Additional Comments by the Nick Xenophon Team

An age-old problem – shamefully handled

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Senator Rex Patrick **Senator Stirling Griff**

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