Chapter 3

Responses

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

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

Regulatory responsibilities

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

Table 3.1–Aged care responsibilities

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

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

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

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

SA Government actions

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

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

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

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

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

The Oakden report

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

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

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

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

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

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

5 *Oakden report*, pp. 31–32.

6 *Oakden report*, p. 57.

7 *Oakden report*, pp. 65–66.

8 *Oakden report*, pp. 89–90.

9 *Oakden report*, p. 100.

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

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

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

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

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

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

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

3.9 The Oakden report made the following key conclusion:

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

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

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

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

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10 *Oakden report*, pp. 113–114.

11 *Oakden report*, p. 115.

12 *Oakden report*, p. 78.

13 *Oakden report*, p. 77.

Response to Oakden report – SA Government

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

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

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

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

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

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

14 *Oakden report*, p. 3.

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

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

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

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

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

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

SA Independent Commissioner Against Corruption

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

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

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

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

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

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

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

> [T]here were identifiable and culpable people who either in the past or still currently do via the position they held or hold either actively sought to cover up, encourage or, at the very least, fail to execute their duties. This facilitated and allowed a systematic abuse of procedure and through inaction and maladministration actively and successfully created and continued to develop a culture of bullying, intimidation and corruption with outright, blatant criminality.[22]

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

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

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

SA Police

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

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

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

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

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

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

Committee view

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

Australian Government responses

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

Quality Agency actions

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

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

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

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

28 *Carnell Paterson review*, p. 34.

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

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

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

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

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

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

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

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

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

31 *Carnell Paterson review*, p. 31.

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

33 *Carnell Paterson review*, p. 35.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Use risk-based compliance monitoring.

(ii) Pre-plan audits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Committee view

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

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

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

Carnell Paterson review

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

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

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

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

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

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

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

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

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

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

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

3.54 The Carnell Paterson review made six key recommendations:

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

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59 *Carnell Paterson review*, p. 29.

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

61 *Carnell Paterson review*, p. 39.

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

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

Committee view

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

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

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

Australian Health Practitioners Regulation Agency

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

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

Concerns with response

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

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

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

65 *Carnell Paterson review*, p. 24.

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

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

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

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

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

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

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

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

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

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

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

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

71 *Carnell Paterson review*, p. 38.

72 *Carnell Paterson review*, p. 40.

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

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

Committee view

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