager.[232] She left on 12 November 2018.[233] Ms Karen Parsons was employed by HelpStreet as Executive Director at Earle Haven in October 2018.[234] She continued to hold this position at the time of the hearing.[235] Ms Parsons was not a clinician.[236] She had been employed in the hospitality and hotel arms of aged care operations.[237] Ms Telecia Tuccori was appointed the Clinical Care Coordinator by HelpStreet on 7 November 2018. Ms Tuccori continued to occupy that role until at least 11 July 2019.[238]

Ms Parsons gave evidence that, by December 2018, she was experiencing difficulties in her relationship with Mr Miller.[239] Ms Parsons said that Mr Miller 'was a bully, and he was quite intimidating'.[240] Mr Miller agreed his relationship with Ms Parson began to deteriorate around December 2018.[241] He said that his relationship with Mr Bunker began to deteriorate in January 2019.[242] He said he was 'very unhappy' that HelpStreet did not 'work in partnership' with People Care. He said his business had never agreed to hire Ms Parsons.[243]

On 20 March 2019, a 90 minute meeting was attended by Mr Miller and about 60 of Earle Haven's residents, their family members and friends. Numerous complaints about the management of Earle Haven were made at the meeting. Its minutes 'noted' that 'key staff from Help Street who were invited to attend did not respond to the invitation'.[244] The minutes record Mr Miller saying David Lamb 'was supposed to be there' for HelpStreet.[245] Mr Miller said that following that meeting, his opinion of HelpStreet's performance of running his facilities was 'very poor'.[246] Ms Parsons said she was not aware of the meeting on the day.[247]

On 30 May 2019, officers from the complaints area of the Aged Care Quality and Safety Commission discovered at a meeting that the relationship between Ms Parsons and Mr Miller had broken down to the point that Ms Parsons was not passing on information about complaints to Mr Miller.[248]

On 31 May 2019, Mr Miller sent a letter to Mr Lamb in which he referred to the 30 May meeting and made complaints about the performance of HelpStreet.[249] Mr Miller gave notice that he had engaged an 'advisor', the former facility manager Ms Karen Heard, to assist, along with the 'Clinical Care Manager', Ms Tuccori, with the monitoring of care.[250]

On 27 June 2019, emails passed between Mr Miller and Mr Lamb regarding outstanding payments said to be due to HelpStreet by People Care. It is unclear how much was in dispute at that time.[251] On 8 July 2019, the solicitors for People Care wrote to the directors of HelpStreet Villages (Qld) Pty Limited and 'Help Street Partnerships Pty Ltd', terminating HelpStreet's licence to occupy Hibiscus House and Orchid House and giving one month's notice to vacate the premises, until 5pm on 9 August 2019.[252]

People Care asserted through its lawyers that, although it was 'minded to revoke the terms of the Licence to Occupy immediately', given that 'the welfare of the residents' was the main concern, it sought, 'an orderly withdrawal from the premises and handover of the management and control of the business'.[253]

Mr Miller gave evidence that during this period his idea was to 're-hire the employees back to People Care and continue to look after the residents in a proper manner and rectify what was happening with HelpStreet'.[254]

The events of 10 July 2019

Removal of computer server

On 9 or 10 July 2019, Mr Bunker caused the computer server at the Earle Haven residential aged care service to be removed from the premises.[255] Early on the morning of 10 July 2019, the solicitor for People Care sent an email claiming the patient records on the server belonged to the residents, were needed on site, that the residents were at risk without any access to them and demanded return of the patient records by close of business.[256]

Ms Parsons accepted that the patient records system was a typical residential aged care program that the facility needed to be able to operate on a daily basis.[257] Ms Tuccori said that she was told about the removal of the servers between 2pm and 3pm and was given no advance notice that it was going to happen.[258]

At 5.17pm on 10 July 2019, Mr Bunker replied by email to People Care's solicitor's email, stating that the servers had been removed to enable an upgrade to occur, and to remove private HelpStreet information—not to prevent patient care.[259] The email stated that continuity of care could occur on a paper-based system.[260]

The servers were never returned.[261]

Staff and the Australian Government informed of the termination

Ms Parsons attended a meeting with Mr Lamb and Mr Bunker at midday on 10 July 2019.[262] At that meeting, she was told that Mr Miller had not turned up to a meeting that had been scheduled for that morning, and she was told about a letter indicating that People Care wished to sever the relationship with HelpStreet.[263]

At 2.05pm on 10 July 2019, Mr Lang (describing himself as 'Approved Provider Delegate' for People Care) sent an email to the Australian Department of Health advising that 'the current management team for our residential and home care services, HelpStreet…have had their management status for People Care terminated' effective 30 August 2019. Mr Lang advised that People Care will continue to manage the services.[264]

Between 3.30pm and 5pm, Ms Parsons was told by Mr Bunker and Mr Lamb that People Care owed HelpStreet 'significant money'. Mr Bunker informed Ms Parsons that unless payments were made in instalments beginning immediately 'he had concerns about the whole Facility'.[265]

Mr Bunker's 5.17pm email, referred to earlier, also sought payment of $3,889,474.86 plus GST to give effect to an 'orderly exit'.[266] This amount was claimed to comprise a discounted amount of $2.7 million plus GST as compensation for lost earnings based on nine years.[267] This appears to be based on the remainder of the 10 years of the lease referred to in the 'Heads of Agreement'.[268] Mr Bunker required confirmation of acceptance within seven hours, and payment by midday on 11 July 2019 of half the above amount, with a further quarter paid on 30 July 2019 and the final quarter on 9 August.[269] This email concluded that should the deadlines pass:

> we will have no choice but to place Helpstreet Villages (Qld) Pty Ltd into administration with immediate effect, ultimately causing the home to be closed, my fear should staff get wind of the current situation before we agree terms and make an official press release, or worse the agency, or local press, this situation could become unavoidable.[270]

In his oral evidence, Mr Bunker said he was concerned that with no payment from People Care, HelpStreet would not be able to trade.[271]

Ms Tuccori said in her statement that she received a call from Ms Parsons stating that Mr Miller owed HelpStreet a large sum of money and that 'we were out' either 11 July 2019 after 12pm or 9 August 2019.[272] Ms Parsons had communicated what she was told by Mr Bunker.[273] Ms Tuccori understood there was a possibility that if HelpStreet left the following day, there would be no staff to care for residents.[274]

The events of 11 July 2017

In her statement, Ms Parsons gave evidence that on 11 July 2019 there was a meeting at 9am involving Mr Bunker, Mr Lamb, Ms Parsons, Ms Tuccori and two other HelpStreet staff.[275] Ms Parsons stated that during this meeting, Mr Bunker told the attendees about a letter of demand he had sent and said that staff should be told that they may not get paid if HelpStreet was not paid the money owing to it.[276]

Ms Parsons said that Mr Bunker directed the HelpStreet team to put some 'structures' in place in preparation for the way Mr Miller might react.[277] The plan included contacting triple zero (000) 'if there became an issue with staff or otherwise there became compromised ability for continuing care for the residents'.[278] Ms Tuccori said that it was Mr Bunker who came up with contacting triple zero as a solution.[279] Ms Tuccori said she did not start talking to respite services after the 9am meeting because she remained 'uncertain of what the outcome would be'.[280]

At 10.16am on 11 July 2019, People Care's solicitor responded by email to HelpStreet's demand the previous evening, indicating that it would attend to the payment of monies owing to 30 June 2019 conditional upon:

- staff being paid all of their entitlements
- all monies owing to People Care (the extent of which was not stated) being paid
- patient records being delivered to People Care
- an audit of management indicating no breaches of the Accreditation Standards that would put People Care's licence at risk.[281]

In that email, the solicitor denied HelpStreet was entitled to any compensation for termination. He indicated that Mr Miller was prepared to meet with Mr Bunker to discuss an orderly transition of the business and the employment of such staff as People Care may wish to offer employment.[282] In his oral evidence, Mr Bunker said that he did not convey People Care's solicitor's response, or the substance of it, to his staff.[283]

Ms Parsons said that Mr Bunker directed one of the HelpStreet staff to book removalists as a 'precautionary' measure.[284] By around midday on 11 July 2019, a removalist van had arrived and the process of removing HelpStreet's assets from the facility had begun, including 14 mattresses that HelpStreet had purchased.[285] At the meeting that morning, HelpStreet staff had been tasked with preparing lists of assets that were to be removed.[286]

Karen Heard, who had been retained by Mr Miller as his advisor, became involved when she was notified by the daughter of a resident that furnishings, bedding and other items were being removed from the facility.[287] She made a decision to attend the facility.[288]

Ms Parsons said that at 1.30pm there was a meeting with staff, that occurred about half an hour before the decision was made to call triple zero. She said that Mr Bunker explained that People Care had made no payment, so wages could not be paid.[289]

The decision to leave Earle Haven

Mr Bunker denied that a decision was made to leave the facility on 10 July 2019 and claimed that no decision at all was made by HelpStreet to leave.[290] He stated that HelpStreet only left after being requested to do so by Ms Heard on behalf of People Care in multiple conversations with her on-site.[291]

However, CCTV footage showed removal of furniture had begun by 12.10pm.[292] Mr Cary Strong, Queensland Ambulance Service, arrived at Earle Haven at 2.13pm and said that there was a removalist truck out the front and property was being removed from the premises. [293] Ms Heard gave evidence that she decided to travel to Earle Haven after being told furniture was being removed. She stated that when she arrived shortly before 3pm the Queensland Ambulance Service was already there.[294]

Ms Parsons said that Mr Miller did not tell HelpStreet to leave.[295] Ms Tuccori said that she was not aware of Mr Miller asking people to leave.[296] Mr Miller said that his intention was to try and keep the staff who wanted to work with People Care, but he did not tell them that if they wanted to stay that day, he would pay them.[297] He said this was because he did not know that 'they were going to walk out'.[298] Whether it is accurate to say that staff 'walked out' is a matter we address below.

The decision to call emergency services

Ms Tuccori made a telephone call to triple zero at 1.33pm on 11 July 2019, which was concluded by 1.41pm.[299] She told the operator that staff had 'gone home', with 'probably five here… not really wanting to work'.[300]

In the call, Ms Tuccori told the operator that they had 'just gone into administration'.[301] Mr Strong's evidence was that Ms Tuccori and Mr Bunker repeated this to him.[302] However, HelpStreet was not in administration on 11 July 2019. The Australian Securities and Investments Commission website does not record HelpStreet Villages (Qld) Pty Ltd (ACN 621 645 332) and HelpStreet Partnerships (Aus) Pty Ltd (ACN 621 644 317) filing forms 205M for voluntary liquidation under section 491 of the *Corporations Act 2001* (Cth) until 27 August 2019 and 21 October 2019 respectively.[303]

The evacuation of Earle Haven on 11 July 2019

Following Ms Tuccori's call to triple zero, Mr Cary Strong, Paramedic and Senior Operations Supervisor with the Queensland Ambulance Service, was dispatched to attend Earle Haven to assess the situation and obtain further information.[304]

When Mr Strong arrived at Earle Haven, he observed removalist trucks and people removing furniture and 'various equipment and items from the premises and packing boxes'.[305]

When he approached Hibiscus House, Mr Strong observed people yelling and arguing.[306] The situation at the facility appeared to be disorganised and chaotic.

Shortly after his arrival, Mr Strong spoke to Ms Tuccori. According to Mr Strong, Ms Tuccori informed him that Earle Haven was in administration and that there were approximately 69 residents who needed to be transported to another location.[307] Mr Strong said that Ms Tuccori told him that she was 'unable to provide clinical records for the Residents because the computer containing them had been removed from the premises. She was uncertain if the facility had stored any hard copy records.'[308] At some stage in the afternoon, Mr Strong was provided with two black folders and a fire evacuation plan, which was later used to assist in the identification of residents.[309]

Ms Tuccori introduced Mr Strong to her manager, Kristofer Bunker. Mr Strong understood Mr Bunker to be the manager of the facility.[310] A man Mr Strong identified as the main participant in the verbal altercations he observed when he first arrived approached him while he was speaking with Mr Bunker and identified himself as 'the owner'.[311] Mr Strong now knows this man to be Mr Arthur Miller.[312] Mr Strong then observed Mr Bunker and Mr Miller become involved in a 'confrontational argument' about who was at fault.[313]

At about 2.15pm, the Gold Coast Hospital and Health Service activated a Code Brown (external emergency) in response to advice from Queensland Ambulance Service that Earle Haven had gone into 'liquidation'.[314] At 2.30pm, the Gold Coast Hospital and Health Service Health Emergency Operations Centre met to discuss the Code Brown. The Health Emergency Operations Centre resolved to deploy a crisis team to Earle Haven to assess the number of residents, their needs and the feasibility of Gold Coast Hospital and Health Service temporarily maintaining operation of the Earle Haven facility.[315] At about 3.05pm, a request was made by the Chief Health Officer and Deputy Director-General, Prevention Division of Queensland Health for the State Health Emergency Coordination Centre to activate. Australian Department of Health liaisons arrived within 30 minutes.[316]

The minutes of a teleconference held at 4pm between personnel present at the State Health Emergency Coordination Centre, the Health Emergency Operations Centre and those on the ground at Earle Haven record as follows:

> The Commonwealth was notified of the liquidation and were advised that the aged care facility had enough resources to last 72 hours. It was confirmed by the GCHHS [Gold Coast Hospital and Health Service] crisis site team that the information provided to the Commonwealth was incorrect.[317]

Around 4.30pm or 5pm, Gold Coast Hospital and Health Service delivered bottled water and food for the residents' dinner to Earle Haven.[318] At some time prior to 5.30pm, an officer from the Queensland Police Service declared an emergency situation at Earle Haven under the *Public Safety Preservation Act 1986* (Qld).[319]

Mr Strong and members of the Gold Coast Hospital and Health Service crisis team determined that, due to the extent of property that had been removed from the facilities, it was not safe for residents to remain at Hibiscus House or Orchid House.[320]

Over the course of the afternoon, personnel from Gold Coast Hospital and Health Service contacted aged care facilities in the area and identified those which could accommodate residents from Hibiscus and Orchid Houses. They also contacted the residents' next of kin to advise them of developments at Hibiscus House and Orchid House. During the afternoon, families began arriving to clear out their family member's room, which added a further layer of complication to the management of an already complex situation for emergency services.[321]

At around 6pm, the process of transporting remaining residents from Hibiscus House and Orchid House to alternative accommodation at other aged care facilities started.[322] The last resident was not removed from the premises until after 12am on 12 July 2019.[323]

In total, 68 residents were evacuated from Earle Haven on 11 to 12 July 2019.[324] Gold Coast Hospital and Health Service located and secured all controlled drugs held on the premises.[325]

During the evening of 11–12 July 2019, Queensland Ambulance Service became aware that a resident who had been relocated from Hibiscus House at around 9pm had sustained a fall very soon after arrival at the alternate aged care facility.[326] The resident was transferred by ambulance to hospital and was diagnosed with an acute right sided frontal subdural haematoma.[327]

Conduct of Mr Bunker and Mr Miller

Counsel Assisting invited adverse findings in strong terms against both Mr Bunker and Mr Miller.[328] No submissions were received from them in response to Counsel Assisting's characterisation of their conduct on and in the lead up to 11 July 2019.

Counsel Assisting submitted that, to some extent, both Mr Bunker and Mr Miller put their own commercial interests above the interests of the residents of Orchid House and Hibiscus House. HelpStreet in particular, abruptly ceased services on 11 July 2019, without any plans for an orderly handover.[329] Adding brinkmanship to the situation is unacceptable. Such situations involve vulnerable people who depend upon the ongoing care that organisations are responsible for providing.

The regulatory response

The Australian Government accepted in its submissions that there were deficiencies in the regulatory response to Earle Haven before the events of 11 July 2019.

This section explores the key deficiencies identified in this case study, which are the regulators' failures to:

- (re)consider People Care's suitability to be an approved provider
- integrate information and conduct risk assessments
- enquire into the use of a management company by an approved provider.

Failure to (re)consider People Care's suitability to be an approved provider

The Earle Haven Case Study also examined the question of People Care's ongoing suitability to remain an approved provider in light of its poor compliance history and other indications.

One of the aged care regulator's roles is to consider the ongoing suitability of approved providers, particularly in circumstances where there is information which may bring in to question that suitability.

From about 2007, the conduct and compliance history of People Care should have caused the Australian Department of Health to reflect on People Care's suitability to be an approved provider. However, there is no evidence that the Department ever reconsidered People Care's suitability to remain an approved provider before 11 July 2019. Mr Speed gave evidence that he was not aware of any reconsideration by the Department about People Care's suitability to be an approved provider.[330]

Mr Speed, in his evidence, accepted that some matters in People Care's history should have led to People Care's suitability as an approved provider being (re)considered.[331] The Australian Government in its submissions agreed that:

> …the conduct of the approved provider in 2016 should have invited further consideration by the former Agency and the Department as to the approved provider's suitability…[332]

This assessment is correct. This case study exposed four circumstances which should have led the Australian Department of Health to consider the question before the events of 11 July 2019:

- People Care's history of non-compliance
- People Care's conduct in respect of its Home Care Packages service in 2017
- the attitude and responsibilities of People Care's key personnel
- People Care's relationship with its adviser appointed pursuant to sanctions in 2016.

People Care's status as an approved provider was revoked under the Aged Care Act after the events of 11 July 2019, effective from 23 October 2019, for both its residential and home care services.[333]

Recommendations relating to the approval of providers, and regulatory intervention in the case of non-complaint providers, are set out in Volume 3.

People Care's residential aged care compliance history

People Care had difficulties complying with the aged care standards over a number of years. People Care was subject to four periods of sanctions since becoming an approved provider of residential aged care and home care in 2005:

- The first period of sanctions were imposed by notice on 30 April 2007 in respect of Hibiscus House.[334]
- The second period was imposed by notice dated 3 June 2016 in respect of Hibiscus House and Orchid House (which merged shortly afterwards).[335]
- The third period was imposed by notice dated 11 May 2017 in respect of People Care's Home Care Package service.[336]
- The fourth period was imposed by notice dated 13 July 2019, the day after the Earle Haven evacuation was completed, in respect of People Care's residential aged care service.[337] Sanctions were imposed on the Home Care Package service by notice dated 9 August 2019, the final day of this hearing.[338]

In each case, the sanctions required the appointment by People Care of an administrator or adviser.

The Aged Care Quality and Safety Commission maintains records for approved providers known as a Home Details Reports, or in the case of a Home Care Package service a Service Details Report. These reports show a service's history of compliance with the Accreditation Standards. The Home Details Reports for People Care show that the Aged Care Quality and Safety Commission found extensive non-compliance with the Accreditation Standards over a period of months in 2007 and multiple periods of months between 2015 and 2017, which was generally not remedied until the imposition of sanctions.[339]

A Serious Risk Report, dated 29 April 2007, relied upon for the first imposition of sanctions, included the following finding:

> Management are not responsive to issues raised, including sufficiency of equipment, staffing requirements, risks in the care environment, and adverse clinical indicators.[340]

In that report, key personnel were described as not having the qualifications to perform 'the requirements of their role'.[341] Regarding the failure to meet expected outcome 1.6 (Human Resources Management), the report stated:

> The Care Services Manager who has responsibility for the overall management of the facility advised that they have no qualifications in management and their experience in managing people is limited to managing 12 staff in a previous occupation (automotive engineer).[342]

One of the Commonwealth witnesses was Queensland Regional Director of the Quality and Monitoring Group of the Aged Care Quality and Safety Commission, Ms Tracey Rees. When asked whether the failure recorded in the above report was an unusually bad failure to meet expected outcome 1.6, Ms Rees said she had not seen something like this before.[343]

The 2016 sanctions were imposed following a Serious Risk Decision dated 3 June 2016 and signed by Ms Rees in her capacity as State Director of Queensland for the then Australian Aged Care Quality Agency.[344] Ms Rees considered that four residents were at serious risk of harm, based on the evidence gathered by assessors between 16 and 29 May 2016 of failures in clinical care.[345]

The compliance history of People Care, as detailed above, should have made clear to the Australian Aged Care Quality Agency and the Australian Department of Health that this approved provider was a potential risk due to a continued tendency to fall into non-compliance. There is no evidence that the Department turned its mind to the question of its suitability to remain an approved provider in response to this risk.

People Care's conduct in 2017 in respect of its Home Care Package service

People Care's conduct in 2017 in respect of its Home Care Package service and the sanctions imposed should also have led to a reconsideration of its suitability to be an approved provider.

By late 2016 and early 2017, People Care's home care operations were persistently non-compliant with the Accreditation Standards.[346] The beginning of this non-compliance coincided with the end of the 2016 sanctions in respect of the residential aged care service.[347]

On 11 April 2017, another approved provider, identified as 'TY' at the hearing, contacted the Australian Department of Health to advise that People Care had approached TY for TY to take over People Care's Home Care Packages. The situation was described in a Department file note as an 'extremely volatile environment'.[348] On 8 May 2017, officers of the Australian Department of Health spoke with the new coordinator of People Care's Home Care Packages. The new coordinator alleged the previous People Care coordinators had been 'sabotaging People Care and trying to get rid of all Home Care Packages by sending all clients' to TY.[349]

The Australian Aged Care Quality Agency found that People Care's home care services remained non-compliant in May 2017, and sanctions were imposed on 11 May 2017.[350] One of the sanctions took the form of a conditional revocation of its approval, unless it agreed to appoint an administrator, for four months from 11 May 2017 to 11 September 2017.[351] The administrator appointed was Ms Karen Heard, who would remain involved with People Care and was present for the evacuation of Earle Haven on 11 July 2019.[352]

Notwithstanding the Australian Department of Health's decision to impose sanctions and place People Care on the Service Providers of Concern list, there is no evidence that officers in the Department turned their minds, at this time, to whether People Care was suitable to continue as an approved provider.

Attitude and responsibility of People Care's key personnel

Evidence received as part of this case study indicated that some of People Care's key personnel, principally Mr Miller, showed a poor attitude and demonstrated a lack of responsibility for their obligations. This attitude should also have caused the Australian Department of Health to consider People Care's suitability to remain as an approved provider of aged care.

Following the sanctions imposed on 3 June 2016, a meeting was held at Earle Haven on 10 June 2016 with those receiving care, relatives, staff, Mr Miller and Australian Government representatives including Ms Rees, then of the Australian Aged Care Quality Agency. The minutes of that meeting, which appear to have been prepared by the Australian Department of Health, record Mr Miller saying that he was 'doing his best to fix problem, doesn't know everything that happens at the residential facilities [they] are a small part of his business, [he] has too many things on his plates and admits responsibility'.[353]

The notes accord with Ms Rees' recollection at the hearing of Mr Miller's attitude at the meeting. She said she came away from this meeting 'with a view that it was a small part of his business and that the responsibility for operating the service rested with the staff at the service'.[354] Ms Rees accepted that this was the sort of information that should raise an alarm bell about whether an approved provider is, in fact, suitable to be an approved provider.[355]

The Aged Care Complaints Commission also had experience of Mr Miller's attitude towards his role as an approved provider. An email from a complaints officer to the Manager of Queensland Complaints Operations, dated 1 February 2016, in relation to an investigation of complaints, reported that Mr Miller's 'response was concerning' and he 'was very difficult to speak with and would not easily provide information'.[356] There is no evidence that anything was done with this assessment. The Manager of Queensland Complaints Operations decided to close the complaint on the basis that the call bells were working at the residential facility, although not in the retirement village.[357]

Mr Speed was unable to tell us whether there had ever been a referral by the Aged Care Quality and Safety Commission or the former Australian Aged Care Quality Agency of concerns about suitability based on Mr Miller's non-cooperation. He said that there had not been, to his knowledge, a revocation by the Australian Department of Health of approval in such circumstances.[358] In its submissions, the Australian Government agreed that Mr Miller's lack of responsiveness to the Australian Aged Care Quality Agency was one factor that should have invited further consideration of the approved provider's suitability.[359]

People Care's relationship with the adviser in 2016

This case study also included evidence about a dispute between People Care and an adviser it had appointed under sanctions, which was known to the Australian Department of Health. People Care appointed this adviser in around mid-June 2016.[360] Within a month, relations between the adviser and People Care had come close to breakdown.[361] The adviser left on about 8 July 2016 after a confrontation in which Mr Miller told him to get off the premises. The adviser later agreed to continue in the role. Communications between

the adviser and the Australian Department of Health at the time suggested that the sustainability of any improvements was doubtful, and that there were continuing prudential concerns.[362]

A further breakdown in relations between the adviser and People Care occurred on about 13 September 2016. The adviser sent two emails to the Australian Aged Care Quality Agency, including Ms Rees, notifying it of this breakdown and his reasons for his intention to cease services.[363] One of the reasons given by the adviser was that People Care was not supporting adequate resourcing or ensuring active management or rectification and sustainability of compliance at the facilities, and was not following advice due to 'financial constraints'.[364]

In her oral evidence, Ms Rees accepted that the communications from the adviser were alarming, and they raised 'red flags' or 'alarm bells' about the approved provider; in particular in relation to the adviser's concerns about the sustainability of improvements, support and resourcing.[365] Ms Rees agreed that the information from the adviser potentially suggested that People Care was unsuitable to be an approved provider.[366]

Following the July 2016 email from the adviser, an internal email within the Australian Department of Health stated that a report on People Care's suitability to remain an approved provider would be drafted. The report does not feature in subsequent updates after the adviser returned to People Care.[367] It does not appear that the Department actually engaged in the task of considering People Care's suitability to remain an approved provider at this time. This may be because Mr Miller then requested that the advisor stay that same day.[368] This is an example of the Australian Department of Health appreciating the importance of a 'red flag', but failing to follow through with any regulatory action.[369]

The Australian Government, in its submissions, accepted that these concerns should also have invited further consideration by the Australian Department of Health of People Care's suitability to be an approved provider.[370]

Failure to integrate information and conduct risk assessments

The various regulatory arms of the Australian Government were privy to a considerable amount of information about People Care, including about its arrangements and deteriorating relationship with HelpStreet in the lead-up to 11 July 2019. This case study exposed deficiencies in sharing and integrating information, and a consequential failure by the regulators to assess and respond to risk.

The Australian Government, in its submissions, stated that 'the Commission and the Department accept that the regulatory response was shaped by deficiencies in information-sharing, follow through and assessment of identified risks'.[371] It acknowledged that:

> more integrated regulatory oversight with greater information sharing between and within the Commission and the Department, would have increased the likelihood that the risks associated with the approved provider, given in particular the business model that they had adopted for the delivery of care and support to residents, may have been reasonably anticipated and prompted further investigation. It follows that such oversight would have provided more opportunity for a different regulatory response.[372]

The key deficiencies explored in the case study were the failures to:

- share information about People Care's arrangements with HelpStreet
- identify the risk in, and share information about, the deterioration in the relationship between People Care and HelpStreet
- integrate the risk indicator of high use of restraints with other regulatory risk analysis
- integrate prudential risk analysis and compliance with other regulatory areas.

These are discussed in the following sections.

Failure to share information about People Care's arrangements with HelpStreet

The evidence in this case study indicated that both the Australian Department of Health and the Aged Care Quality and Safety Commission had some knowledge of the arrangements between People Care and HelpStreet. However, it does not appear that this information was shared between different areas of the regulators, or considered holistically.

It appears that the Australian Aged Care Quality Agency first became aware of the possibility of HelpStreet's involvement at Earle Haven on 22 March 2018, during an assessment contact. The facility manager of Hibiscus and Orchid Houses, Ms Karen Heard, informed visiting assessors of a change in senior management to 'Help Street Group, Sydney', which was scheduled to start on 1 April 2018. It was reported that there would be no changes to current on-site management or staff but that there would be changes to the 'home's identity'.[373]

Ms Rees, of the Australian Aged Care Quality Agency, made enquiries about this arrangement with the Australian Department of Health on 23 March 2018.[374] The Department contacted Bruce Lang within the space of a few hours and the Departmental officer reported to Ms Rees that Mr Lang had advised that People Care would be trialling an arrangement with 'Help Street Group NSW'.[375] This was not recorded in the Department's records system for People Care. Later in the afternoon of 23 March 2018, Bruce Lang of People Care contacted the Australian Aged Care Quality Agency and advised that HelpStreet would not be taking over but would be contracted to 'manage' People Care's aged care facilities. This information was recorded by the Australian Aged Care Quality Agency.[376]

According to reports of unannounced assessment contacts, dated 18 July 2018 and 11 January 2019, the Australian Aged Care Quality Agency was aware that the home was 'taken over by a management team' on 1 April 2018, and that People Care appointed a 'new management team' in November 2018, respectively.[377] However, the Australian Aged Care Quality Agency does not appear to have passed information about the arrangements between People Care and HelpStreet to the Australian Department of Health. It does not appear that the Australian Aged Care Quality Agency enquired further about the new management team either in March or July 2018, or January 2019. The Department does not appear to have made further enquiries after speaking to Mr Lang on 23 March 2018. This is considered further later in this section.

Importantly, the Australian Department of Health had no record of HelpStreet when contacted by Bruce Lang of People Care on 10 July 2019 to advise of the termination of arrangements with HelpStreet.[378] The evidence indicated that the Department had inadequate information about the situation at Earle Haven available to it, and that as a result, it was unprepared to deal with the events that unfolded on 11 July 2019.

Failure to identify and share information about the deterioration in the relationship between People Care and HelpStreet

In post-hearing submissions, Counsel Assisting submitted that a further key failing was inadequate integration of complaints-related information with other risk factors that should have been apparent to the regulators. Important information available to those exercising the Aged Care Quality and Safety Commission's complaint functions was not shared with the Australian Department of Health, nor was it shared within those parts of the Aged Care Quality and Safety Commission responsible for compliance and monitoring functions.[379]

On 4 April 2019, a complaints officer from the Aged Care Quality and Safety Commission, Mr Michael Dalladay, conducted a visit to Earle Haven to investigate complaints about services. He received clarification that People Care was the approved provider and HelpStreet managed the facilities. He further learnt that HelpStreet would not be continuing contracts for domestic services with People Care.[380] On 5 April 2019, the Aged Care Quality and Safety Commission received a complaint about HelpStreet management and an alleged assault by staff.[381] Mr Dalladay again handled the complaint, but on 24 April 2019 he advised the complainant the business relationship with HelpStreet was not a matter he was able to take into account.[382]

On 15 May 2019, Mr Dalladay queried whether an allegation of a reportable assault was reported appropriately with the Australian Department of Health. The Department advised him that the assault had been reported, and that it had made a Type 2 referral to the Aged Care Quality and Safety Commission as a result.[383]

On 30 May 2019, Mr Dalladay and another complaints officer attended Earle Haven to provide an education session on complaints resolution. Notes were made of the meeting which record that the complaints officers were informed that HelpStreet was not passing on complaints to People Care. They were told Ms Parsons did not have direct contact with Mr Miller.[384] Ms Rees, Aged Care Quality and Safety Commission, said she did not recall having the breakdown in communication detailed in the notes of the meeting of 30 May 2019 raised for her attention in the course of her duties.[385] There is no evidence that this important information raised a red flag or was acted upon, and it appears that the information was not provided by the complaints area to the quality and monitoring area of the Aged Care Quality and Safety Commission.[386]

Shona Reid, Executive Director of Complaints at the Aged Care Quality and Safety Commission, acknowledged in her evidence that the complaints area of the Commission failed to show requisite curiosity and communicate with the quality monitoring section within the Commission.[387] The Australian Government acknowledged in its submissions that:

> the information collected at a meeting with the approved provider by the complaints resolution group within the Commission ought to have been passed to the quality assessment and monitoring group within the Commission and, equally, the quality assessment and monitoring group needed to show greater curiosity in informing itself appropriately.[388]

I agree. Evidence about structural separations within the regulatory process is considered later in this section.

Failure to integrate information about use of restraints

On 25 June 2019, the Aged Care Quality and Safety Commission conducted an unannounced assessment contact at Earle Haven, prompted by complaints about staff.[389] All standards were found to be met, and yet the assessment contact report noted 71% of residents were receiving psychotropic medication and 50% had physical restraints.[390] The scope of the assessment contact did not change as a result of this information.

In her evidence, Ms Ann Wunsch, Aged Care Quality and Safety Commission, described the rate of use of restraints as being 'at the very high end'.[391] The restraint screening questions were introduced in January 2019 to gain an understanding of the 'relative risk profile of the service for the purposes of guiding the assessment process'.[392] Ms Wunsch conceded that she could not say whether the concerning levels of restraint use may have been present earlier than June 2019 and that this was not investigated before 11 July 2019.[393]

I agree with Counsel Assisting's submissions that the Aged Care Quality and Safety Commission showed a lack of inquisitiveness after having received information about a concerning use of restrictive practices in residential care at Earle Haven.[394] This information should have prompted a more thorough risk assessment, particularly when considered alongside other red flags.

In its submissions, the Australian Government noted that the Aged Care Quality and Safety Commission is 'currently developing a change in assessment methodology in accordance with which an assessment team is required to immediately notify their supervisor if they identify high levels of restraint in response to the risk screening questions'.[395]

Failure to integrate prudential risk analysis and compliance

People Care was the subject of consideration by the prudential risk areas of the Australian Department of Health in 2016 and 2018–19. By letter dated 10 April 2016, the Department's Prudential Risk and Compliance Section requested information from People Care. The letter sought information on how it planned to return to profitability having experienced losses in the last two financial years and in circumstances where, as at 30 June 2015, current liabilities exceeded current assets by $4,803,519.[396]

People Care's undated reply explains that 92% of People Care's liabilities were owed to entities controlled by Mr Miller, and Mr Miller committed to guarantee the financial performance of People Care.[397] The letter continues that $5,880,509 were services provided 'at cost' by entities owned by Mr Miller.[398] There is no evidence that the Australian Department of Health conducted its own forensic accounting analysis of these costs, or whether the information available to it would have permitted any such analysis. It does not appear that the Prudential Compliance Branch took any further action in relation to the 10 April 2016 letter.

Section 52M-1 of the Aged Care Act requires an approved provider to comply with the Prudential Standards. Section 51 of that Act provides for an annual prudential compliance statement to be lodged with the Australian Department of Health. Further, section 63-1(1)(m) provides that the responsibilities of an approved provider include responsibilities specified in the *Accountability Principles 2014* (Cth). Part 4 of the Accountability Principles provides for aged care financial reports and general purpose financial reports.

From 31 October 2018, it appears that People Care became non-compliant with its reporting obligations for the 2017–18 financial year. On 20 August 2018, the Australian Department of Health wrote to People Care requesting lodgement of its 2017–18 aged care financial report by 31 October 2018.[399] On 22 January 2019, the Department issued a notice of non-compliance to People Care for its failure to lodge its aged care financial report, general purpose financial report and annual prudential compliance statement.[400]

People Care lodged these reports on 29 January 2019.[401] However, they were subject to omissions and errors, and the prudential area of the Australian Department of Health attempted, for many months, to obtain the missing information from People Care, to no avail. Internal emails within the Department, dated 21 March 2019, show the inability of officers to obtain People Care's cooperation in providing the missing information.[402] By 21 March 2019, completed reports were still outstanding and the responsible officers were concerned that People Care's 'priorities may not be particularly well aligned with ours'.[403]

On 13 June 2019, the Australian Department of Health made a decision to take no further action. The decision-maker considered it disproportionate to issue sanctions two weeks out from the end of the financial year.[404] It appears from the record of the decision that when making this decision, the delegate did not seek any up-to-date information from the relevant officers of the Department or the Aged Care Quality and Safety Commission, and did not know of the outsourcing arrangement between People Care and HelpStreet, which had already begun to unravel.[405]

The regulatory response to People Care's prudential compliance suggests a lack of integration of prudential compliance with other information about risk factors available to the Australian Department of Health or the Aged Care Quality and Safety Commission.

Counsel Assisting submitted that People Care's prudential non-compliance was another warning sign that People Care was dysfunctional and presented a risk to those receiving care.[406] In its submissions, the Australian Government noted that the Aged Care Quality and Safety Commission and the Australian Department of Health accept that they could improve oversight of risk factors, including those uncovered through prudential compliance

processes.[407] The Australian Government also noted that the risk profiling tool, to be implemented from 1 July 2020, 'will ensure that the findings from prudential compliance processes are integrated and considered alongside other risk factors'.[408]

Structural deficiencies impeding information sharing

It is clear from the previous sections that both the Australian Department of Health and the Aged Care Quality and Safety Commission were involved with People Care well before 11 July 2019. However, the regulators did not share relevant information between each other, nor internally between different sections with different regulatory responsibilities.

Ms Rees of the Aged Care Quality and Safety Commission explained that due to the separate IT systems used by the complaints operations and quality and monitoring officers at the Aged Care Quality and Safety Commission, a quality and monitoring officer would not be aware of a complaint officer record about concerning information unless deliberate action is taken to send the report on.[409] In its submissions, the Australian Government acknowledged that there remains a degree of structural separation between the complaints resolution and quality assessment and monitoring groups of the Aged Care Quality and Safety Commission.[410] The Australian Government advised that information collation and sharing are 'undergoing structural reorganisation and improvement'.[411]

Ms Rees was also asked by Senior Counsel Assisting whether there is a process for sharing information which raises concerns about an approved provider's suitability with the Australian Department of Health. She gave the following evidence:

> There's a process in place where a service is non-compliant, and reports are provided to the Department for their consideration…I'm not aware of a process that's directly to the approved-provider area. It's to the compliance area, the Department.[412]

By this, we understand Ms Rees to say that if the Aged Care Quality and Safety Commission had relevant information about the suitability of an approved provider or prudential risk, the Aged Care Quality and Safety Commission still had to go through the compliance area of the Australian Department of Health rather than deal directly with the responsible officers.

In its submissions, the Australian Government noted that, as at the date of its submissions, there were reforms underway to address these issues. These include the transfer of additional regulatory functions from the Australian Department of Health to the Aged Care Quality and Safety Commission, and the development and implementation of a new information technology system that 'will support Commission-wide access to its information'.[413]

Failure to enquire into the use of a management company

The evidence in this case study indicated that both the Australian Aged Care Quality Agency and the Australian Department of Health had some knowledge that People Care had made arrangements for a company, which was not an approved provider, to manage its aged care services at Earle Haven. The evidence suggests that neither the Australian Aged Care Quality Agency nor the Australian Department of Health had adequate policies

in place for responding to the issue of approved providers subcontracting out key functions of aged care services.

Ms Wunsch was asked about the process taken by the Aged Care Quality and Safety Commission when it becomes aware of an approved provider entering into subcontracting arrangements. She said:

> aged care service providers routinely contract parts of that service to subcontracted entities. It can be parts of their service such as kitchen or laundry or clinical care and, less commonly, although it is not rare, they subcontract their care delivery operations to a subcontractor.
>
> We wouldn't necessarily take a view, though, that a subcontractor…created risk for a service. In many instances, the engagement of a subcontractor has enhanced the quality of services for an aged care service provider and has been seen in a positive light, rather than a negative light. I'm not saying that, obviously, in the case of Earle Haven, but we have seen circumstances where an approved provider has sought to subcontract to another approved provider or another entity and that has benefitted the quality. And we see that through assessments of performance.[414]

Ms Rees said nothing was done by the Aged Care Quality and Safety Commission with the information that HelpStreet would be 'contracted' by People Care other than to record it.[415] She accepted that, in hindsight, it would have been important for the Aged Care Quality and Safety Commission to find out more about demarcation of roles and responsibilities and accepted that there was a potential risk to continuity of care if those matters were unclear. However, Ms Rees said, at the time HelpStreet did not assess contractual arrangements as part of 'expected outcomes relevant to the delivery of care'.[416]

The Australian Government, in its submissions, acknowledged that the circumstances of this particular outsourcing arrangement warranted closer examination at the time it was made known to the Aged Care Quality and Safety Commission and the Australian Department of Health. This was because:

> (a) the approved provider had outsourced its central functions to a subcontractor to such an extent that it had no role of the management of the service;
>
> (b) the subcontractor did not have appropriate experience in operating a residential aged care service;
>
> (c) the subcontractor was not itself an approved provider as was known to the ACQSC; and
>
> (d) the approved provider did not have appropriate governance structures in place.[417]

Mr Speed was asked about the significance of an approved provider entering into an arrangement of this kind, where an approved provider may have put themselves in a position where they cannot perform their statutory obligations due to the terms of a contract with a subcontractor. He agreed that would present a significant problem.[418] The Australian Government, in its submissions, accepted there is significant risk where an approved provider subcontracts substantial parts of its responsibilities to a third party.[419]

This case study also exposed deficiencies in the notification requirements of approved providers with respect to the use of management companies. When asked whether the Australian Department of Health should have inquired into the nature of the contractual

arrangements when advised they were being trialled in March 2018, Mr Speed stated 'the information didn't come through a material change form; it didn't come through a notification of any change to key personnel. So the information came indirectly through another source', being the Australian Aged Care Quality Agency.[420] Mr Speed agreed with Senior Counsel Assisting that the source of the information did not really matter and that it should have been acted upon.[421]

A material change form notifies the Secretary of changes to circumstances that materially affect an approved provider's suitability to be a provider of aged care. This is a statutory obligation pursuant to section 9-1(1) of the Aged Care Act.[422] The form in question had a field for 'Change to the organisation structure such as a merger or take-over, use of or removal of a management company' under the heading 'Nature of the material change'.[423] However, it is not clear whether the use of a management company amounts to a 'material change'. An issue in the case study was whether the Secretary should specify in a Notice under section 8-5(3) at the time of notification of approval that the use of a management company is a 'material change'. In his oral evidence, Mr Speed accepted that the extent of any obligation to notify of this matter should be clearer.[424]

In post-hearing submissions, the Australian Government noted that the Australian Department of Health is updating the notification form that approved providers use to notify it of material changes, and 'that form will now require notification of, among other things, changes to management company contracting arrangements. Collection of this data will feed into the risk profiling tool and allow for more efficient, effective and targeted regulatory activity.'[425]

The Australian Government also submitted that the Aged Care Quality and Safety Commission and Australian Department of Health 'consider it would be beneficial for there to be a clear obligation to require approved providers to advise the Aged Care Quality and Safety Commission of changes to sub-contracting arrangements from the time that the original application for approval was made'.[426] I agree.

Conclusion

The evacuation of Earle Haven on 11 July 2019 was an extraordinary event. I consider that most approved providers would not permit their relationship with a management company to degrade so badly or rapidly. However, as remarkable as the actions of People Care and HelpStreet examined in this case study were, I am equally struck by how unprepared the regulators appeared to be, and the deficiencies these events revealed in their regulatory processes.

Counsel Assisting submitted that the actions of the Commonwealth regulators in relation to People Care over many years, as illustrated in this case study and particularly those set out in this section, were an example of 'ritualistic' regulation as described by Professors John and Valerie Braithwaite.[427] I agree. The processes appeared to be focused on the means for achieving an outcome, while losing sight of the outcome itself. This is evident in the lack of enquiries made by the Australian Department of Health and the Aged Care Quality and Safety Commission about the management agreement between People Care

and HelpStreet. While the regulators had some concerning information about People Care, that information was not integrated and used to inform the provider's risk profile. It did not prompt the Australian Department of Health to consider the suitability of People Care to remain an approved provider. This was far from the sort of intelligent regulation, based on scrutiny of all available sources of information, described by Professor Paterson.

8.2.2 MiCare Ltd

Introduction

The second case study considered in this hearing was about the regulation of services provided by an approved provider, MiCare Ltd (MiCare), at Avondrust Lodge (Avondrust), a residential aged care facility in suburban Melbourne.[428]

MiCare, Ms Coombe and the Australian Government were granted leave to appear at the public hearing and were legally represented.

In accordance with the directions made on 9 August 2019, Counsel Assisting provided written submissions setting out the findings they considered should be made in this case study.[429] In response to those submissions, the Royal Commission received submissions from the Australian Government.[430]

The case study considered the following issues:

- the approach taken by assessors to assessment contacts, review audits and re-accreditation audits
- the approach taken by decision-makers, including in relation to the imposition and lifting of sanctions
- the role of complaints
- the appointment, role and disclosure requirements of advisers and administrators appointed under the Aged Care Act.

In making my findings below, I have considered Counsel Assisting's submissions, as well as the Australian Government's submissions, and the evidence in this case study.

Regulatory overview—MiCare and Avondrust

At a re-accreditation audit conducted by two assessors from the Australian Aged Care Quality Agency on 17 and 18 April 2018, the residential aged care service at Avondrust was found to have met all 44 of the 44 expected outcomes across the four Accreditation Standards.[431] Having regard to those findings, a decision was made on 31 May 2018 by a delegate of the Chief Executive Officer of the Australian Aged Care Quality Agency to re-accredit the service at Avondrust for the maximum period of three years from 11 July 2018 to 11 July 2021.[432]

On 13 August 2018, Ms Johanna Aalberts-Henderson lodged a complaint with the Aged Care Complaints Commissioner about the treatment of her mother at Avondrust.[433] Information contained in that complaint was disclosed by the Aged Care Complaints Commissioner to the Australian Aged Care Quality Agency as a Type 3 referral on 14 August 2018.[434] As a result of that Type 3 referral, the Australian Aged Care Quality Agency undertook a review audit over the period from 16 to 27 August 2018.[435] Two different assessors from the Australian Aged Care Quality Agency found that the service at Avondrust now did not meet 13 of the 44 expected outcomes.[436]

Having regard to those findings, Ms Elsy Brammesan, as a delegate of the Secretary of the Australian Department of Health, made a decision, on 29 August 2018, to impose sanctions on MiCare in respect of the service at Avondrust.[437] The sanctions were for a six month period, ending on 1 March 2019. In summary, the sanctions restricted payment of subsidies for new people receiving care, and provided that, unless MiCare agreed to appoint an adviser and an administrator and undertake certain training activities, MiCare's approval as an approved provider would be revoked.[438] Ms Brammesan found that there was an immediate and severe risk to the safety, health or wellbeing of people receiving care at the service. She referred to the Australian Aged Care Quality Agency's review audit as having 'identified systemic and pervasive failures to deliver appropriate care across the majority of the Accreditation Standards'.[439]

MiCare subsequently appointed a nurse adviser and an administrator.[440] Those roles were ultimately undertaken by Ansell Strategic and its staff, including Ms Judith Coombe.

On 12 September 2018, Ms Rosenbrock, as a delegate of the Chief Executive Officer of the Australian Aged Care Quality Agency, made a decision to vary the accreditation period for the service at Avondrust so that it would now expire on 12 March 2019.[441] She also decided that the service must make improvements to meet the 13 'not met' expected outcomes and that the timetable for those improvements would expire on 26 November 2018.

On 17 September 2018, Ms Rosenbrock found that MiCare had placed the safety, health or wellbeing of 14 people receiving care at Avondrust at serious risk.[442]

On 6 and 24 September 2018 and 1 November 2018, assessors from the Australian Aged Care Quality Agency conducted assessment contact visits at Avondrust.[443] On each of those occasions, the assessors found that there continued to be the same 13 'not met' expected outcomes at the service. On 19 November 2018, Ms Rosenbrock found that the service still did not meet the 13 expected outcomes.[444]

On 20 and 21 November 2018, Ms Mary Dunn, of MHD Aged Services Consulting, undertook a 'gap analysis' at Avondrust and found that:

> 8 of the 13 'not met' expected outcomes still have gaps, which will not be remedied by next week when the TFI [timetable for improvement] expires…
>
> Another 2 expected outcomes have some gaps, which may lead them to be assessed 'not met' when the end of TFI Review Audit is undertaken.[445]

On 6 December 2018, three assessors from the Australian Aged Care Quality Agency visited Avondrust to conduct an assessment contact and found that the service now met the 13 previously 'not met' expected outcomes.[446]

On 18 December 2018, MiCare applied to the Secretary of the Australian Department of Health to lift the sanctions that were due to expire on 1 March 2019.[447] The application comprised a three-page covering letter and an attached five-page continuous improvement plan.[448] On 11 January 2019, Ms Brammesan decided to lift the sanctions.[449]

On 7 and 8 January 2019, three assessors from the Aged Care Quality and Safety Commission conducted a site audit at Avondrust and found that the service met 44 out of 44 expected outcomes.[450] On 6 February 2019, a delegate of the Aged Care Quality and Safety Commission decided to re-accredit the service for one year until 12 March 2020.[451]

On or about 12 February 2019, Ms Coombe provided a draft report to MiCare about Ansell Strategic's observations of the service at Avondrust.[452] That draft report set out a range of observations about shortcomings in culture and leadership, staffing structure, and in provision for residents' lifestyle and clinical needs. At the conclusion of the report, under the heading 'Future considerations', the report stated that:

> We remain concerned that the home has not yet achieved a sustainable level of performance in relation to leadership, lifestyle and clinical management at the home. The lack of robust clinical processes and reporting provides an ongoing risk for the home. This is not only in relation to a possible catastrophic clinical event, but also in relation to meeting the new Aged Care Quality Standards, meeting the expectations of the stakeholders and preserving the reputation of the organisation.
>
> A strong management presence is required to ensure effective and safe clinical care, hold staff accountable, identify and address trends and manage the transition to the new Standards.
>
> Ongoing staff training is critical to enhance the understanding of the Eden Model and how this translates into practice to support Elders to live the life they choose.[453]

Aged Care Quality and Safety Commission assessors undertook further assessment contacts at Avondrust on 24 April 2019 and 2 August 2019.[454]

On 30 July and 2 August 2019, Ms Rosenbrock received, in total, four Type 1 referrals from the Complaints Resolution Group, within the Aged Care Quality and Safety Commission, relating to complaints about, among other things, organisational governance at Avondrust, staffing levels, and the personal and clinical care of residents, including allegations of poor wound management.[455]

Information provided to assessors

Any assessment of compliance is only as robust as the primary information on which it depends. This case study highlighted the risk that the aged care regulatory framework may promote an over-reliance by the regulator on approved provider disclosure and routine processes, and insufficient investigative initiative by assessors.

Ms Gilda D'Rozario and Ms Rosemary Pace conducted the re-accreditation audit at Avondrust on 17 and 18 April 2018. Ms D'Rozario and Ms Pace concluded that the service at Avondrust met all 44 expected outcomes. Ms D'Rozario, who was the team leader for that re-accreditation audit, said they reached this conclusion 'primarily on the basis that no issues were identified that were not isolated in nature or represented any systemic concerns or a serious failure to provide an expected level of quality care'.[456] Counsel Assisting submitted that this evidence tends to suggest Ms D'Rozario and Ms Pace proceeded on the basis that only systemic or serious problems identified by them would warrant findings that expected outcomes were not met, and they were more prepared to assume that the service at Avondrust continued to comply.[457]

Ms D'Rozario said that prior to the re-accreditation audit, she and Ms Pace each received a 'work pack' and one of the documents in that work pack was a 'self-assessment tool' that had been completed by MiCare, in respect of the service at Avondrust.[458] In that self-assessment tool document, MiCare had stated that, by its own reckoning, the service at Avondrust met all 44 expected outcomes.[459] Ms D'Rozario conceded that, in her experience, she had never seen an approved provider admitting to non-compliance in such a self-assessment, unless the provider was aware that the Aged Care Quality and Safety Commission or its predecessor, the Australian Aged Care Quality Agency, already knew about the non-compliance.[460] I agree with Counsel Assisting that this evidence clearly calls into question the usefulness of the self-assessment tool from a regulatory perspective.[461]

As at 17 April 2018, there was information in Avondrust's improvement register that nursing staff had fallen behind in their review and evaluation of residents' care plans.[462] In addition, a survey of residents conducted in February 2018 had identified dissatisfaction with staffing levels.[463] At the time of the re-accreditation audit on 17 and 18 April 2018, there existed evidence of inadequate staffing levels at Avondrust and of the impact of those problems on the delivery of clinical and personal care to residents.

Ms D'Rozario agreed that, although there was evidence held by MiCare, at the time of the April 2018 audit, which suggested dissatisfaction by both residents and staff with staffing levels at Avondrust, that evidence was not obtained by or provided to her or Ms Pace.[464]

Ms D'Rozario said that aged care regulatory processes could be improved by giving assessors greater powers to access approved providers' electronic systems during on-site visits.[465] She agreed that not having access to the information about staff and resident dissatisfaction highlighted that 'there is a great deal of dependence on the part of an assessment team on the transparency of the approved provider in terms of what material is given to you'.[466]

It appears that there was too much reliance by the assessors, in April 2018, on processes that depended on the approved provider, MiCare, and its staff members being aware of failings and shortcomings at Avondrust and then voluntarily bringing evidence of those matters to the attention of the Australian Aged Care Quality Agency.[467]

Information provided to decision makers

Decision makers under the Aged Care Act have a responsibility to act with intellectual rigour and informed insight. Ms Brammesan was the delegate of the Secretary who made the decisions to impose sanctions on MiCare in respect of Avondrust and then later to lift those sanctions. Ms Brammesan agreed that 'good decision-making depends, at least to some extent, upon having good sources of information'.[468] She said that the main source of information for delegates of the Secretary in their decision-making was, at the time of the hearing, the Aged Care Quality and Safety Commission.[469] She said that before making the decision to impose sanctions against MiCare, nobody from the Australian Department of Health had spoken with any residents at Avondrust or their representatives.[470]

Ms Brammesan stated, in the record of decision to impose sanctions on MiCare, that the only information to which she had had regard was a draft version of the Australian Aged Care Quality Agency assessors' review audit assessment information document.[471] Her decision largely recites information derived from that document and assumes its accuracy. Similar circumstances pertained to Ms Brammesan's decision to lift the sanctions imposed on MiCare.[472] Aside from the brief application lodged by MiCare, that decision depended on the accuracy of information derived from documents prepared by the Australian Aged Care Quality Agency. As observed below, some of those documents contained findings and conclusions based on computer-generated template reasoning.

Ms Brammesan reflected in her oral evidence that it would be preferable for there to be consolidation of regulatory responsibilities within the Aged Care Quality and Safety Commission, so that it could have an 'end-to-end' role.[473]

Template reasoning

The evidence in this case study highlighted a concerning and possibly widespread use of computer-generated template reasoning by the Australian Aged Care and Quality Agency and the Aged Care Quality and Safety Commission, which has the potential to inhibit sound decision-making.

Ms D'Rozario described the process of preparing the re-accreditation audit assessment information document.[474] She stated that the document contained template reasons or 'rationales' for findings that expected outcomes were 'met' or 'not met', and those template reasons were computer generated.[475] She indicated that, while assessors could add their own reasons to the template reasons, they did not have to do so.[476] She stated that the template reasons were sourced from a 'computer assisted template'.[477]

Ms D'Rozario accepted that a 'large proportion' of the content in the April 2018 re-accreditation audit assessment information document for the service at Avondrust was 'template reasoning'.[478] Counsel Assisting in their submissions referred to several examples in that document where reasons additional to the template 'rationales' were expressed by the assessors in imprecise and vague terms.[479]

In the regulatory framework in place at the time of the hearing, the reasoning in reports of assessors largely informed decision-making about accreditation and re-accreditation of a residential aged care service. In this case, the reasoning in the April 2018 re-accreditation audit documents supported a decision to accredit the service at Avondrust for the maximum period of three years. I can understand why Ms Rosenbrock, who was at all times a delegate with power to make accreditation decisions, said to us that 'I have to tell you that, as a decision-maker, the computer-generated reports made me feel quite uncomfortable.'[480]

Ms Colette Marshall was the team leader for the Aged Care Quality and Safety Commission assessors who conducted a re-accreditation audit at Avondrust on 7 and 8 January 2019. She said that, with respect to that audit, large parts of the audit report at that time were substantially identical or similar to the contents of the re-accreditation audit report of April 2018.[481] She stated that the substantially identical or similar contents were the template rationales and reasons. She said that assessors were required to use those template rationales and reasons.[482] Ms Rosenbrock added that 'a large part of the audit report was computer-generated and so the similarity in words is a product of the process by which the report was created'.[483]

The Australian Government submitted that computer-generated templates were primarily introduced to enable the standardisation of a significant amount of information in a form that would facilitate analysis to identify indicators or predictors of performance.[484] The Australian Government further submitted that standardised statements of this kind create efficiencies in the time taken to write assessment reports.[485] Finally, the Australian Government submitted that the use of templates in the preparation of reports is common practice to assist staff to identify and formulate the information which should be included in their assessment report.[486] The Australian Government also clarified that, from 1 July 2019, the Aged Care Quality and Safety Commission's Assessment Methodology has been amended to require that evidence be set out in an assessment report to support findings of 'met' and 'not met' against the Quality Standards.[487]

I accept the Australian Government's submission that computer-generated reasons may promote efficiency. However, I am concerned that there were, in the reports considered in this case study, insufficient evidence and reasons for findings and conclusions where those computer-generated templates were used. This is particularly concerning where the findings and conclusions in those documents informed the exercise of decision-making power under the Aged Care Act. The computer-generated documents considered in this case study should not have provided assurance that they represented the considered opinion of assessors. More generally, I agree with Counsel Assisting's submission that template reasons have the potential to promote rigidity and inflexibility of reasoning as well as a lack of independent investigative rigour.[488]

Approach to audits and reviews

A significant issue traversed in the case study was the different findings made at, respectively, the April 2019 re-accreditation audit and the August 2019 review audit, and whether those differences were attributable to systemic or significant changes at Avondrust or to an inconsistent approach taken by assessors.

Counsel Assisting submitted that there were no significant changes to staff, policies or procedures at Avondrust between the audits that could explain the different findings made by assessors about compliance with expected outcomes of the Accreditation Standards and, in particular, expected outcome 1.6.[489] The Australian Government submitted that there were sufficient differences in the evidence collected by the two assessment teams to warrant the different findings.[490] In this regard, the Australian Government referred to evidence of the departure of five experienced staff between 1 January 2018 and the time of the re-accreditation audit in April 2018.

Section 54-1 of the Aged Care Act relevantly states that one of the responsibilities of an approved provider in relation to the quality of aged care that it provides is 'to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met'. At all relevant times for this case study, expected outcome 1.6 of the Accreditation Standards related to 'Human resource management' and required that 'there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives'. Having regard to that which follows below, I have some concerns about a lack of specificity in the language of this expected outcome. In particular, what might constitute a 'sufficient' level of staffing is not described in any detail.

I accept that between April and August 2018, there was no change to the rostered hours of staff at Avondrust. I also accept that a number of experienced care staff left their employment with MiCare between January and April 2018 and that the facility manager went on sick leave in July 2018. I am satisfied that the hours of all of the staff who left, or were on leave, in 2018, before or during the period from April to August, were filled during that period. Finally, I am prepared to accept that, in some instances, the experience of a staff member might affect the efficiency or efficacy with which the staff member performs her or his role. On some occasions, the number of staff sufficient 'to ensure the care needs of care recipients are met' will be affected by the experience of those staff.

At Avondrust, the experienced staff who departed before April 2018 were four personal care attendants and one enrolled nurse.[491] There was no evidence before the Royal Commission of any significant change to the registered nursing staff at Avondrust between January and August 2018. On the available evidence, I find that there was no loss of experienced registered nursing staff during that time.

Between April and August 2018, the rostered hours of registered nursing staff at Avondrust remained constant and equated to seven minutes per resident per day. However, that rostering of registered nursing staff was regarded by Ansell Strategic as 'insufficient time to effectively assess and manage the clinical needs' of residents.[492] In addition, there was no indication of any significant change to the number and care needs of residents at Avondrust throughout this time.[493]

In any event, the assessors at the April 2018 re-accreditation audit had found that there were 'systems and processes to ensure that there are sufficient skilled and qualified staff to deliver services that meet the Accreditation Standards and the home's philosophy and objectives'.[494] Those systems and processes would, it might be thought, have operated to ensure no staffing deficits between April and August 2018.

In this context, I find it difficult to understand how, in April 2018, two assessors from the Australian Aged Care Quality Agency found that the registered nursing staffing levels were 'sufficient', but in August 2018, two other assessors from the Australian Aged Care Quality Agency found that the same registered nursing staffing levels were inadequate.[495] It would appear that the key difference between those two points in time was that, by August 2018, the Australian Aged Care Quality Agency had received the complaint made by Ms Aalberts-Henderson about the treatment of her mother and, on conducting a subsequent review audit had uncovered, among other things, substandard clinical care.

It is true, as the Australian Government submitted, that there were more expressions of dissatisfaction by people receiving care at Avondrust by August 2018. It is also true that complaints are an important source of regulatory intelligence. However, aged care regulators, such as the Australian Aged Care Quality Agency and its successor the Aged Care Quality and Safety Commission, cannot depend on complaints by people receiving care and their families. It cannot be assumed that residents will be willing or have capacity to make complaints.

Overall, I consider that there was a different approach taken by the assessors at, respectively, the April 2018 re-accreditation audit and the August 2018 review audit, to the assessment of the staffing standard. In this case, it appears that the type of audit being conducted determined the level of rigour applied by the assessors.

In this regard, witnesses from the Aged Care Quality and Safety Commission drew a distinction at the hearing between the approach taken by assessors at a review audit and the approach taken by them at an accreditation or re-accreditation audit. Ms Rosenbrock stated that a review audit typically involves a three- or four-day site visit, whereas a re-accreditation audit usually only involves a two-day site visit.[496] She stated that a review audit is scheduled when the Aged Care Quality and Safety Commission has 'a reasonable belief that the service is not meeting the standards'.[497] As such it would, she said, ordinarily involve deeper and longer consideration of the service, the residents at the service and the service's records.[498] Ms Rosenbrock suggested that the Aged Care Quality and Safety Commission therefore seeks to ensure that experienced assessors undertake review audits.[499] Ms Rosenbrock nonetheless sought to maintain that assessors are as rigorous as they need to be on site, regardless of the type of audit being conducted.[500]

Ms D'Rozario agreed that her approach to an accreditation audit differed from her approach to a review audit.[501] She accepted that she would be 'more mindful of looking for non-compliance at a review audit than…otherwise at an accreditation audit'.[502] Ms Rosenbrock said that:

- review audits have been more likely to commence with expectations on the part of the Aged Care Quality and Safety Commission, or its predecessor the Australian Aged Care Quality Agency, that 'there are issues in the service that might well be identified in respect of the standard of care'
- those expectations have not been in existence, typically, when the Aged Care Quality and Safety Commission, or its predecessor the Australian Aged Care and Quality Agency, have conducted re-accreditation audits.[503]

It may be accepted that these expectations form an understandable feature of regulatory 'triage'. I nonetheless accept the submission of Counsel Assisting that expectations of this kind have the potential to give rise to undue assumptions by assessors that a service is compliant with applicable standards at the time of a re-accreditation audit.[504]

Role of complaints

Ms Rosenbrock gave evidence about the circumstances in which, as a delegate of the Chief Executive Officer of the Australian Aged Care Quality Agency, she instigated the conduct of a review audit by two assessors from 16 to 27 August 2018. She acknowledged, and I find, that:

- the review audit was triggered by the Type 3 referral from the Aged Care Complaints Commissioner relating to Ms Aalberts-Henderson's complaint
- the review audit ultimately led to the decision by the Secretary's delegate, Ms Brammesan, to impose sanctions
- as such, but for Ms Aalberts-Henderson's complaint, it was unlikely that sanctions would have been imposed in late August 2018
- further, the problems at Avondrust leading to those sanctions might not have been identified until sometime later, given that the next assessment contact was not scheduled to take place until October 2018.[505]

Ms Brammesan said that in making her decision to lift the sanctions in January 2019, she did not consult with Ms Aalberts-Henderson.[506] Ms Rosenbrock acknowledged that, for the purposes of indicating where poor care might exist, complaints were 'the most valuable source of information' available to the Commission and its predecessors.[507] The importance of complaints for the regulatory framework demonstrates why complainants should be kept informed of the consequences of their complaints.

Appointment of administrator and adviser

The sanctions imposed on MiCare on 29 August 2018 required MiCare to, among other things, appoint an administrator and a nurse adviser to avoid revocation of its approval as an approved provider. On 31 August 2018, Ms Neeleman advised the Australian Department of Health that MiCare had appointed Ms Coombe of Ansell Strategic as the nurse adviser.[508] On 7 September 2018, Ms Neeleman advised the Australian Department of Health by email that MiCare had changed the administrator, and that Ms Coombe, from Ansell Strategic, would also fill that role.[509]

During the first three to four weeks of Ansell Strategic's appointment as administrator and nurse adviser, Ms Coombe spent one to two days per week on the MiCare engagement. Thereafter, Ms Coombe spent three to four days per fortnight on the engagement.[510] In addition, the Ansell Strategic personnel filling the roles of 'operational nurse adviser' and 'operational administrator' generally each spent three days per week at Avondrust during the period of the sanctions.[511]

Ms Brammesan accepted that the Australian Department of Health had absolutely no say in who MiCare appointed as nurse adviser and administrator to avoid revocation of approved provider status.[512] Ms Brammesan agreed that, since 2016, the Department does not vet the quality of people acting as nurse advisers and administrators.[513] However, the Australian Government clarified in its submissions that the Department does provide 'guidance material' to approved providers regarding the roles and responsibilities of administrators and advisers to assist them in making decisions about suitable personnel for those roles.[514] This material includes information outlining the Department's expectations that the person the approved provider seeks to appoint should have the skills, qualifications and experience to address the areas of non-compliance.[515] We note that that guidance material, including the Department's expectations, does not impose legal obligations on approved providers.

Ms Brammesan also accepted that nurse advisers and administrators had no obligation to give information to the Australian Department of Health or to the Aged Care Quality and Safety Commission.[516] Indeed, the Aged Care Act and the subordinate legislation made under that Act did not stipulate, in any detail, what the role and responsibilities of nurse advisers and administrators are.

On 5 September 2018, Ms Neeleman contacted the Australian Department of Health seeking guidance as to how often the nurse adviser and administrator were to report to the Department, and the details that needed to be reported.[517] A Departmental employee informed Ms Neeleman in a reply email that:

> there are no official guidelines to define the reporting details to the Department. However, as a general guide, once per week Nurse Advisor and/or an Administrator provide a brief verbal (but preferably written) summary / update on the Approved Provider's progress. To ensure that there is no additional reporting burden, usually report is provided in a form of email covering only key progress points, escalating any issues where Department's assistance may be required. Once you finalise the arrangements, you will need to provide a consent authorising advisor and an administrator to engage with the department on your behalf.[518]

The Australian Department of Health subsequently received fortnightly written reports from Ansell Strategic. Ms Coombe provided her first progress report to the Department on 14 September 2018.[519] Before providing the report to the Australian Department of Health, Ms Coombe provided it in draft to Ms Neeleman and others at MiCare and invited comments. In the cover email which attached the draft report, Ms Coombe stated:

> I am happy to have a bit of padding around what Kate has done. We just need to be careful because there are still deficits in the care plans and we don't want to raise the agency's expectations too high.[520]

Ms Coombe stated that she provided the draft report to MiCare before sending it to the Australian Department of Health so that its accuracy could be confirmed.[521] After the first report, Ansell Strategic's reports were mostly one to two pages long.[522]

The appointment of an adviser or administrator or both was an integral part of the sanctions regime under the Aged Care Act, and now under the *Aged Care Quality and Safety Commission Act 2018* (Cth). Until 1 January 2020, section 66-2 of the Aged Care

Act relevantly provided that a sanction of revocation of an approved provider's approval would not take effect where the Secretary permitted the approved provider to appoint an adviser or administrator or both, and the approved provider agreed to do so. It would appear that, in practice, there were very few occasions when, upon the imposition of a sanction of revocation of approval, an approved provider was not first afforded the opportunity to appoint an adviser and an administrator to avoid that revocation.[523] A substantially similar regime continues to exist under section 63U(2) and (3) of the Aged Care Quality and Safety Commission Act.

According to section 66-2 of the Aged Care Act, an adviser was appointed 'to assist the approved provider to comply with its responsibilities in relation to care and services' and an administrator was appointed 'to assist the approved provider to comply with its responsibilities in relation to governance and business operations'.[524] Beyond these general statements, however, the Aged Care Act and relevant subordinate legislation said little, if anything, about the roles, powers, obligations and responsibilities of advisers and administrators. Nothing was said about the qualifications of people appointed to those positions. Other than a person who has been convicted of an indictable offence or is an insolvent under administration or is of unsound mind, anyone can be an adviser or an administrator.[525] The statutory scheme did not confer powers on advisers or administrators. Nothing was said about what, if any, obligations were owed by advisers and administrators to, respectively, approved providers and the Secretary of the Australian Department of Health.

The replacement regime in the Aged Care Quality and Safety Commission Act now enables the Aged Care Quality and Safety Commissioner to notify an approved provider that relevant sanctions will be imposed unless the approved provider appoints an 'eligible adviser' within a specified timeframe. Eligible advisers must have appropriate qualifications, skills or experience to assist the provider to comply with its responsibilities in relation to the care and services it provides, or its governance and business operations.[526] Given the important roles of advisers in the regulatory framework, I consider that there should be greater precision about these matters in the applicable legislation and subordinate legislation.

Approach to compliance at January 2019 audit

The evidence before me indicates that over half of the findings of 'met' expected outcomes in the January 2019 re-accreditation audit documentation rested on reasoning that 'the team was not presented with any evidence indicating that the expected outcome is not met'. I do not regard this form of reasoning to be satisfactory.

Ms Colette Marshall was the team leader of a team of Aged Care Quality and Safety Commission assessors who conducted the re-accreditation audit at Avondrust on 7 and 8 January 2019.[527] She gave evidence about that audit and the findings made by her and the other two assessors, Ms Kathryn Dellar and Ms Bernice Southby.

Like other assessment teams, Ms Marshall, Ms Dellar and Ms Southby were provided with a work pack in the days before their visit to Avondrust.[528] That work pack relevantly contained previous documents prepared by the then Australian Aged Care Quality Agency and, in particular, documents relating to the re-accreditation audit in April 2018, the review audit in August 2018 and subsequent assessment contacts.

Ms Marshall stated that she and her team prepared two documents in respect of this re-accreditation audit: a site audit report and an evidence record.[529] These documents informed the decision-maker about the state of assessed compliance of Avondrust.[530] She also acknowledged that evidence going to the assessors' satisfaction in respect of the template rationales for each expected outcome was separately set out in the evidence record.[531]

Ms Marshall explained that documents such as the site audit report and the evidence record were to be prepared in accordance with the Australian Aged Care Quality Agency's Quality Surveyor Handbook issued in October 2018.[532] In that regard, the Quality Surveyor Handbook relevantly states that:

> The site audit report evidence must include sufficient and relevant evidence that the assessment team considered in the assessment of performance against the Accreditation Standards including information about the care of individual care recipients. The evidence provides information and further explanation to support the relevant rationale statements in the site audit report and allows the Quality Agency to make informed and considered decisions.[533]

Ms Marshall agreed that, as required by the Quality Surveyor Handbook, a site audit report and an evidence record should contain sufficient and relevant evidence considered by an assessment team to assess performance against the Accreditation Standards.[534] She nonetheless conceded that, in the evidence record prepared by her assessment team, 'a very large number' of the expected outcomes were said to be met, together with applicable template rationales being said to be satisfied, on the basis that:

> **Evidence considered in assessment of performance against the standards**
>
> The team was not presented with any evidence indicating that the expected outcome is not met.[535]

Counsel Assisting submitted that this form of reasoning suggests that, in the absence of deficiencies volunteered by an approved provider, regulatory compliance is made out.[536] They further submitted that it is a form of reasoning that is wholly unsatisfactory.[537]

In response, the Australian Government submitted that the use of this 'style of phrasing' was not designed to indicate that assessors assume compliance has been achieved unless they found evidence to the contrary.[538] Rather, it was submitted, the language was designed to capture 'the fact that no adverse evidence had been identified during the course of the assessment that would support a finding that the expected outcome had not been met'.[539] The Australian Government acknowledged that the language used by the assessors did not 'satisfactorily reflect regulatory intent'.[540] Irrespective of what 'regulatory intent' may mean, the assessment set out above does not outline the evidence demonstrating how an expected outcome has been met. Rather, it assumes that an absence of any negative evidence is sufficient to demonstrate that an expected outcome has been met. This approach is concerning, particularly given that the reports of assessors inform decisions about whether to accredit an aged care service for up to three years.

Sustainability of changes at Avondrust

There was evidence in this case study of concerns about the sustainability of changes made by MiCare at Avondrust during the sanctions period. In her memorandum dated 12 February 2019 entitled *Observations of Potential Sanctions Causation Factors—Report DRAFT*, Ms Coombe set out her opinion about the sustainability of changes at Avondrust.[541] She wrote that Ansell Strategic remained concerned that 'the home has not achieved a sustainable level of performance in relation to leadership, lifestyle and clinical management at the home' and that 'The lack of robust clinical processes and reporting provides an ongoing risk for the home…not only in relation to a possible catastrophic clinical event, but also in relation to meeting the new Aged Care Quality Standards'.[542] This memorandum was not provided to or accessed by the Aged Care Quality and Safety Commission assessors.

In her evidence, Ms Coombe said she had concerns about the sustainability of changes at Avondrust around the time of the December 2018 assessment contact and January 2019 re-accreditation audit.[543] She confirmed that she was not asked by anyone from the Australian Department of Health or the Aged Care Quality and Safety Commission in December 2018 or January 2019 for her opinion about the sustainability of changes made at Avondrust.[544] In this regard, she stated that, if she had been asked for her opinion, she would have given it,[545] and specifically she would have indicated the concerns that were outlined in the draft memorandum.[546] Ms Coombe also stated that, by 13 March 2019, she no longer held the same concerns about the sustainability of changes at Avondrust. She said that, by that time, she had been informed that MiCare would be employing a registered nurse manager and a quality, risk and compliance manager.[547] She considered that those prospective changes at Avondrust gave her reassurance.

According to the report prepared by the Aged Care Quality and Safety Commission assessors on the December 2018 assessment contact, they interviewed a number of people at Avondrust at that time.[548] The report does not, however, refer to any interview with the adviser or the administrator appointed by MiCare in connection with the sanctions. In her evidence, Ms Waters, the team leader, said that, 'In retrospect, if I had known she [Ms Coombe] was on site, I would have been interested in speaking to her.'[549]

Ms Marshall said that, while one assessor did speak with a staff member of the adviser and administrator, Ansell Strategic, during the January 2019 re-accreditation audit, that discussion only related to 'standard 3 which covers a range of leisure and lifestyle expected outcomes'.[550] She accepted that clinical care and staffing levels were not discussed with the nurse adviser and administrator.[551]

When asked about Ms Coombe's draft report, Ms Rosenbrock said 'It would absolutely have been very useful to see this document at the time it was written.'[552] Ms Rosenbrock also agreed that, in the circumstances, it would have been useful for Aged Care Quality and Safety Commission assessors to speak with Ms Coombe at the time of the January 2019 re-accreditation audit.[553]

Ms Brammesan also acknowledged that she had not, prior to making her decision to lift sanctions, made contact with the nurse adviser and administrator team at Ansell Strategic or, more specifically, Ms Coombe to discuss the nature and extent of any improvements in the service at Avondrust and the sustainability of those improvements.[554] She agreed that the nurse adviser and administrator would have been a useful source of information for her decision-making at that time.[555] She agreed that, if she had been aware of Ms Coombe's concerns, in January 2019, about an apparent lack of sustainability of improvements at Avondrust, she would have put some stead in that opinion.[556]

Ms Rosenbrock said although the service at Avondrust was re-accredited for a year as a result of the re-accreditation audit in January 2019, the Aged Care Quality and Safety Commission continued to have its own concerns about the sustainability of changes implemented by MiCare.[557] She referred, in particular, to 'some ongoing issues in relation to staffing'.[558] She said that, as a result of those concerns, an assessment contact was scheduled for late April 2019.[559]

Ms Rosenbrock accepted that ongoing complaints about Avondrust raised concerns about the sustainability of changes at Avondrust.[560] She agreed that the complaints in July and August 2019 tended to suggest that 'the concerns that were expressed by Ms Coombe back in February 2019, that she held in January 2019, were warranted'.[561] Even though Ms Coombe held those concerns, the Aged Care Quality and Safety Commission assessors found at the re-accreditation audit on 7 and 8 January 2019 that the service met all 44 out of 44 expected outcomes. Given Ms Coombe's concerns, it is not entirely clear to me why that was so.

Counsel Assisting submitted that, if Ms Coombe had been asked by someone from the Australian Department of Health or Aged Care Quality and Safety Commission, or its predecessor the Australian Aged Care and Quality Agency, for her opinion, she would have informed them of her concerns going to the sustainability of changes at Avondrust that:

- the service had not yet achieved a sustainable level of performance in relation to leadership, lifestyle and clinical management
- the lack of robust clinical processes and reporting was an ongoing risk for the home.[562]

In its submissions, the Australian Government said that it should not be accepted that any greater provision of information by Ms Coombe would necessarily have led to any different outcome.[563] The Australian Government said that this is particularly so where Ms Coombe's conclusions on the level of improvements made by MiCare, and the sustainability of those improvements, changed between her draft report in February 2019 and her final report in March 2019.[564]

In my assessment, Ms Coombe was well placed to offer insights to the assessors during the January 2019 re-accreditation audit. It is reasonable to expect that, where advisers or administrators appointed pursuant to sanctions have spent weeks or months in a facility, they will have significant knowledge of the quality and safety issues at that facility, as well as the suitability and sustainability of changes that have been made to address those

issues. This knowledge would undoubtedly be helpful to those conducting assessments or audits, as well as those making decisions about whether to maintain or lift sanctions.

Notwithstanding the changes Ms Coombe made in the final version of the memorandum dated March 2019, it appears from the draft memorandum of 12 February 2019 that she held concerns about the sustainability of changes at Avondrust at the time of the re-accreditation audit. I decline to speculate on precisely what Ms Coombe might have told the assessors during the audit if they had consulted with her. However, it is notable that Ms Coombe said that she would have indicated the concerns that were outlined in the draft memorandum.

It would have been desirable for the assessors to have sought information from Ms Coombe about her views on the sustainability of changes at Avondrust. In the circumstances of this case, it is of some concern that they did not consult Ms Coombe. It is also of some concern that a residential aged care service can be found to have met all expected outcomes in circumstances where there are concerns held by the adviser and administrator at the time about the sustainability of changes at the service.

I consider that it is reasonable to expect that assessors should take evidence in consultation with advisors and administrators.

The approach to accreditation, assessment and imposition of sanctions is discussed in Chapter 14 of Volume 3, on quality regulation, in Volume 3.

Findings

On the basis of the evidence before the Royal Commission, set out earlier, I find that:

- The review audit conducted by Australian Aged Care Quality Agency assessors in August 2018 was more rigorous in its assessment of compliance by the service at Avondrust with expected outcomes than the April re-accreditation audit had been.
- In preparing re-accreditation audit assessment documentation in April 2018 and January 2019, the assessors made extensive use of computer-generated template reasons.
- The computer-generated template reasons in these re-accreditation audit assessment documents were substantially the same.
- The computer-generated template reasons were ultimately relied upon by those making decisions about whether or not the service at Avondrust should be accredited and, if so, for how long.
- Use of and reliance on computer-generated template reasons has the potential to promote rigidity and inflexibility of reasoning as well as a lack of independent thought by assessors.
- Over half of the findings of 'met' expected outcomes in the January 2019 re-accreditation audit documentation rested on reasoning that 'The team was not presented with any evidence indicating that the expected outcome is not met'.[565] This form of reasoning is unsatisfactory.

- The complaint made by Ms Aalberts-Henderson to the Aged Care Complaints Commissioner triggered the August 2018 review audit and that review audit in turn led to the decision on 29 August 2018 to impose sanctions on MiCare. But for Ms Aalberts-Henderson's complaint, it is unlikely that sanctions would have been imposed until much later than they were.
- Although the sanctions imposed by the Secretary's delegate effectively required appointment by MiCare of a nurse adviser and administrator, neither the Secretary nor anyone else in the Australian Department of Health had any say in who might take on those important roles (other than them not being a disqualified individual).[566]
- During the period of the sanctions imposed on MiCare, the nurse adviser and administrator team at Ansell Strategic, and particularly Ms Coombe, were well placed to form an opinion as to the progress being made at Avondrust to return to compliance with the Quality of Care Principles and the sustainability of any changes at Avondrust.
- In January 2019, Ms Coombe was concerned that the service at Avondrust had not yet achieved a sustainable level of performance in relation to leadership, lifestyle and clinical management and that there was an ongoing risk of a possible catastrophic event due to the lack of robust clinical processes and reporting at Avondrust.
- At all relevant times in 2018 and 2019, nobody from the Australian Department of Health or the Aged Care Quality and Safety Commission, or its predecessor the Australian Aged Care and Quality Agency, asked Ms Coombe or anyone from Ansell Strategic for their opinion about changes to improve clinical care at Avondrust and their sustainability.
- Because Ms Coombe's opinion about the sustainability of changes at Avondrust was not obtained, both the decision on 11 January 2019 to lift sanctions and the decision on 6 February 2019 to re-accredit the service for one year were made without consideration of potentially significant relevant information.
- The decision to lift sanctions was made without any consultation with Ms Aalberts-Henderson.

8.2.3 The Australian Department of Health's response to certain reports of assaults

Introduction

This case study examined the operation of the scheme for compulsory reporting of certain kinds of suspected or alleged assaults in residential aged care facilities.

The compulsory reporting scheme in the Aged Care Act was introduced in 2007 and was overseen by the Australian Department of Health until 1 January 2020. Residential aged care providers were required to make such reports to the police and to the Department. Since 1 January 2020, providers must make such reports to the police and the Aged Care Quality and Safety Commissioner.

In 2017–18, the Australian Department of Health received 4013 notifications of reportable assaults, of which 3773 were deemed as being within the scope of the Aged Care Act.[567]

This case study examined the steps taken on behalf of the Secretary of the Australian Department of Health in relation to 14 reports of reportable assaults in two residential aged care facilities operated by Japara Healthcare Limited, in Victoria.

The reports were made by staff at Japara Bayview, between 15 January 2016 and 2 September 2018, and Japara George Vowell, between 8 December 2016 and 9 May 2019—the Japara Reports.

The Japara Reports include alleged physical and sexual assault by staff members against residents. They include allegations that are serious and concerning.

The hearing also included evidence from other witnesses about recommendations and proposed reform in relation to serious incident reporting in aged care.[568]

The Australian Government and Japara were each granted leave to appear at the public hearing and were represented by counsel and solicitors.

In accordance with the directions made on 9 August 2019 and 15 August 2019, Counsel Assisting provided written submissions setting out the findings they considered should be made on the evidence in this case study.[569]

In response to those submissions, the Royal Commission received submissions from the Australian Government.[570]

The compulsory reporting scheme under the Aged Care Act

Overview of the scheme

The responsibilities of approved providers who operate residential aged care facilities in relation to the reporting of alleged and suspected assaults are set out in section 63-1AA of the Aged Care Act.

A 'reportable assault' is defined in section 63-1AA(9) as follows:

> reportable assault means unlawful sexual contact, unreasonable use of force, or assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory, that is inflicted on a person when:
>
> (a) the person is receiving residential care in respect of which the provider is approved; and
>
> (b) either:
>
> (i) subsidy is payable for provision of the care to the person; or
>
> (i) the person is approved under Part 2.3 as the recipient of that type of residential care.

Before 1 January 2020, section 63-1AA(2) of the Aged Care Act provided:

> If the approved provider receives an allegation of, or starts to suspect on reasonable grounds, a *reportable assault, the approved provider is responsible for reporting the allegation or suspicion as soon as reasonably practicable, and in any case within 24 hours, to:
>
> (a) a police officer with responsibility relating to an area including the place where the assault is alleged or suspected to have occurred; and
>
> (b) the Secretary.

Since 1 January 2020, section 63-1AA(2)(b) refers to the Aged Care Quality and Safety Commissioner.

Pursuant to section 63-1AA(3), the statutory duty to report an allegation or suspicion of a reportable assault does not apply in circumstances specified in the Accountability Principles.

Section 53(1) of the Accountability Principles provides that an approved provider is not required to report an allegation or suspicion of a reportable assault where:

> (a) within 24 hours after the receipt of the allegation, or the start of the suspicion, the approved provider forms an opinion that the assault was committed by a care recipient to whom the approved provider provides residential care; and
>
> (b) before the receipt of the allegation or the start of the suspicion, the care recipient had been assessed by an appropriate health professional as suffering from a cognitive or mental impairment; and
>
> (c) within 24 hours after the receipt of the allegation or the start of the suspicion, the approved provider puts in place arrangements for management of the care recipient's behaviour; and
>
> (d) the approved provider has:
>
> (i) a copy of the assessment or other documents showing the care recipient's cognitive or mental impairment; and
>
> (ii) a record of the arrangements put in place under paragraph (c).

Reports could be made to the Australian Department of Health by completing a reportable assault form or by calling the compulsory reporting telephone line.[571]

Mr Speed explained, in his statement, that approved providers had a responsibility to ensure that staff were trained in how to recognise a situation that may require a compulsory report and how to respond.[572] Reasonable measures had to be taken by approved providers to require that staff members make reports.[573] Approved providers were required to protect the identity of a staff member where the staff member made a disclosure that qualified for protection under the Aged Care Act and ensure the staff member was not victimised.[574]

In his evidence, Mr O'Brien characterised the Australian Department of Health's approach to reports as formerly being 'mainly focused on late reporting and low reporting'. He stated that, since late 2018, the approach was 'now much more focused on the care and wellbeing of the care recipients'.[575]

Purpose of the scheme

The Australian Department of Health's Compulsory Reporting Manual stated that the legislative changes which introduced, among other things, the compulsory reporting requirements:

> acknowledge the government's priority to provide assurance to the Australian community that providers are providing a safe environment for care recipients.[576]

In its written submissions, the Australian Government submitted that the compulsory reporting system is one of a range of processes that are in place to facilitate the safety and wellbeing of residents.[577] It submitted that the purposes of the scheme include:

- placing responsibility on approved providers to provide timely disclosure of reportable assaults occurring within their facilities and keep records of those assaults
- ensuring that residents affected receive prompt and direct support
- ensuring that operational and organisational strategies are put in place by the approved provider to prevent the situation from recurring, to help maintain a safe and secure environment for residents
- ensuring that the appropriate emergency and investigative response is undertaken and those residents affected receive timely assistance, by requiring approved providers to make reports to police.[578]

Based on the evidence relating to the Australian Department of Health's response to reports examined in this case study, it is not apparent that the scheme was an effective mechanism to ensure the safety and wellbeing of residents, either by ensuring an appropriate response to incidents or preventing future incidents. This evidence is discussed in the following sections.

In relation to the points above, it is difficult to see how a requirement to notify the police ensures that residents affected 'receive timely assistance'. In addition, the exemption from reporting allegations of assault by residents who have been assessed as having a cognitive or mental impairment meant the Australian Department of Health did not have any oversight of a significant proportion of assaults against residents in aged care, and limits the extent to which the scheme facilitates the safety and wellbeing of residents.

Further, the scheme has not been an effective mechanism in enabling the Australian Department of Health to identify staff who may be the subject of multiple allegations, particularly where those individuals move between facilities.

It is important that the purposes of any reporting scheme are clear, and that the scheme is designed so that it can effectively achieve those purposes. Our recommendations relating to serious incident reporting are set out in Chapter 14, Volume 3.

Assessment of compulsory reports by the Department

The Australian Department of Health's Compulsory Reporting Manual, which applied from 23 August 2017, set out the following approach for the management and assessment of compulsory reports at the relevant time.[579]

Where a report of a reportable assault was received by the Australian Department of Health, it was recorded as a notification case in the Department's electronic record keeping system, the National Complaint and Compliance Information Management System.[580] All actions, documents, correspondence and decisions relating to the report were required to be recorded.

An Australian Department of Health compulsory reporting officer was required to conduct an assessment of the report. In performing an assessment, compulsory reporting officers were required to identify whether the provider had met its responsibilities under the Aged Care Act, including the timeframe to report to the Department and the police, and the provision of a safe environment.[581] This required the compulsory reporting officer to consider the actions taken by the provider to:

- ensure the health, safety and wellbeing of the care recipient;
- manage or minimise the risk of the circumstances relating to the reportable assault.[582]

The assessment was divided into two phases, being an 'initial assessment' and a 'detailed assessment'.[583] The initial assessment required the compulsory reporting officer to consider whether the approved provider had met its responsibilities outlined above.[584] If the compulsory reporting officer was satisfied that these responsibilities had been met, the detailed assessment did not need to be undertaken. Where insufficient information was provided to make this determination, further information might be sought from the approved provider.[585]

Where it was determined that these responsibilities had not been met, a detailed assessment was required. This required the compulsory reporting officer to consider more specific questions, such as whether the approved provider had been non-compliant with its reporting requirements during the past six months.[586] The detailed assessment also required consideration as to whether a referral should be made on the basis of the information in the report.[587]

If the Australian Department of Health was satisfied that information provided in the report demonstrated that the provider had met its responsibilities under the Aged Care Act and no adverse information was identified, a decision might be made that 'no further action' was required. The report would be closed. [588]

Alternatively, the report might be referred to the Australian Department of Health's Compliance Centre, the then Aged Care Complaints Commissioner or Australian Aged Care Quality Agency, or the Aged Care Quality and Safety Commission.[589]

A report might also be 'escalated' internally. The criteria for escalation included where the issue that was the subject of the report was considered contentious, severe or unusual; presented a concern of high risk to the health, safety or wellbeing of people receiving care; police had charged an individual in relation to the incident; or the incident had resulted, or might result, in media interest, including where representatives of a person receiving care had threatened to approach media.[590]

The Department's handling of the Japara Reports

Counsel Assisting submitted that the following factual findings could be made on the basis of examination of the Australian Department of Health's handling of the 14 Japara Reports:[591]

- None of the 14 Japara Reports examined involving allegations against staff members resulted in a referral to the Aged Care Quality and Safety Commission, including its predecessors, although the Australian Aged Care Quality Agency and the Aged Care Complaints Commission were notified of four reports as part of an information sharing process in late 2016 and early 2017.
- Of the 14 Japara Reports examined involving allegations against staff members, only one was the subject of a detailed assessment.[592]
- It is not apparent from the documents before the Royal Commission what the single detailed assessment conducted entailed, other than ascertaining whether the approved provider had been non-compliant with compulsory reporting requirements during the past six months.[593]
- In assessing each of the Japara Reports, and determining that no further action was required, the Australian Department of Health did not request that the approved provider provide any documentation with respect to internal investigations conducted or actions taken in response to the reportable assault. Where any such documents were provided, this was at the initiative of the approved provider.[594]
- The Australian Department of Health received three reports concerning care worker TD from Japara Bayview, over a three month period, from 15 January 2016 to 16 April 2016. Each of these was the subject of an initial assessment only.
- In deciding that none of these reports concerning care worker TD required further action, the Australian Department of Health did not consider the earlier reports concerning TD, ascertain the outcome of any investigation, and ascertain whether TD was still working at Japara Bayview and what, if any, oversight arrangements had been put in place.
- Until approximately late 2018, the Australian Department of Health did not require approved providers to name alleged victims or alleged offenders as the subject of a report.

In its response to Counsel Assisting's submissions, the Australian Government did not contend that any of these findings proposed by Counsel Assisting should not be made by the Royal Commission.[595] In these circumstances, and having considered the evidence set out above, I make the findings sought by Counsel Assisting.

The discussion in this section focuses on four areas that were explored in this case study:

- the Australian Department of Health's process of assessing reports, in particular the information relied upon in assessments
- the Australian Department of Health's oversight of approved providers' investigations into allegations of reportable assaults
- information sharing, including the use of the process for referrals to the Aged Care Quality and Safety Commission and its predecessors
- the ability of the Australian Department of Health to oversee individuals who were the subject of multiple allegations of assault.

Counsel Assisting submitted that the documentary and oral evidence tendered in this case study shows the process adopted by the Australian Department of Health in relation to the Japara Reports lacked the requisite rigour to ensure the safety and wellbeing of residents the subject of the Reports, or other residents of the Japara facilities concerned.[596] For the reasons set out below, the evidence indicates that the approach adopted by the Department in relation to the Japara Reports operated largely as a ritualistic or 'tick box' process.

In its submissions, the Australian Government focused on reforms that have been implemented, or which were proposed, in relation to the compulsory reporting scheme. This includes six modifications that the Australian Government submitted have been adopted following consideration of the issues raised by this case study.[597]

The Australian Government also submitted that it expects 'significant further modifications' will be implemented with the introduction of the serious incident response scheme, which is discussed elsewhere in this Final Report.

Assessment of reports

The compulsory reporting system, overseen by the Australian Department of Health, placed the responsibility for disclosure of reportable assaults on the approved provider. All of the Japara Reports were closed following an assessment that the approved provider had met its reporting responsibilities and had 'taken reasonable steps to address the issues relating to this reportable assault, and no further action is required by the Australian Department of Health'.[598]

The evidence indicated that when assessing whether reasonable steps had been taken in relation to an incident, the Australian Department of Health relied on the information given by the approved provider.[599] The Department did not make enquiries independently of the provider, for example with the resident, next of kin or other staff.[600]

In his evidence, Mr O'Brien said that when assessing reports, the Australian Department of Health took the approved providers at their word. Mr O'Brien said 'We believe the service. If they tell us they've done these things [taken certain action in response to an incident], we believe what they've advised us.'[601]

For example, if an approved provider stated that a care plan would be reviewed, the Australian Department of Health would not subsequently seek details of what that review entailed, or whether the review has even been conducted.[602]

Indeed, the Australian Department of Health did not take steps to assess the veracity of information from the approved provider in relation to any of the Japara Reports.[603] In addition, as Counsel Assisting observed in their submissions in relation to the Japara Reports, the information provided by Japara in the initial reports, and in response to any requests for further information, was invariably high level and lacking in detail.[604]

For example, a report made by Japara George Vowell, on 8 December 2016, contained the following allegation:

> Male friend of alleged victim advised her family that she had confided to him that she had been slapped by a staff member. She was unable to provide any additional context to the allegation. The family then communicated the allegation to the Facility Manager. Nil injuries noted. The alleged victim does not recall making the allegation.[605]

The report contained no further details about any action taken by the facility. It is unclear from the documents whether the alleged victim had a cognitive impairment. It is also unclear whether the facility conducted an investigation, or otherwise formed a view as to the likely veracity of the allegation. The Australian Department of Health did not appear to have taken any steps to ascertain this information. On the basis of the information before it, the Department concluded that the approved provider had met its reporting responsibilities and had 'taken reasonable steps to address the issues relating to this reportable assault and no further action is required'.[606]

I accept the submission of Counsel Assisting that, in assessing each of the Japara Reports and determining that no further action was required, the Australian Department of Health did not request that the approved provider provide any documentation with respect to internal investigations conducted or actions taken in response to the reportable assault.[607] Where any such documents were provided, this was at the initiative of the approved provider.[608]

In his evidence, Mr Speed agreed with the proposition put by Counsel Assisting that if a request for information by the Australian Department of Health to an approved provider was not recorded in the National Complaint and Compliance Information Management System, it can be inferred that no such request was made.[609] On the evidence before me relating to the Japara Reports, it is apparent that the Department did not make a request to Japara for any documentation of the kind identified by Counsel Assisting.

In these circumstances, I consider there is considerable force in Counsel Assisting's submission that in the case of many of the Japara Reports, it was not apparent how the Australian Department of Health could be satisfied, at anything more than a superficial level, that Japara had taken reasonable steps to address the issues.[610]

Oversight of approved providers' investigations into allegations of reportable assaults

Compulsory reporting officers were not required to investigate the circumstances of an alleged incident that was the subject of a report.[611] Approved providers, or the police, were responsible for investigating alleged incidents.[612]

In a number of the Japara Reports, the approved provider notified the Australian Department of Health in its initial report that it was conducting an investigation into the allegations. In assessing these reports, it is not apparent that the Department considered the nature or adequacy of any investigation conducted by Japara, nor did it have sufficient information to enable it to do so.[613] As set out earlier, the Department did not request documents relating to the investigation in relation to any of the Japara Reports.

Counsel Assisting took Mr O'Brien to a report made by Japara George Vowell on 18 June 2018. The details of the alleged assault were recorded as follows:

> Reported by student on clinical placement that '[PY] was assisting [IC] with his lunch and shovelling large spoons of food into his already full mouth. When he expressed that he didn't want anymore food [PY] quite forcefully slapped her hands on his face (I could hear it from my distance) and said I give up with you. This hand face contact also occurred at lunch on the 13th'.[614]

On 2 August 2018, a compulsory reporting officer sought further information about a number of matters, including the outcome of the investigation.[615] The facility advised that the staff member had been suspended during an investigation but that 'The HR team have investigated thoroughly and could find no evidence to substantiate the claim'.[616]

There is no evidence before the Australian Department of Health indicating what the investigation comprised, or why the facility had concluded the claim could not be substantiated, particularly in circumstances where the provider had notified the Australian Department of Health that it had direct evidence of the alleged assault from a student on clinical placement.

Mr O'Brien agreed that the Australian Department of Health would take at face value that an internal investigation had been conducted and would not seek details as to what the investigation involved, nor make inquiries with the student who alleged that she witnessed the incident.[617]

In its submissions, the Australian Government identified that modifications to its processes in this regard were made since the hearing:

> Compulsory Reporting Officers have been asked to seek further evidence to make an informed decision in completing an assessment…including requesting further details where there is a lack of clarity and details of investigations that approved providers have carried out.
>
> Compulsory Reporting Officers have been asked to request copies of care plans to ensure that the service has complied with section 53 of the Accountability Principles 2014.[618]

The Australian Government also submitted that:

> The Department is also exploring adding further categories of information to be supplied by approved providers in the compulsory report notification form. The Department expects that this information will assist the Commission to conduct further follow-up with residential aged care providers, care recipients and their families.[619]

Unknown outcomes of investigations into allegations of reportable assaults

The evidence in this case study indicated that, in some cases, the Australian Department of Health might have been advised of the outcome of an investigation conducted by the police or the approved provider, or might have sought that information from the approved provider.[620] However, a determination to finalise a report as requiring 'no further action' might be made without the Department being aware of the outcome of the investigation.[621]

In relation to at least five of the Japara Reports, the Australian Department of Health was advised that an investigation was being conducted by Japara but took no steps to ascertain the outcome of the investigation, and finalised the report as requiring 'no further action' without being informed of the outcome.[622]

One example of this approach was a report made by Japara George Vowell on 4 September 2017. The facility notified the Australian Department of Health of an allegation by a resident that a male staff member kissed her and made inappropriate sexual comments to her.[623] The notification entry for this incident states that the resident 'is physically disabled and speech can be difficult to understand but [the resident] is cognitively intact'. The notes record that the resident said that 'in light of the escalation to physical contact…this has made her feel very uncomfortable'.[624]

Information provided to the Australian Department of Health on 6 September 2017 advised that the staff member concerned was currently on leave and that 'upon return from his holiday, he will not be returning to work and will be stood down until investigation has been completed'.[625] An initial assessment was completed by the Australian Department of Health on 6 September 2017, concluding that the approved provider had met its reporting responsibilities and 'taken reasonable steps to address the issues relating to this reportable assault and no further action is required by the department'.[626]

Despite the seriousness of the allegation, the Australian Department of Health appears to have concluded that no further action was required before knowing the outcome of the approved provider's investigation, or the action, if any, taken with respect to the staff member concerned.

When asked by Counsel Assisting about the practice of finalising a report without knowing the outcome of an investigation, Mr O'Brien gave the following evidence:

> the police are responsible for investigating incidents, so we don't necessarily need to know the full outcome of the incident. But, generally, if there is a long delay in processing reports, which has occurred in the past, we would be advised of the outcome of the investigation. But depending if this report was processed close to the incident, the service would still be finalising their investigation, so we wouldn't necessarily know the outcome of the investigation until after the report was assessed.[627]

Mr O'Brien said that 'the main thing is…the service has taken some action to prevent a re-occurrence'.[628] He stated that, where the outcome of an investigation was that the allegation was substantiated, he 'would expect them [the approved provider] to take further disciplinary action', but he accepted that that was not recorded in the documents before the Royal Commission.[629]

Limited use of the detailed assessment process

Counsel Assisting submitted that the documentary and oral evidence before the Royal Commission demonstrates that of the 14 Japara Reports examined involving allegations against staff members, only one was the subject of a 'detailed assessment'.[630] I accept that submission. Each of the other reports was subject to an initial assessment only, the outcome of which was a determination that no further action was required to be taken by the Australian Department of Health.

The report that was the subject of a 'detailed assessment' was given the notification number NF19/002048. This report related to an allegation made by a resident that he was hit in the face by a staff member during the night, resulting in bruising to his eye.[631] The report was made by Japara Bayview on 2 September 2018.[632] On 1 October 2018, the compulsory reporting officer requested further details, in response to which the facility advised that the staff member had been dismissed following an investigation.[633]

On 4 October 2018, the compulsory reporting officer conducted a 'detailed assessment'. In the 'detailed assessment', the compulsory reporting officer recorded that the approved provider had been compliant with the compulsory reporting requirements during the past six months but noted concern 'due to the nature of the incident and also as it appears to have been substantiated'.[634] At the conclusion of the assessment, the compulsory reporting officer proposed that no further action was required. Mr O'Brien approved this assessment on 6 October 2018 and the matter was closed.[635]

Counsel Assisting submitted that it is not apparent from the documents before the Royal Commission what this detailed assessment entailed, other than ascertaining whether the approved provider had been non-compliant with compulsory reporting requirements during the past six months.[636]

The Australian Government submitted that 'whilst the matters considered by the compulsory reporting officer could have been expressed more clearly in the documents, the assessment indicates that the officer considered matters particular to the incident that would be relevant to referring the matter to the Commission'.[637]

Conclusions

It is not apparent how the Australian Department of Health could be satisfied the approved provider had taken reasonable steps to address the issues relating to the incidents that were the subject of the Japara Reports, on the information before it.[638] Without details and relevant documents, it is unclear how the Department was able to assess the suitability of the action taken in response to an incident at anything more than a superficial level.

When asked by Counsel Assisting whether he was satisfied that the Japara Reports were followed up to the extent that he would regard as appropriate for proper public administration, Mr Speed conceded that 'there were opportunities for further follow-up which are not currently available in the compulsory reporting resources'.[639]

In its submissions, the Australian Government stated that more detailed questioning of approved providers in relation to their compulsory reports could be undertaken by Australian Department of Health employees if additional resources were allocated to that function.[640] It submitted that this could lead to further investigations by the Aged Care Quality and Safety Commission in relation to the reports. Counsel Assisting did not seek any specific findings arising out of the case study in relation to the funding of the division of the Australian Department of Health that was responsible for assessing compulsory reports.

Another notable feature of the compulsory reports examined in this case study was the lack of reasons by assessing officers for final decisions, notably decisions that no further action is required. The reportable assault assessment form in evidence, completed by Australian Department of Health officers, did not have any section that would prompt the recording of reasons, but rather allowed officers to simply tick a box.[641]

The recording of reasons is a minimum requirement to ensure transparency and accountability, and it is difficult to see how decisions could have been approved or reviewed in the absence of such reasons.[642]

Information sharing and referrals

Reports made to the Australian Department of Health could be referred to the Aged Care Quality and Safety Commission and, at the time of the earlier Japara Reports, could be referred to the Australian Aged Care Quality Agency or Aged Care Complaints Commissioner.[643] In light of the amendment to section 63-1AA(2)(b) of the Aged Care Act on 1 January 2020, reports are now made directly to the Aged Care Quality and Safety Commissioner, so the issue of referrals must be viewed in this light.

At the time of hearing, the Australian Department of Health's Compulsory Reporting manual provided a list of five instances where a referral to the Quality Agency might be considered, including non-compliance with the scheme, and:

- where a trend of reports had been identified which suggests a possible systemic issue within a service or organisation
- if the issues in the report were severe and particularly concerning; for example, if the report outlined real or potential harm to people receiving care.[644]

In his evidence, Mr O'Brien described the sorts of reports that might be referred to the Aged Care Quality and Safety Commission:

> Generally if a resident is hospitalised, police have charged somebody or may charge somebody, coroner involvement and death, that would definitely be referred. If repeated allegations against the same alleged offender, whether it's a staff member or a resident. Low levels of reporting and late reporting. If there's a bit of a combination. If the service does one late report we probably won't do a referral but if there is a couple in a row that would probably warrant a referral. If the service hasn't reported for five or six years, that might warrant a referral. The particular incident might not but the particular late reporting history for that – or low reporting history for the service might warrant a referral. Sometimes it is just the content or the nature of the allegation or the report that would warrant a referral.[645]

Mr O'Brien said hospitalisation generally resulted in a referral to the Aged Care Quality and Safety Commission, but when asked whether a report that a resident had been punched in the face but not sent to hospital would be referred, Mr O'Brien responded 'Possibly. It could be considered but not necessarily.'[646] I note that there are a range of reasons why hospitalisation may or may not occur, and query the apparent prominence of this factor in decision-making about referrals.

In its submissions, the Australian Government described the Aged Care Quality and Safety Commission as playing a 'complementary' role to the Australian Department of Health in monitoring compliance with the compulsory reporting scheme.[647] It submitted that the compulsory reporting team was 'an important data source' to the Australian Department of Health and the Aged Care Quality and Safety Commission.[648]

However, on the evidence tendered as part of this case study, the referral process did not appear to have been used often. I accept the submission of Counsel Assisting that none of the 14 Japara Reports examined, involving allegations against staff members, resulted in a referral to the Aged Care Quality and Safety Commission or its predecessors. An information sharing process did take place in late 2016 and early 2017, which resulted in the Australian Aged Care Quality Agency and Aged Care Complaints Commissioner being notified of four of the reports.

When asked by Counsel Assisting about particular Japara Reports, Mr O'Brien identified a number that he considered would have warranted a referral to the Aged Care Quality and Safety Commission, based on the Australian Department of Health's risk settings at the time of the hearing.[649]

Mr O'Brien said the approach to referrals had changed gradually over the 17 months he had been in the Australian Department of Health. He stated that referrals were previously:

> mainly focused on late reporting and low reporting. We're now much more focused on the care and wellbeing of the care recipients and that as a gradual change probably from late 2018. And we're now doing— last financial month we did 80 referrals per month, compared to 32 the previous financial year. So you can see that there's a lot more referrals done and much more focused on care and wellbeing of the recipients and that probably started late in 2018.[650]

The Australian Government submitted that, as part of its reforms relating to the compulsory reporting scheme, it was working towards better alignment and sharing of data between the Australian Department of Health and the Aged Care Quality and Safety Commission.[651] It also stated that following consideration of the issues raised by this case study, the Department was 'progressing business enhancement to the National Complaint and Compliance Information Management System data reporting function to enable data analysis and the early identification of trends'.[652]

Staff who are the subject of multiple allegations

Until about October or November 2018, the Australian Department of Health did not require approved providers to name alleged victims or alleged offenders who were the subject of a report.[653]

Documentary evidence was produced to the Royal Commission about three reports of physical assault received by the Australian Department of Health from Japara Bayview over a three-month period from 15 January 2016 to April 2016. Each concerned a personal care worker at Japara Bayview, referred to in this case study as TD.

The three reports recorded the following allegations:

- While assisting a resident to change into her pyjamas, TD forced her head down, causing 'terrible pain'[654]
- TD threw a call bell at a resident, causing pain to her knee[655]
- TD slapped a resident across her face.[656]

On each occasion, Japara advised the Australian Department of Health that TD had been suspended and Japara had commenced an internal investigation.[657]

The notification entry completed by the Australian Department of Health in relation to the first report included TD's name and noted that TD had also been the subject of a separate report the previous year.[658] It appears on the documents that the approved provider was not required to provide TD's name to the Australian Department of Health in relation to the second and third reports. Neither of the subsequent reports named TD, nor referred to the 2015 report. None of the documents relating to the reports involving TD identify that the three reports related to the same alleged offender.

Each of the three reports was the subject of an initial assessment only. The documents before the Royal Commission indicate that, at the conclusion of each assessment, the Australian Department of Health determined that no further action was required.[659]

In relation to the report alleging that TD threw a call bell at the resident concerned, Mr O'Brien was asked by Counsel Assisting whether he would feel comfortable making a determination that appropriate steps had been made to ensure the health, safety and wellbeing of the resident, based on the documents before the Royal Commission. Mr O'Brien said 'with our current lens on, I wouldn't put that through in its current form'.[660]

It is concerning that, despite receiving three reports from Japara Bayview that care worker TD had assaulted residents over a period of around three months, no follow-up steps were taken by the Australian Department of Health. This is despite the Department's manual at the time identifying just this type of case as being appropriate for referral to the Australian Aged Care Quality Agency.[661]

I consider that one consequence of the Australian Department of Health's earlier approach, of not requiring approved providers to name alleged offenders in their reports, was that alleged offenders who were the subject of multiple allegations were not identified by the Australian Department of Health.

When asked whether, as a matter of course, Australian Department of Health staff would check whether an alleged offender had previously been the subject of a report, Mr O'Brien said that staff 'wouldn't necessarily look at the reporting history of the service' when undertaking an initial assessment.[662]

As set out above, Counsel Assisting submitted that the evidence in this case study demonstrates that in deciding that none of the three reports concerning TD required further action, the Australian Department of Health did not:

- consider the earlier reports concerning TD, with the exception of the reference to a 2015 allegation in the notification entry for the first report
- ascertain the outcome of any investigation conducted by Japara Bayview
- take steps to ascertain whether TD was still working at Japara Bayview and what, if any, oversight arrangements had been put in place in relation to him.[663]

In its submissions, the Australian Government acknowledged that further follow-up could and should have occurred in respect of these reports.[664] I agree.

Following the hearing, Counsel Assisting also submitted that the Australian Department of Health had no system for flagging staff members who have been the subject of multiple allegations, or one or more substantiated allegations.[665]

The Australian Government submitted that I should not make this finding sought by Counsel Assisting. It submitted that policy and practices, in place at the time of its written submissions, required compulsory reporting officers to review previous reports made in relation to a service to check whether the alleged offender or victim had been named in any previous reports.[666] Where multiple reports were identified, a detailed assessment would be undertaken and the report would be referred to the Aged Care Quality and Safety Commission.[667] The Australian Government submitted that one of the modifications made following this case study was to require compulsory reporting officers to record the name of alleged offenders and victims on the 'front screen' of the National Complaint and Compliance Information Management System record for the relevant service, to facilitate identification of previous reports involving the same individuals.[668]

This development notwithstanding, it remained the case on the evidence, that the Australian Department of Health had no system for identifying staff members who had been the subject of multiple allegations, or one or more substantiated allegations, across different residential aged care facilities. Whether the transfer of responsibilities to the Aged Care Quality and Safety Commission, on 1 January 2020, has resulted in any material change is an open question.

In some of the Japara Reports, a staff member who was the subject of an allegation of assault resigned prior to the conclusion of the approved provider's investigation.[669] In other instances, the staff member's employment was terminated, due to a finding by the approved provider that the allegations were substantiated.[670]

Mr O'Brien said that, as far as he was aware, where a staff member's employment was terminated following an investigation into a reportable assault, the Australian Department of Health did not take any steps to record that staff member's name, or otherwise flag that the individual might be of concern.[671]

Mr O'Brien's evidence was that the Australian Department of Health was unable to ascertain whether an alleged offender had been the subject of one or more previous reports at a different facility.[672] He said that the Department was limited to looking at the history of a particular facility and accepted that, where a staff member moved to another service, the Department was unable to determine whether that individual had been the subject of a previous report at a different facility.

Where a staff member was dismissed on the basis that an allegation of assault was substantiated, it is concerning that the Australian Department of Health appears to have had no mechanism for flagging the staff member as a person of concern.[673]

When asked by Counsel Assisting whether the Australian Department of Health should maintain a register of alleged or suspected perpetrators of assaults, Ms Amy Laffan, of the Australian Department of Health, stated 'it would be something that would be useful, but I can see a number of implementation issues that would need to be considered and resolved before such a system would be able to be in place'.[674] In its written submissions, the Australian Government acknowledged the merit in establishing a register of care workers 'to identify, earlier and more accurately, any patterns of reportable assaults committed by the same care worker'.[675] The topic of aged care worker registration is explored in Volume 3, in Chapter 12).

Endnotes

1 As part of the Australian Government's response to recommendations in the *Review of National Aged Care Quality Regulatory Processes*, conducted by Ms Kate Carnell and Professor Ron Paterson (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).
2 *Aged Care Quality and Safety Commission Act 2018* (Cth).
3 *Aged Care Legislation Amendment (New Commissioner Functions) Act 2019* (Cth).
4 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0003 [3a].
5 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0003 [3a].
6 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833; Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4592.13–14.
7 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4591.25–30.
8 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4591.38–41.
9 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4369.1–14; T4369.22–25.
10 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4371.1–9.
11 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4505.22–4506.3; Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0009–0014 [28]–[49]; 0015–0019 [52]–[70].
12 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4415.39–41.
13 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4416.2–5.
14 Transcript, Brisbane Hearing, Peter Gray QC, 9 August 2019 at T4798.25–26.
15 Transcript, Brisbane Hearing, Peter Gray QC, 9 August 2019 at T4798.40–41.
16 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4591.25–28.
17 Exhibit 8-30, Brisbane Hearing, Statement of Ann Wunsch, WIT.0283.0001.0001 at 0004 [17]; Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4411.27–28; T4411.45–4412.7.
18 Exhibit 8-30, Brisbane Hearing, Statement of Ann Wunsch, WIT.0283.0001.0001 at 0007 [30].
19 Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0001 [9].
20 Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0002 [11]–0003 [13].
21 Transcript, Brisbane Hearing, Anthony Speed, 7 August 2019 at T4523. 39–42.
22 Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0006 [33].
23 Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0004 [18].
24 Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0003 [14].
25 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4412.43–4413.28; Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0004 [15].
26 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4415.23–24.
27 Transcript, Brisbane Hearing, Anthony Speed, 6 August 2019 at T4414.26–28.
28 Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0001 [9]; 0007 [41].
29 Exhibit 8-22, Brisbane Hearing, Statement of Elsy Brammesan, WIT.0306.0001.0001 at 0007 [36]; Exhibit 8-40, Brisbane Hearing, Statement of Shona Reid, WIT.0307.0001.0001 at 0011 [39].
30 Exhibit 8-25, Brisbane Hearing, Statement of Anthony Speed, WIT.0337.0001.0001 at 0007 [40].
31 Exhibit 8-40, Brisbane Hearing, Statement of Shona Reid, WIT.0307.0001.0001 at 0011 [39].
32 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4414.26–45.
33 Exhibit 8-22, Brisbane Hearing, Statement of Elsy Brammesan, WIT.0306.0001.0001 at 0013 [73]; Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4414.1–11.
34 Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [75]; 0013 [88].
35 Transcript, Brisbane Hearing, Sarah Holland-Batt, 7 August 2019 at T4573.4–4576.9.
36 Exhibit 8-39, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [46].
37 Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0003 [16].
38 Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0005 [31].
39 Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0009 [54].
40 Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0011 [74]; Exhibit 8-39, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [48], [50].
41 Transcript, Brisbane Hearing, Sarah Holland-Batt, 7 August 2019 at T4575.33–40.
42 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4714.38–4715.8.
43 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4705.46–4706.3.
44 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4715.1–8.
45 Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4755.46–4756.17.
46 Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4764.10–18.
47 Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4739.16–19; T4740.19–23; T4761.18–22.
48 Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Rowe, WIT.0319.0001.0001 at 0020 [12].
49 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4708.27–32.
50 Transcript, Brisbane Hearing, Beverley Johnson, 8 August 2019 at T4697.12–21.
51 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4580.9–14.

52 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0002 [15].
53 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4709.36–4710.3.
54 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4703.41–43.
55 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4704.35–36.
56 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4705.376–39.
57 Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0009 [53].
58 Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0011 [64].
59 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4627.14–17; Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4666.7–11.
60 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4627.32–35.
61 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4627.37–46.
62 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4627.41–46.
63 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4627.45–46.
64 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4666.20–22.
65 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4666.45–4667.1.
66 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4667.6–9.
67 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4667.11–27.
68 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4667.29–32.
69 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4666.30–34.
70 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4666.40–43.
71 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4667.40–45.
72 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0015 [18f].
73 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0001 [9]–[10].
74 Transcript, Brisbane Hearing, Valerie Braithwaite, 9 August 2019 at T4784.14–19; Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0004 [5a].
75 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0004 [5a].
76 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4587.1–4.
77 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4592.30–4593.18.
78 Transcript, Brisbane Hearing, John Braithwaite, 9 August 2019 at T4794.35–37.
79 Transcript, Brisbane Hearing, John Braithwaite, 9 August 2019 at T4788.1–2.
80 Transcript, Brisbane Hearing, John Braithwaite, 9 August 2019 at T4794.44–47.
81 Transcript, Brisbane Hearing, Graeme Head, 8 August 2019 at T4677. 4–11.
82 Transcript, Brisbane Hearing, Graeme Head, 8 August 2019 at T4680.40–42.
83 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4579.27–30.
84 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1948.
85 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4583.1–2; T4583.40.
86 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0013 [14a].
87 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0003 [3b].
88 Transcript, Brisbane Hearing, John Braithwaite, 9 August 2019 at T4787.45–4788.5.
89 Transcript, Brisbane Hearing, Valerie Braithwaite, 9 August 2019 at T4784.20–24.
90 See, in particular, Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0013 [87]—0014 89]; Exhibit 8-34, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [46], [49].
91 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0001 [9].
92 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0001 [11].
93 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4778.32–34.
94 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0004 [21]–[24].
95 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4769.28–34.
96 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4770.21–31.
97 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4770.36–38.
98 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4771.39–43.
99 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0007 [6i].
100 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0003 [28].
101 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0007 [37].
102 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0007 [38].
103 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0004 [39].
104 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 8, CTH.0001.7100.0127 at 0138.
105 Exhibit 8-42, Brisbane Hearing, Open Disclosure Framework and Guidance produced by the Aged Care Quality and Safety Commission, RCD.9999.0173.0001.
106 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4778.9–12.

107 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0014–0015 [18b].
108 Exhibit 8-34, Brisbane Hearing, Statement of Graeme Head, WIT.0291.0001.0001 at 0015 [57].
109 Exhibit 8-34, Brisbane Hearing, Statement of Graeme Head, WIT.0291.0001.0001 at 0025–0026 [96c]; Exhibit 8-35, Brisbane Hearing, NDIS Quality and Safeguards Commission Information Paper and attachments, Attachment B, RCD.9999.0166.0138.
110 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4423.17–23.
111 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4778.14–18.
112 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4580.9.
113 Transcript, Brisbane Hearing, Graeme Head, 8 August 2019 at T4671.22–25.
114 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0008 [6l]; Transcript, Valerie Braithwaite, Brisbane Hearing, 9 August 2019 at T4793.45–4794.4.
115 Transcript, Brisbane Hearing, Valerie Braithwaite, 9 August 2019 at T4794.17–18.
116 Exhibit 8-44, Brisbane Hearing, Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai, RCD.9999.0149.0001 at 0010 [10c].
117 Transcript, Brisbane Hearing, Valerie Braithwaite, 9 August 2019 at T4794.18–27.
118 Transcript, John Braithwaite, Brisbane Hearing, 9 August 2019 at 4795.21–23.
119 Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0009 [52].
120 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019, T4715.30–33.
121 Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019, T4705.46–4706.3.
122 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4596.16–28.
123 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4596.35–36.
124 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4596.19–23.
125 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4597.17–24.
126 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4597.33–36.
127 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0002 [17].
128 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4777.20–21.
129 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0009 [55].
130 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4773.16–30.
131 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0010 [56].
132 Transcript, Brisbane Hearing, Graeme Head, 8 August 2019 at T4678.9–27.
133 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4701.35–T4702.11.
134 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4700.39–4701.29.
135 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4702.20–29.
136 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4702.33–39.
137 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4716.17–18.
138 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4706.17–24.
139 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4716.6–10.
140 Transcript, Brisbane Hearing, Natalie Siegel-Brown, 8 August 2019 at T4716.1–4.
141 Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4747.45–4748.9.
142 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833.
143 Transcript, Brisbane Hearing, Senior Counsel Assisting, Peter Gray QC, 9 August 2019 at T4797.41–46.
144 Submissions of the Commonwealth of Australia, Brisbane Hearing, 4 September 2019, RCD.0012.0028.0011 at 0014 [8].
145 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0004 [31].
146 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4636.20–23.
147 Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0002 [11].
148 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4636.4–14; Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0002 [12].
149 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1922–1927.
150 Exhibit 3-2, Sydney Hearing, general tender bundle, tab 39, CTH.1000.0002.6501 at 6513.
151 Exhibit 3-2, Sydney Hearing, general tender bundle, tab 39, CTH.1000.0002.6501 at 6513.
152 Exhibit 3-2, Sydney Hearing, general tender bundle, tab 39, CTH.1000.0002.6501 at 6513.
153 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4640.43–46.
154 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4640.46–4641.24.
155 Submissions of the Commonwealth of Australia, Brisbane Hearing, 4 September 2019, RCD.0012.0028.0011 at 0018 [23].
156 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4588.21–34.
157 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4588.41–4589.2.
158 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4641.6–7.
159 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1937.
160 Exhibit 3-2, Sydney Hearing, general tender bundle, tab 39, CTH.1000.0002.6501 at 6514.
161 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4642.38.
162 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4642.45–4643.9.

163 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4643.9–11.
164 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4643.28–32.
165 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4643.34–38.
166 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1937.
167 Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0003–0004 [22].
168 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4595.27–34.
169 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4645.36.
170 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4645.27–31.
171 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4645.1–5.
172 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4645.36–37.
173 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4646.11–19.
174 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4646.23–30; Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1978.
175 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1937.
176 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4647.5–46.
177 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4595.1–8.
178 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4647.1–3.
179 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4647.30–4648.11.
180 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1959.
181 Exhibit 1-27, Adelaide Hearing 1, Elder Abuse – A National Legal Response, RCD.9999.0011.0302.
182 Exhibit 1-27, Adelaide Hearing 1, Elder Abuse – A National Legal Response, RCD.9999.0011.0302 at 0315.
183 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0003 [14].
184 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0004 [20].
185 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 89, CTH.1016.1006.2900; Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0004 [21].
186 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 99, CTH.1016.1006.7401 at 7403.
187 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 106, RCD.9999.0123.0001 at 0005–0006.
188 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 106, RCD.9999.0123.0001 at 0006.
189 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0012 [56].
190 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0012 [56].
191 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0010 [46].
192 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0011 [49c].
193 Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0013 [57].
194 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 117A, RCD.9999.0174.0021.
195 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4660.6–7.
196 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4665.29–35; T4665.39–43.
197 Transcript, Brisbane Hearing, Peter Gray QC, 9 August 2019 at T4798.1–2.
198 Submissions of the Commonwealth of Australia, Brisbane Hearing, 4 September 2019, RCD.0012.0028.0011 at 0021–22 [39].
199 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1971.
200 See, Part 4A as inserted, commencing on 1 July 2019, by the *Quality of Care (Minimising the Use of Restraints) Principles 2019* (Cth); *Quality of Care Amendment (Reviewing Restraints) Principles 2019* (Cth), which commenced on 29 November 2019.
201 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4600.30–36.
202 Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4600.38–47.
203 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4657.6–10.
204 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4656.32–4657.4.
205 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4656.12–24.
206 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0005 [33].
207 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001.
208 Submissions of Telecia Tuccori, Brisbane Hearing, Earle Haven Case Study, 2 September 2019, RCD.0012.0027.0001; Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024; Submissions of Queensland Health, Queensland Ambulance Service and Gold Coast Hospital and Health Service Brisbane Hearing, Earle Haven Case Study, 5 September 2019, RCD.0012.0029.0005.
209 Transcript, Brisbane Hearing, Peter Gray QC, 5 August 2019 at T4175.1–8.
210 Exhibit 8-10, Brisbane Hearing, Statement of Arthur Miller, WIT.0349.0001.0001 at 0001–0002 [5].
211 Exhibit 8-10, Brisbane Hearing, Statement of Arthur Miller, WIT.0349.0001.0001 at 0001 [4].
212 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 1, CTH.1021.1001.0464 at 0489–0501.
213 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 1, CTH.1021.1001.0464 at 0517.
214 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 1, CTH.1021.1001.0464 at 0490.

215 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4250.21–23; Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 100, CTH.4010.2000.0678; tab 24, CTH.4010.1019.3391.
216 Exhibit 8-9, Brisbane Hearing, Statement of Bruce Lang, WIT.0358.0001.0001 at 0001 [2], [5].
217 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 59, CTH.4000.1019.8110 at 8111.
218 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 62, HSH.9999.0001.0001 at 0002 [10].
219 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 83, PCP.9999.0002.0037 at 0039.
220 Transcript, Brisbane Hearing, Bruce Lang, 5 August 2019 at T4223.34–38.
221 Transcript, Brisbane Hearing, Bruce Lang, 5 August 2019 at T4223.27.
222 Exhibit 8-11, Brisbane Hearing, Statement of Kristofer Bunker, WIT.0350.0001.0001 at 0001 [4].
223 Exhibit 8-11, Brisbane Hearing, Statement of Kristofer Bunker, WIT.0350.0001.0001 at 0001 [6].
224 Exhibit 8-11, Brisbane Hearing, Statement of Kristofer Bunker, WIT.0350.0001.0001 at 0002 [7]–[8].
225 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 64, PCP.9999.0001.0001; tab 69, PCP.9999.0002.0001.
226 Exhibit 8-11, Brisbane Hearing, Statement of Kristofer Bunker, WIT.0350.0001.0001 at 0001 [3].
227 Exhibit 8-4, Brisbane Hearing, Statement of Telecia Tuccori, WIT.0326.0001.0001 at 0002 [11].
228 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 82, PCP.9999.0001.0180; tab 69, PCP.9999.0002.0001; tab 83, PCP.9999.0002.0037.
229 Exhibit 8-13, Brisbane Hearing, Notice of disqualification from managing corporations issued by Delegate of the Australian Securities and Investments Commission relating to Kristofer Andrew Bunker, 27 June 2018, RCD.9999.0164.0001.
230 Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4245.15–17.
231 Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4245.25–32.
232 Exhibit 8-5, Brisbane Hearing, Statement of Karen Heard, WIT.0206.0001.0001 at 0001 [2]–[5].
233 Exhibit 8-4, Brisbane Hearing, Statement of Telecia Tuccori, WIT.0326.0001.0001 at 0002 [11e].
234 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0002 [4.5].
235 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0001 [3].
236 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4198.18–20.
237 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0001–0002 [4].
238 Exhibit 8-4, Brisbane Hearing, Statement of Telecia Tuccori, WIT.0326.0001.0001 at 0001 [5].
239 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4193.6–9.
240 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4197.24.
241 Transcript, Brisbane Hearing, Arthur Miller, 5 August 2019 at T4228.45–4229.1.
242 Transcript, Brisbane Hearing, Arthur Miller, 5 August 2019 at T4229.7–14.
243 Transcript, Brisbane Hearing, Arthur Miller, 5 August 2019 at T4234.40–44.
244 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 76, CTH.4010.3100.0130 at 0130.
245 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 76, CTH.4010.3100.0130 at 0132.
246 Transcript, Brisbane Hearing, Arthur Miller, 5 August 2019 at T4229.42–45.
247 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4194.42–45.
248 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 89, CTH.4010.9000.2056 at 2056.
249 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 90, PCP.9999.0001.0182.
250 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 90, PCP.9999.0001.0182.
251 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 96, PCP.9999.0001.0184.
252 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 97, PCP.9999.0001.0096 at 0098.
253 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 97, PCP.9999.0001.0096 at 0098.
254 Transcript, Brisbane Hearing, Arthur Miller, 5 August 2019 at T4232.3–5.
255 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4198.3–33; Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4245.45–T4246.42; Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0234.
256 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0236.
257 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4199.1–30.
258 Transcript, Brisbane Hearing, Telecia Tuccori, 5 August 2019 at T4215.15–20.
259 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0234.
260 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0234.
261 Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4246.16–22.
262 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0018 [69].
263 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0018 [69].
264 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 98, PCP.9999.0001.0176.
265 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0019 [75].
266 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0235.
267 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0235.
268 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 62, HSH.9999.0001.0001 at 0002.
269 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0234–0235.
270 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0235.
271 Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4238.24–25; T4239.10–12.
272 Exhibit 8-4, Brisbane Hearing, Statement of Telecia Tuccori, WIT.0326.0001.0001 at 0003 [18].

273 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4200.11–33; Exhibit 8-4, Brisbane Hearing, Statement of Telecia Tuccori, WIT.0326.0001.0001 at 0003 [18].
274 Transcript, Brisbane Hearing, Telecia Tuccori, 5 August 2019 at T4209.8–45.
275 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0019 [78].
276 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0019 [79]–0020 [80].
277 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4201.20–22.
278 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0020 [80].
279 Transcript, Brisbane Hearing, Telecia Tuccori, 5 August 2019 at T4210.1–14.
280 Transcript, Brisbane Hearing, Telecia Tuccori 5 August 2019 at T4210.32–35.
281 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0233.
282 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 102, PCP.9999.0002.0233 at 0233.
283 Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4240.20–24.
284 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4203.44–46.
285 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4204.21–4205.46.
286 Exhibit 8-3, Brisbane Hearing, Statement of Karen Parsons, WIT.0327.0001.0001 at 0020 [80].
287 Exhibit 8-5, Brisbane Hearing, Statement of Karen Heard, WIT.0206.0001.0001 at 0001 [8].
288 Exhibit 8-5, Brisbane Hearing, Statement of Karen Heard, WIT.0206.0001.0001 at 0002 [9].
289 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4202.38–44.
290 Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4241.44–47; T4242.8.
291 Transcript, Brisbane Hearing, Kristofer Bunker, 5 August 2019 at T4243.19–33.
292 Exhibit 8-8, Brisbane Hearing, Photograph dated 11 July 2019 at 12.10pm, RCD.9999.0163.0012.
293 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0002 [12]; Transcript, Brisbane Hearing, Cary Strong, 5 August 2019 at T4183.4–13.
294 Exhibit 8-6, Brisbane Hearing, Statement of Karen Heard, WIT.0206.0002.0001 at 0004 [16]–[18].
295 Transcript, Brisbane Hearing, Karen Parsons, 5 August 2019 at T4203.31.
296 Transcript, Brisbane Hearing, Telecia Tuccori, 5 August 2019 at T4213.8.
297 Transcript, Brisbane Hearing, Arthur Miller, 5 August 2019 at T4234.8–11.
298 Transcript, Brisbane Hearing, Arthur Miller, 5 August 2019 at T4234.16–17.
299 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 109, RCD.9999.0154.0001.
300 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 109, RCD.9999.0154.0001.
301 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 109, RCD.9999.0154.0001.
302 Transcript, Brisbane Hearing, Cary Strong, 5 August 2019 at T4182.12–13; Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0002 [18a], 0003 [20].
303 Australian Securities and Investments Commission, *Search ASIC Registers*, 2019, https://connectonline.asic.gov.au, viewed 2 December 2019.
304 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 120, WIT.0322.0001.0001 at 0002 [13c].
305 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0002 [15]; Transcript, Brisbane Hearing, Cary Strong, 5 August 2019 at T4181.21–23.
306 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0002 [16]–[17].
307 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0002–0003 [18].
308 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0003 [18d].
309 Transcript, Cary Strong, Brisbane Hearing, 5 August 2019 at T4185.46–4186.2.
310 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0003 [20].
311 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0002 [16], 0003 [20].
312 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0002 [16].
313 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0003 [20].
314 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0002 [9].
315 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0003 [14].
316 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 122, WIT.0321.0001.0001 at 0004 [14].
317 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0075.
318 Transcript, Brisbane Hearing, Cary Strong, 5 August 2019 at T4185.13–21.
319 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0075.
320 Exhibit 8-2, Brisbane Hearing, Statement of Cary Strong, WIT.0325.0001.0001 at 0004 [25]; Transcript, Brisbane Hearing, Cary Strong, 5 August 2019 at T4188.6–17.
321 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0077.
322 Transcript, Brisbane Hearing, Cary Strong, 5 August 2019 at T4189.7–9.
323 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0081.
324 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0005 [33].
325 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 121, WIT.0324.0001.0001 at 0082.
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328 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0059 [203].

329 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0059 [203].
330 Transcript, Brisbane Hearing, Anthony Speed, 5 August 2019 at T4288.35–4289.4.
331 Transcript, Brisbane Hearing, Anthony Speed, 7 August 2019 at T4543.17–4544.10; T4545.19–30; T4546.32–4547.7.
332 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0028 [12b].
333 MyAgedCare, *Notices of Non-compliance and Sanctions in People Care Pty Ltd (formerly Hibiscus House Nursing House)*, 2019, https://www.myagedcare.gov.au/non-compliance-checker/details-provider/1-DS-531/1-EG-2288, viewed 10 March 2020; MyAgedCare, *Notices of Non-compliance and Sanctions in People Care*, 2019, https://www.myagedcare.gov.au/non-compliance-checker/details-provider/1-DS-531/1-KLL-157, viewed 10 March 2020.
334 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 5, CTH.1021.1001.0166.
335 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 18, CTH.1002.1016.2483.
336 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 47, CTH.1002.1002.0078.
337 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 117, CTH.1021.1000.0215.
338 MyAgedCare, *Notices of Non-compliance and Sanctions in People Care*, 2019, https://www.myagedcare.gov.au/non-compliance-checker/details-provider/1-DS-531/1-KLL-157, viewed 10 March 2020.
339 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 24, CTH.4000.1019.3391; tab 66, CTH.4000.1003.5269; tab 100, CTH.4010.2000.0678.
340 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 4, CTH.1021.1001.0361 at 0363.
341 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 4, CTH.1021.1001.0361 at 0363.
342 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle tab 4, CTH.1021.1001.0361 at 0369.
343 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4253.35–47.
344 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 17, CTH.1002.1001.1753 at 1764.
345 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 17, CTH.1002.1001.1753 at 1757.
346 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 66, CTH.4000.1003.5269 at 5273.
347 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 18, CTH.1002.1016.2483 at 2486.
348 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 38, CTH.1002.1001.2667 at 2667.
349 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 45, CTH.1002.1001.2679 at 2679.
350 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 47, CTH.1002.1002.0078.
351 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 47, CTH.1002.1011.0078 at 0079–0080.
352 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 48, CTH.1002.1011.3312 at 3323.
353 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 21, CTH.4000.1012.3959 at 3959.
354 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4262.27–28.
355 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4262.30–36.
356 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 11, CTH.4000.1000.0188.
357 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 11, CTH.4000.1000.0188.
358 Transcript, Brisbane Hearing, Anthony Speed, 5 August 2019 at T4286.5–4287.9.
359 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0028 [12b].
360 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 19, CTH.1002.1016.0498.
361 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 23, CTH.1002.1001.1835 at 1836.
362 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 23, CTH.1002.1001.1835 at 1836.
363 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle tab 25, CTH.4000.1012.4849; tab 26, CTH.4000.1012.4851; tab 27, CTH.4000.1012.4853.
364 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 27, CTH.4000.1012.4853.
365 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4263.29–4264.4; T4264.24–4265.5.
366 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4265.28–33.
367 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 23, CTH.1002.1001.1835 at 1838.
368 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 23, CTH.1002.1001.1835 at 1836.
369 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0013–0014 [43].
370 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0028 [12b].
371 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0027 [10].
372 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0025 [2].
373 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 56, CTH.4000.1019.7777 at 7782.
374 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 57, CTH.1002.1011.8483 at 8483.
375 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 58, CTH.1002.1011.8491 at 8491.
376 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 59, CTH.4000.1019.8110 at 8111.
377 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 65, CTH.4000.1000.1987 at 1992; tab 72, CTH.4010.2000.0289 at 0292.
378 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 110, CTH.1019.1011.0155 at 0156, 0158.
379 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0053 [180]–0054 [183].

380 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 78, CTH.4010.9000.0210 at 0210.
381 Exhibit 8-1 Brisbane Hearing, Earle Haven tender bundle, tab 86, CTH.4010.9999.0007.
382 Exhibit 8-1 Brisbane Hearing, Earle Haven tender bundle, tab 79, CTH.4010.9000.0294 at 0294.
383 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 84, CTH.4010.7001.0530 at 0530–0531.
384 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 89, CTH.4010.9000.2056 at 2056.
385 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4273.26–39.
386 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0045 [150].
387 Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4764.46–4765.4.
388 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0025 [12d].
389 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 94, CTH.4010.3200.0145 at 0145.
390 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 95, CTH.4010.2000.0708 at 0712–0716.
391 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4623.15–24.
392 Exhibit 3-75, Sydney Hearing, Statement of Christina Bolger, WIT.0106.0001.0001 at 0005–0006 [22]–[23].
393 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4624.32–39.
394 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0046 [156].
395 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0028 [13a].
396 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 12, CTH.1002.1001.1335 at 1338.
397 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 31, CTH.1002.1001.1316 at 1316.
398 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 31, CTH.1002.1001.1316 at 1317.
399 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 68, CTH.1019.1002.0057.
400 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 73, CTH.10021018.1400.
401 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 75, CTH.1019.1006.0628 at 0629–0630.
402 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 77, CTH 1019.1006.0743.
403 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 77, CTH.1019.1006.0743 at 0743.
404 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 92, CTH.1019.1008.0554 at 0554.
405 Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 91, CTH.1019.1008.0113; tab 92 CTH.1019.1008.0554; tab 93, CTH.1019.1002.0120; see also Transcript, Brisbane Hearing, Anthony Speed, 7 August 2019 at T4532.27–4534.20.
406 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0052–0053 [178].
407 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0030 [20].
408 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0030 [20].
409 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4273.9–20.
410 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0027 [12a].
411 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0029 [17].
412 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4257.21–37.
413 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0029 [18a–b].
414 Transcript, Brisbane Hearing, Ann Wunsch, 8 August 2019 at T4619.1–19.
415 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4268.36–4269.23; Exhibit 8-1, Brisbane Hearing, Earle Haven tender bundle, tab 59, CTH.4000.1019.8110 at 8111.
416 Transcript, Brisbane Hearing, Tracey Rees, 5 August 2019 at T4269.25–4270.13.
417 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0027 [10].
418 Transcript, Brisbane Hearing, Anthony Speed, 5 August 2019 at T4277.44–4278.7.
419 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0027 [11].
420 Transcript, Brisbane Hearing, Anthony Speed, 5 August 2019 at T4295.21–26.
421 Transcript, Brisbane Hearing, Anthony Speed, 5 August 2019 at T4295.21–36.
422 Transcript, Brisbane Hearing, Anthony Speed, 5 August 2019 at T4283.19–4284.24.
423 Exhibit 8-12, Brisbane Hearing, Form entitled 'Approved Provider Notification of a Material Change under Section 9-1 of the Aged Care Act 1997', RCD.9999.0162.0001 at 0002.
424 Transcript, Brisbane Hearing, Anthony Speed, 7 August 2019 at T4548.3–5.
425 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0028 [13b].
426 Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0030 [22].

427 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0062-0064 [217]–[221]; Transcript, Brisbane Hearing, John and Valerie Braithwaite, 9 August 2019 at T4788.26–4789.4.
428 At the Royal Commission's hearing in Cairns on 15 July 2019, MiCare was the subject of an earlier case study about the experiences of the late Mrs Bertha Aalberts at Avondrust.
429 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001.
430 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001.
431 See, for example, Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 6, CTH.4008.1000.2320. See also *Quality of Care Principles 2014* (Cth), ss 10, 11 (as then in force); sch 2.
432 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 11, CTH.4007.1000.0003.
433 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 16, CTH.4007.9000.0001.
434 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 17, CTH.1013.1004.0426.
435 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4352.15–4353.17.
436 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 20, CTH.4007.1000.0598.
437 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 30, CTH.1013.1002.0205; Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4405.40–4406.4.
438 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 30, CTH.1013.1002.0205.
439 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 30, CTH.1013.1002.0205 at 0209.
440 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 35, CTH.1013.1004.2007; tab 45, CTH.1013.1002.0368.
441 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 50, CTH.4007.1000.0517; Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4363.20–28.
442 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 59, CTH.4007.1000.3511.
443 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 43, CTH.4007.1000.1855; tab 67, CTH.4007.1000.0760; tab 93, CTH.4007.1000.1778.
444 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 103, CTH.4007.1000.1126; Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4364.41–4365.19.
445 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 105, MIC.5000.0001.2751 at 2751.
446 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 109, CTH.4007.1000.2427.
447 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 117, CTH.1013.1004.5209.
448 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 117, CTH.1013.1004.5134; tab 118, CTH.1013.1004.5192.
449 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 130, CTH.1013.1004.5697.
450 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 123, CTH.4007.1000.5138; tab 251, CTH.4007.2000.0632.
451 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 244, CTH.4007.1000.4628.
452 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 136, MIC.5000.0001.0325.
453 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 136, MIC.5000.0001.0325 at 0325_0003.
454 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 253, CTH.4007.1000.4900; Exhibit 8-18, Brisbane Hearing, Supplementary Statement of Catherine Rosenbrock, WIT.0359.0001.0001 at 0002 [12].
455 Exhibit 8-18, Brisbane Hearing, Supplementary Statement of Catherine Rosenbrock, WIT.0359.0001.0001 at 0002 [10]–[11], [14], [15]–[17].
456 Exhibit 8-19, Brisbane Hearing, Statement of Gilda D'Rozario, WIT.0305.0001.0001 at 0008 [29].
457 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0008 [35].
458 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4366.39–47; Exhibit 8-19, Brisbane Hearing, Statement of Gilda D'Rozario, WIT.0305.0001.0001 at 0004 [20k].
459 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 2, CTH.4008.1000.2508.
460 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4367.5–8.
461 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0006 [25].
462 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 20, CTH.4007.1000.0598 at 0606.
463 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 20, CTH.4007.1000.0598 at 0606.
464 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4372.3–4373.11; T4374.40–4375.16.
465 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4375.46–4376.10.
466 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4375.18–22.
467 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0012 [51].
468 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4416.36–39.
469 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4416.41–4417.3.
470 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4418.34–42.
471 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 30, CTH.1013.1002.0205 at 0209.
472 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 130, CTH.1013.1004.5697 at 5699.
473 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4421.24–45.
474 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4375.46–4376.15; Exhibit 8-19, Brisbane Hearing, Statement of Gilda D'Rozario, WIT.0305.0001.0001 at 0010 [33].
475 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4369.5–14.
476 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4369.18–25.

477 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4369.32–39.
478 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4371.1–9.
479 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0007 [31].
480 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4393.31–32.
481 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4392.28–4393.7; T4393.36–42.
482 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4393.3–7.
483 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4393.9–32.
484 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0006 [19].
485 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0006 [19].
486 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0006 [19].
487 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0006 [23]; Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4393.9–17.
488 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0007 [30].
489 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0009 [36]–0010 [41], 0022 [88].
490 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0002 [3]–0004 [11].
491 Exhibit 8-15, Brisbane Hearing, Amended Further Statement of Petronella Neeleman, WIT.0300.0001.0001 at 0009 [7b].
492 Transcript, Cairns Hearing, Robert van Duuren, 15 July 2019 at T3556.6–3557.43; T3598.18–26.
493 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4360.25–45; Exhibit 8-15, Brisbane Hearing, Amended Further Statement of Petronella Neeleman, WIT.0300.0001.0001 at 0009 [7b].
494 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 6, CTH.4007.1000.1386 at 1393.
495 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 6, CTH.4008.1000.2320 at 2327–2329; tab 20, CTH.4007.1000.0598 at 0605–0607.
496 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4353.19–4354.12.
497 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4354.17–32.
498 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4354.17–32; T4356.1–11.
499 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4356.34–39.
500 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4356.17–25.
501 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4374.27–38.
502 Transcript, Brisbane Hearing, Gilda D'Rozario, 6 August 2019 at T4374.27–38.
503 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4354.17–45.
504 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0008 [34].
505 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4352.15–4353.17.
506 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4436.1–30.
507 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4355.42–47.
508 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 35, CTH.1013.1004.2007.
509 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 45, CTH.1013.1002.0368.
510 Exhibit 8-16, Brisbane Hearing, Statement of Judith Coombe, WIT.0301.0001.0001 at 0012 [65].
511 Exhibit 8-16, Brisbane Hearing, Statement of Judith Coombe, WIT.0301.0001.0001 at 0012 [63]–[65].
512 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4424.1–4425.47.
513 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4427.8–28; Exhibit 8-22, Brisbane Hearing, Statement of Elsy Brammesan, WIT.0306.0001.0001 at 0007 [40]–[42].
514 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0007 [28].
515 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0007 [28].
516 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4426.10–14.
517 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 39, CTH.1013.1002.0337.
518 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 39, CTH.1013.1002.0337.
519 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 54, CTH.1013.1004.2881.
520 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 52, MIC.5000.0001.1280.
521 Transcript, Brisbane Hearing, Judith Coombe, 6 August 2019 at T4334.44–4335.6.
522 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4427.3–6.
523 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4422.11–32.
524 *Aged Care Act 1997* (Cth), s 66-2(1)(a)(iii), (iv) (as then in force).
525 *Sanctions Principles 2014* (Cth), ss 8, 10; *Aged Care Act 1997* (Cth), s 10A-1.
526 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63U(3)(c).

527 Exhibit 8-21, Brisbane Hearing, Statement of Colette Marshall, WIT.0304.0001.0001 (with attached corrigendum WIT.0302.0002.0001) at 0003 [17], [19].
528 Exhibit 8-21, Brisbane Hearing, Statement of Colette Marshall, WIT.0304.0001.0001 (with attached corrigendum WIT.0302.0002.0001) at 0004 [20].
529 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 123, CTH.4007.1000.5138; tab 251, CTH.4007.2000.0632.
530 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4389.13–37.
531 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4390.43–4391.12.
532 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 225, CTH.2000.1000.5319.
533 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 225, CTH.2000.1000.5319 at 5389–5390.
534 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4390.21–36.
535 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4390.38–4391.7; Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 251, CTH.4007.2000.0632.
536 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0019 [77].
537 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0022 [88i].
538 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0007 [26].
539 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0007 [26].
540 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0006 [24].
541 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 136, MIC.5000.0001.0325.
542 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 140, MIC.5000.0001.0325 at 0325_0003; Exhibit 8-16, Brisbane Hearing, Statement of Judith Coombe, WIT.0301.0001.0001 at 0017 [87]–[88].
543 Transcript, Brisbane Hearing, Judith Coombe, 6 August 2019 at T4336.28–4337.1; Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 132, MIC.5000.0001.2885 at 2885_0004.
544 Transcript, Brisbane Hearing, Judith Coombe, 6 August 2019 at T4338.27–31.
545 Transcript, Brisbane Hearing, Judith Coombe, 6 August 2019 at T4338.33–35.
546 Transcript, Brisbane Hearing, Judith Coombe, 6 August 2019 at T4339.1–6.
547 Transcript, Brisbane Hearing, Judith Coombe, 6 August 2019 at T4337.17–27.
548 Exhibit 8-14, MiCare tender bundle, tab 109, CTH.4007.1000.2427 at 2429.
549 Transcript, Brisbane Hearing, Susan Waters, 6 August 2019 at T4383.17–33.
550 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4388.6–40; Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 241, CTH.0001.4000.8666 at 8691.
551 Transcript, Brisbane Hearing, Colette Marshall, 6 August 2019 at T4388.42–4389.11.
552 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4398.13–14.
553 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4398.16–20.
554 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4431.41–4432.8.
555 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4432.10–33.
556 Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4432.35–4433.23.
557 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4399.14–20.
558 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4399.18–19.
559 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4399.16–43.
560 Exhibit 8-18, Brisbane Hearing, Supplementary Statement of Catherine Rosenbrock, WIT.0359.0001.0001 at 0003 [19].
561 Transcript, Brisbane Hearing, Catherine Rosenbrock, 6 August 2019 at T4402.22–31.
562 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, MiCare Case Study, 26 August 2019, RCD.0012.0024.0001 at 0023 [88p].
563 Submissions of the Commonwealth of Australia, Brisbane Hearing, MiCare Case Study, 4 September 2019, RCD.0012.0028.0001 at 0009 [35].
564 Exhibit 8-14, Brisbane Hearing, MiCare tender bundle, tab 136, MIC.5000.0001.0325 at 0325_0003; tab 140, MIC.5000.0001.0491 at 0491_0003.
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567 Australian Department of Health, *2017–18 Report on the Operation of the Aged Care Act 1997*, 2018, p 79.
568 Exhibit 8-29, Brisbane Hearing, Precis of evidence of Ron Paterson, RCD.9999.0143.0001 at 0003 [26]–[27]; Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019; Exhibit 8-31, Brisbane Hearing, Statement of Amy Laffan, WIT.0279.0001.0001 at 0003–0013; Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019.
569 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001.
570 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035.
571 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0003 [13].
572 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0006 [27].
573 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0005 [20c].
574 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0004 [19c].
575 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4482.19–4483.9.

576 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7280.
577 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0036 [4].
578 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0036 [1]–[3].
579 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7276; Transcript, Brisbane Hearing, Anthony Speed, 7 August 2019 at T4556.15–31.
580 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0009 [34]–[35].
581 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7289.
582 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7292.
583 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0010 [37a–b].
584 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0010 [37a].
585 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7290.
586 Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0010 [37b].
587 See, for example, Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 88, CTH.1016.1003.0277 at 0279.
588 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7294; Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4457.25–39.
589 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7294–7295.
590 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7296.
591 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0037–0039 [144a–g].
592 See, for example, report NF19/002048 (Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 67, CTH.1016.1003.0176).
593 Note that there is a contradiction with this form, in that it indicates that the matters should be referred, but also that the Australian Department of Health should take no further action. See Transcript, Peter O'Brien, Brisbane Hearing, 7 August 2019 at T4492.30–42.
594 See, for example, Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 44, CTH.1016.1003.0120 at 0120; tab 42, CTH.1016.1003.0122 at 0123.
595 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035.
596 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0039 [144i].
597 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0037–0038 [7].
598 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0036 [136].
599 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4505.38–4506.3.
600 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4454.32–45.
601 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4454.44–45.
602 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4453.26–4454.15.
603 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0036 [139].
604 Submissions of Counsel Assisting the Royal Commission: The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0036 [137].
605 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 23, CTH.1016.1003.0059 at 0060.
606 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 24, CTH.1016.1003.0061 at 0062.
607 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0038 [144d].
608 See, for example, Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 44, CTH.1016.1003.0120 at 0120; tab 42, CTH.1016.1003.0122 at 0123.
609 Transcript, Brisbane Hearing, Anthony Speed, 7 August 2019 at T4556.14–27.
610 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0037 [142].
611 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7284.
612 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4501.41–42.
613 See, for example, report number NF19/0001272 (Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 63, CTH.1016.1003.0170).
614 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 54, CTH.1016.1003.0143 at 0147.
615 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 56, CTH.1016.1003.0157 at 0157–0158.
616 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 56, CTH.1016.1003.0157 at 0157.
617 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4505.22–4506.3.
618 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0037 [7d–e].
619 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0038 [9].

620 Transcript, Peter O'Brien, Brisbane Hearing, 7 August 2019 at T4501.41–47.
621 Transcript, Peter O'Brien, Brisbane Hearing, 6 August 2019 at T4456.17–26.
622 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 in relation to reports NF16/002395 (at 0009-0011 [28]–[33]; NF16/002791 (at 0011–0012 [34]–[42]); NF16/003709 (at 0013–0015 [43]–[51]); NF19/001272 (at 0015–0017 [52]–[59]); NF19/002048 (at 0017–0019 [60]–[70]).
623 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 40, CTH.1016.1016.0031 at 0033.
624 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 40, CTH.1016.1016.0031 at 0033.
625 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 40, CTH.1016.1016.0031 at 0033.
626 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 38, CTH.1016.1003.0096 at 0097.
627 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4501.41–47.
628 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 0219 at T4502.12–14.
629 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4502.19–21.
630 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0038 [144b].
631 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 67, CTH.1016.1003.0176 at 0180.
632 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 66, CTH.016.1003.0175.
633 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 68, CTH.1016.1003.0182.
634 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 69, CTH.1016.1003.0190 at 0192; Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4492.11–47.
635 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 71, CTH.1016.1016.0053 at 0054.
636 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0038 [144c].
637 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0038 [12a].
638 See, for example, reports NF17/002320 (Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 24, CTH.1016.1003.0061); NF17/002660 (tab 29, CTH.1016.1003.0069); NF17/003138 (tab 36, CTH.1016.1003.0084); NF19/000748 (tab 55, CTH.1016.1003.0160); NF19/003049 (tab 75, CTH.1016.1003.0235).
639 Transcript, Brisbane Hearing, Anthony Speed, 7 August 2019 at T4555.20–23.
640 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0037 [6].
641 See, for example, Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 94, CTH.1016.1003.0309.
642 Mr O'Brien gave evidence that he approved all assessment reports. See Transcript, Peter O'Brien, Brisbane Hearing, 6 August 2019 at T4443.42–4444.11.
643 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7294–7295.
644 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7294.
645 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4457.8–21.
646 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4460.1–21.
647 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0036 [4].
648 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0036 [4].
649 See, for example, report numbers NF16/002395 (Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4507.24–T4510.10); NF16/002791 (T4510.21–4512.16); NF16/003709 (T4512.16–T4514.32).
650 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4482.27–34.
651 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0036 [4].
652 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0038 [7f].
653 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4449.25–39.
654 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 2, CTH.1016.1003.0002 at 0002; tab 3, CTH.1016.1003.0024 at 0024.
655 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 7, CTH.1016.1003.0004.
656 Neither the Reportable Assault Report (Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 14, CTH.1016.1003.0045) nor other documents produced by the Australian Department of Health provide any details about the alleged incident. A table of reportable assaults produced by Japara Healthcare Ltd (Exhibit 5-8, Perth Hearing, Mitcham tender bundle, tab 209, JAH.0123.0001.0001 at 0005) provides details of this allegation.
657 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 2, CTH.1016.1003.0002; tab 8, CTH.1016.1003.0031 at 0032; tab 14, CTH.1016.1003.0045 at 0046.
658 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 3, CTH.1016.1003.0024 at 0026.
659 Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 3, CTH.1016.1003.0024 at 0029; tab 9, CTH.1016.1003.0034 at 0035; tab 15, CTH.1016.1003.0040 at 0041.
660 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4512.11.
661 Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 104, CTH.0001.1000.7275 at 7294.
662 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4451.1–8.

663 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Australian Department of Health of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0038 [144f].

664 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Australian Department of Health of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0036–0037 [5].

665 Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, The Australian Department of Health of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 26 August 2019, RCD.0012.0025.0001 at 0039 [144h].

666 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Australian Department of Health of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0037 [5].

667 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Australian Department of Health of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0037 [5].

668 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0037 [7b].

669 See, for example, report number NF19/003134 (Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 88, CTH.1016.1003.0277).

670 See, for example, report number NF19/002048 (Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 69, CTH.1016.1003.0190).

671 Transcript, Brisbane Hearing, Peter O'Brien, 7 August 2019 at T4491.44–4492.9.

672 Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4450.27–42.

673 See, for example, report number NF19/0002048 (Exhibit 8-23, Brisbane Hearing, second Japara tender bundle, tab 69, CTH.1016.1003.0190).

674 Transcript, Brisbane Hearing, Amy Laffan, 8 August 2019 at T4664.41–47.

675 Submissions of the Commonwealth of Australia, Brisbane Hearing, The Department of Health's response to certain reportable assaults reported by Japara Healthcare Limited, 4 September 2019, RCD.0012.0028.0035 at 0038 [11].

9. Melbourne Hearing 1: Younger People in Residential Aged Care

9.1 Hearing overview

9.1.1 Introduction

Commissioner Richard Tracey and Commissioner Lynelle Briggs held a public hearing in Melbourne, Victoria, from 9 to 11 September and on 13 September 2019. This hearing inquired into younger people in residential aged care, with a focus on the impact, drivers and the appropriateness of allocation policy, as well as how to best support young people wishing to leave residential aged care. It specifically examined:

- the policy responsibilities of the aged care system, the social service system and health systems
- the interfaces between the aged care system, social service system and health systems
- the profile of younger people in residential aged care and any specific circumstances which drive the admission of younger people into residential aged care
- the care of a younger person while they are in residential aged care, and how this may impede their exit from residential aged care
- the special challenges faced by younger people seeking appropriate accommodation
- the nature of services typically provided to younger people in residential aged care.

Twenty-six witnesses gave oral testimony. A total of 221 documents, including 20 witness statements, were received into evidence.

Due to Commissioner Tracey's death in October 2019, the account and findings in this overview are made by Commissioner Briggs.

Younger people who live or have lived in residential aged care, and their family members, gave powerful and important evidence at the hearing. I particularly acknowledge Ms Lisa Corcoran, Mr Neale Radley, Ms Kirby Littley, Mr Mario Amato and Mr James Nutt, all of whom showed great courage and commitment in giving evidence about their personal experiences of life in residential aged care.

Other evidence was given by the Disability Discrimination Commissioner, Dr Ben Gauntlett, advocacy bodies for younger people in residential aged care, representatives from State Government accident insurance schemes, the Secretary of the Victorian Department of Health and Human Services, and representatives of the Australian Department of Health, the Australian Department of Social Services and the National Disability Insurance Agency.

The evidence at this hearing was often harrowing.[1] It demonstrated the life-changing consequences for younger people compelled to live in residential aged care to access care. It also showed that the plans of the Australian Government to reduce the number of younger people in residential aged care have been inadequate. In addition to evidence about the inappropriateness of residential aged care for younger people and the inadequacy of government action to stop younger people entering and remaining in residential aged care, I heard about changes needed to improve the situation. That evidence went to the need for better assessment processes, improved advocacy, increased rehabilitation and accommodation options, and improved data collection and analysis. Together, that evidence showed the need for sustained and dedicated government action.

9.1.2 Residential aged care is inappropriate

At the hearing, witnesses agreed that residential aged care is not an appropriate place for younger people to live.

Ms Lisa Corcoran gave evidence, with the assistance of her speech therapist Ms (Jodie) Elizabeth Chard, about her experience of living in aged care.[2] Ms Corcoran was aged 43 years and had been living in residential aged care for about six years.[3] She described the terrible experiences she had had and said 'we're all humans, and humans crave respect'.[4] She added, 'We're all equal'.[5] 'I feel like I've lost that respect'.[6] She spoke of the persistent suicidal feelings she had experienced in residential aged care.[7] She described residential aged care as 'a nightmare…It's your worst dream ever'.[8] She said that her 'number one goal' was 'to get the fuck out of the nursing home'.[9]

Mr James Nutt entered residential aged care when he was 21 years of age.[10] He had been assaulted while attending a local football match.[11] He suffered an acquired brain injury and paralysis from the waist down.[12] Mr Nutt stayed in various residential aged care facilities for nearly seven years.[13] He said that of his first night in residential aged care:

> I went back into my room after having my tea and I closed my door. I dropped my head into my hands and started crying as I thought to myself, 'I'm only 21 years old. I've got maybe 65 left—years left in my life, I'll be forced to live here for the rest of my life with no ability of ever getting out.'[14]

Mr Nutt said that residential aged care deconditions younger people.[15] He said that 'Your brain goes to mush, as you're not using it.'[16]

Mr Nutt's attendance at the hearing was a reminder of the day-to-day challenges faced by younger people with disabilities. His attendance was delayed by the inability of airlines to accommodate his wheelchair. This resulted in him arriving at the airport only to be told that he could not board the flight.[17] Mr Nutt felt this situation was 'soul destroying'.[18]

Mr Mario Amato lived in residential aged care between late 2015 and early 2019. When he entered residential aged care, he was aged 55 years.[19] He was firmly of the view that younger people should not be in residential aged care.[20] He described how he found it impossible to make social connections in residential aged care:

> I always felt that the facility was not the place for me. I was the youngest person there. Everyone else at the facility was 80 years old or older. Most people were in their 90s and in poor health. It was difficult to socialise with people; they had different interests to me. They wanted to talk about World War Two and the Boer War. I wanted to talk about Pink Floyd, the Beatles, and things like that.[21]

Ms Jessica Dodds' husband, Tony, was 62 years of age when he entered residential aged care.[22] At that time, he had high care needs, including palliative care needs, due to terminal cancer. Ms Dodds said that she had been told that residential aged care was an appropriate place for her husband to receive palliative care:

> I was told that the facility could provide everything that Tony would need including personal care, pain relief, social activities and even spiritual care. I had accepted that this would happen.
>
> I don't think that this is what happened.[23]

Ms Catherine Roche's husband, Michael Burge, entered residential aged care, after a stroke, at the age of 56 years.[24] Ms Roche explained that, for her husband, 'life got worse in aged care … he got increasingly depressed'.[25] She said that 'He did not engage with the activities on offer, as they were not designed for a younger person' and 'His physical condition deteriorated'.[26] In her view, 'There should have been other options available to us so that he could have been properly cared for in a specialised rehabilitation facility, or at home with adequate supports'.[27]

Ms Carol and Mr Kevin Littley, gave evidence about the experience of their daughter, Kirby, living in residential aged care. After surgery for a brain tumour, Kirby had suffered two strokes which left her with severe physical disabilities.[28] For about 13 months, when aged in her late 20s, Kirby lived in residential aged care in Geelong.[29] They stated that their daughter's friends soon stopped visiting her.[30] They also said that she felt 'isolated and lonely' because she was in a different demographic to most of the residents.[31] Ms Carol and Mr Kevin Littley considered that Kirby's experience demonstrated that aged care was not an appropriate place for her to live.[32]

Mr Neale Radley entered residential aged care when he was aged in his late 40s, after an accident left him with a serious spinal injury.[33] He said that he had nicknamed his room at the facility 'Cell 14' because 'I don't have the freedom to get out'.[34] He said 'I feel like a prisoner'.[35] He described how living in residential aged care has affected his social life:

> I don't get to be social anymore. I don't want people to come and see me here. I've seen the look on my friends' faces when they do visit. I try to put on a brave face when I don't have much to talk about.[36]

He also spoke about the terrible toll of coming to know and befriend people in aged care and then seeing them die. He said 'people who I have liked, admired and gotten close to while I've lived here have all since died'.[37]

At their request, Ms Jessie Spicer and her mother, Ms Robyn Spicer, sat together when giving evidence. Ms Robyn Spicer described the experience that her daughter has had as a young person living in residential aged care. Ms Jessie Spicer was born with a complex chromosomal condition that has caused her to need significant assistance from birth; she is unable to speak and has limited communication and mobility.[38] At the time of the hearing, Ms Jessie Spicer had lived in residential aged care for six years since 2013.[39] She still lives in residential aged care and is now aged 37 years.[40]

Ms Robyn Spicer explained that her daughter had no supported accommodation options that were appropriate, available to her in the Castlemaine area.[41] Ms Jessie Spicer's circumstances were truly exceptional. With the support of her family, the facility and a nearby day service, she had her physical, emotional and social needs met.[42] Ms Robyn Spicer said that she is very involved in her daughter's care and does most of the coordination.[43] She said her daughter 'is thriving there'.[44]

Ms Robyn Spicer was concerned that 'some young people are living in residential care when they do not want to be there'.[45] On the other hand, she also said that 'younger people with disabilities and their families should have the option of aged care as a legitimate choice and the opportunity to determine what works best for the individual'.[46]

Dr Ben Gauntlett, the Disability Discrimination Commissioner, said that residential aged care is not an appropriate place for younger people. He stated unequivocally that 'from a human rights perspective, no person being discharged from hospital or having a disability, should be living in aged care whatsoever'.[47] He also said that:

> younger people in Australia living in old age care institutions, because of their disability or medical condition, is a dark and inappropriate circumstance for this country to have allowed to occur. It is a significant human rights issue that we allow this position to be maintained.[48]

A panel of representatives from advocacy organisations for younger people in aged care gave evidence. The panel was comprised of Dr Bronwyn Morkham, National Director of the Young People in Nursing Homes National Alliance, Mr Shane Jamieson, Manager of Youngcare Connect at Youngcare, and Mr Luke Bo'sher, Chief Executive Officer at the Summer Foundation.[49] Each member of this panel agreed that residential aged care facilities are not the right place for younger people to live.[50]

The Victorian Government operates a number of residential aged care facilities. The Secretary of the Victorian Department of Health and Human Services, Ms Kym Peake, acknowledged that some younger people live in those facilities and said that, particularly for young people with disabilities, 'Residential aged care is neither set up for, nor resourced to, facilitate the independence of these younger residents'.[51]

The Australian Department of Health stated that residential aged care should be an option of last resort for younger people.[52]

Dr Nicholas Hartland PSM, First Assistant Secretary, In Home Aged Care Division, Australian Department of Health, agreed with Counsel Assisting that the accounts of Ms Lisa Corcoran, Ms Jessica Dodds and Ms Catherine Roche have indicated, in a way

consistent with Dr Hartland's evidence, that residential aged care is no place for younger people.[53] Dr Hartland also agreed that residential aged care is not equipped to support the functional improvement of younger people with a disability.[54] Dr Hartland described the problem of younger people being inappropriately placed in residential aged care as 'intractable'.[55]

Mr Michael Lye, then Deputy Secretary, Disability and Carers, at the Australian Department of Social Services, conceded that the Australian Government has previously failed to make sufficient inroads in reducing the number of younger people in residential aged care.[56] Mr Lye said:

> I think it's important to say that we don't think it's an appropriate setting for young people with disability. And I think it's been an issue which is—which we have failed—manifestly failed to make inroads into. We have made some attempts at trying to address the issue. But we have—we have manifestly failed and that's evident in the numbers of people who still live in that setting—those settings.[57]

In its post-hearing submission, the Australian Government accepted that:

> The situation of younger people living in residential aged care is a grave and persistent problem. It remains an issue requiring urgent redress.[58]

9.1.3 The Action Plan

On 22 March 2019, the Australian Government announced the Younger People in Residential Aged Care Action Plan.[59] When announced, the Action Plan had the following goals:

- to support those already living in aged care aged under 45 to find alternative, age-appropriate housing and supports by 2022, if this is their goal
- to support those already living in aged care aged under 65 to find alternative, age appropriate housing and supports by 2025, if this is their goal and
- to halve the number of younger people aged under 65 years of age entering aged care by 2025.[60]

Senior public servants from the Australian Department of Health, the Australian Department of Social Services and the National Disability Insurance Agency gave evidence about the adequacy of the Action Plan.

Mr Lye said that the Action Plan is different to previous efforts to help younger people leave aged care because there is more funding allocated to it.[61] This is despite, as Mr Lye acknowledged, the Action Plan not referring at all to any specific funding, nor having any funding directly allocated to it.[62] Ms Peake said that from the Victorian Department of Health and Human Services' perspective, the development of the Action Plan represents a 'missed opportunity' because State and Territory Governments had not been consulted in its development.[63] Representatives from state accident insurance schemes from South Australia, Victoria and New South Wales, who have had success in helping younger people avoid entry into residential aged care, gave evidence that their schemes had also not been consulted in the development of the Action Plan.[64]

Ms Peake was also concerned that 'there is a risk that this plan, like the previous initiative, is too narrowcast as a disability initiative—rather than taking the opportunity to take—to really have a multidisciplinary approach to planning, to governance and to support'.[65] Ms Peake described the multidisciplinary approach which operated in a former Victorian program for people with acquired brain injuries and involved allied health, disability support and planning support. [66] Dr Morkham conceived of the need for a similar multidisciplinary approach to the one described by Ms Peake, suggesting that younger people seeking to leave residential aged care would require support involving health, mental health, housing, disability and community services.[67]

Mr Jamieson and Mr Bo'sher were enthusiastic about the Action Plan showing that the Australian Government is setting measurable targets for getting younger people out of aged care.[68] However, this support does not mean that they think the targets in the Action Plan are satisfactory.[69] Mr Jamieson gave evidence that, while Youngcare does not 'necessarily believe that the targets are good enough…the mere fact that there is a commitment from government at the moment to have those targets is something that we can work towards'.[70] Mr Bo'sher said that having measurable targets is a 'big step forward.'[71] He considered the setting of targets as 'a way to create energy and motivation within government'.[72] However, it seemed to him either the scale or timing of the Action Plan's goals are 'too far out to have generated enough urgent activity.'[73]

Dr Morkham said that while the Younger People in Nursing Homes Alliance was pleased when it heard that an action plan was being developed, it was disappointed when it was announced.[74]

Dr Morkham was of the view that there is a lack of will on the part of the Australian Government to fix the problem of younger people in residential aged care, and that this had not been resolved by the announcement of the Action Plan.[75] For her, the targets in the Action Plan are 'not good enough'.[76] She proposed different targets:

- no younger person entering residential aged care by 2022
- no younger person living in residential aged care by 2025.[77]

To improve the Action Plan, Mr Bo'sher said the Australian Government would need to engage with the State and Territory Governments:

> The Action Plan is very focused on the Commonwealth and disability levers, and the stakeholder reference group does not engage with state governments. It is critical that the Action Plan stakeholder engagement forums bring together senior decision makers from the NDIA [National Disability Insurance Agency], as well as the Commonwealth and State Governments.[78]

In its post-hearing submission, the Australian Government sought to explain that, while State and Territory Governments were not consulted in the formulation of the Action Plan, consultation with them occurred in other forums, such as Disability Reform Council working groups.[79] On behalf of the Victorian Government, Ms Peake gave evidence about a lack of consultation about the Action Plan, saying that it had been presented as a 'fait accompli'.[80] That represented, in her view, 'a missed opportunity'.[81]

Several witnesses expressed concerns about the capacity of the Australian Government to implement the Action Plan.

Dr Morkham said that the Younger People in Nursing Homes Alliance was 'disappointed and quite appalled' that there were no resources dedicated to the Action Plan, that the targets were not acute enough and were not supported by modelling.[82] She considered that the 'main obstacle' to the success of the Action Plan will be its 'failure to take a multi-system approach to address a multi system problem'.[83] She was also disappointed with what she considers to be an absence of consultation with young people, their families and the communities in which they live.[84]

Mr Jamieson said that Youngcare is concerned that the targets set in the Action Plan are not good enough.[85] He also expressed concerns about the adequacy of funding to support the Action Plan, saying that:

> Having the plan in place is one thing, but the reality is that effecting change requires funding. If there is not enough funding and resources directed to assisting those in aged care to access the right information and services, it will be extremely difficult for the Action Plan to meet its goals.[86]

However, Mr Jamieson also noted that responsibility for the success of the Action Plan extends beyond just government, saying that success is also up to the disability, health and investment sectors.[87]

Mr Bo'sher said that the Summer Foundation is concerned about the ability of the Australian Government to meet the goals of the Action Plan on time. He gave evidence that:

> setting a target in 2025 to halve the number of young people in aged care clearly has not led to enough action over the last six months. The action plan was released in March [2019] but six months later we still don't have a lot of progress on the ground to show for the action plan that's been announced.[88]

In his view, there is a lack of urgency on the part of the Australian Government to implement the Action Plan.[89]

Australian Government witnesses were more supportive of the capacity of the Australian Government to implement and achieve the targets in the Action Plan. Nonetheless, Mr Peter Broadhead, Group Manager, National Disability Insurance Scheme Transition Oversight at the Australian Department of Social Services, said that the Australian Government had not made any projections for the implementation of the Action Plan.[90] Ms Vicki Rundle, Acting Chief Executive Officer of the National Disability Insurance Agency, said that she could not confidently say that 'we will absolutely without doubt meet' the goal of having no younger people in residential aged care by 2025.[91]

In its post hearing submission, the Australian Government submitted that there has not been a lack of 'will' to implement the Action Plan.[92] That submission was rejected by Commissioners Tracey and Briggs in the Interim Report.[93] The Australian Government also submitted that, while State and Territory Governments had not been directly consulted in the development of the Action Plan, there are still opportunities for them to be involved in its implementation.[94]

9.1.4 A lack of suitable accommodation

Many witnesses explained that they or their loved one had no alternative other than to go into residential aged care.

Mr Amato entered residential aged care after a stay in hospital. Mr Amato said he had been suffering from depression and tried to kill himself by taking insulin and not eating.[95] He stated he had 144 hypoglycaemic attacks over a year, which resulted in him suffering two strokes and a grand mal epileptic seizure.[96] He gave evidence that he suffered some frontal lobe damage, which included long-term memory loss, but that he has now recovered quite well.[97] Mr Amato said that while he was in hospital, he was given a neuropsychological assessment which concluded that he did not have the capacity to make decisions for himself.[98] Mr Amato said the doctors at the hospital and his brother are worried that he is going to try to die again so he needs to live somewhere that will be able to provide him with constant care.[99] Mr Amato recounted his experience as follows:

> my brother told me that the hospital had explored the possible places for me to live, and found that there was no other option for me except to permanently go into an aged care facility. My brother was told by my doctors at the hospital and I was told by my brother that I couldn't go into a group home for people with disabilities because I was mentally unstable and I had to be cared for all of the time. They told me that they were worried I was going to try to die again, so I wasn't allowed to do things myself. I told my brother that I didn't want to go into a nursing home, because that's where people go to die. He told me that there was nowhere else.[100]

Mrs Dodds said that what she really wanted was for her husband to be able to remain at home. She said that hospital staff 'did not speak to me about care options…I think their view was that Tony's care needs were too high for anything other than residential aged care'.[101]

The Littley family described their emotion when they discovered there was no appropriate option available for Ms Kirby Littley and she would have to enter aged care. Ms Carol and Mr Kevin Littley said that they felt that 'all we were hearing was that there was nowhere for Ms Kirby Littley to go that would give her access to rehabilitation in a suitable environment'.[102] They said that:

> We had a conversation with Kirby and told her she would need to go into aged care because there was no other option. Kirby cried when we told her this and said 'nobody wants me.'[103]

Ms Roche did not think that her husband should have had to go into residential aged care:

> There is no doubt in my mind that Michael should never have had to enter residential aged care. There should have been other options available to us so that he could have been properly cared for in a specialised rehabilitation facility, or at home with adequate supports so that I could continue working and providing financially for us. Instead, I was forced to place him in residential aged care. This decision is not one I should have had to make. Michael was in his 50s and even following the stroke, he should have been able to have years of a meaningful life and enjoyable lifestyle in front of him.[104]

Ms Roche said she began to realise that residential aged care was the only option for her husband after about six months investigating alternatives.[105] She said 'There was nothing. Absolutely nothing. I must have rang hundreds of places'.[106]

Ms Corcoran felt she did not get a choice about moving into residential aged care, stating that she did not even get to look at where she would be living before she went to live there.[107]

Mr Radley said that there was a lack of appropriate disability housing options for him. He looked to go somewhere other than residential aged care 'but there was nothing available'.[108]

While Ms Robyn Spicer felt satisfied with the care that Ms Jessie Spicer receives in residential aged care, she stated that when she was looking at where Jessie could live, 'it appeared that there were no supported accommodation options that were appropriate for Jessie in the Castlemaine area'.[109]

Dr Morkham explained that residential aged care was often not operating as a last resort:

> The pipe-line is really an express route into aged care. So most of these young people enter residential aged care on discharge from hospital. Unfortunately the fact that residential aged care can have a bed available is a very attractive opportunity for a hospital that doesn't provide accommodation, that is there to support sick people to get better and, when the person isn't sick any longer, does need to discharge. We, simply, haven't had the services and supports available to avoid that yet, and having that pipe-line straight into residential aged care has proved irresistible…There's been a complete reliance on aged care to the point where things are not even considered, other options are not even looked for. [A]ged care is the default option...[110]

Mr Bo'sher observed that, even when someone has to enter residential aged care, they should not remain living there:

> admission should be treated as temporary, and it should be clear to the resident that there are pathways being put in place to exit to more appropriate housing as soon as it is practical. The longer the person resides in residential aged care, the greater the impact of the institutional environment on their self-belief to move out...[111]

A panel of representatives from State Government accident insurance schemes in South Australia, New South Wales and Victoria gave evidence. The members of the panel were: Ms Tamara Tomic, Chief Executive, Lifetime Support Authority, South Australia; Ms Deborah Hoffman, General Manager, Care Services and Ms Suzanne Lulham, General Manager, Care Innovation and Excellence, icare, New South Wales; and Ms Liz Cairns, Head of Independence, Transport Accident Commission, Victoria.

Despite working with clients with high and complex care needs, admission of younger people to residential aged care is extremely rare in these schemes. Each of these panel members explained that their organisations make every effort to ensure that clients do not live in residential aged care. Ms Tomic said that 'It would be a last resort to consider a residential aged care facility for someone who didn't need that because of their age.'[112] Ms Hoffman said that offering or placing a participant aged under 65 years in a residential aged care setting will only be considered 'in circumstances where all other accommodation options have been explored and are unable to provide a safe environment for the participant to live in'.[113] Ms Liz Cairns from the Victorian Transport Accident Commission stated that 'The TAC [Transport Accident Commission] regards a Residential Aged Care…

placement as the least preferred option'.[114] She explained the extensive processes in place to ensure that there is 'sufficient scrutiny' before any younger person is supported by the Transport Accident Commission to move into residential aged care.[115]

Ms Cairns described how the Victorian Transport Accident Commission has introduced an Accommodation Advisory Panel which oversees case planning or any client who needs to explore accommodation options.[116] Even where a younger person has had no appropriate alternative but to enter residential aged care, the panel continues to explore alternatives with the client and their family.[117] Additionally, any entry by a younger person into residential aged care requires the approval from a senior manager.[118]

Ms Lulham and Ms Cairns each told me about the dedicated and skilled workers required to plan and implement packages of care that meet the needs and objectives of those requiring long-term care, including helping them avoid entry into residential aged care.[119]

Witnesses also gave evidence that there is an undersupply of short-term accommodation options for younger people. Ms Rundle said that there are difficulties getting younger people into appropriate short-term accommodation because of the modifications that are often required to accommodate younger people with disabilities.[120] Dr Morkham observed that the need for short-term accommodation is high and can play 'an important role in providing time for people to adapt to their disability and more importantly, avoid aged care placement'.[121] Mr Bo'sher said that there is a need for transitional housing which can be available at short notice 'that should offer rehabilitation services so that they can continue their functional improvement, but that is a place they can be while they find the right long-term option'.[122]

9.1.5 Specialist disability accommodation

The evidence is clear that the provision of adequate and appropriate accommodation options for younger people with a disability is essential to prevent younger people entering residential aged care and to give younger people living in residential aged care the opportunity to live independently. Under the National Disability Insurance Scheme, younger people should be supported to identify and access accommodation appropriate to their needs, in the first instance through home modifications, assistive technology and care supports, and if required through funding approval for specialist disability accommodation.[123] It is my view that this must be the case.

Specialist disability accommodation refers to a type of accommodation, offered under the National Disability Insurance Scheme and 'designed for NDIS [National Disability Insurance Scheme] participants who meet specific eligibility criteria because they cannot live in mainstream housing due to extreme functional impairment or very high support needs'.[124] The rules for the provision of speciality disability accommodation are set out in the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cth).[125] These operate with a market-based philosophy whereby a National Disability Insurance Scheme participant can have an entitlement for specialist disability accommodation added to their plan. They can 'go into the market and find, or commission, a home that suits their individual needs'.[126] An entitlement to specialist disability accommodation may allow a younger person to leave residential aged care.

Under the National Disability Insurance Scheme, specialist disability accommodation is often, but not necessarily, accompanied by supported independent living services, by which a person receives support to undertake activities of daily living.[127]

Mr Nutt spoke about moving out of residential aged care into his own accommodation:

> It's absolutely wonderful. I couldn't expect a better unit than what I've got at the moment. I've got a penthouse with my balcony overlooking the lake. It can't get much better than that… The setup is I'm living in my unit by myself…So I've employed every single person that comes into my unit, I've ticked off…It's my decision who comes in and who works with me.[128]

Mr Radley described the challenges he experienced applying for specialist disability accommodation as a part of the National Disability Insurance Scheme:

> It took roughly 6–8 months if not longer for my application to be approved after submitting it. My NDIA [National Disability Insurance Agency] support coordinator did so much work to make sure the application had everything it needed, including an assessment by my OT [occupational therapist]. I received an acknowledgement after we submitted the application but I didn't hear anything after that. I just had to wait. It felt like I was climbing a mountain.[129]

Even though his application for specialist disability accommodation had been approved, at the time of the hearing, Mr Radley remained concerned that he would be unable to get into a property in Bendigo where he would prefer to live.[130] He said that a reason he was enthusiastic about moving into specialist disability accommodation was that there would be 'less dying people around'.[131]

Ms Kirby Littley was able to leave residential aged care in late 2018, after she used proceeds from the sale of a unit she owned and lived in before she had the strokes that caused her disability. She also used funds from her National Disability Insurance Scheme package to purchase a specialist disability accommodation property.[132] She was able to have input into how the property was designed so that it was built for her needs.[133]

Mr Bo'sher described the systemic difficulties that the Summer Foundation and its affiliated development company, Summer Housing, have encountered in constructing specialist disability accommodation.[134] He explained that the majority of younger people in residential aged care would be eligible for specialist disability accommodation but that there was not enough being built.[135] He said the 'single biggest reason that we're not seeing the amount of specialist disability accommodation being built is that providers of housing are not confident that if they build that housing that young people will be able to move into that housing instead of moving into aged care'.[136] He said the Summer Foundation required a person to start the application process at least nine months before a property is complete, with much of this delay being driven by the need to get approvals by the National Disability Insurance Scheme.[137] His evidence was that the process for getting approval for specialist disability accommodation is complicated by the effort needed to demonstrate eligibility under the National Disability Insurance Scheme, as well as the limited workforce to manage a specialist disability accommodation process, a lack of awareness on the part of younger people in residential aged care, and difficulty in locating younger people in residential aged care because of inadequate data collection and sharing.[138]

From Youngcare's perspective, as a provider of specialist disability accommodation, the National Disability Insurance Scheme processes are complex and time-consuming, although there have been some improvements.[139] In Mr Jamieson's view, there is interest from investors to come into the market for specialist disability accommodation, but for such investments to be stable for younger people, they need to be done with a view to long-term partnerships between funders and accommodation providers.[140] He said that access to specialist disability accommodation can be 'improved vastly by having greater visibility on up to date demand data'.[141] Mr Jamieson also emphasised the importance of having supported independent living available to allow people to live in their own homes.[142]

Dr Morkam was highly critical of the current approach to specialist disability accommodation. In her view, the current approach is one of 'build and they will come', rather than asking the young person and their family members what, where and how they want to live.[143] The focus on building housing as the solution to the problem has, according to Dr Morkham, become part of the problem.[144] She said that the solution needed to be broader than accommodation, including improving models of care to deliver more skilled support, and developing workforce skills and appropriate community health services.[145]

Dr Morkham stated that one improvement to accessing specialist disability accommodation would be to give all younger people in residential aged care an entitlement to access specialist disability accommodation, rather than needing to seek approval under the National Disability Insurance Scheme:

> The SDA [specialist disability accommodation] process must be simpler and should be automatic for YPINH [younger people in nursing homes]. The YPIRAC [younger people in residential aged care] Action plan has set objectives for getting SDA into the plans of YPINH so this move should be uncontroversial. Given that the SDA opens up a generous funding stream there does need to be tension applied by the NDIS [National Disability Insurance Scheme] but for YPINH this tension is needed less at the point of entry to the SDA and more around ensuring the option is appropriate and the selection of the SDA payment level is applied correctly.[146]

Dr Gauntlett said he was concerned about the market-based approach taken in the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules.[147] He observed that this may lead to unintended consequences:

> The Specialist Disability Accommodation arrangements set forth in the rules, whilst premised on a number of market criterion, do require that there be a significant supply, both physical assets and care support in a number of locations without—throughout Australia and dealing with a number of individuals that may, as I said before, have complex support needs. They may have an intellectual disability but they also may come from a culturally or linguistically diverse background or be an Aboriginal and Torres Strait Islander. For that reason I think there is a very real concern that what could happen is people get stuck in group arrangements where they're forced to live with people under one roof. And the reality of the situation is it just becomes a mini-institution, rather than independent living arrangement.[148]

Dr Hartland said the Australian Department of Health does not think that there is market failure in providing specialist disability accommodation, but accepts that development has been slower than was desirable.[149] Nonetheless, he expected that, even once the market for specialist disability accommodation matures, there will likely remain an insufficient supply in rural and remote areas to prevent all younger people from entering residential aged care.[150]

Ms Rundle was asked by Counsel Assisting whether there is market failure in providing specialist disability accommodation.[151] She said that it depended on the test applied to such a failure.[152] She then gave two assessments of the state of the market. The first was 'by the fact that there are not sufficient properties to—for people to live in alternatively, then the market is—is failing at the moment'.[153] The second was that:

> If you ask me is there market failure more broadly in terms of where the scheme is at and what you'd expect to see with market development in a scheme like this, the scheme—the market is actually responding to all of the initiatives and is growing.[154]

Ms Rundle accepted that there is an insufficient number of specialist disability accommodation properties available.[155]

Despite the importance that a number of witnesses placed on the development of specialist disability accommodation, Ms Rundle said that no projections have been undertaken to forecast the supply of specialist disability accommodation.[156] Ms Rundle acknowledged that there is an inadequate supply of specialist disability accommodation, but said that the market for such accommodation is growing rapidly.[157]

There are some younger people who end up living in residential aged care who are not eligible for specialist disability accommodation because they do not have approved National Disability Insurance Scheme plans.[158] As at 30 June 2019, there were 4271 people with approved National Disability Insurance Scheme plans living in residential aged accommodation.[159] According to the Australian Institute of Health and Welfare, in 2017–18 there were about 8300 younger people living in residential aged care.[160] It appears that there is a significant number of younger people who end up living in residential aged care who are either not eligible for the National Disability Insurance Scheme or have not had their eligibility assessed and so are not eligible for specialist disability accommodation.

9.1.6 A lack of appropriate care

Younger people who live in residential aged care often have significant health and disability support needs, including the need for therapy and rehabilitation.[161] Witnesses at this hearing spoke of younger people in residential aged care being unable to access the kinds of care and support that they require.

Ms Roche said that after her husband Michael suffered a stroke, he required substantial rehabilitation support. She said that because of inadequate access to care, she had to arrange, at her own expense, for additional physiotherapy to supplement the limited physiotherapy provided by the residential aged care service.[162] She also engaged a speech therapist.[163] Despite her efforts, Michael's condition deteriorated in residential aged care.[164]

Ms Carol and Mr Kevin Littley described getting adequate rehabilitation for Ms Kirby LIttley as an 'ongoing challenge'.[165] To them, it seemed that 'the facility was not invested in giving Kirby access to rehabilitation'.[166]

Mr Jamieson described access to rehabilitation for younger people as a 'huge problem'.[167] Dr Morkham gave evidence that it was in the nature of the residential aged care system to provide inadequate rehabilitation:

> Inadequate staff to resident ratios and staff lacking the skills to support their dynamic health and disability needs means YPINH [younger people in nursing homes] cannot obtain the care they need in RAC [residential aged care]. YPINH commonly experience significant functional decline after moving into RAC that can include loss of gains made through rehabilitation prior to admission.[168]

Dr Morkham described the failure to improve access to rehabilitation for younger people in residential aged care as a 'fundamental failure'.[169] Mr Bo'sher stated that when people go into aged care 'their functioning declines, their mental health declines, and it's very, very hard to leave'.[170]

9.1.7 The importance of advocates

Witnesses at the hearing explained that it is vital that younger people living in or at risk of entering into residential aged care, be supported by dedicated advocates. Without a committed and informed advocate, a younger person faces much more difficulty getting what they need to avoid entry into aged care, or what they need to exit from it.

Dr Gauntlett, the Disability Discrimination Commissioner, gave evidence that:

> The best way to ensure that a person is properly represented in those situations is to have some form of independent advocacy for them, where the person is not beholden either to the care provider, the National Disability Insurance Scheme, or the accommodation provider. That means that there is a clear voice for that individual to enable them to live the life…they choose.[171]

Mr Amato explained that the visit that he received from the ACT Disability Aged and Carer Advocacy Service, helped him set goals to leave residential aged care and 'start living again'.[172] The service advocate continued to visit him throughout 2016, 2017 and 2018.[173] The advocate helped Mr Amato look at accommodation options other than residential aged care, and to access National Disability Insurance Scheme funding.[174]

Ms Kirby Littley said that younger people 'need advocates and they need somebody helping them that's not employed by the nursing homes'.[175]

Ms Corcoran's advocates have been supporters like her brother and her speech pathologist, Ms Chard.[176] She acknowledged that others do not have those supporters and said that she feels sorry for those people.[177] She said that in 2019, she was left without care coordination for a period of time and this meant that 'I didn't have anyone to make sure I got the supports I needed under my [National Disability Insurance Scheme] plan or to help me with my goal of getting out of aged care.'[178]

Ms Robyn Spicer emphasised the importance of care coordination, stating that:

> I think as I get older and for people who are not able to do all the liaison work for their kids or for people with a disability who are unable to do the liaison stuff themselves, that coordinator role will become more and more important as time goes on. And I think that specialised coordinators who really look into young people in aged care, who have—who specialise in that, can have a terrific role in the future in looking after those needs, doing the liaison type and coordination work that I find myself doing. And I would hope that, you know, when I'm no longer able to do it that these will be the key people who will keep her programs going, who will coordinate between day centre and NDIS [National Disability Insurance Scheme] and—and the facility, really.[179]

Dr Morkham, Mr Bo'sher and Mr Jamieson reinforced the need for advocates for younger people living in, or at risk of, entering residential aged care.[180] Mr Jamieson described advocacy as 'absolutely vital'.[181]

The nature of such an advocate was considered by Dr Morkham, who said:

> we need to have a case manager key worker approach, a dedicated person for every young person at risk of entering residential aged care or who is in residential aged care to work with them to provide the solutions they need to live in the community.
>
> That case manager key worker would also be responsible for wrangling those systems, for getting them to come together, to sit down and deliver what they need to do. Unless we do that, we're never going to get to the solution we've got to have.[182]

Mr Bo'sher was not sure at the time if a single key worker model or a 'more-consortium-based approach' was to be preferred. He said that:

> what we know is that these systems are each complex, and we want someone who's expert in each of those systems, and trying to find one individual that can do all of that can be quite challenging. …I would say Government should work with the sector and people with disability to design what are those skillsets…that are needed to help people navigate the system, and if we can find one person to do that—that's fantastic, and if we need a team-based – multidisciplinary team that might have a key worker that engages with the person but that key worker's able to then draw on other expertise—I think that would be really critical for success.[183]

9.1.8 Interfaces between aged care, health care and disability services

Much of the evidence at this hearing was about younger people living in, or at risk of, entering residential aged care related to the health care system. This is hardly surprising considering the high health care needs of them. Much of the evidence also concerned the National Disability Insurance Scheme.

Many younger people enter residential aged care due to circumstances at the interface between the health and aged care systems.[184] The process for accessing aged care involves being assessed for eligibility for aged care services by an Aged Care Assessment Team.[185]

The Australian Government sets the standards that Aged Care Assessment Teams apply in determining a person's eligibility for aged care under the *Approval of Care Recipients Principles 2014* (Cth).[186] Under these principles, a younger person is only eligible for residential aged care services if an Aged Care Assessment Team determines that there are no other care facilities more appropriate to meet that person's needs.[187] Guidelines released in 2019 directed Aged Care Assessment Teams to engage with the National Disability Insurance Scheme in relation to younger people with a disability.[188] A 2019 report from the Australian Institute of Health and Welfare showed that many younger people enter care with a condition that is not covered by the National Disability Insurance Scheme; for example, at least 12.5% of younger people who enter residential aged care have cancer.[189] A total of 80% of younger people with cancer who enter residential aged care die within a year of entry.[190] This suggests a proportion of younger people is entering residential aged care to receive palliative care as they die.[191]

There was evidence about whether this group of younger people would benefit from the Action Plan. In July 2019, the Younger People in Residential Aged Care Project Board—an interdepartmental group with representatives from the Australian Department of Health, the Australian Department of Social Services and the National Disability Insurance Agency overseeing the implementation of the Action Plan—met and discussed the abovementioned report from the Australia Institute of Health and Welfare.[192] In the minutes of this meeting, the group of younger people entering residential care with cancer were said to be:

> a challenge for Health [Australian Department of Health] because if entry to aged care is closed to all under 65s with the assumption that the NDIS [National Disability Insurance Scheme] will care for them instead, there will be a substantial unmet need. Palliative care is a state responsibility rather than a Commonwealth one and DSS [Australian Department of Social Services] will raise this issue with the states and territories as soon as the implementation of the new disability-related health measures is further progressed.[193]

Shortly after this discussion, the Project Board amended the plan which defined the scope of work the Project Board was undertaking.[194] This updated document makes clear that younger people not eligible for the National Disability Insurance Scheme are out of scope of the actions the Project Board will take.[195] The focus of the Project Board is to implement the Action Plan through use of the National Disability Insurance Scheme.[196]

Evidence was heard about guidance provided to Aged Care Assessment Teams when assessing whether a younger person is eligible for residential aged care. Counsel Assisting took Dr Hartland to two examples of assessments by Aged Care Assessment Teams into the eligibility of a younger person where there was no documented evidence of any consideration given to alternatives to that person going into residential aged care.[197] Dr Hartland said there is no third-party auditing conducted of the decisions by Aged Care Assessment Teams that a younger person had no other care facility available to them other than residential aged care.[198]

Guidelines provided to Aged Care Assessment Teams used to recommend that they 'fully' explore alternatives to aged care available to a younger person, however this guidance was removed in 2019.[199] Dr Hartland said that this change was made to make it easier for younger people to enter residential aged care. This was after concerns were raised by

aged care providers with responsibility for homeless people that barriers were preventing some younger people from accessing the care they needed.[200] Dr Hartland acknowledged that the decision-making process could be 'more structured'.[201]

Mrs Dodds spoke of the difficulties that she had getting direction and assistance for her husband.[202] Mr Dodds had poor vision and was receiving support for this under the National Disability Insurance Scheme.[203] Mrs Dodds said that when she tried to speak to the National Disability Insurance Agency about Tony's declining condition and getting respite services for him:

> The NDIA [National Disability Insurance Agency] said that the only thing I could do under the NDIS [National Disability Insurance Scheme] was complete a 'change of circumstances' application. The NDIA representative told me that a change of circumstances form would take several months to be processed, approved and implemented.[204]

According to Mrs Dodds, the National Disability Insurance Agency 'representative did not offer an alternative solution or express concern about the prospect of Tony entering residential aged care'.[205] She said that she 'did not feel that the NDIA [National Disability Insurance Agency] offered to help in any meaningful way'.[206] Overall, Mrs Dodds said she felt like she was 'trapped between two systems'.[207]

Ms Rundle said it could be as long as three months after a younger person enters residential aged care for the National Disability Insurance Agency to find out, from data received from the Australian Department of Health, that this had occurred.[208] Ms Rundle admitted that 'we don't understand very much about the group of people that are coming into the agency'.[209]

Dr Nicholas Hartland gave evidence about the pathways younger people, particularly those with disabilities, follow into the aged care system. He agreed that residential aged care was not an appropriate place for younger people to live.[210] Dr Hartland said that the introduction of the National Disability Insurance Scheme was a step of great significance for the ability of younger people with disability to leave residential aged care, because:

> we are now in quite a different situation, I think, than we've ever been in before in that we do actually have the institutional underpinnings to address this problem, whereas before that was created, either relying on a bespoke program that was not going to cover the full cohort or State and Territory disability systems that were chronically underfunded, I don't think we ever had the building blocks to be able to address them.[211]

Mr Scott McNaughton, Acting Deputy Chief Executive Officer, Government, Communication and Stakeholder Engagement, National Disability Insurance Agency, said that getting younger people out of residential aged care:

> will take a collective effort across all layers of government. Health systems, hospital systems, accommodation systems, the NDIS [National Disability Insurance Scheme] and the aged care system and the department, and all connecting and having early identification so that we can have our planners in there working with those respective systems.[212]

Other witnesses were less enthusiastic about the prospects of the National Disability Insurance Scheme resolving all these difficulties. Mr Bo'sher believed that it is often the simultaneous failure of government systems which lead younger people to go into aged care.[213] He stated that it is 'critical that governments take responsibility for ensuring the coordinated provision of supports across the National Disability Insurance Scheme, health and housing portfolios'.[214] He said that:

> young people going into aged care often need support from the disability system, the health system and also a housing response. It's the lack of being able to work across those different silos that see people go into aged care.[215]

The picture painted by Mr Bo'sher was one of different systems failing to cooperate:

> Health systems lack knowledge of NDIS [National Disability Insurance Scheme] pathways and processes; there are gaps in knowledge and expertise of disability in health systems; NDIS processes are delaying hospital discharge; there are incompatible timelines and concepts of 'urgency' between the NDIS and Health; NDIS planners and support coordinators lack knowledge of how to incorporate clinical expertise in plans; new gaps in services have emerged; and, communication between health and the NDIS is not streamlined.[216]

Dr Morkham described the plight of younger people in residential aged care as 'a system problem':

> These young people come along with integrated health and disability needs and they need concurrent services from health, from disability, through the NDIS [National Disability Insurance Scheme] and from housing. We need those services to be delivered in an integrated or joined-up manner and we need those programs and the governments that manage them to work together.[217]

Ms Peake spoke of her experience in navigating the divides between the aged care, disability and health care systems. She said there was a 'lack of shared tools for assessment and needs identification between sectors', which has contributed to reliance on aged care as 'the provider of last resort'.[218] She explained that younger people who have been in slow stream rehabilitation programs have been transitioned over to the National Disability Insurance Scheme, but that there needs to be continued investment in building the capability of National Disability Insurance Scheme planners to understand the principles that support such rehabilitation programs, and how they support younger people, to avoid entering residential aged care.[219]

9.1.9 Data collection is inadequate

Mr Jamieson, Dr Morkham and Mr Bo'sher each explained that government collection of data about younger people living in residential aged care is inadequate.[220] Dr Morkham said the National Disability Insurance Agency:

> don't know what the level of need these young people in nursing homes have. They haven't asked what it is they would like in terms of leaving aged care; they don't know where these young people would like to live and what circumstances they would like to live in.[221]

Mr Lye admitted that a previous recommendation to the Australian Government to assemble a dataset in relation to younger people in aged care was reasonable.[222] Despite this, the Government did not implement this recommendation.[223] It was apparent at the hearing that even the most basic data about the characteristics of younger people who enter residential aged care was not certain, and that much more work needed to be done to lay the basis for reform of the arrangements.

Dr Hartland described the Australian Department of Health's knowledge about the number of younger people living in residential aged care as 'evolving'.[224] He admitted that the Department has not set up a database containing information about all the younger people living in residential aged care, including the factors that will need to be addressed for the person to move out of residential aged care, as recommended by a 2015 Senate Committee report.[225] He said that the Department was able to track some information about younger people in residential aged care, but that there is not 'an easy way of customer by customer understanding the factors that need to be addressed to have the person move out of the aged care facility'.[226] Dr Hartland suggested that the Australian Department of Health considers that the National Disability Insurance Agency is 'better placed' to understand younger people in residential aged care, despite the Department having responsibility for the aged care system and some younger people being ineligible for the National Disability Insurance Scheme.[227]

Mr Christopher Carlile, Branch Manager, Hearing and Disability Interface, at the Australian Department of Health, said that the way that information about people accessing aged care services is collected is incompatible with the need to track younger people through the aged care system.[228] He explained that:

> The data set for the My Aged Care and the administration of the aged care is to do with administrative data, to do with transaction and payment data. It just wasn't designed or set up to capture the type of information that DSS [Australian Department of Social Services] need in order to look at entry points. It's designed for people who are in permanent residential aged care and to administer a payments system and transactions to do with permanent residential aged care.[229]

Mr Broadhead acknowledged deficiencies in the way that data is collected about National Disability Insurance Scheme participants:

> So what we have is records of decisions of, you know, there's kinds of assessments and transactions that happen as people travel through but we don't know what happened to bring them to that point and we don't have much richness in the detail of what was going on for them when it happened. And…I think it's exemplified by some of the direct evidence that the Commission has heard. You learn a lot from hearing from the people concerned about how it did or didn't work for them. And our administrative data sets are not terribly good at telling us that.[230]

In its post-hearing submissions, the Australian Government accepted that the evidence was clear that 'more detailed data is required to understand the characteristics and needs of this cohort [younger people in residential aged care] to ensure they are properly accommodated, as well as to prevent their entering residential aged care in the first place'.[231]

9.1.10 Conclusion

Younger people deserve more appropriate places to live than residential aged care. The often harrowing evidence given by younger people who live in, or have lived in, residential aged care is compelling. The Australian Government's plan, at the time of this hearing, to help younger people leave and avoid entering residential aged care, is shown to be inadequate. The Australian Government must deploy sustained and dedicated effort to ensure that younger people do not live in residential aged care.

Endnotes

1 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 1, p 233.
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3 Exhibit 9-3, Melbourne Hearing 1, Statement of Lisa Corcoran, WIT.1240.0001.0001 at 0001 [4].
4 Transcript, Melbourne Hearing 1, Jodie Chard, 9 September 2019 at T4826.35–36.
5 Transcript, Melbourne Hearing 1, Lisa Corcoran, 9 September 2019 at T4826.38.
6 Transcript, Melbourne Hearing 1, Lisa Corcoran, 9 September 2019 at T4827.1–2.
7 Exhibit 9-3, Melbourne Hearing 1, Statement of Lisa Corcoran, WIT.1240.0001.0001 at 0001 [4].
8 Transcript, Melbourne Hearing 1, Lisa Corcoran, 9 September 2019 at T4823.5–9.
9 Transcript, Melbourne Hearing 1, Lisa Corcoran, 9 September 2019 at T4821.43–44.
10 Transcript, Melbourne Hearing 1, James Nutt, 11 September 2019 at T5155.30–32.
11 Exhibit 9-18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001 at 0001 [4].
12 Exhibit 9-18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001 at 0001 [4].
13 Exhibit 9-18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001 at 0005 [47].
14 Transcript, Melbourne Hearing 1, James Nutt, 11 September 2019 at T5161.20–24.
15 Exhibit 9-18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001 at 0008 [77].
16 Transcript, Melbourne Hearing 1, James Nutt, 11 September 2019 at T5164.22.
17 Transcript, Melbourne Hearing 1, James Nutt, 11 September 2019 at T5154.11–22.
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19 Exhibit 9-13, Melbourne Hearing 1, Statement of Mario Amato, WIT.1244.0001.0001 at 0003 [16]; 0007 [57].
20 Transcript, Melbourne Hearing 1, Mario Amato, 11 September 2019 at T5120.4.
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22 Exhibit 9-5, Melbourne Hearing 1, Statement of Jessica Dodds, WIT.1239.0001.0001 at 0001 [4] and 0012 [76].
23 Exhibit 9-5, Melbourne Hearing 1, Statement of Jessica Dodds, WIT.1239.0001.0001 at 0015 [98]–[99].
24 Exhibit 9-4, Melbourne Hearing 1, Statement of Catherine Roche, WIT.1238.0001.0001 at 0002 [8], 0006 [47].
25 Exhibit 9-4, Melbourne Hearing 1, Statement of Catherine Roche, WIT.1238.0001.0001 at 0011 [94].
26 Exhibit 9-4, Melbourne Hearing 1, Statement of Catherine Roche, WIT.1238.0001.0001 at 0011 [94].
27 Exhibit 9-4, Melbourne Hearing 1, Statement of Catherine Roche, WIT.1238.0001.0001 at 0011 [91].
28 Exhibit 9-11, Melbourne Hearing 1, Statement of Kirby Littley, WIT.1241.0001.0001 at 0001 [8]–[10].
29 Exhibit 9-11, Melbourne Hearing 1, Statement of Kirby Littley, WIT.1241.0001.0001 at 0003 [27].
30 Transcript, Melbourne Hearing 1, Kirby Littley, 11 September 2019 at T5088.15–18.
31 Transcript, Melbourne Hearing 1, Kirby Littley, 11 September 2019 at T5088.11–13.
32 Exhibit 9-12, Melbourne Hearing 1, Statement of Carol Littley and Kevin Littley, WIT.1242.0001.0001 at 0005 [46].
33 Transcript, Melbourne Hearing 1, Neale Radley, 10 September 2019 at T4966.38–4967.34.
34 Transcript, Melbourne Hearing 1, Neale Radley, 10 September 2019 at T4969.19–21.
35 Transcript, Melbourne Hearing 1, Neale Radley, 10 September 2019 at T4969.21.
36 Exhibit 9-8, Melbourne Hearing 1, Statement of Neale Radley, WIT.1251.0001.0001 at 0003 [25].
37 Transcript, Melbourne Hearing 1, Neale Radley, 10 September 2019 at T4969.05–08.
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45 Exhibit 9-9, Melbourne Hearing 1, Statement of Robyn Spicer, WIT.1245.0001.0001 at 0008 [76].
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47 Transcript, Melbourne Hearing 1, Ben Gauntlett, 11 September 2019 at T5150.28–40.
48 Transcript, Melbourne Hearing 1, Ben Gauntlett, 11 September 2019 at T5152.20–25.
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51 Exhibit 9-22, Melbourne Hearing 1, Statement of Kym Peake, WIT.0420.0001.0001 at 0003 [18]–0004 [22] and 0005 [30]–[32].
52 Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 1, CTH.0001.1000.9493 at 9495 [11].
53 Transcript, Melbourne Hearing 1, Nicholas Hartland, 9 September 2019 at T4866.8–14.
54 Transcript, Melbourne Hearing 1, Nicholas Hartland, 9 September 2019 at T4866.17–26.
55 Transcript, Melbourne Hearing 1, Nicholas Hartland, 9 September 2019 at T4866.35–43.
56 Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019 at T4938.38–45.
57 Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019 at T4938.38–43.

58 Submissions of the Commonwealth of Australia, Melbourne Hearing 1, 25 September 2019, RCD.0012.0031.0001 at 0002 [3].
59 Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 9, CTH.0001.5000.1931; Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 1, CTH.0001.1000.9493 at 9496 [16].
60 Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 9, CTH.0001.5000.1931 at 1931; Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 1, CTH.0001.1000.9493 at 9496–9497 [16].
61 Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019 at T4964.9–4965.20.
62 Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019 at T4965.5–20.
63 Transcript, Melbourne Hearing 1, Kym Peake, 13 September 2019 at T5233.23.
64 Transcript, Melbourne Hearing 1, Tamara Tomic, 11 September 2019 at T5143.30–35; Transcript, Melbourne Hearing 1, Suzanne Lulham, 11 September 2019 at T5143.43–5144.1; Transcript, Melbourne Hearing 1, Liz Cairns, 11 September 2019 at T5144.5.
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68 Transcript, Melbourne Hearing 1, Shane Jamieson, 13 September 2019 at T5183.40–41; Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5184.6–7.
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74 Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5184.33–38.
75 Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5183.29–35.
76 Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5184.44.
77 Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5184.44–5185.3.
78 Exhibit 9-20, Melbourne Hearing 1, Statement of Luke Bo'sher, WIT.0373.0001.0001 at 0036 [194]–[195].
79 Submissions of the Commonwealth of Australia, Melbourne Hearing 1, 25 September 2019, RCD.0012.0031.0001 at 0003–0004 [8]–[9a].
80 Transcript, Melbourne Hearing 1, Kym Peake, 13 September 2019 at T5233.1–18.
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90 Transcript, Melbourne Hearing 1, Peter Broadhead, 10 September 2019 at T5014.31–38.
91 Transcript, Melbourne Hearing 1, Vicki Rundle, 11 September 2019 at T5068.16–33.
92 Submissions of the Commonwealth of Australia, Melbourne Hearing 1, 25 September 2019, RCD.0012.0031.0001 at 0007 [19].
93 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Volume 1, p 252.
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95 Transcript, Melbourne Hearing 1, Mario Amato, 11 September 2019 at T5105.11–17.
96 Exhibit 9-13, Melbourne Hearing 1, Statement of Mario Amato, WIT.1244.0001.0001 at 0001 [5]–[7].
97 Transcript, Melbourne Hearing 1, Mario Amato, 11 September 2019 at T5106.12–24.
98 Exhibit 9-13, Melbourne Hearing 1, Statement of Mario Amato, WIT.1244.0001.0001 at 0002 [12].
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100 Exhibit 9-13, Melbourne Hearing 1, Statement of Mario Amato, WIT.1244.0001.0001 at 0002 [13].
101 Exhibit 9-5, Melbourne Hearing 1, Statement of Jessica Dodds, WIT.1239.0001.0001 at 0011 [69].
102 Exhibit 9-12, Melbourne Hearing 1, Statement of Carol Littley and Kevin Littley, WIT.1242.0001.0001 at 0005 [39].
103 Exhibit 9-12, Melbourne Hearing 1, Statement of Carol Littley and Kevin Littley, WIT.1242.0001.0001 at 0005 [43].
104 Exhibit 9-5, Melbourne Hearing 1, Statement of Catherine Roche, WIT.1238.0001.0001 at 0011 [91]–[92].
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108 Transcript, Melbourne Hearing 1, Neale Radley, 10 September 2019 at T4967.26–28.
109 Exhibit 9-9, Melbourne Hearing 1, Statement of Robyn Spicer, WIT.1245.0001.0001 at 0003 [27].
110 Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5193.38–47.
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112 Transcript, Melbourne Hearing 1, Tamara Tomic, 11 September 2019 at T5136.35–46.
113 Exhibit 9-15, Melbourne Hearing 1, Statement of Deborah Hoffman, WIT.0432.0001.0001 at 0009 [43].
114 Exhibit 9-16, Melbourne Hearing 1, Statement of Liz Cairns, WIT.0421.0001.0001 at 0007 [36].
115 Exhibit 9-16, Melbourne Hearing 1, Statement of Liz Cairns, WIT.0421.0001.0001 at 0010 [51].

116 Exhibit 9-16, Melbourne Hearing 1, Statement of Liz Cairns, WIT.0421.0001.0001 at 0010 [51.2].
117 Exhibit 9-16, Melbourne Hearing 1, Statement of Liz Cairns, WIT.0421.0001.0001 at 0010 [51.2].
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122 Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5204.35–38.
123 Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 146, CTH.0001.8000.0001 at 0039 [134].
124 Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 1, CTH.0001.1000.9493 at 9497 (footnote 8).
125 Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 32, RCD.9999.0177.0042; see also *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020* (Cth).
126 Exhibit 9-1, Melbourne Hearing 1, general tender bundle, tab 2, CTH.0001.5000.2844 at 2852 [41a].
127 Transcript, Melbourne Hearing 1, Vicki Rundle, 11 September 2019 at T5070.34–45.
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129 Exhibit 9-8, Melbourne Hearing 1, Statement of Neale Radley, WIT.1251.0001.0001 at 0004 [33].
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132 Exhibit 9-11, Melbourne Hearing 1, Statement of Kirby Littley, WIT.1241.0001.0001 at 0005 [57]–0006 [62].
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134 Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5200.14–18.
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139 Exhibit 9-21, Melbourne Hearing 1, Statement of Shane Jamieson WIT.0371.0001.0001 at 0004 [21], 0004–0005 [23].
140 Exhibit 9-21, Melbourne Hearing 1, Statement of Shane Jamieson WIT.0371.0001.0001 at 0008 [40].
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10. Melbourne Hearing 2: Diversity in Aged Care

10.1 Hearing overview

10.1.1 Introduction

We held a public hearing, which focused on diversity in aged care, in Melbourne, Victoria, from 7 to 11 October 2019. During the five-day hearing, we heard oral testimony from 27 witnesses and received written statements from 25 witnesses and 28 exhibits into evidence. We explored the aged care experience of older people categorised as 'people with special needs' by the *Aged Care Act 1997* (Cth). We heard direct accounts from witnesses with diverse backgrounds and life experiences who told us about access to, and use of, the aged care sector including:

- people from Aboriginal and Torres Strait Islander backgrounds residing in an urban setting
- people from culturally and linguistically diverse backgrounds
- veterans
- people who are homeless or at risk of becoming homeless
- care leavers made up of Forgotten Australians, the Stolen Generations and former Child Migrants
- parents separated from their children by forced adoption or removal
- lesbian, gay, bisexual, transgender and intersex people.

We also heard evidence from aged care provider representatives with expertise in caring for older people with diverse needs and life experiences. They spoke of the commonality of past trauma and the importance of creating a culturally safe environment. Providers also discussed the fundamental importance of communication to enable older people to access aged care services and avoid social isolation and neglect.

10.1.2 Diversity

Diversity is a hallmark of humanity, yet we have heard that aged care providers and the aged care sector have not always responded to needs that are out of the so-called 'ordinary'. To ensure that the diverse needs of older people are properly met, the Australian Government, through the Aged Care Sector Committee, which consults between government and the aged care sector, developed the Aged Care Diversity Framework and associated Aged Care Action Plans.[1]

Ms Samantha Edmonds, Policy and Research Manager for the National LGBTI (Lesbian, Gay, Bisexual, Transgender, and Intersex) Health Alliance and Chair of the Diversity Sub Group of the Aged Care Sector Committee told us:

> The intent of the Diversity Framework is to embed 'diversity in the design and delivery of aged care; and support action to address perceived or actual barriers to consumers accessing safe, equitable and quality aged care while enabling consumers and carers to be partners in this process'…It was also designed to assist providers in meeting the needs of diverse groups and to meet the diversity requirements under the new Aged Care Quality Standards.[2]

Dr Phillip O'Meara, Director of the Participation and Inclusion Branch, Department of Health and Human Services Victoria, described the *Designing for Diversity* initiative, developed by the Department, by referring to the creation of an approach to system design that seeks to equip people at the outset to consider the 'complexity of lived experience and need'.[3] Dr O'Meara said that *Designing for Diversity* is one mechanism that can be adopted to improve service delivery to particular groups that do not fare as well in life outcome measures.[4]

Legislative definition of 'people with special needs'

Numerous witnesses at the hearing spoke of the suitability of the current legislative definition of 'people with special needs'. Ms Noeleen Tunny, Acting Director of the Policy and Advocacy Unit at the Victorian Aboriginal Community Controlled Health Organisation, and a member of the Diversity Sub Group, stated:

> The usage of the term 'people with special needs' in the 1997 Aged Care Act signifies the difficulty in accessing aged care supports experienced by those groups of people listed. There is no provision in current legislation to address these barriers to access by people with diverse characteristics and life experiences. In short, the current recognition does not promote equity of access to any form of aged care service for people with diverse characteristics and life experiences.[5]

Ms Edmonds's view is that recognition of 'people with special needs' under the Aged Care Act, 'has gone some way to ensuring that people with diverse characteristics and life experiences have access to aged care', but falls short of 'guaranteeing access to safe and high quality aged care services'.[6] Dr David Panter, Chief Executive Officer of aged care provider ECH Incorporated, South Australia, expressed a view that there needs to be better mechanisms to identify 'emerging groups' and their unique needs.[7] Ms Jaklina Michael, Diversity Manager at aged care provider Bolton Clarke, agreed, stating that the definition of 'people with special needs' needs to be broadened:

> Currently, the definition of 'people with special needs' in the Act focuses on groups of people defined by one shared diversity characteristic. While the definition is valuable in improving awareness of the types of 'people with special needs', it fails to recognise that 'people with special needs' consists of people with multiple diversity characteristics. A system that recognises 'people with special needs' based on one characteristic for an entire population group is not enough to support these people.[8]

Ms Helen Radoslovich, Manager of Growth and Development in the Research and Development Unit of aged care provider Helping Hand Aged Care, South Australia, said the conversation about whether 'special needs' is 'the right language', and how groups

are identified, is important. Ms Radoslovich also said that, like a lot of things in aged care, the concept of 'special needs' has evolved over time and a conversation about 'a more sophisticated, better, more effective way' to address diversity is needed.[9]

Intersectionality

We heard a number of witnesses express the view that each person engaging with the aged care system is unique, and that there is much 'diversity within diversity', or intersectionality.[10] People may have variable kinds of complex needs, be part of multiple diverse groups and have multiple diverse parts to their identity. As a result of one or more of these diverse aspects, they may face additional issues or barriers such as discrimination.[11] Dr O'Meara explained that:

> intersectionality is…this concept of diversity within diversity. And the idea that an individual may, because of the multiple rather than one strand of their identity, face additional barriers to either accessing services, which are there for them or to participating in community life.[12]

We heard Ms Edmonds explain that the notion of intersectionality is about:

> acknowledging that people aren't in a box…So, when we're talking intersectionality, we're saying that someone who is a lesbian may also be from an Aboriginal community, may also be homeless, may also have, obviously, mental health concerns and may have experienced other forms of trauma in their life. So it's recognising that people don't exist in a bubble or within one particular identity or expression, that there's lots of different aspects to a person that we need to consider, and that those aspects can result in multiple stigmatisation, discrimination experienced by that person.[13]

Throughout their lifetime, some people might experience multiple forms of trauma, discrimination, violence, homelessness or other adversity. This adverse experience may relate to their diverse characteristics and life experiences, including, but not limited to, their religion, culture, gender, sexual orientation, language or direct experience. When multiple forms of disadvantage or exclusion interact, a person may experience a unique set of inter-related and compounding negative consequences. It follows that a singular approach to diversity cannot cater for everyone in the aged care system.

Dr O'Meara told us that there needs to be:

> a significant shift in practice by policy makers and service designers. This includes an evolution from a purely 'population-specific' approach to diverse communities towards greater recognition of the variability within groups themselves and of the complex intersectional effects of multiple and compounding factors on outcomes for individuals.[14]

Similarly, Dr Panter's view is that the aged care system does not respond well to intersectionality overall, as this requires a degree of sophistication which is currently beyond the majority of providers in the sector.[15] Dr Panter said that diversity should not be seen as a 'nice frilly add-on'.[16] He said:

> It's got to be core to the business, and it has to inform the way in which you do your core business. So, for us, that's just as much about what happens in our recruitment process for staff, our induction for staff, how we advertise our services to the community, how we guide the way in which we practise in our day-to-day delivery of a service. All is part of the diversity framework.[17]

Dr Panter said the Aged Care Act presents 'people with special needs' as a 'list of equals' but that this is not the case:

> Some population groups within this list have been subject to ongoing, systemic discrimination promoted by Government and the Law whilst others on the list have not… This leaves a person with a very different set of concerns about their aged care needs to someone who may have limited services available to them because they live in a remote area or were a war veteran. Each has a unique experience and a need to have those characteristics addressed as appropriate within services they are using yet some will face greater challenges in doing this than others and will need greater support to overcome those challenges. This 'list' approach also compartmentalises people into one or other categories whereas a person may occupy multiple special needs categories—e.g. they could be a gay man, who is a war veteran and who lives in a small rural township.[18]

We heard from Dr Panter that person-centred care requires one to look at the 'unique history' of each individual person and 'that takes you straight to diversity'.[19] Dr O'Meara said that intersectionality is the 'theoretical underpinning' of Victoria's *Designing for Diversity* initiative. It encourages human services providers in Victoria to cater for the intersectional nature of diversity. He said that it is 'a vital ingredient in making person-centred care effective'.[20]

It follows that to deliver person-centred care, service providers need an awareness of a person's unique characteristics related to, among other things, their religion, culture, language, gender, sexual orientation and/or life experiences. Service providers need to take an intersectional approach and work with the 'whole person' to understand their situation, wants and needs to feel comfortable and be more in control of their circumstances. More broadly, the aged care system needs to be flexible and adaptable enough to cater for the particular needs of the many different people who access it.

10.1.3 Cultural safety

We have heard evidence in earlier hearings, particularly those in Broome and Perth, about the importance of providing culturally safe care to older people. In Melbourne, Ms Radoslovich described culturally safe care as:

> providing an environment which is safe psychologically, emotionally, physically for everybody to be able to be who they are, express themselves and have a sense of identity. Identity is core to who we are as humans. It is also a place that people can feel that they can have some control over about what is happening in it. So that they can enter that, continue to be who they are and make changes when the environment around them doesn't support them. When I say environment, I don't just mean physical, I mean the whole sense of service and place and feeling.[21]

Ms Edmonds said that culturally safe care involves much more than just person-centred care delivered through the development of a care plan. She said while a care plan is important, 'if your organisation isn't culturally safe then that care plan isn't going to be sufficient to meet that person's needs'.[22]

To illustrate her point, Ms Edmonds provided the example of a transgender woman who is receiving aged care services from a service provider whose workers are unaware that she is trans and gender diverse. Ms Edmonds said that this woman feels she will not 'come out', revealing her gender, 'because the environment isn't safe'.[23] She said:

> I would believe the provider thinks they're delivering fantastic person-centred care to this person but they're actually not because that person is not feeling safe, is not feeling included, is listening to transphobic slurs that are happening across the organisation and, you know, so they're just sort of hiding themselves and just going along and pulling the line and pretending that everything is fine. So, while person-centred care is important, it's only a part of the whole picture. And unless we actually have fully culturally safe services, person-centred care will never be as actually effective as it could be.[24]

Speaking regarding LGBTI people, Ms Edmonds said:

> LGBTI older people have lived through a time of intense discrimination and stigmatisation. We know it still continues today, and every time there's a public debate about the rights of LGBTQI [Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex] people, you know, it then builds in and reinforces that trauma that our elders and people have faced. So, we need to ensure when they are accessing aged care, whether it's residential care or home care, that it, in fact, is safe for them to be there, it is safe for them to be out, and they don't have to feel they have to hide when they access those services.[25]

The words of Malloy, an 84-year-old lesbian woman, echoed this view, with her saying 'LGBTIQ people should be treated with respect and people should be able to be themselves without having to hide their sexual orientation'.[26]

Ms Michael said cultural safety is one of the 'most important factors' in providing care and meeting the needs of people receiving care:

> Culturally safe aged care means that care recipients feel safe in their experience of aged care services and that they can share their life story and experience, without fear of discrimination or stigma.[27]

Ms Michael also spoke of the 'high potential to re-traumatise care recipients' if a provider fails to provide culturally safe care due to care recipient's previous experiences. These may include 'racism, discrimination, abuse or institutionalised care'.[28] Malloy described the impact of her experience at a facility that she feels 'has done nothing to promote an LGBTIQ culture':

> I am not aware of the staff undertaking any specific training to help educate them on the needs of LGBTIQ people. This discrimination has had a significant impact on me. It has brought back memories of younger days. I experienced a lot of discrimination when I was younger and these events brought back all of those negative feelings.[29]

Ms Elizabeth Drozd, Chief Executive Officer of Australian Multicultural Community Services Incorporated, said:

> if people with diverse characteristics and life experiences are not always supported with services that are culturally appropriate / 'safe', there is a significant risk of people dropping out of services, which can lead to missing out on much needed assistance, necessary in supporting people to remain living independently in the comfort of their own home for as long as possible.[30]

The words of Ms Anne Tudor, a 69-year-old woman who gave evidence about her experience and that of her wife, Ms Edith Maree Mayhew (Edie), reinforced the importance of understanding and celebrating difference:

> I think we all have to be very mindful that when somebody who has a very different background comes into residential care that extra effort is made to assist that person to settle in and to have a life there that is, you know, worthy of them as human beings and provides them with what they need. So someone who looks different or someone who is different, we need to be celebrating this. We need to be celebrating diversity and not be frightened of it.[31]

Fear of institutional re-traumatisation

We heard evidence from a number of people who had survived abuse in institutional care as children. For the most part, these witnesses did not want to live in an institutional setting again, fearing it would re-traumatise them.

Ms Heather Brown, a Forgotten Australian, who was a Ward of the State from two years of age and who lived in a number of State ward homes, told us that she perceives aged care facilities as institutions similar to those in which she grew up. She shared her reflections about her fear of re-entering an institution:

> I would be terrified if someone told me I had to move into a residential aged care facility. I would resist it, not literally, but I would fight it. I see aged care facilities as institutions just like the ones I grew up in. They are exactly the same to me. I don't like the idea of confinement and lifestyle. I think it would cause me to have flashbacks of my time in care as a child…
>
> Lots of Forgotten Australians are terrified of when they are no longer able to care for themselves. Some say to me that they would rather be given injections and killed than go back into an institution.[32]

Ms Janette McGuire, also a Forgotten Australian, spoke about her fear of being placed back into an institution. She said Forgotten Australians:

> are scared of going back into an institution and having experiences similar to when we were younger. In my experience with an aged care facility you are not in control. You are told what to do all the time. It is just like when Forgotten Australians were being told what to do in institutions as children.[33]

When Ms McGuide was aged 14 years, her mother had 'gone missing' and never returned. Ms McGuire was moved into a State controlled child welfare institution. Ms McGuire told us about the impact of this on her more recent experience of staying in a short-term aged care facility after an operation. She said it triggered memories and flashbacks of her time as a State ward.[34]

Ms Edmonds said that we often fail to recognise that the environment where person-centred care is delivered can be quite frightening to a person who may have experienced abuse or institutionalisation throughout their lifetime:

> we are saying to that very person, 'Hey, come and trust these services that actually discriminated against you for your whole lifetime. You know, you can trust them now. They're going to do person-centred care, you will be fine, and you will get good services.'[35]

Ms Moreen Lyons, a Jaadwa woman of the Wotjobaluk nations and Chief Executive Officer of Aboriginal Community Elders Services Inc, said that for Aboriginal and Torres Strait Islander people, the need for trauma-informed care is very much linked to 'intergenerational trauma'.[36] This view was also expressed by Uncle Brian Campbell, a Murri man and a Stolen Generation survivor, who described his experience of living in an institution as a child:

> They wouldn't tell us anything. They didn't want to tell us that my father was Aboriginal. We weren't to deal with our language, our culture or anything like that, and that's why a lot of Aboriginal people committed suicide because they weren't told about their family.[37]

It is apparent that there is a need for effective systems in the community to help trauma survivors manage their lives in whatever setting they choose to live in now. These need to follow a trauma-informed approach.

Trauma-informed care

We heard that aged care service providers need to implement a trauma-informed approach that includes ongoing staff training, and trauma-informed policies and practices. Dr Duncan McKellar, Head of the Older Persons' Mental Health Service in Northern Adelaide Local Health Network, South Australia, discussed the importance of a trauma-informed approach to care provided by his service:

> What we are trying to achieve is a service where we have that universal precaution of trauma-informed approach that means we won't re-traumatise anyone, that we will be ready to provide dignified respectful care to all.[38]

Dr McKellar said that this should be a 'universal precaution…just the same as we teach all health practitioners to wash their hands; we should also be ensuring that all care providers are trauma-informed'.[39] Dr McKellar said that service providers need to be mindful that trauma can re-emerge at any time during a person's interactions within the system and organisations need to recognise their employees may also have a trauma history.[40] However, Dr McKellar acknowledged that trauma-informed care is in the 'early stages of uptake in aged care contexts', and that 'one of the main challenges in implementing trauma informed care is the gravity and breadth of culture change required'.[41]

Mr Nathan Klinge, Chief Executive Officer of RSL Care SA, and a former Australian Army Officer, said the 'cultural factors of military service' are generally not understood by the broader community.[42] He said that most aged care providers were well positioned to manage issues associated with ageing, such as dementia, however his organisation's position was that the industry was less well informed and resourced to manage other mental health issues.[43]

Mr Klinge explained that a range of factors can impact on a veteran's life. Consequently, RSL Care SA has been confronted with 'younger veterans who are physically unwell, that are facing a range of mental challenges and that don't have a network of family and social support to provide the supports they need'.[44] He said RSL Care SA has partnered with Phoenix Australia, an organisation which has expertise in working with people who have experienced post-traumatic stress disorder, to help address this.[45]

Mr Klinge described trauma-informed care as an 'evidence based' approach which informs RSL Care SA's behaviour as a care provider.[46] Benefits emerged because:

> when you are having an interaction with a resident, what you are seeing as in front of you, it's about actually understanding what's going on behind that scene, understanding the causes, understanding, and the second way is to help the residents either de-escalate from a fairly significant issue of anxiety and concern for them, but ideally understanding ahead of time so that we don't get there. We understand the triggers for residents, we know what the residents like.[47]

Ms McGuire spoke of the need for understanding and trauma-informed care within the community and by carers of survivors of trauma:

> Forgotten Australians don't want much. We just want the government and the community to understand the trauma we suffered as children. This will inform people's ability to care for us when we again enter into a vulnerable time of our lives in old age. We continue to try to move on with our lives. But being a Forgotten Australian means the trauma is always with you. As we get older, our fears become worse. We are becoming more and more terrified of entering aged care.[48]

Ms Tunny, from the Victorian Aboriginal Community Controlled Health Organisation, recommended that while requiring training for staff about how to provide trauma-informed care would be a 'good start', the approach needs to be 'embedded through the organisation's policies', and 'boards need to be made aware of it and how it can be addressed… in communities that they serve'.[49]

Specialisation

We heard various perspectives about aged care services that specialise in providing care to a particular cohort. Ms Lyons stated that:

> Aboriginal people won't seek to be admitted into western services…there's going to be a considerable spike in demand over the next 10 years for aged care services for Aboriginal people and there needs to be some really good planning around that or there will be a real crisis in terms of how people are looked after and where they're looked after.[50]

Uncle Brian Birch, an 83-year-old Aboriginal man who has lived for three years at Aboriginal Community Elders Service in Victoria, said that he feels uncomfortable living in an aged care facility that does not specialise in Aboriginal and Torres Strait Islanders.[51] Uncle Brian Campbell, aged 65 years, said that although he would prefer to live independently, he is 'feeling safe' at Aboriginal Community Elders Service. He said 'the main thing for me is safety… and I have my independence as well there; so it's not all-cut-and-dried like most places are'.[52]

Mr Brian Lynch, a 73-year-old veteran, spoke of his experience in aged care. He said he lived in a mainstream regional facility in New South Wales, prior to moving, in 2016, to the War Veterans' Home in Adelaide, South Australia. The War Veterans' Home is a residential aged care facility for veterans. He told us that he has no memory of the time spent at the regional facility between 2010 and 2015. He was treated for a number of illnesses, including post-traumatic stress disorder, depression and dementia. Mr Lynch

gave evidence that his medication has been reduced, his memory has returned, and his diagnosis of dementia has been reversed.[53] Mr Lynch said that for him, it is 'very important to be in a place where my experience as a Vietnam Veteran is understood'.[54]

Ms McGuire said that the general community does not understand enough about Forgotten Australians and what they have been through. She said that if she had to enter residential aged care, she would, 'prefer to be surrounded by other Forgotten Australians'. She said she would 'need that peer support and shared experience to feel comfortable'.[55]

Ms Brown spoke of her fear of not being understood as a Forgotten Australian. She questioned whether aged care facilities will be properly equipped to 'understand the trauma that we have already suffered', and whether 'they can assure us that we will not suffer that trauma again in aged care'.[56] Ms Brown expressed her reluctance to register with services, such as My Aged Care, because of a fear that the service does not 'understand' Forgotten Australians. Ms Brown said that she would find it helpful to have 'someone liaise between Forgotten Australians and My Aged Care'. She said, 'I do feel different and I feel that if there was an agency for Forgotten Australians in aged care that would be a great idea'.[57]

Ms Catharina Nieuwenhoven, a 78-year-old Dutch woman, told us that her mother's experience in hospice care motivated her to establish a Dutch residential aged care facility in Adelaide, South Australia. Ms Nieuwenhoven grew up in Amsterdam, Netherlands, until she was aged 16 years, when she and her family emigrated from there to Australia. Ms Nieuwenhoven said that the Dutch culture is very important to her and she now receives home care services from the same provider that she established.[58]

Ms Mary Patetsos, Chair of the Federation of Ethnic Communities' Councils of Australia and a member of the Aged Care Sector Committee Diversity sub-group, said that aged care should be designed to encourage a concept of 'clustering', which she views as providing a double benefit of enabling 'the provision of higher quality services and provides much needed social support'.[59] She said:

> In short, we think it's a very sensible market response to a challenge which is diversity in terms of culture and language. So, I think it's a rational business decision because you can market yourself as a very good provider, an expert on doing that community. It also addresses some of the very fundamental needs that individuals have, which is the joy that we all have to be around people we share many things with. So, it's not a very complex idea to describe and it actually makes sense, but it has been almost impossible to execute.
>
> …
>
> It's certainly a model where research has been found to be very positive in respect to people with dementia because, again, you can become very good at doing that and you can market to the community that that's what you're good at. You can invest in it as a provider. You can train your staff. You can get staff, in the case of dementia, [who] are experts in that or in the case of catering for the Vietnamese community, perhaps speak Vietnamese, understand the culture. And you can do it in a way that has a positive business outcome for you. You can be meeting your standards, you know, with flying colours and you can meet your community need and people will be happy. So that's the concept, in a nutshell.[60]

Ms Patetsos said that the aged care system should be designed to encourage providers to consider the social demographic profile of their population and design services to cater to the needs of those specific groups, adding that this enables higher quality services and provides much needed social support.[61] However, Ms Patetsos was cautious to note that 'clustering', by developing and implementing a model which provides ethno-specific aged care services, will not solely address the challenges of dealing with diverse populations:

> Every provider that gets Commonwealth funding that exists with a licence to operate has a responsibility to meet the needs of any individual that may knock on their door. And to focus on an ethno-specific model as if that is not the case is not doing a service to anyone. So, the point being that ethno-specific works for some communities. It's wonderful when it does work. It can't meet the needs of the majority of people. If 36 per cent of the population are CALD [culturally and linguistically diverse] they will not all be in ethno-specific facilities. So, our responsibility is to make sure that the whole system is totally responsive and the models of care will follow and ethno-specific is one of those.[62]

Mr Klinge said that because RSL Care SA's Morlancort facility is located in a very strong Vietnamese community, management at that facility has become aware of certain cultural practices and ensures that they have staff who are able to speak Vietnamese.[63] Mr Klinge also told us that he believes there is a need for culturally and linguistically diverse specialist providers and providers across the board to cater for diverse groups. Mr Klinge acknowledged that there are both challenges and opportunities when catering for a multicultural society as the population changes.[64]

10.1.4 Communication

Ms Patetsos expanded on her evidence, given during Adelaide Hearing 2, regarding the importance of effective communication:

> language, and communication is critical and remains critical. The reasons for that is that a lack of communication, a lack of capacity to communicate undermines people's wellbeing, it undermines people's right to be understood and to understand. And it also undermines their capacity to control their care plans and their experience in care, regardless of whether that care is happening at home, but particularly so if it's happening in a residential facility, where they get less access to family members who can assist.[65]

Right to communicate

The right to communicate in the language of choice is key to meeting the needs of people with diverse characteristics and life experiences.[66] Ms Drozd spoke of the potential for older people who speak English as a second language to experience language regression.[67]

Ms Patetsos told us that the number of older people suffering from dementia-related disease is increasing, and dementia impacts on the ability to retain language learnt later in life.[68] She said, 'communication is critical…So, without resolving that issue, anything we do falls short…people's communication needs need to be met in full where that communication requires formal communication'. She said that where communication relates to a personal care matter or daily routine, 'perhaps you can use unqualified staff to manage'. However, 'where it is about explaining clinical conditions, medical

conditions…[the] right to have that information direct from a professional requires the use of professional interpreters'.[69]

Ms Nieuwenhoven spoke of the need for interpreters once a Home Care Package is granted so that people's entitlements can be explained in simple language.[70] Ms Drozd said there can also be issues around the types of questions asked by assessors and a lack of understanding from culturally and linguistically diverse older people about the purpose of such questions. This can lead to incorrect assessment outcomes.[71]

Mr Jaye Smith, First Assistant Secretary, Residential and Flexible Aged Care Division, Australian Department of Health, said that the Department provides access to interpreting services primarily for the purposes of 'initial access to the system, establishing and understanding contracts or agreements with providers and care planning' through Translating and Interpreting Services National.[72] For the period 1 July 2018 to 30 June 2019, the cost to the Department for interpreting services was $1.455 million, with people bearing some of the cost of those services through their Home Care Packages when accessing interpreter services during regular service delivery.[73] Ms Michael said that Translating and Interpreting Services National has a shortage of interpreters. There are a high number of cancellations and older people can wait up to one month for services as no interpreter is available.[74]

Mr Smith agreed with the proposition made by Senior Counsel Assisting that the current interpreting services provided are generally linked to the context of entry into the system, and that this is 'woefully inadequate'. When put to Mr Smith that interpreting services need to be better resourced by the Australian Department of Health, he said that once a recipient is in care, it is the responsibility of the provider to ensure that they are able to deliver appropriate care, including accessing interpreting services. However, he noted that when a recipient is in residential services, there is more flexibility for the provider to access interpreting services required for particular instances of care, as opposed to the general day-to-day support required for providing care.[75]

The role of interpreters

Deficient communication or failures in communication have a direct impact on those attempting to access aged care and on people receiving care. Interpreters play a crucial role in assisting with effective communication for those who do not speak English as a first language, including older Aboriginal and Torres Strait Islander people. Numerous witnesses spoke of the need for professional interpreting services for culturally and linguistically diverse older people throughout each stage of accessing aged care services.

Ms Tunny stated that there is a need for older Aboriginal and Torres Strait Islander people, living in remote areas, to have access to interpreting services.[76]

Mr Smith gave evidence that through the Australian Government Diversity Action Plan 2019, the Australian Department of Health is committed to improving Aboriginal and Torres Strait Islander language interpretation services, with work starting through an agreement dated September 2019, to provide interpreting services through Aboriginal Interpreter Service in the Northern Territory.[77] Mr Smith said that there are interpreting services

available now for people speaking an Aboriginal and Torres Strait Islander language when contacting My Aged Care. Interpreting through assessment and care planning processes has not yet been established, but a project is underway to identify how this might occur.[78]

Auslan interpreting services are not available for My Aged Care. However, deaf older people, hard-of-hearing older people, or people with a speech impediment, can access the Australian Government's National Relay Service which enables them to make and receive phone calls. The National Relay Service will notify My Aged Care of an older person's communication requirements so that arrangements, including Auslan services, can be made for the assessment process. Mr Smith said that older people in receipt of a Home Care Package can negotiate with providers to use their Home Care Package funds to purchase interpreting services.[79] However, this is an impost on care funds that others are not required to bear.

Mrs Elizabeth Karn, a 68-year-old woman who is profoundly deaf, gave evidence about the gap in services between the National Disability Insurance Scheme and My Aged Care, impacting on deaf Australians aged 65 years and over. While Auslan interpreters are available through the scheme, they are not available through My Aged Care. Mrs Karn stated that because this service is not provided by My Aged Care, she relies on her daughter to assist her with appointments and meetings.[80] She said:

> As a Deaf Elder, I am exhausted and feel broken along with my friends who are in the same situation as me. We feel excluded, neglected and now isolated because of our disability and age. Where do we belong? When are we going to be included and accepted as valued Australian citizens? We just want the right to gain access to services and funding that allows Deaf Elders the right to communicate freely in our country. [81]

In post hearing submissions, the Australian Government acknowledged that the need for Auslan interpreters is an area of service delivery that requires development, stating that the Australian Department of Health will, 'examine options to expand interpreting services'.[82]

Impact of deficient communication

We heard about the importance of considering the impact of insufficient communication on older people, including social isolation. Ms Patetsos told us:

> The critical nature of language is there because without language not only are you left with less information, but you're also in a position where you're socially isolated. If you cannot communicate with the people around you, you have no one to talk to for most of the day, because your family is only there for a limited amount of time, if at all. So, the level of socialisation for individuals who do not share a common language in a facility is extreme…I believe that the research shows quite strongly that their socialisation [social isolation] leads to compounded complexity in their care and to mental health issues within residential facilities.[83]

Mr Angelos Angeli told us about issues he has encountered in accessing Greek-speaking workers to provide home care services for his mother. Mr Angeli and his parents were Cypriot refugees who moved to Melbourne, Victoria, in 1975. Mr Angeli lives with, and is the carer for, his 82-year-old mother.[84] Despite his requests, the majority of the workers

who assist Mr Angeli's mother do not speak Greek. He said he observed his mother becoming socially isolated and lonely because the workers who attend her are unable to communicate with her.[85] Mr Angeli also spoke of the impact that his mother's social isolation has had on him because he is aware that she is anxious and not able to relax when she is alone.[86]

Communication of diverse needs

The need for effective communication goes beyond issues with language. Mr Klinge gave evidence that RSL Care SA has a program called 'Really Special Life' which involves the facility holding a number of interviews within the first few weeks of a resident's admission. This program gives the facility 'a picture' as to who the resident is, and who they want to be in residential care, which is then fed into their model of care.[87] He provided an example of where this program has worked with respect to a resident's palliative care plan. A resident at RSL Care SA had a religious belief which meant that she did not want to be touched for 24 hours after she passed away. Through their Really Special Life assessment, staff members were able to alter their usual practices to align with the resident's wishes.[88]

Ms Radoslovich told us that it is critically important that staff understand a client's background and the circumstances which might impact on their care:

> We can't work with a person, effectively, and understand their needs or give them space to communicate those needs to us if we don't have some understanding of who they are and what that background is. We need to provide opportunities at every part of every interaction we have with people for them to feel that they can trust us, to open up and declare to us who they are and what they want. Sometimes we will find that we will work with someone for a long time before they will declare certain information and that's part of their learning—their learning to trust us. And we need to be open and listen all the time and be quick to respond.[89]

Ms Patetsos gave an example of a group of Jewish women who migrated to Australia, following World War II. They had worked in factories in the 1950s and 1960s and went into aged care. The facility's staff members were unaware of the women's experiences. As a form of entertainment, staff members gave them craft work to do throughout the day. However, the women interpreted this as debt recovery for the board, rather than a form of entertainment or a pastime. Ms Patetsos said:

> So, they literally knitted and crocheted for hours on end feeling it was their obligation as women who had no rights to ask for anything else, but to continue to produce as they did in the factory, to produce goods, to have the right for the meal at the end of the day. So, the example that I give is one where there was a complete lack of understanding across culture, a complete lack of understanding of the vulnerability of these women that they never felt they had an entitlement to something unless they worked for it, and so the facility in the end would gift these crocheted goods across to the Red Cross.[90]

Ms Radoslovich said that that staff training about communication culture is important and recommended it as an ongoing process:

> We need to work with everybody, our residents, our home care service clients and our staff to be appreciative of, and think positively around what other cultures can offer us. We can learn a lot from some cultures about respect of older people which is not necessarily a feature of the Australian society, which is, yes, can be quite ageist in some ways…Culture is not – or people with a cultural or linguistic difference are not that group over there. It's actually all of us. And we need to learn how we communicate with each other and how we seek to understand that difference. It's an ongoing process, and some of it is dealt with at individual levels, some of it would be more through our training.[91]

10.1.5 Navigation and assistance to access aged care

The Royal Commission has heard about issues and challenges with system navigation and access to aged care services in previous hearings. These issues and challenges can be compounded for people from diverse backgrounds.

Ms Michael gave evidence that My Aged Care may not be appropriate for older people with diverse needs and may act as a barrier to accessing services.[92] These difficulties include, 'managing an overly complex website, the complexity of language used in My Aged Care correspondence, and the complexity of the application process to receive care.'[93] Ms Samantha Jewell, Executive Manager of Sales and Marketing at Lifeview Residential Care, Victoria, told us that often those who have experienced discrimination may be afraid to access care, requiring funding for programs that assist people to access services.[94] Ms Drozd said:

> People with diverse characteristics and experiences (CALD etc.) continue to experience a number of barriers in accessing aged care services. The most common problem is both a language and a lack of information barrier, where many people struggle to understand and navigate the complex aged care system. This often requires one-on-one or face-to-face support and client advocacy... Providing this kind of support ensures that clients do not miss out on needed aged care support services because of their diverse needs.[95]

Dr Panter spoke about older people needing to rely on advocates, often family members, when accessing and navigating My Aged Care. Dr Panter said it may be unlikely for a member of the LGBTI community to have that family support who could assist them in accessing services. ECH Incorporated's LGBTI Connect service was co-designed with the LGBTI community to address this need for assistance in navigating the aged care system.[96]

Similar issues are faced by members of the culturally and linguistically diverse community. Ms Drozd also paid attention to the need for culturally and linguistically diverse older people to rely on family support to access aged care services. They may experience disadvantage if family members do not have the time, or the language skills, to assist in accessing aged care services.[97] Australian Multicultural Community Services has prepared information resources for other providers so that they can respond to culturally and linguistically diverse older people in a more appropriate way.[98]

Dr Panter said that in ECH Incorporated's experience, new migrant communities may be reluctant to engage in aged care services. The older generation may expect the younger generation to be their primary care providers and may not be aware of the Australian aged care system. However, he said this arrangement is becoming less likely, leaving the older generation vulnerable at home.[99]

The Victorian Access and Support Program Network submitted that, as part of their Commonwealth Home Support Programme services, the network 'ensures equitable access to the aged care system for people from diverse backgrounds, who may be experiencing barriers to receiving services.'[100] The Victorian program is funded with Australian and State Government support. Dr Nicholas Hartland PSM, First Assistant Secretary, Home Aged Care Division, Australian Department of Health, gave evidence that this program was valuable, but its suitability for application nationally has not yet been evaluated.[101]

Ms Michael said that the Victorian Access and Support Program was:

> making a valuable contribution to the aged care sector. It is successfully providing culturally appropriate support and access / navigation to special needs populations. I believe that it should be maintained and extended across the aged care system, as it is essential for the effective access and use of aged care services to CALD, Aboriginal, LGBTI and other special needs groups.[102]

Ms Drozd spoke of the importance of one-on-one support for culturally and linguistically diverse communities, praising the Victorian Access and Support Program. Australian Multicultural Community Services has 54 people on staff, based in various organisations in Victoria, who form a 'bridge' between services and older people who will have difficulty accessing services. Ms Drozd told us that the majority of their Access and Support worker's time is spent on one-on-one assistance.[103] Ms Nieuwenhoven spoke of her involvement, as a community liaison officer, with her local council and experience in assisting peers from the Dutch Community who are not aware of My Aged Care and their entitlements.[104]

Mr Lynch spoke of the difficulties he experienced accessing and receiving services which he is entitled to through the Australian Department of Veterans' Affairs.[105] Ms Elizabeth Cosson AM CSC, Secretary of the Australian Department of Veterans' Affairs, agreed that assessments and administrative steps required by veterans during the transition from department-specific services to mainstream services should be consolidated.[106]

Homelessness

The Royal Commission has heard many witnesses speak about the benefits of ageing in place and home care. Older people who are homeless or at risk of homelessness do not have equitable access to the opportunity to age in place. Ms Fiona York, Executive Officer of Housing for the Aged Action Group, gave evidence that difficulties arise in accessing and providing care in the home if housing is inappropriate, insecure or unaffordable.[107]

Over the last 10 years, there has been a change in the demographic profile of older people in relation to their housing. Ms York said that between 2011 and 2016 there was a 42% increase in the number of people aged over 65 years paying unaffordable rent. Between 2006 and 2016, there was a 48% increase in homelessness for people aged 55 years and over, and a 53% increase in those aged 65–74 years.[108] Ms York told us that there has been an increase in people retiring with mortgages, people relying on the private rental market, and people experiencing rental stress. She said that not having access to stable housing impacts on the health and wellbeing of older people:

> it's not just around service delivery either. It's about social connection and it's about health and wellbeing…there has been a recent study through the Benevolent Society that said that the number one factor for an older person's health and wellbeing is affordable housing. So…what we find…is that once they've got their stable housing…lots of their other health issues drop away. So, they suddenly become socially connected and they suddenly… are able to manage other chronic health conditions.[109]

Ms York spoke of Housing for the Aged Action Group's involvement in the navigator pilot project targeting homelessness. The group has found that the My Aged Care workers are unaware that those who are homeless, or at risk of homelessness, are entitled to services at the age of 50 years. Ms York's evidence was that one of the first questions that applicants are asked by My Aged Care telephone staff members is whether the person is aged over 65 years. Those aged 50–65 years are refused an initial appointment for an assessment on the basis of their age. Ms York said, 'You just get bumped off…We've been told there's going to be training but first cab off the rank you can't get through that door.'[110] She continued:

> Then if by some miracle you do get through the door, then you need to go through assessment and often the assessors aren't aware of the eligibility. They have really inconsistent information around what they tell each other, what they tell their clients…so that's another barrier. And then if they do actually get assessed then there's…where do the letters go to? Do you have 100 points of ID? All of those things are quite difficult for people who are transient, who are couch surfing, who are moving from place to place relying on friends and family. The letter with the number goes missing, or they're confused about what the letter means. So, there are so many barriers before you get even the most basic of support.[111]

Ms York also spoke of issues associated with access to services for someone who is in unstable, or in unsuitable housing, but who is granted a Home Care Package. She told us that there have been occasions where Commonwealth Home Support Programme and Home Care Package services 'may be denied or withdrawn due to occupational health and safety factors for staff where the service provider determines the environment to be inadequate or unsafe as a workplace'.[112] For instance, where the house is overcrowded or mouldy.[113]

The Australian Government disagreed, in post hearing submissions, with comments made by Senior Counsel Assisting in closing remarks that the aged care system is predicated on the assumption that a person has access to a home to reside in, or sell, to access aged care services.[114] However, the Australian Government only referred to measures applicable to residential care and did not address equity of access to home care.[115] It appears that stable access to home care is predicated on not being homeless, or at risk of homelessness, and having security of tenure.

10.1.6 Leadership and culture

Many witnesses spoke about the importance of strong organisational leadership to create the structural and cultural changes needed to address diversity. Dr Panter also gave evidence about the approach taken by ECH Incorporated when restructuring the organisation to have a focus on diversity:

> The key challenge for ECH in embracing diversity has been to ensure that the organisation is authentic and follows through on the commitment it has made openly to members of these communities. This required the leadership of the organisation, both the Board and the Executive, to fully understand and support the approach taken and have an appropriate risk appetite when incidents arise that could derail the work.[116]

Dr Panter also stated:

> It is also critical to ensure that all staff have an awareness and understanding of why paying attention to diversity is an important component of providing good quality services to any person as they age. For ECH this is founded from a Human Rights perspective and the importance of self-determination.[117]

Ms Michael gave evidence about Bolton Clarke's diversity framework and the reason that they took this approach:

> When you have a geographically-dispersed organisation and workers working in people's homes and in different environments, in order to understand and to have shared values for diversity, we…decided that we needed an organisational strategy that would support all our workers with understanding and responding to the diverse care needs and choices of care recipients. And so a structured strategy like the diversity framework that looks at establishing policy and practices to enable greater diversity and equity was required.[118]

Similarly, Ms Jewell spoke of changes made to the recruitment and education protocols of Helping Hand Aged Care to reflect that the organisation is LGBTI inclusive. She said these measures include being clear about their policy of inclusivity: in jobs advertisements and on Helping Hand's website; at job interviews; when analysing responses to 'a series questions based around acceptance and inclusivity and respect'; and in face-to-face training for new employees through local resources such as Transgender Victoria, Val's Café and LGBTI Health Alliance.[119]

Dr Panter outlined difficulties which may be faced by aged care providers if they were to adopt ECH Incorporated's approach, speaking specifically about the organisation obtaining the Rainbow Tick Accreditation:

> Creating a culture that recognises and supports diversity takes time and resources. This can be seen by some providers as an unnecessary 'extra' that is not given the same status as other compliance requirements even though this is clearly a key requirement of the Aged Care Quality Standards — Standard 1 (Consumer Dignity and Choice).[120]

Ms Tudor told us that she encountered an example of good leadership at the residential aged care facility where she and wife, Edie—diagnosed with younger onset dementia—were welcomed. She felt reassured by the Chief Executive Officer's attitude, 'because if management have an open and accepting attitude towards LGBTI people, this attitude

will filter down to staff'.[121] This contrasts with the experience that they had had previously with Edie's home care provider. Ms Tudor said that:

> I would have liked for our relationship to be recognised in some way. I would have liked the organisation to have been more considered in the carers they sent to our home because of our LGBTI status and more sensitive to our feelings about opening our home and our relationship to a stranger. Having encountered a lack of acceptance and discrimination through our lives, such efforts would have been gratefully received.
>
> …
>
> One of the carers who attended Edie that week knew both Edie and I by reputation in the LGBTI community. The care worker herself was a member of the LGBTI community. I was shocked that our HCP provider had such a suitable carer in their workforce and that she had never been offered to us before as a carer for Edie.[122]

She also said:

> I believe that a service that is meant to support you and help keep your loved one home for longer failed Edie and I miserably. I am still angry and sickened about that. I had to place Edie in residential care earlier than I wanted as I was completely worn out, defeated and demoralised.[123]

There is a need to develop a culture of inclusiveness, in addition to the need for strong leadership. Evidence given by approved providers illustrated that recruitment is critical to develop this cultural change.[124] Dr McKellar gave evidence of a values-based workforce as a core element of recruitment:

> I think that building a values-based workforce is going to bring passion and care and commitment and humanity back in as a core recruitment element. And a principal thing that we're seeking to build within a workforce [is] people who are committed to removing those sorts of power imbalances that happen between doctors or nurses or clinicians and people who receive care. And that needs to be organisationally embraced then as well. It needs to go across whole organisations and it needs to go from the CEO through to the people that are managing hotel services or cleaning or delivering food or whatever. It should be part of the whole package.[125]

Dr McKellar attributed poor workplace culture to the principal causes of events that led to the closure of Older Persons Mental Health Service, Oakden, South Australia, in September 2017. He emphasised that it is 'critical to understand' that it was a 'cultural failing' of the 'organisation and… the people that worked within it', and that was at the core of what went wrong.'[126] Dr McKellar said organisational support is important and that commitment is required 'from the CEO level right through to the…grass roots delivery of care'.[127] An article written by Dr McKellar and Jackie Hanson and referred to in Dr McKellar's oral evidence, outlines the importance of values-based recruitment:

> Values based recruitment requires strategic thought, planning, preparation and skilled recruiters…The results of values based recruitment include reduced agency and recruitment costs, reduced staff turnover, improved morale, more positive work environments, reduced sick leave, increased job satisfaction and improved quality of care.[128]

When discussing the approach adopted by ECH Incorporated, Dr Panter said:

> I think it's been about that issue of authenticity. It's been about how do you actually make sure that it's something you're not paying lip service to, and therefore you do have to put the time and the energy in terms of the staff into training and development. There's no reason to believe that our workforce is any different to the wider community; they will come with their own views, values etcetera etcetera. And it's our responsibility as their employer, to help them look at what being inclusive means, what diversity is about. And so that does take time and energy and resource, to actually make sure that we're providing the support to our staff.[129]

Malloy recommended there be mandatory staff training, particularly with respect to working with LGBTI people so that LGBTI people feel welcome and safe, saying:

> Due to LGBTIQ elders not speaking about the discrimination they are experiencing, it may seem to other people that there is no issue. I believe there should be mandatory training on caring for LGBTIQ elders. This training should be for all staff at all levels of these organisations and facilities. Steps should be taken to make sure LGBTIQ people, particularly elders who have often suffered through a life of non-acceptance, are made to feel welcome and safe in residential aged care facilities.[130]

This view was reinforced by Ms Tudor:

> I encourage mandatory training for all aged care staff on providing care that is sensitive to LGBTI people's experience, many of whom have experienced institutionalised discrimination and negative judgement.[131]

Ms Michael gave evidence about the need for a culturally competent workforce:

> We need a workforce that is culturally competent, a workforce that receives the training that they need and receives that training in an ongoing way to ensure that they are capable, that the system is capable to meet the needs of a very diverse care recipient population that we have.[132]

Co-design

Dr McKellar was a member of the Oakden review panel, led by SA Health's then Chief Psychiatrist, Dr Aaron Groves, in 2017, and assisted in writing the Chief Psychiatrist's report into the facility's failings. Dr McKellar was then involved in the task of transforming Oakden over two-and-a-half years. In doing, so he applied a model of co-design which he described as follows:

> co-design in simple terms is actually collaborating and partnering with the people that service design actually impacts. At the heart, it's actually bringing the people who will use that service in as equal partners into the process of actually dreaming and designing a service, and it's applicable across any kind of domain.[133]

Dr McKellar said that the co-design process was important to the transformation of Oakden as it allowed the concept of being 'trauma-informed' to be embedded throughout the process.[134]

ECH Incorporated adopted a co-design approach when creating that provider's service response to the LGBTI Community. Dr Panter told us that through this process, issues of 'navigation and finding your way through the system came up as a really big issue', and this led to the development of ECH Incorporated's LGBTI Connect service.[135]

Ms Radoslovich stated that the co-design approach to service delivery 'makes sure that the people who are going to be affected by services are engaged in designing those services.'[136] Helping Hand Aged Care has produced several position statements based on projects developed in collaboration with diverse communities. One, *Everyone is welcome and included*, speaks to the needs of LGBTI people.[137] Another, *Real Care the Second Time Around*, addresses the needs of Forgotten Australians.[138] Another position statement relates to people from culturally and linguistically diverse backgrounds. These position statements are publicly available and articulate issues regarding aged care, as told by the communities affected. Ms Radoslovich spoke of the positive response Helping Hand Aged Care has received in making these resources available publicly.[139]

Ms Radoslovich also spoke about Helping Hand Aged Care's collaborative research project with the University of South Australia around communication with the workforce. She said that the studies have shown that culturally and linguistically diverse workers are unable to understand the jargon of the aged care industry. This was used as an opportunity to co-design training modules regarding culture and communication.[140] Ms Radoslovich spoke of the benefit to staff in completing this training:

> to come to this point of understanding that we all have our own culture that impacts on how we view the world around us, how we understand concepts such as care and safety and that we need to create learning places and spaces and procedures that allow people to understand what is actually required in that space. We also learnt through that, that the way we converse, the conversations we have, and the way we speak with each other, needs to take account of those different cultural backgrounds.[141]

Impact of consumer-directed care

Evidence illustrated the lack of clarity about the impact of consumer-directed care for people with diverse backgrounds. Ms Edmonds said there is no way of knowing whether consumer-directed care is meeting someone's needs because data on LGBTI people is lacking. In her discussions with older people, she has heard that some are finding the model to be inclusive.[142] However, others face difficulties having the model implemented:

> you know, we have this Consumer Directed Care model, but we can't actually, really, implement it because we're living within communities where the people around us are actually quite homophobic, biphobic or transphobic, but we have to invite them into our home to provide services, so we just—you know, we hide who we are.[143]

Ms Patetsos raised concerns regarding the consumer-directed care model. She told us that there is a lack of connection between the needs of older people and that which is being provided. She said that this may be an issue for the general population, however may be exacerbated in the culturally and linguistically diverse community because of a lack of understanding.[144]

Dr Hartland said that the pre-2017 system 'wasn't a great system for people with special needs' as providers were allocated Home Care Package special needs places and there was no transparency for older people 'over which providers actually held a special needs place'.[145] Dr Hartland said that the National Prioritisation System, introduced under the *Aged Care Legislation Amendment (Increasing Consumer Choice) Act 2016* (Cth), was thought to be 'a fairer way' to allocate package places to older people as it 'would actually

help special needs groups'.[146] Despite this intention, Dr Hartland advised that the National Prioritisation System for package place allocation 'does not directly consider' whether a person is a member of a special needs group.[147]

In relation to Home Care Package data collection, Dr Hartland gave evidence that the Australian Department of Health has 'good data on the person', however there are limitations in the data such that 'we don't know what it's spent on'.[148] He told us that the needs of those with diverse characteristics are one of the main considerations when implementing consumer-directed care, saying:

> So we thought at the time that this was actually—one of the big rationales for changing to this system was actually to help special needs. From a provider's perspective, the specialist providers found it very hard to win places at ACARs [Aged Care Approvals Round] so they weren't getting into the system. So at the time the thinking was that this new system of a fairer way of putting people on the queue would actually help special needs groups.[149]

Dr Hartland said consumer-directed care had seen 'improvements' to Aboriginal and Torres Strait Islanders and culturally and linguistically diverse communities.[150] He was unable to confirm whether an impact analysis on 'special needs groups' was done prior to the implementation of consumer-directed care.[151] He accepted that undertaking such an analysis prior to the implementation of consumer directed care would have assisted the Australian Department of Health monitor its effectiveness.[152]

Dr Hartland also said that research showed that 'Overall, there were no significant variances in the findings from rural and remote, CALD [culturally and linguistically diverse] and Aboriginal and Torres Strait Islander participants to that from the general population'.[153] In response to a question from Senior Counsel Assisting, Dr Hartland agreed that regarding Aboriginal and Torres Strait Islanders, the satisfaction of people receiving care was lower than that of the general population.[154] The research in question is, in any event, based on a survey with 1688 care recipient respondents, so is not particularly significant .[155]

Dr Panter said that his vision of an aged care system that responds to diversity would be genuinely person-centred, providing the consumer-directed care approach to the 'full spectrum of service provision from entry level to residential care'.[156] He said that ECH Incorporated's approach was that they had to 'do it whole heartedly or not at all'.[157]

10.1.7 Government regulation

Diversity Framework and Action Plans

In relation to the uptake of the Diversity Framework throughout the aged care industry, Ms Tunny stated:

> There are potential resource implications related to the implementation of the Diversity framework, and consequently, some mainstream aged care providers appear unwilling to address the unmet needs of older Australians with diverse characteristics and life experiences.[158]

Ms Edmonds gave evidence that the Aged Care Action Plans were developed concurrently with the Diversity Framework.[159] The original intent of the Diversity sub-group was:

> to have aged care providers develop Diversity Action Plans to demonstrate what they were doing to be inclusive and to show ongoing quality improvement in the delivery of services. Unfortunately, any attempt to make these a requirement was opposed by the Aged Care Provider Peaks as they were concerned about additional work / reporting requirements and more 'red tape'.[160]

Ms Patetsos also referred to 'push back', by peak bodies, from the Diversity Framework and associated Aged Care Action Plans. She gave evidence that in her view, for aged care providers to meet the current Aged Care Quality Standards, they are required, in effect, to meet the principles outlined in the Diversity Framework.[161]

Ms Edmonds's words reflected this view, stating that approved providers are both expected and required to meet the Aged Care Quality Standards. She said the National LGBTI Health Alliance, 'would certainly like to see' the Diversity Framework and Action Plans made mandatory through the Aged Care Quality Standards process.[162]

Ms Ann Wunsch, Executive Director, Quality Assessment and Monitoring Operations, Aged Care Quality and Safety Commission, agreed with Senior Counsel Assisting's statement that cultural safety is quintessentially a safety issue, potentially including a clinical-safety issue.[163] She agreed that this is because if the environment is not culturally safe, there is a real risk that clinical and personal care needs will not be understood.[164] She said that cultural safety is 'embedded across the eight [Quality] Standards' and it is the 'responsibility of the provider to evidence that they can meet the standards' to the satisfaction of the Aged Care Quality and Safety Commission Assessors.[165]

Ms Wunsch told us that the Aged Care Quality and Safety Commission views the Action Plans as a 'fantastic resource' and has linked the Action Plans to their guidance materials for providers, with the Quality Standards, particularly Standard 1.[166] However, while acknowledging that the Action Plans are useful documents 'to assist providers to identify where they currently stand' and identify opportunities 'to improve their performance', Ms Wunsch believed the Action Plans should not be made a mandatory requirement.[167]

Mr Smith expressed the view that, while the Diversity Framework and Aged Care Action Plans are an excellent resource, which the Australian Department of Health promotes to all providers, they should not be made mandatory in the accreditation process conducted across the aged care sector. Rather, Mr Smith's view was that accreditation is, 'really about the outcomes for the consumer', and adoption of the Diversity Framework and Action Plans is one mechanism available to 'demonstrate… ways in which providers can actually be providing the higher level and better care'.[168]

Dr Panter raised concerns on the deliverability of the Diversity Framework and associated Aged Care Action Plans. He questioned how system providers will be held to account. He also questioned how it is determined who is using the services, as there is no data collection, and whether the Action Plans are having an impact. Dr Panter told us that the

current system relies on people being 'good consumers, and for a disadvantaged group who lack confidence… they're not necessarily going to be the people speaking out and raising a concern about their provider.' [169]

Accreditation assessors

Ms Jewell said that Lifeview Residential Care would like to see more diversity among Aged Care Quality and Safety Commission Quality Assessors:

> From the assessors who have been to our homes, we don't see many from multicultural backgrounds. So, we'd like to see a bit more of a mix of assessors coming from those backgrounds. We'd also like to see assessors coming from other industries, where they've got different learnings and different approaches to what we do, because at the moment aged care is, sort of, stuck and the same people are being recycled through the assessors. And they don't come with a lot of innovation thoughts or look at different ways that things can be done.[170]

Ms Michael's words echoed this and she noted that some of the Aged Care Quality and Safety Commission's Quality Assessors come into the roles with 'limited knowledge on issues around health' or 'how to communicate with people with diverse needs'.[171]

Ms Wunsch said the 2020 continuing professional development program for the Aged Care Quality and Safety Commission's Quality Assessors will include mandatory content, focusing on 'cultural safety as a concept', acknowledging that it is integral to the Quality Standards in the ongoing education of the Aged Care Quality and Safety Commission's Quality Assessors .[172]

10.1.8 Data and information collection

Evidence in this hearing highlighted the importance of data collection about people with diverse backgrounds. Ms Edmonds said that a lack of data can contribute to a 'cycle of invisibility':

> The cycle of invisibility is very much about providers saying, 'Well, we don't have anyone here. There's no one in my service that's LGBTI.' They have never asked the question but as far as they're concerned there's no one in that service that's LGBTI.[173]

Ms Edmonds said that the lack of data collected about LGBTI people highlights the misconception conveyed by the cycle of invisibility.[174] She described the consequences as follows:

> people go back into the closet, hide themselves, hide who they are, don't explain who they are. They become even more invisible in the service. Service believes there's no one in the service, and round and round we go. And that's then highlighted by there's no data collected. So, if you're not asking questions, you are not collecting data; you don't know who is in your service. So, they continue to remain invisible in the services. So, the more invisible people become, the less services they receive, the less appropriate services they receive and the less likely they are to disclose.[175]

Malloy gave evidence that she believes LGBTIQ older people 'are not speaking up about issues they are experiencing in aged care.' She raised concerns that this may create the illusion that there are no issues.[176] Ms Tunny stated that the effectiveness of aged care services for Aboriginal people is not measured, saying:

> older Aboriginal people demonstrate higher rates of chronic conditions and co-morbidities so it appears logical that this group should have greater representation than the general population in the aged care system overall, and as recipients of high level (3-4) Home care packages in particular, but no data modelling has yet been done to establish the expected rates of access to aged care for Aboriginal people compared to older people from the general population.[177]

Dr O'Meara said effective data collection requires being clear from the outset as to what the expected outcomes are for health and wellbeing. This will ensure the right data is collected to allow initiatives to be assessed and to determine whether particular outcomes are being achieved.[178] Ms Patetsos referred to the importance of data collection at critical points, such as entry and exit from aged care services, where possible. Ms Patetsos explained that there is a 'fear of collecting data' which leads some organisations not to engage in data collection.[179] Ms Patetsos said:

> I think that government has a responsibility to ensure that the entities that it accredits and licences to operate meet their responsibility in terms of data collection.[180]

A witness for the Australian Department of Health, Mr Smith, acknowledged in the following exchange that there is a disparity in data collection for the various special need groups:

> MR GRAY: But as a very general proposition, is it still the case that there's a marked disparity between the information available for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse populations on the one hand, and the other groups on the other?
>
> MR SMITH: At this point of time that is still the case.[181]

Dr Hartland gave evidence that the Australian Department of Health had 'pretty good ability' to extract data for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, and rural and remote people, and was able to give 'a bit of a picture' for people facing homelessness, veterans and those suffering financial disadvantage. However, Dr Hartland told us that the Department experienced 'problems' extracting data for the remaining special needs groups.[182] He acknowledged that any analytics which could be performed on the data was therefore limited.[183]

Dr Hartland detailed that the blockage experienced by the Department in data collection for special needs groups is 'not absolutely a funding issue'; rather it has simply been 'the difficulty of mapping where the information sits in the transactional processing side, understanding how that information is constructed'.[184] He said:

> It just takes time to understand where the data is, how to draw the data out of that system and then how to put it into a big database. If the [Royal] Commission was to say you should have done this quicker I don't think there's anyone in the Commonwealth going to say that is unfair. I think we accept that we should have.[185]

In its written submission, the Australian Government acknowledged that 'in some aspects of the aged care system the lack of data collection limits the understanding of how people with diverse needs access and experience the system'.[186]

Aged Care Allocation Rounds

In response to questioning by Senior Counsel Assisting on the Australian Department of Health's ability to monitor the allocation of residential aged care places to approved providers under the Aged Care Allocation Rounds, Mr Smith acknowledged that the Department has not been able to effectively monitor the allocation of places for people with special needs under the allocation rounds, primarily due to a 'data deficiency'.[187] Mr Smith gave evidence that:

> We don't have a lot of detail about people having identified or being identified as belonging to particular special needs groups which does make the monitoring of that difficult.[188]

Mr Smith agreed there is an assumption that because the allocation rounds system creates an incentive, that it must have some effect. Mr Smith acknowledged, however, that there was no actual monitoring of approved providers' compliance with conditions that are imposed under the allocations and acknowledged that monitoring 'needs to occur'.[189] Mr Smith gave the commitment that 'it is a priority for the next ACAR [Aged Care Approval Rounds] to make sure we have a much more robust process in place in terms of follow-up conditions of allocation for special needs groups.'[190]

Commonwealth Home Support Programme

Dr Hartland gave evidence that the Australian Department of Health does have data on what services are being accessed under the Commonwealth Home Support Programme, noting that the data was 'not fantastic'. However, he acknowledged that the Department has no ability to 'track the person' due to the program being a grant-funded arrangement.[191]

Further, Mr Smith acknowledged that the Government does not undertake any monitoring of providers' compliance with the obligations imposed on them under the program guidelines, and that is not a 'defensible' Government policy.[192] Mr Smith explained that with the extension of the Commonwealth Home Support Programme to 2022, a program of work has recently commenced to 'map the various obligations providers have in their agreements and the obligations that are set out in the CHSP manual to identify where additional reporting would be required to gather more information'.[193]

Australian Department of Veterans' Affairs

The Australian Department of Veterans' Affairs supports veterans, including potentially through a range of departmental aged care services. The Department does not administer aged care provided under the Aged Care Act.[194] Ms Cosson noted that 'there are a range of definitions of a 'veteran' and the Department estimates that there are around 631,000 veterans in Australia.[195] Mr Klinge explained that the definition of veteran as 'a little bit grey' and accordingly, no one can say definitively 'right there's this many veterans in Australia'.[196]

Ms Cosson explained that there is a data matching process undertaken between the Department, the Australian Department of Health and the Australian Department of Human Services, to track the level of services provided to veterans. She noted that the data matching is only for veterans in receipt of Australian Department of Veterans' Affairs aged care and not for the purposes of assessing the care needs of veterans who are in receipt of mainstream services.[197] Ms Cosson agreed that one of the purposes of this data matching was to ensure that veterans who are receiving services through her Department's aged care services are not receiving the same services through the Commonwealth Home Support Programme, however acknowledged that the data matching was not sophisticated enough for that purpose.[198]

Ms Cosson agreed that veterans have poorer physical and mental health outcomes than the general population and that Government policy is that they deserve to have their sacrifices recognised for the whole of their lives.[199] Ms Cosson also agreed that the interface between the Australian Department of Veterans' Affairs and the Australian Department of Health may lead to confusion, resulting in veterans not receiving services to which they are entitled.[200]

Ms Cosson acknowledged that historically, the Australian Department of Veterans' Affairs has been 'quite passive in our role in relation to our veterans moving into mainstream aged care' and out of departmental funded services. Ms Cosson referred to the Department's multi-year reform program, called 'Veteran Centric Reform', as a 'transformation' aimed at 'changing the way we frame our engagement with veterans'. As part of that reform, Ms Cosson told us that work had started to track veterans through the mainstream aged care services, however the end result will still be 'a few years away'.[201]

Ms Cosson acknowledged that despite the Australian Department of Veterans' Affairs process of transformation, the Australian Department of Health's systems continue to remain 'a little bit separate' to her Department's systems.[202] Ms Cosson said:

> From a whole of government perspective, the aim is to have that interoperability across our systems and have better data sharing. That is a few years down the track, but it is certainly on the agenda for transformation through our departments.[203]

Dr Hartland agreed with Ms Cosson, acknowledging that there was 'clearly a gap' as the Department's 'customer relationship management system doesn't integrate well with the veterans' customer relationship management system'.[204]

In post hearing submissions, the Australian Department of Veterans' Affairs and the Australian Department of Health acknowledged that 'the interface between Commonwealth agency IT systems will need to be improved'.[205]

Accuracy of claims on My Aged Care

A number of witnesses raised concerns that approved providers can make representations on the My Aged Care website stating that they cater for certain demographics without verification. Ms Tunny stated:

> Service providers are able to describe their organisations on the MAC [My Aged Care] portal service finder, as 'specialists' in the provision of care to Aboriginal people. The Commonwealth Department of Health does not check the accuracy of these claims.[206]

Ms Jewell suggested that providers should be able to indicate that they have received the Rainbow Tick accreditation to illustrate that they are LGBTI inclusive.[207] The Rainbow Tick accreditation is a set of standards run by Quality Improvements Performance which any aged care provider can apply for to prove that they are LGBTI inclusive.[208]

Dr Panter stated that while the current system does not prevent innovation in response to diversity, equally, it does not incentivise it.[209] He gave evidence that the My Aged Care tick box system is 'fairly meaningless' without some form of accreditation process. His evidence was that this system allows for providers to tick a box indicating that they are LGBTI inclusive. The box may be ticked on the basis that the provider treats everyone the same, and is therefore inclusive, regardless of any special attributes. This does not take into consideration structural disadvantage or particular needs of that special needs group.[210]

Mr Smith acknowledged that currently there is no evaluation of the claims made by providers on My Aged Care as to their specialisations such as servicing of special needs groups, noting that the Department has committed to exploring verification options as part of the Diversity Framework Government Action Plan.[211] Mr Smith told us:

> The Department agrees that we need to do a lot more to be able to quality assure the information that is on My Aged Care in terms of providers indicating that they're able to service particular special needs groups.[212]

Mr Smith also acknowledged that the Department needs to do this in a timely manner.[213] Ms Wunsch gave evidence that, following the introduction of the Aged Care Quality Standards, information on claims made on My Aged Care by approved providers is used as a relevant 'piece of regulatory intelligence' that is provided to assessment teams as part of their work packs alongside the approved provider application for accreditation.[214] However, Ms Wunsch confirmed that this process was only introduced from September 2019 and that previously the details appearing on My Aged Care were not used by the Aged Care Quality and Safety Commission 'to inform its assessment and monitoring activities'.[215]

The Australian Government does not propose to verify these representations regarding specialisation of services 'due to the constant monitoring and thus significant resources that would be required.' However, the Australian Government submits that if a service is providing false information then it may be found to be non-compliant with Standard 1(3)(e).[216]

Veterans' Supplement

On the topic of accessing the veterans' supplement, Mr Klinge stated:

> The supplement is paid by the Department of Health directly to an Approved Provider on behalf of an eligible veteran and it is designed to ensure a veteran's mental health condition does not act as a barrier to accessing appropriate care. However, of RSL Care SA's current population of War Veterans (39 residents), only six were receiving the supplement as at 1 July 2019 (representing 15%), when it would appear based on our assessment of clinical needs and information that around 20 of our war veteran residents would have some form of mental health condition that warrants support (indicating the percentage of funding should be around 51%). This suggests that the coverage of the supplement is not necessarily sufficient.[217]

In light of the above, Mr Klinge expressed a concern that other providers not experienced in veterans' issues and interacting with the Australian Department of Veterans' Affairs may not be receiving the funding (in the form of the veterans' supplement) to which they are entitled.[218] In response to questioning from Senior Counsel Assisting as to whether there was any plan for the Australian Department of Health to evaluate whether there is a proper take-up of the veterans' supplement in accordance with expected demand in the home care area, Dr Hartland confirmed that the Department did not 'have a project in prospect for the future'.[219]

10.1.9 Conclusion

There is great diversity in the Australian population. This includes, but is not limited to, diversity with respect to religion, culture, language, gender, sexual orientation and/or life experiences. However, aged care providers and the aged care system have not always responded to needs that are out of the so-called 'ordinary'. The new aged care system needs to be flexible and adaptable enough to cater for the particular needs of the many different people that access it. We make recommendations about how to accommodate diversity in the aged care system in Chapter 4, in Volume 3.

Endnotes

1 Australian Department of Health, *Aged Care Diversity Framework*, 2017, https://www.health.gov.au/resources/publications/aged-care-diversity-framework, viewed 25 September 2020; Shared actions to support all diverse older people; Actions to support older Aboriginal and Torres Strait Islander people; Actions to support older Culturally and Linguistically Diverse people; Actions to support Lesbian, Gay, Bisexual, Transgender and Gender Diverse and Intersex elders (Exhibit 10-1, Melbourne Hearing 2, general tender bundle, tabs 11 to 17, CTH.0001.1001.2215; RCD.9999.0198.0099; CTH.0001.1001.2233; RCD.9999.0198.0001; RCD.9999.0198.0033; CTH.0001.1001.2255; CTH.0001.1001.2529).
2 Exhibit 10-3, Melbourne Hearing 2, Statement of Samantha Edmonds, WIT.0396.0001.0001 at 0006–0007 [22].
3 Transcript, Melbourne Hearing 2, Phillip O'Meara, 10 October 2019 at T5628.12–21.
4 Transcript, Melbourne Hearing 2, Phillip O'Meara, 10 October 2019 at T5627.11–19.
5 Exhibit 10-5, Melbourne Hearing 2, Statement of Noeleen Tunny, WIT.0422.0001.0001 at 0019 [47].
6 Exhibit 10-3, Melbourne Hearing 2, Statement of Samantha Edmonds, WIT.0396.0001.0001 at 0016 [81].
7 Exhibit 10-24, Melbourne Hearing 2, Statement of David Panter, WIT.0448.0001.0001 at 0007 [12].
8 Exhibit 10-27, Melbourne Hearing 2, Statement of Jaklina Michael, WIT.0457.0001.0001 at 0027 [91].
9 Transcript, Melbourne Hearing 2, Helen Radoslovich, 8 October 2019 at T5407.23–46.
10 Transcript, Melbourne Hearing 2, Phillip O'Meara, 10 October 2019 at T5627.47–5628.5.
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15 Exhibit 10-24, Melbourne Hearing 2, Statement of David Panter, WIT.0448.0001.0001 at 0006–0007 [11].
16 Transcript, Melbourne Hearing 2, David Panter, 10 October 2019 at T5655.12–13.
17 Transcript, Melbourne Hearing 2, David Panter, 10 October 2019 at T5655.13–17.
18 Exhibit 10-24, Melbourne Hearing 2, Statement of David Panter, WIT.0448.0001.0001 at 0006 [8].
19 Transcript, Melbourne Hearing 2, David Panter, 10 October 2019 at T5655.3–6.
20 Transcript, Melbourne Hearing 2, Phillip O'Meara, 10 October 2019 at T5628.4–5; Exhibit 10-24, Melbourne Hearing 2, Statement of David Panter, WIT.0448.0001.0001 at 0010 [54].
21 Transcript, Melbourne Hearing 2, Helen Radoslovich, 8 October 2019 at T5398.33–39.
22 Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5292.40–5293.4.
23 Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5300.31–35.
24 Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5300.35–42.
25 Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5282.12–18.
26 Exhibit 10-20, Melbourne Hearing 2, Statement of Malloy, WIT.0485.0001.0001 at 0006 [34].
27 Exhibit 10-27, Melbourne Hearing 2, Statement of Jaklina Michael, WIT.0457.0001.0001 at 0024 [76].
28 Exhibit 10-27, Melbourne Hearing 2, Statement of Jaklina Michael, WIT.0457.0001.0001 at 0026 [82b].
29 Transcript, Melbourne Hearing 2, Malloy, 10 October 2019 at T5593.39–43.
30 Exhibit 10-23, Melbourne Hearing 2, Statement of Elizabeth Drozd, WIT.0449.0001.0001 at 0012 [47].
31 Transcript, Melbourne Hearing 2, Anne Tudor, 8 October 2019 at T5421.12–18.
32 Exhibit 10-18, Melbourne Hearing 2, Statement of Heather Brown, WIT.0537.0001.0001 at 0002 [8]–[9].
33 Transcript, Melbourne Hearing 2, Janette McGuire, 8 October 2019 at T5458.26–30. See also Exhibit 10-14, Melbourne Hearing 2, Statement of Janette McGuire, WIT.0527.0001.0001 at 0002 [17]–[18].
34 Exhibit 10-14, Melbourne Hearing 2, Statement of Janette McGuire, WIT.0527.0001.0001 at 0001 [6]; 0004 [29]–0005 [37].
35 Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5299.34–41.
36 Transcript, Melbourne Hearing 2, Maureen Lyons, 11 October 2019 at T5687.43–45.
37 Transcript, Melbourne Hearing 2, Brian Campbell, 11 October 2019 at T5702.44–47.
38 Transcript, Melbourne Hearing 2, Duncan McKellar, 8 October 2019 at T5474.32–40.
39 Transcript, Melbourne Hearing 2, Duncan McKellar, 8 October 2019 at T5476.17–20.
40 Transcript, Melbourne Hearing 2, Duncan McKellar, 8 October 2019 at T5474.22–T5475.19.
41 Exhibit 10-15, Melbourne Hearing 2, Statement Duncan McKellar, WIT.0530.0001.0001 at 0017 [61]; 0004 [14].
42 Exhibit 10-9, Melbourne Hearing 2, Statement of Nathan Klinge, WIT.0410.0001.0001 at 0028 [61].
43 Exhibit 10-9 Melbourne Hearing 2, Statement of Nathan Klinge, WIT.0410.0001.0001 at 0008 [18].
44 Transcript, Melbourne Hearing 2, Nathan Klinge, 8 October 2019 at T5382.13–20.
45 Transcript, Melbourne Hearing 2, Nathan Klinge, 8 October 2019 at T5385.5–15.
46 Transcript, Melbourne Hearing 2, Nathan Klinge, 8 October 2019 at T5385.31–40.
47 Transcript, Melbourne Hearing 2, Nathan Klinge, 8 October 2019 at T5385.42–47.
48 Transcript, Melbourne Hearing 2, Janette McGuire, 8 October 2019 at T5461.35–43; Exhibit 10-14, Statement of Janette McGuire, WIT.0527.0001.0001 at 0006 [45].
49 Transcript, Melbourne Hearing 2, Noeleen Tunny, 7 October 2019 at T5305.31–39.
50 Transcript, Melbourne Hearing 2, Moreen Lyons, 11 October 2019 at T5696.17–26.
51 Transcript, Melbourne Hearing 2, Brian Birch, 11 October 2019 at T5710.6–26.
52 Transcript, Melbourne Hearing 2, Brian Campbell, 11 October 2019 at T5710.35–37.

53 Exhibit 10-8, Melbourne Hearing 2, Statement of Brian Lynch, WIT.0513.0001.0001 at 0005 [32]–0008 [46].
54 Exhibit 10-8, Melbourne Hearing 2, Statement of Brian Lynch, WIT.0513.0001.0001 at 0009 [58].
55 Transcript, Melbourne Hearing 2, Janette McGuire, 8 October 2019 at T5458.39–41; Exhibit 10-14, Melbourne Hearing 2, Statement of Janette McGuire, WIT.0527.0001.0001 at 0003 [20].
56 Transcript, Melbourne Hearing 2, Heather Brown, 9 October 2019 at T5536.5–11; Exhibit 10-18, Melbourne Hearing 2, Statement of Heather Brown, WIT.0537.0001.0001 at 0003 [20].
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58 Exhibit 10-25, Melbourne Hearing 2, Statement of Catharina Nieuwenhoven, WIT.0515.0001.0001 at 0003 [17]–[23]; 0006 [43]; 0004 [26].
59 Exhibit 10-4, Melbourne Hearing 2, Statement of Mary Patetsos, WIT.0437.0001.0001 at 0002 [17]–0003 [19].

61 Exhibit 10-4, Melbourne Hearing 2, Statement of Mary Patetsos, WIT.0437.0001.0001 at 0002 [16]–[17].
62 Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5302.32–5303.15.
63 Transcript, Melbourne Hearing 2, Nathan Klinge, 8 October 2019 at T5388.8–25.
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65 Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5285.32–38.
66 Exhibit 10-4, Melbourne Hearing 2, Statement of Mary Patetsos, WIT.0437.0001.0001 at 0002 [10].
67 Transcript, Melbourne Hearing 2, Elizabeth Drozd, 10 October 2019 at T5637.47–5638.5.
68 Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5285.43–45.
69 Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5285.31–5286.12.
70 Transcript, Melbourne Hearing 2, Catharina Nieuwenhoven, 11 October 2019 at T5683.21–24.
71 Transcript, Melbourne Hearing 2, Elizabeth Drozd, 10 October 2019 at T5638.13–32.
72 Exhibit 10-17, Melbourne Hearing 2, Statement of Jaye Smith, WIT.0427.0001.0001 at 0054 [204].
73 Exhibit 10-17, Melbourne Hearing 2, Statement of Jaye Smith, WIT.0427.0001.0001 at 0054–0055 [206].
74 Exhibit 10-27, Melbourne Hearing 2, Statement of Jaklina Michael, WIT.0457.0001.0001 at 0031 [105b].
75 Transcript, Melbourne Hearing 2, Jaye Smith, 9 October 2019 at T5531.5–41.
76 Exhibit 10-5, Melbourne Hearing 2, Statement of Noeleen Tunny, WIT.0422.0001.0001 at 0021 [54].
77 Exhibit 10-17, Melbourne Hearing 2, Statement of Jaye Smith, WIT.0427.0001.0001 at 0054 [205].
78 Transcript, Melbourne Hearing 2, Jaye Smith, 9 October 2019 at T5532.1–11.
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80 Exhibit 10-28, Melbourne Hearing 2, Statement of Elizabeth Karn, WIT.0516.0001.0001 at 0001 [6]; 0002 [10].
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82 Submissions of the Commonwealth of Australia, Melbourne Hearing 2, 25 October 2019, RCD.0012.0035.0002 at 0013 [55].
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84 Exhibit 10-2, Melbourne Hearing 2, Statement of Angelos Angeli dated 2 October 2019, AIT.0511.0001.0001 at 0001 [5]–[6].
85 Transcript, Melbourne Hearing 2, Angelos Angeli, 7 October 2019 at T5272.40–T5273.10.
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87 Transcript, Melbourne Hearing 2, Nathan Klinge, 8 October 2019 at T5386.23–31.
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89 Transcript, Melbourne Hearing 2, Helen Radoslovich, 8 October 2019 at T5399.28–36.
90 Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5306.34–13.
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94 Transcript, Melbourne Hearing 2, Samantha Jewell, 7 October 2019 at T5329.5–14.
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98 Transcript, Melbourne Hearing 2, Elizabeth Drozd, 10 October 2019 at T5637.11–17.
99 Exhibit 10-24, Melbourne Hearing 2, Statement of David Panter, WIT.0448.0001.0001 at 0007 [12].
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101 Transcript, Melbourne Hearing 2, Nicholas Hartland, 9 October 2019 at T5582.9–18.
102 Exhibit 10-27, Melbourne Hearing 2, Statement of Jaklina Michael, WIT.0457.0001.0001 at 0032 [105d(i)].
103 Transcript, Melbourne Hearing 2, Elizabeth Drozd, 10 October 2019 at T5638.44–T5639.33.
104 Exhibit 10-25, Melbourne Hearing, Statement of Catharina Nieuwenhoven, WIT.0515.0001.0001 at 0005 [37].
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106 Transcript, Melbourne Hearing 2, Elizabeth Cosson, 8 October 2019 at T5441.5–7.
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115 See, for example, financial assistance for those with assets below a certain threshold; hardship supplement; accommodation supplement; viability supplement; homeless supplement: Submissions of the Commonwealth of Australia, Melbourne Hearing 2, 25 October 2019, RCD.0012.0035.0002 at 0015 [66].
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118 Transcript, Melbourne Hearing 2, Jaklina Michael, 11 October 2019 at T5715.20–26.
119 Transcript, Melbourne Hearing 2, Samantha Jewell, 7 October 2019 at T5321.44–5322.14.
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121 Exhibit 10-11, Melbourne Hearing 2, Statement of Anne Tudor, WIT.0514.0001.0001 at 0007 [43].
122 Exhibit 10-11, Melbourne Hearing 2, Statement of Anne Tudor, WIT.0514.0001.0001 at 0005 [30]; 0006 [35].
123 Exhibit 10-11, Melbourne Hearing 2, Statement of Anne Tudor, WIT.0514.0001.0001 at 0008 [47].
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125 Transcript, Melbourne Hearing 2, Duncan McKellar, 8 October 2019 at T5471.17–25.
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130 Transcript, Melbourne Hearing 2, Malloy, 10 October 2019 at T5594.2–8; Exhibit 10-20, Melbourne Hearing 2, Statement of Malloy, WIT.0485.0001.0001 at 0006 [35]–0007 [37].
131 Exhibit 10-11, Melbourne Hearing 2, Statement of Anne Tudor, WIT.0514.0001.0001 at 0009 [50].
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142 Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5313.44–5314.4.
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207 Transcript, Samantha Jewell, Melbourne Hearing 2, 7 October 2019 at T5323.13–15.
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11. Melbourne Hearing 3: The Aged Care Workforce

11.1 Hearing overview

11.1.1 Introduction

We held a public hearing, which focused on the aged care workforce, in Melbourne, Victoria, from 14 to 18 October 2019. Oral testimony was provided by 40 witnesses, some giving direct accounts about their experiences of working in the aged care system. A further 29 written statements and 72 exhibits were received into evidence. We also conducted two case studies. This added to evidence about the aged care workforce provided throughout our inquiry. The following were examined during this hearing:

- staffing levels, skills mix and their relationship to quality and safety
- education and training
- regulation of personal care workers
- remuneration and conditions for aged care workers, and the need to attract and retain a larger workforce
- workforce leadership.

At the end of the hearing, written submissions were sought on a number of identified policy issues. We received a number of submissions in response and these are referenced below.

Some of the evidence has been drawn upon in Volumes 2 and 3 of this report. Our findings and conclusions about the two case studies are set out later in this chapter.

11.1.2 Staffing levels and mix

How staffing levels and mix are currently regulated and set in aged care

The *Aged Care Act 1997* (Cth):

- provides a definition of 'residential care' for the purposes of the residential care subsidy which includes a requirement for 'appropriate staffing to meet the nursing and personal care needs of the person (s 41-3)(1)(a)(i))
- requires approved providers to maintain an adequate number of appropriately skilled staff to ensure that the care needs of people are met (s 54(1)(b))
- requires approved providers to comply with the Aged Care Quality Standards made under section 54-2 (s 54(1)(d)).

Standard 7 requires that the workforce be planned so that the number and mix of its members enables the delivery and management of safe and quality care and services. Ms Ann Wunsch, Executive Director, Quality Assessment and Monitoring Operations, Aged Care Quality and Safety Commission, told us that 'providers have sufficient information in our guidance material that talks to the issues that are relevant to coming to a view about sufficiency and competence, recruitment and all those other elements that make up the staffing profile'.[1]

The Aged Care Quality and Safety Commission guidance material, entitled *Human Resources, Standard 7,* relevantly states:

> This requirement expects organisations to have a system to work out workforce numbers and the range of skills they need to meet consumers' needs and deliver safe and quality care and services at all times...It's expected that an organisation uses a structured approach for rosters and schedules, hiring and keeping members of the workforce, managing different types of leave and the use of contracted staff…[2]

Mr Paul Gilbert, Assistant Branch Secretary of the Australian Nursing and Midwifery Federation (Vic Branch), said that there is 'no science to the number of staff that employers provide now'. He thought that at best, it is informed by industry comparisons, or at worst, 'the least that they can survive with, without coming to grief in the media or with the regulator'.[3]

The industry comparisons that Mr Gilbert referred to are those conducted by chartered accountants StewartBrown. Mr Gilbert said StewartBrown obtain data from about 900 aged care facilities for comparison within the industry. Participating aged care facilities can then use that work to compare themselves against other facilities and determine if the facility is 'sitting at this comfortable level that's kind of like most other people, that's good enough. And that's the benchmark they're now using to set staffing levels'.[4]

Mr Charles Wann, First Assistant Secretary, Aged Care Reform and Compliance, Australian Department of Health, told us the Department does not support the mandating of staff to aged care consumer ratios. This includes mandating nursing numbers.[5] Mr Wann said that this is because the Department:

> does not consider that there is a single optimum number of staff, or combination of staff qualifications, that will result in quality aged care in all circumstances. Rather, the number of staff required to look after a consumer, or consumers, will depend on the care needs of those consumers, the facility size and design, and the way work is organised including the extent to which certain services are outsourced.[6]

The then Secretary of the Australian Department of Health, Ms Glenys Beauchamp PSM, agreed that there is a link between numbers and quality of staff and quality of care.[7]

Mr Darren Mathewson, Executive Director of Services, Support & Engagement, Aged & Community Services Australia, considered staffing levels need 'to be flexible to adapt to the changing needs of residents, models of care and service delivery, geographical location, mix of residents, access and reliability of external workforce (health professionals), and physical design'.[8]

Mr Gilbert said that the current system, in which providers use the 'benchmark' of StewartBrown data, 'couldn't be more blunt'.[9] He warned that the current system involves a race to the bottom where directors may query why a provider is spending more than their competitors on their workforce. Mr Gilbert said the system already has 'dreadfully low' ratios.[10]

Mr Gilbert told us that appropriate staffing methodologies are unlikely, at present, to come from industrial agreements. He told us that of over 180 enterprise agreements in Victoria, only three have prescribed staffing levels in excess of a bare requirement to have a registered nurse on duty 24 hours a day.[11] Mr Gilbert told us that when it comes to staffing numbers in aged care, it is time 'to stop kicking the can down the road'.[12]

Ms Lisa Alcock, Industrial Officer, Health Workers Union, said that any ratio in a residential care facility should reflect residents' complex and changing needs. Ms Alcock referred to the ratio contained in the *TLC Aged Care Victoria, ANMF and HSU Enterprise Agreement 2017–2022*, which specifies numbers of staff members by time of day. Ms Alcock said that this ratio fails to meet the needs of those living and working in residential facilities as it does not address actual need. Any ratio, she said, needs to be expressed by the minimum hourly care needs of residents, translated into the staffing requirement needed to meet those needs.[13]

An Australian Nursing and Midwifery Federation survey, conducted in January and February 2019, reveals that of Victorian aged care members:

- 42.6% had had staff hours reduced multiple times in the last year
- 75% had had to start early, or stay late, to finish work on an unpaid basis
- 80% believed better staffing ratios would have prevented some hospital transfers
- 87.5% believed mandated minimum ratios would make residential aged care a more attractive place to work.[14]

The greatest concern of almost 91% (n = 2517) nationally was 'having adequate staffing levels for meeting basic care needs for residents'.[15]

The Health Workers' Union conducted a survey of its members in July 2019 and received more than 1600 responses; 53.96% of them being personal care workers. Seventy-five per cent of aged care worker respondents did not believe there were enough carers in their workplaces to provide adequate care to residents, while 77.87% of respondents believed they were being exploited in the aged care industry.[16]

Staffing ratios in Victoria

Ms Kym Peake, Secretary of the Victorian Department of Health and Human Services, gave evidence about the staff ratios that became mandatory in Victoria by the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (Vic). Ms Peake said that the ratio is based on a range of academic literature that demonstrates the relationship between staffing levels and patient outcomes. Ms Peake told us this shows that higher nurse staffing numbers lead to better patient outcomes, with lower mortality rates, shorter lengths of stay, fewer re-admissions to hospitals, fewer falls with injuries, and fewer health care associated infections.[17]

Ms Peake said Victoria legislated nurse to patient ratios to support appropriate care and quality of life for public sector aged care residents, as well as to support workforce recruitment and retention. The Safe Patient Care Act applies to public sector residential aged care services operated by public health services, plus four independently operated residential aged care services.[18] She described the relevant ratios as:

- one nurse for every seven residents and one nurse in charge on a morning shift
- one nurse for every eight residents and one nurse in charge on an afternoon shift
- one nurse for every 15 residents on a night shift.[19]

Ms Peake said that other methodologies are used to calculate staffing levels such as nursing hours per patient day. All methodological approaches are sensitive to clinical specialty needs and adjustment, based on the clinical judgment of senior nursing staff.[20] Ms Peake explained that the ratio is 'not intended to be a ceiling on the staffing that is provided but, really, the minimum necessary for safe and quality care'.[21] The Victorian Government provides approximately $97.8 million each year in supplementary funding to support nurse to resident ratios.[22]

Ms Peake told us that publicly funded residential aged care services in Victoria also have 'lower utilisation of residential in-reach services' delivered by acute health services.[23] She said that having fewer in-reach services as a result of fewer pressure injuries and falls results in a net financial benefit for the State as well as maintaining care of people in an appropriate setting.[24]

National Aged Care Staffing and Skills Mix Project

The Australian Nursing and Midwifery Federation developed a methodology for estimating staffing requirements, as set out in the *National Aged Care Staffing and Skills Mix Project*.[25]

The authors of the report recommended that aged care residents should receive an average of four hours and 18 minutes of care per day for safe residential and restorative care.[26] The Australian Nursing and Midwifery Federation proposed that mandated staffing arrangements, with minimum direct care hours, nurse ratios and a staff mix, need to be implemented over a transition period from 2019 to 2025. The proposed skill mix requirement is: 30%—registered nurse; 20%—enrolled nurse; and 50%—personal carer worker.[27]

Mr Robert Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch), explained that the estimates for daily care hours for each resident type are based on the amount of time ideally required, given the residents' characteristics, rather than the actual time taken in environments where there may be staffing constraints, saying:

> if we had just gone out and looked at care where staffing was insufficient or not of the right mix, then what you would observe is the inadequacy that is already there rather than working from what is required and then building the hours from a zero base. So that's the difference of our approach from Professor Eagar's team approach which was they are observing what is there with whatever constraints are around it. We were building for the assessment, building what should be occurring with clients, how much time is required regardless of what was there.[28]

Professor Kathleen Eagar, Director, Australian Health Services Research Institute at the University of Wollongong, said that the Federation's proposed minimum direct care hours (4.3) and skill mix of 30% of care delivered by registered nurses would yield a five star rating under the United States Centers for Medicare and Medicaid Services rating system, discussed later in this report.[29]

11.1.3 Path to an alternative staffing model based on casemix classification

Professor Eagar said that the Aged Care Funding Instrument is inefficient and creates 'perverse incentives'. She says 'funding should be aligned with care needs of residents, and people getting the same amount of funding had vastly different needs and we needed an instrument that resulted in people with the same needs getting the same level of funding'.[30]

Professor Eagar's view is that there is 'ample anecdotal evidence that registered nurses are spending a disproportionate amount of time on paperwork for ACFI [the Aged Care Funding Instrument]'.[31]

Professor Eagar led the Resource Utilisation and Classification Study. The aims of the study were to: identify the characteristics of aged care residents that influence the cost of care they receive; identify shared costs across residents; and develop a casemix classification system to underpin a funding model.[32]

Professor Eagar told us that casemix classification would enable approved providers to identify people in particular classes with different needs, providing care based on a person's particular care needs. She said that this is a better way of describing and comparing individual need as some may be allocated twice the care than others. .[33]

The University of Wollongong report

Commissioners Tracey and Briggs commissioned Professor Eagar and her research institute at the University of Wollongong to produce a report entitled *How Australian residential aged care staffing levels compare with international and national benchmarks*.[34]

Professor Eagar and her team determined that the United States staffing methodology was the most appropriate equivalent to the Australian system and compared Australian facilities against that. The authors of the report state that the United States model 'provides a basis on which to build a contemporary Australian aged care staffing model that could be progressively refined and tailored to the range of care needs—nursing, personal and allied health—of Australian aged care residents'.[35]

The system proposed in the report uses nursing hours and total care hours to reach a certain star rating. The system is flexible in that it permits several different combinations of nursing and care staff members to reach to the same star level. Professor Eagar told us that this sort of system allows providers to have a 'quite different mix of staff in each home, depending on the unique needs of their residents'.[36]

Professor Eagar told us that in the United States system, the median cut-point between two and three stars is the pivotal point at which a facility is 'more likely than not to have quality problems'.[37] Professor Eagar's view is that care homes that have a rating of one or two stars have an 'unacceptable level of staffing'. Those with three stars have an 'acceptable level', those with four stars have a 'good level', and those with five stars have 'best practice levels' of staffing.[38]

Using this methodology, Professor Eagar said that 57.6% of Australian residents receive care in aged care homes that have unacceptable levels of staffing—one and two stars. Professor Eagar told us that to bring staffing levels up to three stars would require an increase of 37.3% more staff hours as an average across the relevant facilities. This would translate into an additional 20% in total care staff hours across Australia.[39] Only 1.4% of Australian residents are in facilities that are rated at five stars for registered nurse staffing.[40]

Professor Eagar said 'the thresholds won't ever come down whilst people in our community want to stay at home and whilst we provide systems of support which allow them to do so'.[41] Professor Eagar noted:

> the more successful we are in providing genuine options for people to stay in their own home, the more the cohort who go to residential care will be extremely high need.[42]

Professor Eagar told us that a significant limitation of the United States system is that it does not include allied health staffing levels. Professor Eagar noted that the system in British Columbia does include allied health care and considered an Australian system could be designed by considering a combined United States and British Columbian system.[43]

The system in British Columbia recommends that residents receive an average of 22 minutes of allied health services per day. The current Australian average is eight minutes of allied health care a day. Achieving the level recommended in British Columbia would require a 175% increase in allied health staffing.[44]

Professor Eagar said she would make further adjustments to a star ratings model if it were adopted in Australia. She would have a model using the three domains of staffing levels, accreditation reporting and quality indicators, and measures of consumer and carer experience to produce a balanced 'score card' for a facility.[45]

Response to the University of Wollongong report

A copy of the University of Wollongong report was provided, in advance of the hearing, to a number of the witnesses called to give evidence, and they were asked, in advance of the hearing, for comments they wished to make in relation to it.[46]

We received written responses from the following: Professor John Pollaers OAM, Former Chair of the Aged Care Workforce Strategy Taskforce; Mr Robert Bonner, Director, Operations & Strategy, Australian Nursing and Midwifery Federation (SA Branch); Mr Paul Gilbert, Assistant Branch Secretary, the Australian Nursing and Midwifery Federation (Vic Branch); Ms Patricia Sparrow, Chief Executive Officer, Aged and Community Services Australia; the Aged Care Workforce Industry Council; and Leading Aged Services Australia.[47] Some witnesses also responded with oral evidence.

Professor Pollaers supported aspects of the report including: a move to casemix based funding; an increase in overall funding; and adjusting skills to reflect the casemix—providing the casemix is based on holistic care planning. However, he considered the report did not adequately recognise all roles that are vital to deliver holistic care and emphasised that aspects of the workforce strategy provided important context.[48]

Leading Aged Services Australia indicated that it supports a casemix system, but has reservations about too close a reliance on the United States system.[49]

The Australian Nursing and Midwifery Federation did not consider the system proposed by Professor Eagar's team to be a staffing model. It contended that it could 'form the basis of a suitable quality reporting system for Australia' which could work 'in conjunction with the ANMF's [Australian Nursing and Midwifery Federation's] proposed staffing model'.[50] The Australian Nursing and Midwifery Federation highlighted that the United States system does not build its staffing profile on the basis of resident need determined by casemix, but rather 'on analysis of supply against outcomes'.[51] In other words, it said it looks at how much time it takes to do a task. Mr Bonner said that the Australian Nursing and Midwifery Federation's model uses the time it should take to perform a task properly rather than the time actually spent, which may have been constrained by resourcing.[52]

Mr Mathewson told us that Aged & Community Services Australia's 'initial position' was that the system proposed by the University of Wollongong report 'potentially acts as the circuit-breaker because it does offer a move away from a blunt instrument that the industry can consider'.[53] Mr Mathewson said he thought if it was converted into a staffing model, with an allied health component, and a number of other components around holistic care, it has 'real potential'.[54] He agreed there is value in star ratings, but thought there needs to be an 'agreed community benchmark' of care that the community expects facilities to reach.[55]

Mr Gilbert said that if funding was determined by reference to staffing ratios, 'it sets in stone that that money is for care'.[56] Professor Eagar said 'government funding for care should actually be invested in care'. She considers this funding should be treated differently to accommodation and hotel costs.[57]

Ms Beauchamp told us there is 'a place for a star rating system on the performance of aged care services' which 'needs to incorporate not just staffing, but a range of other factors'.[58]

11.1.4 Education and training

The majority of aged care workers are trained through the vocational education and training system. We heard that reform of the vocational education and training sector is underway.

Universities provide general training for undergraduate allied health professionals, doctors and nurses, and these courses focus, to varying degrees, on the needs of older people.

Ms Rachel Yates, Policy Director, Health and Workforce, Universities Australia, and member of the Aged Services Industry Reference Committee, told us that because the proportion of older people in the population is increasing, health professionals will encounter older people increasingly in their practice, irrespective of whether these professionals choose to work specifically in aged care.[59]

Dr John Maddison, President of Australian and New Zealand Society for Geriatric Medicine, and Consultant Geriatrician and Clinical Pharmacologist, told us that:

> the changing profile of health and ageing within Australia presents challenges and opportunities for both undergraduate and postgraduate medical, nursing and allied health training. A paradigm shift is required, where we develop curricula to equip the health professionals of the future with the skills and attitudes they need for their core patient groups of tomorrow and not yesterday.[60]

Professor James Vickers, Dean of Medicine and Director of the Wicking Dementia Research and Education Centre of the University of Tasmania, explained that the Australian Medical Council is the authority for the accreditation of education providers and curriculum for medicine, as stipulated under the Health Practitioner Regulation National Law. He said:

> The AMC [Australian Medical Council] monitors and accredits medical providers and programs that lead to general registration as a medical practitioner. Medical program providers and their curricula are assessed against accreditation standards. These standards broadly relate to medical graduate outcomes that encompasses the knowledge, skills and professional attributes to practise medicine in Australia. More specifically, the purpose of these standards is to ensure that graduates are competent to practise safely and effectively as interns, with 'an appropriate foundation for lifelong learning and for further training in any branch of medicine'. It is important to highlight that medical curricula often have a substantial focus on preparing students for internship in the acute care system. Graduation from an Australian medical program leads to provisional registration, whereas successful completion of an approved 12-month internship program leads to full general registration as a medical practitioner.[61]

Professor Vickers also said that medical curricula are often dense, which makes it difficult to accommodate teaching material related to new and emerging health challenges such as ageing, aged care and dementia. While dementia is now the second leading cause of death nationally and a major cause of disability, most medical programs do not include content on the major causes of dementia, nor on pharmacological and non-pharmacological approaches to management. He said:

> when I have my single lecture on dementia—a single lecture on dementia in a five-year program because of a very tight curriculum—the point I make to medical students, unless you choose very specifically your future career options to go into paediatrics or obstetrics and gynaecology, there's a very good chance that every day that you will be working with older frail people with lots of conditions and, into the future, a lot them with dementia.[62]

Professor Vickers added that there is limited will among medical educators to accommodate more course content relating to geriatrics. Programs continue to be focused on acute and primary care.[63] However, he said that:

> It may be appropriate for the AMC [Australian Medical Council] to consider elderly people with complex needs, and dementia, as part of their established review processes. An engagement with organisations such as Medical Deans Australia and New Zealand may help stimulate interest and discussion towards a curricular orientation to these emerging areas.[64]

Ms Amy Lazzaro, Nurse Practitioner and Program Lead Geriatric Rapid Evaluation and Treatment Team Hospital Outreach, Westmead Hospital, told us that because of a lack of education of nursing staff, patients are quite often sent to hospital because staff members just lack confidence, skill and experience in the basic assessment of patients.[65]

Ms Yates told us that universities offer a broad range of postgraduate programs to support health professional specialisation. However, she said that specialist courses need to be viable and attract sufficient student enrolments. Courses to support the development of specific workforces cannot be sustained without some form of subsidy or support and most postgraduate qualifications are not offered as Commonwealth Supported Places.[66]

Job roles and career structures

The Aged Care Workforce Strategy Taskforce recommended that there is a need to define and standardise the industry's job families, designs, grades and definitions. It further proposed to extend the levels within the personal care worker job family so that they can be recognised for their experience, or skills, or additional educational qualifications.[67]

Vocational education and training sector

The basics of how the sector works

The vocational education and training sector trains the majority of personal care workers in aged care, leading to qualifications including Certificates III and IV.

Responsibility for the vocational education and training sector is shared by the Australian Government, the State and Territory Governments, and industry. The States and Territories are largely responsible for the delivery and operation of vocational education and training in their own jurisdictions, including the funding of Registered Training Organisations.[68]

The Australian Skills Quality Authority registers training providers, monitors compliance with national standards, and investigates quality concerns for all States and Territories that have referred their powers. In Victoria and Western Australia, the Australian Skills Quality Authority only regulates providers that enroll international students or are multi-jurisdictional providers. The remaining Registered Training Organisations are registered, either with the Victorian Registration and Qualifications Authority or the Training Accreditation Council, Western Australia.[69]

The Australian Industry and Skills Committee comprises government appointed industry representatives from the Australian Government, and each State and Territory, and advises the Council of Australian Governments Industry and Skills Council on policy directions and decision-making in the national training system. It is also responsible for coordinating the development of training packages.[70]

A training package is a set of nationally endorsed standards and qualifications for recognising and assessing the skills of workers in a specific industry, industry sector or enterprise. Training packages are developed by Industry Reference Committees working with Skill Service Organisations, to ensure that industry skill requirements are reflected in the national training system. Industry Reference Committees report to the Australian Industry and Skills Committee, which refers training packages to the Council of Australian Governments Industry and Skills Council for final approval.[71]

The most relevant Industry Reference Committees for the aged care sector are the Aged Services Industry Reference Committee and the Enrolled Nursing Industry Reference Committee. They are supported by the SkillsIQ Limited, a Skills Service Organisation.[72]

Ms Nadine Williams, Deputy Secretary, Skills and Training Group, Australian Department of Employment, Skills, Small and Family Business, gave evidence that:

> the Commonwealth and State and Territory governments have joint responsibility for the VET [Vocational Education and Training] system. The Commonwealth is responsible for providing funding contributions to the States and Territories to support their training systems and operates a number of programs aimed at supporting key priorities such as apprenticeships and literacy and numeracy.[73]

Mr Wann's evidence was that the Australian Department of Health is liaising with the Australian Department of Employment, Skills, Small and Family Business in relation to the skills of the aged care workforce and developing education and training opportunities for the aged care workforce.[74]

Professor Pollaers said:

> The Workforce Strategy, through Strategic Actions 3 and 4, is reliant on the VET [Vocational Education and Training] and Higher Education sectors to deliver improved training outcomes in an accelerated manner. This is as much a state government responsibility as it is a federal government responsibility. Whilst the Aged Services IRC [Industry Research Committee] has been established under the current construct, I believe the VET sector should continue to look at ways to enhance its capability and remain responsive to industry requirements… A system that better aligns aged care and disability training and education across both sectors (VET and Higher Education) would be an advantage.[75]

Certificate III in Individual Support

Mr Bonner told us that the industry feedback is that Certificate III in Individual Support 'was not adequately preparing workers for job-ready roles in the sector'.[76] Mr Bonner said that 'we are preparing workers at a cert 3 level for roles that are requiring skills, knowledge and competence that are far beyond that'.[77]

Ms Jane Trewin, Executive Director, Education Delivery, Box Hill Institute, agreed that Certificate III is not keeping up with the needs of people with greater acuity.[78]

Ms Michelle Eastman, Executive Director, Pathways & Vocational Education, Swinburne University of Technology, said:

> Certificate 3 was never intended nor could it be intended to provide solutions to all of those complex problems. It's to be part of a multidisciplinary team working with certificate 4 level graduates, with diploma graduates, with degree and masters qualified graduates…the nature of that expanding role and expectations of a Certificate 3-level worker is incongruent with what a Certificate 3-level worker can do.[79]

Mr Bonner said:

> you can keep on adding more and more content into a Certificate 3 level program. So you can add Certificate 3 level knowledge in relation to palliation or dementia or behavioural care. But it doesn't add to the capacity of the worker to assess independently of other people, to have the knowledge and skills to make the decisions about whether or not it's appropriate to medicate or not medicate a client...So that's why we need to build pathways that take people up that knowledge tree and capacity tree as well as broadening skills across the workforce.[80]

The Aged Services Industry Reference Committee has determined to conduct the work associated with the review and development of qualifications in two phases. Phase 1 involves the immediate review of the Certificate III in Individual Support. Phase 2 is the wider review of qualifications that relate to work in aged care including the aged care specific qualifications.[81]

Certificate IV

Mr Bonner explained that Certificate IV was meant to put enrolled nurse level skills into an aged care qualification, without having licensing rules apply to the group.[82] The proportion of personal care workers in residential aged care who had completed a Certificate IV in Aged Care was 8% in 2003, 20% in 2012 and 23% in 2016.[83]

Ms Eastman told us that there is a 'very slim employment demand within the sector' for Certificate IV graduates.[84] Ms Trewin said that she finds that when students undertake a placement, some providers give them guaranteed employment when they have finished the Certificate III, and that does not encourage them to go on to a Certificate IV.[85]

11.1.5 Aged Services Industry Reference Committee

The Aged Services Industry Reference Committee operating framework primarily relates to Strategic Actions 3 and 4 of the Aged Care Workforce Strategy Taskforce report.[86]

Joyce Review

The Honourable Steven Joyce made a number of recommendations in his report, *Strengthening Skills—Expert Review of Australia's Vocational Education and Training System*, referred to as the Joyce Review, relevant to skills and training within the aged care sector.[87] These include specifying the average amount of training required for a new learner with no experience in the industry to develop the required competency.[88]

The proposal for benchmark hours in training competencies reflects concerns about the quality of vocational education and training qualifications. Ms Sandra Hill OAM, Chief Executive Officer, Benetas, gave evidence that:

> Inconsistent governance in the RTO [Registered Training Organisation] sector has led to inconsistent quality of qualifications offered. Certificate III qualified people are often not job ready despite completing a qualification including placement hours. This results in hidden costs to providers to retrain employees, and in some cases employees quit soon after commencement because the job wasn't what they thought it would be.
>
> Certificate III level qualifications appeal to people who do not hold existing qualifications, and can access government funding to complete a low cost qualification. There are significant cost barriers to people who may be a great fit for the sector, but hold existing qualifications in a different field at or above the Certificate III level.[89]

Ms Williams gave evidence about the Australian Government's response to the Joyce Review:

> In the 2019–20 Budget, the Commonwealth announced $525 million Delivering Skills for Today and Tomorrow package to strengthen the VET [Vocational Education and Training] system in response to the Strengthening Skills: Expert Review of Australia's Vocational Education and Training System (Joyce Review). The two measures in the Skills Package that are of most relevance to the aged care industry are the National Skills Commission and the pilot Skills Organisations.[90]

Ms Williams stated that 'the Commonwealth has committed $41.7 million over the forward estimates through the Skills Package to establish pilot SOs [skills organisations] in human services care and digital technologies (including cyber security)'.[91] According to Ms Williams:

> The pilots will be industry-led with governance arrangements developed with the target industries during the design phase. Pilot SOs [skills organisations] will give the targeted industries an opportunity to shape the national training system to be more responsive to their skills needs.[92]

Both Ms Eastman and Mr Bonner told us that the pilot skills organisation in human services is in danger of undermining the work of the Aged Services Industry Reference Committee.[93] Mr Bonner described the Joyce Review as another example of 'rearranging the deck chairs of the system, but failing to address the fundamental problem of what the qualification looks like'.[94] Mr Bonner said:

> the proposal to pilot industry training organisations in the aged care sector and disability sector is just an horrendous thought. We are one year into a three-year change process for qualifications for this sector, and government is proposing we start again by a new parallel training organisation taking responsibility for the same area. Why would we continue our work? So we would be saying to government, if you want to pilot this model, do it somewhere else rather than crossing over into an area that has a critical workforce need that we are only just into addressing.[95]

Apprenticeship model

Ms Eastman recommended looking at an apprenticeship model for aged care. However, she said that it would require 'radically different funding and economic levers and buy in and participation from providers themselves, and a rethinking around what that experience looks like'.[96]

Ms Eastman distinguished apprenticeships from traineeships as having 'status and recognition from employers and from government'.[97] Mr Bonner said that 'traineeships are fundamentally a funding vehicle' with 'no learning model'. Mr Bonner said that apprenticeships have a specific learning model 'which applies both workplace learning alongside institutional learning leading to a vocational outcome'.[98]

Mr Bonner noted that the challenge with an apprenticeship model would be in areas like home care, where typically one worker goes out on their own. An apprenticeship model would necessarily mean accompaniment and direct supervision.[99]

Ms Kerri Rivett, Chief Executive Officer, Shepparton Retirement Villages, told us that:

> I was looking at developing a traineeship model, and we have developed the traineeship model, and we implemented it in an abridged version, but what I was looking at is employing a group of young people, and they'll be—like becoming apprentices in the workplace, and that—we actually bring the TAFE colleges into the workplace to do the training, and they would be supernumerary for six months, and then they would actually go into the rosters for six months. The course would be over a nine-month period, the PCW [personal care worker] course, and then at the end they would be trained and work-ready to fully go into the workplace.
>
> Now, we have initially done the first round and the board approved the funding of some of that and I know Sandra does some of this, and all nine kids have actually been fully employed and are actually happy in the workplace and are fully work-ready. But we were after around 1.7 million to actually implement, you know, having 56 young unemployed people employed and over a three-year period. And we were unsuccessful in getting some of that funding, and I tried multiple, multiple areas to try and attract that kind of funding, yes.[100]

Ms Rivett was asked by Counsel Assisting if an Australian Government fund that was available to support appropriately evaluated proposals like that would be something the industry would welcome. She said:

> Like a HR [human resources] innovation fund would—yes, I think that would be extremely beneficial to the industry, yes.[101]

Ms Rivett also suggested that the recent initiative of the Victorian Government to provide subsidies to teachers to work in rural and remote areas should be given serious consideration for the aged care sector.[102]

We were interested to hear evidence about:

- a scholarship program offered by Benetas which provides employees with financial assistance toward professional learning and development[103]
- a Graduate Nurse Program at Resthaven, which provides structured supported learning for recently registered nurse graduates.[104]

Tertiary education

Nursing

Professor Kylie Ward, Chief Executive Officer, Australian College of Nursing, said she would not expect a nursing graduate, on a foundational degree, to have had any specialist training in aged care-related matters.[105] Professor Ward advocated for life-long learning, including postgraduate certificates in aged care specialities. She also advocated for investment in leadership capability development of nurses, stating that effective leadership 'ensures a positive, supportive and efficient workplace culture'.[106] Professor Ward said this will ensure that nurses are better supported and less isolated and lonely.[107]

Placements

Ms Yates noted the 'immediate benefits' of placements in aged care:

> It teaches them how to care because often when you are working with older people and the frail elderly, it's more than just clinical skill.[108]

Professor Vickers identified placements as being the opportunity for medical students to have exposure to issues affecting older people.[109] He said:

> 10 years or so ago, that the Wicking centre, in collaboration with the school of nursing and the school of medicine, decided we needed to provide high-quality placements to a range of health-professional students in the residential-aged care sector, and that was really borne out of research that we had conducted that showed that many of these health-professional students have a negative view of aged care and that might be because they've had an unsupported placement in residential aged care or, probably, more so that they've had very little experience of that domain in their regular curriculum.[110]

Professor Vickers said that supported placements of medical students in an aged care facility requires 'senior experienced clinicians who take responsibility for those students on placement'. Even then, there is work to do to get nurses, aged care workers and management on side to 'buy into this idea that a learning environment is a higher quality environment for everybody, including the residents'.[111]

Professor Vickers told us that the Teaching and Research Aged Care Services funding enables an interdisciplinary approach:

> What the TRACS [Teaching and Research Aged Care Services] funding also gave us too at the time was also that opportunity to be a bit more interdisciplinary. So at the moment fairly much our students are going on separate placements, but when we had more resources, they were able to do some activities together, and that's when health-professional students start to learn about what other groups of health professionals think and their attitudes towards older people, so forth.[112]

Placements are part of the undergraduate, bachelor degree for registered nurses (800 hours) and a diploma in nursing for an enrolled nurse (400 hours).[113] The Australian Nursing and Midwifery Accreditation Council approves education providers for a program leading to enrolled nursing registration.[114]

Professor Ward said:

> Well, we would see that there would be more opportunity to extend the experience in clinical settings, including residential-aged care facilities, and that there would be more opportunity to assimilate in a fourth year or more and with other professionals, including inter-professional learning. So, yes, there would be far more opportunity.[115]

Professor Ward went on to speak about the difficulties with current placements in aged care:

> It is still dependent on the experience of the person in some ways or the culture of the facility that a student is allocated to. It is a compounding and complex issue, because the pressure on—I'll speak on behalf of nurses—on registered nurses is so high in demand in areas, including residential-aged care facilities, where there's either no registered nurse or one registered nurse with, potentially, on an evening shift, up to hundreds of residents. So the requirement then to support somebody in a learning-phase through university is increasingly demanding.[116]

Medical curricula

Professor Vickers emphasised that the average patient coming through is getting older and older. Professor Vickers warned that the current model of teaching medical students to attend to one thing is not going to be enough when it comes to an older population with multiple conditions.[117]

Professor Vickers said that he would 'love to see more on the [medical] curricula related to older people, multimorbidity, frailty, dementia'. His view was that the way to do this is to develop a teaching in aged care facilities program which gives substantial experience for 'all kinds of students'.[118]

Professor Vickers identified dementia as the second leading cause of death in Australia and, in five years' time, the leading cause of death. Professor Vickers's view is that there is a high priority to think about how programs are reoriented, which may involve adjustment of the medical curriculum. Professor Vickers considers that there are flexible ways of doing this, and referred to short online courses on dementia.[119]

Geriatric medicine

Dr Maddison explained that a geriatrician has specific training in managing frailty, cognitive impairment and dementia, confusion and delirium, changed behaviours and behaviours of concern, multiple morbidity and polypharmacy. The major diagnostic and therapeutic intervention which geriatricians provide is known as a Comprehensive Geriatric Assessment. The application of the comprehensive assessment has been shown to reduce morbidity, mortality and the likelihood of placement in residential aged care. This assessment has been recognised by the Australian Government through specific item numbers in the Medicare Benefits Schedule. This highlights that access to geriatricians is quite dependent on general practitioners recognising the value of geriatricians in the care of older people and making the necessary referrals.[120]

Dr Maddison explained that in terms of 'political, public and professional interest, geriatrics is something of a Cinderella among consulting physician and procedural specialties. It is not fashionable, or glamorous'.[121]

Dr Maddison referred us to an estimate made in 2018 by South Australian geriatrician Dr Toby Commerford that Australia needs around 1000 full-time geriatricians.[122] Current estimates are that there are around 874 registered geriatric medicine specialists.[123] It is significant that there has been a 39% increase in the number of geriatricians between

2013 and 2017, which compares well to the 20% increase in the number of cardiologists and the 6.5% increase in general physicians over the same period.[124]

Dr Maddison attributed the growth in geriatrician numbers to two factors: some jurisdictions making an investment in specialist geriatric medicine training; and the introduction of Medicare Benefits Schedule items for geriatric services which makes it financially viable to practise primarily as a geriatrician.[125]

He explained that under current data limitations, it is difficult to model future demand for geriatricians:

> Modelling workforce demand is similarly difficult - methodology which relies on acute hospital data (reliant on Diagnosis Related Groups) is likely to under-estimate demand. Similarly it is not always possible to specifically identify geriatrician activity with the Medical Benefits Schedule.[126]

Dr Maddison said that as the public hospital system is unlikely to create new positions for geriatricians at the same rate as it has over the last decade, much of the new geriatrician workforce will be available to undertake significant activity in the private aged care sector.[127]

Dr Maddison stated that the introduction of dedicated geriatric Medicare Benefits Schedule item numbers was an important validation of the Comprehensive Geriatric Assessment. However, the proposed abolition of geriatric specific item numbers, which is likely to reduce access to these assessments in the private sector, may remove an incentive for geriatricians to provide comprehensive services and may discourage physicians from specialising in geriatrics.[128]

Dr Maddison cited a 2018 survey of Australian Medical Schools, which found that robust teaching in geriatric medicine is deficient. Rotations in geriatric medicine are not required in seven of the 18 schools surveyed. Duration of attachments in geriatric medicine vary from one to eight weeks, with one-third not exclusive to geriatric medicine.[129]

The Royal Australian College of Physicians offers a Clinical Diploma in Palliative Medicine, but no Diploma exists for Geriatric Medicine. Dr Maddison's view is that there is no financial incentive to undertake this training as there are no Medicare Benefit Schedule items specific to practitioners who do.[130] He explained:

> there is no program out there that is…targeted to doctors…to build on their formal training in geriatric medicine unless you choose to become a geriatric medicine specialist. There are graduate diplomas in palliative care which are administered by the College and in the past, some universities in different places across the country have run graduate programs targeting doctors to upskill them. Those programs have failed…One speculates that there wasn't a high enough demand for them because, I guess, doctors couldn't see the benefit in doing it because it wasn't linked into remuneration. So I think the two things have to go together; if we're going to ask universities or tertiary organisations to develop these programs, we need to work out how and why would we incentivise people to do them to upskill themselves in those areas.[131]

11.1.6 Regulation of personal care workers

Current situation

The Australian Department of Health and the Aged Care Quality and Safety Commission regulate approved providers, but not aged care workers.[132]

The Australian Health Practitioner Regulation Agency and National Boards regulate nurses, medical practitioners and allied health professionals who operate in aged care. Personal care workers are not regulated professionally by the Australia Government. However, the Australian Government supports the introduction of a registration scheme, and some scoping work for that scheme is underway.[133]

National Code of Conduct

In 2015, the terms of a National Code of Conduct for health care workers were agreed to by Health Ministers through the Council of Australian Governments' Health Council. It is a matter for each State and Territory to determine how the National Code of Conduct is implemented and progressed.[134]

A Communique from the Council of Australian Governments' Health Council on 17 April 2015 said this about the code:

> The National Code will set standards of conduct and practice for all unregistered health care workers. Ministers agreed to use their best endeavours to give effect to the National Code and code-regulation regime, noting that those jurisdictions with existing schemes will consider adjustments to their codes and arrangements to achieve national consistency.[135]

The code is at various stages of implementation. In each State or Territory that has implemented the National Code of Conduct, the extent to which a personal care worker is subject to regulation by the health regulator in that jurisdiction depends on whether they are providing a 'health service', as defined in the relevant State or Territory law. The scope of the definition of a 'health service' varies significantly between jurisdictions. [136] For example, in Queensland, the definition is broad and encompasses 'a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing', as well as a 'support service' to such a service.[137] According to the Queensland Health Ombudsman, in-home care provided to an older person, that consists only of house cleaning, shopping, cooking and transportation, is unlikely to be characterised as a 'health service'. If a service extends to helping older people shower, or go to the toilet, such services are likely to be subject to the jurisdiction of the Queensland Health Ombudsman. Similarly, services such as transportation or catering may come within the Queensland Health Ombudsman's jurisdiction as 'support services', if provided by a health service, such as a residential aged care facility.[138]

By contrast, the definition of 'health service' of the *Health Care Complaints Act 1993* (NSW) identifies various services, such as 'medical, hospital, nursing and midwifery services' and 'optical dispensing, dietitian, massage therapy, naturopathy, acupuncture, speech therapy, audiology and audiometry services'.[139] According to the New South Wales Health Care Complaints Commissioner, whether or not a personal care worker was providing a 'health service' requires consideration of whether 'there was a therapeutic/treatment aspect to the care provided'—so that non-therapeutic support, such as assistance with dressing or cleaning, would be unlikely to constitute provision of a 'health service'.[140]

Statements were obtained from the following health complaints officers, in each jurisdiction, in relation to whether and how they regulate unregistered aged care workers and complaints about aged care:

- Ms Karen Toohey, Discrimination, Health Services, Disability & Community Services Commissioner in the ACT Human Rights Commission[141]
- Mr Stephen Dunham, Commissioner, Health and Community Services Complaints Commission, Northern Territory[142]
- Mr Richard Connock, Tasmanian Health Complaints Commissioner[143]
- Dr Grant Davies, Commissioner of the Office of the Health and Community Services Commission, South Australia[144]
- Ms Susan Dawson, Commissioner, New South Wales Health Care Complaints Commission[145]
- Ms Sarah Cowie, Director of the Health and Disability Services Complaints Office, Western Australia[146]
- Ms Karen Cusack, Health Complaints Commissioner, Victoria[147]
- Mr Andrew Brown, Health Ombudsman of Queensland.[148]

Ms Cusack, Mr Brown and Ms Shona Reid, Executive Director, Complaints, Aged Care Quality and Safety Commission, gave evidence as a panel on 18 October 2019. Table MH3-1 summarises aspects of each health complaints officer's jurisdiction to regulate personal care workers in aged care workers.

Table MH3-1: Summary of health complaints officers' statements—jurisdiction to review complaints

State / Territory	Whether jurisdiction exists for personal care workers working in aged care	Whether complaints are referred to the Aged Care Quality Safety Commission	Number of complaints about aged care for the period 1 July 2014 to 30 June 2019
ACT	No jurisdiction[149]	N/A	33 (0 about unregistered workers)[150]
NT	Yes[151]	N/A[152]	9[153]
Tas	Yes[154]	Complaints are referred to the Aged Care Quality and Safety Commission or the Office of Aged Care Quality Compliance[155]	10 (within jurisdiction) 34 (outside jurisdiction) no data held on categories[156]
SA	Yes[157]	Some are referred to the Aged Care Quality and Safety Commission [158]	64 (11 about unregistered workers)[159]
NSW	Yes, subject to 'therapeutic / treatment aspect' to service[160]	N/A[161]	892 (59 in relation to unregistered workers)[162]
WA	Likely, yes[163]	Some referred to the Aged Care Quality and Safety Commission[164]	217[165]
Vic	Likely, yes[166]	No power to formally refer to the Aged Care Quality and Safety Commission. *Complainants* are referred.[167]	96[168]
Qld	Yes, subject to providing or supporting a 'health service'[169]	Complaints concerning the operation of facilities including their systems and processes are referred to Aged Care Quality and Safety Commission[170]	856 (90 about unregistered workers)[171]

From 1 July 2014 to 30 June 2019, only the New South Wales, South Australian and Queensland health complaints officers had exercised their respective powers to issue prohibition or interim prohibition orders restricting the ability of aged care workers to provide a health service.[172]

During the same period, the New South Wales Health Care Complaints Commissioner issued two prohibition orders against personal care workers: one was against a person for posing as a registered nurse and one against an assistant in nursing.[173] The South Australian Health and Community Services Commissioner issued one.[174]

Since 1 July 2014, the Health Ombudsman of Queensland has taken immediate registration action against six registered practitioners and made 17 interim prohibition orders in relation to practitioners working in an aged care setting, including 12 against unregistered practitioners, eight of whom were assistants in nursing.[175]

Ms Cusack gave evidence that complaints received by her office were assessed to determine whether another agency should deal with the complaint. In such a case, 'as a general rule' her office will not deal with the complaint.[176] She said that the *Health Complaints Act 2016* (Vic) establishes express referral processes by reference to the *Disability Act 2006* (Vic), *Mental Health Act 2014* (Vic), and Australian Health Practitioner Regulation Agency, among others.[177] However, Ms Cusack considered that confidentiality provisions in the Victorian Act means she does not have power to refer a complaint to the Aged Care Quality and Safety Commission.[178] She told us that there is a dedicated agency to 'assist the complainant', in aged care, with how they can make a complaint to the Aged Care Quality and Safety Commission.[179]

The Aged Care Quality and Safety Commission confirmed that no complaints were referred to it by the Victorian Health Complaints Commissioner or the Tasmanian Health Complaints Commissioner, between July 2014 and June 2019. By contrast, 25 complaints were referred by the Queensland Health Ombudsman during the same period.[180]

The Health Ombudsman of Queensland told us that his office is the single point of contact in the first instance for any complaints about registered practitioners or health services. After the Ombudsman's office determines that the complaint is not 'frivolous, vexatious, lacking in substance or trivial', a complaint about a registered practitioner, other than complaints about matters that may constitute professional misconduct, will be referred to the Australian Health Practitioner Regulation Agency. Complaints about matters that go to professional misconduct, or which otherwise might constitute grounds for suspending or cancelling the practitioner's registration, will be dealt with internally by the Health Ombudsman's office.[181]

The Queensland Health Ombudsman said that his power to take action against an unregistered practitioner turns on an assessment of whether they 'pose a serious risk to persons and it is necessary to act to protect the community'. He considered this is 'almost a separate test' to the National Code of Conduct, and a 'mere breach of that code wouldn't necessarily be actionable' by the Health Ombudsman's office.[182]

The Office of the Health Ombudsman of Queensland has arrangements in place with Queensland Police to obtain information about allegations made to police about the conduct of health professionals. The Health Ombudsman of Queensland funds a position within the Queensland Police information service that 'does daily checks in relation to practitioners that may be charged with offences or under serious investigation'.[183] The Victorian Health Complaints Commissioner said that her office does receive some information from Victoria Police, 'but not to the same extent' as in Queensland.[184]

Ms Reid provided a statement setting out the arrangements the Aged Care Quality and Safety Commission has with the various health complaints officers in the States and Territories.[185] The arrangements established by the former Aged Care Complaints

Commission were governed by separate Memoranda of Understanding with each health complaints entity. Since its establishment, the Aged Care Quality and Safety Commission has been pursuing new arrangements with State and Territory health complaints entities, but at the time of the hearing, a Memorandum of Understanding had been finalised with New South Wales only.[186]

The Aged Care Quality and Safety Commission's ability to share information with health complaints officers is constrained by section 61 of the *Aged Care Quality and Safety Commission Act 2018* (Cth). In the case of allegations about the conduct of an unregistered aged care worker, disclosure is permitted in limited circumstances, including if the Commissioner believes, on reasonable grounds, that the disclosure is necessary to prevent or lessen a serious risk to the 'safety, health or wellbeing of an aged care consumer', or 'in the public interest'.[187] Ms Reid told us that between July 2014 and June 2019, the Aged Care Quality and Safety Commission, or its predecessors, referred three complaints about the 'health, conduct or performance of a particular unregistered aged care worker' to a State or Territory health complaints entity.[188]

Counsel Assisting referred the panel to evidence we heard during our Brisbane hearing from Ms Sarah Holland-Batt and the Japara Bayview Case Study.[189]

Ms Holland-Batt told us that a whistleblower had raised allegations about abuse of her father by an assistant in nursing at the residential aged care facility where he lived in Queensland. Ms Holland-Batt took those concerns to the Aged Care Complaints Commissioner, which told her she should take her complaint to the Queensland Health Ombudsman.[190]

The Victorian Health Complaints Commissioner was asked how her office would respond to allegations of the kind raised by Ms Holland-Batt, if they concerned the conduct of an unregistered aged care worker at a residential aged care facility in Victoria. Ms Cusack said that notwithstanding that the Aged Care Quality and Safety Commission has no power to take action directly in relation to an aged care worker, she considered it was the appropriate body to deal with the complaint against the worker as the 'oversight body for the quality and safety standards in aged care'.[191]

By contrast, Mr Brown told us that his office reached out to Ms Holland-Batt shortly after it became aware of her evidence to the Royal Commission at the Brisbane Hearing. Ms Holland-Batt has now made a complaint to the office of the Queensland Health Ombudsman.[192] Mr Brown considered the complaint is 'clearly within our jurisdiction'.[193]

The witness panel members were asked to consider the employer's findings of misconduct, and evidence of further allegations, made against UA in the Japara Bayview Case Study, discussed below. The findings and allegations included physical assaults on residents. Ms Cusack took the view that her office would not deal with such a complaint and would refer a complainant to the Aged Care Quality and Safety Commission.[194] Mr Brown said that the office of the Queensland Health Ombudsman would consider the complaint. He said that if the allegations could be made out, they would likely satisfy 'the 'serious risk threshold', and the matter would be investigated by his office and consideration would be given to issuing an interim prohibition order.[195]

Ms Reid accepted that there is a gap in the regulation of unregistered aged care workers in Victoria, in light of the role of the Victorian Health Complaints Commissioner and the Aged Care Quality and Safety Commission's lack of direct powers. Ms Reid said the Aged Care Quality and Safety Commission needs to rely on the service provider taking action against their employee.[196] Surprisingly, Ms Reid said that she had only become aware in the lead-up to this hearing that the Victorian Health Complaints Commissioner takes the view that complaints about the conduct of an individual in an aged care setting are matters that should be dealt with by the Aged Care Quality and Safety Commission.[197]

Ms Reid also accepted that there is a risk that a complainant turned away by the Aged Care Quality and Safety Commission will not proceed to make a complaint to the State or Territory health complaints officer. In that situation, the Aged Care Quality and Safety Commission will attempt a 'warm transfer' to an advocate to assist the complainant, or refer the complaint itself if the complaint meets the test in section 61 of *the Aged Care Quality and Safety Commission Act*.[198]

Ms Reid was asked by Counsel Assisting about allegations concerning the conduct of a personal care worker at a residential aged care facility in Victoria, which are explored as part of the Menarock Case Study, discussed below.[199] Ms Reid accepted that the allegations in relation to the worker's conduct at least suggest a breach of the obligation in the National Code of Conduct, in particular the obligation to provide health services in a safe and ethical manner.[200] Although the allegations were the subject of a complaint to the Aged Care Quality and Safety Commission, there was no referral to the Victorian Health Complaints Commissioner.[201]

Ms Reid stated that the Aged Care Quality and Safety Commission is 'strengthening the instructions for complaints officers' to make it clearer when 'a referral to the relevant State-based body (where the Code of Conduct has been adopted) and/or police services by either the provider or ACQSC [Aged Care Quality and Safety Commission] should be considered'.[202] Ms Reid said that it has been open to the Aged Care Quality and Safety Commission to refer the allegations concerning the personal care worker at the Menarock facility to the Victorian entity, however this has not been done. Ms Reid accepted that the Aged Care Quality and Safety Commission needs to review its guidance material and information to 'try and clarify the differences around the country' to make the referral process clearer for complaints officers.[203]

Ms Reid said that it is 'not an easy task' for complaints officers to understand the National Code of Conduct for health care workers because it is 'not very specific when we look at some of the areas of abuse', such as verbal abuse.[204]

Ms Cusack considered that it is critical that the different regulatory schemes and regulators work together and understand one another's roles and responsibilities. She said, 'fragmentation can potentially lead to people slipping through the cracks and that's what we want to avoid at all costs'.[205]

In Mr Brown's opinion, a fragmented scheme can work if there is good cooperation.[206] Mr Brown considered it essential for the various regulatory players to ensure that the limits of jurisdiction are understood and there is good information sharing between them.

He thought this is the case between his office and the Aged Care Quality and Safety Commission. He also thought it is important that the general public, service providers and workers have access to information that explains the fragmented system.[207]

Mr Brown considered that there are 'pros and cons' with both national and fragmented systems. He thought that there are some national systems which 'are just going to be too big and too cumbersome to work properly'.[208]

Ms Reid said that harmonised laws in the States and Territories would 'be very nice from my own personal perspective'.[209] She considered there would be value in a national oversight body or shared register for State-based health complaints officers to share information.[210]

11.1.7 A national register for personal care workers

Ms Reid considered that the aged care system would be improved by 'some sort of unregistered carer' national register. She thought this would assist service providers to be able to 'screen people that they employ to ensure that they are getting good quality staff'.[211]

Other witnesses were also asked to comment on a national registration scheme.

Mr Darren Mathewson, Executive Director, Services, Support & Engagement, Aged & Community Services Australia, said that 'the time has come' to look at a registration scheme for care workers. He said that such a scheme is consistent with his organisation's focus on 'supporting right-fit workers', and will also operate to professionalise the workforce so that care workers are 'recognised as a key contributor to the aged care team, whether it be home care or residential'.[212] Mr Mathewson considered the purpose of a registration scheme should be to 'provide adequate screening to protect residents / clients in aged care whilst also providing information on the criminal and work history, work readiness, training, skills and qualifications of individual workers'.[213] He said that Aged & Community Services Australia would support establishment of a scheme and would work collaboratively with whatever agency was responsible for administering it.[214] Mr Mathewson noted that Aged & Community Services Australia's members would consider it a benefit and thought that government and industry have a role to play where a low-paid workforce may lack the capacity to cover the costs of the scheme themselves.[215] He warned that higher regulation may deter needed workers from the workforce.[216]

Mr Paul Gilbert, Assistant Secretary, Victorian Branch of the Australian Nursing and Midwifery Federation, considered that there should be a mandated minimum qualification of a relevant Australian Qualifications Framework Certificate III for any worker delivering nursing care approved by the Australian Nursing and Midwifery Accreditation Council.[217] He told us that the Victorian Branch of the Federation thinks registration, through the Australian Health Practitioner Regulation Agency, for the aged care workforce would 'inject much needed public confidence, while at the same time enhancing the professionalism of the occupation'.[218] Mr Gilbert's view was that the Australian Health Practitioner Regulation Agency has the expertise and systems to register aged care workers.[219] Registration with that Agency, he said, may avoid unnecessary duplication if nurses are required to

register with the agency and a new scheme, and could be used with the National Disability Insurance Scheme.[220] In Mr Gilbert's view, the Australian Government should fund this expansion of registration to personal care workers.[221]

Ms Clare Tunney, Industrial Officer, United Voice, 'absolutely' agreed that there is a need for regulation and registration of aged care workers.[222] She considered, however, that regulation by the Australian Health Practitioner Regulation Agency is not the right model. According to Ms Tunney, the key issue is 'safeguarding and protecting residents' and, accordingly, a model akin to that used by the National Disability Insurance Scheme 'based on police clearances, reporting of criminal activity, reporting of so-called reportable incidents' is the correct approach.[223] She thought that aged care workers should not be doing nursing work or subject to the Australian Health Practitioner Regulation Agency's extensive criteria.[224] She said it would be unreasonable to create cost barriers for low-paid workers to enter the workforce.[225]

Ms Lisa Alcock, Industrial Officer, Health Workers Union, did not support the establishment of a registration scheme. According to Ms Alcock, the Health Workers Union considers that 'a registration scheme places the onus on the employee to meet safety screening mechanisms' and 'the cost and burden' would operate as a barrier to entry to the workforce for workers in 'a particularly low-paid industry'.[226] Ms Alcock said that if any measure is necessary, the Health Workers Union's preference is a 'worker exclusion scheme'. Ms Alcock noted that 'the majority of home care workers in Victoria will probably already be holding a Working With Children Check card because the work that they're performing will probably already come in contact with children'. According to Ms Alcock, 'the concerns that you would be wanting to monitor will probably be picked up in that scheme, at least in Victoria'.[227] She considered that the Working With Children Check scheme could be expanded to include aged care.[228] Ms Alcock considered a worker exclusion scheme is sufficient.[229]

Ms Beauchamp told us that the Australian Department of Health had done 'much work' on it. She said the work is about ensuring that they have 'good information on who is affected by reportable assaults'.[230]

Ms Beauchamp told us that 'going forward, the relationship between the Serious Incident Response Scheme and the idea of a screening or registration scheme will provide us with an extra avenue to ensure that we have the ability to track workers through the aged care system'.[231] She said the Department is 'looking to have something in place over the next 12 months, assuming that we can get legislation through Parliament and a range of other things done'.[232]

The Serious Incident Response Scheme was originally proposed in the Carnell-Paterson *Review of National Aged Care Quality Regulatory Processes* in October 2017.[233] Ms Beauchamp told us that at about two years later, the Department is working as hard as they 'possibly can to look at what occurs in other jurisdictions, other countries, and making sure that we are well-aligned with other workforces that do provide support for our most vulnerable', including the National Disability Insurance Scheme.[234] Ms Beauchamp told us she is 'happy to provide, in whatever form the Commissioners would like, a regular update' on the Department's reform agenda.[235]

11.1.8 Terms of employment

Remuneration

Mr Gilbert said that the comment he hears about members, when he goes to meetings at the Australian Nursery and Midwifery Federation, is '"I could get paid more, working on the checkout at Aldi," and it's technically true'. Mr Gilbert said that aged care workers:

> see themselves as—'Why is my life treated as being—my—what I dedicate myself to being seen as of less worth than that position?'. And that's, interestingly, what they tend to compare themselves to, because they see those jobs advertised with an hourly rate of 24, 25 and 26 dollars.[236]

Ms Alcock gave evidence about two examples, which she is privy to, of aged care workers getting disproportionate remuneration. One was a woman whose partner works in an aluminium smelter, in a role not needing specific education or training, who is paid $100,000 a year. By comparison, she has a TAFE qualification in aged care and is paid $21 an hour, which works out to be about $40,000 a year 'at best with penalty rates and loadings'.[237] The other example was of a woman who had to pay a man $150 an hour to clean her gutters, when as an aged care worker, she is only paid $21 an hour to clean a person and 'everything that goes with that, to provide dignity and care and support'.[238]

Sara Charlesworth, Professor of Work, Gender and Regulation at RMIT University, Melbourne, stated that the poor pay of aged care workers reflects the gendered nature of work in the caring professions, of which aged care is one.[239] Professor Charlesworth told us that aged care work requires increasingly complex skills, but it:

> is assumed to be the work that women are born to do naturally and, as such, with paid care work being seen as equivalent to unpaid care work it's therefore viewed as something that a lot of women are capable of doing, and so that it's not particularly skilled work.[240]

We heard how poor remuneration of aged care workers directly affects both attraction and retention of workers to the aged care sector. Ms Alcock told us:

> workers in this industry enter it because they care deeply about providing high quality care to residents. I think it's probably true to say they don't enter the industry to earn incredible amounts of money; they know they're not going to come out with $100,000 a year. But we're not going to be able to retain workers unless we increase their rates of pay, and we make the industry safer. We're just not going to be able to retain workers, and we're not going to be able to generate and attract the next generation of high quality workers either. I think from the HWU's [Health Workers Union] perspective we need to increase funding and that funding needs to be directly linked to wage increases and increases in staffing.[241]

Ms Janice Hilton has been working as a carer for 10 years, the last six years in providing care at home in aged care, and before that in disability, youth and children's' services. Ms Hilton gave this warning:

> Our pay doesn't keep up with the cost of living so we're attracting the wrong sort of people into the positions now.[242]

Evidence from representatives of the peak bodies of approved providers, Mr Darren Mathewson, Chief Executive Officer, Aged & Community Services Australia, and Ms Jenna Field, Employment Relations / Industrial Relations Adviser for Leading Age Services Australia, is that approved providers will pay their staff higher wages, but are unable to do so because of the amount of funding provided by the Australian Government.[243] Peak bodies, who represent approved providers of aged care, use this as a reason to explain why they, as employers, are unable to increase wages.[244] The implication of this is that if the Australian Government was to increase funding, approved providers would increase the wages paid to its workers. However, the evidence of Mr Gilbert is that there have been three times, in his 24 years of industrial experience, where 'the Commonwealth Government has increased taxpayer subsidies to aged care for the express purpose of improving wages and not once did that deliver a dollar in improved wages'.[245]

Professor Charlesworth stated:

> The aged care industry is highly dependent on and constrained by government funding which impacts directly on employment conditions and the organisation of work in aged care…The level of funding is a significant consideration when employers make decisions in relation to wages and conditions to be afforded to their employees…
>
> Inadequate government funding and individualised models of service delivery such as CDC [consumer-directed care] also work to limit the improvement of minimum employment standards via industrial mechanisms.[246]

Mr Charles Wann, First Assistant Secretary of Aged Care Reform and Compliance, Australian Department of Health, gave evidence that the Department 'does not have full visibility of the remuneration and working conditions applicable to the hundreds of thousands of aged care workers across the country at any one point in time'. He is of the view that 'issues relating to remuneration and working conditions are matters for providers as employers'.[247] In its written submission, the Australian Government stated that the issue of low remuneration, in contrast to comparable care sectors, must be addressed.[248]

Industrial mechanisms to increase wages

Along with the fact that care work is predominantly undertaken by women, we heard evidence that there are systemic reasons for low remuneration of workers in aged care. A key factor in the systemically low remuneration of the sector is the operation of the industrial relations system. Evidence about this was received from an academic perspective from Professor Charlesworth, as well as from representatives of the peak bodies of approved aged care providers and from aged care workers through union representatives.

The two main industrial mechanisms these witnesses spoke of were enterprise agreements and awards.

Enterprise Agreements

We heard evidence that the enterprise bargaining system is not working to increase wages in the aged care sector. Key points included:

- the Australian Government provides the majority of funding, and some approved providers are unable to afford wage increases within the funding framework[249]
- a decentralised workforce makes organising and collective discussion among workers in the aged care sector very difficult[250]
- aged care workers are reluctant to take strike action, as it may pose a risk to the health and safety of the people they care for, i.e. their residents or home care clients[251]
- workers who are already low paid may not be able to afford to miss work, and the associated income, that results from taking industrial action.[252]

Professor Charlesworth said that 'enterprise bargaining is not practical', particularly in home care, where 'it's almost impossible'.[253]

Ms Tunney said that:

> We have not found enterprise bargaining to be an effective means to increase the pay and conditions of the majority of workers in the aged care sector. Today, not only are we struggling to maintain existing terms and conditions with many providers, but we are also seeing the erosion of these conditions.[254]

Awards

The *Social, Community, Home Care and Disability Services Industry Award 2010* covers home care and other workers.[255] The *Aged Care Award 2010* covers aged care workers in a residential setting.

As part of an industrial safety net, modern awards set the minimum pay rates for workers covered by the relevant award. In the case of personal care workers working in a residential environment, that rate is only $2.09 an hour more than National Minimum Wage. For personal care workers working in a home care setting, that rate is only $1.49 an hour more than the minimum wage.[256]

Professor Charlesworth told us that the job classification structures in the awards is 'very meagre'.[257]

Conditions

Working conditions within the aged care sector were identified by workers as being a further key source of job dissatisfaction and stress. These include irregular and split shift patterns, insufficient and variable working hours, and casual employment contracts. Care workers, to a greater degree than nurses, also expressed dissatisfaction with their managers, complaining of incidences of insufficient support, inappropriate decision-making and poor channels of communication.[258]

Ms Tunney told us:

> Members report that they are provided with fewer types of training, and that training is occurring less frequently. Furthermore, some training that used to be conducted face-to-face is now being provided online. Often, workers are required to complete online training outside of work hours.[259]

> We consistently hear that they're concerned about low pay, the erosion of existing conditions, that they don't have adequate training, they don't have manageable workloads, that there aren't enough staff on the floor and that they have significant concerns about job security.[260]

Mr Gilbert gave evidence that:

> With the right incentives (decent minimum standards, professional recognition, low or no fees, and career paths) people will want to work in aged care and, over time, seek out the education opportunities required.[261]

Travel time

A number of witnesses raised the issue of payment for travel time for home care workers. There is no provision for paid travel time as work time between clients in the Social, Community, Home Care and Disability Services Industry Award.[262] Some workers are entitled to and are compensated for travel time with a travel allowance or payment of motor vehicle expenses from their employer, however we have heard that this does not reflect the true nature of the travel required by home care workers in the course of their employment as they travel between clients.

Ms Alcock told us that:

> There are women right now, sitting in their cars, waiting to go into someone's home and not being paid for that time. And that isn't their time. So they're not paid for kilometres travelled. They're not paid to travel between homes. That's not their time, and they're not paid for any of that work.[263]

Ms Hilton told of her personal experience, which is that although she is paid some allowance towards travel time, it did not always reflect the actual time spent.[264]

Professor Charlesworth gave evidence about her research into travel time for home care workers, both in Australia and internationally.[265] She says the issue of travel time goes directly to the question of whether personal care work is valued:

> I think the whole issue of travel time is absolutely—it's very revealing about the lack of value we accord home care workers' work. It's hard to think of any other job where you are required to travel from client to client and you are not paid for your travel time. You are recompensed for your mileage when you travel, when you use your own car, which home care workers do but you are not paid for your travel time.[266]

Split shifts

A related issue for personal care workers is that of the split shift arrangements available under the *Social, Community, Home Care and Disability Services Industry Award 2010*. The consequence of this provision is that workers are only paid for the time they tend to clients, not for waiting times in between.[267] Ms Alcock described the situation:

> For a part-time employee—because in my experience those workers are not engaged as casuals, they are engaged as part-time employees, there is no minimum period of engagement. So they can be engaged on the split shift provisions for, say, 30 minutes or an hour at a time over, say, 12 hours, and they're not paid for the time between people—between those shifts.[268]

Low hour contracts

Some employees are engaged on low hour part-time contracts that can be increased by their employer. This leads to reduced certainty and security of hours for employees.[269] Ms Hilton gave evidence of the effect that this arrangement has on her life:

> I'm on a 30-hour contract fortnightly, which can be up to 39 hours fortnightly. If I ask—if I get asked to do extra shifts, I do them, if I can. I have foster children, one with a disability. So I need to spend time with them as well. Rosters are changing regularly, which makes it difficult to try and have some work-life balance and plan ahead for events.[270]

Risks of assault

The physical demands of direct care work and the risk of work-related injury and illness were described by both occupational groups as a key challenge in the sector.[271] We heard evidence of the daily risk of assaults, by those receiving care, which aged care workers face. Ms Alcock described the situation as:

> I think we have a culture at the moment which accepts that in aged care and social community—that if you work in this industry, you should be prepared to be assaulted and sexually assaulted on a weekly basis.[272]

Ms Tunney drew attention to the situation faced by home care workers:

> we repeatedly hear from aged care workers and particularly home care workers that they regularly experience assaults. The home care workers are particularly vulnerable because they're in private residences, they are exposed to difficult situations both with the clients that they care for but also the families of clients, and also…they don't have any control over the actual work spaces that they work in and the sorts of hazards that they are exposed to also like heat—excessive heat and cigarette smoke, those sorts of things.[273]

Mr Gilbert described assaults in nursing homes as 'very common':

> There are a couple of aspects to it. I think sometimes you [can] be assaulted…because you happen to be down doing up somebody's shoe laces and it's a matter of convenience…I've been assaulted—in my history—in that same circumstance. On other occasions, it's a consequence of being rushed. People are rushing people to comply with their timelines and that's creating a situation where someone who has already got issues around their mental competence is getting frustrated and angry at being forced down a path and that's a consequence of being rushed. People are getting six minutes to get a resident out of bed, washed, in a chair, in a lounge room. It's just madness.[274]

Ms Alcock highlighted the seriousness of the problem:

> I'm convinced that we will potentially have a death in residential aged care unless we address occupational health and safety seriously.[275]

Physical work

Ms Hilton described doing 'six hours of cleaning without a break' and described her work in aged care as 'physically demanding, especially in a heatwave'.[276]

Ms Lavina Laboya came to Australia in 2007 and has been working in residential aged care since 2018.[277] Ms Laboya said she had been warned by more experienced workers that she should leave the job if she wanted to avoid back problems:

> My back and my shoulder are always sore and I worry that if I [injure] my back while I am young, I won't be able to get a job after that. A lot of the people I work with are much older than me and they tell me to get out and save my back. If there were more staff and better equipment I might stay in aged care but management refuse to acknowledge that there is a problem.[278]

Ms Laboya also described the pressures of working in an under-resourced environment, both in terms of staff and equipment:

> During the morning shift at both facilities there isn't enough time to spend with each resident, and other staff and I spent each around 10 to 15 minutes with the residents and we're constantly rushing.[279]
>
> …
>
> The other issues that affect the staff at both facilities I work is the lack of equipment. We don't have enough equipment or the equipment is faulty. We put tags on the equipment to advise that it's faulty, but it may not be fixed. For example, at the first facility, we only [have] one hoist that can raise all the residents. We have to run back and forth with the one weight hoist across the facility.[280]

Inadequate training

Both Ms Hilton and Ms Laboya told us of their frustration with the current system of continued education and training at their workplaces. Ms Hilton's evidence was that:

> Established care workers also don't get a lot of refresher training. They just provide small courses, that is on small complex-care issues. They provide some online training, but the quality is lacking. I get repeat messages on my phone that my training is out of date. I just have to work around the required training.[281]

Ms Laboya said:

> At both facilities we have ongoing training that we do fortnightly or monthly. At the first facility most of the ongoing training has become online involving listening to someone talk in a video and then answering the questions. The training is compulsory, so if you don't do it you won't be included on the roster regardless whether you are part-time or you are a casual. We are supposed to be able to do the training during work hours but often we are too busy.[282]

Leadership for the aged care workforce

Aged Care Workforce Strategy Taskforce

In 2017, the then Assistant Minister for Health and Aged Care, the Honourable Ken Wyatt AM, briefed the Aged Care Workforce Strategy Taskforce to develop an aged care industry workforce strategy, with implementable actions to address issues identified through the course of the Aged Care Workforce Strategy Taskforce's work and also previous reviews.[283]

Professor Pollaers was appointed independent chair of the Aged Care Workforce Strategy Taskforce on 14 September 2017.[284] The Aged Care Workforce Strategy Taskforce delivered its report *A Matter of Care, Australia's Aged Care Workforce Strategy* in June 2018.[285]

Professor Pollaers summarised the scope and purpose of the Aged Care Workforce Strategy Taskforce as:

> attempting to deal with a substantial number of open issues resulting from very many previous reports that had touched upon workforce but hadn't actually addressed it. So the intention was to make sure that we looked at the current structure of the workforce, the changing nature of consumer expectations, and then the various models and responses to the issues that arose.
>
> They went to the areas of workforce planning. They went to the areas of supply and retention, leadership capability within the sector, education and training. And the brief was wide enough, if you like, to also enable us to look at interface with other sectors of the care system, to understand the funding needs and requirements developing over time. And to look at this in both a short-term and a long-term context.[286]

The Aged Care Workforce Strategy Taskforce report referred to an indicative analysis undertaken by the Korn Ferry Hay Group, asked to cost the savings that could be expected from the implementation of the strategic actions. The report estimates that, by taking an integrated program approach across the industry, there is a potential productivity saving for industry of an estimated $488 million per annum. This includes:

- annual cost savings (on average) from reduced workforce turnover (20% to 12%) of $311 million
- annual cost savings (on average) from reduced workforce absenteeism (5% each year) of $177 million.[287]

The role of the aged care sector industry

Professor Pollaers described the aged care industry as a 'fragmented industry in adolescence'.[288] He expanded on that characterisation in oral evidence:

> So the adolescence is really represented by, I think, three factors: it's that lack of consolidated position; the fragmented way in which government engages it and, you know, the very, very many reports, you know, I think that haven't led to a decision is an example of the way in which this industry has not been big enough to resist that kind of oppression. It has been quite an oppressed set of circumstances. And then, finally, I think the way in which the industry is structured, we often do in Australia talk about small to medium enterprise.

> Now, internationally, a small to medium enterprise is between 20 and 50 million dollars of revenue. In this industry it's between—we are seeing one to five million, you know, with employees of up to 20. So unless we start to talk about it as a microindustry that needs to have policy settings to help it to build over time, then I think we are going to face continued issues. So that's another reason why I call it adolescent is that it's an industry that hasn't really found a way of properly representing itself. [289]

Professor Pollaers was asked whether he thought the people leading the aged care industry can understand the importance of engagement and enablement of staff, in ensuring staff retention.[290] In responding, Professor Pollaers reiterated his concern about the need for the industry to develop its own capacity:

> I think, Commissioner, that the—I think we have got to keep going back and reminding ourselves that many of these are very small companies that have grown over time and haven't necessarily developed those skillsets. So when we do start to think about the transition of this industry, it's not just about skilling people as they come in or personal care workers or nurses, there is a leadership growth requirement right across the board that needs to reflect the size—the small business, all the way through, if we're going to get the kind of shift that we need.[291]

We heard from a panel of Chief Executives of approved providers:

- Mr Richard Hearn, Chief Executive Officer, Resthaven. Resthaven offers Commonwealth Home Support Programme, Home Care Packages, Veterans' Home Care, Veterans' Home Nursing, private services, retirement living, residential aged care and respite care. Resthaven supports around 10,000 people in the community and 1290 in residential aged care.[292]
- Ms Sandra Hills OAM, Chief Executive Officer, Anglican Aged Care Services, trading as Benetas. Benetas is a not-for-profit organisation, with approximately 1069 residential care places and 121 retirement units. It also provides home care and respite services.
- Mr Jason Howie, Chief Executive Officer, KinCare Health Services Pty Ltd. KinCare is an in-home care provider, serving aged care, health and disability customers. It is not involved in residential aged care.[293]
- Ms Kerri Rivett, Chief Executive Officer, Shepparton Retirement Villages. Shepparton is a not-for-profit community-based service in regional Victoria. It consists of 301 residential care beds, 272 independent living units, and a community-based home care program, which includes short-term restorative care.[294]

The panel responded to the question how, in their view, change can be embedded in the industry.[295]

Mr Howie said there were well-established change management frameworks that he expected many professional organisations would already be accessing. Mr Howie considered leadership is of fundamental importance, starting with the board and governance structures.[296]

Ms Rivett said that it is necessary to use clear and simple messages and engage with the coalface, to ensure their buy-in to the proposed change. Ms Rivett noted the importance of open disclosure, and listening and hearing the truth 'warts and all' about what is actually happening.[297]

Ms Hills referred to recommendations from the Aged Care Workforce Strategy Taskforce report, in particular the voluntary code of practice and the Centre for Growth and Translational Research, which would provide an opportunity to look at new models, to go outside the sector and look to see what is happening internationally and nationally in other sectors.[298]

In responding to a question on the difference between an approved provider organisation that is struggling, providing substandard care, and is poorly staffed, and an approved provider organisation that is well-managed and providing a terrific service, Ms Hills identified culture as the key determinant.[299] She said:

> I think it all starts from the culture of the organisation right from the very top, the board of directors, right through to the executive.[300]

Ms Hills told us of the 'huge commitment' in the aged care industry, but cautioned that 'there are some providers that shouldn't be in the industry and perhaps will choose one way or the other to move on because hopefully your recommendations will be such that it will be very clear that this is the way going forward and if you are not on the boat, there's the sea'.[301]

The role of the Australian Government

Ms Hills told us that the Australian Government is not currently providing sufficient leadership on aged care workforce development and planning.[302]

Mr Howie noted that the Australian Government has a role in workforce planning in terms of sharing data and information with industry that will support industry to meet demand. He said:

> We would welcome a detailed report from government that forecasts workforce supply… Ensuring that there is sufficient training funding available and that we have a community wide strategy in place to reskill workers from other industries is also a Government responsibility.[303]

Professor Pollaers submitted that:

> The workforce strategy started with a clear premise to see what industry could do itself first; and then be clear on those areas where it could not accomplish change without government support.
>
> What emerged through the course of the work [was] the need for government to:
>
> - Engage in a social change campaign
> - Review the interfaces of aged care with primary / acute care
> - Engage in an alternative approach to support to remote and very remote Australia
> - Recognise the funding gap relating to hours of care and employee reward, recognition and compensation
> - Recognise the importance of industry research collaboration, and to acknowledge the role of the opportunity of the aged care sector in economic development
> - Consider alternative funding models to deliver holistic care planning.[304]

According to Ms Beauchamp:

> We do absolutely have a leadership role in terms of workforce matters in the aged care system… not just the Department, it's across the Commonwealth more broadly.[305]

The Australian Government submitted that it has a key role to play in partnership with industry and others in addressing the challenges of attracting and retaining appropriate staff, including ensuring the aged care workforce is developed, trained and supported.[306]

Professor Charlesworth described the Australian Government as 'the majority purchaser of aged care services in Australia' and 'the head of a supply chain'.[307]

Ms Hills put the investment by the Australian Government in aged care in this way:

> most organisations receive 70 per cent of their income from the government and then they in turn spend it on staff salaries and wages. So government clearly has a huge investment in this for…of course, the important fact that they have a role in the health and wellbeing of older people.[308]

Ms Beauchamp described the role of the Australian Government in aged care:

> when we are talking about leadership of the workforce and the Commonwealth's role, there are a number of agencies involved in workforce matters and do, indeed, play a leadership role. For example, the Department of Education around higher education, particularly for the professional streams in health, when you're talking of nurses, physios, doctors and the like. There's also the Department of Employment and Small Business—Family and Small Business, that do take a role in establishing vocational education and training system, and skills for job-seekers, and matching up available jobs with job-seekers, and do actually take a leadership role in ensuring that vocational education and training system and the competencies that go with that meet the needs of industry, and there has been, as we have heard this week, the set-up of the committee under the Department of Employment. There's also the Department of Immigration that provides workforce, fills workforce gaps and shortages through the skilled migration program for us and we work closely with the Department of Home Affairs as well on that. And, of course, us in the Department of Health have a very big role to play to ensure we've got the skills and competency and attitude of workers to support the needs of clients in care, whether it's residential aged care facilities, home care or other elderly people accessing the system. So there's a lot of areas of the Commonwealth that do take a leadership role.[309]

Ms Beauchamp described the Secretaries Social Policy Committee, which seeks to bring those various agencies together, and examines matters impacting across health, disability, social services and employment, including in relation to the workforce.[310]

Mr Charles Wann, Australian Department of Health, explained that the Secretaries Social Policy Committee was established in January 2019. It was established by Ms Beauchamp writing to the Secretary of the Australian Department of Social Services to the effect that the two Departments needed to work more closely to explore how the Australian Government can help build a high quality, skilled workforce of sufficient size and geographic distribution in the short to medium-term across the sectors. Mr Wann said the Australian Department of Health and Australian Department of Social Services share a similar profile of workforces delivering services and support for consumers across the aged care and disability sectors.[311]

Mr Wann described two government programs that support aged care workforce capacity: the Boosting the Local Care Workforce Program, led by the Australian Department of Social Services and the skilled migration program, managed by the Australian Department of Home Affairs.[312] He also described four health workforce strategies that the Australian Department of Health conducts relating to rural health, Aboriginal and Torres Strait Islander health, the medical and mental health workforces.[313] The Australian Department of Health also monitors supply and demand of medical, nursing and midwifery and palliative care workforces.[314]

Senior Counsel Assisting asked Ms Beauchamp whether she had confidence that the Australian Department of Health has workforce planning mechanisms and settings in place to ensure that it is going to be able to achieve the significant increase in staff numbers required to meet demand. She replied:

> I think we need more information in terms of the workforce planning, and I think we need to do, as a Commonwealth, across all of those other Agencies I mentioned earlier, a much better effort around workforce planning, particularly if we're looking at getting—'a million workers', I think I've said previously in my statement—by 2050, and I think that is a challenge for us all in attracting and retaining good-quality staff to the industry.[315]

The role of the Australian Government in relation to home care was described by Mr Howie as:

> We don't have a transparent marketplace at the moment. You know, a precondition of a marketplace is fully informed buyers and sellers, and we don't have enough information in the marketplace at this point to be able to say that we've got a genuinely functioning marketplace. So creating the conditions for the home care industry to really thrive, I think, is probably the major role of the government.[316]

Professor Pollaers told us that he had identified five strategic actions in the Aged Care Workforce Strategy Taskforce report that are directed at the Australian Government.[317] Professor Pollaers gave evidence that the Government had yet to establish its position with respect to those strategic actions.[318] He explained:

> there has been no detailed response at all to each of those recommendations but for a pre-election commitment to fund the Aged Care Centre for Growth and Translational Research…
>
> But with all others, I wrote to the Minister asking for a point-by-point response to those and did not receive a response. I think they're important because strategic action 1 is a co-commitment, if you like, between industry and government. It's one that needs to be done together but essentially what we were focusing on is in—the philosophy of the taskforce was let's see how far industry can go on its own, and then what's left is the work of government. So we made sure that not everything was, if the government doesn't do it, we can't do it. And industry have been stepping up in this timeframe, they have responded in the main. But on these areas we haven't had a sufficient—or a response at all from government.[319]

Professor Pollaers clarified that he received an email from the Australian Department of Health in response to his request to the Minister, but that he did not consider that response to be sufficient, and so he asked for a 'step-by-step' response.[320] Professor Pollaers's view is that the Department, in its response to him, had not 'done justice to the brief they were given'.[321]

Ms Beauchamp told us that 'the Government has come out in broad support of the recommendations of the taskforce'.[322] She also said that:

> the Department doesn't embrace things publicly when there have been reports made to Government. Our role is to support implementation and delivery, and it wasn't our place, to embrace it or not.[323]

The Australian Department of Health produced a briefing note, dated 26 October 2018, prepared by officers of the Australian Department of Health for the Ministers of Aged Care and Health respectively.[324] The note is entitled '*Issue: Government Response to the Aged Care Workforce Strategy'* with advice to the Ministers from the Department that:

> Release of a formal response to the strategy would carry several risks for government.[325]

The authors of the note, senior officers in the Australian Department of Health, explained to the Ministers the risks to government in releasing a response would be to:

> Invite renewed criticism of the absence of similar responses to other aged care review reports, including the Legislated Review of Aged Care and the Review of National Aged Care Quality Regulatory Processes.
>
> …
>
> A formal Government response will invite public statements by key stakeholder groups, drawing renewed attention to sensitive matters such as staff ratios, aged care funding, access to health services for older Australians and service quality.[326]

Mr Kevin McCoy, Acting Chair of the Aged Care Workforce Industry Council Limited and Chief Executive Officer, Australian Unity, thought the Australian Government should take a lead on four of the Strategic Actions: Strategic Actions 1, 9, 10 and 12.[327] However, Mr McCoy said that he is 'not sure what progress has been made to date on these actions'. Mr McCoy said that in preparing his statement, he:

> made enquiries with the nominated representative of the Department of Health. In response the Department of Health has indicated they will be making their own statement regarding workforce matters to the Royal Commission. I expect their statement may address this matter further.[328]

Mr Mathewson said that:

> on an average, 70 per cent of all—of the subsidies that we receive go into wages and salaries, and that's fairly constant. It's just that our view is the subsidies aren't high enough to build on that. The four elements I've just mentioned is, our view is that the Matter of Care: The Workforce Strategy report is crucial and that the 14 strategic actions need to be accelerated. They need to be implemented and they need to be well resourced and funded.[329]

Ms Hills said that industry needed resources and Australian Government support to implement the strategic actions.[330] By Australian Government support, she was referring to funding, but also to their role in implementing those strategic actions it is responsible for, and to ensure that their plan for the future 'synchronises well with our plan; we need to work together'.[331] Ms Rivett agreed, saying 'it's imperative that we get John Pollaers' work done fairly quickly, really, really quickly and not stall it whatsoever'.[332]

Professor Pollaers said of the Australian Department of Health:

> I do believe that this is not a department that is resourced well enough, that has sufficient experience and/or weight within the current government department that it sits. Quite often the Secretary, the deputy secretaries have other portfolios and not the focus.
>
> I was very surprised through the course of the work, the extent to which…the Prime Minister and Cabinet, were sitting on top of the Minister with respect to these issues, and I was very surprised in many instances about how important it was for me to speak to the Minister to ensure that he got a full briefing, and that whenever I spoke to the Secretary of the Department, it was always in such a way that, you know, the number of people around it was almost impossible to give as frank a point of view as you would.
>
> So, you know, my sense is that the way that government has positioned itself over the last few years is that, to the extent that this can be an industry issue and they can leave industry to deal with union, and then use the fragmentation as a reason to say, 'Well, without one voice we don't know what you're asking', has been, you know, a reasonably successful approach, and if not a strategic approach then a real shame because the answers to many of these questions have been on the table for quite some time.[333]

Aged Care Workforce Industry Council

Strategic action 14 of the Aged Care Workforce Strategy Taskforce report recommended the establishment of an Aged Services Industry Council to 'lead execution of the strategic actions in a coordinated and systematic manner'.[334]

Mr McCoy gave evidence that at the time of making his statement:

- The Government's funding commitment to the Aged Care Workforce Industry Council Limited of $2.6 million is yet to result in a direct funding agreement, other than the funding of Miles Morgan for secretariat services until 30 June 2020.[335]
- Without the agreement, the Council is acting with no funding, and it did not have any insight into when funding is expected.[336]
- In the short-term, the Council is self-funding its operations.[337]
- The Council has sought engagement with the Australian Department of Health since its formal establishment in May 2019.
- The Australian Department of Health participated in a phone dial-in with the Council in September 2019.
- The Council hopes to develop a more meaningful and collaborative dialogue with the Australian Department of Health in the future.[338]

Mr McCoy gave evidence that without more government support, the Industry Council's capacity to implement the Strategic Actions of the Workforce Strategy is poor.[339] Mr McCoy said:

> the Council cannot implement reform by itself. It can lead the reform, using the networks of its members to demonstrate change within the industry, but it needs to collaborate with its key stakeholders, notably the peak bodies for providers, consumers and the workforce, to bring about a more cohesive dialogue and action between the industry, government and the community.[340]

This view is supported by Ms Hills.[341]

Mr Wann told us that the Australian Department of Health is working with the Aged Care Workforce Industry Council to scope the requirements of a framework to evaluate and monitor the industry-led implementation of the recommendations for action set out in the Aged Care Workforce Strategy Taskforce report.[342] Mr Wann said:

> in terms of funding arrangements for—for the body, I think it was made clear and the council accepts that some money has been put aside for the implementation of the strategy. In an early discussion that I had with the former interim chair, when I called them to introduce myself, and part of that discussion went to funding; at that discussion I made clear that what was currently available for funding for the commission had been identified in the '19-20 budget. It was—and part of that funding—and there's other bits of funding, but relevantly here, the 2.6 million for that implementation.
>
> …
>
> we will inevitably be in a partnership context, but they've been tasked with taking the lead in implementation. We are a very important part of that but they—and part of the requirements in any case of the work orders was that they produce an implementation plan. And in the evidence that I've seen, they've actually done a pretty good job at that, and I presume that's something that will come to me to have a look at and we will meet and work through and identify with them where they think they need additional funding.[343]

Mr Wann also gave evidence that 'to meet the key challenge' of ensuring the sector can attract and retain a much larger aged care workforce, 'the Department will be guided by the work of the Council [Aged Care Workforce Industry Council] and the Commonwealth more broadly'.[344]

Following Melbourne Hearing 3, the Australian Department of Health indicated that it received a 'draft implementation plan', entitled '*Delivering a Matter of Care: An approach to implementation and engagement*', from the Secretariat of the Aged Care Workforce Industry Council Limited on 6 November 2019. The Department indicated that it is working closely with the Council to finalise the draft implementation plan.[345]

11.2 Case studies

11.2.1 Menarock Greenway Gardens

Introduction

We examined aspects of staffing arrangements at Greenway Gardens from April 2018 to 4 February 2019. Greenway Gardens is a residential aged care facility operated by Menarock Aged Care Services (Victoria) Pty Ltd.

Oral evidence was given by:

- Ms Sandra Nisi and Ms Christine Lynch, whose father was a resident at Greenway Gardens[346]
- Ms Yvonne Henderson, Former Director of Nursing at Greenway Gardens[347]
- Ms Bridget Scarff, Group Operations Manager—Former Lead Education[348]
- Ms Fiona van den Berg, Group Operations Manager—Quality and Compliance[349]
- Mr Brendan Coulton, Former Chief Group Operations Manager at Menarock[350]
- Mr Craig Holland, Director of Menarock [351]
- Ms Ann Wunsch, Executive Director of Quality Assessment and Monitoring Operations at the Aged Care Quality and Safety Commission.[352]

A tender bundle was admitted into evidence containing 309 documents. Counsel Assisting lodged written submissions on 6 November 2019. No person with leave to appear at this hearing made substantive submissions in reply.

The purpose of the case study was to inform us about how staffing decisions were made by Menarock and to inquire as to the adequacy of the current regulatory arrangements relating to the number and skills mix of aged care workers in residential facilities.[353]

We were asked by Counsel Assisting to make findings arising from this case study. We begin with a discussion of the evidence and written submissions of Counsel Assisting and then turn to the findings sought.

Regulatory scheme, assessments and decisions

From April 2018 to February 2019, section 54-1(1) of the Aged Care Act provided:

> The responsibilities of an approved provider in relation to the quality of the *aged care that the approved provider provides are as follows:
>
> (a) to provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question;
>
> (b) to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;
>
> (c) …
>
> (d) if the care is provided through a residential care service – to comply with the Accreditation Standards made under section 54-2
>
> …

In the same period, and up to 30 June 2019, Schedule 2 of the *Quality of Care Principles 2014* (Cth) contained four Accreditation Standards applicable to residential care.[354] Each Part of Schedule 2 reflected standards and contained a principle and expected outcomes. There were 44 expected outcomes across the four Parts of Schedule 2.

Part 1 of Schedule 2 dealt with management systems, staffing and organisational development for the provision of residential care. Of particular relevance to this case study is item 1.6, which specified an expected outcome in relation to human resource management in the following terms:

> There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.

To determine whether an approved provider had a sufficient number of nurse hours a day that might be regarded as reasonable, care assessors from the Aged Care Quality and Safety Commission were required to:

> understand the basis by which the service provides the nurse hours to a consumer by describing the assessments that inform that rostering, and we seek to understand that the experience of that care through our observations and interviews with consumers and their representatives, we also seek to understand that through interviews with staff about whether there is adequate time to undertake the tasks associated with supporting consumers with complex needs.[355]

Assessors were provided with guidance from the 'ACQSC's Results and Processes Guide', 'ACQSC's Pocket Guide to the Accreditation Standards' and the 'Quality Assessor Handbook', also known as the Quality Surveyor Handbook.[356]

Following a review audit at Greenway Gardens, conducted between 31 January 2019 and 5 February 2019, a delegate of the Secretary of the Australian Department of Health decided to impose sanctions on Menarock on 15 February 2019, under section 65-1 of the Act, being satisfied that Menarock had not complied with its responsibility under section 54(1)(d) of the Act to comply with the Accreditation Standards. The Australian Department of Health served a sanctions notice on Menarock, by email, dated 15 February 2019.[357]

The delegate was satisfied that there was an 'immediate and severe risk' to the safety, health or wellbeing of people receiving care at Greenway Gardens. The delegate identified 'human resourcing' as one of the areas of critical deficiency.[358] The delegate stated:

> Your failure to ensure sufficient numbers of appropriately skilled staff are employed to provide care is resulting in adverse outcomes for care recipients including delays in responding to care recipients' needs. Staff are unable to attend to care delivery including showering, toileting, wound management, and implementing individualised behavioural management strategies. Staff are also not being provided training across a range of disciplines which is resulting in poor care practices. Your failure to manage allegations of assault by staff towards care recipients and several instances of staff misconduct. These wide-ranging failings are resulting in the risk of immediate and severe consequences to care recipients' health and well-being. [359]

On 13 March 2019, a delegate of the Aged Care Quality and Safety Commissioner determined that Greenway Gardens did not meet 21 of the 44 expected outcomes, including expected outcomes 1.3 (education and staff development), 1.6 (human resource management) and 2.4 (clinical care). The delegate decided not to revoke accreditation, but to vary the period of accreditation. That decision was based, in part, on the evidence of the Aged Care Quality and Safety Commission Assessment Team and the response given by the approved provider.[360]

Following an assessment contact on 13 and 14 June 2019, a delegate of the Aged Care Quality and Safety Commissioner determined that Greenway Gardens met all 21 previously not met expected outcomes, including 1.6.[361]

Insufficient staff and vacant shifts

Menarock appointed Ms Yvonne Henderson as Director of Nursing at Greenway Gardens in April 2018. Ms Henderson held that position until about 14 January 2019, although she was on leave and played no active role at the facility from 17 December 2018.[362]

Mr Brendan Coulton, Menarock's Operational Manager, who was responsible for overseeing the daily operations of all Menarock facilities, sent an email to Ms Henderson on 22 June 2018. [363] The email said, in part:

> As discussed on Wednesday this email contains next steps in the hope it will provide some guidance for change management of the rosters, recruitment requirements and eliminating the use of agency. As we agreed it is complex particularly in context of being a new DON [Director of Nursing] to Menarock, Greenway being a new facility to Menarock and that transition from GA [Greenway Gardens] to Menarock hasn't really occurred.
>
> The drivers for the roster review are:
>
> - Clinical care and support resources match resident needs and continue to build a strong reputation of high quality care for Menarock Greenway Gardens
> - Eliminate a previous culture of Agency Use. Last month alone was $10k, not financially sustainable nor consistent with achieving the above
> - Ensuring the allocated roster hours are consistent with our model meeting clinical and fiscal needs
> - Providing a stable and set roster which will provide more certainty for staff and a base for developing a strong team culture that are flexible and resident focused.[364]

Both Ms Henderson and Ms Bridget Scarff, who was acting as the Director of Nursing from the time that Ms Henderson went on leave in mid-December 2018, gave evidence that Mr Coulton was the only person who could authorise the use of agency staff. Mr Coulton required that all options to fill a shift be exhausted before he would authorise the use of agency staff.[365]

Ms Scarff was an aged care management consultant and Registered Nurse Division One who was appointed as 'Group Operations Manager—Lead Education' with responsibility for seven Menarock sites in Victoria including Greenway Gardens.[366] In December 2018, after Ms Henderson went on leave, Ms Scarff was appointed acting Director of Nursing and remained in that position until after the review audit in January and February 2019.[367]

Ms Henderson explained that in relation to the period from September to November 2018, staff at Greenway Gardens tried very hard not to have to request agency staff. She said 'We spent hours on the telephone trying to ring staff, literally begging sometimes'.[368] She said they would email to say this shift is available:

> not only to our staff and casuals but also to anyone else who worked within Menarock to see if anybody wanted to pick up the shift. And we would have to keep a list of everybody that we had contacted by phone before we did this and when all those avenues had failed, then and only then could we request an agency.[369]

It was Ms Henderson's view that the difficulty getting staff to cover shifts was due to 'too many vacant positions'.[370] She said that she was unable to fill the positions while Greenway Gardens was undergoing the roster restructure.[371] This was contradicted by Ms van den Berg, who said that both she and Mr Coulton encouraged Ms Henderson to recruit staff.[372]

Ms Scarff conducted an analysis of the fortnight's roster leading up to the Christmas and New Year period in 2018 and identified that there were 21 registered nurse shifts that were not filled.[373]

Mr Coulton accepted that he had been informed by Ms Henderson in October and November 2018 that there were not enough staff to fill the roster because they had a high casual pool and people were not in permanent part-time shifts.[374] He also accepted that Ms Henderson was telling him for months that there were inadequate staff numbers at the facility.[375]

When asked why he did nothing further about it and in response to being told there was not enough staff at Greenway Gardens, Mr Coulton said:

> MR COULTON: There were more things inside the culture around the casual nature of the staff and permanent part-time staff and not knowing whether that was the reason that they felt rushed or they felt like they weren't able to care. So there were more elements to that total roster that we needed to understand.
>
> MR BOLSTER: What were those elements?
>
> MR COULTON: As I said, the casual staff, so the continuity, lacked continuity of care, you could argue, and if we were able to put the part-time staff that worked five days a week, we would get some more consistency and that might've been the issue. We had poor staff attitudes and so that also had an impact.[376]

On 28 December 2018, Menarock Life Aged Care Services placed advertisements for a number of categories of staff at Greenway Gardens.[377]

Counsel Assisting submitted that Menarock failed to maintain a sufficient number of staff available to work at Greenway Gardens. Counsel Assisting further submitted that the staffing levels contributed to poor care outcomes for Greenway Gardens residents, as evidenced by the accounts of Agatha, daughter of Ms Giovanna Buda, and the daughters of the late Mr UG, Ms Sandra Nisi and Ms Christine Lynch.[378] Ms Buda and Mr UG were two of multiple residents whose treatment was the subject of adverse comment following the review audit conducted by assessors from the Aged Care Quality and Safety Commission during the period 31 January to 5 February 2019.[379]

Ms Giovanna Buda

Ms Buda was a resident at Greenway Gardens from 20 August 2018 to 28 January 2019.[380] In early November 2018, Ms Buda complained, to her daughter, of excruciating pain in her leg for several days.[381] Ms Buda also said that someone had twisted her leg, pulled her hair and slapped her head. She complained that someone had twisted her leg when she was not getting dressed quickly enough.[382]

The Evidence Record for the Review Audit Report indicates that:

- On 7 November 2018, a nurse recorded that Ms Buda's *'left knee looked to be larger than right knee and discomfort noted'*. She was given Panadol as needed. Her general practitioner reviewed her that day, and noted a swollen, painful left ankle and referred her for X-ray.
- On 9 November 2018, a physiotherapist reviewed Ms Buda, noting that the knee was 'warm to touch' and that the pain appeared to be 'stemming from the [left] hip'. The notes indicate that questions were raised as to whether there was a dislocation of the hip or a flaring up of osteoarthritis. Later on the same day, a nurse recorded that 'Mrs Buda now has left swollen leg from toes to hip with bruising apparent on knee and inner thigh left foot'.
- No mobile X-ray being available until the following Monday, Ms Henderson made the arrangements to transfer Ms Buda to the hospital for further investigation.
- At the hospital, a doctor found her hip bone protruding. A fractured left neck of femur was identified.[383]

Ms Henderson reported the injury to the Australian Department of Health, informing them that an allegation that Ms Buda had been assaulted had been made. She advised Ms Buda's daughter that she would investigate.[384]

A document entitled 'Mandatory Reporting' indicates that Ms Buda suffered the fracture in an undocumented fall that occurred on the morning of 4 November 2018.[385]

Menarock described the 4 November 2018 incident to the Aged Care Quality and Safety Commission:

> In this instance there was a subsequent report post event reported to the Director of Nursing verbally on 12th November that Mrs Buda had been found on the floor on Sunday 4th November at 07:10 hours by a PCA [personal care assistant] after being alerted by the sensor mat alarm. This PCA was completing her shift so alerted two of the morning PCA day staff to assist her to attend to Mrs Buda.
>
> There was a communication breakdown as the PCA thought that the morning PCA would have reported the incident to the RN [registered nurse] for assessment, this did not occur and therefore no RN assessment took place.[386]

These are serious matters. However, the evidence does not establish that they are directly related to insufficient staffing at the facility. Agatha, Ms Buda's daughter, made the following observations about staffing at Greenway Gardens:

> During my Mum's time at Greenway Gardens, I noticed a lot of staff had left. I would visit every day, so I got to know the faces of the staff members and noticed that they weren't there towards the ends of Mum's time at Greenway Gardens. We were never told about anything. There wasn't good communication.
>
> Staff were regularly run off their feet. There were a number of other incidents where staff were unable to attend to Mum's essential needs due to insufficient staffing levels:
>
> On one particular occasion, Mum said that she needed to go to the toilet. Staff said they needed to use a lifting machine, and when they finally came back with the machine and pulled her pants down, Mum soiled herself right there on the floor in her room as she could not wait any longer.
>
> Initially my mum was able to feed herself, towards the end of her stay there she needed total assistance at meal times. Mum also lost weight while at Greenway Gardens. I think this is because there were not enough staff to assist residents at meal times. The food would go cold and the staff would remove the meals as soon as the residents said they didn't want it.
>
> On one occasion I found Mum had slid from her chair with her head hanging right over the chair and her legs right off. Staff said they could not lift Mum because they had to wait until another staff member returned from break for a two-person lift.[387]

We accept Agatha's evidence of her observations of staffing levels and the consequences for her mother's quality of care and safety.

Mr UG

On 3 May 2017, Mr UG moved into the 'Jarrah' wing of Greenway Gardens.[388] He remained there until September 2018, when he was moved to the dementia ward, known as 'Blue Gum'.[389] He died on 28 November 2018.[390]

Ms Nisi said that when Mr UG was moved to Blue Gum he was not mobile and 'pretty much bedridden'.[391] She said:

> although he needed two people to do everything, we were often told when—if we went in and one Sunday night my husband and I went in about quarter to seven and Dad had been asking to go to the toilet, and we don't know how long he had been asking. And we went out to get some assistance and I kept getting told, 'We're short staffed', and then I got told somebody had gone on their break; 'We couldn't come—we can't take him to the toilet because we need two people and such and such is on their break, they won't be back for 15 minutes.' And that went on for about three-quarters of an hour and then he soiled himself. And then I went out and spoke to him, two staff members came in with plastic gloves on, and said, 'We've come here to take him to the toilet'. I said, 'Well, it's too bad. It's disgusting. You know, he has already soiled himself'.[392]

Ms Nisi said that when she was there she would feed her father, which took up to an hour.[393] She said:

> my younger sister, she said she used to go in quite often in the morning and he would be sitting there looking at a bowl of porridge, and then someone would come along and say, 'You're not hungry today,' or, 'Have you finished?' and whip the bowl of porridge away. Well, he had no way of eating it himself and no one had bothered to help him. And there were—on one morning there were two staff members who were the only two staff members there in the dining area and they were both having tea and toast at the bain-marie while however many residents sat there staring at their bowl of porridge.[394]

About September 2018, Ms Nisi and Ms Lynch became concerned when Mr UG complained to them that a nurse had slapped him, swore at him or pushed him against a wall. They put a camera in his room to ascertain what was happening.[395] The video camera recordings were summarised in the Evidence Record of the audit conducted by assessors from the Aged Care Quality and Safety Commission from 31 January to 5 February 2019. The Evidence Record states that the video footage:

> includes incidents of care staff, berating, using profanities, denying toileting and water, unnecessarily rough handling and failure to provide care after an episode of Mr UG collapsing during care.[396]

About three weeks before Mr UG died, the family was advised that Mr UG needed palliative care. Ms Nisi said 'nobody explained to us that he was at the end of his life and what that meant and so he just was left'.[397] She described the last day of his life in these terms:

> I went in on Tuesday at lunchtime to feed him and I went into the dining area and I asked the staff, 'Where is he?' and they said, 'In his room.' And so I went around there and he was laying—it was horrible, he was yellow and rattling, breathing but I didn't know that he was dying and nobody had told me, and so I wouldn't have gone home. And so they came around and tried to feed him and they were trying to pour sloppy stuff to his mouth and it wasn't going in. And so I was really, really upset and angry. So I went to the—see Yvonne and she had a sign on her door saying she was in a meeting or something or she wasn't there.[398]

Mr UG died that evening. His palliative care plan had not been activated and he was not receiving palliative care at the time of his death.[399] Ms Nisi received a phone call at 8.30am the following morning informing her that her father had died, but staff could not tell her when.[400]

We accept Ms Nisi's evidence of her observations of staffing and the consequences for her father's quality of care and safety. While the events of about September 2018 depicted on video footage are deeply troubling, the evidence does not establish that the misconduct was caused by insufficient staffing.

Rostering decisions

Ms Henderson, together with Ms van den Berg, were involved in a staffing restructure as part of the implementation of the Menarock Model of Care. The restructure had started by June 2018. Ms Henderson said:

> we were going to introduce Menarock's model of care which was what was happening and ongoing throughout all of their facilities and the staffing levels were based on the size of the facility, on the bed numbers at the facility.[401]

The master roster at Greenway Gardens fixed the number of care hours at a maximum of 2469 hours. The maximum hours were adjusted down to account for vacancies.[402] Mr Coulton explained that the maximum hour figure was an existing number when Menarock acquired the facility. It was put into the roster system that Menarock used.[403] Menarock say that a review of roster variations across 14 pay periods showed slightly more hours of care were delivered to residents against the master roster.[404]

The maximum hours, as described by Mr Coulton, appears not to have made any allowance for the increased level of acuity of Greenway Gardens' residents. Mr Coulton agreed as much during his evidence:

> MR BOLSTER: The master roster figure, the master roster hours figure, does not seem to keep pace with acuity. Is that a fair criticism of it?
>
> MR COULTON: Yes. The system—the master roster is the master roster and it's fixed in the system. So from that perspective, yes, it's a fair criticism.[405]

From the time Greenway Gardens was acquired in April 2018 to the time of the review audit in late January 2019, the facility's average Aged Care Funding Instrument rose from $168 to $197. In the same period, there was a 9.6% decrease in occupancy.[406]

Mr Coulton's evidence was that he believed some of the increase in the average Aged Care Funding Instrument was because:

> there were poor record keeping at the site when we took over and we did improve our record keeping and collection of the data required to validate ACFI [Aged Care Funding Instrument]. So that did have an impact as well.[407]

A document prepared by Mr Coulton, with the assistance of others, in response to the audit carried out by the Aged Care Quality and Safety Commission in January and February 2019, relevantly states:

> Average ACFI [Aged Care Funding Instrument] has increased since April 2018 to January 2019 which does support and reflect an increase in the acuity and care needs [of] residents, in particular this effects those residents in Bluegum specific dementia unit. The change has coincided with the reviewed clinical care model and increased hours of support staff. [408]

Ms van den Berg told us that the Director of Nursing reviews resident care needs to monitor the adequacy of staff numbers as the resident cohort changes.[409] That may be so, but Mr Coulton told us that he did not agree to increase staffing despite being told by the Director of Nursing for months that there were not enough staff.[410]

Counsel Assisting submitted that the evidence of Ms van den Berg, along with the claim in the document prepared by Mr Coulton that increased resident acuity coincided with increased hours of support, is not supported by the balance of evidence before us.[411]

Findings

Counsel Assisting submit that we should make the following findings.

- During the period 1 September 2018 to 4 February 2019, Menarock failed to ensure that it had a sufficient number of staff available to work at Greenway Gardens, despite concerns being raised by senior clinical management about staffing levels and care needs during that time.
- Menarock's failure:
    - impacted on the quality and safety of care to residents at Greenway Gardens
    - manifested in ongoing difficulties for management when attempting to find employees to cover vacant shifts, and that these difficulties were compounded by poor organisational culture and significant delays in recruiting staff.
- Rostering decisions at Greenway Gardens were based on fixed hours, with insufficient consideration of the changing care needs of residents.
- Menarock failed to implement necessary staffing arrangements at Greenway Gardens to meet the care needs of residents in appropriate timeframes.[412]

Menarock made no submissions in response. The evidence before us includes assessments made by the Aged Care Quality and Safety Commission that a review audit in January and February 2019 revealed insufficient appropriately skilled staff to consistently meet all the needs of people receiving care. On 15 February 2019, a delegate of the Secretary of the Australian Department of Health was satisfied that there was an immediate and severe risk to the safety, health or wellbeing of people receiving care, with human resources being one of the areas of 'critical deficiency'.[413]

It is clear that concerns about staffing were being raised by senior employees during, or from about, September 2018. Ms Henderson explained difficulties in covering shifts in the period September to November 2018, which she attributed to too many vacant positions. By December 2018, she said there was no buffer to replace staff. Ms Scarff's analysis of the Christmas and New Year period identified 21 registered nurse shifts that were not filled. Mr Coulton was aware of those concerns and told us that there were probably insufficient staff members to pool from, so filling shifts became difficult.

Menarock did not seek review of the Australian Department of Health's decisions.[414] We accept the delegate's assessment of the risk and the identification of human resourcing being an area of critical deficiency. Menarock failed to ensure it had a sufficient number of staff to work at Greenway Gardens from 1 September 2018 to 4 February 2019 despite concerns being raised about staffing levels.

The Australian Department of Health's assessment was that Menarock's failure resulted in an immediate and severe risk to the safety, health or wellbeing of people receiving care, with human resources being one of the areas of 'critical deficiency'. The evidence of Agatha and Ms Nisi about their experience of the care provided to their family members by Menarock is significant.

Counsel Assisting submit that Menarock's rostering decisions were based on fixed hours and had insufficient regard to the changing needs of residents. Mr Coulton acknowledged that master roster hours did 'not seem' to keep pace with resident acuity. He explained that Menarock had continued to use the maximum roster hours used when they acquired the facility and were in the process of implementing Menarock's model of care. That model of care was based on size of the facility and occupancy, but seemingly not resident acuity. Menarock's rostering decisions may have been made with insufficient consideration of the changing needs of residents.

11.2.2 Japara Bayview

Introduction

In this case study, a personal care worker identified as 'UA' was found by his employer, Aged Care Services Australia Group Pty Ltd, referred to as Japara, to have engaged in misconduct against aged care residents on repeated occasions, including throwing a call bell at a resident and slapping them.[415] Ultimately, UA resigned before further allegations could be investigated and possibly result in the termination of his employment.[416] Japara provided UA with a Statement of Service, also referred to as a certificate of service.[417]

UA worked at the Bayview residential aged care facility.

Oral evidence was given by Ms Dianne Mnich, the Bayview Facility Manager at the relevant time, and Ms Nicole Farrell, who was Japara Healthcare Limited's Senior Human Resources Business Partner at the relevant time.[418] Counsel Assisting tendered a statement by Ms Valeria Camara, Group-Executive, People and Development for Japara Healthcare Limited.[419] A tender bundle containing 53 documents was admitted into evidence.[420] The

case study was conducted on the basis of the factual findings made by Japara about UA's conduct.[421] We did not investigate whether those findings were appropriately made.

Counsel Assisting provided written post-hearing submissions on 6 November 2019.[422] Japara provided written submissions on 15 November 2019.[423] Counsel Assisting provided written submissions in reply on 21 November 2019.[424]

We are asked by Counsel Assisting to make findings arising from this case study. We begin with a discussion of the evidence and written submissions.

The regulation of UA's employment with Japara

UA's employment was governed by the *Aged Care Services Australia Group Pty Ltd, ANMF and HSU Enterprise Agreement 2014* (Enterprise Agreement).[425] Clause 61 of the Enterprise Agreement provided:

> **61 DISCIPLINARY PROCEDURE**
>
> 61.1 Where disciplinary action may be necessary, the management representative shall notify the Employee of the issues in writing and the Employee will be given an opportunity to respond to these issues. In the event that the Employee's response is unsatisfactory, a first warning in writing may be issued. This warning will be recorded on the Employee's personnel file.
>
> 61.2 If the problem continues, the Employee will again be notified in writing of the matter and a response requested from the Employee. If appropriate, a second warning in writing will be given to the Employee and recorded on the Employee's personnel file.
>
> 61.3 In the event that the problem continues, the Employee will again be notified in writing of the matter and a response requested. If appropriate, a final written warning will be issued to the Employee and recorded on the Employee's personnel file.
>
> 61.4 In the event of the matter recurring, then the Employee may be terminated after the matters have been investigated and is found to be substantiated.
>
> 61.5 Summary dismissal of an Employee may still occur for acts of 'serious misconduct' (as defined in the *Fair Work Act 2009*). Where an allegation of 'serious misconduct' is proven and the Employer, having considered all the circumstances does not wish to terminate the Employee's employment, a warning may be issued under Clauses 61.2 or 61.3.
>
> 61.6 During all steps in the Disciplinary Procedure, the Employee has the right to representation of his or her choice, including the ANMF [Australian Nursing and Midwifery Federation] or HSU [Health Services Union]. The Employer may be represented by the representative of their choice.
>
> 61.7 Records relating to disciplinary procedures will be disregarded where a continuous period of 12 months elapses without further warning/s. Records relating to disciplinary procedures will be removed from the personnel file after a period of two (2) years where no further warning/s arise.[426]

This procedure allowed a graduated series of sanctions for employee misconduct from a first warning to termination of employment. It preserved Japara's right to dismiss an employee summarily for acts of 'serious misconduct' as defined in the *Fair Work Act 2009* (Cth).

Section 12 of the *Fair Work Act 2009* provided that 'serious misconduct' had the meaning prescribed by the regulations. Regulation 1.07 of the *Fair Work Regulations 2009* (Cth) defines 'serious misconduct' as follows:

> **Meaning of serious misconduct**
>
> (1) For the definition of **serious misconduct** in section 12 of the Act, serious misconduct has its ordinary meaning.
>
> (2) For subregulation (1), conduct that is serious misconduct includes both of the following:
>
> (a) wilful or deliberate behaviour by an employee that is inconsistent with the continuation of the contract of employment;
>
> (b) conduct that causes serious and imminent risk to:
>
> (i) the health or safety of a person; or
>
> (ii) the reputation, viability or profitability of the employer's business.
>
> For subregulation (1), conduct that is serious misconduct includes each of the following:
>
> (a) the employee, in the course of the employee's employment, engaging in:
>
> (i) theft; or
>
> (ii) fraud; or
>
> (iii) assault;
>
> (b) the employee being intoxicated at work;
>
> (c) the employee refusing to carry out a lawful and reasonable instruction that is consistent with the employee's contract of employment.
>
> Subregulation (3) does not apply if the employee is able to show that, in the circumstances, the conduct engaged in by the employee was not conduct that made employment in the period of notice unreasonable.

Under his contract of employment, UA was required to comply with the policies and procedures at Bayview and of Japara.[427] This included the Japara *Employee Discipline Procedure.* Clause 3 of that procedure outlined the discipline process used by Japara:

> **Step 1**
>
> Identify the issue and gather factual information of the employee's unsatisfactory performance or conduct in a timely manner then contact Human Resources for advice and guidance.
>
> **Step 2**
>
> Where the circumstances of the issue are so grave that there is risk to people, property or assets regarding the employees actions, in consultation with Human Resources the decision may be made to suspend the employee from service.
>
> Approval to suspend any employee must be authorised by the Group General Manager of Human Resources.

Step 3

Provide Human Resources with copies of relevant Incident Report/s and any relevant Witness Statements.

Step 4

Provide written notification (from Human Resources) to the employee to discuss the performance/conduct issue. The notification must advise the employee of the following (at a minimum):

- The details of the allegations or conduct or performance issue.
- The opportunity for the employee to bring a support person or independent representative to the meeting.
- The meeting place, date and time.
- Who from management will be attending the meeting.

Step 5

Conduct the meeting and obtain the employees response:

- The employee is provided the opportunity to respond to all the allegations or performance / conduct issues raised.

Step 6

Consider the employees response in consultation with Human Resources

Step 7

Determine the outcome in consultation with Human Resources that may result in of one of the following:

- First Written Warning
- Second Written Warning
- Third Written Warning
- First and Final Warning (Where an allegation of 'serious misconduct' is proven and ACSAG, having considered all the circumstances, does not wish to terminate the employee's employment and it is deemed appropriate that this be issued.)
- Termination of employment
- Summary Dismissal (Termination of employment as a result of Serious Misconduct)

Step 8

Deliver the outcome to the employee and discuss remedial measures (if applicable) such as but not limited to:

- education and training
- policy and procedure revision / acknowledgement
- supervision / monitoring / mentoring by a more senior member of staff which may include changing rostered shifts to allow such supervision / monitoring / mentoring
- requirement to attend staff meetings
- regular meetings with the employees manager or supervisor to discuss progress and work through any workplace issues affecting the employees ability to meet the required standard

Step 9

Monitor the employees' progress.[428]

In summary, under this policy, in cases of 'serious misconduct', Japara could terminate an employee's employment or issue a 'first and final warning'. Such a warning could be issued if, having considered all the circumstances, Japara did not wish to terminate the employee's employment and considered a warning was appropriate.[429]

'Serious misconduct' was defined in clause 1 of the Discipline Procedure.[430] While possibly based on the definition in the *Fair Work Regulations 2009,* the definition in the procedure differed from the statutory definition in a number of respects. However, differences may be disregarded for present purposes because the evidence was that Japara assessed UA's conduct against the statutory definition.[431]

The first four incidents

On 23 March 2015, Bayview Facility Manager, Ms Dianne Mnich, wrote to UA informing him that four allegations of 'serious misconduct' had been made against him.[432] The letter described the misconduct as follows:

On 18 March 2015 you worked as a PCA from 15:00hrs to 22:15hrs. It is alleged that on this shift:

- At approx. 17:45hrs you were attending to Resident [UC] and [redacted] entered the room and found you standing in the room, with the resident, sitting on the toilet. The Resident was allegedly, crying, visibly distressed, and stated words to the effect "get him out of here I don't want him to touch me or be in my room." You allegedly Stated words to [redacted] "I have to put her on the toilet to piss". [UC] then stated words to the effect "get him out of here ". You then allegedly left the room.
- At approx. 17:50hrs you were attending to Resident [UD]. It is alleged Resident [UD] started screaming, stating words to the effect "no, I don't want to". It was noted you were attending to this Resident at this time. PCA [redacted] went into check Resident [UD] at approx. 18.00hrs and noted Resident was in bed and changed – The resident alleged stated words to the effect to [redacted] "he made me go to bed". The resident was allegedly distressed, crying and visibly upset.

> - At approx. 18:30hrs, you were attending to Resident [UB] with PCA [redacted], Resident [UB] was awaiting to be showered, where you had allegedly turned on the water in the shower and started to wet the Resident. You allegedly put the hose on the Resident, and the Resident reacted, 'yelling' and 'raising her voice '. At this time, [redacted], PCA, entered the room/bathroom and Resident allegedly stated words to the effect to [redacted] "the water is cold". [Redacted] allegedly felt the water and stated words to the effect to you "Don't you check the water - its cold". You then allegedly responded words to the effect to [redacted] "you can do it then". The Resident was visibly cold, with goose bumps and was shivering. The resident stated words to the effect to [redacted] "he shouldn't be allowed in women's rooms".
>
> On 19 March 2015, at approx. 09:00hrs [redacted](EN) [enrolled nurse] had received information from Resident [UB] about an alleged incident that occurred prior, specifically:
>
> - You were working as a PCA on or around 4 March 2015, where it is alleged that during your shift, you were attending to this Resident and alleged slapped her hand stated words to the effect "you can't have that". It is then alleged you took the Resident's biscuit/s away. The Resident notes your behaviour as "loud, sharp". The incident was reported to the Facility manager at 09:30hrs by [redacted].

UA was suspended from duty.[433] In oral evidence, Ms Mnich agreed that she had 'no doubt' that the conduct she was describing in the letter was serious misconduct. She later explained that the alleged conduct had been characterised as 'serious misconduct' by 'someone' in Japara's Human Resources Department. She told us that she 'certainly went along' with that characterisation.[434] In post-hearing submissions, Japara observed that Ms Mnich was not directed to the definition of 'serious misconduct' and was not asked to explain her view of the differences between misconduct and serious misconduct. Japara emphasised Ms Mnich's evidence that characterisation of the conduct was a matter for human resources representatives.[435] Ms Farrell also gave evidence that that decision was made by human resources representatives.[436]

The allegations of serious misconduct were substantiated by Japara and it was open to Japara to dismiss UA summarily.[437] However, Japara imposed a first and final warning on UA, only because of 'the absence of proven wilful and malicious intent'. Ms Mnich explained this in a letter to UA:

> On the balance of probabilities I deem your conduct to be a serious risk to the health and safety of our residents and a grave concern for the continuation of your contract of employment.[438]

Representations from the Health Workers' Union

The Health Workers Union, of which UA was a member, wrote to Japara challenging its power to issue a first and final warning.[439] Japara's reply, dated 15 April 2015, did not satisfy the union. It threatened to refer the matter to the Fair Work Commission if Japara failed to provide it with an adequate response.[440]

Following further communications with the Health Workers' Union, on 4 June 2015, Ms Farrell informed the union that Japara had decided to downgrade the finding from 'serious misconduct' to 'misconduct', 'based on the responses ascertained by [UA] through our formal disciplinary procedure'.[441] UA was informed by letter, dated 4 June 2015, that he had been issued with a 'first written warning'.[442] Japara withdrew the 'first and final warning'.

A letter from Japara to the Health Workers' Union, dated 4 June 2015, explained that the 'absence of *wilful* and *deliberate* misconduct' meant that characterisation as 'serious misconduct' would be 'unreasonable'.[443] It is to be recalled that, having found serious misconduct, it was only the absence of 'proven willful and malicious intent' on the part of UA that caused Japara to 'stop short of terminating' UA's employment.

It is unclear to us how the same essential features of the case were now being relied upon to re-characterise that which Japara's executives had earlier characterised as 'serious misconduct', and Ms Mnich had 'no doubt', in April 2015, was 'serious misconduct', to mere 'misconduct' in June 2015.

Japara submitted that on review of UA's employee file, three matters were disclosed relevant to the seriousness of the misconduct:

> (a) In respect of the third incident of alleged misconduct (showering the resident with cold water), the personal care assistant who was present with UA at the time of the incident provided a statement the next day, 19 March 2015. In the statement the co-worker said she and UA had gone to shower the resident who had been incontinent. The co-worker had taken the resident's nightie off. UA turned on the water. The co-worker did not see him check the temperature. UA sprayed the bottom half of the resident's body with the shower hose and the resident started yelling. "*Within seconds*", the other personal care assistant came in and checked the hose, stating, "don't you check the water – it's cold". Neither Ms Farrell nor Ms Mnich were asked about the co-worker's statement, a copy of which is held by the Commission;
>
> (b) Separate notes of an interview with the same co-worker on 26 March 2015 record the co-worker stating that the showering lasted only two seconds and that the water was not strong. Again, neither Ms Farrell nor Ms Mnich were asked about or had their attention directed to the notes of interview;
>
> (c) As to the fourth incident of alleged misconduct (slapping the resident's hand and taking the biscuits away), a file note of 20 March 2015, also held by the Commission, records a discussion that had taken place the previous day with the resident's daughter. Present was Ms Mnich, among others. The file note records the resident's daughter stating that her mother had an inclination to fabricate issues, and that she (the daughter) did not consider the allegation against UA to be correct.[444]

Each of the documents referred to by Japara was created prior to the original decision to characterise the misconduct as 'serious misconduct'. Ms Farrell accepted that no new facts came to light between March and June 2015 which changed the application of the definition of 'serious misconduct'.[445] In the circumstances, we consider that the documents identified by Japara provide little justification for the decision to downgrade the finding of serious misconduct.

Ms Farrell's statement to us, made on 3 October 2019, provided no explanation for Japara's decision to downgrade the sanction.[446] More information was provided in a second statement, dated 15 October 2019. Ms Farrell referred to internal correspondence which had been found in the 'last few days' between Mr Ashley van Winke, the General Manager of Human Resources at Japara, and her.[447]

When pressed by Counsel Assisting about who made the decision to downgrade the sanction, Ms Farrell said that 'it would have been the General Manager of HR, Mr Van Winkel'.[448] She candidly acknowledged that she had not personally changed her mind between March and June 2015 about the appropriate characterisation of the conduct as 'serious misconduct'.[449]

While Ms Farrell denied that it was the campaign of the Health Workers' Union that changed Japara's position, it is clear that the union's representations led to a review of the matter which resulted in the change in the characterisation of the misconduct.[450] The decision on 23 March 2015 to suspend UA, because 'the circumstances of the issue were so grave that there is risk to people', is not easy to reconcile with the 'misconduct' characterisation and the light sanction of a first written warning.[451]

As to the consequences of the downgrading, Ms Farrell agreed that if the first and final warning of 9 April 2015 had not been withdrawn, UA's employment would 'in all likelihood' have been terminated when the next incident occurred in January 2016.[452] Japara submitted that while it may have been reasonably open to issue UA with a first and final warning in respect of the allegations of misconduct in March 2015, as submitted by Counsel Assisting, it was likewise 'reasonably open' for Japara not to issue a final written warning.[453] We return to this issue below.

The fifth incident of serious misconduct

On 18 January 2016, Ms Mnich wrote to UA informing him that he had been suspended again from duty while new 'very serious allegations' were investigated.[454] Those new allegations were outlined in a letter to UA dated 19 January 2016 under the heading, 'Allegations of serious misconduct':

> On Tuesday, 12 January 2016 you worked as a PCA from 14:30hrs to 21:00hrs. It is alleged at approx. 17:00hrs, Resident [FR] was sitting in her chair, in her room when you entered and proceeded to change her into her night wear. You allegedly forced the Resident's head with your hands out of her top/blouse, causing pain, moving her forward in her chair. The Resident alleged stated words of the effect to you "stop it, I can't do this, I can't bend over". It is alleged you continued to remove her top and responded, stating words to the effect of "don't be stupid, don't be stupid". The Resident is noted to be [visibly] shaken from this incident.[455]

Those allegations were substantiated by Japara after an investigation.[456] UA was given a second written warning by letter, dated 5 February 2016, and was required to comply with an improvement plan.[457] Ms Mnich agreed that if the first and final warning had stood in relation to the March 2015 conduct, the substantiation of the January 2016 incident would have resulted in the termination of UA's employment.[458]

In written submissions, Japara also accepted that in all likelihood, UA would have been terminated as a result of this incident if the first and final warning had stood. Japara also noted that Senior Counsel Assisting made no other criticism of the decision to issue the second written warning to UA.[459]

The sixth and seventh incidents of serious misconduct

The 'improvement plan' obliged UA to complete certain training by 19 February 2016.[460] However, before that date, further allegations of serious misconduct by UA were made. The allegations were outlined in a letter to UA dated 16 February 2016:

> On 12 February 2016, it was brought to management's attention by Resident [FS] that on Wednesday 10 February 2016 when you worked as a PCA [personal care assistant] from 14:30 – 21:30hrs, you allegedly engaged in unacceptable and unprofessional behavior that posed a risk to the health and safety of residents and your actions are potentially damaging to the reputation of the organization, ACSAG [Aged Care Services Australia Group] and residents. Specifically it is alleged that:
>
> - At approximately 17:30hrs you were feeding Resident [UE] a mixed pureed vegetable and meat meal in the dining room. Resident [UE] stated words to the effect of "it is too hot".
> - You responded and stated words to the effect of "blow on it then" and forced a mouthful of food in Resident [UE]'s mouth.
> - Resident [FS] witnessed the Resident [UE] "cough and splatter" and you continued to push food in her mouth.
> - Resident [FS] stated words to the effect of "If you fed me like that I would spit it back at you". You then stopped feeding the resident and walked away from the table.
> - On the same day, at approximately 19:00hrs, you were assisting Resident [FS] to go to bed. Whilst in bed, the Resident stated words to the effect of "I don't have Charlie (the call bell)."
> - You picked up Charlie, threw it at her right leg just below her knee and your actions caused her to experience pain. You then left the room immediately.[461]

UA was suspended from duty while the allegations were investigated.[462] Once again, these incidents were substantiated after an investigation by Japara.[463] UA was given a final written warning on 3 March 2016.[464] Japara noted in its submissions that Senior Counsel Assisting made no criticism of this decision to issue a final written warning.[465]

The eighth to twelfth allegations of serious misconduct

On 17 April 2016, Ms Mnich received a letter from the daughter of a resident at Japara Bayview in which she wrote of the verbal abuse and humiliating treatment she claimed her mother had suffered at the hands of UA. The letter continued:

> I believe he should be sacked because it is unacceptable for a person in charge of the wellbeing of a resident to do what he did, especially when it was completely unprovoked. It isn't good enough for him to continue at Bayview, even in a different section. He shouldn't have any access to mum whatsoever, who knows what he is capable of.
>
> I suppose it will be like the Catholic priests who were moved on to offend elsewhere.[466]

On 18 April 2016, Ms Mnich wrote to Ms Julie Reed, Executive Director of Japara, Ms Farrell, Ms Narelle Wood, Quality Manager, and Mr Ashley van Winkel, General Manager of Human Resources, attaching the letter from FT's daughter in the following terms:

> Good morning,
>
> Please find attached letter from [FT]'s daughter regarding the alleged assault on Saturday. I can not have this man back in my facility.[467]

Japara wrote to UA on 27 April 2016 once again advising him that he was suspended from his employment while the new allegations were investigated. The letter outlined these new allegations as follows:

> On 16 April 2016 it was brought to management's attention by PCW [redacted] that when you worked as a PCA [personal care assistant] from 0700-0845hrs on 16 April 2016, you engaged in unacceptable and unprofessional workplace behavior that posed a risk to the health and safety of our residents and your actions are potentially damaging to the reputation of the organization, ACSAG and residents. Specifically it is alleged that:
>
> - You shouted at Resident [FT] and threatened to break her walker
> - You hit Resident [FT] on the right side of her cheek and it hurt
> - The Resident [FT] shouted and hit you and you swore at the resident
> - [redacted] heard Resident [FT] scream and entered room 4. In your presence, the Resident [FT] stated words to the effect of '[UA] slapped me on the side of my face...stay with me… don't go'. [Redacted] asked you to leave the room which you did.
> - Prior to leaving the room, [redacted] witnessed you stomping on Resident [FT's] personal clothes and wiping the bathroom floor with your feet.[468]

Japara commenced an investigation into these serious allegations.[469] However, the investigation was incomplete when UA resigned on 2 May 2016. The investigation was never completed. [470]

The terms of UA's departure from Japara

A Deed of Agreement dated 30 May 2016 recorded the terms of UA's departure from his employment at Japara.[471] Japara paid UA for two weeks' notice and undertook to provide him with a certificate of service. A certificate of service, dated 30 May 2016, was provided to UA.[472] The certificate was signed by Ms Michelle Sultana, Human Resources Manager. After setting out that UA had worked at Japara Bayview as a Part-Time Personal Care Worker, Grade 1, between 2007 and 2016, the certificate stated that 'UA's duties included that he:

- Contributes to the physical, emotional and lifestyle need and wants of the residents[473]

The certificate invited any reader to contact Ms Sultana 'to verify the matters contained herein'.

Ms Farrell told us that she did not draft the certificate.[474] She was asked by Senior Counsel Assisting if she thought it accurately described UA's time at Japara:

> MS FARRELL: The statement of service outlines what they're expected to do in terms of their role and their tasks. In terms of specific to UA, I didn't write it, I couldn't comment but potentially that could be a question mark. But, again, he did resign. So—based on the information.
>
> MR ROZEN: What do you mean 'potentially it could be a question mark', Ms Farrell?
>
> MS FARRELL: Well, if you think about it from—essentially what he has done in the past, would you put that in there? I don't think that that would warrant it, I agree with you.
>
> MR ROZEN: It might be a little—
>
> MS FARRELL: It was questionable.
>
> MR ROZEN: It might potentially be misleading to a future employer, do you think?
>
> MS FARRELL: Yes, but the future employer may not have information of what has previously happened at Japara.
>
> MR ROZEN: Well, that's my point, really.
>
> MS FARRELL: Yes.
>
> MR ROZEN: If this is all they had, then it could potentially be misleading.
>
> MS FARRELL: I agree.[475]

Counsel Assisting submitted that the statement that UA 'contributes to the physical, emotional and lifestyle needs and wants of the resident' was potentially misleading to a future employer.[476] In post-hearing submissions, Japara argued that 'it is not reasonably open' for us to find that the statement of service was potentially misleading. Japara contended that listing some of UA's duties was done in a neutral fashion and did not amount to a reference to his performance of any of those duties. It submitted that issuing a statement of service, as distinct to an employee reference, was common practice in the aged care industry and clause 31.2 of the Enterprise Agreement required the provision of a certificate of service.[477] In submissions in reply, Counsel Assisting drew our attention to clause 31.2 of the Enterprise Agreement which did not require duties to be listed in the Service and Training Certificate.[478]

The steps taken by Japara in response to substantiated misconduct

The warning letters issued by Japara all contained 'improvement plans'.[479]

Ms Farrell said:

> The steps Japara took to ensure resident care and safety in response to substantiated misconduct by the employee were to notify the employee of the consequences of the written warnings issued to him (namely that further incidents could result in further disciplinary action and termination of employment) and to require the employee to comply with the improvement plan set out in each written warning issued to him.[480]

The adequacy of the steps Japara took to ensure resident safety while UA remained employed by Japara are therefore tied to the adequacy of the improvements plans to address the misconduct.

On 4 June 2015, the First Written Warning letter contained the following improvement plan which was duplicated from the 9 April 2015 'First and Final Written Warning':

> In reaching a decision, I have considered your response, and in accordance with the ACSAG [Aged Care Services Australia Group] Disciplinary Procedure I now advise that I am issuing you with a First Written Warning. In addition to the warning letter you are required to comply with the following improvement plan:
>
> - Read and sign as confirmation of your understanding the enclosed resident charter of rights. A signed copy should be returned to the Facility Manager no later than 20 April 2015 (**completed**)
> - Complete the Elder Abuse self directed learning package and return to the Facility Manager no later than 20 April 2015 (**completed**)
> - Complete the "Customer service in Health Care" questionnaire based on the DVD and return the completed questionnaire to the Facility Manager no later than 20 April 2015 (**completed**)
> - Always maintain the ACSAG values whilst in the workplace:
>   - Resident Focus - To respond to each resident with care and sensitivity
>   - Integrity - To be ethical. confidential and accountable
>   - Quality - Excellence through innovation and continuous improvement
>   - Honesty - To be open, trustworthy and truthful
>   - Respect - To treat each other with dignity, courtesy and as individuals
>   - Justice - To be fair and impartial.[481]

The Second Written Warning letter, dated 5 February 2016, contained a near identical improvement plan to that in the 4 June 2015 letter. The only differences were the date for completion, that the new improvement plan did not include the final dot point to 'maintain ACSAG [Aged Care Services Australia Group] values', and that it included a requirement to complete a self-directed learning package on privacy and dignity. [482]

The Final Written Warning letter, dated 3 March 2016, noted that the improvement plan from the Second Written Letter, dated 5 February 2016, had not been completed. It should have been completed by no later than 19 February 2019. Despite the escalation in conduct by UA in the incidents which were the subject of the Final Written Warning, Japara did not substantively amend the improvement plan from the Second Written Warning improvement plan. [483]

The tasks in the improvement plan

The improvement plans which UA was required to complete were not extensive.

The *Charter of Care Recipients' Rights & Responsibilities—Residential Care* that UA was required to read and sign is a single page document issued by the Australian Department of Health.[484]

The *Privacy & Dignity Questions* self-directed learning package required the participant to complete 12 multiple choice, dot point or short sentence questions.[485] UA completed this questionnaire on 15 March 2016, likely in response to the improvement plan imposed on 3 March 2016 in respect of the Final Written Warning. In response to question 9, he circled 'h', 'all of the above', acknowledging that he understood smacking a resident's hand was 'unacceptable behaviour'.[486]

The *Customer Service in Health Care* DVD questionnaire is a single page document containing the following questions:

(1) What do we mean by Customer Service

(2) How many thoughts do we have in 24 hours?

(3) How many of these thoughts are negative?

(4) What are negative emotions?

(5) What effect does negative emotions have on us?

(6) What constitutes service?

(7) What are the 5 basic needs

(8) What is the aim of service?

(9) What are the 7 Service Skills?

The version of this document completed by UA, provided to us by Japara, is undated.[487]

Counsel Assisting submitted that based on the questions in the questionnaire, the *Customer Service in Health Care* DVD was unlikely to have contained significant material directed towards addressing UA's misconduct.[488]

The *Elder Abuse Questions* self-directed learning package required the participant to complete five questions over two pages as follows:

(1) 'What is elder abuse?' (2 lines short answer)

(2) 'What are the 7 key guidelines for the care of older people?' (list 7 items)

(3) 'Name the different categories of Elder Abuse' (list 6 items)

(4) 'What should you do if you suspect an abuse has occurred?' (list 5 items)

(5) 'Which of the following behaviours is elder abuse & which abuse might it be?' (12 items).[489]

Japara provided us with two copies of the Elder Abuse questionnaire completed by UA. The first was completed on 28 March 2013.[490] The second was completed on 15 March 2016.[491] The questionnaire is unchanged between 2013 and 2016. With the exception of question 4, which may have reflected a change in Japara policy, UA's responses are identical in both questionnaires.

Counsel Assisting submitted that an improvement plan containing the above elements was not tailored to the misconduct of UA and was not appropriate or sufficient to address UA's misconduct.[492]

In response, Japara submitted that the topics of training—elder abuse, privacy and dignity, customer service in health care, and resident's rights—were apt to the problems underpinning UA's misconduct. They observed that we were not invited to examine the adequacy of the training by reference to source materials and Counsel Assisting made no suggestions as to how it may have been improved.[493]

Other steps in response to the misconduct

Japara took few other steps to protect its residents in response to UA's misconduct. After the first episodes of misconduct, Japara wrote to UA on 8 April 2015 and invited him to use the services of Japara's 'Employee Assistance Provider'.[494]

After the second incident on 12 January 2016, Ms Farrell provided instructions to Ms Mnich on points of discussion and directions to UA. Ms Farrell directed Ms Mnich to ask UA to:

> have a think about whether aged care is for you…If you continue with this type of conduct towards the residents it [won't] end well. You might need a role that focus' more so on tasks.[495]

Ms Farrell concluded that UA is 'expected back on the floor tomorrow'.

After the third series of incidents, on 12 February 2016, Ms Farrell provided a 'script' to communicate with UA. UA was again asked to 'have a think about whether this role is for you'.[496]

Despite substantiated misconduct in the previous two months and no amendment to the improvement plan, Ms Farrell advised that UA was to be directed 'to return to back to work on your next shift'.[497]

In April 2016, Japara began investigating the final series of allegations against UA. UA resigned in May 2016.[498]

Counsel Assisting submitted that 'the improvement plans and the steps taken by Japara, in response to the misconduct of UA while he remained in Japara's employment, were inadequate to manage the ongoing risk to resident safety presented by UA'.[499]

Counsel Assisting further submitted that in requiring UA to return to his work before he had taken or completed steps to address his misconduct and its possible source/s, Japara should have known it was exposing residents to risk.[500] Japara submitted that it 'sought to protect the safety and wellbeing of its residents, while at the same time respecting the requirements of the statutory employment regime'.[501]

Findings

The case study was presented by Counsel Assisting on the basis of facts as found by Japara in relation to UA's conduct. Those findings were made following investigations conducted in accordance with the Enterprise Agreement and the Employee Discipline Procedure.

Managerial employees at Japara differed in their characterisation of UA's conduct. Whether or not the threshold of 'serious misconduct'—as that term was defined relevantly—was reached in relation to allegations one to four, the misconduct was of a serious nature and occurred in the context of UA being employed to care for vulnerable residents. The misconduct was unacceptable and regrettable, as Japara agreed.[502]

Counsel Assisting invited us to make 11 findings arising from this case study. Japara resisted many of those findings. We address them briefly.

Counsel Assisting asserted, and Japara agreed, that:

- Japara has a duty to the residents of its facilities to provide them with a safe environment. This includes taking steps to protect residents from the risk of abuse by unsuitable employees.[503]
- An employee who has a demonstrated tendency of engaging in aggressive misconduct directed at residents is not a suitable employee.[504]
- UA resigned from his employment with Japara in May 2016 and was provided with a statement of service.[505]

These matters are not controversial and we agree.

Counsel Assisting sought a finding that between March 2015 and April 2016, UA engaged in 'aggressive misconduct' towards residents on seven substantiated occasions.[506] Japara submitted that the relevant period was between March 2015 and February 2016 and that the phrase 'aggressive misconduct' was not put to witnesses at the hearing.[507] The relevant period ended in February 2016 given that the seventh incident of misconduct occurred on 12 February 2016 and, having regard to the facts found by Japara, UA's conduct on 19 March 2015, 12 January 2016 and 10 February 2016 appears to have been aggressive towards residents.

We are asked by Counsel Assisting to find that by February or March 2016 at the latest, Japara should have identified a pattern of misconduct by UA and taken appropriate steps to address his misconduct.[508] A pattern should have been investigated by Japara as early as 9 April 2015 when four allegations of abuse of different residents had been identified.

Japara submitted that they 'did identify such misconduct on each occasion that it was brought to their attention'. They deny that there was a relevant course of conduct by March 2015 on the occasion of the first employee disciplinary process and note that 'UA had not previously engaged in any misconduct over some eight years' of prior employment with Japara'.[509] The first four instances of misconduct occurred in the space of less than 16 hours, but they adversely impacted on three residents in Japara's care. When Japara first determined its response to that misconduct, it did so on the basis of its original finding that UA had engaged in serious misconduct. Accepting that, Japara, at least with the benefit of hindsight, should have done more than issue a first and final warning, require some self-directed learning and offer voluntary counselling through their employee assistance provider.

By February 2016, Japara had found that UA had engaged in misconduct on 18 March 2015, 19 March 2015 and 12 January 2016. On or about 28 January and 2 March 2016, Japara asked UA to 'have a think' about whether aged care / his role is for him. In early March 2016, Japara prepared a script for a meeting with UA which included, 'These two incidents spoken about on Monday and incidents that have been bought up prior (your second warning), have a pattern that we cannot ignore.'[510]

Counsel Assisting submitted that the steps taken by Japara to address the misconduct in March 2016 were not reasonably appropriate or adequate to respond to the misconduct it had found.[511]

Japara did not accept that steps taken by it in March 2016 were not reasonably appropriate or adequate to respond to the misconduct it had found. It did concede that it ought to have considered, both then and earlier, the prospect of requiring UA to undertake mandatory counselling.[512] The steps taken by Japara in March 2016, in response to events on 12 February 2016, were to issue a final written warning, including a requirement that UA complete an improvement plan. They also asked UA to consider whether the role was for him.[513] The improvement plan was in the same terms as the improvement plan that had to be completed under the second written warning, other than dates for compliance were adjusted.[514] Japara told UA that the improvement plan was to 'be carried forward from the second warning, as it is believed you have not completed all aspects of this'.[515]

The key intervention was the improvement plan. Counsel Assisting submitted that the improvement plan was not extensive and was not tailored to the misconduct of UA. Further, the self-directed training was inadequate.[516]

Counsel Assisting submitted that the 'failure by Japara to take appropriate steps in 2015 put vulnerable residents at risk'.[517] Counsel Assisting's submissions appear to be directed to the decision to downgrade the characterisation of the conduct and, perhaps, the decision not to terminate UA's employment. We accept the decision made by Japara in 2015 to continue UA's employment was reasonably open to it and cannot assess that decision through the lens of subsequent events.

Counsel Assisting then submitted that the failure by Japara to take appropriate steps, not later than March 2016, in response to UA's course of misconduct evident in early 2016, put vulnerable residents in Japara's care at risk.[518]

Counsel Assisting submitted that it was reasonably open to Japara to issue UA with a final written warning earlier. Japara submitted that while it may have been 'reasonably open' to issue UA with a first and final warning earlier, it was likewise reasonably open for Japara *not* to issue a final warning.[519]

The final written warning was issued on 3 March 2016 after Japara found the sixth and seventh allegations proven.[520] The Enterprise Agreement provides that, if further misconduct is committed after a second written warning has been issued to an employee, then a final written warning may be issued. Alternatively, where serious misconduct is proven and the employer does not wish to terminate, a second or final written warning may be issued to the employee.[521] Other than the initial characterisation of 'serious misconduct', which was downgraded on review, Japara did not find that UA had engaged in 'serious misconduct'.[522] Absent such a finding, Japara was required to follow the process set out in the Enterprise Agreement. We accept Japara's submission.

Counsel Assisting submitted that:

> if Japara considered summary dismissal or a 'First and Final Warning' inappropriate in June 2015, it should have taken further and better steps to protect residents from the identified risk of UA's misconduct. These steps could have included: moving UA to different duties, mandating counselling, intensive supervision, mandating more intensive training…among others.[523]

Japara submitted in response that education and training in elder abuse, privacy and dignity, customer service in health care and resident's rights were all apt. It submitted, and we agree, that we have not been invited to examine the adequacy of the training by reference to the source material.[524] However, as already discussed, Counsel Assisting's criticisms of the assessment tools have force. We accept Japara's submission that UA was a 'longstanding and experienced' employee and was counselled to consider whether his current role was for him. Japara contended that the problems involving UA did not arise from a lack of supervision and note that some of the misconduct occurred in the presence of other staff. It also emphasised the lengthy gap between the February 2015 and February 2016 misconduct. Japara submitted that moving UA to different duties or a different facility would not have reduced the likelihood of further incidents occurring.[525]

Japara accepted that it owed a duty to the residents of its facilities to provide them with a safe environment.[526] It was concerned that UA's current role may not be right for him, and by March 2016 it knew there was a pattern of misconduct it could not ignore.[527] Its discipline procedure, at step eight, sets out a range of potential remedial measures which include:

- education and training
- policy and procedure revision / acknowledgement
- supervision / monitoring / mentoring by a more senior member of staff which may include changing rostered shifts to allow such supervision / monitoring / mentoring
- requirement to attend staff meetings
- regular meetings with the employee's manager or supervisor to discuss progress and work through any workplace issues affecting the employee's ability to meet the required standard.[528]

Finally, Counsel Assisting submitted that UA's statement of service was potentially misleading to a future employer, which would be unlikely to have information about UA's history at Japara, because of the words 'contributes to the physical, emotional and lifestyle needs and wants of the resident'.[529]

Japara submitted that clause 31.2 of the Enterprise Agreement required the provision of a certificate of service. Further, the provision of a statement of service, which in effect is a position description, is common practice in the aged care industry, and is distinct from an employee reference.[530]

The case study illustrates the risks for older people in the absence of any form of registration of personal care workers. This issue is considered further in Volume 3.

Endnotes

1 Transcript, Melbourne Hearing 3, Ann Wunsch, 15 October 2019 at T5965.18–20.
2 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 122, CTH.4016.2000.0010 at 0015.
3 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0028 [156].
4 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6016.27–35.
5 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0027 [121].
6 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0027 [121].
7 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6283.28–32.
8 Exhibit 11-19, Melbourne Hearing 3, Statement of Darren Mathewson, WIT.0362.0001.0001 at 0010 [38].
9 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6016.35–38.
10 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6016.38–46.
11 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5988.27–42.
12 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6017.4–8.
13 Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0018 [95]–0019 [98].
14 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0026-0028 [143]; [147]–[148]; [150]–[151].
15 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 6, RCD.9999.0203.0054 at 0062.
16 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 5, HWU.0001.0001.0001 at 0002; 0021.
17 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0005 [32].
18 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0005 [33]–[34].
19 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0005-0006 [35].
20 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0006 [37].
21 Transcript, Melbourne Hearing 3, Kym Peake, 16 October 2019 at T6057.13–15.
22 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0009 [50].
23 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0008 [49].
24 Transcript, Melbourne Hearing 3, Kym Peake, 16 October 2019 at T6067.13–22.
25 Exhibit 11-20, Melbourne Hearing 3, National Aged Care Staffing and Skills Mix Project Report 2016, ANM.0001.0001.3151.
26 Exhibit 11-20, Melbourne Hearing 3, National Aged Care Staffing and Skills Mix Project Report 2016, ANM.0001.0001.3151 at 3159.
27 Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler, WIT.0020.0001.0001 at 0006 [39]–[47]; Exhibit 11-28, Melbourne Hearing 3, Statement of Robert Bonner, WIT.0488.0001.0001 at 0025 [64]–[65].
28 Transcript, Melbourne Hearing 3, Robert Bonner, 16 October 2019, at T6041.27–30.
29 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 215, RCD.9999.0239.0001.
30 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5765.40–45.
31 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5787.22–24; T5790.28–33.
32 Exhibit 11-2, Melbourne Hearing 3, Statement of Kathleen Eagar, WIT.0459.0001.0001 at 0003 [12]; [15].
33 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5767.43–47.
34 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001.
35 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001 at 0005; 0038.
36 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5788.42–5789.8.
37 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5793.1–3.
38 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001 at 0038; Exhibit 11-2, Melbourne Hearing 3, Statement of Kathleen Eagar, WIT.0459.0001.0001 at 0010 [42].
39 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001 at 0038.
40 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001 at 0025.
41 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5793.20–23.
42 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5793.21–23.
43 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5783.6–7; Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001 at 0039.
44 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001 at 0039.
45 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5782.10–17; T5782.45–5783.2.
46 The invitation to make comments was extended by letter from the Royal Commission dated 27 September 2019.
47 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 166, RCD.9999.0231.0001; tab 167, RCD.9999.0231.0011; tab 168, RCD.9999.0231.0028; tab 169, RCD.9999.0231.0031; tab 170 RCD.9999.0231.0032.
48 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 166, RCD.9999.0231.0001 at 0003; 0008.
49 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 170, RCD.9999.0231.0032 at 0032–0033.
50 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 167, RCD.9999.0231.0011 at 0013 [11].
51 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 167, RCD.9999.0231.0011 at 0017 [3].
52 Exhibit 11-28, Melbourne Hearing 3, Statement of Robert Bonner, WIT.0488.0001.0001 at 0005–0006 [8.2]. See Exhibit 1-20, Adelaide Hearing 1, National Aged Care Staffing and Skills Mix Project Report 2016, ANM.0001.0001.3151 at 3173–3174; 3180.
53 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T6018.11–15.
54 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T6018.20–24.

55 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T6018.28–34.
56 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6016.42–6017.2.
57 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5794.10–16.
58 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6286.31–33.
59 Transcript, Melbourne Hearing 3, Rachel Yates, 17 October 2019 at T6192.20–22.
60 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0009 [56].
61 Exhibit 11-63, Melbourne Hearing 3, Statement of James Vickers, WIT.0462.0001.0001 at 0002 [11]. Footnote from original text omitted.
62 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6203.40–45.
63 Exhibit 11-63, Melbourne Hearing 3, Statement of James Vickers, WIT.0462.0001 at 0004 [20]–0005 [25].
64 Exhibit 11-63, Melbourne Hearing 3, Statement of James Vickers, WIT.0462.0001 at 0005–0006 [27].
65 Transcript, Melbourne Hearing 3, Amy Lazzaro, 16 October 2019 at T6080.37–39.
66 Exhibit 11-64, Melbourne Hearing 3, Statement of Rachel Yates, WIT.0461.0001.0001 at 0006 [21]–0007 [22].
67 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 205, ACW.9999.0001.0022 at 0071.
68 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 4, RCD.9999.0181.0001 at 0021.
69 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 4, RCD.9999.0181.0001 at 0021.
70 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 4, RCD.9999.0181.0001 at 0021.
71 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 4, RCD.9999.0181.0001 at 0021.
72 Exhibit 11-6, Melbourne Hearing 3, Statement of Robert Bonner, WIT.0443.0001.0001 at 0005 [24].
73 Exhibit 11-26, Melbourne Hearing 3, Statement of Nadine Williams, WIT.0471.0001.0001 at 0008 [45].
74 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0005 [33]
75 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0016.
76 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5850.43–45.
77 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5851.39–41.
78 Transcript, Melbourne Hearing 3, Jane Trewin, 14 October 2019 at T5851.29–35.
79 Transcript, Melbourne Hearing 3, Michelle Eastman, 14 October 2019 at T5851.43–5852.2.
80 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5852.19–27.
81 Exhibit 11-6, Melbourne Hearing 3, Statement of Robert Bonner, WIT.0443.0001.0001 at 0007 [35]; [39].
82 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5864.35–41.
83 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2844.
84 Transcript, Melbourne Hearing 3, Michelle Eastman, 14 October 2019 at T5864.30–33.
85 Transcript, Melbourne Hearing 3, Jane Trewin, 14 October 2019 at T5865.37–41.
86 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 90, ANM.0009.0001.0001 at 0007–0008.
87 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 4, RCD.9999.0181.0001.
88 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 4, RCD.9999.0181.0001 at 0051.
89 Exhibit 11-59, Melbourne Hearing 3, Statement of Sandra Hills, WIT.0450.0001.0001 at 0011 [62]–[63].
90 Exhibit 11-26, Melbourne Hearing 3, Statement of Nadine Williams, WIT.0471.0001.0001 at 0011 [55].
91 Exhibit 11-26, Melbourne Hearing 3, Statement of Nadine Williams, WIT.0471.0001.0001 at 0011 [59].
92 Exhibit 11-26, Melbourne Hearing 3, Statement of Nadine Williams, WIT.0471.0001.0001 at 0011 [61].
93 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5867.26–5868.12; Transcript, Melbourne Hearing 3, Michelle Eastman, 14 October 2019 at T5868.16–24.
94 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5867.26–32.
95 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5867.34–41.
96 Transcript, Melbourne Hearing 3, Michelle Eastman, 14 October 2019 at T5859.26–30.
97 Transcript, Melbourne Hearing 3, Michelle Eastman, 14 October 2019 at T5859.34–38.
98 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5859.40–44.
99 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5864.6–9.
100 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6177.7–22.
101 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6177.24–29.
102 Exhibit 11-61, Melbourne Hearing 3, Statement of Kerri Rivett, WIT.0441.0001.0001 at 0020 [65].
103 Exhibit 11-59, Melbourne Hearing 3, Statement of Sandra Hills, WIT.0450.0001.0001 at 0014 [83].
104 Exhibit 11-62, Melbourne Hearing 3, Statement of Richard Hearn, WIT.0440.0001.0001 at 0017 [97].
105 Transcript, Melbourne Hearing 3, Kylie Ward, 17 October 2019 at T6195.45–6196.4.
106 Exhibit 11-65, Melbourne Hearing 3, Statement of Kylie Ward, WIT.0483.0001.0001 at 0018 [86].
107 Transcript, Melbourne Hearing 3, Kylie Ward, 17 October 2019 at T6196.5–6197.37; T6199.37–45.
108 Transcript, Melbourne Hearing 3, Rachel Yates, 17 October 2019 at T6192.13–24.
109 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6194.8–17.
110 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6189.27–34.
111 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6190.11–16.
112 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6191.16–21.
113 Transcript, Melbourne Hearing 3, Kylie Ward, 17 October 2019 at T6187.1–3.
114 Transcript, Melbourne Hearing 3, Kylie Ward, 17 October 2019 at T6188.1–5.
115 Transcript, Melbourne Hearing 3, Kylie Ward, 17 October 2019 at T6188.18–22.
116 Transcript, Melbourne Hearing 3, Kylie Ward, 17 October 2019 at T6188.29–37.
117 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6194.9–17.

118 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6195.14–20.
119 Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6195.26–43.
120 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0002 [14]–[16].
121 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0014 [90].
122 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0007 [41] referring to T Commerford, '*How many geriatricians should, at minimum, be staffing health regions in Australia?*', Australasian Journal on Ageing, 2018, Vol 37, 1, pp 17–22.
123 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0005 [35].
124 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0006 [38]; Transcript, John Maddison, Melbourne Hearing 3, 17 October 2019, at T6211.2–4.
125 Transcript, Melbourne Hearing 3, John Maddison, 17 October 2019, at T6211.8–25.
126 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0006 [40].
127 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0014 [89].
128 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0014 [91]; 0015 [100]; 0018 [106].
129 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0009 [54].
130 Exhibit 11-66, Melbourne Hearing 3, Statement of John Maddison, WIT.0484.0001.0001 at 0011 [67]–[68].
131 Transcript, Melbourne Hearing 3, John Maddison, 17 October 2019, at T6215.8–21.
132 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6241.10–20.
133 Submissions of the Commonwealth of Australia, Melbourne Hearing 3, 15 November 2019, RCD.0012.0033.0002 at 0013 [69].
134 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0010 [37].
135 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 85, CTH.0001.1001.0854 at 0854.
136 See ACT: Exhibit 11-32, Melbourne Hearing 3, Statement of Karen Toohey, WIT.0386.0001.0001 at 0002–0003; SA: Exhibit 11-35, Melbourne Hearing 3, Statement of Grant Davies, WIT.0390.0001.0001 at 0005–0006 [24]; 0008 [50]–0009 [52]; NSW: Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0002–0003 [10]; 0008 [27]–[28]; NT: Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001 at 0001 [4]; Tas: Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001 at 0001 [5]–0002 [6]; [10]; Qld: Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0002 [8]; 0008 [37]–[38]; Vic: Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001 at 0002 [1]; 0006 [22]; WA: Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001 at 0003–0004 [12]; 0010 [39].
137 *Health Ombudsman Act 2013* (Qld), s 7(1); 7(3).
138 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0002 [11]–[12].
139 *Health Care Complaints Act 1993* (NSW), s 4.
140 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0004 [15].
141 Exhibit 11-32, Melbourne Hearing 3, Statement of Karen Toohey, WIT.0386.0001.0001.
142 Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001.
143 Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001.
144 Exhibit 11-35, Melbourne Hearing 3, Statement of Grant Davies, WIT.0390.0001.0001.
145 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001.
146 Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001.
147 Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001.
148 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001.
149 Exhibit 11-32, Melbourne Hearing 3, Statement of Karen Toohey, WIT.0386.0001.0001 at 0002.
150 Exhibit 11-32, Melbourne Hearing 3, Statement of Karen Toohey, WIT.0386.0001.0001 at 0002.
151 Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001 at 0001 [1].
152 Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001 at 0001 [2].
153 Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001 at 0001 [2].
154 Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001 at 0001 [3]–[4].
155 Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001 at 0001 [6]–0002 [7].
156 Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001 at 0001 [6]; 0002 [8].
157 Exhibit 11-35, Melbourne Hearing 3, Statement of Grant Davies, WIT.0390.0001.0001 at 0003 [20].
158 Exhibit 11-35, Melbourne Hearing 3, Statement of Grant Davies, WIT.0390.0001.0001 at 0006 [29].
159 Exhibit 11-35, Melbourne Hearing 3, Statement of Grant Davies, WIT.0390.0001.0001 at 0006 [27]; 0007 [45].
160 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0004 [15].
161 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0004 [16]–0006 [18].
162 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0006 [18d].
163 Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001 at 0005 [20].
164 Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001 at 0004 [15]–0005 [17].
165 Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001 at 0005 [20].
166 Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001 at 0002–0003 [3].
167 Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001 at 0004 [10]; Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6233.5–33.
168 Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001 at 0003 [7].
169 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0002 [10]–[12].

170 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0005 [24].
171 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0004 [20]; 0005 [26].
172 Exhibit 11-35, Melbourne Hearing 3, Statement of Grant Davies, WIT.0390.0001.0001 at 0008 [46]; Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0007 [32]; Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0008 [23].
173 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0008 [23].
174 Exhibit 11-35, Melbourne Hearing 3, Statement of Grant Davies, WIT.0390.0001.0001 at 0008 [46].
175 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0006 [30]–0008 [36], as corrected in Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6227.25–31.
176 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6230.30–35.
177 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6233.9–15.
178 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6233.26–33.
179 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6233.1–3.
180 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0030–0032.
181 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6233.40–6234.9.
182 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6234.37–T6235.2.
183 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6236.25–33.
184 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6237.17–21.
185 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001.
186 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0006 [21]–[23]; 0007 [29]; 0008 [32a]; Transcript, Shona Reid, Melbourne Hearing 3, 18 October 2019 at T6242.30–32.
187 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0012 [41].
188 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0028–0029.
189 Transcript, Brisbane Hearing, Sarah Holland-Batt, 7 August 2019 at T4562.10–4576.27; Transcript, Melbourne Hearing 3, Japara Bayview Case Study, 17 October 2019 at T6105–6151.
190 Exhibit 8-40, Brisbane Hearing, Annexure to Statement of Shona Reid, WIT.0307.0002.0001 at 0002 [5]–0003 [7].
191 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6238.23–39.
192 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6238.45–6239.7.
193 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6239.25.
194 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6240.12–21.
195 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6240.25–30.
196 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6243.23–30.
197 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6243.3–9.
198 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6244.11–22.
199 Transcript, Melbourne Hearing 3, Menarock Case Study, 15 October 2019 at T5877–5965.
200 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6245.41–46.
201 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6245.30–39.
202 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0018 [56].
203 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6246.4–18.
204 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6248.9–12.
205 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6250.8–16.
206 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6249.33–36.
207 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6249.6–13.
208 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6249.43–46.
209 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6250.20–28.
210 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6247.45–46.
211 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6247.38–40.
212 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T6009.27–32.
213 Exhibit 11-19, Melbourne Hearing 3, Statement of Darren Mathewson, WIT.0362.0001.0001 at 0008 [22].
214 Exhibit 11-19, Melbourne Hearing 3, Statement of Darren Mathewson, WIT.0362.0001.0001 at 0010 [33]–[35].
215 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T6010.11–14.
216 Exhibit 11-19, Melbourne Hearing 3, Statement of Darren Mathewson, WIT.0362.0001.0001 at 0009 [30].
217 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0032 [181].
218 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0033 [186].
219 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0035 [202].
220 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0035 [200].
221 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0038 [215].
222 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6007.21–22.
223 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6007.22–25.
224 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6007.31–6008.2.
225 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0010 [41].
226 Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0016 [78].
227 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6008.17–26.
228 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6009.10–16.
229 Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0016 [79].

230 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6281.29–31.
231 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6281.31–35.
232 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6282.1–4.
233 Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, Carnell and Paterson, October 2017, RCD.9999.0011.1833.
234 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6282.29–36.
235 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6291.25–26.
236 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5978.24–30.
237 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5979.44–5980.5.
238 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5979.36–42.
239 Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0001.0001 at 0003 [14].
240 Transcript, Melbourne Hearing 3, Sara Charlesworth, 16 October 2019 at T6085.36–44.
241 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6017.18–27.
242 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6158.16–17.
243 Exhibit 11-23, Melbourne Hearing 3, Statement of Jenna Field, WIT.0363.0001.0001 at 0005 [24]; Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T5996.28–30. See also Exhibit 11-62, Melbourne Hearing 3, Statement of Richard Hearn, WIT.0440.0001.0001 at 0006 [25].
244 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5975.9–13.
245 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5997.7–17; Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0007 [32].
246 Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0001.0001 at 0005 [20]–[21].
247 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0022 [100].
248 Submissions of the Commonwealth of Australia, Melbourne Hearing 3, 15 November 2019, RCD.0012.0033.0002 at 0012 [59].
249 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T5984.39–47; T6003.4–7.
250 Transcript, Melbourne Hearing 3, Sara Charlesworth, 16 October 2019 at T6087.16–19; Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5990.39–42.
251 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5991.29–34.
252 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5991.21–27.
253 Transcript, Melbourne Hearing 3, Sara Charlesworth, 16 October 2019 at T6087.16–21.
254 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0007 [25].
255 Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0001.0001 at 0005–0006 [21].
256 Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0001.0001 at 0008 [28].
257 Transcript, Melbourne Hearing 3, Sara Charlesworth, 16 October 2019 at T6086.35–44.
258 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 1, RCD.9999.0176.0001 at 0017 [4.1.3.5].
259 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0006 [24a].
260 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T5976.28–31.
261 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0038 [213].
262 Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0001.0001 at 0006–0007 [24].
263 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5999.40–6000.4.
264 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6156.17–18.
265 Transcript, Melbourne Hearing 3, Sara Charlesworth, 16 October 2019 at T6089.12–38.
266 Transcript, Melbourne Hearing 3, Sara Charlesworth, 16 October 2019 at T6089.12–17.
267 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6005.26–43.
268 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6005.31–36.
269 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5981.40–43.
270 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6155.32–36.
271 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 1, RCD.9999.0176.0001 at 0017 [4.1.3.4].
272 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6001.15–18.
273 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6006.36–42.
274 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6012.1–9.
275 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6017.35–37.
276 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6153.34–35.
277 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6221.14–15; T6221.28–29.
278 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6224.40–47.
279 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6222.26–28.
280 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6224.3–8.
281 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6157.10–13.
282 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6224.14–20.
283 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0011.
284 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0004.
285 Exhibit 1-4, Adelaide Hearing 1, Statement of John McCallum, WIT.0004.0001.0001 at 0015 referring to UVH.0001.0007.0001.
286 Transcript, Melbourne Hearing 3, John Pollaers, 14 October 2019 at T5798.28–40.
287 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 205, ACW.9999.0001.0022 at 0129.

288 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0011.
289 Transcript, Melbourne Hearing 3, John Pollaers, 14 October 2019 at T5801.20–35.
290 Transcript, Melbourne Hearing 3, Commissioner Briggs, 14 October 2019 at T5809.7–9.
291 Transcript, Melbourne Hearing 3, John Pollaers, 14 October 2019 at T5809.11–18.
292 Exhibit 11-62, Melbourne Hearing 3, Statement of Richard Hearn, WIT.0440.0001.0001 at 0001 [8].
293 Exhibit 11-60, Melbourne Hearing 3, Statement of Jason Howie, WIT.0383.0001.0001 at 0003 [12]; [14].
294 Exhibit 11-61, Melbourne Hearing 3, Statement of Kerri Rivett, WIT.0441.0001.0001 at 0001 [4].
295 Transcript, Melbourne Hearing 3, Commissioner Briggs, 17 October 2019 at T6181.21–22.
296 Transcript, Melbourne Hearing 3, Jason Howie, 17 October 2019 at T6181.37–41.
297 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6182.28–37.
298 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6182.39–6183.8.
299 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6166.11–15.
300 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6166.14–18.
301 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6184.5–10.
302 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6178.18–23.
303 Exhibit 11-60, Melbourne Hearing 3, Statement of Jason Howie, WIT.0383.0001.0001 at 0038 [113].
304 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0014–0015.
305 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6260.15–17.
306 Submissions of the Commonwealth of Australia, Melbourne Hearing 3, 15 November 2019, RCD.0012.0033.0002 at 0003 [1].
307 Transcript, Melbourne Hearing 3, Sara Charlesworth, 16 October 2019 at T6086.1–8.
308 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6178.3–8.
309 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6260.27–46.
310 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6261.6–12.
311 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0013 [67]; 0014 [71].
312 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0014 [72]–[73].
313 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0015–0016 [76].
314 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0014 [72]–[73]; 0016–0018 [77].
315 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6287.34–39.
316 Transcript, Melbourne Hearing 3, Jason Howie, 17 October 2019 at T6179.12–16.
317 Transcript, Melbourne Hearing 3, John Pollaers, 14 October 2019 at T5811.40–5812.8. Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0012.
318 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0012; 0014.
319 Transcript, Melbourne Hearing 3, John Pollaers, 14 October 2019 at T5812.23–38.
320 Transcript, Melbourne Hearing 3, John Pollaers, 14 October 2019 at T5812.44–46; Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 244, CTH.1000.0003.5922.
321 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 244, CTH.1000.0003.5922 at 5923.
322 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6269.11–12; Submissions of the Commonwealth of Australia, Melbourne Hearing 3, 15 November 2019, RCD.0012.0033.0002 at 0005 [10].
323 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6269.19–21.
324 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 226, CTH.1000.0003.5207.
325 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 226, CTH.1000.0003.5207 at 5208.
326 Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 226, CTH.1000.0003.5207 at 5208.
327 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0014 [94].
328 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0014 [95].
329 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T6018.6–11.
330 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6177.36–46.
331 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6178.3–16.
332 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6179.21–22.
333 Transcript, Melbourne Hearing 3, John Pollaers, 14 October 2019 at T5813.8–31.
334 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0002 [9]–[10].
335 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0010 [65]; 0011 [70].
336 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0011 [68].
337 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0011–0012 [77].
338 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0007 [47]–[48].
339 Transcript, Melbourne Hearing 3, Kevin McCoy, 14 October 2019 at T5833.19–25.
340 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0005 [32].
341 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6178.3–16.
342 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0007 [36].
343 Transcript, Melbourne Hearing 3, Charles Wann, 18 October 2019 at T6276.15–42.
344 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0013 [65].
345 Submissions of the Commonwealth of Australia, Melbourne Hearing 3, Letter from the Commonwealth regarding the Evidence of Glenys Beauchamp, 15 November 2019, RCD.0012.0037.0001 at 0002 [7].

346 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5883–5892; Transcript, Melbourne Hearing 3, Christine Lynch, 15 October 2019 at T5883–5892.
347 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5892–5914.
348 Transcript, Melbourne Hearing 3, Bridget Scarff, 15 October 2019 at T5915–5925.
349 Transcript, Melbourne Hearing 3, Fiona van den Berg, 15 October 2019 at T5925–5944.
350 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5945–5958.
351 Transcript, Melbourne Hearing 3, Craig Holland, 15 October 2019 at T5945–5958.
352 Transcript, Melbourne Hearing 3, Ann Wunsch, 15 October 2019 at T5958–5965.
353 Submissions of Counsel Assisting, Menarock Case Study, 8 November 2019, RCD.9999.0262.0001 at 0002 [3].
354 From 1 July 2019 the Accreditation Standards were replaced by the Aged Care Quality Standards.
355 Transcript, Melbourne Hearing 3, Ann Wunsch, 15 October 2018 at T5963.4–10.
356 Exhibit 11-16, Melbourne Hearing 3, Statement of Ann Wunsch, WIT.0470.0001.0001 at 0002 [10].
357 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 111, MRA.0002.0001.0017 at 0018.
358 Exhibit 11-18, Melbourne Hearing 3, Statement of Elsy Brammesan, WIT.0546.0001.0001 at 0001–0002 [10]; Exhibit 11-18, Melbourne Hearing 3, EB2-1, CTH.1029.1000.0070 at 0074.
359 Exhibit 11-18, Melbourne Hearing 3, EB2-1, CTH.1029.1000.0070 at 0074.
360 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 143, CTH.4020.3000.1452 at 1454.
361 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 147, CTH.4020.3000.1717; tab 148, CTH.4020.3000.2487.
362 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5893.20-28; Transcript, Melbourne Hearing 3, Bridget Scarff, 15 October 2019 at T5915.24–33.
363 Exhibit 11-14, Melbourne Hearing 3, Statement of Brendan Coulton, WIT.0456.0002.0001 at 0001 [3]; 0002–0003.
364 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 304, YVH.0001.0001.0022 at 0022.
365 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5913.5-14; Exhibit 11-12, Melbourne Hearing 3, Statement of Bridget Scarff, WIT.0493.0001.0001 at 0011 [14].
366 Exhibit 11-12, Melbourne Hearing 3, Statement of Bridget Scarff, WIT.0493.0001.0001 at 0002 [4].
367 Exhibit 11-12, Melbourne Hearing 3, Statement of Bridget Scarff, WIT.0493.0001.0001 at 0006.
368 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5913.18–19.
369 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5913.3–8.
370 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5913.24.
371 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5913.24–27.
372 Transcript, Melbourne Hearing 3, Fiona van den Berg, 15 October 2019 at T5941.19–39.
373 Transcript, Melbourne Hearing 3, Bridget Scarff, 15 October 2019 at T5918.32–38.
374 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5949.38–44.
375 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5953.12–15.
376 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5953.19–29.
377 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 79, CTH.4020.9000.0897.
378 Submissions of Counsel Assisting, Menarock Case Study, 8 November 2019, RCD.9999.0262.0001 at 0007 [30].
379 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 145, CTH.4020.3000.1520.
380 Exhibit 11-9, Melbourne Hearing 3, Statement of Agatha, WIT.0480.0001.0001 at 0002 [16]; 0005 [42].
381 Exhibit 11-9, Melbourne Hearing 3, Statement of Agatha, WIT.0480.0001.0001 at 0003 [26].
382 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 145, CTH.4020.3000.1520 at 1554; Exhibit 11-9, Melbourne Hearing 3, Statement of Agatha, WIT.0480.0001.0001 at 0003 [26].
383 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 145, CTH.4020.3000.1520 at 1533–1534; Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5912.25–26.
384 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5911.43–44; T5912.36–37.
385 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 252, MRA.0003.0001.0123 at 0133.
386 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 73, CTH.4020.3000.0602 at 0603–0604.
387 Exhibit 11-9, Melbourne Hearing 3, Statement of Agatha, WIT.0480.0001.0001 at 0006 [48]–[49].
388 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5885.4–7; T5886.9–12.
389 Exhibit 11-10, Melbourne Hearing 3, Statement of Sandra Nisi, WIT.0539.0001.0001 at 0002 [8]–[9]; Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 133, CTH.4020.3000.2541 at 2546.
390 Exhibit 11-10, Melbourne Hearing 3, Statement of Sandra Nisi, WIT.0539.0001.0001 at 0003 [25].
391 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5887.25–33.
392 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5888.2–12.
393 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5888.32–35.
394 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5888.23–30.
395 Exhibit 11-10, Melbourne Hearing 3, Statement of Sandra Nisi, WIT.0539.0001.0001 at 0003 [18]; Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5889.1–13.
396 Exhibit 11-18, Melbourne Hearing 3, Menarock tender bundle, tab 145, CTH.4020.3000.1520 at 1525.
397 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5890.32–44.
398 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5891.20–10.
399 Exhibit 11-18, Melbourne Hearing 3, Menarock tender bundle, tab 145, CTH.4020.3000.1520 at 1542.
400 Transcript, Melbourne Hearing 3, Sandra Nisi, 15 October 2019 at T5891.15–20.
401 Transcript, Melbourne Hearing 3, Yvonne Henderson, 15 October 2019 at T5898.28–42.

402 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 277, MRA.0003.0001.0945 at 0946.
403 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5947.44–5948.8.
404 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 277, MRA.0003.0001.0945 at 0946.
405 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5949.1–5.
406 Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 277, MRA.0003.0001.0945 at 0945–0946.
407 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5948.42–45.
408 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5947.10–12; Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 277, MRA.0003.0001.0945 at 0945.
409 Transcript, Melbourne Hearing 3, Fiona van den Berg, 15 October 2019 at T5944.6–10.
410 Transcript, Melbourne Hearing 3, Brendan Coulton, 15 October 2019 at T5949.24–46.
411 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Menarock Case Study, 8 November 2019, RCD.9999.0262.0001 at 0012 [50].
412 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Menarock Case Study, 8 November 2019, RCD.9999.0262.0001 at 0001 [1].
413 Exhibit 11-18, Melbourne Hearing 3, EB2-1, CTH.1029.1000.0070 at 0074; Exhibit 11-8, Melbourne Hearing 3, Menarock tender bundle, tab 142, CTH.4020.3000.1422.
414 Exhibit 11-14, Melbourne Hearing 3, Statement of Brendan Coulton, WIT.0456.0002.0001 at 0006 [7b].
415 Pursuant to a pseudonym direction (PND-H10-0002) dated 9 October 2019, the employee was given the pseudonym 'UA'. The residents involved were given pseudonyms to protect their privacy. Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 2, JAH.0126.001.0015; tab 35, JAH.0126.001.0409; tab 15, JACH.0126.001.0432; Exhibit 11-56, Melbourne Hearing 3, Statement of Nicole Farrell, WIT.0490.0002.0001 at 0002–0005 [28]. The final alleged incidents also included allegations of UA slapping residents. See Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 40, JAH.0126.001.0400.
416 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 43, JAH.0126.002.0243.
417 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 47, RCD.9999.0215.0003.
418 Exhibit 11-54, Melbourne Hearing 3, Statement of Dianne Mnich, WIT.0489.0001.0001 at 0001 [8]; Exhibit 11-56, Melbourne Hearing 3, Statement of Nicole Farrell, WIT.0490.0002.0001 at 0001 [8].
419 Exhibit 11-57, Melbourne Hearing 3, Statement of Valeria Camara, WIT.0575.0001.0001.
420 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle.
421 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0009 [14].
422 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001.
423 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001.
424 Submissions in Reply of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 21 November 2019, RCD.9999.0259.0023.
425 Exhibit 11-56, Melbourne Hearing 3, Statement of Nicole Farrell, WIT.0490.0002.0001 at 0002 [9]; Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 6, JAH.0030.0001.0001.
426 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 6, JAH.0030.0001.0001 at 0075–0076.
427 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 2, JAH.0126.001.0015 at 0017 [10].
428 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 7, JAH.0031.0001.0001 at 0003–0004.
429 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 7, JAH.0031.0001.0001 at 0003–0004.
430 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 7, JAH.0031.0001.0001 at 0002.
431 Transcript, Melbourne Hearing 3, Nicole Farrell, 17 October 2019 at T6136.26–29.
432 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 8, JAH.0126.001.0427.
433 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 8, JAH.0126.001.0427 at 0427.
434 Transcript, Melbourne Hearing 3, Dianne Mnich, 17 October 2019 at T6112.33–44.
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438 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 9, JAH.0126.001.0430 at 0431.
439 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 10, JAH.0126.002.0038.
440 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 11, JAH.0126.002.0031; tab 12, JAH.0126.002.0006.
441 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 14, JAH.0126.001.0434 at 0434.
442 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 15, JAH.0126.001.0432.
443 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 14, JAH.0126.001.0434 at 0434 (emphasis in original).
444 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0006 [21]. Footnote removed from original.
445 Transcript, Melbourne Hearing 3, Nicole Farrell, 17 October 2019 at T6145.12–15.
446 See Exhibit 11-56, Melbourne Hearing 3, Statement of Nicole Farrell, WIT.0490.0002.0001 at 0003 [15]–[16].
447 See Exhibit 11-56, Melbourne Hearing 3, Statement of Nicole Farrell, WIT.0490.0002.0001 at 0003 [16]; Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 52, JAH.0034.0001.0001; Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 53, JAH.0034.0001.0004; Transcript, Melbourne Hearing 3, Jim Delany QC, 17 October 2019 at T6105.12–14.
448 Transcript, Melbourne Hearing 3, Nicole Farrell, 17 October 2019 at T6144.31–37.
449 Transcript, Melbourne Hearing 3, Nicole Farrell, 17 October 2019 at T6145.3–10.

450 Transcript, Melbourne Hearing 3, Nicole Farrell, 17 October 2019 at T6144.45–6145.1; T6145.17–23.
451 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 7, JAH.0031.0001.0001 at 0003; Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 8, JAH.0126.001.0427.
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454 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 18, JAH.0126.0001.0415.
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456 Transcript, Melbourne Hearing 3, Dianne Mnich, 17 October 2019 at T6122.1–45.
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459 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0009 [35].
460 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 25, JAH.0126.0001.0421 at 0421.
461 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 28, JAH.0126.001.0406 at 0406.
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464 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 35, JAH.0126.001.0409.
465 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0010 [39].
466 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 38, JAH.0126.002.0165 at 0165–0166.
467 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 39, JAH.0126.002.0175 at 0176.
468 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 40, JAH.0126.001.0400 at 0400.
469 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 39, JAH.0126.002.0175; Transcript, Melbourne Hearing 3, Dianne Mnich, 17 October 2019 at T6128.43–6129.3.
470 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 42, JAH.0126.002.0123 at 0123; Transcript, Melbourne Hearing 3, Dianne Mnich, 17 October 2019 at T6128.43–46; T6129.36–40.
471 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 44, JAH.0126.002.0230.
472 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 45, JAH.0126.002.0232. The original signed Statement of Service listed the wrong Japara facility. A replacement letter with the correct facility was sent by email but does not appear to have been signed. See Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 46, RCD.9999.0215.0001; tab 47, RCD.9999.0215.0003.
473 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 45, JAH.0126.002.0232.
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476 Submissions of Counsel Assisting, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0002 [1k].
477 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0011 [44]; 0016 [54k].
478 Submissions in Reply of Counsel Assisting, Submissions in Reply of Japara Bayview Case Study, 21 November 2019, RCD.9999.0259.0023.
479 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 9, JAH.0126.001.0430 at 0431; Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 25, JAH.0126.0001.0421 at 0421; Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 15, JAH.0126.002.0432; Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 35, JAH.0126.001.0409 at 0410.
480 See Exhibit 11-56, Melbourne Hearing 3, Statement of Nicole Farrell, 15 October 2019, WIT.0490.0002.0001 at 0007 [38].
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482 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 25, JAH.0126.001.0421.
483 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 35, JAH.0126.001.0409 at 0410.
484 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 49, JAH.0021.001.9764.
485 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 36, JAH.0126.001.0291.
486 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 36, JAH.0126.001.0291 at 0292.
487 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 50, JAH.0126.001.0461.
488 Submissions of Counsel Assisting, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0018 [43].
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491 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 37, JAH.0126.001.0289.
492 Submissions of Counsel Assisting, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0019 [46].
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495 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 24, JAH.0126.002.0081.
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497 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 33, JAH.0126.002.0124 at 0125.
498 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0010 [41]–[42].

499 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0020 [52].
500 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0020 [53].
501 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0002 [5].
502 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0002 [6].
503 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0001 [1a]; Submissions of Japara, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0014 [54a].
504 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0001 [1b]; Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0014 [54b].
505 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0001 [1d]; Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0014 [54d].
506 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0001 [1c].
507 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0014 [54c].
508 Submissions of Counsel Assisting, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0001 at [1e].
509 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0014 [54e].
510 Exhibit 11-33, Melbourne Hearing 3, Japara tender bundle, tab 33, JAH.0126.002.0124 at 0124 (emphasis added).
511 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0001 [1f].
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513 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 33, JAH.0126.002.0124 at 0124.
514 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 25, JAH.0126.0001.0421; tab 35, JAH.0126.001.0409.
515 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 33, JAH.0126.002.0124 at 0124.
516 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0017 [39]; 0019 [46]; 0020 [52].
517 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0002 [1g].
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519 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0015 [54i].
520 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 35, JAH.0126.001.0409.
521 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 6, JAH.0030.0001.0001 at 0075–0076.
522 Exhibit 11-53, Melbourne Hearing 3, Japara tender bundle, tab 52, JAH.0034.0001.0001 at 0001.
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524 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0013 [49].
525 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0013 [50]; [52].
526 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0014 [54a].
527 Submissions of Japara, Melbourne Hearing 3, Japara Bayview Case Study, 15 November 2019, RCD.0012.0034.0001 at 0014 [54e].
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529 Submissions of Counsel Assisting the Royal Commission, Melbourne Hearing 3, Japara Bayview Case Study, 6 November 2019, RCD.9999.0259.0001 at 0002 [1k].
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12. Mudgee Hearing: Provision of Aged Care in Regional Areas

12.1 Hearing overview

12.1.1 Introduction

We held a public hearing in Mudgee, New South Wales, from 4 to 6 November 2019, which examined the provision of aged care services in regional and remote areas. It had a particular focus on aged care services in the Mudgee region. During the three-day hearing, we heard oral testimony from 20 witnesses and received written statements from 24 witnesses and 26 exhibits into evidence.

Mudgee is a town located approximately 266km north-west of Sydney, 128km south-east of Dubbo, and 192km north of Orange. It has a population of more than 11,000 people, with high percentages of people aged over 65 and 85 years when compared with national figures. The percentage of Mudgee's currently employed working-age population employed in aged care is 2.4%—higher than the national average of 2%. According to the Australian Statistical Geography Standard Remoteness Structure, Mudgee is classified as 'inner regional', but its immediate surrounds are 'outer regional'.[1]

The Mudgee Hearing particularly examined challenges arising from the conditions under which rural and regional providers operate their services, and areas and mechanisms for potential improvements, including:

- actions to improve the delivery of aged care which is financially supported through a specific State, Territory and Australian Government initiative, called the Multi-Purpose Services Program. Multi-Purpose Services are bricks-and-mortar facilities which provide co-located aged care and acute health care services in regional locations which cannot otherwise support standalone services
- the sustainability of the mainstream model of service delivery in regional and remote areas in light of workforce and cost-related challenges
- how to address issues in providing home support and care in regional areas, including inquiring into the effects of consumer-directed care in the home care program
- monitoring and development of capacity to provide home care services in country areas
- workforce supply issues and potential interventions to improve the quality and quantity of available staff.

Counsel Assisting submitted that people living in rural, regional and remote areas ought to have the same levels of access to quality and safe aged care as those living in metropolitan areas, regardless of the special challenges that exist for the delivery of aged care in these areas. We agree.

Challenges in providing aged care services in rural, regional and remote areas include 'financial viability, geographical isolation, workforce challenges, economies of scale, and emphases in policies on competition rather than collaboration'.[2] Geographical isolation presents particular challenges to home care. The workforce challenges include the recruitment and retention of appropriately skilled staff, and the need for local training opportunities.

Innovation, as well as significant reform to the existing system, is needed to address these challenges.[3] We heard about how local initiatives can create solutions tailored to the needs and circumstances of particular communities, and the importance of collaborating to ensure access and service delivery.[4] In the following sections, we outline some of the evidence we heard about these challenges, as well as how they could be addressed.

The hearing began with a case study which examined the challenges faced by a small, not-for-profit residential aged care provider in Mudgee, Pioneer House. This provided a practical illustration of the challenges associated with providing aged care services in rural, regional and remote areas, and it raised workforce, cost and funding issues. We discuss this evidence later in this chapter.

12.1.2 Multi-Purpose Services

A lack of choice and availability of health and aged care services in many regional, rural and remote areas can mean that older Australians are forced to move away from their homes and communities to access care. The Multi-Purpose Service Program is a model that delivers residential aged care and home care services in areas which might otherwise not be able to support the costs and demand of a dedicated aged care provider, by sharing space with pre-existing acute health care facilities. These shared facilities are called 'Multi-Purpose Services'. However, limitations and discrepancies associated with the model mean that, at present, Multi-Purpose Services are not being used to the degree that they could, or should be.

Multi-Purpose Services are funded by the Australian Government to deliver aged care services,with State or Territory funds for the delivery of health services and capital infrastructure.[5] These funds are pooled to ensure that there is flexibility to allocate resources where required. Multi-Purpose Services are used in rural, regional and remote areas which could not otherwise sustainably support standalone hospitals or residential aged care services.[6] As at 30 June 2018, a total of 1986 older people received residential aged care services in a Multi-Purpose Service, and in 2019 there were 180 Multi-Purpose Services across the country. This indicates an average service coverage of 11 older people each, and illustrates the small size of communities served by them.[7]

Witnesses spoke about their personal experiences, and representatives of local organisations, communities, the Australian Government, and State health departments from New South Wales and Western Australia gave evidence about the role of the Multi-Purpose Services in providing aged care services. Mr Graeme Barden, Assistant Secretary, Residential and Flexible Care Branch of the Australian Department of Health, told us that the program is regarded as 'an innovative, flexible and integrated delivery model which allows providers to adapt their service delivery to respond to the changing health and aged care needs of their community'.[8]

Shortly before the Mudgee Hearing, a review team from the Centre for Health Economics Research and Evaluation at the University of Technology Sydney, led by Professor Michael Woods, finalised the report of their review into the Multi-Purpose Services program, commissioned by the Australian Department of Health and called the Woods Review.[9] The review stated:

> Access to, and delivery of, health and aged care services to rural and remote communities has many challenges. The joint Commonwealth/State Multi-Purpose Services (MPS) Program has been a longstanding and successful response to these challenges, commencing in 1993. In 2019 there were 180 MPS, located in all States, the Northern Territory and Norfolk Island.[10]

The authors observed that Multi-Purpose Services:

> are seen to flexibly meet the locally identified health and aged care needs of individual regional, rural and remote communities through the integrated delivery of State and Commonwealth services by a single provider, a cohesive workforce and a single undifferentiated pooled fund.[11]

The review made a number of recommendations to improve the operation of Multi-Purpose Services. In this hearing, Counsel Assisting raised a number of these recommendations for consideration, including:

- addressing differences in how much people pay for Multi-Purposes Services in comparison to mainstream residential aged care services to ensure everyone can access services and there is equity[12]
- introducing uniform assessments of people's needs in determining whether people can receive residential or home care services from a Multi-Purpose Service[13]
- investing in a large amount of infrastructure improvements to ensure that all Multi-Purpose Services are able to provide a home-like environment, and that quality and safe dementia care can be delivered[14]
- ensuring that State and Territory Governments should work together to expand the Multi-Purpose Services program.[15]

There is a disparity in the fees and charges associated with living in a Multi-Purpose Service in some jurisdictions compared with those charged in mainstream residential aged care. Co-contributions are required of residents living in mainstream residential aged care facilities, but not by those in some jurisdictions where the Multi-Purpose Services program is delivered.

There is also no legislative requirement for an older person to obtain an Aged Care Assessment Team assessment as a prerequisite to accessing aged care services offered by a Multi-Purpose Service. The introduction of a uniform assessment of need would increase transparency in the decision-making process.[16]

Advantages of the Multi-Purpose Services Program

The Multi-Purpose Services program has unique benefits.

We heard about York Health Advisory Group, formed by the major provider of aged care services in the Western Australian wheat belt, WA Country Health. The advisory group is comprised of community members and health care users who:

> represent the views and opinions of the broader community to health service providers and assist clients of the health system by advocating on their behalf to achieve successful outcomes, sometimes on an individual basis but more often about the collective needs of the community.[17]

Mr Julian Krieg, Chairman of York Health Advisory Group, gave evidence that in the York region of Western Australia:

> The MPS is effective because it is compassionate flexible care delivered by locals for locals, supported by a large volunteer network that suits our low-density population and significant distances between population sites.[18]

He said the service 'is as much about the relationship between those providing the service and the client as the service itself'.[19] Mr Krieg stated that the relationships that exist in smaller regional centres mean that Multi-Purpose Services attract volunteers who provide additional services, such as driving clients to medical appointments at no cost to the system.[20] He told us that services delivered by the Multi-Purpose Service in the town of York, which is run by York Health Advisory Group, are monitored by a coordinator 'who develops a personal relationship and care plan with the clients and staff'. He said that this means the Multi-Purpose Services program can be extended 'beyond delivering "task-oriented services" to "client focused compassionate care"'.[21] However, he said that the Western Australian Government had excluded the York service from providing aged care packages, which had meant that some older people could not receive a package, or get continuity of care.

Mr Krieg was concerned that Multi-Purpose Services would become unsustainable if comprehensive aged care services were no longer offered, because the Emergency Department workload would be too low. He told us:

> You actually need an MPS model in these small country towns to…make it work. They've got to have a broad range of activities to keep the nursing staff actively involved in the community.[22]

Mr Krieg also said that relationships formed between the nurses and people receiving care is an important part of the York Multi-Purpose Service model:

> People need face-to-face contact. They need care from people. And compassionate care is more than the delivery the services. My experience is that a lot of the service providers are delivering services. So you can tick the box, they delivered the service. But is it compassionate care? There's a big difference and people in aged care need compassionate care.[23]

Mr Peter Harris's wife Beth entered the Nyngan Multi-Purpose Service in western New South Wales in late 2018, when her care needs became too great for him to continue caring for her at home. He said there is strong community involvement at the service and a sense 'that everyone knows each other within the community' means that they will act if they see something wrong.[24] Of the staff, Mr Harris said '…I know every one of them by name. I know their families. Unreservedly, I put my life in their hands.'[25] He told us that their experience is:

> a sad story, but it's also a good story and it's a good story because of the caring community we live in, because of the MPS system we have and because of the people that work in that system.[26]

Mr Harris said that Beth's entry into the service has 'given me a life and it's given Beth a life'.[27] He said:

> It feels selfish to say, but I'm happy that Beth is at the MPS [Multi-Purpose Service]...I know that Beth understands why she had to go into care and I think that she knew this was best for both of us. As complex issues continue to develop, she needs qualified support on hand.[28]

In Victoria, Alpine Health provides a range of aged care and other community and health services, including acute care, National Disability Insurance Scheme services, and child and youth services. Chief Executive Officer, Mr Lyndon Seys, explained that Alpine Health provides aged care services in the form of home care and residential aged care through Multi-Purpose Services.[29] He said that the provider's model of providing multiple services in regional communities has clear benefits, such as increased revenue through pooled funding, improved coordination and integrated services, plus greater participation in and ownership of health care by the local community.[30]

Ms Sharon-Lee McKay, Director of Rural Health Services in western New South Wales, stated that she believes Multi-Purpose Services have an advantage over mainstream residential aged care facilities because they provide acute and subacute services, and Emergency Department services, and are therefore 'part of a bigger machine'.[31] Dr Nigel Lyons, Deputy Secretary, Health Systems Strategy and Planning, Ministry of Health, New South Wales, expanded upon this:

> So the whole concept of having these services together is actually a huge advantage in having a sustainable service model for the town and enables us to provide services in a very cost effective way...Now, that creates some challenges because there are different philosophies in care delivery which we're addressing, as well, but it's been very important in creating a sustainable model of health service delivery into small rural communities.[32]

Communities where aged care services are limited or unavailable are sometimes referred to as 'thin' markets. In response to a question about whether the Multi-Purpose Services Program should be expanded upon in such markets, Dr Lyons said these services are a way 'to address providing access to care and service to communities that would otherwise not receive access to that care', but added that 'each community needs to be assessed', and 'if there is a market there, then there's a potential to use other providers'.[33]

We also heard evidence about how aspects of the Multi-Purpose Services Program could be improved, which we consider in the following sections. Each section also addresses points raised in the Woods Review.

Fees and charges

We were told about inconsistencies relating to fees and charges, which create discrepancies between the Multi-Purpose Services Program services and mainstream aged care services. As well as being a focus of the 2019 Woods Review, this issue was addressed previously by Mr David Tune AO PSM in the 2017 Tune Review. The review concluded that this is largely due to variations in government policy regarding accommodation fees and payments between the two services.[34] Further, according to this review:

> Feedback from some providers suggested that MPS [Multi-Purpose Service] and mainstream residential and home care services in the same location have become competitive rather than complementary.[35]

Ms McKay gave evidence consistent with this observation. She said that in her experience, competition can arise in areas where there is a Multi-Purpose Service and a pre-existing residential aged care provider, such as Gulgong, because:

> a lot of the population would probably prefer to come into an MPS [Multi-Purpose Service] where there's no income and asset testing, there's no bond or deposit and it's just the daily rate that's set by the State.[36]

Ms McKay said that the lack of means testing creates a tension with other residential aged care providers, which can be unfair.[37] When asked about whether State-wide uniform means testing for contributions would be implemented in the Multi-Purpose Services program in New South Wales, Dr Nigel Lyons said, 'I think we need to tailor our approaches to the fact that it [service provision] is different in different environments'.[38]

People receiving care from a Multi-Purpose Service can also be disadvantaged financially by the current fee structure. For example, these people are unable to access financial assistance for their care fees, unlike people receiving care in mainstream residential aged care.[39]

Funding, capital and infrastructure

Funding models can prevent the Multi-Purpose Services program from consistently and most effectively meeting care needs.

Mr Barden agreed that the funding model underpinning the Multi-Purpose Services program 'has not kept pace with changes in funding to mainstream residential services'.[40] He said that this has meant Multi-Purpose Services have not received funding increases commensurate with those for mainstream residential services.

Many Multi-Purpose Services face infrastructure issues. They are commonly established in communities with pre-existing local hospital networks providing sub-acute care.[41] They have traditionally been set up in small, ageing hospitals which must compete with metropolitan areas for capital funds for hospital refurbishments or developments.[42]

The Australian Government currently provides capital funding grants to aged care providers, but not to Multi-Purpose Services, with the States and Territories being responsible for funding this aspect of these services.[43]

Capital funding is important to ensure that Multi-Purpose Services have infrastructure that meets contemporary standards. Without the appropriate capital infrastructure, service delivery can become disrupted as these services struggle to provide the necessary care for recipients with escalating needs.[44]

Mr Seys stressed the importance of capital funding. He referred to a 'low care' Multi-Purpose Service in Bright, Victoria, which had not received any capital funding for infrastructure for the last 20 years.[45] He said that this has meant that 'critically sick' people have had to leave that service to go to another hospital when 'their needs have gone well beyond our capacity to deliver…We're not meeting our obligations as an MPS in that environment'.[46] Mr Seys said that five residents with escalating needs associated with dementia had been transferred out of the 'low care' Multi-Purpose Service, because the service was unable to continue providing care.[47]

Mr Seys agreed that the Australian, and State and Territory Governments should work together to establish a capital grants program to rebuild or refurnish older Multi-Purpose Service facilities to bridge this gap.[48]

12.1.3 Ensuring a home-like environment

The Aged Care Quality Standards that started on 1 July 2019 include Standard 5 (3), which relates to the organisation's service environment:

> (a) the service environment is welcoming and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function
>
> (b) the service environment:
>
> (i) is safe, clean, well maintained and comfortable; and
>
> (i) enables consumers to move freely, both indoors and outdoors;
>
> (c) furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.[49]

The Australian Commission on Safety and Quality in Health Care is responsible for issuing the National Safety and Quality Health Service Standards for the accreditation of acute and sub-acute health care services. Multi-Purpose Services must meet the National Safety and Quality Health Service Standards for both the acute and aged care sections of the service.[50] Multi-Purpose Services have been required to meet the Aged Care Quality Standards from 1 July 2019.[51]

The Australian Commission on Safety and Quality in Health Care issued a discussion draft for an Aged Care Module, in July 2019, which would supplement the National Safety and Quality Health Service Standards as they apply to Multi-Purpose Services.[52] The purpose of the Aged Care Module is to propose standards that address six gaps representing those aspects of the new Aged Care Quality Standards that are not addressed by the National Safety and Quality Health Service Standards. One such gap, in relation to an organisation's service environment, is addressed by the Aged Care Module's proposed Standard A4:

> The health service organisation provides a welcoming and homelike environment that optimises consumer's sense of belonging and interactions, with support to access indoors and outdoors.[53]

Dr Lyons agreed that to meet the requirement for a home-like environment, Multi-Purpose Services may require further infrastructure investment. Dr Lyons said that the New South Wales Ministry of Health has made a commitment to such investment.[54]

Ms Margaret Anne Denton, Chief Operating Officer of the WA Country Health Service, also acknowledged shortcomings in relation to home-like environments in Multi-Purpose Services in Western Australia. She said that:

> in today's standards, we probably would struggle in a number of cases to fully address the standards required. I can think of numerous facilities where, you know, a whole ward has been converted into a residential aged care wing and it's lovely, but it doesn't meet standards so, you know, bathroom infrastructure is shared, people don't have their own outdoor areas, a whole range of things in terms of security mechanisms for people with dementia who may be wandering.[55]

Ms Denton said that while her services do what they can with limited State funds, there is a role for the Australian Government to support the delivery of aged care, including through a greater investment in infrastructure upgrades of Multi-Purpose Services.[56]

Mr Barden said that the variability of infrastructure funding between States and Territories 'may create barriers to expanding or establishing MPS', including that 'availability of capital funding can result in delays in making MPS facilities operational, expanding existing services or establishing new services'.[57] He agreed that the Multi-Purpose Services program could be further enhanced to address the challenge of 'delivering services in a home-like environment in a clinical setting'.[58]

12.1.4 Workforce

Common issues often arise regarding the delivery of aged care services that can become compounded when they are translated into regional, rural and remote areas. This is particularly true of workforce issues, where challenges associated with recruiting, training and retaining staff are exacerbated by isolation, and sometimes vast distances between people receiving care. Addressing these issues involves flexibility, greater support, and new ways of problem-solving.

A number of witnesses spoke of the difficulties that providers of aged care services in rural, regional and remote areas have in training, recruiting and retaining staff. These difficulties were also illustrated in the Pioneer House Case Study, discussed later in this chapter.

We also heard evidence about how some innovative models have been developed in local communities to address these challenges. The chapter on aged care in regional, rural and remote areas, in Volume 3 of our Final Report, considers how these challenges should be addressed by the aged care system.

12.1.5 Challenges in regional, rural and remote areas

A number of witnesses gave evidence about the workforce challenges faced in regional, rural and remote areas by both home and residential aged care providers. These can arise or be exacerbated by travel distances. Ms Helen Miller, then Head of Operations Aged and Communities at LiveBetter Community Services, said:

> Sick days in rural areas, where there is one staff member, often results in us having to send staff from a nearby larger centre, resulting in hundreds of dollars of associated travel costs. During school holidays we are often unable to respond due to distances involved...We employ many casual staff to fill unplanned absences; however, the physical location is often problematic, leading to increased travel time and cost.[59]

The General Manager Branch Operations of Home and Disability Services (Independent and Assisted Living Division) at Australian Unity, Mr Dean Chesterman, explained that the organisation has challenges in recruiting and retaining appropriately skilled staff members in rural, regional and remote areas. He said, for example, when a staff member resigns, they cannot be easily replaced by another care worker in the same region, and this can impact on service provision.[60] Mr Chesterman said that for recipients of aged care services in remote areas, services can be even more limited and consumers are likely to experience delays in accessing home care services, as well as primary health care.[61]

We also heard evidence that reliable funding is important to enable providers in rural settings to attract and retain a stable workforce. Dr Rachel Winterton, a research fellow at the John Richards Centre for Rural Ageing Research, and convenor of the Regional, Rural and Remote Special Interest Group within the Australian Association of Gerontology, told us:

> block funding is integral in ensuring that a secure workforce can be provided in rural settings, which is integral not only from the perspective of enabling people to be recruited and retained, particularly from outside of rural communities, but also in terms of the continuity of care for older people in these regions, in terms of enabling them to build trust and relationships with their service providers which is really integral…where care needs change and all that sort of thing.[62]

In written submissions in reply to Counsel Assisting's submissions, the Australian Government acknowledged that 'the recruitment and retention of adequate, skilled aged care staff in rural and remote areas is a challenge to delivering aged care services in these communities'.[63]

Linked to the difficulties associated with the recruitment of staff are often limited training opportunities for aged care workers in rural, regional and remote areas. Ms McKay told us that in her experience, staff need to travel to larger regional centres, such as Dubbo, to participate in training for assistant-in-nursing or Certificate III qualifications.[64]

Ms Miller stated that to improve workforce issues, there should be sustained, attractive pathways presented for people wanting to work in aged care which involve continued training and development opportunities.[65]

12.1.6 Addressing workforce challenges

There are some initiatives that have been adopted to address workforce issues at the local level.

Mr Seys explained how Alpine Health in Victoria invests in its own staff development through the Initial Registration of Overseas Nurses (IRON) Project. That project, established by Alpine Health, involves bringing nurses from overseas to Victoria and training them through an in-house education program. This has become a business that has generated surplus revenue for the organisation.[66] Mr Seys said the project was the basis for building their own Registered Training Organisation, the Alpine Institute, which prepares 'our community for employment in the health and aged care industry'.[67]

Mr Seys told us that prior to establishing the Alpine Institute, Alpine Health struggled to recruit sufficient nursing and other staff members to meet the needs of existing and new service delivery.[68] He said the program 'actually proved to be a really important part of our future. It gave us certainty in our workforce and…it helped us…improve our service delivery models'.[69]

Mr Seys told us that 'today all Alpine Health staff have a post-secondary qualification and we now produce our own enrolled nurses for hospital, aged care and community services'.[70]

The Loxton and Districts Health Advisory Council Incorporated funds a scholarship and training program for people living in the Riverland, South Australia, to complete a Certificate III in Individual Support (Ageing and Home & Community Care).[71] The program operates from the local hospital which has an aged care unit. Ms Sally Goode, Presiding Member of the Advisory Council, explained that the body uses community funding to pay the balance between the State Government subsidy and the cost of the course, meaning that students have no out-of-pocket expenses for it. She told us:

> The idea for a local and onsite training program and scholarship was borne out of a need to address workforce shortages and from that an idea, that we could actively contribute to social change and how the community views aged care, through the promotion of the training.[72]

Ms Margaret Denton spoke about a graduate nurse program run by the WA Country Health Service. She said that as nurses graduate from university, the Country Health Network offers them an 'extended period of time whilst they're working to further their upskilling and development. That's our graduate nurse program'.[73] There are now 120 newly-graduated nurses enrolled in this program.

In instances where the current system is failing to meet the needs of communities, community support can be integral to the success of these training programs. Mr Seys stated:

> We…needed community support…we have extraordinary support from our communities and…where we did need some additional capital we went to the Bright Hospital Op Shop and asked them to help…that's how it's possible. We work our relationships across the community. We work our relationships across our other health services, and our students all become employed.[74]

Ms Goode doubted that without community involvement and funding, the program would work as well.[75] She said:

> You have to have community involvement. The community funding gives the community ownership of the program. It enables them to feel proud of the staff that they've got in aged care because they've actually helped with their training and they know they've got the right people working in aged care.[76]

The success of particular initiatives at a local level is one thing, but the issue of addressing workforce challenges at the national level is another. Dr Winterton drew our attention to the recommendations made in the Australian Association of Gerontology's report of July 2019 from the Regional, Rural and Remote Special Interest Group workshop, entitled *Addressing aged care workforce issues in rural and remote Australia*.[77]

One of these recommendations was for the development and implementation of a national strategy to ensure an adequately trained and skilled aged care workforce across rural and remote Australia.

Counsel Assisting advocated that the Australian Government should establish mechanisms aimed at increasing the number of qualified aged care workers in rural areas experiencing workforce shortages.[78] They proposed that this could include three strategies:

- a targeted scholarship program
- a conditional scholarship program
- assisting rural providers to become Registered Training Organisations.

Dr Winterton said she thought training scholarships in rural, regional and remote areas would be effective as a way of addressing issues around remuneration and making sure that people were trained in the contexts in which they would be working.[79] However, Dr Winterton emphasised that the scholarships alone would not be enough:

> I think that if we are going to be pushing for students to be trained in rural regions, in residential aged care, community aged care, there—it's critical that these providers are supported to provide that training. The research evidence…suggests this is a sector experiencing significant pressure in terms of workload. So they will need to be supported to actually support these students.[80]

These issues are considered further in the chapter on aged care in rural, regional and remote areas, in Volume 3 of this Final Report.

12.1.7 Availability and accessibility of home support and care

Accessible home care services in regional, rural and remote areas can be a vital and only lifeline for older Australians who want to continue to live independently in their homes and communities. However, we heard evidence about issues with the availability and accessibility of aged care services provided in the home faced by those living in these areas, including the absence of nearby service providers, and long waiting times for packages. We also heard about the unique difficulties that home care providers in these areas face in ensuring the viability of their services.

Mr Barden outlined the following statistics on home support and home care in inner regional, outer regional, remote and very remote areas:

- As at 30 June 2019, 33,804 people were receiving services from a Home Care Package, while 31,381 people were in the Home Care National Prioritisation System and were not receiving care through an interim level Home Care Package.
- Between 1 July 2018 and 30 June 2019, 306,867 people accessed the Commonwealth Home Support Programme.[81]

Unmet demand for home care is estimated from the numbers of people waiting for a Home Care Package, broken down by region.[82] We received no evidence that any analysis has been conducted by the Australian Department of Health on the supply of, or unmet demand for, particular services that can be purchased with Home Care Package funds in particular regions, or at all.[83] This is both alarming and disappointing.

Dr Winterton advised us that there is limited availability of home care services, particularly for those requiring high care, in rural and remote areas.[84] She noted that a lack of availability of home care services has implications, including the early admission to residential care in situations where the assessed level of home care is not available.[85] Ms Attridge said there is an inverse correlation between the distance from a major town in which a recipient of care services lives, and the number of aged care providers that are available to choose from.[86]

Mr Phillip and Mrs Sue Dunlop, who live on a farm in a small country town three hours from Mudgee, spoke about the challenges they had experienced in finding a provider prepared to travel to their rural property to deliver care. Mrs Dunlop told us:

> I don't want to move. I love having animals around me. But it is so, so hard when you can't get any help out there.[87]

The Dunlops agreed that keeping people in their own homes longer, via packages, is a good idea.[88] However, with limited providers servicing a regional location, we heard that people receiving home care are more vulnerable to interruptions in their care. After their home care was suspended during a dispute with their provider, Mr Dunlop told us that Mrs Dunlop was left with virtually no support.[89]

Unlike the block-funded Commonwealth Home Support Programme, providers of Home Care Packages are under no contractual obligation to provide services in a particular area.[90] The geographical coverage of services under the Home Care Packages Program does not therefore necessarily extend to all parts of Australia. Equally worrying is that data that shows whether Home Care Package providers deliver services in specific locations is not available to the Australian Department of Health.[91]

Mrs Sue Hood of Dubbo shared her experience of trying to get assistance for her husband, Alan, after he experienced a rapid decline in his health. Once she had received the recommendation from her husband's geriatrician that he needed full-time care, she told us that she 'still couldn't access any services'.[92] Eventually, Mrs Hood received a letter notifying her that her husband had been approved for a Level 4 package. However, she told us 'we weren't given any direction in the letter about where to go to access these things, or about what to do next. It was very difficult'.[93] Mrs Hood said:

> I would have liked to have taken him back home, but I had no option but to put him into [an] aged care facility, because I couldn't get a package.[94]

Mr Chesterman, General Manager Operations of aged care provider Australian Unity, stated that he had seen customers who had to move hundreds of kilometres from their community because they did not have access to the aged care services to continue living at home.[95]

Ms Jaclyn Attridge, Head of Home and Community Care Operations, Uniting NSW.ACT, told us that the impact of long waiting times to access a Home Care Package is amplified in regional and remote areas. A person's inability to maintain independence at home can result in them having to move away from their community and support network to access

care.[96] Ms Attridge told us that the long waiting times for services are making people frailer far more quickly.[97] We note with concern that she also said, 'We are acutely aware of circumstances where the person has passed away waiting for a HCP [Home Care Package] to be assigned'.[98] Mr Chesterman said that to address long wait times for access to services, more responsive mechanisms that allow consumers to access funding in their time of need should be considered.[99]

Mrs Hood told of the difficulty she experienced while trying to access care assistance for her husband in a regional location. She said, 'I discovered that you can't get respite around Dubbo. It felt like the facilities don't want to know you'.[100] She said that after unsuccessful attempts to obtain assistance, she was told 'the only way I was going to get any help was to ring an ambulance and get him admitted to hospital'.[101]

Mr Barden stated that average occupancy rates in mainstream residential aged care in each of the regional and remote areas for 2018–19 were:

- inner regional—91.1%
- outer regional—90.0%
- remote—71.9%
- very remote—71.9%.[102]

Based on Australian Bureau of Statistics population projections, the Australian Department of Health expects that the demand for residential care and home care in regional and remote areas will increase by about 41% by 2029, from 30 June 2019.[103] Mr Barden said that to ensure that adequate services will be available to meet this increased demand, the Department should undertake an assessment of need prior to running the aged care allocation rounds.[104] He stated that this assessment is conducted by the Department 'typically annually, predicated on the decision to make places available'.[105]

Mr David Hallinan, Acting Chair of the Aged Care Group of the Australian Department of Health, said that there is 'good and improving cooperation around data sharing and around the sorts of information that you would use to make those projections' between the Australian Government and the States and Territories to enable the Department to undertake these assessments.[106] However, he acknowledged that the data sharing is 'not yet perfect' and remains 'a work in progress'.[107]

12.1.8 Service viability and costs in rural and regional settings

The residential care and home care programs both include a Viability Supplement, which aims to improve the financial position of smaller, rural and remote residential care facilities and home care services that incur additional costs due to their location. It is partly based on the Modified Monash Model, which defines whether a location is city, rural, remote or very remote. Levels 4 to 7, which attract the Viability Supplement, apply to areas with a population of less than 15,000.[108] This means that the Viability Supplement is available

to aged care service providers who operate in areas with very small populations.[109] The evidence in the Mudgee Hearing suggests that there is some doubt as to whether the Viability Supplement is adequate.

The Aged Care Financing Authority has expressed concerns about the financial performance and viability of providers in regional and remote locations.[110] In its *Seventh Report on the Funding and Financing of the Aged Care Industry* (July 2019),[111] the authority reported that in 2017–18:

> 44 per cent of residential care providers reported a loss compared with 32 per cent in 2016-17. There was a very significant decline in the financial performance of regional residential care providers in 2017-18 and, on average the performance of not-for-profit providers dropped significantly more than for-profit providers.[112]

In the Pioneer House Case Study, we received evidence of the challenging operating environment and financial performance pressures that a small rural residential aged care provider can face. We also heard from a panel of providers of home and community care. The panel spoke about some of the challenges associated with the delivery of home care services in regional, rural and remote areas, including the additional cost associated with providing aged care services in these areas, and the absence of funding to address these additional costs.

An important issue in the panel's evidence was the impact of travel and transport costs on providing aged care services to people who live in rural, regional and remote areas. The panellists described how the available funds for Home Care Packages are reduced by the costs of a carer's travel or cost of freight for equipment delivery.[113] Ms Attridge stated:

> It is clear that people who live out of town and require assistance to attend appointments, do shopping or access the community will pay a higher proportion of their available package funds on travel related expenses.[114]

In addition to the costs of fuel and staff time associated with travelling greater distances to attend to clients, Ms Attridge, Mr Chesterman and Ms Miller described needing to purchase larger vehicles suitable for travelling long distances on unsealed roads, needing to maintain a greater number of fleet cars, and the higher costs associated with vehicle breakdowns and repairs.[115] Tradespeople, such as those providing home modifications, may charge travel time, including to provide a quote.[116] Ms Miller told us that in instances where service providers cannot recruit locally, they may broker to another regional provider, who may still be located some distance away from the person needing care.[117] She said that people receiving aged care often bear the impact of additional travel costs for a staff member to travel to them.[118] The limitations of delivering services to more remote areas can then result in increased costs to a person's Home Care Package, ultimately reducing the funding available for actual care needs.[119]

In light of travel requirements, the costs of providing aged care services in rural, regional and remote areas differs to that in metropolitan areas. Ms Attridge gave examples of how the particular features of providing rural, regional and remote services affect the wage costs of home care providers. For instance, travel time and remoteness between a provider's service locations make it difficult, or impossible, to share resources from service

to service, requiring more self-sufficiency to be built into local teams.[120] Ms Miller said that to attract staff to regional and remote areas, providers may offer incentives, such as paying for relocation costs.[121]

Mr Chesterman said that to address the issue around equitable care in rural and remote areas, 'there needs to be greater recognition of the differential costs in delivering services in—particularly in remote and very remote areas of Australia'.[122] According to Mr Chesterman, consideration needs to be given to the adequacy of Viability Supplements to ensure that they 'more appropriately address those cost differentials in delivering services'.[123] Mr Barden acknowledged that the higher costs of service delivery in regional and remote areas, coupled with uncertainty of demand and irregular incomes, heightens risks to the financial viability and sustainability of aged care service delivery in regional areas.[124] He suggested that flexible, collaborative and pooled funding arrangements may assist in meeting this and other challenges.

Counsel Assisting proposed that there be a review of the costs faced by rural aged care providers and a commensurate increase in their funding.[125] The Australian Government agreed that:

> it is important to have a clear understanding of the costs faced by regional, rural and remote aged care providers and to use that as an evidence base to reconsider the current aged care funding model.[126]

As already mentioned, that funding model includes the Viability Supplement. The purpose of the viability supplement is:

> to improve the financial position of smaller, rural and remote aged care services that incur additional costs due to their location and are constrained in their ability to realise economies of scale due to smaller numbers of care recipients.[127]

The Viability Supplement for residential care providers increased by 30% from March 2019 to the present, but there was no corresponding increase for home care providers.[128] Mr Hallinan stated that the Viability Supplement had been 'increased on numerous occasions', but he was unaware of any detailed cost study to support the basis of the Viability Supplement.[129] He agreed with Counsel Assisting that there was a case for cost studies to be performed on an 'annual' or 'regular basis' to support the level of the Viability Supplement paid to eligible services, and that it 'makes sense' that the studies be performed by an independent authority along the lines of the Independent Hospital Pricing Authority.[130]

12.1.9 Collaboration in rural, regional and remote areas

In areas characterised by thin markets and limited options, traditional ideas about the impact of market competition do not provide solutions for isolated older Australians who are unable to access aged care services, or service providers who are spread too thinly as they attempt to deliver care to a geographically broad area. Instead, collaboration is necessary to ensure service delivery in rural, regional and remote areas. Mr Chesterman

said that there is a need and a place for collaboration between home care providers in small communities. That is because:

> it allows providers that have different specialisations or capabilities to complement services of other providers in those communities and really what communities need when you think about access is that multidisciplinary capability set that's accessible in those communities and I don't know that one provider could ever really do that.[131]

Ms Attridge said that in rural, regional and remote areas, it is better for providers to collaborate, rather than compete.[132] However, she also told us that the deregulation of community care through Home Care Packages has hindered the ability of providers to collaborate. She said that, prior to deregulation, providers were better able to collaborate because 'there wasn't the competition for the packages back in block funding'.[133] While she acknowledged that this model still had faults, Ms Attridge said that:

> you would talk to other providers if you had a consumer that was in need that you couldn't meet the need, you would pick up the phone and talk to other providers to see what options were available. There was good networking opportunities there that don't kind of exist the way that they used to anymore…sector development looks different now with the competition.[134]

In her witness statement in relation to the limits of relying on competition to deliver services in rural, regional and remote areas, Dr Winterton cited the Australian Association of Gerontology's report, entitled *Towards an Action Plan for Aged Care for Rural and Remote Australia*.[135] This states that the current market-driven approach, which relies solely on competition between providers, may ultimately mean that in particular regional or remote areas, there are insufficient services to meet care needs at all, let alone offer a choice in who is delivering those services.[136]

According to Dr Winterton, collaboration could be expanded further in rural, regional and remote areas through a 'rural workforce centre model'.[137] Under such a model, separate service providers would collaborate to share costs and create a pooled workforce of qualified workers.[138] That would address some of the high costs associated with delivering care in rural, regional and remote areas like travel and administrative costs.

12.2 Case study

12.2.1 Pioneer House

Pioneer House Living Ltd (Pioneer House) is the approved provider of a not-for-profit residential aged care service in Mudgee, originally established in 1964 after concerned local citizens identified the need for an aged care facility in the district. The facility was reopened in 2008, after a major refurbishment in June 2007 with services available for 81 residents, including general and dementia care areas.[139]

The Pioneer House Case Study did not involve any allegations against the provider, or its staff, management or board of directors. The case study was conducted so that we could gain an understanding of the challenging operating environment faced by the provider.

Introduction

This case study examined the challenges faced by Pioneer House from January 2018 to September 2019, and the causes of its non-compliance during that period with the Accreditation Standards for residential aged care services.[140] Counsel Assisting submitted that the purpose of the case study was to test a series of propositions relating to the challenges faced by not-for-profit, community-based aged care providers in rural areas.[141]

The evidence included:

- the statement of Allan Codrington, Chair of the board of Pioneer House[142]
- the statement of Tania Sargent, a registered nurse and Deputy Director of Nursing at Pioneer House[143]
- the statement of Prudence Dear, a registered nurse and the nurse consultant engaged by Harcourt Aged Care Advisors Pty Ltd to provide nurse advisor services to Pioneer House during the period March 2019 to June 2019[144]
- the statement of Dr Robyn Daskein, acting Chief Executive Officer and Director of Nursing at Pioneer House for the period 9 September 2019 to 29 November 2019[145]
- the statement of Catherine Brown, a nurse practitioner and contractor to Aged & Community Services Australia who provided services to Pioneer House during the period April 2019 to August 2019[146]
- the statement of Michelle Harcourt, a registered nurse and Director, Harcourt Aged Care Advisors Pty Ltd, appointed as Nurse Advisor to Pioneer House during the period March 2019 to September 2019, following the imposition of sanctions by the Australian Department of Health on Pioneer House on 27 February 2019.[147]

In addition, oral evidence was given by Allan Codrington, and registered nurses Tania Sargent and Prudence Dear.[148] On 20 November 2019, Counsel Assisting's post-hearing submissions were provided to us, and to all parties with leave to appear associated with the Pioneer House Case Study.[149] We received written submissions in reply from the Australian Government on 4 December 2019.[150] Pioneer House did not make written submissions in reply. A short supplementary statement, which has been treated as a post-hearing submission, was received from Mr Codrington.[151]

Overview

This section sets out the timeline of the events leading up to, and the circumstances surrounding, the regulatory action taken in relation to Pioneer House in 2019.

2018 finding of non-compliance

On 30 January 2018, assessors from the Australian Aged Care Quality Agency carried out a reaccreditation audit at Pioneer House. Pioneer House was found to have not met expected outcomes 1.1 (continuous improvement) and 1.6 (human resource management).[152]

In about January 2018, Pioneer House increased its roster by one assistant-in-nursing on the evening shift.[153] In about February 2018, there was an increase of one assistant-in-nursing in each of the morning and night shifts.[154] In response to a question by Counsel Assisting about whether the increases in staff were in response to the reaccreditation audit, Ms Sargent stated:

> I think it was probably partly in response to that, but I think possibly also in response to what our staff were telling us…our assistants in nursing, say, for example, on night shift, it was difficult without the extra night shift AIN [assistant-in-nursing], the RN [registered nurse] was caught up, you know, manning one of the [w]ings, for a better word, while they had their breaks and that sort of thing. So it allowed a floater to—to go around and help in the different areas. So—but I think it was probably partly in response to the audit and partly just in response to what the staff were telling us anyway.[155]

On 13 March 2018, the Australian Aged Care Quality Agency decided to reaccredit Pioneer House for a truncated period of two years, rather than three, on the basis of non-compliance with outcomes 1.1 (continuous improvement) and 1.6 (human resource management). Pioneer House was required to submit a revised plan for continuous improvement by 28 March 2018.[156]

Mr Codrington gave evidence that the board of Pioneer House was aware of the reduced accreditation period as a result of the not met findings. He told us that the then Chief Executive Officer / Director of Nursing indicated that accreditation for a reduced period was expected as a result of these findings.[157] Mr Codrington said:

> In hindsight, should it have raised bigger awareness that it was a potential problem? In all probability it should have been. But…our accreditation standard was—was in pretty good condition prior to that.[158]

As part of the actions taken by the board to address the not met findings, it engaged an external firm, Insync Surveys Research Consulting (Insync), to undertake a series of staff surveys at Pioneer House in March 2018.[159] Mr Codrington stated that the board felt there was an 'apparent disconnect with staff' and measures were put in place 'in an endeavour to make sure that we could bring our staff together as one'.[160]

On 3 and 4 May 2018, a series of focus groups and interviews were conducted by Insync in which staff members of Pioneer House identified areas for improvement in relation to the clarity of staff roles, values for actions and behaviour, staffing levels and training, communication between management and staff, and respect and recognition.[161]

Mr Codrington confirmed that the board was aware of the contents of the Insync report and was quite concerned by some of the comments made by staff. He said that:

> there was a lot of fairly damning information come out in that Insync report. The board took it very seriously to the point that we were pretty dismayed that some of our staff would consider it necessary to make those comments.[162]

By May 2018, Pioneer House was regarded as compliant by the Australian Aged Care Quality Agency.[163]

Resident Mr 'UI'

A person (assigned the pseudonym, Mr 'UI') started as a respite resident at Pioneer House on 16 July 2018.[164] Mr UI was living with dementia. Ms Sargent said that during his stay as a respite resident, Mr UI displayed 'challenging aggressive behaviours' which impacted on some of the other residents at Pioneer House.[165]

On 30 August 2018, Pioneer House arranged for a consultant from Dementia Support Australia to assess Mr UI and provide some 'strategies to help manage Mr UI's behaviours and help him settle in'.[166]

On 1 September 2018, Mr UI became a permanent resident of Pioneer House.[167] Ms Sargent gave evidence that despite Mr UI's challenging behaviours, she thought that he may just need a 'settling-in period', with review by his general practitioner. Initially, she was not concerned about Pioneer House's ability to care adequately for Mr UI.[168]

However, Mr UI's behaviours continued to present challenges for the staff at Pioneer House. These challenges were reported to the board in a series of reports by the Chief Executive Officer / Director of Nursing, from late 2018 to early 2019.[169] Pioneer House continued to engage with Dementia Support Australia in relation to strategies to manage Mr UI's behaviours. Ms Sargent said that Dementia Support Australia provided the staff with strategies to try with him, some of which helped his behaviours 'at times, but not fully'.[170]

Dementia Support Australia proposed to fund a short period of one-on-one care for Mr UI. However, Ms Sargent said that the implementation of that strategy was difficult for Pioneer House, which was already short-staffed and experiencing challenges filling its roster. She said that 'we would have put someone one-to-one there but it may have meant somebody else in the facility—another area did not have as many staff as they should have'.[171]

Reduction in staff levels

By 9 January 2019, the management of Pioneer House had decided to reduce staff levels in the morning and evening shifts by one assistant-in-nursing to save costs. Mr Codrington stated that the board was 'aware that it was going to happen'.[172] However, board members were asked not to attend the staff meeting at which the changes were announced as it was a 'management matter'.[173]

Minutes of the staff meeting record that the Chief Executive Officer / Director of Nursing 'spoke to the inability to sustain the rosters as they are'.[174] The minutes record that the proposed roster changes were to: reduce one assistant-in-nursing on the morning and evening shift (from nine assistants-in-nursing to eight), have two endorsed enrolled nurses on the morning shift (6.30am–3pm) and '1 x B shift either 10–6.30pm or 11–5.30pm)', with only one endorsed enrolled nurse on all afternoon shifts. The minutes record that staff were told that 'No-one will lose hours as we believe in our commitment to staff, however we will not be recruiting to positions that are no longer on the roster', and that the 'aim of the efficiencies will decrease the wages expenses of the facility by a forecasted $350,000pa'.[175]

Ms Sargent agreed with Counsel Assisting that 'in effect, although the roster was reduced in January 2019, the actual number of staff present may not have substantially changed' because Pioneer House had 'already been working short-staffed'.[176] Despite this, Ms Sargent remained concerned about staffing because Pioneer House was 'having trouble filling the roster as it stood anyway. We weren't getting the full complement'.[177]

On 14 February 2019, Pioneer House's Finance Manager submitted the January 2019 Finance Report to the board. It stated:

> Nursing wages are 50K below Plan for the rest of the year. This is based on the new Care rosters introduced on 1st February which had a reduction of 2 AINs [assistants-in-nursing] and 1EN [enrolled nurse] from the previous rosters.[178]

The report also stated that Pioneer House was providing 3.37 care hours per resident per day, which was 'very close' to the benchmark 'mean care hours per day per resident' for not-for-profit providers of 3.30 hours. The main issue identified was that the amount assessed under the Aged Care Financing Instrument remained at $163.92 'versus a $173.45 mean for NFPs' [not-for-profits].[179]

Further compliance issues

From 20 to 21 February 2019, the Aged Care Quality and Safety Commission conducted an assessment contact, which found that Pioneer House did not meet at least five expected outcomes, including expected outcome 1.6 (human resources management) and expected outcome 2.13 (behavioural management).[180]

The Commission's report records that there were unfilled assistant-in-nursing shifts nearly every day during the period from 15 January 2019 to 21 February 2019, and also unfilled enrolled nurse shifts.[181] Ms Sargent accepted that the list was consistent with the short-staffing that Pioneer House was experiencing during that period, and reflected the difficulties experienced by Pioneer House in filling even its reduced roster.[182]

On 27 February 2019, the Secretary of the Australian Department of Health imposed sanctions on Pioneer House on the basis that there was an 'immediate and severe risk to the safety, health or well-being of care recipients' there.[183] Areas of critical deficiency were identified as: human resource management; behavioural management; and regulatory compliance. Factors contributing to the critical deficiencies included 'a lack of systems and processes to support the management of challenging and aggressive behaviours'.[184]

Conditions imposed by the sanction included restriction of payment of 'any further subsidy for new care recipients until the sanction period has ended'. Additionally, Pioneer House was required to appoint an advisor to assist with its compliance, and provide training for its officers, employees and agents.[185]

To comply with the sanction conditions, on about 6 March 2019, Pioneer House appointed Ms Michelle Harcourt, Director of Harcourt Aged Care Advisors Pty Ltd, as its Nurse Advisor. Ms Harcourt was engaged as Nurse Advisor until the sanctions expired on 27 August 2019.[186]

Ms Harcourt retained registered nurse, Ms Prudence Dear, as a nurse consultant, to assist her to perform the role of Nurse Advisor for Pioneer House.[187] Both Ms Harcourt and Ms Dear lived interstate. Ms Dear commenced on site at Pioneer House on 11 March 2019. From that time until 26 June 2019, Ms Dear was generally present at Pioneer House four days per week.[188] During the term of the engagement, Ms Harcourt spent about 27 days on site at the facility.[189]

In March 2019, Pioneer House engaged Ms Catherine Brown, a nurse practitioner consultant specialising in psychogeriatrics and cognition, to review the Pioneer House environment, lifestyle program and behaviour management practices, and to provide training for staff in dementia, responsive behaviours and delirium.[190] Ms Brown attended Pioneer House two days per month from April to August 2019, inclusively.[191]

On 26 March 2019, the Commission issued a notice of consideration of serious risk to Pioneer House in relation to the care and behaviour management of three residents living with dementia, including Mr UI. Pioneer House responded to the notice on 28 March 2019, outlining the various strategies that had been implemented in an attempt to manage the behaviours of the three residents.[192]

On 8 April 2019, the Commission decided not to revoke Pioneer House's accreditation following a review audit conducted on 4 to 6 March 2019, which found that Pioneer House met only 23 of 44 expected outcomes. The Commission varied Pioneer House's period of accreditation to less than one year, from 8 April 2019 to 8 January 2020.[193]

On 8 and 9 April 2019, Ms Brown attended Pioneer House and recommended strategies and action plans for improving dementia care and behaviour management of Pioneer House residents using the results of an 'Environmental Audit Tool – High Care' review.[194] She concluded that one of the factors impeding the delivery of quality and safe care at the facility was that 'the architectural design of both dementia units was inherently limiting'.[195] Ms Brown also concluded that 'Pioneer House's location in rural New South Wales significantly affected the ability to source suitable leisure and lifestyle staff', which was another factor that affected its ability to deliver quality and safe care to residents.[196]

On 26 April 2019, the Commission decided that Pioneer House had not complied with expected outcome 2.13 (behavioural management), such that it placed the safety, health or wellbeing of Mr UI and one other resident at serious risk.[197]

The Commission undertook a further assessment contact at Pioneer House on 3 and 4 July 2019. In its response dated 17 July 2019, Pioneer House expressed the belief that it had done 'everything possible' in relation to the care of Mr UI, and that it had 'exhausted all…options' in attempting to locate alternative accommodation and assessment for him. Pioneer House contended that it should be found to have met expected outcome 2.13 because Mr UI's behaviours had 'substantially decreased, and the intensity of his episodes of reportable assaults has diminished', with no further reportable assaults and only one incident involving Mr UI or any other resident at the facility since 3 July 2019.[198]

On 25 July 2019, the Commission decided that Pioneer House had addressed 19 of the 21 previously not met expected outcomes, but continued to not meet expected outcomes 2.13 (behavioural management) and 3.7 (leisure interests and activities).[199]

On 12 August 2019, the Nurse Advisor, Ms Harcourt, wrote to the board in relation to the likely status of Pioneer House when sanctions were due to expire on 27 August 2019, noting that two outcomes remained unmet.[200] Ms Harcourt expressed confidence that Pioneer House would be compliant with the old Accreditation Standards, but was less confident that it would be compliant if required to meet the new Quality Standards.[201]

Ms Brown's engagement with Pioneer House ceased in May 2019 and Ms Harcourt's engagement ceased in September 2019. Mr Codrington stated that the cost to Pioneer House of the sanctions was '$482,000 in lost revenue because of an inability to accept new residents and $452,000 for the actual monies paid to the Advisor'.[202]

Managing challenging behaviours

As set out earlier in this section, a significant area of non-compliance for Pioneer House was its management of the challenging behaviours of some of its residents living with dementia, including Mr UI.

Mr Codrington detailed the extensive list of measures that Pioneer House had implemented since Mr UI became a resident of Pioneer House, including requesting assistance from Dementia Support Australia, engaging a nurse practitioner, changing the layout of the facility, and providing specific dementia training to staff. However, he said that ultimately, Pioneer House remained in the same position with respect to Mr UI as it had been when it was sanctioned on 27 February 2019. Mr Codrington said:

> it put enormous pressure on our staff and enormous pressure on our CEO/DON [chief executive officer / director of nursing], who had to control, educate the staff, and continually told us he [Mr UI] had a tenure that we had to recognise, a security of tenure, which made it difficult to move him. We did arrange to go to another bed. And his family, rightfully so, said that they didn't want to do that. It didn't help us, but everyone seems to have their rights except the facility to do something that makes this better for us and makes it better for our residents and staff.[203]

Ms Dear was asked by Counsel Assisting whether, in her experience, there was a point at which standalone approved providers in rural areas would not be able to cope with the challenging behaviours associated with the progression of dementia, where government intervention to facilitate the transfer of the resident to a different facility might be warranted. She said:

> in an ideal situation, you would have an environment, you would have the training, you would have the support in place. But that's not always the case even in a larger town or city, let alone in rural or remote. So it would be a last resort and I guess it would have to be specific each time. It would need to be specific on the individual situation…also with some support for the family and their—or their representatives to be able to compensate them or to visit their loved one, wherever that person may be, on a short-term basis, but all with flexibility for them to be able to return once the situation has settled or the person has—behaviour has changed.[200]

Ms Dear identified the need for specialist training for staff working in aged care in relation to dementia in regional areas, to build local capacity so that there is 'expertise on the ground to be able to assist and support the staff and guide the staff' to deal with challenging behaviour when it arises.[204] She identified a difficulty with 'bringing in services' from external providers, which may then not be available should challenging behaviour occur after-hours or on weekends.[205]

Staffing challenges

Pioneer House experienced significant difficulties in filling its staff roster. Mr Codrington said:

> we've just had a lot of difficulty getting registered nurses, enrolled nurses with particular experience in aged care with good clinical knowledge. It's very difficult.[206]

He noted that the 'regional setting' of the facility contributed to its 'inability to access nursing staff with aged care specific experience' which meant they were 'overly reliant' on agency staffing solutions.[207] Mr Codrington said that Pioneer House's difficulty in filling its shifts was recognised by the board, although the board had always been given to understand that the base roster was being adequately filled.[208]

Ms Tania Sargent told us that she was concerned about the lack of consistency in the skills of newly-recruited assistants-in-nursing at Pioneer House, which made it difficult to ensure a consistent standard of care for residents.[209] However, she said that ultimately:

> As a result of the shortage of staff, any apparent issues with skills or levels of training, became almost a secondary concern, because the primary focus was finding enough staff to satisfy the basic core functions of the facility and its operations.[210]

Ms Dear said that when she first attended Pioneer House, there was 'insufficient staff' as well as a lack of 'clinical expertise' and 'appropriately skilled staff'.[211] Mr Codrington stated:

> any incentive to bring people to the country areas might be an advantage. We, obviously, pay to the standard, but aged care—aged care nursing is a lot more demanding, with incontinent people, people with dementia, people with very serious—and vulnerable people.[212]

Governance challenges

The Pioneer House Case Study also illustrated the challenges faced by some small providers in rural, regional and remote areas in maintaining a suitably experienced board.

From January 2018 to September 2019, the directors of Pioneer House were all volunteers. Mr Codrington told of the challenges faced by the organisation in attracting and retaining volunteers to act as board members, particularly in light of the financial pressures impacting on the viability of rural aged care providers such as this facility.[213] He said that Pioneer House also experienced difficulty in attracting board members with appropriate aged care experience.[214] While the board included a physiotherapist, there were no other board members with clinical experience.[215]

Mr Codrington spoke of his desire to recruit and retain board members with expertise in risk management and the law, as well as members with clinical experience. However, he acknowledged:

> I would love to have a doctor, a solicitor and a risk manager on the board but I'm flat out keeping the guys I've got. As I just said, I brought back three people that resigned. They've got heaps of experience.[216]

Nurse consultant, Ms Prudence Dear, stated that providers in rural, regional and remote locations are often stand-alone facilities that do not have the same governance and operational structures in place as larger providers in metropolitan areas.[217] In addition, she told us that staff filling key leadership roles in larger organisations, such as a Deputy Director of Nursing, often receive training that small stand-alone organisations do not have the capacity to offer. She said:

> In a larger organisation they will usually have an orientation program that those staff go through and they're given clear responsibilities and expectations but often in these small stand-alone organisations you don't have the capacity to be able to do that. So to be able to have some assistance with that and to have some support from the government; I think that was a great idea of—of them being able to come in to assist in regional areas.[218]

In written submissions in reply to Counsel Assisting's submissions, the Australian Government agreed that targeted advisory and practical assistance should be available, in certain circumstances, for standalone, not-for-profit aged care service providers in regional, rural and remote settings. The Australian Government suggested that existing programs, such as the Remote Aboriginal and Torres Strait Islander Service Development Assistance Panel, and the Business Advisory Service, could potentially be expanded to address that need.[219]

Financial performance and viability

There were concerns raised about the financial performance and viability of Pioneer House. One of the issues of concern to the management and board was whether Pioneer House was claiming its full entitlement under the Aged Care Funding Instrument.

Following a series of poor financial results, in about late 2017, Pioneer House's finance manager and board of directors considered that the facility was under-claiming this entitlement. Pioneer House decided to engage a consulting firm it had previously retained, Mirus Australia, to assist it to raise its Aged Care Funding Instrument levels toward industry benchmark levels.[220] Mr Codrington said:

> the fact that our management team couldn't get our ACFI [Aged Care Funding Instrument] anywhere near the level that would make us viable, it was necessary to look to bring Mirus in to try and train our staff, review how we handled ACFI and put systems in place to make sure we could claim the full entitlement that was available to us under the government regulations.[221]

Mr Codrington said that through a combination of lower than planned occupancy levels and low Aged Care Funding Instrument levels, the board recognised that Pioneer House was not 'tracking at a level where we were going to end up financially stable'.[222] As a result, in late December 2018, Mr Codrington, together with the vice-chair of the Pioneer House board and the Chief Executive Officer / Director of Nursing, drove to Canberra to try to meet with the Minister of Health and Ageing to discuss the board's concerns about the status and viability of Pioneer House.[223]

Mr Codrington said that Pioneer House 'was heavily reliant on, and limited by, ACFI'. In his view, small rural providers would benefit from changes to the Aged Care Funding Instrument system aimed at 'simplifying the process' to ensure that 'facilities received the funding they are entitled to rather than it being 'lost' on account of human error'.[224] In written submissions in reply to Counsel Assisting's submissions, the Australian Government acknowledged that the Aged Care Funding Instrument is no longer fit for purpose.[225]

Conclusion

This case study demonstrates the unique challenges, including difficult operating environments, staffing issues and financial performance pressures, faced by providers such as Pioneer House that operate in regional, rural and remote areas. We further address these challenges in chapter 8 of Volume 3.

Endnotes

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5 Exhibit 12-25, Mudgee Hearing, Statement of Graeme Barden, WIT.0498.0001.0001 at 0014 [55]; 0015 [57c]; 0018 [67].
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11 Exhibit 12-1, Mudgee Hearing, general tender bundle, tab 13, CTH.1000.0003.8206 at 8214.
12 Exhibit 12-1, Mudgee Hearing, general tender bundle, tab 13, CTH.1000.0003.8206 at 8219
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18 Exhibit 12-19, Mudgee Hearing, Statement of Julian Krieg, WIT.0590.0001.0001 at 0002 [12].
19 Exhibit 12-19, Mudgee Hearing, Statement of Julian Krieg, WIT.0590.0001.0001 at 0003 [12].
20 Exhibit 12-19, Mudgee Hearing, Statement of Julian Krieg, WIT.0590.0001.0001 at 0003 [17].
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25 Transcript, Mudgee Hearing, Peter Harris, 6 November 2019 at T6579.20–21.
26 Transcript, Mudgee Hearing, Peter Harris, 6 November 2019 at T6580.24–28.
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117 Exhibit 12-13, Mudgee Hearing, Statement of Helen Miller, WIT.0548.0001.0001 at 0010 [67].
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133 Transcript, Mudgee Hearing, Jaclyn Attridge, 5 November 2019 at T6441.27–28.
134 Transcript, Mudgee Hearing, Jaclyn Attridge, 5 November 2019 at T6441.27–33.
135 Exhibit 12-15, Mudgee Hearing, Statement of Rachel Winterton, WIT.0589.0001.0001 at 0006–0007 citing Australian Association of Gerontology (2017).
136 Australian Association of Gerontology, *Towards an Action Plan for Aged Care for Rural and Remote Australia*, Melbourne Association of Gerontology, 2017, p 17. https://www.aag.asn.au/documents/item/2220, viewed 3 June 2020.
137 Transcript, Mudgee Hearing, Rachel Winterton, 5 November 2019 at T6460.4–24.
138 Transcript, Mudgee Hearing, Rachel Winterton, 5 November 2019 at T6460.4–15.
139 Exhibit 12-7, Mudgee Hearing, Statement of Allan Codrington, WIT.0522.0001.0001 at 0002 [14].
140 As set out in Schedule 2 to the *Quality of Care Principles 2014* (Cth) prior to its replacement with the new Aged Care Quality Standards on 1 July 2019.
141 Submissions of Counsel Assisting, Mudgee Hearing, Pioneer House Case Study, 20 November 2019, RCD.9999.0270.0001.
142 Exhibit 12-7, Mudgee Hearing, Statement of Allan Codrington, WIT.0522.0001.0001.
143 Exhibit 12-8, Mudgee Hearing, Statement of Tania Sargent, WIT.0598.0001.0001.
144 Exhibit 12-9, Mudgee Hearing, Statement of Prudence Dear, WIT.0525.0001.0001.
145 Exhibit 12-5, Mudgee Hearing, Statement of Robyn Daskein, WIT.0469.0001.0001.
146 Exhibit 12-6, Mudgee Hearing, Statement of Catherine Brown, WIT.0523.0001.0001.
147 Exhibit 12-4, Mudgee Hearing, Statement of Michelle Harcourt, WIT.0524.0001.0001.
148 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6336–6369; Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6369–6384; Transcript, Mudgee Hearing, Prudence Dear, 4 November 2019 at T6384–6400.
149 Submissions of Counsel Assisting, Mudgee Hearing, Pioneer House Case Study, 20 November 2019, RCD.9999.0270.0001.
150 Submissions of the Commonwealth of Australia, Mudgee Hearing, Pioneer House Case Study, RCD.0012.0044.0002.
151 Submissions of Allan Codrington, Mudgee Hearing, Pioneer House Case Study, 6 December 2019, RCD.0012.0046.0001. Mr Codrington clarified certain evidence about the composition of the board of Pioneer House.
152 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 6, PAC.0001.0001.0975 at 0975–0976; Exhibit 12-8, Mudgee Hearing, Statement of Tania Sargent, WIT.0598.0001.0001 at 0012 [73].
153 Some providers refer to personal care workers as Assistants-in-Nursing. Other titles for the same role are personal care attendants or personal care assistants, or simply care workers, attendants or assistants. These terms are all used to refer to unregistered care staff.
154 Exhibit 12-8, Mudgee Hearing, Statement of Tania Sargent, WIT.0598.0001.0001 at 0007 [37b]; Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6374.37–6375.1.
155 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6375.3–14.
156 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 6, PAC.0001.0001.0975 at 0975.

157 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6339.6–9.
158 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6339.9–12.
159 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 8, PAC.0001.0001.0678.
160 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6340.1–5.
161 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 8, PAC.0001.0001.0678 at 0682–0693.
162 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6341.24–27.
163 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6375.16–20.
164 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 73, PAC.000.0001.0043.
165 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6378.44–6379.13.
166 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 9, PAC.0002.0001.2482 at 2482.
167 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 74, PAC.9999.0001.0001.
168 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6379.34–41.
169 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 1, PAC.0002.0001.0176 at 0208–0209; tab 23, PAC.0002.0001.0255; tab 50, PAC.0002.0001.0283.
170 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6380.1–3.
171 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6380.18–21.
172 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6349.4–9.
173 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6349.4–10.
174 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 11, PAC.0001.0001.0028 at 0029.
175 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 11, PAC.0001.0001.0028 at 0029.
176 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6376.26–30.
177 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6377.34–38.
178 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 19, PAC.0002.0001.0350 at 0352 [3].
179 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 19, PAC.0002.0001.0350 at 0353.
180 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 21, PAC.0001.0001.0082.
181 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 21, PAC.0001.0001.0082 at 0093–0094.
182 Transcript, Mudgee Hearing, Tania Sargent, 4 November 2019 at T6378.17–31.
183 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 26, PAC.0001.0001.0723 at 0726.
184 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 26, PAC.0001.0001.0723 at 0726.
185 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 26, PAC.0001.0001.0723 at 0724.
186 Exhibit 12-4, Mudgee Hearing, Statement of Michelle Harcourt, WIT.0524.0001.0001 at 0007 [30].
187 Exhibit 12-4, Mudgee Hearing, Statement of Michelle Harcourt, WIT.0524.0001.0001 at 0008 [33].
188 Exhibit 12-9, Mudgee Hearing, Statement of Prudence Dear, WIT.0525.0001.0001 at 0008 [108].
189 Exhibit 12-4, Mudgee Hearing, Statement of Michelle Harcourt, WIT.0524.0001.0001 at 0007 [29].
190 Exhibit 12-6, Mudgee Hearing, Statement of Catherine Brown, WIT.0523.0001.0001 at 0004–0005 [25].
191 Exhibit 12-6, Mudgee Hearing, Statement of Catherine Brown, WIT.0523.0001.0001 at 0005 [28a]–0006 [28e].
192 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 40, CTH.4011.1000.1794.
193 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 44, CTH.4011.1000.3271 at 3271.
194 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 45, PAC.0002.0002.0407; Exhibit 12-6, Mudgee Hearing, Statement of Catherine Brown, WIT.0523.0001.0001 at 0005 [28a].
195 Exhibit 12-6, Mudgee Hearing, Statement of Catherine Brown, WIT.0523.0001.0001 at 0007 [38a].
196 Exhibit 12-6, Mudgee Hearing, Statement of Catherine Brown, WIT.0523.0001.0001 at 0007 [38d].
197 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 49, PAC.0001.0001.1122.
198 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 66, PAC.0001.0001.0582 at 0582–0583.
199 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 63, PAC.0001.0001.0046 at 0046–0047.
200 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 70, PAC.0002.0001.0715.
201 Exhibit 12-3, Mudgee Hearing, Pioneer House tender bundle, tab 70, PAC.0002.0001.0715 at 0715–0716.
202 Exhibit 12-7, Mudgee Hearing, Statement of Allan Codrington, WIT.0522.0001.0001 at 0014–0015 [77].
203 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6355.11–17.
204 Transcript, Mudgee Hearing, Prudence Dear, 4 November 2019 at T6394.39–44.
205 Transcript, Mudgee Hearing, Prudence Dear, 4 November 2019 at T6395.5–12.
206 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6353.20–23.
207 Exhibit 12-7, Mudgee Hearing, Statement of Allan Codrington, WIT.0522.0001.0001 at 0014 [74.2]; [76.2].
208 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6338.8–9.
209 Exhibit 12-8, Mudgee Hearing, Statement of Tania Sargent, WIT.0598.0001.0001 at 0008–0009 [46].
210 Exhibit 12-8, Mudgee Hearing, Statement of Tania Sargent, WIT.0598.0001.0001 at 0009 [47].
211 Exhibit 12-8, Mudgee Hearing, Statement of Prudence Dear, WIT.0525.0001.0001 at 0008 [112]–[116].
212 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6353.12–25.
213 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6366.28–6367.7.
214 Exhibit 12-7, Mudgee Hearing, Statement of Allan Codrington, WIT.0522.0001.0001 at 0014 at [74.3].
215 Submissions of Allan Codrington, Mudgee Hearing, Pioneer House Case Study, 6 December 2019, RCD.0012.0046.0001 at 0001 [5].

216 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6366.22–26.
217 Transcript, Mudgee Hearing, Prudence Dear, 4 November 2019 at T6396.11–13.
218 Transcript, Mudgee Hearing, Prudence Dear, 4 November 2019 at T6396.16–21.
219 Submissions of the Commonwealth of Australia, Mudgee Hearing, Pioneer House Case Study, 4 December 2019, RCD.0012.0044.0002 at 0004 [3.3]–[3.4].
220 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6342.1–44.
221 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6342.21–25.
222 Transcript, Mudgee Hearing, Allan Codrington, 4 November 2019 at T6347.11–38.
223 Exhibit 12-7, Mudgee Hearing, Statement of Allan Codrington, WIT.0522.0001.0001 at 0003 [15.2].
224 Exhibit 12-7, Mudgee Hearing, Statement of Allan Codrington, WIT.0522.0001.0001 at 0003 [15.2].
225 Submissions of the Commonwealth of Australia, Mudgee Hearing, Pioneer House Case Study, 4 December 2019, RCD.0012.0044.0002 at 0013–0014 [6.7].

13. Hobart Hearing: Aged Care Operations of Selected Approved Providers

13.1 Hearing overview

13.1.1 Introduction

We held a public hearing in Hobart, Tasmania, from 11 to 15 November 2019. Our focus was on the governance of two approved providers of aged care services.

We inquired into the operations of Southern Cross Care (Tas) Inc., particularly at Glenara Lakes Apartments (Glenara Lakes) and Yaraandoo Hostel (Yaraandoo), and Bupa Aged Care Australia Pty Limited at the Bupa South Hobart aged care facility.

The Australian Department of Health and the Australian Aged Care Quality Agency took regulatory action in 2018 because the services failed to meet a number of expected outcomes of the Accreditation Standards. Southern Cross Care (Tas) Inc. and Bupa Aged Care Australia Pty Limited were sanctioned as a result of those failures.

Our inquiry was conducted through the presentation of two case studies. The key areas examined were:

- the importance of leadership and culture within an approved provider of aged care services
- the critical role played by facility managers, their required skill set and the need for experience
- clinical governance and the need to ensure information is shared between facility staff, senior executive staff and board members of an approved provider
- complaints handling and the value of genuine engagement with residents and their families about their experience of aged care
- the need for appropriately skilled boards and reforms to improve the robustness and transparency of decision-making.

We heard oral testimony from 35 witnesses, including nine direct experience witnesses. A total of 632 documents, including 51 witness statements, were received into evidence. Witnesses included current and former employees of Southern Cross Care (Tas) Inc. and Bupa, advisers and administrators, and current and former Southern Cross Care (Tas) Inc. Board members.

Several of the direct experience witnesses gave evidence about their experiences of caring for a loved one living at the Yaraandoo, Glenara Lakes and Bupa South Hobart aged care facilities. A current resident at Southern Cross Care (Tas) Inc.'s Fairway Rise Aged Care Home gave evidence about her experience living at that facility. We also heard evidence from an expert in governance.

13.2 Case studies

13.2.1 Southern Cross Care (Tas) Inc.

Introduction

We inquired into the governance arrangements and executive leadership of Southern Cross Care (Tas) Inc. between 30 June 2016 and 30 June 2019 (relevant period).

Southern Cross Care (Tas) Inc. is a not-for-profit incorporated association that was established in 1972 by the Knights of the Southern Cross.[1] It is now the largest not-for-profit aged care provider in Tasmania and operates nine residential aged care facilities, 13 retirement villages and three regional home care services.[2] At the time of our hearing, Southern Cross Care (Tas) Inc. provided care, accommodation and support for more than 1500 people. It employed around 1200 staff.[3] Southern Cross Care (Tas) Inc. should not be confused with separate providers in other States and Territories that also bear the name Southern Cross Care.

This case study focused on the operations of Glenara Lakes and Yaraandoo. In late 2018, both facilities were found not to meet a number of the expected outcomes of the Accreditation Standards. At that time, Schedule 2 of the *Quality of Care Principles 2014* (Cth) specified 44 expected outcomes across four Accreditation Standards relating to:

- management systems, staffing and organisational development
- health and personal care
- care recipient lifestyle
- physical environment and safe systems.

During this case study, we received 17 written statements from witnesses who gave oral testimony. We also received into evidence the Southern Cross Care Tasmania tender bundle comprising 378 documents.

Southern Cross Care (Tas) Inc., Ms Tammy Marshall, Ms Jo-Anne Cressey Hardy, Ms Kylie Bennett, Mr Andrew George-Gamlyn, Mr Andrew Crane, Mr Richard Sadek and Mr Stephen Shirley were represented by Southern Cross Care (Tas) Inc.'s legal representatives and granted leave to appear at the hearing. Ms Helen Marshall and Ms Pauline Robson were also granted leave to appear at the hearing and were legally represented. Ms Helen Valier was granted leave to appear at the hearing, but was not legally represented.

In accordance with directions we made on 15 November 2019, Counsel Assisting provided written submissions. These included the conclusions that Counsel Assisting consider should be reached on the evidence presented.[4] Southern Cross Care (Tas) Inc. made post-hearing submissions.[5]

In the following sections, we summarise the direct experience evidence, the regulatory history of Yaraandoo and Glenara Lakes, and provide an overview of Southern Cross Care (Tas) Inc.'s governance arrangements. We then address the written submissions.

Direct experience witnesses

Counsel Assisting did not seek any specific conclusions about the quality of care provided to current or former residents at any Southern Cross Care (Tas) Inc. facility. We have not made any such conclusions.

Ellie Valier

Ms Ellie Valier's husband, the late Mr Brian Harvey, became a permanent resident at Yaraandoo on 28 September 2017. Mr Harvey was born in Cairns on 23 February 1935. He and Ms Valier met in 1981 and were together until Mr Harvey's death.[6]

While initially 'relatively happy' with the care that Mr Harvey received at Yaraandoo, Ms Valier became concerned about 'the inconsistent, variable quality of care' over the course of 2018.[7] Her concerns related to, among other things, a lack of consultation regarding a care plan for Mr Harvey, lack of information about the care plan and getting access to it, changes to staffing, management of his medication and management of his continence needs.[8]

On 5 May 2019, Mr Harvey lodged a public submission with us containing a moving account of his experience as a resident. Mr Harvey, who by March 2018 required the assistance of two carers for his activities of daily living, described waiting for prolonged periods for carers to assist him to go to and from the toilet. He described that experience as:

> When neglected like that, I feel I have been dehumanised: left as a carcase in an aged care abattoir; ready to be processed like a slab of meat in a sausage processing factory at some future time.[9]

Mr Harvey died at Yaraandoo on 6 August 2019. Ms Valier said that Mr Harvey had an agonising death.[10] She said that there were multiple occasions in the last years of his life when Mr Harvey, who suffered pain as a result of cancer and other serious conditions, was left for indefinite lengths of time while he waited for staff. She described these incidents as 'dehumanising, undignified and painful', avoidable, and unforgivable.[11] Ms Valier believed her husband's quality of life and care suffered due to understaffing at Yaraandoo. Ms Valier's evidence was that her and Mr Harvey's poor experience at Yaraandoo was compounded by a lack of transparency about important changes such as cuts to staffing hours.[12]

Mary Sexton

Ms Mary Sexton gave evidence about her mother-in-law, the late Ms Lois Parravicini. Ms Parravicini was born in Melbourne on 8 January 1927. In her later years, she enrolled in adult education, taking English grammar and Italian classes.[13]

On 16 January 2017, Ms Parravicini moved into Glenara Lakes as a permanent resident. Ms Sexton and Ms Parravicini's family noticed issues with Ms Parravicini's care soon after. Ms Sexton told us that she and her husband first noticed a deterioration in Ms Parravicini's personal care including with showering, hair washing and teeth cleaning.[14]

Ms Sexton estimated that she received around 20 phone calls in 18 months from Glenara Lakes informing her that Ms Parravicini had fallen in the night. Ms Parravicini had between 20 and 23 falls in 2017. Despite the frequency of falls, Ms Sexton told us that 'no adequate measures' were put in place at Glenara Lakes to mitigate against the risk of Ms Parravicini falling.[15]

Ms Sexton related how she and her husband 'had to initiate a considerable amount of medical and nursing treatments' for Ms Parravicini.[16] She also stated that she 'often observed 20 to 30 minute waits in response to call bells' at Glenara Lakes.[17] Ms Sexton also said that in her view the staff at Glenara Lakes were not 'trained to do any basic physiotherapy exercises with Lois and she suffered because of it'.[18]

Ms Parravicini died on 15 October 2018, aged 91 years. Ms Sexton told us that the problems she and her family faced at Glenara Lakes reflected 'a system that does not support the staff'.[19]

Ann McDevitt

Ms Ann McDevitt gave evidence about her mother, the late Ms Janet Hellyer. Ms Hellyer entered retirement accommodation in 2015. That retirement accommodation was co-located with Glenara Lakes and operated by Southern Cross Care (Tas) Inc. Ms McDevitt described Ms Hellyer as a fun-loving person who loved people, and had a keen interest in antiques, tennis and gardening. Following a fall in May 2018, Ms Hellyer moved into Glenara Lakes on 15 June 2018.[20]

On 1 September 2018, Ms McDevitt visited Ms Hellyer. She told us that Ms Hellyer looked 'clearly very unwell'. Her mother's 'breathing was laboured, erratic and strained'.[21] Although a registered nurse attended to Ms Hellyer, Ms McDevitt considered that her mother was not properly assessed. She raised her concerns to staff but felt that they were dismissed or minimised by care staff. Her requests for an ambulance were resisted. An ambulance was eventually called and Ms Hellyer was transferred to hospital where her initial diagnosis was pneumonia. She died in hospital on 9 September 2018, aged 91.[22]

Ms McDevitt believed there was a lack of leadership and accountability at Glenara Lakes and within Southern Cross Care (Tas) Inc., as well as a lack of responsibility at the executive management level.[23]

Judith King

Mrs Judith King gave evidence about her husband, Mr Neville King OAM. Mr King was a Professor of Psychology at Monash University. In 2018, he was awarded the honour of Officer of the Order of Australia for his services to humanity in recognition of his work with international colleagues, introducing cognitive behaviour therapy to 63 countries.[24]

Mr King was diagnosed with Huntington's Disease in 2011. He moved into Glenara Lakes on 17 July 2018.[25]

Mrs King told us about her experiences of raising concerns with staff on multiple occasions about her husband's medication management and continence care. She said 'it's so tiring having to go…through the same thing multiple times every week with no change'.[26] Mrs King told us, 'at Glenara Lakes there are good people trying to work in an antiquated system that is broken. There is a lack of effective management from the CEO [chief executive officer] down'.[27]

Patricia Job

Mrs Patricia Job was 92 years of age and for five years had been a resident at Fairway Rise, an aged care facility operated by Southern Cross Care (Tas) Inc. and located close to Hobart. Mrs Job moved into Fairway Rise in January 2015, about one week after the facility opened. Earlier in her life, she had trained as a registered nurse and had worked in aged care in the 1960s and 1970s.[28]

Mrs Job said that when Fairway Rise first opened, there were lots of 'little things that weren't right'.[29] She said that, through a process of committee and resident meetings where residents were able to raise these concerns with management, these issues 'have all been sorted'. She informed us that she would give management at the facility 'full marks'.[30]

Mrs Job said there are 'gripes' from some residents about the food at the facility, and that there should 'definitely' be more staff. She said people are coming in much frailer and they need much more care.[31] However, Mrs Job told us that she is happy at Fairway Rise, and she believes most of the residents are as well. When asked by Counsel Assisting how she finds living at Fairway Rise, she said that 'I love it'.[32]

Yaraandoo

Introduction

Yaraandoo is a residential aged care facility located in Somerset, Tasmania. At all relevant times it was managed by a Facility Manager who reported to the Director Residential Business Services, who in turn reported to the Chief Executive Officer. Southern Cross Care (Tas) Inc. is governed by a board of directors.[33]

Regulation history

In September 2016, Yaraandoo was assessed to have met all expected outcomes of the Accreditation Standards. Its accreditation was extended to 1 December 2019.[34]

An assessment contact report was prepared following an unannounced site visit on 7 February 2018. The visit identified some areas for improvement. Mr Patrick Anderson, Facility Manager, responded to the assessment contact report on Southern Cross Care (Tas) Inc.'s behalf. A further assessment contact occurred in August 2018. We were told the facility was found to be compliant.[35]

From 2 to 8 November 2018, assessors from the Australian Aged Care Quality Agency conducted a review audit at Yaraandoo. At the time of the audit there were 79 people receiving care, of whom approximately 60 were identified as receiving high care.[36] Regarding the outcomes of that review audit, a delegate of the Chief Executive Officer of the Agency found that 18 of the 44 expected outcomes were not met, including expected outcomes: 1.6 (human resource management); 2.4 (clinical care); 2.5 (specialised nursing care); 2.8 (pain management) and 2.12 (continence management). The delegate varied Yaraandoo's accreditation period so that it expired on 28 August 2019.[37]

On 9 November 2018, a delegate of the Secretary of the Australian Department of Health was satisfied that, because of Southern Cross Care (Tas) Inc.'s non-compliance, there was an immediate and severe risk to the safety, health or wellbeing of care recipients to whom Southern Cross Care (Tas) Inc. was providing care. The delegate imposed sanctions on Southern Cross Care (Tas) Inc. in respect of Yaraandoo. The sanctions included a prohibition on funding for new care recipients and revocation of Southern Cross Care (Tas) Inc.'s approval as a provider of aged care services. The revocation would not take effect if Southern Cross Care (Tas) Inc. agreed, in writing, to appoint an adviser and administrator and implement additional training. The funding sanction was imposed for a period of six months, but was subsequently extended.[38]

On 19 November 2018, Southern Cross Care (Tas) Inc. appointed Ms Cressey Hardy as an adviser and administrator for Yaraandoo.[39] On 11 December 2018, a delegate of the Chief Executive Officer of the Australian Aged Care Quality Agency decided that Southern Cross Care (Tas) Inc.'s non-compliance with expected outcomes 2.4 (clinical care), 2.8 (pain management), 2.11 (skin care), 2.12 (continence management) and 2.14 (mobility and dexterity) had placed, or may place, the safety, health or wellbeing of a number of care recipient at serious risk.[40]

On 12 and 13 June 2019, assessors from the Aged Care Quality and Safety Commission conducted a site audit against the 44 expected outcomes at Yaraandoo. They found that the service still did not meet six expected outcomes: 1.6 (human resource management); 2.1 (continuous improvement); 2.4 (clinical care); 2.8 (pain management); 2.10 (nutrition and hydration) and 2.11 (skin care).[41]

On 5 July 2019, Ms Cressey Hardy left the role of adviser and administrator at Yaraandoo.[42] She was replaced in that role by the then Facility Manager at Yaraandoo, Ms Kylie Bennett.[43]

On 17 July 2019, a delegate of the Aged Care Quality and Safety Commissioner decided that Southern Cross Care (Tas) Inc.'s non-compliance with expected outcomes 2.8 (pain management), 2.10 (nutrition and hydration) and 2.11 (skin care), had placed and may place the safety, health or wellbeing of a number of care recipients at Yaraandoo at serious risk.[44]

On 8 August 2019, the sanctions which had been imposed in November 2018 expired.[45]

On 3 October 2019, the Aged Care Quality and Safety Commission undertook an assessment contact at Yaraandoo to assess Southern Cross Care (Tas) Inc.'s performance against certain expected outcomes. The Aged Care Quality and Safety Commission's assessors found that the service at Yaraandoo met expected outcomes 1.6 (human resource management), 2.4 (clinical care), 2.8 (pain management), 2.10 (nutrition and hydration) and 2.11 (skin care).[46]

Yaraandoo could accommodate up to 82 residents. At the time of our hearing Yaraandoo had 54 residents.[47]

Richard Sadek, Chief Executive Officer of Southern Cross Care (Tas) Inc., told us that based on his review of the situation at Yaraandoo following the November 2018 audit, he believed there were 11 key contributing factors to the problems at Yaraandoo:

(a) inadequate leadership by the Facility Manager;

(b) inadequate professional support provided to the Facility Manager;

(c) insufficient education and training;

(d) inadequate clinical care documentation;

(e) inappropriate allocation and rostering of staffing resources;

(f) insufficient equipment;

(g) inadequate experience and skill of some members of staff;

(h) poor communication with residents / consumers and their families;

(i) incomplete internal audits;

(j) an unacceptable comments and complaints system; and

(k) an ineffective continuous improvement system.[48]

Mr Sadek also considered that poor leadership and support from within Southern Cross Care (Tas) Inc. contributed to the sanctions being imposed in November 2018.[49] He added that the executive management team 'allowed Yaraandoo to be isolated without support from a clinical involvement perspective', and did not put enough resources into training and education.[50]

Mr Stephen Shirley, Chair of the Southern Cross Care (Tas) Inc. Board, told us that the board received reports from management regarding the substandard care found at Yaraandoo. The reports highlighted deficiencies in leadership, staff training and capacity, and a failure to document actions taken and to escalate areas of concern. He did not believe any reduction in staffing to be a significant cause of issues leading to sanctions.[51]

Glenara Lakes

Introduction

Glenara Lakes is a residential aged care facility located in Youngtown, Tasmania. Glenara Lakes accommodates up to 88 residents. At all relevant times, it was managed by a Facility Manager who reported to the Director Residential Business Services, who in turn reported to the Chief Executive Officer. As noted above, Southern Cross Care (Tas) Inc. is governed by a board of directors.[52]

Regulation history

A re-accreditation audit was conducted at Glenara Lakes between 31 January and 1 February 2017. The facility was assessed as having met all 44 expected outcomes. It was accredited until 10 May 2020.[53]

The Australian Aged Care Quality Agency conducted a review audit between 4 and 14 December 2018. The review auditors assessed that seven of the 44 expected outcomes were not met, namely: 1.6 (human resource management); 1.8 (information systems); 2.1 (continuous improvement); 2.4 (clinical care); 2.7 (medication management); 2.8 (pain management) and 2.11 (skin care).[54] On 27 December 2018, a delegate of the Chief Executive Officer of the Australian Aged Care Quality Agency determined that the facility had not met those seven expected outcomes.[55]

On 7 January 2019, a delegate of the Aged Care Quality and Safety Commissioner decided that the failure to meet expected outcomes 2.4, 2.7, 2.8 and 2.11, had placed and may place the safety, health or wellbeing of a number of care recipients at Glenara Lakes at serious risk.[56]

On 31 January 2019, the Aged Care Quality and Safety Commission conducted an assessment contact at Glenara Lakes.[57] On 13 February 2019, a delegate of the Aged Care Quality and Safety Commissioner determined that Glenara Lakes did not meet expected outcomes 2.1 (continuous improvement) and 2.7 (medication management). The service was required to make improvements to meet those expected outcomes by 4 March 2019.[58]

Following an assessment contact on 5 March 2019, the Aged Care Quality and Safety Commission's assessors recommended that Glenara Lakes be found not to have met expected outcome 2.7.[59] On 17 March 2019, a delegate of the Aged Care Quality and Safety Commissioner notified Southern Cross Care (Tas) Inc. that, after considering further evidence (including Southern Cross Care (Tas) Inc.'s response to the assessment contact report), they were satisfied that expected outcome 2.7 was met. This meant that all assessed expected outcomes were met at that time.[60]

Following an assessment contact on 5 June 2019, the Aged Care Quality and Safety Commission assessors recommended that Glenara Lakes be found not to have met expected outcome 1.6 (human resource management). On 27 June 2019, a delegate of the Aged Care Quality and Safety Commissioner notified Southern Cross Care (Tas) Inc. that, after considering additional information regarding staffing levels and staff education processes, they were satisfied expected outcome 1.6 was met.[61]

Mr Sadek told us that he believed there were six key contributing factors to the problems at Glenara Lakes. They were:

(a) difficulty in establishing a quality culture due to inconsistent Facility managers

(b) inconsistent management, clinical leadership and oversight of resident care by registered and enrolled nurses;

(c) insufficient education and training;

(d) poor communication with staff related to roles and responsibilities;

(e) insufficient participation in SCC (Tas) [Southern Cross Care (Tas) Inc.] continuous improvement processes including internal audits; and

(f) inappropriate allocation of and rostering of staffing resources.[62]

Governance arrangements

Introduction

The Governance Institute of Australia told us that governance encompasses the system by which an organisation is controlled and operates, and the mechanisms by which it, and its people, are held to account. They said that ethics, risk management, compliance and administration are all elements of governance.[63]

The Institute contend that there are five key components to governance:

(1) Transparency: being clear and unambiguous about the organisation's structure, operations and performance, both externally and internally, and maintaining a genuine dialogue with, and providing insight to, legitimate stakeholders.

(2) Accountability: ensuring that there is clarity of decision-making within the organisation, with processes in place to ensure that the right people have the right authority for the organisation to make effective and efficient decisions, with appropriate consequences for failures to follow those processes.

(3) Stewardship: developing and maintaining an enterprise-wide recognition that the organisation is managed for the benefit of its primary stakeholders (including owners / those to whom the services are being provided / families / government and the wider community) taking reasonable account of the interests of other legitimate stakeholders.

(4) Integrity: developing and maintaining a culture committed to ethical behaviour and compliance with the law.

(5) Risk management: taking appropriate risks and avoiding unnecessary risks where the benefit is insufficient.[64]

Ms Catherine Maxwell, General Manager of Policy and Advocacy for the Governance Institute of Australia, told us that her organisation had recognised the aged care sector as one where it could add value. They started to develop governance guidance for those sitting on boards in aged care. In 2016, they formed a working group of their members who worked in the aged care sector. The working group identified some key governance issues, including:

> (a) The maturity of boards and that many boards in the sector are made up of volunteers and are not necessarily aware of their duties and all aspects of the role—skills audits are needed but are not being undertaken
>
> (b) Board education is required but not many are undertaking it
>
> (c) Consolidation and change was occurring in the aged care sector but there are many conflicts of interest
>
> (d) The boundaries between board and management are not well understood, and this is particularly so in incorporated associations…
>
> (e) Scant resources—volunteers can be hands-on but need to understand the differences in roles and accountabilities
>
> (f) the duties to members are different from the duties to stakeholders, for example, those to whom the services are provided, but this is not necessarily understood
>
> (g) The behavioural aspects of the challenging discussions that need to take place on boards—dealing with conflict
>
> (h) How do boards identify risks and make objective decisions.[65]

Ms Maxwell was asked about the imposition of a due diligence duty on board members of aged care providers to ensure safe and quality care. She gave evidence that in her experience, the due diligence duty in the work health and safety context has 'had a very salutary effect' and does concentrate people's minds on a particular issue.[66] Ms Maxwell said that in her view, from a governance perspective, it is important that aged care organisations have a skilled and effective board, along with good culture, management, people and practices.[67]

The Southern Cross Care (Tas) Inc. Board

During the relevant period, the Southern Cross Care (Tas) Inc. Board comprised eight non-executive directors acting in a voluntary capacity. Members of the board included a medical practitioner and a registered nurse.[68]

Mr Stephen Shirley was Chair of the board. He had held that position since 1 July 2018.[69] Mr Raymond Groom AO was Chair between 2006 and 2018.[70]

Mr Richard Sadek was appointed the Chief Executive Officer of Southern Cross Care (Tas) Inc. in 1995.[71] He was in that role at the time of our hearing. The Southern Cross Care (Tas) Inc. Board appoints the Chief Executive Officer who has responsibility for the overall management of Southern Cross Care (Tas) Inc. on behalf of the board.[72] The operations of Southern Cross Care (Tas) Inc. are managed by the Chief Executive Officer and other members of the Senior Executive Management Team.[73]

The board had four committees: Governance Committee, Audit and Risk Committee, Budget and Finance Committee and Capital Works Committee.[74] The Audit and Risk Committee had oversight of clinical governance issues.[75] The committee comprised two board members, one with medical qualifications and one with nursing qualifications, and all members of the Executive Management Team, including Mr Sadek.[76]

The responsibilities of the Audit and Risk Committee included:

> (a) to consider all issues of significance which may increase the risk exposure to Southern Cross Care (Tas) Inc.
>
> (b) to review and monitor the annual internal quality and risk management audit program and ensure that internal audit schedules adequately address the requirements of Southern Cross Care (Tas) Inc.
>
> (c) to receive reports on any inappropriate activity that exposes Southern Cross Care (Tas) Inc. to an unacceptable level of risk and to ensure that appropriate corrective action has or will be taken
>
> (d) to ensure that adequate systems and internal control processes are established and maintained to ensure compliance with accreditation and other applicable legislative requirements
>
> (e) to ensure that adequate systems for effective management and utilisation of resources are established and maintained
>
> (f) to develop and provide recommendations to the Board in relation to:
>
> - monitoring and control of all significant business risks
> - adequacy of all systems and processes
> - compliance with applicable standards
> - legislative and regulation audits
> - review of relevant Board level policies and procedures relating to significant risks for Southern Cross Care (Tas) Inc.[77]

Role of the board

Mr Shirley told us that the board's role is detailed in the Directors' Handbook. In a section called Board Governance Charter, the Handbook states that the 'proper role of the Board is to govern the organisation and not to manage it'.[78] The Charter goes on to state:

> The proper role of the Board is to 'govern' the organisation and not to 'manage it'. Its task is to establish the values and mission of the organisation and to develop a strategic plan for the future as well as policies to guide management. It appoints the Chief Executive Officer ('CEO'), and approves the annual Budget. It monitors financial performance of the organisation and also its compliance with relevant legislation, regulations and other legal requirements. It evaluates its own performance as a Board as well as the performance of the CEO. It also considers succession issues for the Board itself, its office holders and the CEO.[79]

The Charter later lists the key responsibilities of the board as follows:

- To 'govern' and not to 'manage'
- Determine the organisation's values and direction
- Select the CEO [chief executive officer] and review his / her performance
- Ensure resources are managed effectively
- Approve the annual Budget and monitor the organisation's financial performance
- Establish Board Committees as required
- Ensure compliance with legislation and all legal requirements
- Assess risks and establish a risk management strategy
- Protect and enhance the organisation's public image
- Assess its own performance
- Help plan for succession.[80]

While not specifically mentioned in the Charter, Mr Shirley and Mr Groom agreed with Counsel Assisting that directors have responsibilities to understand the quality and safety of care given to residents at the facilities which they govern. They also have responsibilities to ensure the facility is governed in a way that provides quality care to residents.[81]

Mr Shirley and Mr Groom discussed the benefit of having board members with clinical expertise. Mr Shirley explained 'they will see something that even the best meaning director who tries to inform themselves may not see because you cannot—you may not make the connections'.[82]

Ms Maxwell told us that boards must have regular conversations about whether they are getting the right information and ask questions such as 'Is it in the format that we need? Does it assist us?'[83] Mr Shirley thought that board members with clinical experience will play a role in ensuring that the right information is provided to the board.[84]

The importance of the right information getting to boards is perhaps best illustrated by how Southern Cross Care (Tas) Inc. handled the clinical benchmarking reports they received each quarter. These reports were produced by Quality Performance Systems Pty Ltd and included a risk matrix and analysis of 19 key performance indicators for Southern Cross Care (Tas) Inc.[85] Other than in April 2019, the benchmarking reports were never presented to the board of Southern Cross Care (Tas) Inc. Instead, a summary of each benchmarking report was provided to the board's Audit and Risk Committee.[86] That summary did not go to the board. The only information on clinical benchmarks at board level was that recorded in minutes of meetings of the Audit and Risk Committee.[87] For example, the Quality Performance Systems report for the Quarter 4 April to June 2018 contained about 40 pages of information including the risk matrix and analysis of 19 key performance indicators. The corresponding report submitted to the Audit and Risk Committee was a half-page summary.[88] Mr Groom was examined about inconsistencies between that Quality Performance Systems report and the summary. He found the inconsistencies drawn to his attention 'surprising'.[89]

About a month before this hearing, Mr Shirley recommended that the Southern Cross Care (Tas) Inc. Board be provided with the Quality Performance Systems clinical benchmarking reports.[90] Mr Shirley said that change was made because 'there is more information we can provide', but he cautioned against 'overburdening' the board with documents.[91] Mr Shirley believed that executive level staff should synthesise information for senior decision-makers. He told us that the board had recently sought to have a more direct 'line of sight' in relation to quality and safety issues by seeking further information about reports from the Executive Manager Integrated and Clinical Services. That Executive Manager is now required to attend all board meetings so there is an opportunity for direct engagement.[92]

Counsel Assisting asked Mr Shirley if these changes reflected an acknowledgement that the previous practice of not providing the Quality Performance Systems reports to the board was inadequate. Mr Shirley responded it was about continuous improvement and he believed it was a reasonable step.[93]

The Southern Cross Care (Tas) Inc. Board was expecting to establish a Clinical Governance Committee following an Audit and Risk Committee meeting scheduled to take place on 30 October 2019. The Clinical Governance Committee would comprise senior managers, a board member and external members with clinical expertise.[94] Mr Shirley said that the Clinical Governance Committee will report to the board regularly and assume responsibility for some of the tasks previously performed by the Audit and Risk Committee.[95]

Mr Groom was asked if he thought there should be a statutory regime that required boards and directors to regularly inform themselves of quality and safety of care issues and the impact of their own decisions on quality of care issues. He thought there was merit in the idea.[96] Mr Shirley told us he was comfortable with the idea as a concept. However, he raised concerns about the addition of further regulatory requirements in a 'resource constrained area of activity'.[97]

Mr Shirley and Mr Groom also agreed that directors have a responsibility to take reasonable steps to gain an understanding of the operations of the organisation.[98] One way they may do that is set out in the Board Governance Charter:

> Directors may be appointed in a supportive liaison role at particular Southern Cross Care (Tas) Inc aged care facilities or retirement villages. The purpose of such an appointment is to visit the facility or village from time to time and liaise with the facility or village manager to gain an understanding, on behalf of the Board, of the way the site is operating, the activities taking place there and any problems being experienced. It is emphasised that the Director does not have a management role at the site but provides regular reports to the Board on the particular facility or village. It is then for the Board and the CEO to determine if any further action by management is required.[99]

Counsel Assisting asked whether there is a place for directors to observe the operations of a facility on a day-to-day basis. Mr Groom said there was a place 'in a general sense' but there are 'limitations…in terms of proper governance'.[100] Mr Shirley shared Mr Groom's concerns about the need to preserve the functional distinction between day-to-day management and governance. He explained that the issue was canvassed at a workshop with the board a few months previously where he was told fairly clearly that it is getting into the area of management, rather than governance. Mr Shirley agreed with a summary of his evidence suggested by Commissioner Pagone that:

> you take the view that its appropriate and indeed possibly even essential that board members inform themselves about the day-to-day operations of their enterprise, but that it needs to be undertaken in a process and way that does not interfere with the management process that others are charged to do.[101]

Counsel Assisting asked Mr Groom and Mr Shirley about the utility of requiring directors or board members to attest regularly to their promotion of a culture of safety and quality improvement within the organisation.

Mr Groom said that while he saw value in such a requirement, the way in which it was done would need to be considered to ensure that it was not tokenistic.[102] Mr Shirley said as a 'general proposition about transparency' it was worthwhile, but there was a similar approach in the last organisation where he worked which 'went nowhere very quickly'.[103]

Organisational structure

Mr Sadek agreed that clear clinical and quality issues at Yaraandoo went undetected for a considerable period of time. He said a new structure, an integrated services model, was approved in January 2019 to recognise 'the fact that we had to strengthen the reporting and review processes'.[104]

Mr Sadek agreed that there needed to be transparency and a clearer delineation of how information would flow up and down. Further changes were made to the structure from July 2019, including the creation of a new position of Manager Quality Improvement and Risk to commence by 1 November 2019.[105] That position was to assist in maintaining oversight, initiating corrective action and reporting on compliance issues raised in the quarterly Quality Performance Systems reports.[106]

Mr Sadek told us of lessons learned in responding to the sanctions imposed at Yaraandoo. He said that the 'distributed nature' of Southern Cross Care (Tas) Inc.'s organisation requires a structure that can facilitate support for staff at all levels of the organisation. He believed this has been substantially achieved by the integrated services model. [107]

He said Southern Cross Care (Tas) Inc. needed to improve business systems across the organisation, 'specifically to improve performance measures indicating audit and compliance results and feedback from residents / consumers'. He also considered that Southern Cross Care (Tas) Inc. needs to be 'more open with residents, families, government and regulatory officials in the future'.[108]

Inadequate policies and procedures

Following the review audit at Yaraandoo in November 2018, assessors from the Australian Aged Care Quality Agency noted:

> The home has a system to identify relevant legislation, regulatory requirements and guidelines, and for monitoring these in relation to the Accreditation Standards. The organisation's management has established links with external organisations to ensure they are informed about changes to regulatory requirements. Where changes occur, the organisation takes action to update policies and procedures. A range of systems and processes have been established by management to ensure compliance with regulatory requirements. Staff have an awareness of legislation, regulatory requirements, professional standards and guidelines relevant to their roles.[109]

In December 2018, following a review audit at Glenara Lakes, the assessors wrote:

> The service has a system to identify relevant legislation, regulatory requirements and guidelines, and for monitoring these in relation to the Accreditation Standards. The organisation's management has established links with external organisations to ensure they are informed about changes to regulatory requirements. Where changes occur, the organisation takes action to update policies and procedures and communicate the changes to care recipients, their representatives and staff as appropriate. A range of systems and processes have been established by management to ensure compliance with regulatory requirements. Staff have an awareness of legislation, regulatory requirements, professional standards and guidelines relevant to their roles.[110]

Despite those assessments, a number of witnesses suggested that Southern Cross Care (Tas) Inc.'s policies and procedures, at least with respect to Glenara Lakes and Yaraandoo, were deficient.

Mr Patrick Anderson, Facility Manager at Yaraandoo between October 2017 and February 2019, gave evidence that there was no policy for when weight loss required dietitian intervention and there was no formal process for suggesting policy or procedure changes.[111]

Ms Tammy Marshall, Clinical Care Coordinator at Yaraandoo, informed us that at Southern Cross Care (Tas) Inc. staff 'lacked systems' and 'policies were somewhat outdated and difficult for staff to locate'.[112]

Ms Kylie Bennett, adviser and administrator and former Facility Manager at Yaraandoo, told us that 'limited guidance and support material (e.g. policies and procedures) to inform the delivery of up-to-date care services' was a key contributing factor to quality and safety issues at Yaraandoo.[113]

As previously mentioned, Mr Sadek told us that he believed that a key contributing factor to substandard care at Yaraandoo was inadequate clinical care documentation.[114]

Mr Peter Williams, Facility Manager at Glenara Lakes between February and April 2019, said:

> Where the policies were housed on the local intranet it was difficult to navigate. Often things that I was searching for that might be something like catheter management, there was no policy that I could find. I know that Southern Cross Care did subscribe to Joanna Briggs Institute which is a nurse-led evidence-based program where you can log on and look at what the best evidence is but that was also out of date. I think it was last updated in 2015. So my experience told me that this didn't contain the most contemporary and up to date information around clinical practice so it was difficult to then deliver appropriate care if I was trying to update a policy or change the way I wanted staff to operate.[115]

Mr Williams said it appeared that no system existed to define who was accountable to oversee and manage policies and procedures. He saw limited policies and procedures as a key challenge in delivering quality and safe care at Glenara Lakes.[116]

Ms Helen Marshall, Facility Manager at Glenara Lakes between January and October 2018, considered that the policies lacked detail on clinical procedures and said she was not aware if they had been reviewed in recent times.[117]

Ms Pauline Robson was the Director of Residential Business Services at Southern Cross Care (Tas) Inc. from December 2010 to June 2018, and then Executive Manager Home Care and Residential Services North and North West from July 2018 to February 2019. Her role included providing facility managers with leadership, direction and support in the business management of aged care services, and developing standards for each facility and reviewing their application. She was also a member of the board's Audit and Risk Committee.[118]

Ms Robson told us that in the relevant period at least three facility managers, including Mr Anderson, had raised issues about the need to further improve policy and clinical documentation to support managers.[119] She also stated that with the benefit of hindsight, she would want to go back to ensure 'a full analysis of some of the quality governance factors that seem to be missing, the training, the education, the policy development'.[120]

Counsel Assisting submitted that during the relevant period:

(a) the policies and procedures established by Southern Cross Care (Tas) Inc. to guide the provision of clinical care at Glenara Lakes and Yaraandoo were inadequate in that they were not comprehensive and were not kept up-to-date

(b) Southern Cross Care (Tas) Inc. did not have an effective process for ensuring that comprehensive and current policies and procedures were available to care staff at residential aged care facilities.[121]

In response, Southern Cross Care (Tas) Inc. accepted that it was open to us to make the findings proposed by Counsel Assisting in relation to the policies and procedures in place at Southern Cross Care (Tas) Inc. during the relevant period.[122]

Mr Sadek stated that there was inadequate clinical care documentation at Yaraandoo.[123] The evidence of Mr Anderson, Ms Tammy Marshall, Ms Bennett, Mr Williams and Ms Robson suggests that some policies and procedures at Yaraandoo and Glenara Lakes provided limited guidance to managers and staff to inform up-to-date clinical care delivery. This was known at the relevant times, but it seems that no one took responsibility to address the issue.

In its submissions, Southern Cross Care (Tas) Inc. advised that it had engaged an external consultant to 'review the existing policies and procedures of Southern Cross Care (Tas) Inc., with a particular emphasis on clinical care governance'. Southern Cross Care (Tas) Inc. intended for this review to result in 'a modern set of policies and procedures to guide and assist staff to deliver consistent high quality care to residents'.[124]

Management of complaints

Ms Valier said that she was not told how she could raise issues when her husband first moved to Yaraandoo.[125] However, she raised repeated concerns with facility level management about Mr Harvey's care. Ms Valier described her experience of the complaints process as 'frustrating' and the responses received as failing to 'address obvious underlying issues such as understaffing'.[126]

Mrs King described a similar experience at Glenara Lakes. She said that she used a compliments and complaints form on 'multiple occasions' but 'didn't get a response using that'. Mrs King said that she found emails or letters more effective. She told us that she spoke to staff constantly about their use of a wheelchair to move her husband rather than encouraging him to walk.[127] She also raised concerns about the administration of her husband's medications, including with Mr Sadek. When asked by Counsel Assisting whether she had raised her concerns about the management of Mr King's medication before approaching Mr Sadek, Mrs King said:

> Yes. Yes. Yes. But I had raised it with the nursing staff prior to that. I had raised it with the facility manager. I had raised my concerns and there had been no change.[128]

While Mrs King thought that there was a genuine desire at the Facility Manager level to address her complaints, she believed no action was taken because the model of care was 'a custodial dementia care model from 50 years ago'.[129]

Mr Sadek described the process for raising complaints across Southern Cross Care (Tas) Inc. as:

> The process for raising of complaints which was in place across the whole organisation was that the complaint would be referred to…the clinical care consultant in the first place, then escalated to the facility manager, then to the director of residential business services or, indeed, the director of clinical services depending on the nature of the complaint. And if it wasn't resolved through that process it would have been referred to me.[130]

Mr Anderson told us that he was responsible at Yaraandoo between October 2017 to February 2019 for investigating and resolving all complaints from any source. He stated that he would report complaints to the Regional Director, Clinical Director and/or Chief Executive Officer depending on the nature and severity of the complaint. Any complaints to an external body were reported to the Chief Executive Officer via the Regional Director. If a complaint was made to an external body about clinical care, the Clinical Director would provide advice on how to respond. Complaints of a serious nature were also sometimes responded to directly by the Chief Executive Officer. This was decided on a case by case basis by the Regional Director and the Chief Executive Officer. However, in most circumstances no assistance was provided in responding to complaints.[131]

Ms Tammy Marshall, who commenced work at Yaraandoo in 2015, stated that residents and their representatives were encouraged to give feedback and raise issues, concerns and complaints. Complaints were primarily the responsibility of the Facility Manager at Yaraandoo, but she responded to clinical care issues raised with her. Ms Marshall stated that a complaints and comments register was maintained in the Facility Manager's office and complaints were also recorded in a 'Clinical Indicators Report'. The Clinical Indicators Report was emailed to the relevant Area Manager on a weekly basis. At the Facility Manager's discretion, complaints may have been reported to the Southern Cross Care (Tas) Inc. Executive Management Team. As at November 2019, Ms Marshall and the Facility Manager collated information for the report, which contained trends in relation to complaint data.[132]

Ms Cressey Hardy, former adviser and administrator at Yaraandoo between November 2018 and 5 July 2019, gave evidence about the complaints process at Yaraandoo when she commenced in that role. Ms Cressey Hardy said complaints management at Yaraandoo was 'in need of improvement'.[133] She explained:

> So normally what you would expect to see with a robust feedback mechanism and robust CI system is a register of complaints, comments, compliments. And there was one but it was—it wasn't very fulsome which indicated to me that the feedback mechanisms hadn't been supported and encouraged.[134]

Mr Sadek agreed with Counsel Assisting that nothing was ever referred to him from Yaraandoo. He accepted that the complaints process at Yaraandoo was 'virtually non-existent'.[135] Mr Sadek told us he believed that a key contributing factor to substandard care at Yaraandoo was 'an unacceptable comments and complaints system.'[136]

Ms Helen Marshall gave evidence about the complaints process from her experience as a former facility manager at Glenara Lakes from January to October 2018. In her oral evidence, Ms Marshall said that she was not aware of any standard complaints handling procedure at Glenara Lakes or more broadly at Southern Cross Care (Tas) Inc. She said that she would deal with simple matters like a maintenance issue immediately. For other written or verbal complaints, she would meet with the resident, their family or staff member in question.[137]

However, in her written statement, Ms Marshall gave a detailed account of the complaints handling process at Glenara Lakes. She stated that her responsibilities included oversight of the management of the complaints system and described the process as follows:

> (a) Complaints could be verbally presented or presented in written format.
>
> (b) I would meet with the resident representative/s and the resident if they desired. Alternatively, if it was a staff complaint, I would meet with the staff member to discuss the issue.
>
> (c) The issues were documented and a resolution sought.
>
> (d) The Director Residential Business Services would also attend the meetings, where required to assist with resolution of any complex complaints.
>
> (e) Complaints were documented in a register and outcomes also recorded.
>
> (f) Where the complaints were from an external agency these were reported to the Director of Clinical Services (if it was a clinical matter) who would then advise on the matter.[138]

Ms Marshall said that senior management and the board were made aware of 'significant complaints'. She said that she included information about complaints, among other matters, in monthly facility manager reports, but did not get a response to the matters raised from anybody up the chain of command. However, Ms Marshall acknowledged that she did receive support from the Director Residential Business Services on some complaint matters. Despite the above written evidence, Ms Marshall agreed with Counsel Assisting's description of the complaints process as 'an ad hoc process that really depended on your own judgment as to what you thought appropriate in the given circumstances'.[139]

Ms Marshall told us that with respect to the collection and analysis of complaints information, data about complaints was not collected or analysed for trends and root causes.[140] In her written statement, she stated that monthly reports were provided to the Director Residential Business Services who collated the data and presented it to the board. The report included audit results, compliments and complaints received.[141]

Ms Pauline Robson was the Director Residential Business Services from December 2010 to June 2018, and Executive Manager Home Care and Residential Services (North / North West) from July 2018 to September 2018. She stated that her role, at least until February 2018, was to support facility managers in the successful resolution of difficult and complex complaints. She was actively involved in the management and resolution of complaints from families, residents and the Aged Care Complaints Commission when escalated to her level, or at the direct request of the Chief Executive Officer. She recalled being involved in successful complaints management at Yaraandoo and Glenara Lakes.[142]

Mr Williams stated that at the time of his appointment at Glenara Lakes (February 2019) there was a paper-based incident reporting system. This was for resident, staff and visitor incidents, complaints, compliments and suggestions for improvement. He considered an electronic system would have offered advantages such as better record management and automated escalation protocols.[143]

Counsel Assisting submitted that during the relevant period:

> (a) the standard complaints handling process that was intended to operate at all Southern Cross Care (Tas) Inc. facilities was not well understood at Glenara Lakes
>
> (b) the process for responding to complaints and feedback at Yaraandoo was poorly established
>
> (c) there were no effective systems in place at either Glenara Lakes or Yaraandoo to ensure systematic collection and analysis of complaints information
>
> (d) information about complaints from Yaraandoo and Glenara Lakes was escalated to the executive management level on an ad hoc basis.[144]

Southern Cross Care (Tas) Inc. accepted that its complaint handling process 'did not operate effectively at Yaraandoo and Glenara Lakes throughout the relevant period'.[145]

Southern Cross Care (Tas) Inc. criticised Counsel Assisting's submission that the complaints handling process was 'not well understood' on the basis that a finding in those terms would be 'a nebulous and unhelpful finding to the Commission, begging the question by whom it was not "well understood" and where responsibility for any lack of understanding may lie'.[146] We accept Southern Cross Care (Tas) Inc.'s submission on this issue.

Southern Cross Care (Tas) Inc. submitted that Mrs King's evidence did not demonstrate ignorance of the standard complaints handling process but rather, her preference to use email or letter to make complaints.[147] Further, Ms Marshall's evidence to the effect that she was unaware of a standard complaints handling process at Glenara Lakes, or more broadly at Southern Cross Care (Tas) Inc., should be understood in the context of her written statement which detailed the complaints handling process at Glenara Lakes.[148]

Southern Cross Care (Tas) Inc. did not address specifically Counsel Assisting's submissions in relation to the absence of effective systems at Glenara Lakes or Yaraandoo to ensure systematic collection and analysis of complaints information. It appears that by at least November 2019, Southern Cross Care (Tas) Inc. used a Clinical Incident Report which recorded complaints and included some analysis of trends in relation to complaints data. That may have been the result of the management systems action plan developed by Ms Cressey Hardy by May 2019, but this is not clear on the evidence.[149]

Pathway to break-even

Mr Sadek told us that in 2016, the board developed a strategy to ensure the ongoing financial viability of Southern Cross Care (Tas) Inc. The strategy was not to compromise standards of care by ensuring that expenditure, including in relation to staffing, was maintained at a sustainable level. This was called a 'pathway to break-even'.[150]

The strategy included an expenditure target for each residential aged care facility of 60% of total income / revenue. The balance of 40% of income / revenue was to cover indirect care costs such as catering, cleaning, laundry, repairs and maintenance, utilities and administration costs. Mr Sadek had been advised that this objective would be in keeping with recognised national benchmarks.[151]

The strategy was to be adopted for all Southern Cross Care (Tas) Inc. residential facilities in the 2016–17 financial year. Implementation was a matter for each facility manager, subject to the condition that the quality of care was not compromised and all regulatory requirements were complied with. The intention was for each residential aged care facility to have an objective that costs be covered by income for that facility. Other factors such as location, availability of staff, occupancy, resident / consumer profile, and layout of the facility needed to be taken into account.[152]

Mr Crane, the organisation's Director of Finance, said that in relation to the pathway to break-even, the board were not trying to issue a mandate. Rather, they were trying to define a framework to 'put guidelines or markers in the ground to work towards'.[153] Mr Shirley described the approach as:

> The 'pathway to break-even' involves a modest direct-care expenditure target for residential aged care facilities of 60% of total revenue (derived from ACFI [Aged Care Funding Instrument] and resident fees). By reaching this target, a facility is more likely to 'break even' or make a modest surplus at the operating level. It is based on the reasonable assumption that if the income received from the daily activities of the facility can cover the daily costs of operating that facility, there exists the basis for long term sustainability…
>
> In relation to the perceived link between direct care expenditure and the quality and safety of an aged care facility, I note that the SCC Tas [Southern Cross Care (Tas) Inc.] facility at Ainslie Low Head has consistently demonstrated the ability to operate at around the 60% expenditure target while maintaining full compliance with applicable accreditation standards…
>
> One of the intended purposes of the pathway to break-even objective was to reduce direct care expenditure across SCC Tas residential aged care facilities to a sustainable level. I acknowledge that any such reduction in direct care expenditure may be associated with a reduction in staffing levels. However, as noted above, I was and remain satisfied that an expenditure target of 60% is modest, and directed to ensuring the ongoing financial viability of SCC Tas. As demonstrated by the experience of Ainslie Low Head, referred to above, a residential aged care facility can meet the 60% expenditure target while maintaining a high standard of care in accordance with the relevant accreditation standards at the ACFI levels common to SCC Tas facilities. [154]

Mr Crane told us that it was accepted that there was a need for 'facility leadership to own the solution and identify their own pathway to achieve break-even'.[155] He described facility managers as 'the strongest advocate and the strongest control'.[156] Mr Crane said that the strategy was designed with the intention that 'facility managers had a large say in how they moved to this position' because 'there is no one size fits all'.[157]

The pathway to break-even was not implemented at Yaraandoo in the 2016–17 financial year. Changes were developed and introduced during 2018, by which time Mr Anderson was the facility manager. Mr Anderson had no previous experience as a facility manager. He had worked as a nurse for approximately one year and nine months. When asked by Counsel Assisting whether he felt it was 'a big step up in October 2017 to apply for a facility manager's job', he responded 'Yes, I did.'[158]

An employee satisfaction survey undertaken in April 2018 identified concerns from Yaraandoo staff including poor communication between staff and management, shortages of equipment and other stock and insufficient numbers of staff.[159] Counsel Assisting asked Ms Robson whether she was aware of problems with the workforce. She said that she was

aware that Yaraandoo 'was a difficult place'. Ms Robson said that it was because of this that she arranged for a 'competent facility manager who was achieving the break-even' and the Human Resources Manager to provide support to Mr Anderson.[160]

Ms Bennett told us that Mr Anderson's inexperience and the insufficient support, guidance and direction provided to him contributed to quality and safety issues at Yaraandoo.[161] Ms Cressey Hardy also considered Mr Anderson's inexperience and lack of supervision were contributing factors.[162]

Mr Sadek told us that there was a lack of support for Mr Anderson from the entire Executive Management Team for which he apologised to Mr Anderson. Mr Sadek also said that Southern Cross Care (Tas) Inc. had allowed Yaraandoo 'to be isolated without support from a clinical involvement perspective'.[163]

Mr Anderson told us that, with the benefit of hindsight, Yaraandoo was a site 'much more appropriate for a veteran manager'.[164] Mr Groom told us that the job of facility manager 'is one of the toughest, most difficult jobs in the whole aged care sector'.[165]

Ultimately, staffing changes were introduced at Yaraandoo in August 2018.[166] Mr Sadek said those changes came about as part of a review with the facility manager in consultation with Mr Crane. Ms Robson was also involved in what she described as a collaborative approach.

Mr Sadek told us that prior to approving the August 2018 changes at Yaraandoo, he had rejected an earlier recommendation from the review because he believed it was 'too severe', and 'would have caused industrial chaos' and 'compromised the quality of care'.[167]

Mr Crane said only a small part of the plan was actually implemented at Yaraandoo and similarly at Glenara Lakes.[168] Mr Crane described the changes at Yaraandoo as 'only a relatively small adjustment to rosters' and 'no adjustments were made to clinical team staffing'.[169] The changes required adjustments to the staff roster in two stages. The first stage involved reductions of:

(a) 15.2 registered nurse hours per fortnight through the removal of registered nurse hours being worked 'off the floor'

(b) 1 hour kitchen and servery per day

(c) 14 hours extended care assistant per day, comprising eight hours in the day shift and six hours in the afternoon shift.[170]

The second stage involved a further reduction of eight hours of extended care assistant time. It was to be implemented if there was no Aged Care Funding Instrument uplift (improvement) of $4 per resident per day after four months. A memorandum to all Yaraandoo employees on 19 June 2018 said the proposed changes were to ensure consistency with staffing levels at other Southern Cross Care (Tas) Inc. facilities and made no reference to the break-even pathway.[171] The same explanation was given by letter dated 20 June 2018 to the Australian Nursing and Midwifery Federation (Tasmanian Branch).[172]

As mentioned previously, Mr Shirley told us that he did not believe any reduction in staffing to be a significant cause of issues leading to sanctions at Yaraandoo.[173]

Submissions and conclusion

Counsel Assisting submitted that the decision to approve staffing changes at Yaraandoo in June 2018 as part of the pathway to break-even was focused on financial considerations without an equivalent or sufficient assessment of clinical risk.[174] Counsel Assisting pointed to the following matters:

(a) the team responsible for the implementation of the Break Even Strategy at Yaraandoo, including the decision to recommend approval of reduction in care staff hours in June 2018, comprised Mr Crane and Ms Robson, two executive managers who did not have clinical qualifications, and Mr Anderson, an inexperienced facility manager[175]

(b) Mr Anderson felt under considerable pressure to implement staff reductions as part of the Break Even Strategy, which was presented to him as a necessity, in particular by Ms Robson[176]

(c) at the beginning of June 2018, Mr Crane queried with Ms Robson whether Mr Anderson was 'complying under pressure' with the Break Even Strategy, and wrote that there was a need for Mr Anderson to be 'totally transparent about changes and whether it will impact on his ability to deliver quality of care or put unreasonable burden on his staff'[177]

(d) the Director of Clinical Care, Ms Wallace, had nothing to do with the decisions made about rosters[178]

(e) assessment of potential clinical risk associated with the staffing changes was limited because the Director of Clinical care was not visiting Yaraandoo.[179]

Southern Cross Care (Tas) Inc. rejected these submissions. They submitted that, among other things, Mr Sadek gave evidence about matters he had regard to when approving the staff reductions.[180]

Southern Cross Care (Tas) Inc. emphasised the role of facility managers in the implementation of the pathway to break-even in its post-hearing submissions. Southern Cross Care (Tas) Inc. stated that:

> The processes in place for measuring and assessing clinical risk in the context of the '*Pathway to Break Even*' relied, to a significant extent, on individual facility managers supported by…members of the SCC [Southern Cross Care (Tas) Inc.].[181]

Southern Cross Care (Tas) Inc. submitted that, to the extent that there was a failure to adequately assess the clinical risk associated with staffing reductions at Yaraandoo, the responsibility for that failure lay with Mr Anderson.[182]

Southern Cross Care (Tas) Inc. submitted that, in assessing clinical risk associated with staffing reductions, Mr Sadek took seven matters into consideration:

(a) the absence of any adverse findings in relation to Yaraandoo in accreditation reports

(b) the fact that Yaraandoo was found to be compliant in each of the assessed areas following an accreditation audit conducted in August 2018

(c) the absence of any clinical concerns expressed in relation to Yaraandoo at executive management team meetings or audit and risk committee meetings

(d) the absence of any complaints in relation to resident care at Yaraandoo that had been brought to his attention

(e) the fact that relevant unions had been consulted

(f) the fact that the proposal had been reviewed by Jenny Thomas, an experienced human resources practitioner

(g) the fact that the Director of Residential Business Services had advised him that the proposed staffing cuts would not compromise the quality of care at Yaraandoo.[183]

We deal with each of these considerations in turn. The most recent accreditation report for Yaraandoo that was available to Mr Sadek at the time was prepared in September 2016. At that time, Yaraandoo was assessed to have met all expected outcomes.[184] We doubt whether a September 2016 report was a reliable indicator about potential clinical consequences of reducing staff hours in June 2018.

There was no 'accreditation audit' in August 2018. Mr Sadek told us:

> I was satisfied in respect of a report that Mrs Robson just referred to, that in August 2017—'18, the accreditation audit had made a—undertaken a contact visit and had assessed—undertook a review of eight outcomes and assessed them as being compliant.[185]

Ms Robson's evidence was that she had intended to refer to an assessment contact rather than an 'accreditation audit' in August 2018.[186] That is consistent with Mr Sadek's description of a 'contact visit'. However, the precise description used in the submissions is of little consequence. The decision to make changes at Yaraandoo was made in June 2018 and well before the contact from the Aged Care Quality and Safety Commission in August 2018.[187]

Mr Sadek had regard to the fact that no complaints concerning resident care at Yaraandoo had been brought to his attention. He relied on an absence of any clinical concerns being expressed to him in relation to Yaraandoo at executive management team meetings or audit and risk committee meetings. However, it may have been unwise for Mr Sadek to rely upon the absence of hearing about clinical concerns.

We are also mindful of Mr Anderson's evidence that there was no analysis of the effect of the proposed staffing cuts on resident care at Yaraandoo. Mr Anderson accepted that this was a failure on his part.[188] This is important evidence given the role of facility managers in implementing the pathway to break-even as explained by Mr Crane and Mr Sadek and set out above.

It is necessary to return briefly to Counsel Assisting's submission that Mr Anderson was placed under considerable pressure to implement staff reductions which was presented to him as a necessity, in particular by Ms Robson. Southern Cross Care (Tas) Inc. submit that it would be unfair to rely upon evidence of communications between Mr Anderson and Ms Robson on this issue. That is because Mr Anderson's claims were not put to Ms Robson in examination. We accept Southern Cross Care (Tas) Inc.'s submission.

Mr Sadek was the decision-maker in relation to staffing changes at Yaraandoo. He told us of the factors he had regard to in making his decision. As discussed above, some of those factors may have been of little assistance. He explained that he acted on a recommendation from a committee of three and had the benefit of other advisers, as we have noted.

Southern Cross Care (Tas) Inc. submitted that responsibility for assessing clinical risk associated with the staff reductions lay with Mr Anderson. Mr Anderson was inexperienced and he was unsupported by Southern Cross Care (Tas) Inc. He told us that he did not analyse the effect of the staff cuts on resident care. He told us he had reservations about the changes at the time and that neither Mr Crane nor Ms Robson—the other members of the committee of three relied upon by Mr Sadek—ever sought to gauge his views about the effect of the staff reductions.[189] Mr Anderson told us the staffing cuts occurred 'without adequate regard for care'.[190]

Southern Cross Care (Tas) Inc. submitted that there is no cogent evidence to support a characterisation that any of the persons responsible for the implementation of the pathway to break-even was prepared to place financial considerations above quality resident care. They also submitted that an allegation in those terms was not put to Mr Crane, Ms Robson, Mr Sadek or Mr Anderson.[191]

We make recommendations about the governance of approved providers in Chapter 13, Volume 3 of our Final Report.

13.2.2 Bupa South Hobart

Introduction

In this case study our focus was on the governance of and the services provided by Bupa Aged Care Australia Pty Limited (Bupa Aged Care or Bupa) at Bupa South Hobart aged care facility. We examined the period between November 2014 and September 2019 (the relevant period).

During this case study, we heard oral testimony from 17 witnesses. We also received 23 written statements and the Bupa South Hobart tender bundle comprising 298 documents.

We conducted a site visit at Bupa South Hobart aged care facility on 13 November 2019.

Attempts were made to serve a summons on Mr David Neal, former General Manager at Bupa South Hobart aged care facility. However, these attempts were unsuccessful and Mr Neal did not give evidence. Bupa, Ms Davida Webb, Ms Linda Hudec, Ms Stephanie Hechenberger, Ms Cynthia Payne, Dr Marguerite Haertsch, Mr John Engeler, Dr Elizabeth Monks, Ms Carolyn Cooper, Ms Elizabeth Wesols and Ms Sarah Gaffney were granted leave to appear and were legally represented.

In accordance with directions we made on 15 November 2019, Counsel Assisting provided written submissions.[192] We received submissions from Bupa, Ms Merridy Eastman, Ms Hechenberger, Dr Monks and Ms Webb.[193]

In the following sections, we set out the background to the case study including an overview of Bupa Aged Care's model of care and various initiatives it implemented which we consider impacted on the quality and safety of care at Bupa South Hobart aged care facility. We summarise the evidence of the direct experience witnesses in relation to complaints they made. We discuss the organisational governance, leadership, culture and clinical governance at Bupa South Hobart aged care facility.

Overview

Bupa South Hobart aged care facility is an aged care facility in Tasmania, operated by Bupa Aged Care. The facility can accommodate up to 119 residents.[194] When the former Australian Aged Care Quality Agency undertook an assessment contact on 9 October 2018 there were 118 residents, all of whom had high care needs.[195]

The Bupa South Hobart aged care facility case study considered the following issues:

(a) the role of governance in ensuring the quality and safety of aged care services

(b) whether deficiencies in the quality and safety of care at Bupa South Hobart aged care facility were attributable to deficiencies in the clinical governance arrangements at Bupa.

Bupa Aged Care's Model of Care

Between 2014 and 2017, Bupa Aged Care implemented a model of care in its residential aged care facilities known as the Bupa Model of Care (BMOC 1). BMOC 1 aimed 'to provide a "person centred" approach to put the resident at the centre of decision making to ensure that their rights and needs were first priority'. As part of BMOC 1, three key changes to staffing occurred:

(a) general practitioners were employed or engaged

(b) clinical managers (who were registered nurses) were employed to work alongside those general practitioners

(c) care managers (who were also registered nurses) supervised care staff.[196]

In May 2017, Bupa Aged Care Australia introduced an initiative to 'save shifts' to improve their 'commercial position'.[197] This involved 'saving' an equivalent of two shifts per day in residential aged care facilities like Bupa South Hobart aged care facility. This was to be achieved by means including not replacing staff who called in sick.[198] On 9 May 2017, Mr Ian Burge, Bupa Aged Care's Director of Operations, sent an email to all Bupa general managers, regional support managers and regional directors. In that email, Mr Burge said that there were 'no sacred cows and anything's possible' with the goal of reducing operating costs so as to 'roughly…double our current monthly profit'.[199]

On 12 May 2017, Bupa South Hobart aged care facility's then General Manager David Neal reported that he had 'saved a shift' every day that week, 'saving' a total of 57 care hours.[200] In oral evidence, Ms Cooper agreed with Senior Counsel Assisting's suggestion that it was unrealistic to implement 'save a shift' without having a deleterious effect on care. Ms Cooper also stated that she would not endorse the policy of saving money by saving shifts.[201]

From 2017 to 2018, as part of what was called 'the Back to Base program',[202] Bupa Aged Care implemented two other initiatives designed to improve the organisation's commercial position by reducing staffing levels across its 72 aged care facilities:

(a) Bupa Model of Care 2 (BMOC 2), where the separate roles of Clinical Manager and Care Manager were combined to create the role of Clinical Care Manager. This was implemented in or around October 2017 at Bupa South Hobart aged care facility and one staff member was made redundant as a result[203]

(b) Project James, which involved 'changes to the rostering model through the reduction in the number of Registered Nurses and Enrolled Nurses, and their hours'. By around 21 May 2018, Bupa South Hobart aged care facility 'had reduced its Registered Nurse and Enrolled Nurse hours by 26 hours as part of the implementation of Project James'.[204]

We heard from direct experience witnesses Ms Diane Daniels, Ms Merridy Eastman, US and UQ. They considered that the reduced staffing levels impacted on the quality of care received by vulnerable residents living at Bupa South Hobart aged care facility, and on their everyday lives.[205] Ms Eastman and Ms Daniels gave evidence about the general neglect that, in their view, occurred due to understaffing.[206] UQ and US used their own resources to pay for the supplementary care their father needed which was not being provided at Bupa South Hobart aged care facility.[207]

External audit and sanctions

The Australian Aged Care Quality Agency conducted an audit at Bupa South Hobart aged care facility from 15 to 18 October 2018. During that audit, fundamental care deficiencies were observed.[208] The Agency's auditors concluded that Bupa South Hobart aged care facility did not meet 32 of the 44 expected outcomes set out in the Accreditation Standards. This included 13 of 17 expected outcomes concerned with health and personal care.

On 21 November 2018, a delegate of the Chief Executive Officer of the Australian Aged Care Quality Agency determined that the facility did not meet 32 of the 44 expected outcomes.[209] One important unmet expected outcome was the requirement that Bupa South Hobart aged care facility have appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with the Accreditation Standards.

On 25 October 2018, following the Agency's audit, a delegate of the Secretary of the Australian Department of Health concluded that Bupa Aged Care's non-compliance with the Accreditation Standards had placed some residents at an immediate and severe risk to their safety, health or wellbeing. The delegate described the failure to meet the majority of the health and personal care outcomes as an 'extremely high and concerning level of non-compliance'. He considered it was appropriate to impose sanctions. Sanction 1 was to restrict payment of subsidy under Part 3.1 of the Aged Care Act. Sanction 2 was to revoke approval as an approved provider of aged care services unless Bupa Aged Care appointed an adviser and an administrator and agreed to provide training to its officers, employees and agents.[210]

Bupa South Hobart aged care facility was one of 10 Bupa residential aged care facilities in respect of which Bupa was sanctioned between July 2018 and March 2019.[211]

From 1 November 2018, Bupa South Hobart aged care facility added an additional 33.5 care giver hours a week to the roster.[212] Bupa South Hobart aged care facility continued to operate on this roster as at the date of Bupa Aged Care's submissions.[213]

On 23 July 2019, the sanctions imposed on Bupa South Hobart aged care facility were lifted.[214]

Management of complaints

Four direct experience witnesses told us about the care their loved ones received and their own experiences of Bupa South Hobart aged care facility and Bupa Aged Care's management. Counsel Assisting did not seek any specific findings arising from the evidence given by the direct experience witnesses.

Ms Daniels' mother, Ms Emily Flanagan, had been a resident at Bupa South Hobart aged care facility since February 2015. Ms Daniels said that she started having problems with, and making complaints about, the level of care her mother was receiving almost immediately after her mother moved into Bupa South Hobart aged care facility.

Her concerns included the lack of rehabilitation and physiotherapy Ms Flanagan received following two falls, a lack of assistance with meals, long waits for other assistance and general untidiness of her room. She said her mother had told her of being 'bashed during the night' and seemed frightened.[215] Despite her regular complaints to personal care attendants, care managers, the General Manager at Bupa South Hobart aged care facility and the Regional Support Manager, Ms Daniels said that many of these issues continued. Ms Daniels told us that in 2017, she made a complaint to the Aged Care Complaints Commission. Of the 15 issues she raised in that complaint, eight continued to be ongoing concerns.[216]

Ms Daniels became increasingly frustrated with the lack of response or positive change when she made complaints. She said:

> I felt like I was failing her [her mother]. It felt like no matter what I tried, I wasn't able to access the right kind of care for her. Bupa sent people to try and smooth over my complaints, but nothing changed.[217]

Ms Merridy Eastman's parents, the late Mr Walter Eastman OAM and Mrs Berenice Eastman, began receiving care at Bupa South Hobart aged care facility in January 2016. Five months after they moved in, Ms Eastman and her siblings began receiving calls from their mother complaining about the quality of care she and her husband were receiving. Ms Eastman gave evidence that despite raising these complaints with then General Manager David Neal via email and during a family conference, the same problems continued.[218]

Ms Eastman described feeling contempt from management at Bupa South Hobart aged care facility directed towards families such as hers who attempted to advocate for their loved ones. She did not believe there was transparency in relation to complaints management at Bupa South Hobart aged care facility. At the time of her evidence, she was not aware of the complaints process.[219]

Mr Eastman died in January 2018, but Mrs Eastman was still receiving care at Bupa South Hobart aged care facility. Ms Eastman told us that her family's complaints continued.[220] Following Mr Eastman's death, the facility wanted Mrs Eastman to change rooms, which she considered to be her home. Ms Merridy Eastman considered emails she received from the facility at the time were callous and business like. She said 'our situation couldn't have been more personal and distressing, requiring compassion'. She felt as though the family was robbed of the whole grieving process for her Dad because of that issue. She thought it was 'really hurtful because it seemed deliberate'.[221]

UQ and US are sisters. Their late father received care at Bupa South Hobart aged care facility between December 2013 and September 2018. UQ and US gave evidence that they raised complaints about their father's care during family conferences with staff and management at Bupa South Hobart aged care facility in February and July 2014. However, the same problems continued.[222]

Ms Tiffany Wiles, a Director from Key2Care Pty Ltd, was appointed as an adviser at Bupa South Hobart aged care facility on 1 November 2018. She was overwhelmed with contact from families seeking to raise concerns with her. She told us this suggested people who had been raising issues with facility management felt they were not heard, or satisfied that their issues had been resolved.[223]

Dr Penny Webster and Ms Bethia Wilson AM were engaged through Wilson and Webster Consultancy Services to meet with residents at a number of Bupa Aged Care facilities, including Bupa South Hobart.[224] They considered Bupa's failure to respond adequately to complaints was 'a lost opportunity'. They told us that if Bupa Aged Care had listened respectfully to the complaints and investigated them fully, the quality of care may not have deteriorated as comprehensively as it did.[225]

In its submissions, Bupa Aged Care conceded that there 'was a failure to adequately address comments and complaints' at Bupa South Hobart aged care facility.[226] Bupa Aged Care also accepted that feedback from residents and their families was 'not always acted upon appropriately at Bupa South Hobart aged care facility'.[227]

Bupa Aged Care further accepted that there were times when the culture at Bupa South Hobart aged care facility was such that 'residents, their families and staff members did not feel encouraged or supported to provide comments and complaints'.[228] Bupa Aged Care acknowledged that the 'failure to adequately address comments and complaints is in itself an instance of substandard care.'[229]

In its submissions, Bupa Aged Care recognised that complaints should be seen, and responded to, as an opportunity for continuous improvement.[230] Bupa Aged Care pointed to remediation measures undertaken to improve complaints handing after Bupa South Hobart aged care facility was sanctioned, including the creation of a dedicated complaints manager role, a new complaints management framework and further education and training on complaints handling.[231]

Conclusion

We heard about the importance of good complaints handling processes through evidence relating to Bupa South Hobart aged care facility. As noted above, Dr Webster and Ms Wilson told us that if Bupa Aged Care had listened respectfully to the complaints and investigated them fully, the quality of care may not have deteriorated as comprehensively as it did.[232]

We acknowledge Bupa Aged Care's submissions that it has taken remediation measures to improve its complaints handling process, including by improving its organisational culture.[233] We note that Bupa South Hobart aged care facility met all the outcomes for Aged Care Quality Standard 6, on feedback and complaints, in an audit undertaken by the Aged Care Quality and Safety Commission from 17 to 19 July 2019.[234]

Leadership, culture and organisational governance

Ms Cooper told us that 'stable leadership and stable clinical leadership is really important' and something Bupa Aged Care saw as being a major issue for Bupa South Hobart aged care facility.[235] Ms Wilson and Dr Webster stated that 'carers expressed dismay at constant changes of senior management citing 14 changes in managers over 12 months' at Bupa South Hobart aged care facility.[236] Ms Cooper considered that the 'transient nature of the leadership' at Bupa South Hobart aged care facility immediately after the sanctions delayed the implementation of remediation measures.[237]

Ms Cooper explained that the Regional Operations Director for Bupa Aged Care's South Region has overall operational leadership and management of care homes in Victoria, Tasmania and South Australia, including the Bupa South Hobart aged care facility. In Tasmania, a Regional Manager is responsible for overseeing the conduct of operations of six care homes, including the Bupa South Hobart aged care facility. The General Manager of the Bupa South Hobart aged care facility has responsibility for the day-to-day management and operations of that facility and there are two clinical care managers at that facility.[238]

Ms Cooper considered that the primary factors contributing to instances of substandard care at the Bupa South Hobart aged care facility during 2018 included an apparent failure to provide appropriate leadership. As an example, she referred to the apparent failure to implement and oversee appropriate and safe systems and processes.[239] Referring again to leadership, Ms Cooper told us that:

> it is critical to appoint the right person to manage and monitor the care home…It also involves leading by example and engaging with the people that are providing care directly to residents, their families and staff…[240]

She thought the General Manager's limited engagement with staff and not holding staff to account during 2018 contributed to poor culture.[241] Ms Hudec thought the culture at Bupa Aged Care became 'problematic' due to 'significant turnover of general managers and care managers'.[242] Ms Hudec explained that the various restructures blurred reporting lines and people within the organisation did not know how to escalate concerns. Ms Webb explained that 'leadership in a care home is essential' and it is important to have oversight of the culture in a facility.[243]

Ms Wilson told us there was a culture at Bupa South Hobart aged care facility that if someone complained, it could mean that their relative would not receive good care.[244] Dr Webster said the element of fear attached to the complaints process was indicative of poor culture and the opposite of best practice complaints handling.[245]

The Governance Institute of Australia states:

> It is an essential element of governance for a board to understand if there is any disjunction between the desired and stated culture and the actual culture, for it is only the actual culture… that matter[s].[246]

The Institute identifies an excessive emphasis on short-term financial targets as a warning sign of poor corporate culture.[247] Counsel Assisting submitted that the cost saving strategies implemented at Bupa South Hobart aged care facility including BMOC 2, Project James and 'Save a Shift' are examples of such an excessive emphasis on short-term financial targets.[248]

Bupa Aged Care accepted that, with the benefit of hindsight, the 'implementation of 'Save a Shift' and Project James at Bupa South Hobart was misguided'.[249] Bupa Aged Care pointed to the difficulties associated with Bupa South Hobart aged care facility, namely its location, competition with the public health system for quality clinical staff, and its layout.[250] Bupa Aged Care accepted that in light of these difficulties, these projects contributed to instances of substandard care at Bupa South Hobart aged care facility.[251] As conceded by Ms Hechenberger, all these challenges would have been known to Bupa Aged Care at the time it designed and implemented those projects.[252]

Bupa Aged Care also accepted that there were deficiencies in its governance, leadership and culture during the relevant period, which impacted upon the quality and safety of care at Bupa South Hobart aged care facility.[253] Further, Bupa Aged Care accepted that the culture within Bupa South Hobart aged care facility 'contributed to the manner that comments and complaints were handled by the General Manager and the leadership team'.[254] Ms Cooper told us that one lesson from this is the importance of having employees with the appropriate skills and the right attitude, including empathy and integrity.[255]

In its submissions, Bupa Aged Care pointed to changes that it has made to address these deficiencies, including improved complaints handling processes and efforts to strengthen governance arrangements. They also include ensuring Directors and senior managers of Bupa Aged Care are fit and proper persons to carry out their responsibilities, undertaking education and training on clinical governance, and the appointment of an independent non-executive chair to Bupa Aged Care's board.[256]

Finally, Bupa Aged Care submitted that the various changes made following the sanctions at Bupa South Hobart aged care facility being lifted demonstrated the organisation's ongoing commitment:

> to foster a culture that promotes the quality and safety of care to its residents whilst…allowing for the proper scrutiny of decisions made by management that may affect the quality and safety of care.[257]

Conclusion

Effective leadership, the right culture and strong organisational governance are key factors contributing to the ability to provide high quality and safe care. Bupa Aged Care acknowledged that its leadership, culture and governance at Bupa South Hobart aged care facility were deficient.[258]

Bupa Aged Care agreed with Counsel Assisting's submission that the failure to foster an organisational culture that encourages feedback is a systemic failure that may cause substandard care.[259]

We accept Counsel Assisting's submission that the cost saving strategies implemented by Bupa Aged Care such as BMOC 2, Project James and 'Save a Shift' placed greater weight on short-term financial targets and suggested poor corporate culture.[260] As previously noted, Mr Burge, Bupa Aged Care's then Director of Operations, told managers and directors in an email that in the context of caring for frail and vulnerable residents, there were 'no sacred cows and anything's possible' with the goal of reducing operating costs to 'roughly…double our current monthly profit'.[261] Bupa Aged Care accepted that these projects contributed to instances of substandard care at Bupa South Hobart aged care facility.[262] We agree.

An approved provider must take active steps to foster a good organisational culture and this culture must be promoted by senior leadership and facilitated by strong governance arrangements. We note that significant remediation efforts have been undertaken by Bupa Aged Care to improve its organisational culture, governance and leadership.[263]

We now consider Bupa Aged Care's clinical governance framework and its actions during the period after sanctions were imposed in October 2018.

Clinical Governance Framework

Ms Maureen Berry, the Executive Clinical Advisor and former Chief Operating Officer and Clinical Service Improvement Director of Bupa Aged Care, described the clinical governance framework in her statement as:

> A framework of responsibility and accountability, that continuously measures, monitors and improves the safety and quality of clinical services…and differentiates the quality of clinical services Bupa provides and funds promoting optimal patient / customer health outcomes and clinical excellence.[264]

In the framework, Bupa Aged Care's objective is described as:

> To provide an overview of the Clinical Government Framework to ensure that BVAC Aus [Bupa Aged Care and Vilages] adopts a robust, consistent and proportionate approach to the development, implementation and monitoring of clinical governance and to promote and assure (where practically possible) the safety and quality of care for its residents. It also supports the promotion of a culture of quality improvement.[265]

We heard that the framework states that the complexities of the aged care sector underlie the importance of viewing clinical governance as a system—not just a set of policies and procedures, but a complex set of interrelationships and interactions. It says that integrated clinical governance systems are fundamental to clinical excellence and providing quality person-centred care. Bupa Aged Care's published approach to clinical governance comprises seven component principles, configured as below.[266]

Bupa Aged Care's clinical governance framework is intended, in part, to allow the organisation to identify 'significant or high risk areas of the business in conjunction with legislation and compliance with the Australian Aged Care Accreditation Standards'.[267] This was to be partially achieved through a process of clinical governance reviews and mock audits.

A clinical governance review is undertaken for care homes identified at risk of not meeting Accreditation Standard Two – Health and Personal Care. That risk might be identified from information or data gathered through complaints, clinical data indicators, incidents relating to clinical care, or changes in the clinical care team. Depending on the size of the facility, a clinical governance review could take one to two days and involve an examination of clinical data and a review of at least 10 clinical files. A clinical governance review is undertaken by a Clinical Governance Consultant. [268]

A mock audit is said to be 'far more thorough than a clinical governance review'.[269] Mock audits were designed to support care home leadership teams prepare for accreditation and assess the care homes against all the Quality of Care Principles to ensure that safe and effective care is delivered.[270] A mock audit is conducted by two Clinical Governance Consultants or one Clinical Governance Consultant and one General Manager or Care Manager.[271]

The operation of the Clinical Governance Framework was an important issue in this case study. There were competing submissions between Counsel Assisting and Bupa Aged Care about the decision not to undertake a clinical governance review following the October 2016 mock audit. Counsel Assisting submitted that this demonstrated a misunderstanding of the Clinical Governance Framework.[272] Bupa Aged Care did not agree.

Mock audits

Four mock audits were conducted at Bupa South Hobart aged care facility between November 2014 and July 2018. Each mock audit assessed compliance with the expected outcomes and provided an overall clinical governance risk rating of either green, amber or red. Green represented low risk with red representing the highest clinical governance risk.[273] The audits showed that at no time during that period was Bupa South Hobart aged care facility compliant with expected outcomes related to human resources, clinical care, specialised nursing care needs, medication management, nutrition and hydration, skin care, continence care, or behavioural management.[274]

The first mock audit was conducted in November 2014. Among other things, it revealed that Bupa South Hobart aged care facility did not comply with six of the 14 expected outcomes for Standard 2 of the Quality of Care Accreditation Standards (Health and Personal Care) and was partially compliant with a further five expected outcomes for Standard 2.[275] A mock audit in February 2016 found the facility to be only fully compliant with six of the 14 expected outcomes for Standard 2.[276]

Ms Stephanie Hechenberger, the former Regional Director for Bupa South Hobart aged care facility, said that the February 2016 audit 'demonstrated Bupa South Hobart aged care facility had a record of historical non-compliance'.[277] Ms Hechenberger and Ms Elizabeth Wesols, the former Regional Support Manager for Bupa South Hobart aged care facility, both described the findings from that audit as 'alarming'.[278]

Ms Hechenberger told us that the improvement plan implemented in response to the February 2016 audit was completed before she commenced her role at Bupa Aged Care in August 2016. She said she was 'alarmed' to receive an email in September 2016 from Bupa Aged Care's full-time general practitioner, Dr Elizabeth Monks, detailing a number of concerns regarding clinical care and other issues at Bupa South Hobart aged care facility.[279] She agreed with Counsel Assisting that taken together, the February 2016 mock audit results and the email from Dr Monks presented a picture of some serious clinical deficiencies at Bupa South Hobart aged care facility.[280]

Ms Wesols said that she requested a further mock audit be carried out at Bupa South Hobart aged care facility in October 2016.[281] Ms Hechenberger stated that the mock audit carried out on 25 to 28 October 2016 'highlighted continued compliance issues within the home'.[282] This audit found the facility to be compliant with only two of the 17 expected outcomes under Standard 2 of the Quality of Care Accreditation Standards.[283] Ms Wesols told us that she was deeply concerned about the standard of clinical performance at Bupa South Hobart aged care facility following the results of the October 2016 mock audit.[284]

Ms Linda Hudec led the Clinical Services Improvement team between March 2018 and January 2019. She explained the role of her team included conducting some of the mock audits. She said that her team would send 'recommendations of improvement initiatives' to the General Manager and Regional Manager.[285] An improvement plan would be prepared by the operations team, led by Ms Davida Webb, during the relevant period.

Ms Hudec said her team did not assess the efficacy of improvement plans created by the Operations team. She felt that 'was a fundamental flaw from the auditing process'. She also said that the mock audit tool was 'clearly not effective in what it was intended to do'.[286] Ms Hudec considered that the mock audit tool 'focused on work instructions, rather than Accreditation Standards' and 'didn't necessarily assess the quality of care standards'.[287]

Ms Hechenberger, who left Bupa Aged Care's employ in May 2018, pointed to a further weakness in the clinical governance framework:

> it was the assumption that the completion of an action plan meant that the home was going to remain compliant from that point on. And the completion of the action plan only rectified the errors up until that time and once that intensity was taken away, the teams would revert to poor practice.[288]

Another mock audit was conducted on 9 to 11 July 2018. Ms Hudec and Ms Webb were not provided with the outcome of that audit.[289] Ms Hudec explained that mock audit outcomes were often not escalated to her, but upon reflection said that the identified non-compliance should have been brought to her attention.[290] Ms Webb agreed.[291]

Ms Webb explained that the results of the July 2018 audit 'went to the care homes and to the operations managers to enact an action plan and to remediate at the care home', but they did not go to the heads of Clinical Services Improvement or Operations.[292] Ms Hudec agreed that, as the mock audit in July 2018 was the third audit in under three years which had achieved a red risk rating for Bupa South Hobart aged care facility, the audit result should have been escalated to someone at her level.[293] Ms Webb said that any one audit result achieving a red risk rating should be escalated to someone at her level.[294]

Clinical governance reviews

Ms Hechenberger described the clinical governance review as 'very similar to the mock audit, just much narrower in focus, clinical and continuous improvement only'.[295] In October 2016, she requested a mock audit because that was her understanding at the time of the 'correct way to go'. The mock audit gave her 'considerable information on compliance or lack thereof against Standard 2 and other standards'.[296]

Ms Hechenberger told us that she understood 'that a mock audit is far more thorough than a clinical governance review across Standard 2' and 'supersedes the Clinical Governance Review in its capability to provide information to the home'.[297] However, she also said that following an email from Dr Monks raising concerns about clinical care at Bupa South Hobart aged care facility in November 2017, she requested a clinical governance review to 'get a clear picture of exactly where the gaps are and the depth of them'.[298]

Ms Hechenberger stated that the clinical governance review was not carried out because a mock audit had already been scheduled for December 2017. Ultimately, no clinical governance review or mock audit was conducted at that time.[299] Instead, Ms Wesols commenced a review of care at Bupa South Hobart aged care facility on the day Dr Monks raised her concerns. Consequently, Ms Wesols made recommendations to Ms Hechenberger and Mr Neal including about the need for additional training and a review of diabetic needs.[300]

Ms Carolyn Cooper, the former Chief Operating Officer of Bupa, told us that she agreed that the Clinical Governance Framework did not operate effectively at Bupa South Hobart aged care facility during the relevant period, and that the problems raised in the mock audits were not addressed.[301]

In post-hearing submissions, Counsel Assisting submitted that we should find that there were 'serious shortcomings in the clinical governance framework at Bupa South Hobart between 2014 and 2018' for reasons that include:

(a) the series of mock audits conducted in accordance with Bupa Aged Care Australia Pty Limited's clinical governance framework revealed fundamental deficiencies in compliance with the Accreditation Standards, but Bupa Aged Care Australia Pty Limited failed to address the deficiencies in any meaningful way[302]

(b) a clinical governance review was not recommended by the Clinical Services Improvement Team, despite two mock audits in that year and the detailed concerns of Dr Monks in her September 2016 email.[303]

In reply Bupa Aged Care submitted that its 'clinical governance framework was not operating as it should have at the care home prior to the October 2018 Site Audit Report'.[304] Bupa Aged Care noted that:

> the internal audits conducted at Bupa South Hobart [from November 2014 to 18 September 2019] had correctly identified significant and recurrent compliance issues, particularly in relation to Standard 2 of the Accreditation Standards, but the measures put in place to address these issues were not sustained[305]
>
> …the governance structure and the Clinical Governance Framework in place to support Bupa South Hobart were deficient insofar as instances of substandard care were able to manifest (and audit issues were able to repeat) over the Relevant Period [from November 2014 to 18 September 2019].[306]

Bupa Aged Care also raised the importance of effective communication of information between each level of its Clinical Governance Framework, in the context of ongoing issues of substandard care that were repeatedly identified in internal audits. Bupa Aged Care accepted that:

(a) the General Manager did not provide appropriate leadership in the care home through implementing appropriate and safe systems and processes.[307]

(b) strong lines of communication and clear lines of responsibility between the Clinical Services Improvement Team and Operations Team did not exist at Bupa Aged Care Australia Pty Limited at the time of, or prior to, the October 2018 site report or sanctions.[308]

(c) the Clinical Services Improvement Team and Operations Team at Bupa Aged Care did not identify issues with the processes and systems at Bupa South Hobart aged care facility in a timely way. That team also failed to identify that the staff at Bupa South Hobart aged care facility had limited knowledge or awareness of Bupa Aged Care's systems and processes.[309]

Conclusion

A function of Bupa Aged Care Australia Pty Limited's Clinical Governance Framework is to ensure that identified clinical deficiencies are sustainably addressed. The mock audits successfully identified clinical and compliance deficiencies at Bupa South Hobart aged care facility, but the Clinical Governance Framework may not have been effective in ensuring that those deficiencies were sustainably addressed. We do not know if a clinical governance review would have made a practical difference, but we accept the evidence of Ms Hudec and Ms Webb that the outcomes of the July 2018 mock audit should have been escalated within Bupa Aged Care.

Bupa Aged Care accepts that the governance structure and the Clinical Governance Framework in place to support Bupa South Hobart aged care facility were deficient, as instances of substandard care occurred, and audit issues were repeated over the relevant period.[310]

Bupa Aged Care submitted that it has made changes to its Clinical Governance Framework, governance structure and compliance function.[311] These changes were detailed in Bupa Aged Care's submissions and in the evidence of Ms Cooper. In submissions, Bupa Aged Care stated that its board and leadership team have each 'undertaken specific education and training on clinical governance and the Aged Care Quality Standards', and that the board of its parent company also undertook training about compliance and clinical care.[312] Bupa Aged Care also noted the creation of a new Head of Risk position, and stated that changes to the terms of charter of the board would facilitate proper scrutiny of decisions that could affect the quality and safety of care.[313]

Post-sanctions—2019 roster

Between February and June 2019, Bupa Aged Care developed a new staffing roster to apply to all 72 of its aged care facilities in 2019, known as the '2019 roster'.[314] Counsel Assisting submitted that the new roster demonstrated a continued desire by Bupa Aged Care to reduce staffing levels.[315] Bupa Aged Care did not agree.

Ms Cooper was responsible, together with others, for overseeing the development of the 2019 Roster. She stated:

> The 2019 Roster implements a minimum of 2.5 direct care hours per resident per day. This figure was identified because it is just above the benchmarking of the top 25% of performing homes that were identified by StewartBrown in the 2018 Aged Care Financial Performance Survey.[316]

She explained that the 2019 Roster was intended to be implemented through an 80:20 split in which the aim was to provide 20% of direct care hours by registered nurses and 80% of care hours to carer roles.[317]

Ms Cooper approved the 2019 Roster for Bupa South Hobart aged care facility on or around 21 June 2019. In doing so, she approved certain 'warranted variations' on the basis of the 'acuity and environment…as well as the remediation efforts at that time'.[318] The warranted variations were:

(a) direct care hours for each resident per day were 3.0, rather than 2.5

(b) registered nurse to carer ratio was a 78:22 split, rather than 80:20.[319]

Dr Marguerite Haertsch and Mr John Engeler, of Anchor Excellence, were appointed as adviser and administrator respectively at Bupa South Hobart aged care facility in 2019. They told us of concerns they had in relation to proposed staffing cuts at the facility at that time. Dr Haertsch wrote to Ms Webb on 5 July 2019 strongly recommending that the proposed staffing cuts not be implemented at Bupa South Hobart aged care facility. Both Dr Haertsch and Mr Engeler were concerned that to do so would potentially expose Bupa South Hobart aged care facility to some of the problems it had when the sanctions were imposed in 2018.[320]

Given that the 2019 Roster was approved for Bupa South Hobart aged care facility on or around 21 June 2019, it appears likely that Dr Haertsch and Mr Engeler were, in their 5 July 2019 email, referring to the proposed staffing cuts sought to be implemented through the 2019 Roster.[321]

Dr Haertsch made it clear in her 5 July 2019 email that the proposed staffing cuts would affect the quality and safety of care delivered to residents at Bupa South Hobart aged care facility, including by likely increasing 'call bell response times'.[322] Dr Haertsch gave evidence that her impression was that the proposed staffing cuts at Bupa South Hobart aged care facility were an attempt to 'fulfil a…centralised request from Bupa'.[323]

Ultimately, the 2019 Roster was not implemented at Bupa South Hobart aged care facility and the facility continued to operate on a roster that had been approved on 1 November 2018. Ms Cooper told us that was because, as a recently sanctioned facility, Bupa South Hobart aged care facility was being monitored by a transition team and Bupa Aged Care's executive leadership team had not approved a 'return to business as usual'.[324]

Ms Cooper explained that the figure of 2.5 hours in the 2019 Roster was identified because it was just above the benchmarking of the top 25% of performing homes identified by StewartBrown in its 2018 Aged Care Financial Performance Survey (2018 Survey).[325]

Ms Cooper was asked by Counsel Assisting what she understood the term 'top 25%' to mean in the 2018 StewartBrown Survey. She responded:

> We actually talked about this quite a lot, because we actually weren't sure what they meant either, but we felt that if we were actually above a lot of the people that were actually involved in the survey—that it would be a better place to be, and it was actually an increase in hours for about half of the care homes.[326]

The more recent StewartBrown survey for the period ending March 2019 states that the 'first 25%' of residential aged care facilities had superior financial performance compared to the average of the 1011 facilities that were the subject of the survey. The 2019 survey makes it clear that the 'first 25%' is calculated without regard to the quality of care provided by the residential aged care facilities that were the subject of the survey. In particular, the 2019 survey states:

> We analyse the First 25% of aged care homes (remember: this is based on financial performance and not an indicator of quality of care)…[327]

Ms Cooper said that the 2019 Roster was intended to provide more direct care hours to care homes working at risk and lower than external benchmarks.[328] She also stated that the 2019 Roster was developed in consideration of a variety of factors, including the acuity of residents, skill requirements within available staff and full-time equivalent budget for the relevant facility.[329] In particular, Ms Cooper explained that she approved the warranted variations to the 2019 Roster in acknowledgement of the acuity of the situation at Bupa South Hobart aged care facility and ongoing remediation efforts there.[330]

Counsel Assisting submitted that the 2018 Survey does not use the expression 'top 25%' and that Ms Cooper was likely referring to the phrase 'first 25%' instead.[331] This was on the basis that the 2018 Survey uses the expression 'first 25%' rather than 'top 25%' and states that the first 25% represents the quartile of programs with the highest earnings per day, before interest and taxes.[332]

Counsel Assisting submitted that the phrase 'first 25%' represents the residential aged care facilities with the highest earnings before interest and tax and that these facilities are the 25% of residential aged care providers with the strongest financial performance.[333] Counsel Assisting submitted that the 'first 25%' did not take into account the standard of quality and safety of care at those homes.[334]

Counsel Assisting further submitted that the approach taken to setting the 2019 Roster, and other evidence about reduction in staff levels at Bupa South Hobart aged care facility in 2019, 'indicates that the desire to reduce staffing levels and save costs is an ever present reality at Bupa'.[335]

Bupa Aged Care submitted that Counsel Assisting's submissions did not accurately represent the development, implementation and purpose of the 2019 Roster. Bupa Aged Care stated that the assertion by Counsel Assisting that the 2019 Roster was based on the 2018 Survey with a view to achieving better financial performance was incorrect.[336] Bupa Aged Care submitted that the 2018 Survey was 'merely a reference tool to determine what Bupa Aged Care Australia Pty Limited's competitors were providing in terms of direct care hours'. Further, Bupa Aged Care submitted that the 2018 Survey was the only objective mechanism available to use when considering the most appropriate staffing levels in the aged care industry in Australia.[337]

Bupa Aged Care submitted that the 2019 Roster demonstrated it has taken steps to ensure Bupa South Hobart aged care facility 'is appropriately and adequately resourced to meet the needs of its residents and their families'.[338] Bupa Aged Care submitted that the fact that Ms Cooper approved a warranted variation to the 2019 Roster to allow for three direct care hours at Bupa South Hobart aged care facility refuted the suggestion that the 2019 Roster demonstrated Bupa Aged Care's continuing desire to reduce staffing levels. In addition, Bupa Aged Care submitted that the fact that Bupa South Hobart aged care facility continues to operate on the roster with an additional 33.5 nursing hours 'should be acknowledged and recognised as a positive step by Bupa'.[339]

Conclusion

The evidence before us suggested that the 2019 Roster was developed primarily using a benchmark of financial performance, although the warranted variations made to the 2019 Roster for Bupa South Hobart aged care facility had some regard to care needs at that facility.

We acknowledge Bupa Aged Care's submission that the 2018 Survey was the only objective mechanism available to use when considering the most appropriate staffing levels in the aged care industry in Australia.[340] In our view, this does not detract from the importance of ensuring that the basis of any staffing benchmark used is well understood and includes an assessment of the potential impact on quality and safety of care. It also points to a system-wide issue which we examine in Volume 2 of this report.

The 2019 Roster was not implemented at Bupa South Hobart aged care facility. However, any further initiative to reduce staffing levels at the facility soon after sanctions were lifted should have been well understood, and included an assessment of the potential impact on quality and safety of care.

Counsel Assisting submitted that the approach to developing the 2019 Roster suggests the desire to reduce staffing levels and save costs is an 'ever present reality' at Bupa. Counsel Assisting further submitted that if unchecked by proper scrutiny of management by the board, this could easily lead to future problems for the residents in Bupa Aged Care Australia Pty Limited's care.[341] Any organisational focus on reducing staffing levels and minimising operating costs at Bupa Aged Care must not compromise the quality and safety of care.

As with the Southern Cross Care (Tas) Inc. Case Study, we consider that the evidence in this case study demonstrates how important it is that the board of an approved provider takes all reasonable steps to ensure that quality and safe care is always provided to those in its care.

Endnotes

1 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0004 [18].
2 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0002 [9].
3 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0002 [9].
4 Submissions of Counsel Assisting the Royal Commission, Hobart Hearing, 2 December 2019, RCD.0012.0042.0001.
5 Submissions of Southern Cross Care (Tas) Inc, Hobart Hearing, 18 December 2019, RCD.0012.0049.0001.
6 Exhibit 13-3, Hobart Hearing, Statement of Helen Valier, WIT.0599.0001.0001 at 0004 [35]; 0002 [15].
7 Exhibit 13-3, Hobart Hearing, Statement of Helen Valier, WIT.0599.0001.0001 at 0006 [50]–[53].
8 Transcript, Hobart Hearing, Helen Valier, 11 November 2019 at T6607.25; T6612.12–42.
9 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 251, AWF.001.02142 at 0003; Exhibit 13-3, Hobart Hearing, Statement of Helen Valier, WIT.0599.0001.0001 at 0005 [41].
10 Transcript, Hobart Hearing, Helen Valier, 11 November 2019 at T6618.39–40.
11 Exhibit 13-3, Hobart Hearing, Statement of Helen Valier, WIT.0599.0001.0001 at 0016 [140]–[141].
12 Exhibit 13-3, Hobart Hearing, Statement of Helen Valier, WIT.0599.0001.0001 at 0016 [137]; [141]; 0017 [143].
13 Exhibit 13-8, Hobart Hearing, Statement of Mary Sexton, WIT.0602.0001.0001 at 0001 [6]–[7].
14 Exhibit 13-8, Hobart Hearing, Statement of Mary Sexton, WIT.0602.0001.0001 at 0004 [24]–[25]; Transcript, Hobart Hearing, Mary Sexton, 11 November 2019 at T6691.6.
15 Exhibit 13-8, Hobart Hearing, Statement of Mary Sexton, WIT.0602.0001.0001 at 0006 [40]; Transcript, Hobart Hearing, Mary Sexton, 11 November 2019 at T6692.44–45.
16 Exhibit 13-8, Hobart Hearing, Statement of Mary Sexton, WIT.0602.0001.0001 at 0011 [72].
17 Exhibit 13-8, Hobart Hearing, Statement of Mary Sexton, WIT.0602.0001.0001 at 0007 [45].
18 Transcript, Hobart Hearing, Mary Sexton, 11 November 2019 at T6697.11–13.
19 Exhibit 13-8, Hobart Hearing, Statement of Mary Sexton, WIT.0602.0001.0001 at 0002 [8]; 0017 [104].
20 Exhibit 13-9, Hobart Hearing, Statement of Ann McDevitt, WIT.0600.0001.0001 at 0002 [9]; 0001 [8]; 0002 [10]–[13].
21 Exhibit 13-9, Hobart Hearing, Statement of Ann McDevitt, WIT.0600.0001.0001 at 0005 [31].
22 Transcript, Hobart Hearing, Ann McDevitt, 11 November 2019 at T6703.6–28; T6705.38–6706.2; Exhibit 13-9, Hobart Hearing, Statement of Ann McDevitt, WIT.0600.0001.0001 at 0005 [36]–[37].
23 Exhibit 13-9, Hobart Hearing, Statement of Ann McDevitt, WIT.0600.0001.0001 at 0008 [56]–[58].
24 Exhibit 13-10, Hobart Hearing, Statement of Judith King, WIT.0611.0001.0001 at 0001 [6]–[7].
25 Exhibit 13-10, Hobart Hearing, Statement of Judith King, WIT.0611.0001.0001 at 0001 [9]; 0002 [19].
26 Transcript, Hobart Hearing, Judith King, 12 November 2019 at T6721.31–32.
27 Exhibit 13-10, Hobart Hearing, Statement of Judith King, WIT.0611.0001.0001 at 0016 [110].
28 Exhibit 13-19, Hobart Hearing, Statement of Patricia Job, WIT.0601.0001.0001 at 0001 [4]–[6]; 0002 [8].
29 Exhibit 13-19, Hobart Hearing, Statement of Patricia Job, WIT.0601.0001.0001 at 0002 [10].
30 Exhibit 13-19, Hobart Hearing, Statement of Patricia Job, WIT.0601.0001.0001 at 0002 [10]–[11]; Transcript, Hobart Hearing, Patricia Job, 13 November 2019 at T6887.30; T6888.5.
31 Transcript, Hobart Hearing, Patricia Job, 13 November 2019 at T6890.32–33.
32 Exhibit 13-19, Hobart Hearing, Statement of Patricia Job, WIT.0601.0001.0001 at 0003 [14]–[16]; 0005 [31]–[32]; Transcript, Hobart Hearing, Patricia Job, 13 November 2019 at T6887.43; T6888.29.
33 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 336, SCT.5016.0001.0008.
34 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 241, CTH.4018.2002.2892 at 2896.
35 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 57, SCT.0011.0004.0190; tab 64, CTH.4018.2000.3138; Transcript, Hobart Hearing, Pauline Robson, 12 November 2019 at T6818.14–18; T6820.28–38.
36 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 175, SCT.0011.0004.0129 at 0130.
37 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 190, SCT.0011.0004.0118.
38 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 176, CTH.1033.1002.1043 at 1043–1048.
39 Exhibit 13-5, Hobart Hearing, Statement of Jo-Anne Cressey Hardy, WIT.0496.0001.0001 at 0007 [29].
40 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 196, CTH.1033.1002.1594.
41 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 259, SCT.0011.0004.0002.
42 Exhibit 13-5, Hobart Hearing, Statement of Jo-Anne Cressey Hardy, WIT.0496.0001.0001 at 0007 [29].
43 Exhibit 13-6, Hobart Hearing, Statement of Kylie Bennett, WIT.0500.0001.0001 at 0007 [28].
44 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 273, SCT.0011.0006.0015.
45 Exhibit 13-6, Hobart Hearing, Statement of Kylie Bennett, WIT.0500.0001.0001 at 0019 [66].
46 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 320, SCT.5019.0001.0008.
47 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 336, SCT.5016.0001.0008; Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6825.16.
48 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0034 [136].
49 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0034 [138].
50 Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6834.45–T6835.10.
51 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0017 [76]–[78].
52 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 336, SCT.5016.0001.0008.
53 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 289, SCR.0010.0003.0016.
54 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 197, SCT.0010.0003.0107.
55 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 202, CTH.1033.1002.1682.

56 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 207, SCT.0010.0009.0002.
57 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 216, SCT.0010.0003.0147.
58 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 215, CTH.1033.1002.2203.
59 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 233. SCT.5008.0014.5460.
60 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 239, SCT.5008.0015.0540; Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 232, SCT.0010.0003.0163 at 0167.
61 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 263, SCT.5008.0014.1311.
62 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0033 [133].
63 Exhibit 13-1, Hobart Hearing, Hobart general tender bundle, tab 1, RCD.9999.0260.0001 at 0005.
64 Exhibit 13-1, Hobart Hearing, Hobart general tender bundle, tab 1, RCD.9999.0260.0001 at 0005.
65 Exhibit 13-40, Hobart Hearing, Statement of Catherine Maxwell, WIT.0620.0001.0001 at 0003 [13]–0004 [15].
66 Transcript, Hobart Hearing, Catherine Maxwell, 15 November 2019 at T7168.27–T7170.4.
67 Transcript, Hobart Hearing, Catherine Maxwell, 15 November 2019 at T7172.18–T7172.25.
68 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0003 [13]; Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6862.27–34; T6864.25.
69 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0001 [1].
70 Exhibit 13-18, Hobart Hearing, Statement of Raymond Groom, WIT.0550.0001.0001 at 0001 [3f].
71 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0001 [1].
72 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6848.26–35; Exhibit 13-18, Hobart Hearing, Statement of Raymond Groom, WIT.0550.0001.0001 at 0003.
73 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0003 [12].
74 Exhibit 13-18, Hobart Hearing, Statement of Raymond Groom, WIT.0550.0001.0001 at 0002 [4].
75 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0009 [31].
76 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6862.27–41; Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0024 [95].
77 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0008 [30a–b; d].
78 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 376, SCT.5017.0001.0002 at 0048–0057.
79 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 376, SCT.5017.0001.0002 at 0050.
80 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 376, SCT.5017.0001.0002 at 0050.
81 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6856.41–45; Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6856.34–6857.1.
82 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6864.32–37; Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6864.22–28.
83 Transcript, Hobart Hearing, Catherine Maxwell, 15 November 2019 at T7175.9–10.
84 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6867.9–13.
85 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 110, SCT5008.0014.9007.
86 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0016 [71]–[74].
87 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0016 [72]–[74].
88 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 330, SCT.5008.0010.6134; tab 110, SCT5008.0014.9007.
89 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6870.27–6871.33.
90 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6859.17–24; T6869.27–30.
91 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6870.10–17.
92 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0014 [61].
93 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6869.38–44.
94 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0009 [32]; 0010 [35].
95 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0010 [36]; Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0015 [36].
96 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6878.43–6879.10.
97 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6879.14–17.
98 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6852.29–33; Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6852.29–38.
99 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 376, SCT.5017.0001.0002 at 0050.
100 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6853.1–3.
101 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6854.19–37.
102 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6876.21–30.
103 Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6877.1–6.
104 Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6834.19–24; T6834.41–43; Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0040 [155].
105 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0004 [20]; Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6837.45–6838.10.
106 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0022 [88]–[89]; 0035 [140].
107 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0040 [155].
108 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0040 [155].
109 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 175, SCT.0011.0004.0129 at 0134.

110 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 323, CTH.4018.2002.6650 at 6654–6655.
111 Exhibit 13-7, Hobart Hearing, Statement of Patrick Anderson, WIT.0578.0001.0001 at 0002 [4a]; 0004.
112 Transcript, Hobart Hearing, Tammy Marshall, 11 November 2019 at T6622.27–29.
113 Exhibit 13-6, Hobart Hearing, Statement of Kylie Bennett, WIT.0500.0001.0001 at 0012 [50c].
114 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0034 [136d; k].
115 Transcript, Hobart Hearing, Peter Williams, 12 November 2019 at T6741.15–23.
116 Exhibit 13-11, Hobart Hearing, Statement of Peter Williams, WIT.0609.0001.0001 at 0007 [38].
117 Transcript, Hobart Hearing, Helen Marshall, 12 November 2019 at T6759.25–39.
118 Exhibit 13-15, Hobart Hearing, Statement of Pauline Robson, WIT.0560.0001.0001 at 0004 [6c(iii)].
119 Transcript, Hobart Hearing, Pauline Robson, 12 November 2019 at T6818.30–31.
120 Transcript, Hobart Hearing, Pauline Robson, 12 November 2019 at T6819.34–36.
121 Submissions of Counsel Assisting the Royal Commission, Southern Cross Care (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 at 0019 [64].
122 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Care (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0001 [2b]; 0005 [17].
123 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0034 [136d].
124 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Care (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0006 [18].
125 Transcript, Hobart Hearing, Helen (Ellie) Valier, 11 November 2019 at T6607.8–11.
126 Exhibit 13-3, Hobart Hearing, Statement of Helen (Ellie) Valier, WIT.0599.0001.0001 at 0016 [142].
127 Transcript, Hobart Hearing, Judith King, 12 November 2019 at T6719.1–26; T6719.45–47.
128 Transcript, Hobart Hearing, Judith King, 12 November 2019 at T6722.3–5.
129 Transcript, Hobart Hearing, Judith King, 12 November 2019 at T6725.45–6726.2.
130 Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6830.19–24.
131 Exhibit 13-7, Hobart Hearing, Statement of Patrick Anderson, WIT.0578.0001.0001 at 0002 [4d]; 0004–0005.
132 Exhibit 13-4, Hobart Hearing, Statement of Tammy Marshall, WIT.0581.0001.0001 at 0004 [14]–[15]; 0006–0007 [26].
133 Exhibit 13-5, Hobart Hearing, Statement of Jo-Anne Cressey Hardy, WIT.0496.0001.0001 at 0010 [41].
134 Transcript, Hobart Hearing, Jo-Anne Cressey Hardy, 11 November 2019 at T6640.45–6641.2.
135 Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6830.6–28; T6839.18–21.
136 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0034 [136j].
137 Transcript, Hobart Hearing, Helen Marshall, 12 November 2019 at T6764.1–19.
138 Exhibit 13-12, Hobart Hearing, Statement of Helen Marshall, WIT.0603.0001.0001 at 0003 [8d(ii)].
139 Transcript, Hobart Hearing, Helen Marshall, 12 November 2019 at T6764.16–24.
140 Transcript, Hobart Hearing, Helen Marshall, 12 November 2019 at T6764.26–29.
141 Exhibit 13-12, Hobart Hearing, Statement of Helen Marshall, WIT.0603.0001.0001 at 0005 [10.3]; 0008 [11.5]; 0008 [12].
142 Exhibit 13-15, Hobart Hearing, Statement of Pauline Robson, WIT.0560.0001.0001 at 0015 [14].
143 Exhibit 13-11, Hobart Hearing, Statement of Peter Williams, WIT.0609.0001.0001 at 0006 [35].
144 Submissions of Counsel Assisting the Royal Commission, Southern Cross Care (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 at 0002 [4].
145 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0001 [2b]; 0006 [20].
146 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0001 [2c].
147 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0007 [22].
148 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0007 [23].
149 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 354, SCT.5019.0001.0005.
150 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0013 [46]–[47]; 0019 [72]–[75].
151 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0013 [46], [48]–[49].
152 Exhibit 13-16, Hobart Hearing, Statement of Richard Sadek, WIT.0492.0001.0001 at 0013 [50]; 0019 [74].
153 Transcript, Hobart Hearing, Andrew Crane, 12 November 2019 at T6794.5–8.
154 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0010 [44]; [46]; [48].
155 Exhibit 13-14, Hobart Hearing, Statement of Andrew Crane, WIT.0559.0001.0001 at 0004 [8].
156 Transcript, Hobart Hearing, Andrew Crane, 12 November 2019 at T6796.19–20.
157 Transcript, Hobart Hearing, Andrew Crane, 12 November 2019 at T6794.22–25.
158 Transcript, Hobart Hearing, Patrick Anderson, 11 November 2019 at T6661.15–22; T6661.45–6662.1.
159 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 80, SCT.0012.0004.0098 at 0098–0099.
160 Transcript, Hobart Hearing, Pauline Robson, 12 November 2019 at T6815.10–15.
161 Exhibit 13-6, Hobart Hearing, Statement of Kylie Bennett, WIT.0500.0001.0001 at 0012 [50a–b].
162 Exhibit 13-5, Hobart Hearing, Statement of Jo-Anne Cressey Hardy, WIT.0496.0001.0001 at 0009 [36]; 0009 [38].
163 Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6835.3–9.
164 Transcript, Hobart Hearing, Patrick Anderson, 11 November 2019 at T6662.37–39.
165 Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6882.39–40.

166 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 175, SCT.0011.0004.0129 at 0135–0137.
167 Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6826.40–6827.7.
168 Exhibit 13-14, Hobart Hearing, Statement of Andrew Crane, WIT.0559.0001.0001 at 0008.
169 Exhibit 13-14, Hobart Hearing, Statement of Andrew Crane, WIT.0559.0001.0001 at 0007.
170 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 100, SCT.0013.0001.0075 at 0075.
171 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 100, SCT.0013.0001.0075.
172 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 102, CTH.4018.2001.0257.
173 Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0017 [76]–[78].
174 Submissions of Counsel Assisting the Royal Commission, Southern Cross Case (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 at 0002 [4c]; 0030 [107].
175 Submissions of Counsel Assisting the Royal Commission, Southern Cross Case (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 at 0002 [4c(i)]; 0030 [107a].
176 Submissions of Counsel Assisting the Royal Commission, Southern Cross Case (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 at 0002 [4c(ii)]; 0030 [107b]; Transcript, Hobart Hearing, Patrick Anderson, 11 November 2019 at T6680.7–14.
177 Submissions of Counsel Assisting the Royal Commission, Southern Cross Case (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 at 0002 [4c(iii)]; 0030 [107c]; Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 92, SCT.0013.0001.0064 at 0064.
178 Submissions of Counsel Assisting the Royal Commission, Southern Cross Case (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 at 0002 [4c(iv)]; 0030 [107d].
179 Submissions of Counsel Assisting the Royal Commission, Southern Cross Case (Tas) Inc Case Study, 2 December 2019, RCD.0012.0042.0001 0002 [4c(v)]; 0030 [107e].
180 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0009–0010 [33]; 0011 [41].
181 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0008 [29].
182 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0010 [34].
183 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0010 [34]. Citing Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6827.35–37; T6829.44–46; T6830.1–3; T6827.35–37; T6827.22; T6827.19–20; T6828.7–10.
184 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 13, SCT.0011.0004.0216.
185 Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6829.44–47.
186 Transcript, Hobart Hearing, Pauline Robson, 12 November 2019 at T6820.28–38; Transcript, Hobart Hearing, Richard Sadek, 12 November 2019 at T6829.44–47.
187 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 102, CTH.4018.2001.0257.
188 Transcript, Hobart Hearing, Patrick Anderson, 11 November 2019 at T6670.33–46.
189 Transcript, Hobart Hearing, Patrick Anderson, 11 November 2019 at T6679.16–31.
190 Transcript, Hobart Hearing, Patrick Anderson, 11 November 2019 at T6681.8–9.
191 Submissions of Southern Cross Care (Tas) Inc, Southern Cross Case (Tas) Inc Case Study, 18 December 2019, RCD.0012.0049.0001 at 0011 [39]–[40].
192 Submissions of Counsel Assisting the Royal Commission, Bupa South Hobart Case Study, 2 December 2019, RCD.0012.0041.0001.
193 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001; Submissions of Merridy Eastman, 9 December 2019, RCD.0012.0045.0001; Submissions on behalf of Stephanie Hechenberger, 16 December 2019, RCD.0012.0047.0001; Submissions on behalf of Elizabeth Monks, 18 December 2019, RCD.0012.0048.0001; Submissions on behalf of Davida Webb, 18 December 2019, RCD.0012.0051.0001.
194 Exhibit 13-41, Hobart Hearing, Statement of David Neal, WIT.0557.0001.0001 at 0001 [4].
195 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 82, CTH.4018.2000.4908 at 4908.
196 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0014 [54]; 0015 [54].
197 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 23, BPA.010.021.2067 at 2067.
198 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6991.29–33.
199 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 23, BPA.010.021.2067.
200 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 25, BPA.055.008.3316 at 3316.
201 Transcript, Hobart Hearing, Carolyn Cooper, 15 November 2019 at T7137.7–18.
202 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0016 [59]–0017 [60].
203 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0017 [60]. This strict rule was modified at South Hobart with the rostering of an additional Care Manager. See Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0042 [159]; Exhibit 13-27, Hobart Hearing, Statement of Stephanie Hechenberger, WIT.0607.0001.0001 at 0014 [79].
204 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0038 [146]; 0040 [153b].
205 Exhibit 13-24, Hobart Hearing, Statement of Merridy Eastman, WIT.0582.0001.0001; Exhibit 13-21, Statement of Diane Daniels, WIT.0583.0001.0001; Exhibit 13-35, Hobart Hearing, Statement of UQ, WIT.0584.0001.0001; Exhibit 13-36, Hobart Hearing, Statement of US, WIT.0585.0001.0001.
206 Exhibit 13-24, Hobart Hearing, Statement of Merridy Eastman, WIT.0582.0001.0001 at 0005 [28]; Exhibit 13-21, Statement of Diane Daniels, WIT.0583.0001.0001 at 0006 [34]–0008 [42].

207 Transcript, Hobart Hearing, UQ, 15 November 2019 at T7093.8–13; Transcript, Hobart Hearing, US, 15 November 2019 at T7093.8–11.
208 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 85, BPA.001.202.2084.
209 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 103, CTH.1006.1004.0162.
210 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 89, CTH.1033.1002.0383 at 0386.
211 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 136, CTH.1033.1002.5362 at 5369.
212 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0052 [191]; 0055 [208a].
213 Submissions of Bupa Aged Care Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0121 [33c].
214 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 168, CTH.1033.1003.3869.
215 Transcript, Diane Daniels, Hobart Hearing, 13 November 2019 at T6911.19–21.
216 Exhibit 13-21, Hobart Hearing, Statement of Diane Daniels, WIT.0583.0001.0001 at 0006 [27]–0007 [40].
217 Exhibit 13-21, Hobart Hearing, Statement of Diane Daniels, WIT.0583.0001.0001 at 0006 [27]–0007 [40]; 0008 [46].
218 Exhibit 13-24, Hobart Hearing, Statement of Merridy Eastman, WIT.0582.0001.0001 at 0002 [10]; 0003 [21].
219 Exhibit 13-24, Hobart Hearing, Statement of Merridy Eastman, WIT.0582.0001.0001 at 0020 [114]. Transcript, Merridy Eastman, Hobart Hearing, 14 November 2019 at T6960.4–28.
220 Exhibit 13-24, Hobart Hearing, Statement of Merridy Eastman, WIT.0582.0001.0001 at 0018 [106]–[108].
221 Transcript, Merridy Eastman, Hobart Hearing, 14 November 2019 at T6958.37–T6959.9.
222 Exhibit 13-35, Hobart Hearing, Statement of UQ, WIT.0584.0001.0001 at 0003 [20].
223 Transcript, Tiffany Wiles, Hobart Hearing, 14 November 2019 at T7043.31–34; Exhibit 13-31, Hobart Hearing, Statement of Tiffany Clara Wiles, WIT.0499.0001.0001 at 0006 [15].
224 Exhibit 13-31, Hobart Hearing, Statement of Tiffany Clara Wiles, 8 October 2019, WIT.0499.0001.0001 at 0002 [4b].
225 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 75, BPA.059.009.5065 at 5071.
226 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [4c].
227 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5c].
228 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0020 [50].
229 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0021 [50].
230 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0024 [59].
231 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0024 [59]–0027 [66].
232 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 75, BPA.059.009.5065 at 5071.
233 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0024 [59]–[63].
234 Submissions of Counsel Assisting the Royal Commission, Bupa South Hobart Case Study, 2 December 2019, RCD.0012.0041.0001 at 0026 [64] referring to Exhibit 13-1, Hobart Hearing, general tender bundle, tab 166, CTH.4018.2100.0296 at 0306.
235 Transcript, Hobart Hearing, Carolyn Cooper, 15 November 2019 at T7122.44–46.
236 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 75, BPA.059.009.5065 at 5074.
237 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0035 [135].
238 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0017 [62].
239 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0033 [130a].
240 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0047 [179].
241 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0033 [130b].
242 Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T7030.5–9.
243 Transcript, Hobart Hearing, Davida Webb, 14 November 2019 at T7030.25–32.
244 Transcript, Hobart Hearing, Bethia Wilson, 15 November 2019 at T7110.38–40.
245 Transcript, Hobart Hearing, Dr Penny Webster, 15 November 2019 at T7110.42–47.
246 Exhibit 13-1, Hobart Hearing, general tender bundle, tab 3, RCD.9999.0261.0010 at 0016.
247 Exhibit 13-1, Hobart Hearing, general tender bundle, tab 3, RCD.9999.0261.0010 at 0017.
248 Submissions of Counsel Assisting, Bupa South Hobart Case Study, 2 December 2019, RCD.0012.0041.0001 at 0026 [101].
249 Submissions of Bupa Aged Care Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5a].
250 Submissions of Bupa Aged Care Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5a].
251 Submissions of Bupa Aged Care Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5a].
252 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6999.1–24.
253 Submissions of Bupa Aged Care Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5].
254 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0026 [63].

255 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0026 [63].
256 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0024 [59]–0027 [66].
257 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0027 [66].
258 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0011 [59]–0012 [66].
259 Submissions of Counsel Assisting, Bupa South Hobart Case Study, 2 December 2019, RCD.0012.0041.0001 at 0025 [97].
260 Submissions of Counsel Assisting, Bupa South Hobart Case Study, 2 December 2019, RCD.0012.0041.0001 at 0256 [101].
261 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 23, BPA.010.021.2067.
262 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5a].
263 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0011 [59]–0012 [66].
264 Exhibit 13-42, Hobart Hearing, Statement of Maureen Berry, WIT.0553.0001.0001 at 0010 [39].
265 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 263, BPA.001.258.0008 at 0010–0011.
266 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 263, BPA.001.258.0008 at 0011.
267 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 7, BPA.001.198.0363 at 0366 [15.3.1b].
268 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 7, BPA.001.198.0363 at 0366 [15.3.5].
269 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6988.7–8.
270 Exhibit 13-30, Hobart Hearing, Statement of Linda Hudec, WIT.0610.0002.0001 at 0002 [5].
271 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 7, BPA.001.198.0363 at 0367 [15.3.6].
272 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0016 [46a]–0017 [46c].
273 See, for example, Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 69, BPA.001.033.8415 at 8415.
274 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 2, BPA.001.197.0001; Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 6, BPA.057.006.6321; Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 10, BPA.019.004.2059; Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 69, BPA.001.033.8415.
275 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 2, BPA .001.197.0001.
276 Exhibit 13-26, Hobart Hearing, Statement of Stephanie Hechenberger, WIT.0607.0001.0001 at 0016 [88]. Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 6, BPA.057.006.6321.
277 Exhibit 13-26, Hobart Hearing, Statement of Stephanie Hechenberger, WIT.0607.0001.0001 at 0016 [88].
278 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6974.40–6975.4; Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6976.19–23; Transcript, Hobart Hearing, Elizabeth Wesols, 14 November 2019 at T6977.5–8.
279 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6978.33–36; T6979.21–22. Exhibit 13-27, Hobart Hearing, Supplementary Statement of Stephanie Hechenberger, WIT.0607.0002.0001 at 0001 [6].
280 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6979.10–15.
281 Transcript, Hobart Hearing, Elizabeth Wesols, 14 November 2019 at T6979.37.
282 Exhibit 13-26, Hobart Hearing, Statement of Stephanie Hechenberger, WIT.0607.0001.0001 at 0016 [88].
283 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 10, BPA.019.004.2059.
284 Transcript, Hobart Hearing, Elizabeth Wesols, 14 November 2019 at T6986.33.
285 Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T6016.18–19; T7016.36–38.
286 Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T7017.1–2; T7017.10–11.
287 Exhibit 13-30, Hobart Hearing, Statement of Linda Hudec, WIT.0610.0002.0001 at 0002 [5]; 0010 [45]. Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T7017.18–20.
288 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T7004.37–41.
289 Exhibit 13-30, Hobart Hearing, Statement of Linda Hudec, WIT.0610.0002.0001 at 0010 [41]; Exhibit 13-28, Hobart Hearing, Statement of Davida Webb, WIT.0608.0001.0001 at 0016 [122].
290 Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T7019.37–41.
291 Transcript, Hobart Hearing, Davida Webb, 14 November 2019 at T7019.46–7020.4.
292 Transcript, Hobart Hearing, Davida Webb, 14 November 2019 at T7020.16–21; Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T7020.19–23.
293 Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T7020.37–43.
294 Transcript, Hobart Hearing, Davida Webb, 14 November 2019 at T7020.37–2021.4.
295 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6981.16–17.
296 Transcript, Hobart Hearing, Elizabeth Wesols, 14 November 2019 at T6987.36–47.
297 Transcript, Hobart Hearing, Stephanie Hechenberger, 14 November 2019 at T6988.7–8.
298 Exhibit 13-27, Hobart Hearing, Supplementary Statement of Stephanie Hechenberger, WIT.0607.0002.0001 at 0002 [12]; 0003 [16].
299 Exhibit 13-27, Hobart Hearing, Supplementary Statement of Stephanie Hechenberger, WIT.0607.0002.0001 at 0003 [17].
300 Exhibit 13-25. Hobart Hearing, Statement of Elizabeth Wesols, WIT.0444.0001.0001 at 0014 [76]–[79].
301 Transcript, Hobart Hearing, Carolyn Cooper, 15 November 2019, T7141.45–7142.11.
302 Submissions of Counsel Assisting, Bupa South Hobart Case Study, 2 December 2019, RCD.0012.0041.0001 at 0027 [110].
303 Submissions of Counsel Assisting, Bupa South Hobart Case Study, 2 December 2019, RCD.0012.0041.0001 at 0019 [70].

304 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5b].
305 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5b].
306 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0017 [47].
307 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0018 [47a].
308 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0018 [47b].
309 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0018 [47c].
310 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0017 [47].
311 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0002 [5b].
312 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0026–0027 [65b]; Transcript, Hobart Hearing, Carolyn Cooper, 15 November 2019 at T7129.30–47.
313 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0027 [65c]; 0027 [66].
314 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0054 [203].
315 Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0011 [31]–0012 [33].
316 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0054 [200]; [201].
317 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0054 [202].
318 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0054 [205]; 0055 [207].
319 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0055 [206].
320 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 163, BPA.060.002.5503.
321 Exhibit 13-38, Hobart Hearing, Statement of Carolyn Cooper, WIT.0444.0002.0001 at 0054 [205].
322 Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 163, BPA.060.002.5503.
323 Transcript, Hobart Hearing, Marguerite Haertsch, 14 November 2019 at T7067.5–9.
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14. Canberra Hearing: Interfaces between the Aged Care and Health Care Systems

14.1 Hearing overview

14.1.1 Introduction

We held a public hearing in Canberra, Australian Capital Territory, from 9 to 13 December 2019, focussing on interfaces between the aged care and health care systems, particularly access to health care for people living in residential aged care. During the five-day hearing, we heard oral testimony from 36 witnesses and received 36 written statements from 34 witnesses. We also received 37 exhibits into evidence. Issues raised and examined included:

- challenges faced by people living in residential aged care when attempting to access health services funded under Medicare, or by State and Territory Governments
- whether there is a need to improve access to primary, secondary and tertiary (subacute and acute) health care services for older people in residential aged care and for those who access aged care in their own homes, and if so, how this could be achieved
- challenges faced by those receiving care in accessing medical specialists, and the adverse consequences of inadequate access
- the necessity or desirability of improving transfers between residential aged care facilities and hospitals, including the appropriateness of rehabilitation and transition care services after older people have been in hospital
- whether there is a need to improve data collection, communication and planning in relation to the health care needs of older people when accessing aged care services
- the need for interoperability of care management information systems
- the sufficiency of access to State and Territory funded palliative care services for people living in residential aged care.

The hearing explored interfaces between aged care and all broad areas of the health system, defined and explained as follows.

Primary health care refers to a broad range of treatments provided in the home or in community-based settings. It is often the care a person receives first as a part of the Australian health system. This care can be provided by a number of different health practitioners including general practitioners, nurses, allied health professionals, pharmacists, dentists and Aboriginal health workers.

Secondary health care refers to treatment given for a short period of time for brief but serious illnesses, injuries and health conditions. This care is given by specialist medical professionals and it is often given in a hospital emergency department. Secondary health care includes acute care, which means active but short-term treatment in circumstances such as severe injury or acute exacerbation of chronic illnesses.

Subacute care refers to care for people who are not severely ill but who need support or help to regain their ability to carry out activities of daily living either after an episode of illness, or to manage new or changing health conditions.

Tertiary health care means highly-specialised health care that is provided mostly in hospitals, or on referral from a primary or secondary health care professional.

In preparation for this hearing, members of staff of the Royal Commission prepared a series of propositions about possible solutions to key deficiencies in the interfaces between aged care and health care. The propositions were provided to a number of witnesses before they gave oral evidence. Throughout the hearing, the propositions were tested and developed by Counsel Assisting. A revised version of the propositions was provided to all parties who were granted leave to appear at the hearing to enable them to make submissions in response to them.[1]

14.1.2 Impact of breakdown at the interface

The word 'interface' refers to the point or circumstance where two systems interact. At its core, our inquiry was concerned with when and how well the health care needs of older people are being met in the aged care system. The evidence we heard supports our broader understanding that people receiving aged care, particularly residential aged care, are often denied practical access to the health care they need.

Witnesses provided insights into the extent to which the interfaces between the aged care and health care systems do not work, and the damaging impact this has on people's health and quality of life. A number of witnesses told us that they, or their family members, have not been able to receive adequate access to health care, whether from general practitioners, allied health practitioners, medical specialists, or in hospitals. We heard from five daughters about the experience of each of their parent, or parents, in residential aged care facilities. Almost all spoke of their parents' difficulty in accessing, or choosing, a general practitioner, and the impact this had on their parents' health.[2]

Ms Rhonda McIntosh told us about difficulties experienced by her father, Mr Allan Sheldon, in accessing proper medical care as a resident in an aged care facility. Speaking of her frustrations about her father's inability to access a general practitioner when he needed one urgently, Ms McIntosh said:

> Dad's still an Australian, he's still entitled to Medicare like we all are. He should be able to see a doctor when he wants to or when he needs to. He shouldn't have to…wait until we're able to advocate for him.[3]

Ms Rhonda Payget described her mother's experience at a residential aged care facility. Her account highlighted the importance of access to primary and specialist health care for people living in residential aged care and the need for proper care coordination. Ms Payget told us that there is a lack of choice with respect to her mother's general practitioner. Ms Payget said that after her mother's long-term general practitioner retired, she was unable to find a general practitioner of her choosing who was prepared to visit the facility. She said:

> As I understand it, there is a requirement for a GP [general practitioner] to provide certain information to the RACF [residential aged care facility] before they are permitted to practise there. In reality, we have not been able to source a GP locally who will come into the nursing home. When my mother moved in, my sister rang all around the local area and could not find a single GP that would visit her. Because of her disability, my mother can't go out to see a GP. Someone needs to come into the facility. However, it has proven really hard to get external GPs to visit residential aged care facilities.[4]

Ms Payget's mother began seeing one of the two general practitioners who had an arrangement with the aged care facility's approved provider to conduct visits to the facility.[5] She told us that her mother's relationship with the new general practitioner 'has broken down, but she has no option but to remain' in his care.[6] Ms Payget said that her mother had told her that she feels that the general practitioner at the facility does not listen to her, or pay attention to her as a 'whole person'.[7] Ms Payget also said that she has had difficulties obtaining information about her mother's care. Ms Payget said that her family members have been told by the aged care facility that they are not able to speak with her mother's general practitioner directly. If they need information about her mother's health, they need to speak with the registered nurse at the aged care facility, who will then pass the message onto the general practitioner. She thinks this is because the general practitioner does not want to have direct contact with family members. She has been told by someone at the residential aged care facility that they do not have a policy on this.[8] It was not clear to Ms Payget whether the general practitioner, or the aged care provider, has responsibility for managing her mother's care.[9]

We heard from Ms Jennifer Walton about the benefit to her mother of maintaining a relationship with her long-term general practitioner.[10] She described the difficulties that arose when her mother had a fall, after-hours, and her mother's general practitioner was unavailable. Ms Walton told us that her mother would typically become distressed when being treated by an unfamiliar general practitioner. She told us that she believed that her mother was transferred unnecessarily to hospital. She explained that this was because her regular general practitioner was unavailable, and the after-hours locum general practitioners who visited her mother failed to understand the behaviours associated

with her mother's dementia.[11] Ms Walton said that the regular general practitioner provided high quality care. She said this was because of his understanding of her mother's health care needs, resulting from their longstanding relationship.[12]

Ms Catherine Davis described her mother's lack of access to quality palliative care and her surprise at the lack of capacity of the aged care facility staff members to provide such care. Ms Davis also told us about the difficulty of driving her mother to see her regular general practitioner, who did not visit residential aged care facilities.[13] She said that once her mother became immobile, she had 'no choice' but to accept the recommendation of facility staff members that her mother see the general practitioner who regularly visited her mother's facility.[14]

Ms Kris Stevens gave evidence about her parents' difficulty in seeing their regular general practitioners after her parents entered residential aged care. She said that the general practitioner was busy and it was difficult for him to find time to see all his patients.[15] She noted a lack of general practitioners in regional areas.[16]

Poor clinical care at residential aged care facilities was another feature of the evidence of witnesses with experience at interfaces of aged care and health care. Ms Stevens described the significant adverse consequences of her mother's undiagnosed urinary tract infection and the development of a stage four pressure injury that was not properly treated by aged care facility staff.[17] Ms McIntosh recounted a number of occasions when aged care facility staff members were slow to respond to, or were unaware of, the medical needs of her father, who had diabetes. She said that, despite obvious deterioration in his condition, her father's diabetes was not managed at the aged care facility, leading to further hospitalisation.[18] Ms Walton gave evidence about her mother's inability to access specialist rehabilitation and her physical decline. She said that her mother had had a series of falls at the aged care facility where she lived.[19] She attributed a decline in her mother's health to the hospital's lack of understanding of, or inability to accommodate, her mother's dementia symptoms.[20]

Dr Clare Skinner, a specialist emergency physician and Director of Emergency Medicine at Hornsby Ku-ring-gai Hospital, told us that in her personal experience with three grandparents in residential aged care, coordination of care was 'very difficult'.[21] Dr Skinner said that the emergency department in which she works is seeing increasing numbers of transfers of residents from aged care facilities for assessments, mostly after hours.[22] She estimated that roughly half of these transfers are potentially avoidable, and involve conditions that Dr Skinner thinks could have been treated in the facility.[23]

Mr Hamish MacLeod, who lives in residential aged care, was unable to give oral evidence. He explained in his statement that he has experienced difficulties getting access to health care from general practitioners and specialists. He said that he has also had to change his general practitioner on a number of occasions:

> When I first moved to the original facility, I was given a new General Practitioner (GP) who visited the original facility. I had to change GPs a number of times at the original facility as a different GP left and another replaced them. When I moved into my current facility, I had to change my GP again. I began to see a GP who did rounds in the facility...[24]

Professor Leon Flicker, Professor of Geriatric Medicine at the University of Western Australia, told us that people in residential aged care facilities and people using high level home care services have difficulty accessing specialist care.[25] Professor Flicker told us that 'Private specialist care is extremely difficult for them to access, so older people are essentially denied specialist care in any reasonable format'.[26] Professor Leonard Gray, Director of the Centre for Health Services Research at the University of Queensland, said that 'some of the most needful persons in Australia have the worst access to specialist health care'.[27] Professor Gray also told us that older people who are supported by their families and living in the community, experience the same difficulties accessing health care.[28]

We also heard from witnesses about the impact on residents of residential aged care facilities being unable to access care from a general practitioner. This resulted in a lack of continuity in care, increased hospital transfers and admissions, inadequate care coordination and clinical handovers, and delayed discharges from hospital to residential aged care.[29]

The importance of rectifying these critical points at which health care services are absent, inaccessible, or disconnected, is self-evident. It puts people's health and lives at risk and diminishes the quality and safety of their care. As Ms Walton said:

> continuity of care should be the standard, not the exception and it shouldn't be a fight to get consistent care across aged care and health settings. They should work together and provide wrap around support for people.[30]

14.1.3 Reforming funding

Professor Christopher Poulos, Head of Research & Aged Care Clinical Services at HammondCare and consultant physician in rehabilitation medicine, told us that 'the backbone of medical care in residential care' is 'consistent high quality general practice'.[31] We heard from a number of witnesses about the funding issues that create barriers to primary health care practitioners providing quality and timely care for people in residential aged care facilities.[32] 'Primary health care' means the most basic and first-line care that people receive from general practitioners, registered nurses or nurse practitioners. We first set out below a brief description about the evidence we heard on the current measures designed to facilitate access to primary health care services in residential aged care facilities. We then set out some observations of witnesses on reform of funding primary health care in aged care more generally.

Ms Glenys Beauchamp PSM, the then Secretary of the Australian Department of Health, explained that there are several measures designed to assist people in residential aged care facilities access primary health care services. These include:

- new rebates for attendances at residential aged care facilities for general practitioners applying under the Medicare Benefits Schedule, from 1 March 2019, 'to recognise the costs' of medical practitioners 'spending time outside consulting rooms and travelling to a residential aged care facility'[33]

- bulk billing incentives for primary health care services provided to people holding a concession card[34]
- the Practice Incentive Program, which includes the General Practitioner Aged Care Access Incentive, paid on the basis of the number of services provided in residential aged care facilities that are eligible under the Medicare Benefit Schedule. A general practitioner providing over 60 eligible services in one financial year receives $1500 annually and one providing over 140 eligible services in one financial year receives $3500 annually. At most, a general practitioner can be paid $5000 in a financial year for providing over 200 services in residential aged care. These payments are made in addition to Medicare Benefit Schedule payments and are designed to 'encourage general practitioners to provide more services to residential aged care facilities'.[35]

Dr Paresh Dawda, a general practitioner and Director and Principal of Prestantia Health, explained that the main payment models for doctors are 'fee for service' and 'capitation' models.[36] Fee for service is a simplified model of funding where a payment is provided for each discrete service provided. The Medicare Benefits Schedule is a fee for service funding model. In describing the fee for service model, Dr Dawda said that 'a fee is paid for each health care service', and that this model 'incentivises volume of care and access'.[37] Capitation or enrolled funding is a model that delivers a fixed payment per patient per time period. This fixed payment is made regardless of the type and amount of services delivered. Dr Dawda described capitation as 'a broader concept using fixed payment per patient…made regardless of the type and amount of service'. He said that capitation 'encourages greater appropriateness of care, collaboration, continuity and prevention', but noted that underservicing can be a risk.[38]

Director General of Queensland Health, Dr John Wakefield PSM, said that under the current 'provider-driven fee for service model', it is unlikely that most general practitioners will choose to provide services to residential aged care facilities.[39] Dr Troye Wallett, a general practitioner and Aged Care Consultant at GenWise Healthcare, said that the Medicare Benefit Schedule structures 'don't make provision for general practitioners working in aged care facilities'.[40] Dr Wallett explained that the itemised fee for service model provides incentives for reactive care over proactive care.[41] Echoing this view, Dr Skinner observed that, for people receiving aged care who have complex ongoing health care needs, 'it's about longitudinal relationships; it's not about one-off events'.[42] She said that 'we need to start thinking about how we run medical workforce into aged care facilities quite differently'.[43]

Professor Gray said that in the current system, where practitioners are funded through the Medicare Benefits Schedule and residential aged care facilities are funded through the Australian Department of Health, there is 'no assurance of an integrated approach to health care delivery'.[44] Professor Gray said that medical practitioners are 'rewarded only to attend to residents individually. There is no funding mechanism to support other activities'.[45]

Ms Judith Gardner, Clinical Care Manager at Buckingham Gardens Aged Care Service in Queensland, told us that, under the current fee for service system, general practitioners 'will come in their lunch hour sometimes' and that they are 'very limited to the time that they can come'.[46] Ms Fiona Lysaught, the Director of Care Services at a Whiddon Group facility, said that a major barrier to access to primary health care in residential aged care

facilities is that general practitioners 'are so strapped for time'.[47] Mr Thomas Woodage, Facility Manager at a Baptistcare aged care facility, stated that his organisation is 'unable to get a local GP [general practitioner] that is interested in visiting'.[48]

According to Dr Dawda, the fee for service model has 'certain disadvantages such as appropriateness of care, allowing and supporting a team-based care delivery model and disincentivising, really, innovation in service delivery'.[49] He noted other payment models also have their own disadvantages, and considered that no payment model would be fit for purpose on its own.[50] Professor Flicker said that there was 'absolutely' scope for greater flexibility in funding for primary care beyond the fee for service model. He said, however, that there were certain matters that would need to be considered 'if you're going to provide quality care in a residential aged care facility:

> you're going to have to start thinking about, 'Well, what about family conference time? When do I talk to the family? Do I do it over the phone? Do I do it in person? When do I do it? How do I organise it?' You have all these other things that are required. 'When do I talk to the facility? When do I talk about some of the governance issues about the facility? When do I do that? Who do I see?' And those things should be reimbursed.[51]

We heard evidence from a number of witnesses about the potential introduction of a new funding model to improve access to primary health care. Professor Gray suggested that:

> maybe there should be a funding stream that's held by the facility that provides funding for the primary care doctors to fulfil those functions, not the MBS [Medicare Benefits Schedule] … that gets the right alignment of accountability…so maybe a mixed-payment arrangement might work better.[52]

Dr Dawda suggested a 'blended' payment model, involving a mix of the current fee for service and capitation payments of a fixed amount per person, irrespective of the type and number of services delivered, with the possibility of building in additional payments to encourage certain practices.[53] He said:

> A blended payment model which makes [the] most of the advantages of the different models and tries to minimise the disadvantages is perhaps the way to go in my opinion. With both of those models, they can be sort of topped and tailed, if you like, with various mechanisms such as capping for fee for service to restrict the amounts of payments people can make or, if you want to enhance quality through some sort of quality incentive payment or quality incentive mechanism, and so that's a third mix that can be introduced into a blend to try and get that ideal balance between appropriateness of care, prevention and coordination of care, access to care but also high quality care.[54]

He said that in light of the complexity of care that is required in residential aged care, there was 'no doubt' in his mind that a blended funding model is 'the fit for purpose funding model'.[55] Dr Wallett and Professor Poulos supported similar approaches.[56] Likewise, Dr Anthony Bartone, the President of the Australian Medical Association, said that 'aged care would really be a screaming example, in my opinion, of where that blended approach needs to be considered even more so'.[57] He explained that there is 'an increased understanding that fee for service alone will not support the increase in chronicity of care, the increased complexity of care and the increase in non-face-to-face care'.[58] Dr Bartone supported Medicare Benefits Schedule items to compensate doctors for telehealth, supervision of others in a delegated care model, and related travel

and administrative tasks, but said adjusting financial levers alone would not address the problem.[59] Ms Beauchamp agreed that a fee for service model should not be dispensed with, but it should be augmented, and possibly blended with a capitation model.[60]

14.1.4 Comprehensive health assessments

We heard from a number of witnesses that older people in aged care settings often have complex care needs.[61] We heard from Dr Bartone that a comprehensive assessment of their care needs is a critical component of maintaining their health while in aged care and ensuring that they have a smooth transition into care.[62] Comprehensive health assessments are currently funded through the Medicare Benefits Schedule. We heard evidence about how the Medicare Benefits Schedule might be amended to improve the frequency of health assessments. We also heard about the potential for nurse practitioners to conduct such health assessments.

Ms Beauchamp told us that, at the time of the Canberra Hearing in December 2019, comprehensive health assessments for residential aged care residents were only available on admission, and yearly thereafter.[63] Dr Bartone told us that 'anything that supports the comprehensive assessment on a more frequent basis and/or allows that to happen on a more frequent basis would be a good thing'.[64]

Professor Poulos suggested that changes should be made to the Medicare Benefits Schedule so that the remuneration available through the Medicare Benefits Schedule geriatric medicine Item Numbers 'is closer to being a reasonable rate' for a private specialist practitioner than is currently the case.[65] He explained:

> Specialist medical practitioners in private practice, who are not geriatricians and who therefore cannot access the MBS [Medicare Benefits Schedule] item numbers specific to geriatric medicine, have a practical financial barrier to visiting nursing homes. While geriatricians have access to MBS Item 145 and Item 147, consultant physicians who conduct similar comprehensive assessments of older people within residential care and generate complex management plans, only have access to MBS Item 132 and Item 133, which are remunerated at much lower rates.[66]

Mr Peter Jenkin, a palliative care nurse practitioner at Resthaven Incorporated, South Australia, raised a similar point, stating that:

> there needs to be reform of the MBS [Medicare Benefits Schedule] so that older persons requiring palliative care in residential and community aged care settings can access Nurse Practitioner services in an affordable and equitable manner.[67]

Dr Wallett also expressed concerns about remuneration levels under the Medicare Benefits Schedule, stating that the Medicare Benefits Schedule 'provides general rebates which fall far below what would be expected to provide high quality care for the complex type care needed for patients'.[68] Dr Wallett told us that the current Medicare Benefits Schedule 'incentivises acute care over proactive care' and 'having more provision for proactive care is very important'.[69] Ms Payget's experience with the care that was provided to her mother illustrated this point. Ms Payget told us that 'the care is very reactive' to 'whatever

is happening in that moment'.[70] She said that general practitioners were only being called by staff at the aged care facility in response to events. Ms Payget suggested that a 'more proactive and preventative attitude to care where you had a regular care plan that was updated every six months' may allow those caring for older people to pre-empt health issues before they arise.[71]

Dr Skinner recommended that there should be a workforce at residential aged care facilities that includes 'practitioners who are regularly based in the facility who do regular ward rounds, who do proactive care reviews, who develop care plans, hold regular multidisciplinary meetings with families and patients'.[72] She stated that:

> we could move to a much more proactive model and I think that would stop the reactive medicine which is sending people into acute hospitals in the middle of the night for often quite minor problems.[73]

The Western Australian Department of Health stated that:

> Diagnosis and treatment of a resident's changed health care needs should be undertaken by a suitably qualified and experienced clinician, for example, a GP [general practitioner] or Nurse Practitioner (NP). The WA DoH [Department of Health] notes that MBS [Medicare Benefits Schedule] items intended to incentivise the appropriate referral to GP through additional funding should be reviewed to ensure fitness for purpose.[74]

Dr Wallett put forward a similar view, and suggested that nurse practitioners should be involved in comprehensive health assessments.[75] Ms Irvine took a similar position, and informed us that in addition to support for a blended funding model, Medicare Benefits Schedule items for nurse practitioners need to include health assessments and chronic disease management plans.[76]

In post-hearing submissions, Queensland's Department of Health expressed its support for any changes to the Medicare Benefits Schedule that support ongoing primary care and regular health assessments, and support for the addition of nurse practitioner items to help deliver better care in aged care facilities.[77]

Dr Bartone was less convinced of the utility of nurse practitioners in this role. He stated that nurse practitioners cannot substitute entirely for 'an appropriately trained medical workforce', and cautioned that giving nurse practitioners access to Medicare Benefits Schedule items for comprehensive health assessments may fragment care, increase duplication and increase unintended outcomes.[78]

Ms Penny Shakespeare, Deputy Secretary for Health Financing, Australian Department of Health, was asked about increasing the frequency of comprehensive health assessments under the Medicare Benefits Schedule. She told us that the relevant Medicare Benefits Schedule items 'are…under consideration by the primary care committees of the MBS [Medicare Benefits Schedule] Taskforce' and that a response will be provided to those recommendations once they are finalised.[79]

14.1.5 Engagement of primary care practitioners

Professor Gray told us that improving access to general practitioners at residential aged care facilities extends beyond remedying issues with remuneration. He suggested a need for 'structural arrangements' to establish an allegiance between general practitioners and aged care providers.[80] We heard about ways in which the relationships between primary care workers and residential aged care facilities could be improved to help facilitate access to timely, continuous and appropriate care.

Residential aged care facilities already engage a number of health care practitioners to provide care within their facilities, in accordance with the *Quality of Care Principles 2014* (Cth) and in particular, the Aged Care Quality Standards in Schedule 2 of those Principles. Salaried nursing staff are responsible for providing clinical care and in some cases, are supported by other allied health staff such as physiotherapists and speech therapists. A large proportion of primary care is provided by other non-salaried staff, including general practitioners, who are remunerated through the Medicare Benefits Schedule.

We heard evidence about whether the Australian Government should amend the Quality of Care Principles to require residential aged care providers and providers of high level home care to engage general practitioners, or nurse practitioners, to help provide primary health care to the people are providing aged care to. This proposition was generally supported in post-hearing submissions by the governments of South Australia, New South Wales, Queensland and Victoria.[81] The Department of Health and Human Services Victoria expressed reservations about mandating memoranda of understanding, or service contracts. They said:

> Such a measure will place a further administrative burden on all parties, and as such has the potential to disincentivise engagement of primary health practitioners with the aged care sector.[82]

The Department of Health and Human Services Victoria also noted that consideration must also be given to the potential conflict of interest for practitioners entering such an agreement. They noted that 'there are times when a practitioner must advocate for their patient with the aged care provider. The proposed contract may be perceived to affect this important advocacy role'.[83]

14.1.6 Engaging general practitioners

Associate Professor Mark Morgan, Expert Member of the Royal Australian College of General Practitioners Quality Care Committee, said formalising the relationship between general practitioners and residential aged care facilities will ensure that residents can access timely, continuous and appropriate care.[84] Dr Bartone emphasised that such collaborative relationships should have 'clear lines of clinical responsibility' between the general practitioner and care staff at the residential aged care facility.[85] Professor Poulos said that general practitioners appointed to work in residential aged care facilities must demonstrate skills and experience in aged care, and be willing to provide specific aged care services. He said that those services might include regular support, clinical reviews and continuing aged care specific medical education.[86]

Both Associate Professor Morgan and Dr Bartone suggested that residential aged care facilities be used for general practitioner training to encourage an interest in aged care. Associate Professor Morgan recommended a potential apprenticeship model for general practitioner registrars in aged care.[87] He cautioned that any such model should preserve a resident's right to choose their own general practitioner.[88]

Ms Gardner and Ms Lysaught said that general practitioners with aged care experience are most able to treat residents at the facility because residents increasingly have complex comorbidities.[89] Each of the facilities, run by Ms Gardner, Mr Woodage and Ms Lysaught, has informal arrangements with general practitioners. These are verbal agreements that the general practitioner will attend the facility to provide health care to residents.[90] Ms Lysaught said that these informal arrangements work well, but she sees formalised agreements as 'being helpful'.[91] Mr Woodage said that any formalised arrangements will need to consider funding for travel because general practitioners will likely have to work across multiple facilities to have a full schedule of work.[92]

Dr Skinner said that general practitioners should train to develop a special aged care interest and then be employed by aged care providers or the Australian Government to provide comprehensive medical care to residents of residential aged care facilities.[93] She suggested that this should occur through a proactive model of care with regular rounds, reviews and comprehensive care plans.[94] She also suggested that this can be achieved through a 'salary with incentives' model, or by the creation of appropriate Medicare item numbers that recognise complex aged care work.[95] She said that primary care for older people should be a holistic service focused on longitudinal relationships, rather than one-off events.[96]

Dr Wallett cautioned against imposing a requirement for residential aged care facilities to engage primary health practitioners, because of the additional burden it will create for facilities.[97] Ms Beauchamp emphasised that it is necessary for the health system to ensure there is choice for both aged care residents and general practitioners, and that different models should be supported.[98] She did not agree with prescriptive approaches to 'engagement' of general practitioners with residential aged care facilities.[99] In post-hearing submissions, the Australian Department of Health reiterated the importance of flexibility of arrangements between residential aged care facilities and general practitioners and emphasised the importance of residents' choice of general practitioner.[100]

14.1.7 Engaging nurse practitioners

Nurse practitioners are registered nurses who have undergone additional training to be able to function autonomously and collaboratively in an advanced and extended clinical role.[101] A registered nurse can apply for the endorsement 'nurse practitioner' when they have completed postgraduate study at a Masters level and have a minimum of three years practice at advanced clinical nursing practice level.[102] Nurse practitioners have a broader scope of practice than registered nurses. They have the ability to prescribe some medicines, order some diagnostic tests, and provide some referrals to medical specialists.

Ms Susan Irvine, a registered nurse and General Manager at Home Nurse Services, spoke about the role that nurse practitioners can play in improving access to primary health care.[103] Her evidence was that nurse practitioners are well suited to coordinating care with family members.[104] She said that they can also provide mentoring and training for staff within residential aged care.[105] She said the presence of nurse practitioners complements existing primary health care services.[106]

Ms Irvine suggested that a 'higher level of clinical oversight' and 'advanced practice' provided by nurse practitioners, is the layer of clinical care missing from residential aged care facilities.[107] She said that the role of nurse practitioners in residential aged care includes advanced coordination of clinical care, and supporting the aged care service and residents through visits from the general practitioner, in a team approach. Ms Irvine described the 'team case-based approach' as follows:

> you've got a nurse practitioner coordinating and assisting the residential aged care and their residents and their families in conversations with the visiting GPs [general practitioners] and making that a true team care-based approach is the most effective, cost effective and appropriate clinical model for residential aged care.[108]

On the contrary, Dr Bartone warned about the limitations of this approach. He referred to the differences between general practitioners' and nurse practitioners' respective scopes of practice.[109] Dr Bartone said that nurse practitioners have a 'defined scope of practice, usually under supervision or delegation with a supervising medical practitioner' and 'They work really well in acute clinical environments such as emergency departments or hospital departments where there are an abundance of other medical specialists…present'.[110] He also said that 'nurse practitioners cannot substitute entirely for an appropriately trained medical workforce'.[111] In Dr Bartone's view, nurse practitioners offer 'an alternative standard of care' to an 'appropriately trained medical workforce'. He said that 'it's only in collaboration…will they really fully exert their benefit, their true worth'.[112] He also said that 'having independent access to the MBS [Medicare Benefits Schedule] is only going to fragment care and increase duplication and increase unintended outcomes'.[113]

Others disagreed with this view. Ms Gardner described a nurse practitioner as a 'major benefit', particularly in facilities where general practitioners do not attend after hours, and so staff members rely on nurse practitioners during that time.[114] Ms Lysaught said that 'there's a fantastic scope of practice, especially with dementia care, that there could be a lot of work done by a nurse practitioner'.[115]

Ms Irvine said that the Medicare Benefits Schedule should include items especially for nurse practitioners to conduct health assessments, chronic disease management plans and mental health care plans.[116] Ms Irvine's assessment was consistent with the evidence of Mr Woodage, who described the positive experiences he had had when working at facilities that engaged visiting nurse practitioners.[117]

The words of palliative care nurse practitioner, Mr Peter Jenkin, and Ms Nikki Johnston OAM, a palliative care nurse practitioner at Clare Holland House, reinforced the benefits of nurse practitioners playing a significant role in aged care settings. Mr Jenkin suggested that facility-employed nurse practitioners would be fundamental to a cost effective model

of nurse practitioners and general practitioners working together to provide primary health care to residential aged care facilities.[118] Ms Johnston told us that nurse practitioners are able to 'cross barriers and fill the gaps in the health system'.[119] Ms Johnston also said that nurse practitioners possess the experience and expertise required to treat residents and improve their quality of life.[120] Ms Johnston told us that 'nurse practitioners do not need to be supervised by doctors' and that a collaborative arrangement is needed.[121]

Mr Woodage said that nurse practitioners have more time than general practitioners to gather information from residents and can coordinate clinical care. He also said that nurse practitioners can provide 'simple medical care through antibiotics, pain management, prescriptions' in a more timely, accurate and in-depth way than general practitioners.[122] Ms Gardner suggested that a nurse practitioner be employed at big facilities, or for a cluster of smaller ones.[123]

Dr Skinner said that nurse practitioners' diverse skills and ability to coordinate with medical and other health practitioners make them valuable to aged care. She suggested that 'many' of the roles currently performed by general practitioners can also be provided by nurse practitioners.[124] She said that the role of nurse practitioners in residential aged care facilities includes training other facility staff members about wound, end-of-life and other clinical care.[125] Mr Jenkin agreed that capacity building is a priority of nurse practitioners working in residential aged care.[126]

Professor Brendan Murphy, then the Chief Medical Officer of Australia, described 'existing employment models' as barriers to the engagement of nurse practitioners in residential aged care facilities. He said 'there is a stronger case to enhance the role of registered nurses' and increase the number of registered nurses with advanced aged care skills.[127] He said that the major advantage of nurse practitioners being able to prescribe tests and make referrals becomes unnecessary when partnered with a general practitioner.[128]

14.1.8 More nurse practitioners

Ms Johnston said that a workforce of nurse practitioners needs to be built.[129] She believed that approximately 600 additional nurse practitioners are required nationally to support aged care.[130] We heard evidence about the barriers that exist to increase this workforce and about suggestions for how to do so. We heard that there is a shortage of jobs for nurse practitioners in aged care. Ms Lysaught told us that as the industry already struggles to fill registered nursing roles, she is concerned about filling the more specialised nurse practitioner roles.[131] Dr Dawda described recruiting nurse practitioners as 'challenging' because of the workforce's limited numbers and the better incentives to work in the public health system.[132] Mr Jenkin said that there are many registered nurses who have completed the academic training required to become nurse practitioners, but they have not sought registration as positions available are limited.[133]

We also heard about remuneration for nurse practitioners. Ms Johnston said that for nurse practitioners to work in the aged care sector, they need to be paid equally to nurses working in the public sector. She said that current remuneration for nurses working in aged care makes them feel undervalued.[134] Dr Skinner said that it is important to create jobs

where nurse practitioners can be independent and take pride in their work.[135] Ms Johnson said that with funding for education and employment, the nurse practitioner workforce can be ready in approximately four years.[136] Mr Woodage said that nurse practitioners should be made available as an option, but not a requirement for residential aged care facilities.[137]

Counsel Assisting tested the proposition that the Australian and State and Territory Governments should introduce measures to increase the available workforce of nurse practitioners in the aged care system, including establishing and expanding a nurse practitioner scholarships program, with an obligation for scholarship recipients to work in aged care for a time after completing their studies. Professor Murphy said that previous scholarship programs for nurse practitioners have had high drop-out rates because of the lack of career pathways.[138] Mr Jenkin told us that 'there simply aren't enough NPs [nurse practitioners] to fill all the potential roles, or pathways for nurses to enter training and positions'.[139]

Ms Johnston and Ms Irvine each agreed that a scholarship program would help to support the necessary growth.[140] Mr Jenkin said that aged care nurses should be supported to become nurse practitioners with academic scholarships and on-site training, including clinical mentors. Mr Jenkin stressed that in addition to return of service arrangements with employers who fund training, or government funded scholarships, nurse practitioners need practical clinical training and supervision.[141] According to Ms Beauchamp:

> What I would like to see is…rather than nurse practitioners being treated separately, how do you get from the career pathway assistants in nursing, enrolled nurses, registered nurses and then nurse practitioners. I think the focus on registered nurses with specialties around aged care, palliation and dementia is absolutely worthy...[142]

The Department of Health Queensland submitted that the Australian and State and Territory Governments must ensure adequate funding for nurse practitioner training and positions.[143] In their view, providing scholarships for nurse practitioner training would ultimately improve quality of life and could provide 'palliative and end of life care, mental health, primary care, wound care and chronic disease management' for residents of aged care facilities.[144] SA Health also supported scholarships.[145]

In post-hearing submissions, the Victorian Department of Health and Human Services identified funding barriers to nurse practitioner roles in aged care as the first priority for increasing nurse practitioner access for residents.[146] SA Health submitted that nurse practitioners should be supported through a dedicated funding model and specific Medicare items.[147] The NSW Ministry of Health submitted that it supports an increase to nurse practitioners funded by Medicare.[148]

In post-hearing submissions, the Australian Government expressed support for increasing the availability of nurses in residential aged care facilities generally.[149] However, the Australian Government also noted a lack of success by the existing Aged Care Nursing Scholarships program, offered by the Australian Department of Health since 2011, to increase the numbers of nurse practitioners in aged care, as well as the difficulty of enforcing any obligation to continue working in aged care after the completion of scholarship recipients' studies.[150] It also noted that the role of nurse practitioners was being considered by the Medicare Benefits Schedule Taskforce.[151]

14.1.9 Accreditation for mobile general practices

General practitioners who do not work for an 'accredited practice' are unable to access payments under the Practice Incentive Program.[152] To be a formally 'accredited practice', general practices need to be accredited against the Royal Australian College of General Practitioners' *Standards for general practices*.[153] We heard that these can act as a barrier to the development of innovative mobile, or virtual general practices that specialise in providing primary health care to older people in their own homes or in aged care facilities. For example, mobile aged care practices are unlikely to meet Standard 5, which describes the physical standards that a general practice must meet. This standard assumes the existence of a physical facility with equipment on site.

We heard from two general practitioners who have established mobile aged care specialist general practices, Dr Dawda and Dr Wallet. Both had experienced difficulty obtaining accreditation in establishing their businesses.[154] Dr Wallett explained that GenWise has only been able to become accredited under the standards for general practice published by the Royal Australian College of General Practitioners in South Australia. It has been unable to become accredited in any other State.[155] In South Australia, GenWise has set up a practice in a residential aged care facility.[156] GenWise suggested that the accreditation standards for general practitioners should support the kind of work required in residential aged care facilities and encourage more general practitioners to provide those services.[157] He also said:

> The advantage of the Aged Care Specific General Practices is that there is a focus on aged care. The major difference between these Practices and 'Bricks and Mortor' based practices is the focus on proactive and preventative care which is an extremely important component of providing continuous care. There is a tendency for GPs [general practitioners] to feel like they attend the residential aged care facility and 'put out fires'. The list of residents to see, generated by the residential aged care facility staff, is often long and takes up the GP's entire allocated time, leaving very little or no time to be involved in proactive type care such as advanced care planning.[158]

Dr Dawda described it as a 'paradox' to require general practices providing care to residents inside residential aged care facilities to have equipment such as a height adjustable bed, and said he supports the proposition for mobile general practices to be exempted from the restrictive standards for general practices developed by the Royal Australian College of General Practitioners.[159]

Professor Murphy suggested that the standards 'probably haven't evolved with these new models' and encouraged flexibility for accreditation of quality models of primary care delivery in aged care.[160] Associate Professor Morgan, on behalf of the Royal Australian College of General Practitioners, agreed that the College will need to create standards that are appropriate for emerging models of primary care in aged care.[161] In post-hearing submissions, the Australian Government supported the Royal Australian College of General Practitioners reviewing its standards to support innovative models providing care in residential aged care facilities. It also suggested that the College consider developing fit-for-purpose standards for mobile general practices.[162] The proposition was generally supported by a number of other State and Territory Governments.[163]

14.1.10 Infrastructure for visiting primary health practitioners

We heard about how the physical infrastructure at a residential aged care facility can impact on the ability, and in some cases the willingness, of health practitioners to deliver services. We also heard about a proposition that Quality of Care Principles, and any subsequent instrument, should include a requirement for approved providers of residential aged care to provide a room with sufficient lighting and privacy for consultations, which could be the resident's room, and access to necessary equipment and levels of clinical support staff so that visiting primary health practitioners can ensure residents have timely and quality access to primary health care services. Visiting health practitioners may also include non-primary health care practitioners, such as geriatricians. Associate Professor Morgan explained that:

> I think what GPs [general practitioners] need to support their care is high quality responsive staff within residential aged care facilities that are able to implement a plan and do so reliably and effectively, coupled with access to expertise where necessary and the right equipment to provide the levels of care that they can provide in their general practices, and those are things that are missing or lacking at the moment.[164]

He also said:

> A fully equipped office or consultation room is essential, especially access to a dedicated room with sufficient lighting and adequate equipment…This would provide a suitable venue for 'hospital in the home' activities and mean fewer patient transfers to hospitals.[165]

Professor Poulos said that residential aged care facilities should remain as 'home-like' as possible, while ensuring that skilled clinical care is provided to residents.[166] In post-hearing submissions, Ms Irvine suggested that a consulting room for general practitioners will cause residential aged care services to operate more like general practices, and stunt further innovation in aged care.[167] Dr Dawda suggested that a consulting room for general practitioners will take time away from facility staff who would need to bring residents to the room for consultations.[168] Dr Dawda agreed with Dr Wallett that the minimum requirements for general practitioners visiting residential aged care facilities are good internet, printer and computer access.[169]

Ms Lysaught said that general practitioner visits in residents' rooms make it like a 'home visit'. She had not heard of a resident not wanting to see their general practitioner in their room.[170] Mr Woodage said that consultations in residents' rooms accorded them sufficient privacy and confidentiality.[171] Ms Payget emphasised the importance of privacy. She described her mother's discomfort when the visiting general practitioner speaks to her in public places at the facility.[172] She said that consultations in residents' rooms are suitable and comfortable for the residents.[173]

Director General of ACT Health Directorate, Mr Michael De'Ath, agreed that the well-lit and private room of a resident is an adequate place for a consultation.[174] Similarly, Professor Murphy said he expected that residents' rooms generally have sufficient lighting for consultations and that most equipment required by general practitioners will be brought by them to facilities.[175] The Australian Government submitted that approved providers should ensure that each resident's room has sufficient lighting and privacy for consultations and should not be required to provide a separate consultation room.[176]

Dr Wallett said that creating a standard for mandatory equipment for residential aged care facilities should be done cautiously, because general practitioners require various levels of equipment.[177] Dr Wallett also spoke about the importance of support from nursing staff, and said that GenWise has employed registered nurses to assist general practitioners on rounds at facilities where there is no available registered nurse at the facility.[178]

Mr Woodage told us that he expects general practitioners to bring their own equipment to consultations at residential aged care facilities. He said that approved providers are not funded to provide equipment.[179] Ms Gardner agreed.[180] She said that the key elements required by visiting general practitioners are adequate lighting for procedures and support from a registered nurse.[181] Ms Lysaught said that at her facility, it is expected that a registered nurse go on rounds with visiting general practitioners.[182] Professor Murphy said this was a reasonable expectation.[183]

In post-hearing submissions, the Australian Government said that support for primary health care practitioners by clinical nursing staff employed at aged care facilities is already required by the Quality of Care Principles under the principles of treatments, procedures and nursing services to be provided, required by Standard 3.[184] The Australian Government also said that interpretive and guiding material should be distributed to approved providers.[185]

14.1.11 Access to specialists

Ms Beauchamp confirmed that the Australian Department of Health is aware, based on Australian Institute of Health and Welfare data, that:

> residents of RACFs [residential aged care facilities] see specialists through the MBS [Medicare Benefits Schedule] at a lower rate compared to older persons who receive home support, home care or no aged care services.[186]

Ms Beauchamp noted that poor access can be due to difficulties for older people with travelling to services, specialists not visiting them, as well as the problems experienced by the general population in accessing specialists. These latter problems include a lack of available specialists and costs associated with accessing private specialists.[187]

We heard about the practical difficulties of transporting residents to specialists' rooms. Ms Gardner told us that older people who are frail should not be expected to travel to see specialists.[188] Professor Flicker was of a similar opinion, describing the transport issues as a 'major barrier' to access to specialists.[189] This was a view also echoed by Dr Wallett:

> It is very challenging as a general practitioner looking after our residents when we do need that specialist input. The options often are to look around to see if somebody will attend, and that's very rare. The palliative care specialists and the geriatricians are the only two that I find are able to come into aged care facilities…but if your resident is not able to be transported, a dermatologist won't come in, there's no incentives there. So changing the incentives to allow for specialists to attend aged care facilities, I think would make a big difference. We've heard about it as a wound care specialist, etcetera. Those things would help a lot if we could implement them.[190]

Ms Lysaught told us that the two rural aged care facilities she manages 'are full of people who have waited a long time or travelled a long way to go and see a specialist, all their lives usually'.[191] She also observed that 'none [of the specialists] currently visit our facility'.[192] Ms Gardner told us that she had 'never met a specialist medical practitioner who has volunteered to visit onsite at a RACS [residential aged care service]'.[193] Mr Woodage also described 'a lack of access' to specialists.[194] He stated that:

> specialists do not visit facilities because of the time and energy factor. Time is lost for a specialist to drive out to the facility and see the patient, particularly when they could have seen three or four patients during that same period if they had stayed in their consulting rooms.[195]

In his statement, Professor Poulos identified a number of 'professional cultural and systemic barriers' which affect access to specialist medical care in residential aged care. He particularly referred to:

(a) a lack of exposure to residential aged care during training;

(b) misperceptions about the needs of people living in residential aged care homes; and

(c) the difficulties associated with attending residential aged care homes.[196]

He also described the 'disordered' nature of visiting a nursing home as a systemic barrier, and noted the following challenges for visiting specialists:

(a) knowing where to find the resident;

(b) having a health care professional present to convey relevant clinical and social information;

(c) meeting family;

(d) accessing medical records, investigation results, and previous patient correspondence; and,

(e) finding somewhere to properly examine the resident.[197]

Professor Poulos offered some solutions to these issues, suggesting:

(a) increasing exposure to residential aged care during medical undergraduate education;

(b) training by the relevant specialist medical colleges; and

(c) developing shared workforce competencies across the health and aged care workforce.[198]

Ms Gardner suggested use of telehealth and telemedicine technologies as part of the solution.[199] Professor Poulos also agreed with the use of telehealth. He noted that telehealth was best provided only after the health care provider had already met the person receiving care in person.[200]

In her statement, Ms Beauchamp said that the Medicare Benefits Schedule Taskforce 'is currently reviewing specialist consultation MBS [Medicare Benefits Schedule] items through its Specialist and Consultant Physician Clinical Committee'.[201] She gave oral evidence that improved access by people receiving aged care to health care services from psychogeriatricians, geriatricians and palliative care specialists is something the Australian Government needed 'to do more work on'.[202]

14.1.12 Care coordinators

We heard evidence about the coordination of care across health and aged care systems, including whether older people with high care needs should have a designated care coordinator responsible for managing their various health and aged care needs. Ms Payget said that a care coordinator is necessary to provide 'resident-centric care'.[203] The need for coordination of care in the context of a residential aged care facility, was illustrated in the evidence of Ms Kristine Stevens. Ms Stevens spoke about the experience of her mother and father who both lived in residential aged care facilities. Ms Stevens said:

> Staff often did not know what the current status of my parents' health was. I would often ask a carer or nurse a simple question and would be told they needed to follow it up with someone else and would get back to me, but no one ever did.[204]

In a joint statement, emergency medicine specialists Dr Ellen Burkett and Dr Carolyn Hullick said that residents of residential aged care facilities are 'complex patients and may receive multiple assessments from multiple specialists, highlighting the need for coordinated care via a GP [general practitioner]'.[205] Dr Burkett is a founding member of the Geriatric Emergency Medicine Section at the Australasian College for Emergency Medicine. Dr Hullick is the Chair of the Geriatric Emergency Medicine Section at the Australasian College for Emergency Medicine.

While the notion of improved care coordination met with general support at the hearing, multiple witnesses argued that their role—be it general practitioner, nurse practitioner, or facility nursing staff—was best suited to that of care coordinator.[206] Ms Lysaught said that registered nurses or experienced enrolled nurses should be care coordinators.[207] She said that general practitioners should not be care coordinators because they do not spend the same amount of time with the residents as the nurses.[208] Professor Murphy agreed that registered nurses should be care coordinators and 'should have a much stronger leadership role'.[209] In post-hearing submissions, the Australian Government reiterated that care coordination should be performed by a registered nurse within a residential aged care facility, with general practitioner input.[210] Ms Gardner also agreed that care coordination should be performed by registered nurses. She said: 'I think it's a RN's [registered nurse's] role, I think, because we—we're the people who are with the residents all of the time and we advocate for them'.[211]

Ms Irvine expressed the view that nurse practitioners would be ideal to perform the care coordinator role because they 'speak the same language as doctors'.[212] Her evidence was that nurse practitioners are well suited to coordinating care with family members. They can also provide mentoring and training for staff within the residential aged care facility. Dr Skinner agreed that nurse practitioners based in residential aged care facilities should be care coordinators.[213]

Dr Nash said that general practitioners are already performing the care coordinator role.[214] Dr Bartone agreed.[215] Ms Payget also agreed, stating that it was her understanding that 'in the general community general practitioners are a central linchpin to coordinating clinical care for people with multiple health issues like my mother'.[216] However, Ms Payget also said that the registered nurse in her mother's residential aged care facility had been 'the de facto care coordinator'.[217] Ms Stevens gave evidence that her mother's general practitioner was not coordinating care:

> I actually felt like the responsibility lay with me and the family, and because I'm the only representative in Dubbo it was sort of my responsibility to access allied health professionals and other health professionals.[218]

Professor Gray described a medical director role used in other jurisdictions, including in the United States and the Netherlands.[219] Medical directors coordinate residents' medical care.[220] Professor Gray said that 'well-trained registered nurses who have skills in aged care' can act as medical directors.[221] Professor Gray expressed the view that the '"standards" should include a requirement that this role be established in each facility'.[222] Dr Dawda expressed the view that the care coordinator role is a function and should not be assigned to any particular group:

> I don't think we should say it's a particular craft group. I think we should say it's a function that's required, and then the craft group that fulfils that function, subject to appropriate training and regulations and so on can vary.[223]

Several witnesses gave evidence that care coordinators should be based within residential aged care facilities. Ms Beauchamp said that care coordinators should be 'embedded within the residential aged care facility'.[224] Ms Beauchamp further explained that:

> having a separate designated care coordinator outside of those relationships that have already been developed with GPs [general practitioners], geriatricians, nurses and, indeed, the residential aged care facility, I think would add another layer and take it away from the responsibilities of treating clinicians and others there.[225]

Associate Professor Morgan also agreed that care coordinators should be embedded within the residential aged care facility:

> Where care coordinators are external to an organisation and have little power to change things within an organisation, the results have been disappointing of care coordination trials. So it seems like a good idea but the reality is often not as good as the idea appeared unless the care coordinators are deeply embedded either as part of the residential aged care facility or as a role of the primary health care.[226]

Dr Dawda expressed the view that care coordinators should be embedded within general practice:

> let's not tie it to a craft group, let's embed it within general practice because we know from high performing primary care from around the world that's where contemporary general practice is heading towards, and that's where the evidence is[227]

Dr Wallett agreed, stating that it is important to have a flexible system so that care coordination can function in rural areas.[228] Dr Wallett also stated that it is important to have the support of a nurse practitioner in a residential aged care facility for care coordination to be successful.[229]

The Victorian Department of Health and Human Services submitted that aged care providers should perform the care coordinator role, and that it needs to 'be a clear expectation and factored into Commonwealth funding'.[230] The Victorian Government also submitted that care coordinator responsibilities are already required of approved providers under the Quality of Care Principles, in particular Standard 2 and Standard 3.[231] Standard 2 relates to ongoing assessment and planning for care services.[232] Standard 3 relates to delivering safe and effective personal and clinical care.[233] The Victorian Government also submitted that it may be appropriate in some specific instances for a general practitioner to coordinate care, especially care involving specialists.[234]

In post-hearing submissions, the NSW Ministry of Health said that, in accordance with the Quality of Care Principles, aged care facilities are already required to undertake the proposed care coordinator functions of ensuring that: residents are accessing appropriate health care at an appropriate time; health care plans are implemented; and that there is liaison with general practitioners, and family.[235]

The Queensland Department of Health noted in post-hearing submissions that introducing the care coordinator role 'would require significant funding and training which would presumably be funded by the Australian Government as the primary funders of primary and aged care'.[236] The Department of Health Queensland also stated that 'consideration should also be given to the provision of care coordination for special needs communities'.[237] In post-hearing submissions, the Western Australian Department of Health supported having a designated care coordinator.[238]

Responsibilities of aged care providers

We heard about whether there is a need to clearly define respective responsibilities of aged care providers and health care providers in delivering health care to those receiving aged care. We heard a number of different perspectives on the health care responsibilities of aged care providers. Dr Maggie Jamieson, Deputy Chief Executive, Health Policy and Strategy, Northern Territory Department of Health, said that approved providers of residential aged care 'should meet the responsibilities for arranging access to health care as set out in the Aged Care Quality Standards'.[239]

Mr Symonds said that Part 3 of Schedule 1 to the Quality of Care Principles is a 'pretty good guide to the health care responsibilities that aged care providers have under the Act'.[240] Part 2 of Schedule 1 also sets out other health care responsibilities of aged care providers. Mr Symonds was of the view that aged care providers might wrongly consider the matters set out in that Schedule as an optional list of services to be provided to people receiving aged care.[241] Dr Burkett said:

> However, the aged care standards hold within them, certainly, responsibilities that really lie in the realm of the general practitioner to be able to effect change in. So I think an important step forwards would be consideration of defining the clinical governance to include the general practitioner and the aged care facility together, as a joint entity, to be reporting against the aged care standards.[242]

Mr Symonds also said that 'facilitating access to health care is the core responsibility' of the residential aged care service.[243] Mr Symonds stated that residential services 'should be able to provide for day-to-day and foundational health care needs including routine management of chronic health conditions'.[244] Dr Skinner agreed with this view, stating that facilities 'should have the capacity to provide high level, high quality nursing care'.[245] Mr De'Ath stated that approved providers of residential aged care 'should provide and fund a high standard of best practice health care to residents'.[246]

Professor Gray said that 'Simple acute and chronic diseases should be managed in the residential aged care facility'.[247] Professor Gray also said that 'an expectation that a range of conditions should be managed competently in house…might need to be integrated into the aged care "standards"'.[248]

Need for greater clarity

Ms McIntosh's evidence about her father's experience illustrated the need for greater clarity on the roles and responsibilities of residential aged care providers in delivering health care.[249] Ms McIntosh told us specifically about two incidents, one in which her father had a heart attack at the facility and another when, due to his diabetes, he experienced a hyperglycaemic attack at the facility. Ms McIntosh told us that prior to her father's heart attack, he told her that for five days he complained about chest pain but the staff 'dismissed his concerns'. She told us 'Dad said to me, "I'm telling anyone who will listen. I'm telling everyone"'.[250] After Ms McIntosh's father experienced a hyperglycaemic attack, he was required to have his blood sugar levels tested daily immediately prior to dinner. Ms McIntosh told us that she and her son had, on a number of separate occasions, visited her father at the facility prior to dinner and not seen blood sugar level tests carried out by staff.[251] She commented:

> It felt like the staff at the facility weren't taking Dad's needs seriously and I was convinced they were not following the hospital's directions. I did not have any confidence in that facility's ability to get Dad's care right.[252]

Speaking of her frustrations about her father's care in a residential aged care facility, Ms McIntosh said:

> We put him in the aged care facility because he needed complex care and we thought that he would get it there, but it appears that is they just—really just house you and feed you, and any type of care that you need is the family's responsibility.[253]

A number of witnesses agreed that the responsibilities of aged care providers need to be clarified. Ms Beauchamp stated that 'we could all benefit also in a system sense looking at where the responsibilities of providers start and finish'.[254] Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning, New South Wales Ministry of Health, said that defining the respective responsibilities of aged care providers and the health system is 'critical then to designing a system that can best support the care needs of the residents'.[255] Dr Lyons also said that the 'roles and responsibilities for providing palliative care need to be clearly defined for aged care providers'.[256]

Ms Irvine suggested utilising a service agreement between general practitioners and aged care providers to clarify the responsibilities of each.[257] However, Dr Dawda's view was that service agreements and memorandums of understanding create the risk of a transactional, rather than transformational system.[258]

In post-hearing submissions, the NSW Ministry of Health supported the proposition that the Quality of Care Principles should be amended to clarify the responsibilities of aged care providers, stating that 'having greater clarity on the roles and responsibilities of residential aged care facility providers…is critical before propositions about models of care can be properly considered'.[259]

The Department of Health Queensland stated in post-hearing submissions that 'responsibilities for funding and health care support for the aged care system should be provided under the programs for primary health care and aged care (Commonwealth), not acute hospitals (states and territories)'.[260]

14.1.13 Hospital outreach services

We heard evidence about ways of increasing the access of those receiving aged care to hospital services. Some form of outreach, sometimes referred to as in-reach, into aged care facilities exists in every State and Territory.[261] Each State and Territory also has outreach services that provide care to people in their homes.[262] Dr Michael Montalto, Medical Director of Epworth Hospital's Hospital in the Home Unit, and a Director of Aged Care Imaging Pty Ltd, explained how these types of services have allowed people to receive treatment in their residence that would otherwise have been provided in hospital.[263] We describe below the outreach services that we heard about.

Local Hospital Network led outreach services

Mr De'Ath described the Geriatric Rapid Acute Evacuation, Rapid Assessment of the Deteriorating Aged at Risk, and Canberra After-hours Locum Medical Service programs—all of which are intended 'to aid RACF [residential aged care facility] residents to get further access to primary health care where there are gaps in primary health care and to reduce hospital admittances'.[264] Mr De'Ath stated the purpose of these programs went 'well beyond hospital avoidance' and was also about 'maintaining the best quality of life and providing the highest quality care'.[265]

We also heard from Dr Montalto regarding the Hospital in the Home service, in Victoria, which delivers 'nursing, medical, pharmacy and personal care and treatments, including intravenous therapy: antibiotic, antiviral, antifungal, fluids, antiemetics, steroid, chemotherapies, blood and blood products, inotropes, and diuretics' either at home or in a residential aged care setting.[266] Dr Montalto said that Hospital in the Home 'could become the default hospital care provider' for those in residential aged care requiring acute hospital care.[267] Dr Montalto told us that Hospital in the Home delivers all aspects of acute care until the patient is discharged or dies.[268]

We heard about the benefits of Queensland Health's Comprehensive Aged Residents Emergency and Partners in Assessment Care and Treatment initiative, known as CARE-PACT. A partnership between Metro South Hospital and Health Service, residential aged care facilities and general practitioners, CARE-PACT aims to provide care for aged care residents 'in the most appropriate location'.[269] Ms Meegan Beecroft, CARE-PACT Clinical Nurse Consultant, and Dr Terry Nash, Clinical Lead at CARE-PACT, described how it has improved health care service delivery for residents of aged care facilities and also educated aged care staff.[270] Ms Gardner stated that:

> CARE-PACT can do everything in a RACS [residential aged care service] that is available in the Emergency Department, except diagnostic tests such as x-rays and ultrasounds. It is generally better for a Resident to be treated in the RACS, as they do not get distressed. This is crucial for Residents with dementia, who get distressed when they are taken out of familiar environments. CARE-PACT can respond quicker than if a Resident was sent to Hospital.[271]

In a similar account, Mr Woodage told us that he 'only had positive experiences' with the triage and advice telephone line service, Residential Care Line, to which his aged care service has access.[272] Ms Lysaught described 'a very positive experience with Hunter New England Health in the public system with the use of multidisciplinary services'.[273]

On the other hand, we heard from Professors Flicker and Gray that the health and aged care system does not promote outreach services, and that 'there is often poor support for multidisciplinary teams to function in residential care'.[274] Professor Gray noted that:

> the national fee for service system...is not well designed to incentivise a service that is multi-disciplinary in nature and which requires an infrastructure that is not built around private consulting rooms.[275]

Professor Flicker told us in that wider structural implementation of outreach services is:

> something that I think has been necessary for many years…older people in residential care and who have advance frailty…find it hard to access routine specialist care by any other means.[276]

Professor Flicker disagreed with a suggestion that outreach services would be unnecessary if there was better access to comprehensive and effective primary care:

> within residential care and high level community care services we have the sickest, frailest, most disabled and the most complicated Australians. And those Australians normally would get specialist care from all sorts of different specialists. And for saying that because they are now in a facility they don't require specialist care is totally foreign to me.[277]

Professor Gray agreed with this point, noting, in respect of older people receiving residential aged care or high level community care services:

> They're not fit enough to undertake surgery. They're not fit enough to tolerate certain drugs. This, in many people's minds means it's kind of palliative; we don't worry about it. But, in fact, it just amplifies the difficulty in providing the care. It actually means you need more sophisticated care, not less sophisticated care.[278]

A number of witnesses emphasised that these programs must focus on improving the quality of health care, and not merely avoiding hospital. Professor Flicker noted that many outreach services have developed on the basis of 'hospital avoidance' and, although that is a good thing, the goal should actually be to 'maximise the health care and the health benefits' for older people.[279] He also cautioned against the development of outreach services, leading to a reduction of funding in other areas, such as subacute care, and stated that the funding for outreach services should not be a replacement for primary care.[280]

Professor Poulos acknowledged that 'outreach models have an important role to play'.[281] He did, however, state that in his view:

> they do not provide the full answer to the issue of access to specialist medical care in residential care…they do not address the important need for ongoing consistent and planned medical care provided by general practitioners in partnership with local medical specialists.[282]

Professor Poulos warned there could be an inherent tension between avoiding hospital and providing care in the long-term, and that this would need to be resolved in outreach design.[283] Having regard to the way in which current outreach services are configured, he said that they are often 'not well placed to provide good longitudinal care'.[284] He stated that:

> A potential unforeseen impact of the use of outreach models designed for admission avoidance is that the development of good longitudinal care models…might be hindered, because:
>
> (a) the pressure placed on public hospital beds could result in resources being directed towards the 'admission avoidance' aspects of programs rather than on longitudinal care; and
>
> (b) the fact that an outreach program can be called when a resident deteriorates might remove the impetus for embedding ongoing, coordinated specialist medical care into routine practice.[285]

According to Dr Nash, a nationwide outreach service can only be established with 'the support of the local hospital and health service executive'.[286] He said that in any given area, the local health network needs to understand the local residential aged care facilities and the general practitioners who visit those facilities, and make them a part of the process of rollout of any program.[287]

Professor Gray agreed that it is important that there be a regional solution incorporating hospitals and aged care facilities relatively near to them. He emphasised that under this approach, it would be necessary to ensure that it is clear who is responsible for ensuring the quality of care provided under such a service, either aged care services or local hospitals.[288] Professor Gray also said, in relation to the relationship between primary health care services and outreach services, that there needs to be both a national framework setting out general understandings for such services and also local frameworks setting out specific responsibilities.[289] He noted that it would be important that there is a clear understandings at the day-to-day level, to avoid 'blaming the federal or state government every time there's a kind of difficulty'.[290] Professor Flicker agreed:

> In general, one of the things I've noticed over the years that if you want something done you have to make it very clear at the national level—at the higher levels exactly who's responsible for what and where the money is coming from, otherwise people will retreat from the space. But at the local level you want to maximise the flexibility of the services so that people can move the local situations. Particularly when you get out of the urban centres you need to be able to maximise flexibility in rural and remote areas because otherwise you get service failure. So at the top levels you really need it to be very clear and consistent and [have] clear governance arrangements and who's responsible for what. But once you get down to the local level, particularly smaller places, you want to maximise the flexibility so as to be able to provide those services.[291]

On the question of dedicated funding for systematic outreach services for aged care, Ms Beauchamp stated:

> The principles that the Royal Commission has put forward are sound. I think people in residential aged care facilities should have access to multidisciplinary teams when they need it, and access to State-based health services. And I think the only…comment I would make about the model is it's a separate dedicated team rather than using a network of providers and specialists that might be in a particular region.
>
> So one of the things that we've been looking at is for the primary health networks and the local health networks to look at a combined, if you like, arrangement where we can use specialists and GPs [general practitioners], including specialists in hospitals, including GPs, and GP primary care that we fund through Medicare and looking at can we have a much more integrated model around that.[292]

Palliative care outreach

We heard about the need to increase palliative care competency within residential aged care facilities. At present:

> The primary responsibilities relating to palliative care in Australia are shared between the Australian Government and the states and territories, alongside other services delivered through the Australian health care system.[293]

Ms Davis described the positive effect palliative care outreach services can have on older people and their families. She told us that in June 2015, she was asked to participate in a focus group operated by Clare Holland House ACT. She commented:

> There were a number of people in the group who were also experiencing the same issues that I was with Mum's care. All of the participants, including myself, felt that we needed that support that was provided by the Specialist Palliative Care team. We all needed someone to provide information and education to staff, as well as having someone to provide the family with support.[294]

She told us that the specialist palliative care service engaged for her mother in residential aged care arranged for a visit by a geriatrician.[295] She also said that it was the palliative care service that explained what palliative care actually is and what it would mean for her mother.[296] She said that it was only the external palliative care service that seemed to have the expertise to be able to change syringe drivers for her mother.[297] She told us that she believed staff members at the aged care facility in which her mother lived were not properly equipped to provide palliative care to her mother, and relied on the palliative care outreach service.[298] She told us that she thought that if not for the intervention of Palliative Care ACT, her mother would have 'spent her last days in debilitating pain without appropriate care'.[299]

Mr Jenkin told us that palliative care should be 'core business' in residential aged care, because people:

> are coming in older, sicker, frailer, multi morbidities and are needing much more care, and … because of that they're coming in—significant numbers of them needing palliative care in the first instance.[300]

Mr Jenkin also raised concerns about the Australian Government's proposed new residential funding model, the Australian National Aged Care Classification, noting that it still focused palliative care services on a very narrow period of time before death.[301]

We also heard evidence from Ms Johnston about the Palliative Care Needs Rounds model of care used in the Australian Capital Territory. This aims to integrate specialist palliative care into aged care facilities in Canberra.[302] It involves the use of triage meetings, multidisciplinary case conferences, and clinical work with residents.[303] A specialist palliative care clinician attends triage meetings with facility staff, which are one hour monthly meetings, to discuss residents who are at risk of dying without a palliative care plan in place.[304] Staff are taught how to identify residents that they suspect might die within the next six months.[305] Staff choose up to 10 residents to discuss at the triage meeting.[306] A resident's treatment plan, symptom management and support system are discussed. These meetings educate facility staff about symptom management.[307] Multidisciplinary case conferences involve discussions of resident concerns and goals, and completion of an advance care plan.[308] These conferences are attended by facility staff, general practitioners, residents, relatives, and health care providers. At the outset, the specialist palliative care clinician usually facilitates these conferences. Typically, they then hand over to facility staff to lead the conference.[309] The Palliative Care Needs Rounds model also includes a clinical component where clinicians from the Palliative Aged Care Specialist team provide clinical care to residents. This includes conducting a comprehensive assessment and creating a treatment plan.[310]

Ms Johnston considered that palliative care needs clear articulation in aged care standards, and should also be compulsory in aged care training.[311] In her evidence, she also detailed results of the 'Integrating specialist palliative care into residential care for older people: a stepped wedge trial', known as the 'INSPIRED trial', which sought to establish the effectiveness of the Palliative Care Needs Rounds outreach service. This trial's results concluded the Palliative Care Needs Rounds:

(a) reduced length of stay in hospital;

(b) substantially reduced overall number of hospital admissions;

(c) cost savings from reducing admissions;

(d) better anticipatory care planning;

(e) improved residents' ability to die in their preferred place;

(f) improved care staff understanding of death and dying; and

(g) improved quality of death and dying.[312]

Ms Johnston considered this model of palliative care outreach services could be rolled out nationally, but would require funding for training, specialist palliative care positions, an education program, and for more registered nurses in residential care. She also said that she believes the model could be adapted for rural, regional and remote areas.[313]

Mr Terry Symonds, Deputy Secretary of the Health and Wellbeing Division of the Victorian Department of Health and Human Services, suggested that a palliative outreach service should be a 'supplement' to palliative care provided within residential aged care by all clinicians involved in the care of the resident.[314]

Ms Beauchamp told us in her statement that:

> the Commonwealth is taking steps to support improved access to palliative care. This is being addressed through the Palliative Care Strategy which was developed by the Commonwealth in consultation with the states and territories, and endorsed by all Australian Health Ministers in December 2018.[315]

Ms Beauchamp told us that:

> The Palliative Care Strategy aims to ensure investments of all governments are directed towards the same priorities, strengthening communication, collaboration and partnership between governments, and improving transition of care including by enhancing care pathways and shared care arrangements across all settings. [316]

In the course of the hearing, Ms Beauchamp confirmed that:

> under the National Palliative Care Framework we're required to deliver and finalise an implementation plan at the end of this calendar year to present to all Ministers, State and Territory and the Commonwealth, early next year.[317]

Ms Beauchamp also agreed there is currently uncertainty in the interface between aged care services and State and Territory Government funded palliative care services. She said that the roll out of the National Palliative Care Strategy will assist with clarifying these roles and responsibilities, and concluded that:

> palliative care…does require a team-based multidisciplinary approach, and I would absolutely support the implementation plan that we're working on with the States and Territories in terms of how we might give effect to much better coordination across both our [Australian Government and State and Territory Government] systems.[318]

14.1.14 Advance care planning

An important part of the evidence on palliative care concerned the need for staff members at aged care facilities to have the skills to engage in advance care directive processes so the directives are comprehensive, available and up-to-date throughout the palliative process.[319] Ms Davis spoke of her mother's palliative care experience at a residential aged care facility in the Australian Capital Territory. Ms Davis said staff members at the facility did not discuss advance care planning when her mother first entered the residential aged care facility, and only discussed it with her a number of years later, following a cancer diagnosis.[320]

Ms Tess Oxley, an experienced paramedic, emphasised the need for an ongoing discussion about advance care planning for people living in residential aged care. Ms Oxley has worked as a registered paramedic in New South Wales for approximately nine years and has attended to jobs in metropolitan and regional locations around Sydney. Ms Oxley said that:

> individuals are only asked if they'd like to have an advance-care directive when they move into the facility, and when they move in, they may be well. It's is traumatic enough for them…A lot of the times it's not by choice. And so the thought of having to do an advanced-care is quite distressing; so they'll say they don't want one. And then it's not brought up again. So when we say 'do they have one?', the answer is 'no'.
>
> …
>
> It's hard, because it means that we are sometimes having to initiate treatment or transport that, you know, is not beneficial to that patient, that may be more distressing, that may be going against what you would consider to be best practice or in the best interest of that patient.[321]

Ms Lysaught and Mr Woodage both gave evidence that advance care planning is discussed with both the resident and the resident's family on entry to the aged care facility.[322] Ms Gardner said that she provides residents and families with a Statement of Choices form on admission to the facility.[323] Ms Lysaught told us that 'All care plans are reviewed every three months, but the advance care plan does not usually change.'[324]

Speaking from her own personal experience as a specialist emergency physician with grandparents in residential aged care, Dr Skinner told us of her concerns about implementing advance care planning, including that templates lacked guidance for the person making the plan.[325] Dr Skinner told us that 'advance care planning processes need

to be more realistic with formal clinical input'.[326] Dr Skinner further explained that residents need to have discussions with 'senior clinical care providers', such as general practitioners or nurse practitioners, about the limits of care that can be provided.[327] This includes offering options to people for their care even where some of those options are clinically futile.[328] Ms Johnston told us that having an advance care plan only works where it is an 'effective care plan'.[329] Ms Johnston said that such plans need skill to develop so that an agency nurse can pick one up 'on a Sunday morning and read and know what to do for that person'.[330]

Ms Johnston also told us that differences between end-of-life laws in every jurisdiction in Australia cause difficulties in advance care planning.[331] Her overall assessment of advance care planning is 'there's just so many flaws and holes in it'.[332] On the lack of a consistent legal framework for advance care planning across jurisdictions, the Department of Health Queensland supports a national law for reciprocal recognition of advance care planning documentation.[333]

Dr Burkett expressed some reservation about requiring advance care plans in residential aged care. She said that:

> residents entering aged care [should] have an opportunity to have facilitated discussions around how they would like their care to be provided, and importantly that that be informed by an accurate picture of what's feasible and what's able to be provided safely in which environments. I do think that mandating a requirement for advance care planning is something that I feel challenged by because I think that people entering aged care are often at a very vulnerable time. They're not always in the best state at that particular time to make decisions around what it is that they would wish to have seen happen in future.
>
> So I think that some flexibility around the process and, ideally, bringing the process forward so that it's actually occurring at a point where people are cognitively able to document their own wishes would be the ideal scenario but I would certainly support the provision of advance care planning discussions and facilitation of those in aged care environments.[334]

Dr Skinner agreed, saying 'I don't like mandatory, I have to admit; I would rather create incentives for people to do this well rather than mandatory.'[335] Dr Burkett and Dr Hullick told us that funding should be reformed to incentivise advance care planning.[336]

The Western Australian Department of Health suggested that the Australian Government and the State and Territory Governments should explore using the Transition Care Program to assist clients with advance care planning, including the development of an advance care directive.[337]

In their joint statement, Dr Burkett and Dr Hullick proposed a number of changes to advance care planning in Australia:

- introduce Medicare item numbers for doctors to work with patients and families to develop and regularly review advance care plans;
- develop and implement quality indicators to assess rates of advance care planning between RACFs [residential aged care facilities] to facilitate benchmarking;
- support minimum standards for ACPs [advance care plans];

- support a central portal of storage of ACPs that facilitates visibility and accessibility across the care continuum;
- support evaluation of models of care to ensure meaningful advance care plans are documented including goals of care…as well as hospitalisation preferences and most importantly, the name, contact details and authority of the substitute health decision maker.[338]

14.1.15 Hospital transfers

A number of witnesses told us about their concerns with the intersection between the hospital system and residential aged care. We also heard about ways through which communication and collaboration could be improved between hospitals and residential aged care facilities.

Discharge from hospital to residential aged care

We heard about the ways in which older people's health information is shared across the interface, particularly during discharge from hospital to residential aged care. Witnesses told us about the problems that can arise, including when discharges can happen too soon or where there is inadequate information provided to staff members at the residential aged care facility.

Mr MacLeod told about his experience of discharge from hospital to a residential aged care facility. He explained:

> I was sent back to the facility from hospital with only two tablets of medication. There were no medical notes sent back with me from hospital. The staff of the facility called the hospital pharmacy to get an understanding of the medications that the hospital doctors had prescribed.
>
> Staff at the facility told me that they had to ring the hospital and ask for the medical information relating to my stay in hospital. I was told that the records had been sent to another hospital and not to the facility where I live. I understand that it took a week or two for the facility to receive my medical file.[339]

Ms Walton told us about the experience of her mother in a residential aged care facility. Ms Walton said that she felt pressure from staff at the hospital in which her mother was being treated to acquiesce to her mother's prompt discharge. She stated that she was made to feel like her mother was in a bed that should be being used by someone else. She said that she felt a decision was being made to discharge her mother irrespective of whether it was the right thing for her.[340] She also said that, when her mother was discharged from hospital, she was not told by anyone from the hospital.[341] Ms Oxley emphasised the importance for a patient, carer and residential aged care facility to 'understand all the information around how they're [the patient] being discharged, why and any further treatment or follow-up that's required'.[342] Dr Burkett said that:

> it's critical that there is a process that is akin to the same degree of scrutiny that we would apply to an inter-hospital transfer as what we do to a discharge to aged care.[343]

In their evidence, two facility managers, Mr Woodage and Ms Lysaught, drew attention to challenges associated with the discharge of people from hospitals back to residential aged care, as well as the sharing of information between general practitioners and residential aged care. They pointed to a lack of interoperability of systems—the ability of different computer software systems work together—and poor communication from hospitals on discharge.[344] They suggested these challenges could be addressed through sharing software between residential aged care services and visiting general practitioners or jointly utilising My Health Record. The possibility of a live interface was also raised.[345] Mr Woodage told us that staff at the aged care facility he manages 'have enormous difficulty, getting discharge summaries' and had difficulty getting 'information to say that a handover – to say that our resident is actually going to come back from hospital to us'.[346] Ms Lysaught gave similar evidence, stating that:

> Residents have returned to the facilities from hospital without a discharge summary. This can be frustrating and something that should be sent when the resident returns.[347]

Witnesses described processes, guidelines and models in place to ensure appropriate discharge practices.[348] However, Mr Symonds acknowledged that medication changes made in hospital are frequently not explained in medical discharge summaries.[349] In his evidence, Mr Symonds referred to research published in 2012 which states that 'Discrepancies between discharge summaries and discharge prescriptions occur in up to 80 per cent of cases'.[350] He also cautioned that:

> There are risks I think, in us—our expectations of discharge summaries as a fix for the clinical problem of handover, and I think we should widen our view to the handover as a process rather than focusing on the document and a policy requirement around the discharge summary itself.[351]

Dr Hullick said that that proper clinical handover should be about maintaining 'continuity of care':

> it needs to be a continuous transition or continuous patient journey…that person…shouldn't have to recognise that they're going through different parts of the system. Ideally, that's a smooth transition across the whole system with clear handover from one person to the other and delivering them the care that they want.[352]

Ms Beauchamp acknowledged that there are barriers to ensuring continuity of care for residents in residential aged care facilities. In her statement, she said:

> A simple indicator of service integration is the proportion of a hospital's patients whose GPs [general practitioners] are provided with a discharge summary within twenty-four hours of discharge. Currently, Australia's performance appears poor. Less than 20% of Australian GPs were always told when a patient was seen in an emergency department compared with 68% in the Netherlands, 56% In New Zealand and 49% in the United Kingdom.[353]

Dr Skinner said that in her personal experience, with three grandparents in residential aged care, coordination of care was very difficult.[354] Dr Skinner also told us that in her professional experience as a specialist emergency physician, the quality of transfer

information was 'very variable' and she often received 'photocopies of photocopies'. She described the transfer of information between aged care facilities and the acute hospital sector as 'very, very error-prone'.[355] She told us of her 'wish list' for transfer documents:

> everyone should have a really, really good health summary. It should be compiled by the person with the assistance of their general practitioner or a skilled nurse, and that should be the definitive document; it should form the basis for what we work on. It should be updated in an authorised way that's accountable, and that should move with the patient electronically.[356]

Representatives from the governments of New South Wales, Queensland, Western Australia and South Australia supported a proposition requiring public hospitals to provide discharge summaries to staff in residential aged care facilities before a transfer can take place.[357] However, Dr Wakefield said that the more important question is the process through which information is shared, rather than its form.[358] Representatives from the Australian Capital Territory and Northern Territory Governments said that their existing requirements for hospital discharges to residential aged care services broadly align with the National Safety and Quality Health Standards.[359] Mr De'Ath told us that 'Discharge summaries must include enough detail about an inpatient episode to allow subsequent health professionals to continue the patient's care post-discharge'.[360] He said that discharge summaries are 'printed and given to the person and/or their carer and then sent electronically to the person's nominated general practitioner and any additional recipients'. He said that 'at this time, the summary will also be sent to the My Health Record system if the person has consented to this'.[361]

Transfers to hospital from residential aged care

A number of witnesses told us about issues that can arise when people are transferred from residential aged care to hospital. We heard that research indicates that people in residential aged care are more likely to be transferred to hospital. Professor Flicker described research from 2009 in which 'we found that people in residential aged care facilities were 70% more likely to go to an emergency department than people of the same age and sex' who were not living in residential aged care, and stated that in general, these results were confirmed by a 2019 report.[362] We heard from experts that there are frequent incidents of transfers to hospital which are not in the clinical best interests of the resident.[363] As Ms Beauchamp acknowledged:

> a reduction in the number of avoidable hospitalisations and therefore the number of transfers of residents from residential aged care to hospitals is always desirable.[364]

We received a witness statement from Associate Professor Jason Bendall into evidence. He described ambulance services as 'the stop gap for a significant proportion of unscheduled or unexpected health care which could be managed by other providers if such services existed'.[365] Associate Professor Bendall described extended care paramedic programs. Paramedics taking part in these programs 'undergo further training to enhance assessment, critical thinking, clinical risk management, management of minor illness and injuries, provision of definitive care and referrals to non-emergency department alternatives'. The programs are intended, among other things, to reduce 'unnecessary presentation to emergency departments' and have achieved 'increased non-conveyance to emergency departments'.[366]

Ms Oxley's perspective was that 'over 50' and 'nearly 60 per cent' of transfers by ambulance from residential aged care facilities to an emergency department are 'not necessary'.[367] She told us that:

> Often, visits to hospital are treated as an inevitability. Staff are so used to working without support structures in place that calling for an ambulance seems to have become part of the resident care plan and management. There is almost a flippancy to calling an ambulance. There is little connection made between how traumatic transporting a resident and a hospital stay can be for an unwell, disorientated resident. It is not inevitable. The cause is not being examined. The cause does not just mean the illness or injury, it is also about the lack of support and appropriate mix of staff to treat the resident at the facility.[368]

She continued:

> When I ask residents what the doctor has said to them or if they understand what their condition is they will often make comments like, 'the doctor just takes a quick look at me' or 'they do not know what is going on, they did not have any time with me.' This is always alarming to me. If there are not enough staff on to spend time with a resident and those staff are not regular, this impacts the continuity of care. It makes it very hard for us to find out what has gone on before we arrived.[369]

Ms Oxley and Dr Skinner told us that the number of ambulance call-outs to residential aged care facilities has increased.[370] Ms Oxley further explained that:

> generally a lot of the calls that we get will be throughout the night and on weekends, when there aren't GPs [general practitioners] and other health networks available. There's also limited staffing on within the facilities at that time which then makes ambulance the primary, I guess, option for health care.[371]

Ms Davis described staff at residential aged care facilities calling for an ambulance as 'a go-to mechanism for them to deal with the situation'.[372] Ms Oxley told us that residential aged care facilities do not engage in 'measured' risk assessment in terms of ambulance call outs. She said:

> I think if it's deemed to be almost any form of risk, if there's any concern we're immediately called, and expected to transport. I think if there was a measured risk assessment, it would allow for other options. Generally I find that there are no other options.[373]

Ms Oxley gave her opinion on why this approach is taken by residential aged care facilities to calling out an ambulance:

> I think it's—I would like to say it's patient welfare but I think it's to try and cover any kind of—whether it's litigation or any kind of detriment to the facility itself. They know that if they've booked an ambulance and they've said that that patient has to go to hospital there's no risk to the facility if anyone deteriorates, that anything bad will happen to the facility.[374]

Dr Hullick's and Dr Burkett's words echoed this point. They stated that:

> In a study where workers in RACFS [residential aged care facilities] were interviewed, it was identified that patients were transferred to the ED [Emergency Department] because staff were concerned about their duty of care, and were ill equipped in regards to acute illness management alongside a lack of access to other medical personnel.[375]

Dr Hullick and Dr Burkett also said that:

> studies have identified that staff at RACFs [residential aged care facilities] are often risk-averse and fear litigation if they do not transfer a resident, given their duty of care to that resident.[376]

Performance indicator relating to ambulance call-outs

We heard evidence about the potential to use ambulance call-outs as a performance indicator for aged care services. Dr Nash warned that an ambulance call-out performance indicator may drive change in a direction that may not improve care in residential facilities.[377] This warning was also illustrated in the evidence of facility managers. Ms Gardner and Mr Woodage raised concerns about how the data would be interpreted and used.[378] Ms Gardner said:

> I would question the validity of collecting that information. Are we going to equate lots of ambulance calls with good care, or are we going to equate lots of ambulance calls with poor care.[379]

Mr Woodage agreed with these views and stated that:

> If you've got a facility with a lot of clinical needs, you're going to be sending more residents to hospital as part of our good care practice. If you're—may be a little hospice facility with low comorbidities, you're probably not going to be sending too many to hospital. So it's not only…collect that data, how is it going to be used, and is it going to be standardised as well—would be my concern.[380]

Ms Lysaught also agreed, stating that collecting data relating to ambulance call-outs might not be helpful for smaller facilities whose staff call the ambulance when doctors are not available.[381] Dr Lyons said that 'before we came to a performance indicator we would need to agree on what is that actually telling us about what we want the system to do in support of a resident'.[382] Dr Lyons further explained:

> So if it's done because there is no after-hours access to a clinician to make an assessment, and there should be, and we've defined that as a requirement of the system to do that, then yes, I would agree those sorts of indicators would reflect where the performance is not as it should be.[383]

Dr Andrew Robertson CSC PSM, Assistant Director-General, Public and Aboriginal Health and Chief Health Officer, Western Australian Department of Health, expressed concerns about using ambulance call-out data due to issues with the accuracy of the data and collection methods.[384] Dr Wakefield warned against 'the potential for unintended consequences' and stated that 'residents also have a right to access and get benefit from the acute hospital sector when they need it'.[385] Dr Wakefield stated that it is important to have:

> transparency of indicators without thresholds or performance targets, and then very clear sharing between providers, across the sector, the transparency of that so that people get a—have a sense of how they're going compared to others, and that creates a sort of learning and improvement system.[386]

Ms Oxley expressed the view that data on ambulance call-outs could be 'beneficial', provided that it is 'considered in context'.[387] She said:

> I think it would be beneficial so long as it's followed up. It's one thing to collect a whole heap of data and to have it sat there; it's another thing to use it. I think it's also important to note not just that an ambulance was called and it was a 000 but what the follow up for that patient was because did they have an extended stay in hospital or were they returned within two hours is a lot more beneficial to know than just that the ambulance came lights and sirens or not, because quite often we will go slow and the patient will be critically ill or we will go fast and it will be something that's not as serious as stated.[388]

In post-hearing submissions, the Victorian Department of Health and Human Services said that collecting data on ambulance call outs 'has the potential to drive perverse behaviour impacting quality of care' and gave the example of staff members at facilities potentially not calling ambulances even when needed.[389]

14.1.16 Subacute rehabilitation

Professor Poulos told us that 'older Australians in residential aged care should have the same opportunity to access rehabilitation appropriate to their needs as other Australians'.[390] Professor Gray agreed and said that 'frail, older people should have access to targeted and coordinated rehabilitation'.[391] Professor Poulos gave the following reasons why, in practice, people living in residential aged care are less likely to access hospital-based rehabilitation:

> (a) the pressure on hospital beds being such that people who remain living in their own homes in the community are seen to be in greater need of rehabilitation than people already residing in residential care;
>
> (b) the higher prevalence of dementia in the residential care cohort, coupled with a belief that people with dementia are unable to participate effectively and benefit from rehabilitation, compared to people without dementia …;
>
> (c) the fact that aged care residents often have greater degrees of functional impairment and medical complexity, and may therefore be seen to be unable to tolerate the more intensive rehabilitation associated with hospital rehabilitation services;
>
> (d) the above reason can be coupled with a lack of appreciation amongst hospital staff of the limited availability of allied health services in residential care (that is, hospital staff might expect that the residential aged care facility will be able to provide rehabilitation);
>
> (e) people from residential aged care may not have a person that can advocate for them; and
>
> (f) the split in responsibilities between federal (residential aged care) and state/territory (hospitals) governments, with the result being that people living in residential aged care with rehabilitation needs fall through the gaps.[392]

Professor Poulos suggested that rehabilitation for older people may sometimes be more appropriately delivered in residential aged care, although he noted:

> I don't think that we've looked at the rehabilitation-in-the-nursing-home model at all in Australia…because of various conflicts between Commonwealth and State, and no one's really got together to design some models.[393]

Professor Poulos also noted that the current rehabilitative services available in Australia are focused on intensive, short periods of rehabilitation, whereas for older people the better approach is often a less intense and longer period of rehabilitation that is not available.[394]

Ms Walton told us about her mother's experience of rehabilitation as a resident of an aged care service. She recalled that she had to insist that her mother not be discharged from a public hospital until other options for rehabilitative care had been pursued 'because residential aged care did not have the facilities to provide rehabilitation'.[395]

Mr Woodage, Ms Lysaught and Ms Gardner all gave evidence about the limited rehabilitation they were able to offer in their facilities, and their desire to be able to provide more and better rehabilitative care to residents.[396]

We also heard evidence about the potential for performance targets and reporting requirements in delivery of subacute rehabilitation. Mr Ross Smith, Deputy Secretary of the Tasmanian Department of Health, told us that he would not support 'KPIs [key performance indicators] or measurement on the number of treatments provided' and any measurements would need to be 'gear[ed] towards the outcome' of rehabilitation.[397]

The question of performance targets for subacute rehabilitation, and funding of this care through the National Health Reform Agreement for delivery into residential aged care, was put to representatives of the health departments of New South Wales, Queensland, South Australia and Western Australia. Each representative responded positively to these suggestions.[398] However, in post-hearing submissions, the Western Australian Department of Health agreed with the need for performance targets in relation to subacute rehabilitation, but considered two further aspects of subacute care, namely geriatric evaluation and management and psychogeriatric care, should also be assessed.[399] Department of Health Queensland stated in its submissions that the National Health Reform Agreement was an inappropriate instrument to use to require subacute rehabilitation reporting requirements.[400]

The Australian Government said in post-hearing submissions that 'tying funding to performance targets may not be an appropriate mechanism to encourage the provision of sub-acute rehabilitation'.[401] This is because:

> performance targets may not take into account the variation between jurisdictions in models and levels of provision of sub-acute rehabilitation services, and could create perverse incentives rather than encouraging clinically appropriate access to care.[402]

14.1.17 Data on access to primary health care

Members of staff of the Royal Commission prepared several papers analysing data obtained from the Australian, State and Territory Governments, entitled as follows:

- New Arrangements for General Practitioner Services in Residential Care[403]
- Trends in Residential Aged Care Services during 2013–14 to 2017–18[404]
- Providers of Services for People in Residential Aged Care.[405]

Senior Counsel Assisting told us that the data in these papers was indicative only, but that there were 'startling' results within them.[406] According to the data:

- in 2016–17, 70% of permanent aged care residents did not see a medical specialist outside of hospital settings, compared with 40% per cent of similarly aged people living in the community[407]
- about 9% of people living in permanent residential aged care did not see a general practitioner in 2016–17[408]
- about 46% of general practitioners did not deliver any services in residential aged care in the same period.[409]

The Australian Government took issue with whether or not it is possible to conclude that around 9% of people living in residential aged care did not see a general practitioner.[410] According to the Australian Government, there are at least three situations where an older person living in residential aged care can see a general practitioner outside of Medicare Benefits Schedule arrangements:

- where care is provided by a general practitioner under Australian, State and Territory Government programs, which the Australian Government claimed do not generally attract Medicare Benefits Schedule rebates
- where the person accesses primary health and/or specialist health services health services through programs funded by the Australian Department of Veterans' Affairs, which are not funded through the Medicare Benefits Schedule
- where the person is ineligible for Medicare Benefits Schedule funded services, such as foreign nationals.[411]

14.1.18 Data collection and linkage

We heard about whether there should be better data collected on use of State and Territory-funded health services by people receiving aged care to inform policy monitoring and design. A number of witnesses, including Professor Gray and Professor Flicker, said there is a significant problem in Australia about data collection at the interface between health and aged care.[412] As Dr Hullick said, 'we have to understand the data, and at the moment that data is actually very difficult to see in the State health system. So I think at a systems level, an evaluation level, a research level, we need good access to the data'.[413]

Dr Nash told us that the States and Territories need real-time data linkage to My Aged Care datasets because this identifies residents of aged care facilities.[414] Dr Hullick and Dr Burkett said that My Health Record is not a solution to issues of data linkage and that it does not support data extraction.[415] Commenting on the impact of data collection on the ability of the Western Australian Government to plan its health services, Dr Robertson said:

> because we don't have the data we can't really…have a clear understanding of our health service usage by the recipients of aged care. So our planning for any growth or any issues in that area is, obviously, compromised by not having that data.[416]

Dr Montalto said:

> It has been difficult in my experience to search, and analyse, hospital admission data on the basis of the residents' status as living in a RACF [residential aged care facility]. Specific patient admission data fields either do not exist, or are not always accurately completed.[417]

Ms Beauchamp said that the 'Commonwealth does recognise that there may also be improvements made in data collection'.[418] She also said:

> I am of the view the collection and sharing of timely and relevant data in relation to the provision of health care to residents of RACFs [residential aged care facilities] needs to improve. The Department should have access to data to assess performance and impact of services being provided to elderly people.[419]

Dr Hullick highlighted that:

> the primary issue from an aged care facility resident perspective at the moment is that hospital systems across Australia don't have the ability to accurately identify aged care facility residents.[420]

Mr Symonds agreed that one of the difficulties in data collection is that residents of aged care facilities are recorded on discharge from hospital as returning to their usual place of residence instead of returning to an aged care facility.[421] Ms Kathrine Morgan-Wicks, Secretary of the Tasmanian Department of Health, also identified this problem.[422] According to Dr Nash:

> The current data systems employed do not accurately represent the home or living status of a patient. In many reports a patient who is living in an RACF [residential aged care facility] may be identified by their residential address. This style of reporting is not accurate—this is due to the common occurrence of shared mailing address for an independent living unit and RACF beds. This causes significant data integrity issues across the entire health sector.[423]

We heard from a number of witnesses about identifiers for residents of aged care facilities in hospital data. Dr Burkett said:

> one of the things that I think is critical to improving the quality of care of residents of aged care facilities across the care continuum is the ability to accurately identify who this cohort is.[424]

Dr Burkett said that no reliable identifier exists for residents of aged care facilities because aged care facilities often have multiple addresses.[425] Ms Beauchamp agreed with this.[426] Dr Montalto said:

> it's very difficult, to know from the hospital level what proportion or which patients are coming from residential-aged care facilities. Those data fields are not—either they're not there, or they're not reliably filled in.[427]

The South Australian, New South Wales, Western Australian and Queensland health care systems do not have an aged care identifier in either admitted patient data or ambulance call-out data.[428] Mr Smith said that the Tasmanian health care system has the capacity to record that a resident is being discharged to an aged care facility, but that the 'extent to which it's diligently and appropriately recorded is something we could do more on'.[429] Dr Jamieson said:

> There is opportunity to improve the data which are being collected in relation to the provision of health care to residents of aged care facilities. NT Health does not have any current initiatives to improve the data collected in relation to residents of aged care facilities.[430]

Mr Symonds said that the Victorian health care system:

> is improving the quality of data collected in its emergency and admitted datasets (the Victorian Emergency Minimum Dataset and the Victorian Admitted Episodes Dataset) in terms of identifying people from residential aged care on presentation to and discharge from hospital.[431]

Dr Wakefield gave evidence that data on people receiving aged care and numbers of admitted patients is already available in certain repositories but just needs to be linked.[432] He claimed that this would not require the introduction of a specific identifier for aged care.[433]

In relation to the difficulties in collecting data, Ms Beauchamp said that there 'are significant privacy and data security issues with access to, storage, linkage and use of personal health data held by the Commonwealth and these entities'.[434] On the delay in applying an aged care identifier to State and Territory hospital data, Ms Beauchamp said 'it's a key priority of the health care agreement'.[435] She explained that the delay had occurred because system changes need to be made 'on a number of different systems which are very fragmented'. An Addendum to the National Health Reform Agreement came into force on 1 July 2020. Ms Beauchamp told us that the Addendum would 'improve data and data linkage'.[436] The Addendum states:

> The AIHW [Australian Institute for Health and Welfare], in consultation with States, Territories, and the Commonwealth, will develop health, primary care, aged care and disability interface performance indicators and an associated data collection and reporting for COAG Health Council (CHC) consideration by June 2021. The indicators will monitor the impact of interface performance on client outcomes (with a focus on priority population groups), in domains including, but not limited to:
>
> (a) responsiveness of assessment and decision making processes;
>
> (b) equity of access to primary care, aged care, and disability care systems;
>
> (c) public hospital efficiency, including access to public hospital services, avoidable admissions, and appropriate discharge.[437]

Ms Beauchamp said that the Australian Government has implemented integrated dataset projects, such as the Multi-Agency Data Integration Project, the National Integrated Health Services Information data asset, and the Health Aged Care Interface Data Project, in an effort to, among other things, 'improve the Commonwealth's understanding of health care to residents in aged care facilities'.[438]

Dr Christopher McGowan, Chief Executive of the South Australian Department for Health and Wellbeing, said that Department is leading the Health Aged Care Interface Data Project, which aims 'to develop a national approach to monitoring and identifying new and existing interface pressure points'.[439]

Witnesses gave evidence that data linkage is needed. Dr Burkett said 'there needs to be the willingness to share information and data across the care continuum to allow us to achieve better outcomes and to measure and improve against outcomes of care'.[440] Professor Gray said that standardised information collection in the aged care system 'would enable communication of the person's current and past status as he / she moves across settings'.[441] Dr Hullick and Dr Burkett said that there is an 'urgent need' for linking Australian Government data items and State health systems to improve access to health care.[442] Dr Wakefield agreed, stating that there 'remains an urgent need for real-time data linkage to Commonwealth data items to facilitate identification of RACF [residential aged care facility] patient cohort on state health databases'.[443]

Ms Beauchamp said that the Multi-Agency Data Integration Project is a linked dataset that can 'identify people who are in residential aged care and home care'.[444] Ms Beauchamp told us that this is one example of a data linkage project that will:

> allow for data matching and grow capability or organisations such as the AIHW [Australian Institute of Health and Welfare] to undertake analysis of data on residents of RACFs [residential aged care facilities]'.[445]

Professor Flicker said that 'Linkage of information at the level of Local Hospital Networks would be helpful both clinically and for ongoing data monitoring.'[446] Dr Hullick said that 'at the moment that data is actually very difficult to see in the State health system'.[447] She contended that it 'needs to be timely, ideally live, that we can access every day, every minute in an emergency department in order to be able to deliver the care that's required'.[448]

State and Territory Government witnesses gave evidence about performance indicators relating to interface issues. Ms Morgan-Wicks said that there should be 'a national approach to the development of performance indicators to measure the impact of interface issues and to support service planning and improvement of models of care'.[449] Mr Symonds said:

> Victoria and the other states and territories are advocating for interface performance indicators to drive monitoring, reporting and response in areas such as public hospital efficiency, including reducing avoidable hospital admissions and appropriate discharge into the community setting. These indicators could act as a lever for measuring defined roles and responsibilities in relation to aged care and will support jurisdictional response to interface issues that may arise.[450]

During the hearing, Counsel Assisting tested the proposition that the Australian Government, in any future health funding agreement with States and Territories, should require States to collect and publish data on use of State and Territory-funded health

services by people receiving aged care to inform policy monitoring and design. The data should include the following categories of data at the local hospital network level, or more refined level if practicable:

- use of palliative care services
- use of Local Hospital Network-led multidisciplinary outreach services ambulance call-outs
- emergency department presentations
- hospital separations and lengths of stay
- performance on compliance with clinical handover requirements.

The Australian Government agreed in its post-hearing submissions with the proposition requiring State and Territory data collection, but said it 'is subject to the agreement of the states and territories'.[451] The Australian Government stated that 'exact parameters of the type of data to be collected and shared also need to be considered'.[452] The Australian Government also made submissions about the importance of having interoperable systems to ensure the analysis and use of data is meaningful.[453]

In post-hearing submissions, the Department of Health South Australia agreed with the proposition that States and Territories should collect data relating to health services used by people receiving aged care. The Department of Health South Australia stated that 'the Commonwealth will need to provide linked data on aged care recipients to assist in this collection of data'.[454]

In post-hearing submissions, the NSW Ministry of Health said that 'reportable data sets need to be developed through nationally agreed data governance mechanisms and preferably actioned through data linkage as part of the National Integrated Health Services Information project'.[455] This project is undertaken by the Australian Institute of Health and Welfare.

In post-hearing submissions, the Department of Health Queensland did not support the proposition requiring data collection by States and Territories because it 'would require significant changes to be made to hospital data systems and rely on hospital staff and patients to obtain the data'.[456] The Department of Health Queensland stated that the most effective solution to identify aged care residents 'would be for the Commonwealth to share the details of people who are accessing Commonwealth subsidised aged care services'.[457] The Department of Health Queensland also identified the National Integrated Health Services Information project of the Australian Institute of Health and Welfare as a way to link Australian Government data with State and Territory data.[458]

In post-hearing submissions, the Department of Health and Human Services Victoria suggested that the proposition around State and Territory data provision needs to be 'better articulated' because only some of the categories of data health system indicators relate 'to the performance of the aged care system'.[459] The Department of Health and Human Services Victoria also said a definition of 'aged care recipient' is needed to clarify whether Home Care Packages and Commonwealth Home Support Programme recipients

should be included in data collection.[460] The Department of Health and Human Services Victoria suggested that the timing of the implementation of the proposition be 'in the final stages of Royal Commission reform rollout so that it accurately captures the changed landscape'.[461]

14.1.19 Record keeping and interoperability

We heard evidence about record keeping and care management systems. Currently, there are no consistent standards for care management systems in residential aged care. Ms Irvine told us 'We have many aged care providers across the country who still don't use digital systems at all, so they're still paper based in a lot of ways.'[462] Equally, Ms Morgan-Wicks said:

> Record keeping is not standardised across all RACFs [residential aged care facilities]. Various private providers run RACFs and contractual arrangements for electronic systems integration would be required with each of these providers to improve the interoperability of record keeping. This can cause a reliance on paper-based information.
>
> Documentation needs to be streamlined across all RACFs to enable better management and care for patients presenting not only to ED [emergency department] but to a range of services.[463]

Dr Nash said that that poor record keeping and lack of appropriate care management systems impacts CARE-PACT's ability to provide electronic discharge summaries to aged care facilities.[464] Dr Dawda also said that aged care facilities are not using My Health Record. Dr Dawda said that My Health Record is not a 'two-way communication tool, and therefore I don't think [we] should limit ourselves just to My Health Record'.[465] Some witnesses expressed reservations about the use of My Health Record as a care management system. Associate Professor Morgan said that My Health Record 'is not designed or intended as a tool for communication between health professionals and others caring for a patient'.[466] Dr Hullick said that the information in My Health Record may be outdated at times.[467] Dr Hullick and Dr Burkett said that My Health Record is not an appropriate solution to the lack of data linkage because it does not allow for 'data extraction and clinical audit'.[468]

We heard from Ms Walton that she would have been 'completely comfortable' with her mother's information being uploaded to My Health Record. She explained:

> it's just ease of information sharing; you know, if you go to hospital you're not having to send a pack of information, that doctors can go back into a computer system and see everything that's recorded. It's just logic in this day and age. I don't know. I mean, they were established in 2015. It's beyond my comprehension why they didn't just have a computer-based system from the start.[469]

Ms Beauchamp said that interoperable systems will improve care coordination, efficiency, data availability, and communication, and will reduce administrative costs.[470] Ms Beauchamp said that 'the Commonwealth's ongoing efforts to improve utilisation of technological innovations such as My Health Record should contribute to improved health services and outcomes for individuals'.[471]

We heard a mix of views on whether aged care providers should be required to use My Health Record. Dr McGowan agreed with the proposition that aged care providers should be required to access My Health Record.[472] Ms Beauchamp expressed the view that aged care providers should be required to use My Health Record if people receiving aged care give consent.[473] Dr Dawda agreed that aged care providers should be required to use My Health Record 'as a stepping stone' until the interoperability framework of the Digital Health Agency is available.[474] Dr Wallett agreed.[475] Ms Irvine expressed reservations about mandating use of My Health Record because staff at many aged care facilities use paper-based records. However, Ms Irvine agreed that aged care providers and their staff should ideally access digital systems.[476] Dr Hullick also expressed reservations about the use of My Health Record because the information may not be current.[477]

We also heard about interoperability between the health management systems in aged care and in health care. Dr Burkett made a case for live data interoperability between My Aged Care and hospital-based services.[478] Dr Hullick noted that a flexible approach to how this might be achieved was required but endorsed the notion of real time live access.[479] Mr De'Ath noted the importance of interoperability of systems:

> The interoperability of record keeping systems is critical in the provision of care to people living in RACFs [residential aged care facilities], given their multiple comorbidities and need for regular care in a range of clinical settings. Better utilisation of My Health Record may be a feasible option for improvement.[480]

The Western Australian Department of Health said that interoperability of care management systems is important because:

> It supports better continuity of care and reduces the risk of failed discharge and return to hospital; it improves the health and functional outcomes for an older patient, as well and their quality of life; and it better supports families/advocates of older patients in the transition of their loved one into a RAC [residential aged care] facility.[481]

In post-hearing submissions, the NSW Ministry of Health said that compliance with the 2023 timeframe for the introduction of record keeping systems interoperable with My Health Record 'would require a co-ordinated approach between the Australian Government and aged care providers with leadership by the Australian Government'.[482]

Mr Woodage agreed with the proposition that interoperable software systems should be mandated.[483] Dr Skinner agreed that aged care facilities should be required to have software that is interoperable with My Health Record.[484] However, Dr Skinner explained that finding critical information in My Health Record can be difficult due to the volume of information available and that 'you'd have to dig deep into lots of different documents to find critical information'.[485] On the other hand, Dr McGowan said:

> I think the utility of My Health Record is probably understated in the discussions so far. I think some small tweaks to some of the privacy provisions, to allow data to flow across, provides a lot of the access to the clinical decision-making data that's necessary.[486]

We also heard evidence about initiatives of the States and Territories to improve system interoperability. Dr McGowan gave evidence that the Australian Health Ministers' Advisory Council had 'agreed…to a high-level direction of interoperability of health-related data'.[487]

Dr McGowan also said that 'there's quite large financial implications to implement integrated interoperability of data across the system'.[488] Mr Symonds described the interoperability of systems in Victorian hospitals with My Health Record:

> We are most of the way towards connecting our health services to My Health Record. Easily the majority of our beds now are covered by systems that are able to upload and view, upload data to My Health Record and view data in My Health Record. I can't comment on how visible that is in aged care facilities. But we have no concerns about that. It's a direction that we are committed to.[489]

Mr De'Ath gave evidence about the Digital Health Record to be introduced in the Australian Capital Territory in 2023.[490] The Digital Health Record will be a 'comprehensive record of interactions between a person and publicly funded health services in the ACT'.[491] This information will be capable of being viewed by staff at residential aged care facilities.[492] The Digital Health Record will record discharges to residential aged care facilities and clinical visits at facilities.[493]

Dr Wakefield gave evidence about 'The Viewer' clinical database used by Queensland Health, which can be accessed by practitioners to view patient information.[494] Dr Hullick and Dr Burkett recommended that States and Territories should 'Enable read-only access to state health summary data systems for general practitioners and residential aged care facility clinicians to facilitate improved continuity of care'.[495] Dr Hullick and Dr Burkett also recommended that the Australian Government:

> lead inter-jurisdictional co-operation that enables data linkage between My Aged Care and state/territory jurisdictional hospital clinical data systems to allow reliable and early identification of RACF [residential aged care facility] residents and older persons with home care packages to facilitate safe transitions of care.[496]

In post-hearing submissions, the Australian Government submitted that the 'availability, cost and training associated with the technology' needs to be considered for small providers and providers in rural and remote areas.[497] The Australian Government also submitted that 'consultation with the aged care industry is needed to determine a suitable timeline' for implementing interoperable systems.[498] The Department of Health and Human Services Victoria also stated in post-hearing submissions that consideration of the resources and timeframes for implementing interoperable technology is needed, especially for small providers.[499]

We also heard from facility managers about the use of care management systems in aged care facilities. Ms Gardner said that Buckingham Gardens has an electronic care system that general practitioners access.[500] Ms Gardner said that general practitioners either type notes into the facility's system or they write handwritten notes which are scanned into the system by facility staff.[501] Mr Woodage said that the majority of general practitioners that attend Baptistcare facilities enter progress notes into the electronic system at the facility.[502] Mr Woodage said that interoperability between the facility's system and My Health Record 'would be great'.[503]

Ms Lysaught told us that general practitioners do not enter notes into the electronic record at the Whiddon Group facilities and instead handwrite notes for inclusion on the facility's files.[504] Ms Lysaught said that this practice is 'not perfect' and agreed that the facility would benefit from using an electronic system that was interoperable with general practitioners' systems.[505] Ms Gardner also agreed that her facility would benefit from interoperable systems because staff at the facility 'don't really have a great understanding of what's going on' due to being unable to see notes of general practitioners who do not attend at the facility.[506]

We also heard evidence about difficulties with interoperable systems. The Western Australian Department of Health said that the challenges to interoperability are legal limitations on exchanging information, frequent changes to record keeping systems, increasing staffing to be able to share records, requirements of different levels of government and different record-keeping requirements of the different sectors.[507] They further explained that 'technological solutions, such as cloud-based processes', could be used to overcome these challenges.[508]

Dr Skinner agreed that facilities should be required to have interoperable care management systems, but said care is needed in relation to the design of the software to ensure it is operable for clinicians.[509] Dr Bartone said that the draft Royal Australian College of General Practitioners' *Standards for general practice residential aged care* could recommend that aged care facilities be assessed against interoperability of care management systems.[510] In relation to electronic care management systems in aged care facilities, Associate Professor Morgan said that:

> IT systems within aged care facilities are woeful where they exist at all, and are really designed for kind of ward-based processes, and not for clinical care of patients in an ongoing way that's searchable or useable.[511]

14.1.20 Technology

We heard about the introduction of technological innovations to assist in the health care of older people. Professor Gray defined telehealth as 'the provision of health care at a distance' and said telehealth 'is most used for diagnostic or follow-up purposes'.[512] We heard from Dr Jamieson that telehealth in an aged care facility 'would be extremely helpful' because the resident does not need to travel.[513] Professor Poulos said that telehealth 'will overcome the tyranny of distance' but is not 'the full answer'.[514] Professor Poulos said telehealth is especially important in consultations relating to care management plans and follow-up consultations to monitor patient progress.[515]

Professor Gray considered that 'there should be a telehealth capability in every' residential aged care facility.[516] Mr Symonds said that specialists are willing to provide telehealth services and that it has been shown to work, so it is 'a reasonable expectation' that facilities will provide telehealth.[517]

The facility managers who gave evidence at the hearing also supported the use of telehealth. Mr Woodage said that his Baptistcare facility does not have telehealth but that it would be beneficial.[518] Ms Gardner said that 'telehealth would be great for residents' because they would not have to be transported to appointments.[519]

Mr Symonds supported the adoption of telehealth, stating that 'aged care providers know it's not mandatory to provide telehealth' but uptake would be improved if it was mandatory.[520] Mr Smith expressed reservations about mandating telehealth in aged care facilities and said that care should be approached from the perspective of ensuring access to the right care, which might require consideration of whether telehealth is appropriate for a resident's needs.[521]

Multiple witnesses gave evidence that the success of telehealth relies on staff within aged care facilities. Professor Gray said that 'the staff interaction is the most crucial part of telehealth'.[522] Professor Flicker agreed, stating that staff need to 'feel it's part of their job to support that service'. He said that without 'quite a lot off information at the distal site…telehealth becomes almost useless'.[523]

Ms Beecroft said increased staffing is required for telehealth.[524] She explained that telehealth consultations require a nurse to attend the consultation, which is problematic because usually only one registered nurse is working at an aged care facility and this removes the nurse from the rest of the residents.[525] Dr Hullick agreed that adequate staffing is a requirement for telehealth.[526] Dr Jamieson agreed that facility staff need to be able to operate telehealth facilities and need to remain in the conference.[527]

We also heard evidence about the barriers to telehealth. Subsidisation and costs were a common theme. In relation to access to specialists, Professor Gray said that health practitioners need to offer telehealth but that this will likely not occur without subsidisation, expectation and demand.[528] Professor Gray said that the Medicare Benefits Schedule item numbers for telehealth consultations attract 'generous loadings'. He provided the example of a 50% loading for geriatricians conducting a comprehensive assessment via telehealth.[529] When asked if the Medicare Benefits Schedule rebates for telehealth consultations are sufficient, Dr Montalto said that they are not.[530] Ms Beecroft said that what she called 'private services' offer wound reviews via telehealth but that often the residents cannot afford the cost of these consultations.[531] Professor Gray identified a lack of access to medical records in a facility as an issue with telehealth.[532] He also suggested that not all nursing staff are capable and informed, so they do not know the resident and do not understand the specialist's advice.[533]

Witnesses also spoke of the technological issues associated with telehealth. Professor Gray said that telehealth can be challenging without reliable equipment and can be challenging for people with visual and hearing impairments. However, Professor Gray said these issues can be overcome by use of appropriate equipment, which is not expensive.[534] Mr Symonds said that some specialist services do not use telehealth because aged care facilities do not have appropriate technology.[535] Professor Poulos said that good internet connection and bandwidth, and a device with a camera and microphone, is primarily all that is need to make telehealth work for consultations that are 'not diagnostic intensive'.[536]

We also heard evidence about technological innovations used by aged care facilities. Ms Morgan-Wicks gave evidence about GP Assist, a telephone line used by aged care facility staff in Tasmania that provides tele-triage to manage residents in the aged care facility.[537] Mr Symonds gave evidence about the Geri-Connect project in Victoria, which provides geriatric appointments to patients via telehealth.[538]

14.1.21 Conclusion

Older people accessing aged care should have full access to Australia's universal health care system. They should be able to access health care commensurate with their needs on the same basis as others in the community. In our view, this does not currently occur consistently and reliably, particularly for people in residential aged care. Professor Flicker put it well when he said:

> This is me in a few more years; this is you. This is all of us. And we should be trying our best to make sure, that the standards of healthcare we have is as good as it can be, and the quality of life of older people who are disabled, who have complex medical problems: that should be maximised at all times.[539]

We agree. We make recommendations about the interfaces between the aged care and health care systems in Chapter 9, Volume 3.

Endnotes

1 Post-hearing submissions, Canberra Hearing, Counsel Assisting's Propositions under consideration provided to parties to assist their submissions, RCD.9999.0291.0001.
2 Transcript, Canberra Hearing, Rhonda McIntosh, 9 December 2019 at T7201.10–15; T7201.32–7202.2; Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7221.29–7222.33; Transcript, Canberra Hearing, Jennifer Walton, 10 December 2019 at T7300.31–36; Exhibit 14-18, Canberra Hearing, Statement of Catherine Davis, WIT.1304.0001.0001 at 0004 [25]; Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0004 [22]–[23]; Exhibit 14-4, Canberra Hearing, Statement of Kristine Stevens, WIT.1308.0001.0001 at 0004 [26]; Exhibit 14-3, Canberra Hearing, Statement of Rhonda McIntosh, WIT.1307.0001.0001 at 0002 [14]–[15].
3 Transcript, Canberra Hearing, Rhonda McIntosh, 9 December 2019 at T7216.8–11.
4 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0004 [24].
5 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0004 [22]–[23].
6 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0004 [25].
7 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0004 [25].
8 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0005 [28].
9 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0003 [18]; 0005 [26]; Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7591.31–39.
10 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0010 [71].
11 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0009 [66]; 0010 [68].
12 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0009 [65].
13 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7396.46–47; Exhibit 14-18, Canberra Hearing, Statement of Catherine Davis, WIT.1304.0001.0001 at 0004 [25].
14 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7397.20–29.
15 Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7221.39–7222.8.
16 Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7222.7–8.
17 Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7222.35–7223.18; T7224.23–7229.35.
18 Transcript, Canberra Hearing, Rhonda McIntosh, 9 December 2019 at T7211.3–7213.29.
19 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0005 [31]–[38].
20 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0009 [66]; Transcript, Canberra Hearing, Jennifer Walton, 10 December 2019 at T7298.35–42.
21 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7601.17–24.
22 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7602.21–28.
23 Transcript, Canberra Hearing, Claire Skinner, 13 December 2019 at T7602.21–39.
24 Exhibit 14-17, Canberra Hearing, Statement of Hamish Macleod, WIT.1309.0001.0001 at 0002 [7].
25 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7493.12–17.
26 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7493.19–20.
27 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0005 [31].
28 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7494.4–7.
29 Exhibit 14-10, Canberra Hearing, Statement of Mark Morgan, WIT.1317.0001.0001 at 0030; Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7372.40–44; Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7528.30–34; Exhibit 14-27, Canberra Hearing, Statement of Nigel Lyons, WIT.0568.0001.0001 at 0047 [268].
30 Transcript, Canberra Hearing, Jennifer Walton, 10 December 2019 at T7307.4–7.
31 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0011 [68].
32 Exhibit 14-8, Canberra Hearing, Statement of Susan Irvine, WIT.0621.0001.0001 at 0013 [19]; Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7635.24–32; Exhibit 14-28, Canberra Hearing, Statement of John Wakefield, WIT.0571.0001.0001 at 0007 [44]; Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7510.39–7511.20.
33 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0015 [65a].
34 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0015 [65a].
35 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0015 [65b].
36 Exhibit 14-5, Canberra Hearing, Statement of Paresh Dawda, WIT.0618.0001.0001 at 0016–0017 [13.4a]; 0017 [13.4c].
37 Exhibit 14-5, Canberra Hearing, Statement of Paresh Dawda, WIT.0618.0001.0001 at 0017 [13.4c].
38 Exhibit 14-5, Canberra Hearing, Statement of Paresh Dawda, WIT.0618.0001.0001 at 0016–0017 [13.4a].
39 Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7523.36–43.
40 Transcript, Canberra Hearing, Troye Wallet, 9 December 2019 at T7242.11.
41 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7242.21–24.
42 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7608.45–46
43 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7608.45–7609.6.
44 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0006 [41].
45 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0006 [41].
46 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7421.39–42.
47 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7421.29–31.
48 Exhibit 14-19, Canberra Hearing, Statement of Thomas Woodage, WIT.1310.0001.0001 at 0003 [13].
49 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7239.20–23.

50 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7239.19–28.
51 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7510.9–18.
52 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7510.44–7511.2.
53 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7239.19–36.
54 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7239.26–36.
55 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7240.43–47.
56 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7242.37–40; Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0011 [69]–0012 [70].
57 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7270.36–38.
58 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7270.25–27.
59 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7277.33–42; T7284.34–7285.2.
60 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7577.36–43.
61 Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0001 [5]; Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0003 [19]; Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0002 [12]; Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0003 [24]; Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0004 [23].
62 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7274.26–7275.8.
63 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0016 [65c].
64 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7274.32–34.
65 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0007 [43].
66 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0006 [38]–[39].
67 Exhibit 14-23, Canberra Hearing, Statement of Peter Jenkin, WIT.1314.0001.0001 at 0039 [231].
68 Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0007 [36].
69 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7242.21–24.
70 Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7594.1–2.
71 Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7593.35–7594.6.
72 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7614.22–28.
73 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7614.22–28.
74 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 72, WIT.0570.0002.0001 at 0013.
75 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7243.6–9.
76 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7244.28–32.
77 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0003–0004.
78 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7276.13–22.
79 Transcript, Canberra Hearing, Penny Shakespeare, 12 December 2019 at T7581.1–9.
80 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7510.23–26.
81 Submissions of SA Health, Canberra Hearing, 3 February 2020, RCD.0012.0054.0003 at 0005; Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0003; Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0003; Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0004.
82 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0004.
83 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0004.
84 Exhibit 14-10, Canberra Hearing, Statement of Mark Morgan, WIT.1317.0001.0001 at 0030.
85 Exhibit 14-9, Canberra Hearing, Supplementary Statement of Anthony Bartone, WIT.1301.0001.0001 at 0002 [10].
86 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0011 [70].
87 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7286.10–16; Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7286.47–7287.2.
88 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0011 [69].
89 Exhibit 14-20, Canberra Hearing, Statement of Judith Gardner, WIT.1312.0001.0001 at 0004–0005 [23]; Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7422.34–38.
90 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7420.28–29; T7420.34; Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7421.1–2; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7421.7–9.
91 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7422.10–14.
92 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7422.26–32.
93 Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0010 [52].
94 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7614.22–28.
95 Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0010 [52].
96 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7608.45–7609.6.
97 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7260.29–31.
98 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7565.1–8.
99 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at 7565.8–9.
100 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0012 [35]–[36].

101 Australian Department of Health, Nurse Practitioners, https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-nurse-prac, viewed 20 November 2019.
102 Nursing and Midwifery Board of Australia, *Guidelines for nurses applying for endorsement as a nurse practitioner*, https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Guidelines-on-endorsement-as-a-nurse-practitioner.aspx, viewed 20 November 2019.
103 Exhibit 14-8, Canberra Hearing, Statement of Susan Irvine, WIT.0621.0001.0001 at 0005 [7a].
104 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7261.27–31.
105 Exhibit 14-8, Canberra Hearing, Statement of Susan Irvine, WIT.0621.0001.0001 at 0007 [10a].
106 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7243.24–27; T7243.40–46; T7261.36–41.
107 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7256.18–21.
108 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7263.43–47.
109 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7275.39–7276.6.
110 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7275.39–43.
111 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7275.39–7276.6.
112 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7276.17–18.
113 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7276.18–19.
114 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7433.4–10.
115 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7433.32–34.
116 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7244.28–32.
117 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7257.39–7258.3; Exhibit 14-19, Canberra Hearing, Statement of Thomas Woodage, WIT.1310.0001.0001 at 0005 [25].
118 Exhibit 14-23, Canberra Hearing, Statement of Peter Jenkin, WIT.1314.0001.0001 at 0023 [131] and 0040 [235].
119 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0004 [22].
120 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0004 [22].
121 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7468.1–5.
122 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7432.26–30.
123 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7433.1–5.
124 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7609.11–19; Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0010–0011 [54].
125 Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0010–0011 [54].
126 Exhibit 14-23, Canberra Hearing, Statement of Peter Jenkin, WIT.1314.0001.0001 at 0022 [130].
127 Transcript, Canberra Hearing, Brendan Murphy, 12 December 2019 at T7579.41–7580.11.
128 Transcript, Canberra Hearing, Brendan Murphy, 12 December 2019 at T7579.41–7580.11.
129 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7460.36–43.
130 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7243.24–27.
131 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7433.40–45.
132 Exhibit 14-5, Canberra Hearing, Statement of Paresh Dawda, WIT.0618.0001.0001 at 0010–0011 [8.1].
133 Exhibit 14-23, Canberra Hearing, Statement of Peter Jenkin, WIT.1314.0001.0001 at 0029 [157].
134 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7460.45–7461.2.
135 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7615.30–33.
136 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0019 [100]–[102].
137 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7434.1–5.
138 Transcript, Canberra Hearing, Brendan Murphy, 12 December 2019 at T7579.41–7580.11.
139 Exhibit 14-23, Canberra Hearing, Statement of Peter Jenkin, WIT.1314.0001.0001 at 0029 [156].
140 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7243.24–27; Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7460.36–T7461.2.
141 Transcript, Canberra Hearing, Peter Jenkin, 11 December 2019 at T7461.22–38.
142 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7580.13–41.
143 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0003.
144 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0003.
145 Submissions of SA Health, Canberra Hearing, 3 February 2020, RCD.0012.0054.0003 at 0005.
146 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0004.
147 Submissions of SA Health, Canberra Hearing, 3 February 2020, RCD.0012.0054.0003 at 0005.
148 Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0003.
149 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0013 [40].
150 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0013 [41].
151 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0014 [42]. See further [15] and [16] for information about the Medicare Benefits Schedule Review Taskforce.
152 Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0004 [23]–[24].
153 Australian Government, *Practice Incentives Program guidelines*, effective September 2019, https://www.servicesaustralia.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program/who-can-get-it, viewed 27 May 2020.
154 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7249.33–37; Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0004 [23].
155 Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0004 [23]–[24].

156 Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0004 [23]–[24].
157 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7249.41–45.
158 Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0005 [29].
159 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7249.33–37.
160 Transcript, Canberra Hearing, Brendan Murphy, 12 December 2019 at T7578.29–40.
161 Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7288.32–41.
162 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0009 [24]–[25].
163 Submissions of SA Health, Canberra Hearing, 3 February 2020, RCD.0012.0054.0003 at 0004; Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0002; Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0002; Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0003.
164 Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7274.6–10.
165 Exhibit 14-10, Canberra Hearing, Statement of Mark Morgan, WIT.1317.0001.0001 at 0026.
166 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0009 [53].
167 Submissions of Home Nurse Services, Canberra Hearing, 19 December 2019, RCD.0012.0052.0001 at 0001.
168 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7251.16–25.
169 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7250.18–24; Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7251.16–18.
170 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7423.29–32.
171 Exhibit 14-19, Canberra Hearing, Statement of Thomas Woodage, WIT.1310.0001.0001 at 0003–0004 [20].
172 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0007 [41].
173 Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7593.7–25.
174 Transcript, Canberra Hearing, Michael De'Ath, 13 December 2019 at T7623.21–47.
175 Transcript, Canberra Hearing, Brendan Murphy, 12 December 2019 at T7579.15–29.
176 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0009 [27]–[28].
177 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7250.39–43.
178 Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0005 [25]–[27].
179 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7424.14–26.
180 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7425.4–6.
181 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7424.31–37; T7425.27–31.
182 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7427.4–5.
183 Transcript, Canberra Hearing, Brendan Murphy, 12 December 2019 at T7579.15–29.
184 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0010 [30]–[31]; *Quality of Care Principles 2014* (Cth), sch 1 pt 2 div 2.4; sch 1 pt 3 div 3.8; sch 2 ss 1–2.
185 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0010 [32].
186 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0039–0040 [163]–[164].
187 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0039–0043 [163]–[177].
188 Exhibit 14-20, Canberra Hearing, Statement of Judith Gardner, WIT.1312.0001.0001 at 0008 [47].
189 Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0003 [13].
190 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7248.18–26.
191 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7432.1–3.
192 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7429.3.
193 Exhibit 14-20, Canberra Hearing, Statement of Judith Gardner, WIT.1312.0001.0001 at 0008 [46].
194 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7431.24–30.
195 Exhibit 14-19, Canberra Hearing, Statement of Thomas Woodage, WIT.1310.0001.0001 at 0006 [31].
196 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0008 [48].
197 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0008–0009 [52].
198 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0009 [54].
199 Exhibit 14-20, Canberra Hearing, Statement of Judith Gardner, WIT.1312.0001.0001 at 0008 [47].
200 Transcript, Canberra Hearing, Christopher Poulos, 11 December 2019 at T7477.5–24.
201 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, 15 November 2019, WIT.0573.0002.0001 at 0046 [195].
202 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7582.9–16.
203 Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7598.42–43.
204 Exhibit 14-4, Canberra Hearing, Statement of Kristine Stevens, WIT.1308.0001.0001 at 0004 [27].
205 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0013 [44].
206 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7260.8–16: Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7277.33–42; Transcript, Canberra Hearing, Troye Wallet, 9 December 2019 at T7260.39–7261.4; Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7284.15–23; Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7261.15–31; Transcript, Canberra Hearing, Terry Nash, 10 December 2019 at T7361.36–7362.12.
207 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7434.35–39.
208 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7434.46–7435.2.
209 Transcript, Canberra Hearing, Brendan Murphy, 12 December 2019 at T7579.26–29.

210 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0028 [94].
211 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7435.13–15.
212 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7261.19–31.
213 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7609.25–32.
214 Transcript, Canberra Hearing, Terry Nash, 10 December 2019 at T7362.4–12.
215 Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7280.32–34.
216 Exhibit 14-32, Canberra Hearing, Statement of Rhonda Payget, WIT.1306.0001.0001 at 0003 [20].
217 Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7598.44–45.
218 Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7224.19–21.
219 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0007 [42].
220 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7499.13–18.
221 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7499.20–21.
222 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0007 [42].
223 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7262.39–42.
224 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7556.9–11.
225 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7556.21–24.
226 Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7284.16–20.
227 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7263.11–14.
228 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7263.20–24.
229 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7263.31–33.
230 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0010.
231 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0010.
232 *Quality of Care Principles 2014* (Cth), sch 2 s 2.
233 *Quality of Care Principles 2014* (Cth), sch 2 s 3.
234 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0010.
235 Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0009.
236 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0009.
237 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0009.
238 Submissions of the State of Western Australia, Canberra Hearing, 3 February 2020, RCD.0012.0055.0001 at 0004 [15].
239 Exhibit 14-35, Canberra Hearing, Statement of Maggie Jamieson, WIT.0567.0001.0001 at 0005 [17].
240 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7624.24–34.
241 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7624.25–40.
242 Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7316.41–46.
243 Exhibit 14-36, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 0004 [19].
244 Exhibit 14-36, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 0026 [164].
245 Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0009 [47].
246 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0009 [41].
247 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0005 [33].
248 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0006 [36].
249 Exhibit 14-3, Canberra Hearing, Statement of Rhonda McIntosh, WIT.1307.0001.0001.
250 Exhibit 14-3, Canberra Hearing, Statement of Rhonda McIntosh, WIT.1307.0001.0001 at 0003 [19].
251 Exhibit 14-3, Canberra Hearing, Statement of Rhonda McIntosh, WIT.1307.0001.0001 at 0007 [50]–[52].
252 Exhibit 14-3, Canberra Hearing, Statement of Rhonda McIntosh, WIT.1307.0001.0001 at 0007 [52].
253 Transcript, Canberra Hearing, Rhonda McIntosh, 9 December 2019 at T7216.11–14.
254 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7556.5–8.
255 Transcript, Canberra Hearing, Nigel Lyons, 12 December 2019 at T7522.25–34.
256 Exhibit 14-27, Canberra Hearing, Statement of Nigel Lyons, WIT.0568.0001.0001 at 0019 [103].
257 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7251.36–46.
258 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7254.21–29.
259 Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0010.
260 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0009.
261 Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0001 [4]; 0003 [13]; Exhibit 14-28, Canberra Hearing, Statement of John Wakefield, WIT.0571.0001.0001 at 0027 [186]; 0045 (Appendix 2); Exhibit 14-30, Canberra Hearing, Statement of Christopher McGowan, WIT.0566.0001.0001 at 0012 [63]; 0018 [98]–[99]; Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0004 [18]; Exhibit 14-34, Canberra Hearing, Statement of Kathrine Morgan-Wicks, WIT.0569.0001.0001 at 0005–0007 (Q10–13); Exhibit 14-27, Canberra Hearing, Statement of Nigel Lyons, WIT.0568.0001.0001 at 0015 [76]; Exhibit 14-1, Canberra Hearing, general tender bundle, tab 72, WIT.0570.0002.0001 at 0025 (response to Q26); Exhibit 14-35, Canberra Hearing, Statement of Maggie Jamieson, WIT.0567.0001.0001 at 0008 (response to Q24).

262 Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0003 [20]; Exhibit 14-28, Canberra Hearing, Statement of John Wakefield, WIT.0571.0001.0001 at 0027 [186]; 0045 (Appendix 2); Exhibit 14-30, Canberra Hearing, Statement of Christopher McGowan, WIT.0566.0001.0001 at 0012 [63]; 0015 [81]; Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0004 [18b]; Exhibit 14-34, Canberra Hearing, Statement of Kathrine Morgan-Wicks, WIT.0569.0001.0001 at 00018 (response to Q350); Exhibit 14-27, Canberra Hearing, Statement of Nigel Lyons, WIT.0568.0001.0001 at 0015 [76]; Exhibit 14-35, Canberra Hearing, Statement of Maggie Jamieson, WIT.0567.0001.0001 at 0008 (response to Q24); Exhibit 14-1, Canberra Hearing, general tender bundle, tab 72, WIT.0570.0002.0001 at 0018 (Q23).
263 Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0003 [13].
264 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0004 [18].
265 Transcript, Canberra Hearing, Michael De'Ath, 13 December 2019 at T7632.29–46.
266 Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0003 [20].
267 Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0003 [16].
268 Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0003 [18].
269 Exhibit 14-14, Canberra Hearing, Statement of Meegan Beecroft, WIT.1297.0001.0001 at 0001 [5].
270 Exhibit 14-13, Canberra Hearing, Statement of Terry Nash, WIT.1296.0001.0001 at 0007 [32]; Exhibit 14-14, Canberra Hearing, Statement of Meegan Beecroft, WIT.1297.0001.0001 at 0005 [27]–[34].
271 Exhibit 14-20, Canberra Hearing, Statement of Judith Gardner, WIT.1312.0001.0001 at 0013 [75].
272 Exhibit 14-19, Canberra Hearing, Statement of Thomas Woodage, WIT.1310.0001.0001 at 0007 [40].
273 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7439.12–14.
274 Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0002 [9].
275 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0008 [47].
276 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7493.12–17.
277 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7502.27–33.
278 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7502.35–43.
279 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7503.8–24.
280 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7505.30–47.
281 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0010 [62].
282 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0010 [62].
283 Transcript, Canberra Hearing, Christopher Poulos, 11 December 2019 at T7478.11–19.
284 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0011 [64].
285 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0011 [65].
286 Exhibit 14-13, Canberra Hearing, Statement of Terry Nash, WIT.1296.0001.0001 at 0013 [71].
287 Transcript, Canberra Hearing, Terry Nash, 10 December 2019 at T7344.45–7345.6.
288 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7494.35–44.
289 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7507.17–20.
290 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7507.20–24.
291 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7507.26–36.
292 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7581.25–38.
293 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0033 [134].
294 Exhibit 14-18, Canberra Hearing, Statement of Catherine Davis, WIT.1304.0001.0001 at 0009 [57].
295 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7406.8–10.
296 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7407.29–32.
297 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7411.7–28.
298 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7411.7–28.
299 Exhibit 14-18, Canberra Hearing, Statement of Catherine Davis, WIT.1304.0001.0001 at 0009 [55].
300 Transcript, Canberra Hearing, Peter Jenkin, 11 December 2019 at T7448.4–7.
301 Exhibit 14-23, Canberra Hearing, Statement of Peter Jenkin, WIT.1314.0001.0001 at 0016 [95]–[96].
302 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0002 [7].
303 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0013 [78].
304 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0013 [78a].
305 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7450.7–10.
306 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7450.10–11.
307 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0013 [78a].
308 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0013 [78b].
309 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0013 [78b].
310 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0013 [78c].
311 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0010 [59]–[60].
312 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0016 [85]–[86].
313 Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0019 [101]–0020 [103].
314 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7640.33–37.
315 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0034–0035 [140].
316 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0034–0035 [140].
317 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7562.33–42.
318 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7560.43–7561.10.

319 Transcript, Canberra Hearing, Nikki Johnson, 11 December 2019 at T7453.1–31; Transcript, Canberra Hearing, Peter Jenkin, 11 December 2019 at T7465.45–7466.36.
320 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7396.10–18; Exhibit 14-18, Canberra Hearing, Statement of Catherine Davis, WIT.1304.0001.0001 at 0005–0006 [34].
321 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7381.20–34.
322 Exhibit 14-21, Canberra Hearing, Statement of Fiona Lysaught, WIT.1311.0001.0001 at 0008 [50]; Exhibit 14-19, Canberra Hearing, Statement of Thomas Woodage, WIT.1310.0001.0001 at 0009 [55]–[56].
323 Exhibit 14-20, Canberra Hearing, Statement of Judith Gardner, WIT.1312.0001.0001 at 0016 [96].
324 Exhibit 14-21, Canberra Hearing, Statement of Fiona Lysaught, WIT.1311.0001.0001 at 0008 [50].
325 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7611.18–34.
326 Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0005 [26].
327 Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0005 [26].
328 Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0005 [25]–[26].
329 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7452.33–44.
330 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7452.33–44.
331 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7465.1–3.
332 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7465.22–23.
333 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0007.
334 Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7334.46–7335.13.
335 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7612.44–47.
336 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0030–0031 [12a].
337 Submissions of the State of Western Australia, Canberra Hearing, 3 February 2020, RCD.0012.0055.0001 at 0003 [11].
338 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0031.
339 Exhibit 14-17, Canberra Hearing, Statement of Hamish MacLeod, WIT.1309.0001.0001 at 0003 [17]–0004 [19].
340 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0008–0009 [58]–[61].
341 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0008–0009 [61].
342 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7384.6–11.
343 Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7318.43–45.
344 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7427.7–35; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7440.19–41.
345 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7427.31–35; Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7428.1–4; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7428.6–14; T7438.4–10.
346 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7440.19–22.
347 Exhibit 14-21, Canberra Hearing, Statement of Fiona Lysaught, WIT.1311.0001.0001 at 0006 [36].
348 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0019–0020 [98]–[99]; Exhibit 14-36, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 0046 [304]; [306]–[307]; Transcript, Canberra Hearing, Ross Smith, 13 December 2019 at T7641.37–7642.2.
349 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7644.36–44.
350 RA Elliott et al., 'Impact of a pharmacist-prepared interim residential care medication administration chart on gaps in continuity of medication management after discharge from hospital to residential care: a prospective pre- and post-intervention study (MedGap Study)', *BMJ Open Journal*, 2012, https://bmjopen.bmj.com/content/2/3/e000918.full, viewed 6 May 2020.
351 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7644.46–7645.2.
352 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7332.10–14.
353 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0063 [258b].
354 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7601.17–21.
355 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7603.43–7604.12.
356 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7604.26–30.
357 Transcript, Canberra Hearing, Andrew Robertson, 12 December 2019 at T7544.26–7545.4; Submissions of Western Australia, Canberra Hearing, 3 February 2020, RCD.0012.0055.0001 at 0004 [12]; Transcript, Canberra Hearing, Nigel Lyons, 12 December 2019 at T7544.7–22; Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0008; Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7543.43–7544.2; Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7545.8–14; Submissions of SA Health, Canberra Hearing, 3 February 2020, RCD.0012.0054.0003 at 0011.
358 Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7540.26–29.
359 Transcript, Canberra Hearing, Maggie Jamieson, 13 December 2019 at T7642.12–23; Transcript, Canberra Hearing, Michael De'Ath, 13 December 2019 at T7642.25–32.
360 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0018 [91].
361 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0018 [92].
362 Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0004 [19].
363 Exhibit 14-10, Canberra Hearing, Statement of Mark Morgan, WIT.1317.0001.0001 at 0048 (response to Q18); Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0015 [54]; Exhibit 14-13, Canberra Hearing, Statement of Terry Nash, WIT.1296.0001.0001 at 0002 [11]; Exhibit 14-16, Canberra Hearing, Statement of Tess Oxley, WIT.1301.0001.0001 at 0007 [33].
364 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0051 [210].
365 Exhibit 14-2, Canberra Hearing, Statement of Jason Bendall, WIT.1300.0001.0001 at 0003 [17].

366 Exhibit 14-2, Canberra Hearing, Statement of Jason Bendall, WIT.1300.0001.0001 at 0004 [22]–[23].
367 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7375.17–19.
368 Exhibit 14-16, Canberra Hearing, Statement of Tess Oxley, WIT.1301.0001.0001 at 0007 [33].
369 Exhibit 14-16, Canberra Hearing, Statement of Tess Oxley, WIT.1301.0001.0001 at 0010 [46].
370 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7369.29–33; Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0002 [12].
371 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7372.40–43.
372 Transcript, Canberra Hearing, Catherine Davis, 11 December 2019 at T7400.17.
373 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7374.14–17.
374 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7374.22–26.
375 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0011 [38].
376 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0015 [54].
377 Transcript, Canberra Hearing, Terry Nash, 10 December 2019 at T7348.25–31.
378 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7443.13–15; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7443.17–26.
379 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7443.13–15.
380 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7443.21–26.
381 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7443.4–9.
382 Transcript, Canberra Hearing, Nigel Lyons, 12 December 2019 at T7546.21–23.
383 Transcript, Canberra Hearing, Nigel Lyons, 12 December 2019 at T7546.33–36.
384 Transcript, Canberra Hearing, Andrew Robertson, 12 December 2019 at T7547.29–34.
385 Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7546.42–47.
386 Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7547.17–21.
387 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7385.16–28.
388 Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7385.16–23.
389 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0011.
390 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0012 [72].
391 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7504.12–13.
392 Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0012–0013 [77].
393 Transcript, Canberra Hearing, Christopher Poulos, 11 December 2019 at T7483.38–46.
394 Transcript, Canberra Hearing, Christopher Poulos, 11 December 2019 at T7483.38–46.
395 Exhibit 14-11, Canberra Hearing, Statement of Jennifer Walton, WIT.1305.0001.0001 at 0008 [60]–0009 [63].
396 Exhibit 14-19, Canberra Hearing, Statement of Thomas Woodage, WIT.1310.0001.0001 at 0012 [76]; Exhibit 14-20, Canberra Hearing, Statement of Judith Gardner, WIT.1312.0001.0001 at 0019–0020 [119]; Exhibit 14-21, Canberra Hearing, Statement of Fiona Lysaught, WIT.1311.0001.0001 at 0009 [54].
397 Transcript, Canberra Hearing, Ross Smith, 13 December 2019 at T7651.26–32.
398 Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7545.39–40; Transcript, Canberra Hearing, Andrew Robertson, 12 December 2019 at T7546.12; Transcript, Canberra Hearing, Nigel Lyons, 12 December 2019 at T7545.44–7546.3; Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7546.7–8.
399 Submissions of the State of Western Australia, Canberra Hearing, 3 February 2020, RCD.0012.0055.0001 at 0004 [13]–[14].
400 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0007.
401 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0025.
402 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0025.
403 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 63, RCD.9999.0280.0050.
404 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 64, RCD.9999.0280.0067.
405 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 65, RCD.9999.0280.0025.
406 Transcript, Canberra Hearing, Peter Gray QC, 9 December 2019 at T7191.11–14.
407 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 65, RCD.9999.0280.0025 at 0031.
408 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 65, RCD.9999.0280.0025 at 0028.
409 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 65, RCD.9999.0280.0025 at 0026 and 0028.
410 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0004.
411 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0004 [8a–c].
412 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0011 [62]; Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0001 [5]; Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7318.37–45.
413 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7327.29–32.
414 Exhibit 14-13, Canberra Hearing, Statement of Terry Nash, WIT.1296.0001.0001 at 0015 [81].
415 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0026 [74].
416 Transcript, Canberra Hearing, Andrew Robertson, 12 December 2019 at T7551.37–40.
417 Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0004 [26].
418 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [127].
419 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [125].
420 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7328.28–30.

421 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7647.28–34.
422 Exhibit 14-34, Canberra Hearing, Statement of Kathrine Morgan-Wicks, WIT.0569.0001.0001 at 0008–0009 [16].
423 Exhibit 14-13, Canberra Hearing, Statement of Terry Nash, WIT.1296.0001.0001 at 0015 [80].
424 Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7325.30–32.
425 Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7328.42–45.
426 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7584.15–22.
427 Transcript, Canberra Hearing, Michael Montalto, 10 December 2019 at T7367.6–9.
428 Transcript, Canberra Hearing, Andrew Robertson, 12 December 2019 at T7548.10–16; Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7548.20; Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7548.23; Transcript, Canberra Hearing, Nigel Lyons, 12 December 2019 at T7548.26.
429 Transcript, Canberra Hearing, Ross Smith, 13 December 2019 at T7647.36–44.
430 Exhibit 14-35, Canberra Hearing, Statement of Maggie Jamieson, WIT.0567.0001.0001 at 0005 [16].
431 Exhibit 14-36, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 0023 [146].
432 Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7549.37–47.
433 Transcript, Canberra Hearing, John Wakefield, 12 December 2019 at T7549.23–26.
434 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0030 [122].
435 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7584.15–29.
436 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0060 [247].
437 Council on Federal Financial Relations, *Schedule J – Addendum to the National Health Reform Agreement: Revised Public hospital Funding and Health Reform Arrangements*, 2020, p 77, F12.
438 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [128].
439 Exhibit 14-30, Canberra Hearing, Statement of Christopher McGowan, WIT.0566.0001.0001 at 0022 [123].
440 Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7313.35–37.
441 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0011 [66].
442 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0009 [30].
443 Exhibit 14-28, Canberra Hearing, Statement of John Wakefield, WIT.0571.0001.0001 at 0012 [82].
444 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [124].
445 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [124].
446 Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0009 [41.3].
447 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7327.29–30.
448 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7327.41–43.
449 Exhibit 14-34, Canberra Hearing, Statement of Kathrine Morgan-Wicks, WIT.0569.0001.0001 at 0008 [16].
450 Exhibit 14-36, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 0009 [59]–[60].
451 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0031 [102]–[103].
452 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0031 [104].
453 Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0032 [106].
454 Submissions of SA Health, Canberra Hearing, 3 February 2020, RCD.0012.0054.0003 at 0014.
455 Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0011.
456 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0010.
457 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0010.
458 Submissions of Queensland Health, Canberra Hearing, 3 February 2020, RCD.0012.0057.0001 at 0010.
459 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0011.
460 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0011.
461 Submissions of the Victorian Department of Health and Human Services, Canberra Hearing, 10 February 2020, RCD.0012.0059.0001 at 0012.
462 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7266.16–18.
463 Exhibit 14-34, Canberra Hearing, Statement of Kathrine Morgan-Wicks, WIT.0569.0001.0001 at 0029.
464 Exhibit 14-13, Canberra Hearing, Statement of Terry Nash, WIT.1296.0001.0001 at 0014 [76].
465 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7265.31–41.
466 Exhibit 14-10, Canberra Hearing, Statement of Mark Morgan, WIT.1317.0001.0001 at 0025.
467 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7328.15–22.
468 Exhibit 14-2, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0026 [74].
469 Transcript, Canberra Hearing, Jennifer Walton, 10 December 2019 at T7306.31–36.
470 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0064 [262].
471 Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [125].
472 Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7551.4–17.
473 Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7583.19–27.
474 Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7266.1–7.
475 Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7266.11–12.
476 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7266.16–29.
477 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7328.18–22.
478 Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7329.11–14.

479 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7327.27–43.
480 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0025 [126].
481 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 72, WIT.0570.0002.0001 at 0054 [46].
482 Submissions of NSW Health, Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0012.
483 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7428.6–14.
484 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7605.5–14.
485 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 a T7605.16–23.
486 Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7550.32–35.
487 Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7551.17–20.
488 Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7551.20–22.
489 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7649.32–37.
490 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0008 [34]–[37].
491 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0008 [35].
492 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0008 [36].
493 Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0008 [37].
494 Exhibit 14-28, Canberra Hearing, Statement of John Wakefield, WIT.0571.0001.0001 at 0029–0030 [197].
495 Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0032.
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500 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7425.33–41.
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502 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7426.12–28.
503 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7428.9–14.
504 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7427.17–22.
505 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7427.24–35.
506 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7428.1–4.
507 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 72, WIT.0570.0002.0001 at 0054 [46].
508 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 72, WIT.0570.0002.0001 at 0054 [46].
509 Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7605.5–14.
510 Exhibit 14-9, Canberra Hearing, Supplementary Statement of Anthony Bartone, WIT.1301.0001.0001 at 0002 [11].
511 Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7278.17–20.
512 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0013 [75].
513 Transcript, Canberra Hearing, Maggie Jamieson, 13 December 2019 at T7621.46–7622.1.
514 Transcript, Canberra Hearing, Christopher Poulos, 11 December 2019 at T7477.5–9.
515 Transcript, Canberra Hearing, Christopher Poulos, 11 December 2019 at T7477.5–27.
516 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0016 [89].
517 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7622.14–27.
518 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7439.34–45.
519 Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7440.4–5.
520 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7622.36–40.
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522 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7496.24.
523 Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7497.28–43.
524 Transcript, Canberra Hearing, Meegan Beecroft, 10 December 2019 at T7364.15–23.
525 Transcript, Canberra Hearing, Meegan Beecroft, 10 December 2019 at T7364.15–23.
526 Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7320.21–23.
527 Transcript, Canberra Hearing, Maggie Jamieson, 13 December 2019 at T7622.4–10.
528 Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0016 [91].
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530 Transcript, Canberra Hearing, Michael Montalto, 10 December 2019 at T7363.17–33.
531 Transcript, Canberra Hearing, Meegan Beecroft, 10 December 2019 at T7365.1–5.
532 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7496.42–7497.4.
533 Transcript, Canberra Hearing, Leonard Gray, 12 December 2019 at T7497.6–17.
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535 Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7622.23–27.
536 Transcript, Canberra Hearing, Christopher Poulos, 11 December 2019 at T7477.33–39.
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538 Exhibit 14-36, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 0030 [193].
539 Transcript, Canberra Hearing, Leonard Flicker, 12 December 2019 at T7515.18–22.

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