



#### Acknowledgements:

The Review thanks all those who assisted throughout. We are especially indebted to Ms Michele Burman from the Office of Chief Psychiatrist, who worked tirelessly over the 12 weeks, without her assistance the Review would have taken much longer to complete. We also thank, Dr Kate Jackson, Dr Rod McKay and Mr John Nadjarian from NSW, Dr Brett Coulson and Prof Kuruvilla George from Victoria and Dr Helen McGowan from Western Australia for providing a range of materials and advice that informed the Review and Ms Lydia Dennett, the SA Chief Nursing and Midwifery Officer and Mr Steve Morris the Chief Pharmacist who assisted with advice on South Australian standards and policies.

The Review is also indebted to the weeks of tireless effort from Del Thomson, Dr Duncan McKellar and Prof Nicholas Proctor who heard the stories from families and staff, helped bring together and weigh up a wealth of information, and review the report during its production.

Finally, we acknowledge the many families of current and past consumers of Oakden who came forward and told their stories. For them this report tries to faithfully represent the views and lives of their loved ones.

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Hon Leesa Vlahos MP  
Minister for Mental Health and Substance Abuse  
Minister for Disability

Dear Minister

I hereby provide you with the report of the Review of the Oakden Older Persons Mental Health Service.

I formally bring this report to your attention in compliance with the statutory functions of the Chief Psychiatrist outlined in Section 90 (1) (d) of the *Mental Health Act 2009*: 'to advise the Minister on issues relating to psychiatry and to report to the Minister any matters of concern relating to the care and treatment of patients'.

This report raises many areas of significant failure in the care and treatment of patients under the *Mental Health Act 2009* and I bring these to your attention in this report.

Yours Sincerely

A handwritten signature in black ink, appearing to read 'A Groves', written in a cursive style.

Dr Aaron Groves  
Chief Psychiatrist

10 April 2017

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## Contents

1. Introduction	1
2. Background	2
Independence of the Review	2
Conduct of the Review	4
3. Policy Context	9
4. History of Oakden	22
5. Term of Reference - Model of Care	27
6. Term of Reference - Staffing Model	59
7. Term of Reference - Quality and Safety of Care	69
8. Term of Reference - Culture	93
9. Term of Reference – Restrictive Practices	103
10. Conclusion	115

## Appendices

Appendix One Terms of Reference	116
Appendix Two Mental Health Act 2009 – Chief Psychiatrist	118
Appendix Three Biographical Statements	120
Appendix Four Letters to Families of Consumers at Oakden	122
Appendix Five Document Register	126
Appendix Six <i>Mental Health Act 2009</i> – Principal Community Visitor & Community Visitor Scheme	131
Appendix Seven Community Visitor Scheme Reports 2016-17	134
Appendix Eight Guardianship and Administration Act 1983	137
Appendix Nine Media	139
Appendix Ten National Mental Health Policy & Planning Documents	140
Appendix Eleven SA Health Dignity of Care Principles	141
Appendix Twelve Bibliography	142

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## 1. Introduction

On 20 December 2016, the Chief Executive Officer (CEO) of the Northern Adelaide Local Health Network (NALHN), Ms Jackie Hanson contacted the Chief Psychiatrist raising concerns about the level of clinical care provided at the Oakden Older Persons Mental Health Service (OPMHS). Ms Hanson requested the Chief Psychiatrist undertake an external independent review of the Oakden Facility as a matter of urgency with the intention of providing a report in April 2017.

Comprehensively reviewing a service of this size is both complex and demanding. In undertaking this review, I was ably assisted by Professor Nicholas Procter, Dr Duncan McKellar and Ms Del Thomson.

I am indebted to a number of people who assisted me and who were generous with their time, in order that I could fulfil the expectations of this review. I am especially grateful to the large number of brave staff of NALHN, who came forward and spoke to the Review with an openness, honesty and transparency about their experiences and observations that reflects the deeply held concerns they have harboured for many years.

This report is arranged in sections that cover the background; an outline of the policy context; the history of the Oakden facility; and five Chapters each of which is devoted to one of the terms of reference.

The Chapters, addressing each of the Terms of Reference, are arranged in order to describe what the Review considered as the scope of the issue, what was found and finally what recommendations are made to address that aspect of the service. In addition, where it was possible to do so, the Review has given an indicative timeframe for addressing its recommendations.

The report is based on numerous interviews, written submissions, reviews of clinical files, written policies, procedures and protocols, and observations made by the Review team whilst onsite at Oakden.

Great care has been taken to ensure all findings within the report are based on this material and therefore this source material is available to NALHN for verification of the findings. However to ensure the anonymity and confidentiality of those who provided this information, the report does not contain the details of who said what, or which documents, including consumers clinical files, and other correspondence has been relied upon, unless prior permission was given for this to be identified within the report.

A number of Appendices, a Bibliography and a Document register together with a list of references have been provided.

The Review has made findings and recommendations that can provide a new direction for Specialist Older Person Mental Health Services in South Australia. I hope they will be able to be implemented over the coming years.

## 2. Background

In February 2016, a consumer of Oakden OPMHS was referred to the Royal Adelaide Hospital; Emergency Department after it was discovered that he had very significant bruising to his hip for which there was no satisfactory explanation. He did not return to Oakden.

In June 2016, the family of this consumer made their concerns about his care known to the Principal Community Visitor <sup>1</sup>and then to the NALHN Mental Health Service.

Subsequently the family's concerns about the level of his clinical care were raised with Ms Jackie Hanson, the CEO of NALHN, who then met with them in December 2016 to hear their concerns and to respond.

Following this meeting, the CEO, NALHN requested the Chief Psychiatrist undertake a review into Oakden. From the outset it was clear that the CEO, NALHN wanted the review to be extensive and to look into all matters relevant to the Clinical Care of all consumers within the Oakden facility and not be restricted to any one individual. It was clear she wanted no stone unturned in getting to the bottom of the issues.

Furthermore, the CEO, NALHN was clear that she would take actions immediately, to ensure people were safe, and start the long process of changing the service even before the outcomes would be known. Thus the Review would be as much about what went wrong as it would be about recommending what should be done in the future.

However to allow a degree of direction for the Review it was requested that the report focus on five broad areas of clinical care during 2016 without needing to be restricted to that year. The Review could consider all matters that can be covered through the use of statutory powers conferred on the Chief Psychiatrist.

It was anticipated interviews could be undertaken within four weeks and that consideration of all written material would require a further eight weeks to finalise the report.

The Terms of Reference for the Review are included in **Appendix 1**.

### Independence of the Review

In South Australia, the Chief Psychiatrist is appointed as a Statutory Officer under Section 89 of the *Mental Health Act 2009*, and their functions outlined in Section 90. In broad terms, the Chief Psychiatrist role is to promote continuous improvement in the organisation and delivery of mental health services in South Australia, monitor treatment of patients and the use of restraint and seclusion, monitor the administration of the Act and the standard of psychiatric care as well as providing advice to the Minister on issues relating to psychiatry and any matter of concern relating to the care of patients.

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<sup>1</sup> The position of Principal Community Visitor was established under the *Mental Health Act 2009* more detail is found on page 9



The complete wording of Section 89 and Section 90 of the *Mental Health Act 2009* is included in **Appendix 2**.

In addition the Chief Psychiatrist can, with the approval of the Minister, issue standards that are to be observed in the treatment and care of patients as well as having the authority to undertake inspections of any hospitals and to be taken to be an inspector under the *Health Care Act 2008* for that purpose. The Chief Psychiatrist has the capacity to delegate these powers under Section 91 of the Act.

During this Review I delegated the powers of inspection Section 90(4) to:

- Professor Nicholas Procter, University of South Australia
- Dr Duncan McKellar, Central Adelaide Local Health Network
- Ms Del Thomson, Clinical Risk Manager, Office of the Chief Psychiatrist

That is, each member of the Review team had for that time those powers of the Chief Psychiatrist and undertook their duties independent from any other roles they may otherwise have in South Australia. The Biographical statements of the Review team are included at **Appendix 3**.

On 9 January 2017, the CEO NALHN assigned a senior Nurse Manager to Oakden OPMHS to oversee a process of ensuring best clinical care and protecting rights. This was the first of a series of Senior Management initiated actions designed to ensure the consumers within the Oakden facility were provided with the highest quality of care prior to the outcomes of the Review being known. This was an important decision.

During the time the Review was underway, the CEO, NALHN, made a number of other immediate improvements to the service, 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.

These actions occurred separately from the Review which remained independent from the operations at Oakden.

However, as a result of these actions, the Review had an easily accessible method of bringing matters that concerned the Review team to the attention of a new management structure that was dedicated to ensuring the highest quality of care.

The Review determined any matter that was either outside its Terms of Reference; needed an immediate rectification; the possibility of disciplinary action; or referral for consideration of criminal proceedings, would be referred to the management body that has responsibility for such action.

However for some staff of Oakden there was confusion about whether NALHN was taking decisions based on recommendations arising from the Review or as a result of the new senior management structure in place at Oakden. It was apparent to the Review team that some decisions that were taken by NALHN were both as a result of information provided by the Review as well as from information that the new Oakden management structure was able to find.

The Review was however able to form a clear opinion about the different clinical environment at the commencement of the Review and what was in place at the conclusion of the Review. This will be commented on in more detail in later sections of the report particularly in the chapters dedicated to each term of reference.

## Conduct of the Review

### Informing Staff of Oakden

At the request of the Review; in the week prior to the commencement of the Review, Ms Maria West Director of Strategy and Operations, Mental Health, NALHN, circulated a bulletin to Oakden staff informing them of the Review and the Terms of Reference. In addition, the Review circulated information about the Review and requested that this be made available to all staff in prominent places within the Oakden facility.

The Industrial bodies that represent staff at Oakden were also notified of the Review, its terms of reference and mechanisms for providing information to the Review. The Industrial bodies were re-assured that they were encouraged to attend any interviews conducted with staff.

During the Review there were four meetings with staff that were arranged to cover all changes in shifts with a special effort to provide an opportunity to involve staff working overnight shifts. The staff members of Oakden were encouraged to participate through two principal mechanisms.

Firstly, interviews with the Review team could take place either at Oakden, or if the staff member wished to retain anonymity, they could to be interviewed at the Department for Health and Ageing building. Staff members were strongly encouraged to bring support people (including Industrial/Union representatives with them) if they wished. Interviews were conducted with a minimum of two Review members present to ensure reliability of the information that was collected. However, most interviews had at least three Review members present and for many all four members attended the interview.

On rare occasions, Oakden staff met with one member of the Review team, usually as a direct approach to the Review team and as a result of a high level of staff distress at the time. Where this occurred, the Review has not relied on any of this communication in making its findings, unless this was provided to the Review at a later stage.

The second mechanism for participation in the Review was through the provision of written correspondence and submissions. Staff members were invited to provide their observations about Oakden, both positive and negative, either in the form of a named submission or as an anonymous submission if this was preferred. Through the course of the Review we received written correspondence that was emailed, sent by post and hand delivered to members of the Review, usually this occurred at the time of an interview.

The Review also conducted targeted interviews with a very wide range of senior staff of Oakden OPMHS, the Senior Mental Health Executive of NALHN and the Senior Executive of NALHN.

The Review conducted 53 interviews with staff that involved in total 49 hours of interview time.

At the commencement of every interview with staff, the Review team explained the nature of the Review, its scope and powers and specifically indicated that if a person felt uncomfortable with any question they were not compelled to answer.

The Review team outlined that they were keen to hear both positive and negative aspects of Oakden and that they wanted to be provided with views about how the service could be improved.

### **Families of Consumers of Oakden**

The Review requested the contact details of all family members or next of kin held by Oakden for each consumer in Oakden during 2016. This information was used as the basis for involving the families of consumers in Oakden in the Review. It is possible that the Review may not have had all details of people who had an interest in this Review.

Correspondence was sent on 3 February 2017 to the 47 family members and carers of consumers who had been a resident of Oakden during 2016, informing them of the Review and inviting them to attend a meeting with the Review team on 15 February 2017. Unfortunately a small number of letters were returned as either the address was incorrect or the addressee was no longer living at that residence.

All four members of the Review team met with families and carers of consumers of the Oakden facility on 15 February 2017 between 9:30 am and 1:00pm at the Office of the Public Advocate. This meeting was attended by 17 people who had family members in Oakden. In addition, a subsequent meeting was held with three other family members who had been unable to make the initial meeting.

Further correspondence was sent to all families, on 20 February 2017 which outlined, particularly for the benefit of those unable to attend, what had occurred at the meeting and provided information on other avenues that family members or carers could use if they wanted to provide information to the Review team. See **Appendix Four** for a copy of the letters sent to the families

The Review received a number of written submissions, some of which arrived during the final week of the Review, nevertheless all correspondence was considered by the Review so that it would be added to the Review where ever this was possible.

### **The Review of clinical files**

The Review extensively examined the clinical files of nine current and seven former consumers of Oakden, and also examined clinical material related to nearly all consumers of Oakden from the beginning of 2016.

Most of the clinical files were extensive with as many as eleven volumes of material going as far back as 2005, in some cases. In one record, the review of a clinical file required consideration of over 3,000 pages of clinical entries with an estimated 10,000 different clinical entries. On average, each file reviewed contained over 400 pages of clinical entries. This was an invaluable source of material for the Review which greatly assisted the understanding of clinical processes at Oakden.

In addition, the Review considered a wide range of policies, guidelines and procedures that related to clinical processes; provided to the Review by NALHN. This included the minutes of committee processes concerning, the governance of Oakden OPMHS including minutes from meetings prior to 2016. These are outlined in the document register that is found at **Appendix Five**.

These documents related specifically to what should be expected of clinical records, clinical documentation and the clinical processes that NALHN considered essential for maintaining standards.

### **On site visits**

The Review team was on site at Oakden on 17 days, this included two weekends. During that time, the team had the opportunity to spend significant amounts of time on each of the wards observing the practices, interactions and level of clinical care and clinical interventions.

### **Interstate Inspection of OPMHS**

The Review made enquiries with other Australian Chief Psychiatrists (and in some cases their Deputies) about the services considered by Clinical Leaders of OPMHS in those states as current best practice within Australia.

As a result, two members of the Review team completed a visit to services in Victoria and New South Wales as part of the review process. In addition, one member of the Review team had substantial knowledge of OPMHS, in Western Australia, Queensland, Victoria and New South Wales. The purpose of the visit was to examine services in those two jurisdictions that are known to be providing best practice in OPMHS. This allowed the Review, to appropriately benchmark regarding the model of care, including governance structures; utilisation of Commonwealth funded aged-care beds with state funding; the quality of infrastructure; and design of the built-environment. In addition, the Review considered the overall approach to the provision of clinical services to the equivalent populations represented by the cohort of consumers currently at Oakden campus.

During the visit the Review team visited a range of services at the Peter James Centre, Auburn House and North West Health in Melbourne and at the Hammond Care services provided at Hammondville in Western Sydney.

### **External Informants**

The Principal Community Visitor is a Statutory Officer created under the *Mental Health Act 2009*. Together with the Community Visitor Scheme (CVS) their establishment and functions are outlined in sections 50-54 of the *Mental Health Act 2009* (MHA).

The functions of Community Visitors include conducting visits and inspections of treatment centres; referring matters of concern relating to the organisation or delivery of care or the care, treatment or control of patients to either the Minister, Chief Psychiatrist or other appropriate person; and to act as advocates for patients to promote the proper resolution of issues relating to care, treatment or control of patients including those raised by a guardian, relative, carer or friend.

The Principal Community Visitor, Mr Maurice Corcoran and his deputy, Ms Connie Miglione were interviewed and provided to the Review, all correspondence between the CVS and NALHN in relation to Oakden from the beginning of 2016 until March 2017. **Appendix Six** contains the sections of the MHA that outline the functions of the CVS and **Appendix Seven** contains a summary of the correspondence between the CVS and NALHN.

The Public Advocate is a Statutory Officer created under the *Guardianship and Administration Act 1993* (GAA) with functions outlined under section 21 of that legislation, that includes speaking for and promoting the rights and interests of any class of mentally incapacitated persons.

The Public Advocate, Ms Anne Gale, was interviewed with her deputy, Ms Bethany Caldiera and a number of documents were provided to the Review team as a separate submission. **Appendix Eight** contains the sections of the GAA that outline the role and functions of the Public Advocate.

### **Document Review**

In addition to the documents related to clinical policies, the Review also sought the full range of documents that related to Oakden so these could be reviewed to determine the priority issues for the Review to examine in greatest detail. The Review examined several hundred documents to assist with the Review team's considerations. Those documents that the Review has relied upon are cited throughout the document in the sections in which they apply.

Over the course of the Review extensive searches were made of SA Department for Health and Ageing corporate files and archived emails from departmental officers from as far back as 2007. This was undertaken to understand the policy and planning context and to obtain the formal background that related to key events involving Oakden or Older Persons Mental Health Services during the period from 2007 until the present time. Accessing electronic documents prior to 2007 was difficult in practice and unlikely to assist the Review's considerations of the terms of reference.

In total, some 65,000 emails were briefly scanned and of these it is estimated that more than 2000 were then reviewed to consider their contents in more detail. The review of 1,200 corporate files searched under the heading of Oakden OPMHS or OPMHS found 600 documents that were then reviewed.

Notably, a forensic search of archived departmental records for the 2008 calendar year revealed approximately 80 documents or files relating to issues experienced at Oakden at that time. The nature of those issues, including accreditation, complaints about the service, and the future of the site featured prominently and were similar to those found by the Review team as presented in this Report.

### **Media Coverage**

Throughout the Review there were a number of media reports about Oakden that came to the attention of the Review. Primarily, this was as a result of various people including families of Oakden consumers, political figures and external consultants making statements to the media, and secondarily following a recent visit of the Commonwealth's Aged Care Safety and Accreditation Agency (ACSAA) who undertook an inspection of the facility in late February and then a more detailed audit in March 2017.

These issues broadly related to:

- the 'limited' scope of the review, and in particular that the Review was focussed on the Service during the 2016 calendar year only;
- the independence of the review;
- elder abuse, including the inappropriate restraining and seclusion of consumers at Oakden;
- medication errors;
- Commonwealth sanctions following the audit of the Service in March 2017;
- recent suspension of staff at the Service; and
- the release of historical reports and other documentation highlighting issues with the Service.

The Review was aware of all matters raised through media outlets and consequentially they were able to be considered and addressed by the Review Team. Where appropriate in this report, issues relating to the independence of the Review as well as issues relating to the scope are addressed within the body of this Report. **See Appendix Nine** for a full list of the media coverage.

### **Standard of Proof**

The Review was not established with formal powers to compel people to answer questions, nor did it have powers to conduct disciplinary proceedings. As a result it was not intended to operate with a threshold for determining matters with the burden of proof required for formal legal proceedings.

Robert Francis, in the introduction of the final report of the 2013 Mid-Staffordshire NHS Foundation Trust Public Inquiry outlined the relevant arguments relating to standards of proof that should operate when conducting investigations and inquiries (paragraphs 79 through 100)<sup>i</sup>.

The Review team took an approach consistent with Francis as follows:

1. findings are based only on those materials before us during the time of the review (these have been outlined above);
2. much of what we heard and read has not been contradicted. Where this occurred we have accepted the evidence provided;
3. where there are issues in relation to what occurred, the review team has weighed this up carefully and taken the “common sense approach” of accepting what are likely explanations and showing more caution about those explanations and views that are more improbable;
4. in some situations, it is hard to be certain what occurred and therefore the review has chosen to state clearly what may have occurred;
5. the Review was careful to ensure equal weighting of information provided to the report unless there was good reason to reject the information as inherently unreliable; and
6. the Review has searched to find the systemic issues and root causes of issues at Oakden, it has been vigilant not to be critical of any individuals, even when blame may well be attributed to them, as part of any other processes that may occur independent from this review.

### 3. Policy Context

At the time Oakden opened in 1982, many mental health services in Australia were held in very low regard by those people who came into contact with them. This included not only those who were consumers, but also family members, carers, friends, volunteers and even many staff who worked in these facilities.

During the 1980s many examples of significant scandals, together with reviews showing poor standards of care and in some cases systemic abuse and failure to ensure peoples basic rights led to widespread calls for significant reform and the efforts of both levels of Government to work together to achieve these outcomes.

By the end of the 1980s there was a concerted effort to address these failings and this led to the establishment of two key overlapping processes. The first was the Australian Human Rights and Equal Opportunities Commissions (HREOC) National Inquiry into the Human Rights of People with a Mental Illness which brought down its final report in 1993<sup>ii</sup> and the second was the agreement by all Australian Health Ministers in 1992 to implement a National Mental Health Strategy.

#### National Mental Health Reform

Since 1992, when all Australian Health Ministers agreed to a National Mental Health Policy,<sup>iii</sup> reform has been underpinned by a series of plans, statements of rights and responsibilities and funding agreements and designed to achieve a number of key reform outcomes. The current national mental health policy and planning frameworks that apply in SA are listed in **Appendix Ten**.

In summary, there has been agreement by all Governments to close stand-alone Psychiatric Hospitals and to mainstream inpatient services (that is to provide them on the site of General Hospitals); move services, where possible, toward greater integration between services provided in hospitals and those in the community; and to ensure people's rights and facilitate recovery.

During the last 25 years, each jurisdiction has committed to reforming their specialist mental health services in line with the five agreed aims of the national policy supported by a range of nationally agreed actions outlined in four National Plans that were developed to implement the intent of the policy.

In 2003, Health Ministers agreed to the third National Mental Health Plan (NMHP) that proposed adopting a population health framework in which the mental health of older people would be highlighted as a priority. Specifically each government agreed that over the next five years they would improve service responsiveness to older people especially those with diverse and complex needs and to promote continuity of care<sup>iv</sup>. Whilst the evaluation of the Third National Mental Health Plan has not been widely released it is apparent that much of that plan was not implemented.

In 2006, the Council of Australian Governments (COAG) agreed to a National Action Plan on Mental Health with \$ 5.1 Billion in funding to support its implementation



However in 2009, it became apparent that there was no clear agreement about what should constitute the optimal mix of the full range of services that should be provided for a certain population. On agreeing to the Fourth National Mental Health Plan (4<sup>th</sup> NMHP), all Australian Health Ministers agreed that a National Mental Health Service Planning Framework (NMHSPF) would be developed to outline this optimal mix of services<sup>v</sup>.

This NMHSPF was developed by NSW (in conjunction with Qld) with funding from the Commonwealth and oversighted by a group that involved all jurisdictions. In 2013, a first version of the NMHSPF (known as Version 1.0) was made available to all states to assist future state mental health planning<sup>vi</sup>.

In August 2016, jurisdictions were provided the latest version of the NMHSPF (Version 2.1) to assist planning services that are required for a particular population. This version was an update to reflect feedback from jurisdictions that had used the initial version and found issues with the tool. It also included further functionality that was not available with the initial version and addressed some areas not addressed in the initial version.<sup>vii</sup>

Whilst the NMHSPF has certain limitations for very limited highly specific services, it is a very useful guide to planning what Mental Health Services are required for a given population. It is expected that the NMHSPF will be used to inform joint regional planning between LHNs and PHNs under reforms proposed in the draft 5<sup>th</sup> National Mental Health and Suicide Prevention Plan (5<sup>th</sup> NMHSPP).

The NMHSPF was developed using the known Australian epidemiology and burden of disease associated with mental illness, together with an extensive expert development of the annual care packages needed to estimate the level of services needed for a given population.

In the development of the NMHSPF, as it relates to people over 65 years, there has been heavy reliance on the research undertaken by Brodaty et al.<sup>viii</sup>

In 2003, Brodaty, Draper and Low, first described a tiered classification of the Behavioural and Psychological Symptoms of Dementia (BPSD) together with a description of both the prevalence and incidence of these tiers and the nature of services required to respond to these levels of behavioural disturbance.

At the time the model was developed, services for people with BPSD in Australia were described as ad hoc and fragmented. The planning model proposed by Brodaty was based on a comprehensive analysis of the prevalence of various Dementia-related symptoms and the level of care that is considered necessary to satisfactorily assist that person.

The model divides people with BPSD into seven tiers in an ascending order of symptom severity with corresponding bands of service intervention that are required for each tier. The 7 Tier model was supported by a thorough analysis of the available world literature on population prevalence rates for each Tier of the classification.

This classification is now widely accepted as the best international classification of Dementia and corresponding service needs. Since 2003, Brodaty, Draper and Low and their associates have published widely and dominated not only the national, but also international literature on epidemiological planning for people with BPSD. However the model originally described by all three authors is usually referred to as the Brodaty 7 tier model. Throughout this document, we refer to the model as the “Brodaty model” but recognise the equal contributions of Draper, Low and others to Australia’s rich knowledge about BPSD. In addition, for simplicity we also refer to the work of



Brody, whilst recognising that this represents the combined publications of Brodaty et al, Draper et al, as well as a number of their collaborators.

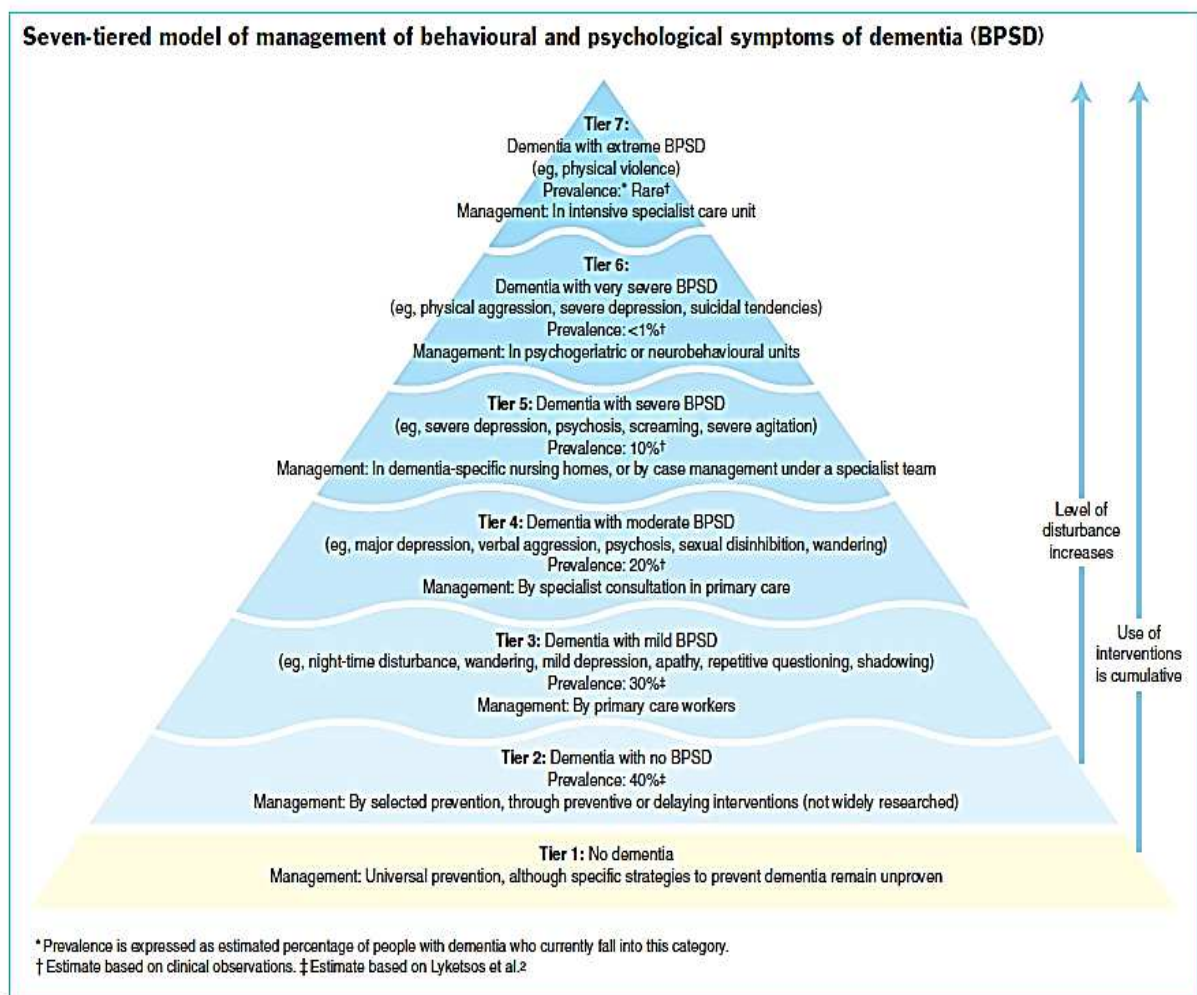
The Review placed special emphasis on the apex of the model (Tiers 6 and 7). The Brodaty model is careful in describing that people with BPSD Tiers 2 through 5 can successfully be managed with services from Commonwealth funded services, albeit with the support of highly specialised teams at Tier 5.

However the key consideration is the service needs of those with very severe (Tier 6) and extreme (Tier 7) BPSD. The Brodaty model clearly describes the level of interventions needed for this rare group of individuals as “Neurobehavioral Units” (Tier 6) or “Intensive Specialist Care” (Tier 7) that is care types that far exceeds the level of care able to be provided by Dementia-Specific Nursing Homes.

It is this key point about the needs of a few people that does not appear to have been planned for in SA as will be outlined later in this chapter.

Figure 1 shows the original 7 Tier model of Brodaty, Draper and Low.

Figure 1



In November 2016, the first draft of the 5<sup>th</sup> National Mental Health and Suicide Prevention Plan (5<sup>th</sup> NMHSPP) was released for public consultation. This plan, which will act as a guide to further national mental health reform is currently expected to be released later in 2017.

Each component of the National Mental Health Strategy (NMHS) has been endorsed by all Australian Health Ministers. In doing so, all jurisdictions committed to using the NMHS as the template to guide their actions at a local level.

Consequently since 1992, all States and Territory Governments have developed and released State Mental Health Plans that have guided the reform and future direction of services based on the NMHS.

During the development of these State plans there has been a significant focus on the planning of specialised OPMHS. It is significant that both NSW and Victoria undertook large scale and detailed OPMHS planning from 2004 onward, in an effort to describe for the first time, at a State level, the full range of services needed (including Commonwealth funded services) to provide comprehensive OPMHS to their population.

Much of this was led by NSW, who had developed a state-wide Mental Health Planning tool referred to as the Mental Health Clinical Care and Prevention planning model (MH-CCP).

In 2005, NSW published a detailed 10-year State Plan for the provision of Older Person's Mental Health Services that was based on MH-CCP and the detailed planning arising from the Brodaty model.

The *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015* (the NSW Plan)<sup>ix</sup> is a comprehensive outline of the relevant policy, planning and demographic context, definition of the scope and functions of OPMHS, together with an OPMHS service delivery model, an implementation plan and a reporting, monitoring and evaluation framework.

In 2011, the NSW plan was subjected to a mid-plan evaluation that also reviewed all additional literature that has become available since the development of the plan. In addition, NSW has also developed a very comprehensive clinician's handbook known as the *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia*.<sup>x</sup> to assist all clinicians working in OPMHS to understand best practice approaches to treating BPSD.

Other Australian states and territories have heavily relied on the work of NSW and Victoria to inform the way in which they provide specialised OPMHS.

### **Dementia as a National Health Priority**

In 2006, all Health Ministers agreed to the National Framework for Action on Dementia 2006-2010<sup>xi</sup> that brought together the various strategies of Australian jurisdictions in an attempt to "treat, improve the care of and delay the onset or progression of dementia"

In August 2012, all Australian Health Ministers agreed to adding dementia to the National Health Priority Areas (NHPA), recognising the increasing burden that the dementia-related illnesses would present to the Australian population, making Australia one of the first countries in the world to elevate Dementia in this way.

This recognition of dementia as the ninth NHPA was intended to help focus attention and research on the area, drive collaborative efforts to tackle dementia at all levels and across government, non-government, clinical and community sectors.

Under the Dementia Initiative, three important programs were developed namely;

- Extended Aged Care at Home Dementia places (EACHD);
- Dementia Training Study Centres; and
- Dementia Collaborative Research Centres (DCRCs) and Dementia Behaviour Management Advisory Services (DBMAS).

In 2012, the Australian Government released *Living Longer. Living Better* an Aged Care Reform package. This was in the context of the cessation of certain elements of the National Dementia Initiative in 2011.

Since that time it has been recognised that severe and very severe BPSD has begun to fall between the cracks of the Commonwealth Aged Care system and the State funded Mental Health Care system, with the need for both levels of government to cooperate in the development of programs that cater for this small group of highly disadvantaged people and their families and carers.<sup>xii</sup>

### **What are Older Person's Mental Health Services?**

Across Australia, the Commonwealth is responsible for primary mental health care. They support the delivery of community based primary mental health services provided by General Practitioners and a range of private specialist providers including Psychiatrists, Psychologist, Nurses and other Allied Health providers through a number of specific programs, many controlled by Primary Health Networks (PHNs).

In addition, the Commonwealth has the lead role in the provision of Aged Care services including funding the Residential Aged Care sector and a range of dementia-specific programs that assist people with Dementia to live in their own home or in Dementia Specific RACFs.

In South Australia, state-funded Health Services provided through each Local Health Network (LHN) are responsible for Specialised Mental Health Services.

In broad terms, specialised Older Persons Mental Health Services (OPMHS) are provided to three groups of people, namely:

- people 65 years or over that have a mental illness or mental health problems;
- people with very severe Behavioural and Psychological Symptoms of Dementia<sup>2</sup> (BPSD); and
- people who may be younger but are "functionally older" and often have a combination of acquired cognitive dysfunction, complex comorbidity and are in poor health<sup>3</sup>.

OPMHS are therefore provided to distinctly different groups of individuals, ranging from those with mental illnesses such as Psychosis, Depression and severe Anxiety Disorders through to people who are severely and persistently affected by challenging behaviours of Dementia such as agitation;

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<sup>2</sup> Dementia is an umbrella term used to describe a condition associated with over 100 different diseases that are characterised by impairment of memory, language, perception, personality and other cognitive functions

<sup>3</sup> This includes people with very early onset Alzheimer's type dementia, some people with severe Alcohol related Brain Disorders and a range of conditions leading to Acquired Cognitive deficits, such as Huntington's Disease

aggression; psychosis; depression; inappropriate sexual behaviours; or are otherwise at risk of harm to themselves or others.

These are provided across a continuum of care, from community based mental health teams, acute mental health inpatient units and consultation-liaison service through to highly specialised state-wide services for people with the highest care needs. These services are expected to be provided in collaboration with a range of Commonwealth funded primary care, aged care and non-government services.

In, larger states of Australia, notably NSW, Victoria and WA, there has also been the development of a number of units variously referred to as Transitional Care Units (TCU) and Intensive Care Behavioural Units (ICBU) that complement the Acute OPMH services. These are considered to be required for that small number of people with the highest levels of long term care needs that cannot be provided by the dementia specific Residential Aged Care sector.<sup>4</sup>

The Services at Oakden primarily provide care for two groups of older people as follows:

- older people with enduring and/or severe mental illness, who require transitional care due to barriers to their accessing community based or mainstream residential aged care; and
- people with dementia or other neurodegenerative conditions with very severe and extreme Behavioural and Psychological symptoms, consistent with Brodaty Tiers 6 and 7 that are unable to be cared for in non-government dementia specific aged care environments.

A third group of older people is also accommodated at the Oakden campus, specifically people from the two target populations whose clinical presentations have progressed such that they no longer require a state-funded specialist bedded service. This group of people if also provided with sufficient support can often be successfully provided care in alternative mainstream and community-based care options.

The services provided at Oakden comprise the only Specialist Mental Health Service for Older People in South Australia that are provided as a State-wide service on behalf of all LHNs.

The criteria for determining that a single State-wide service model should apply, is usually based on the highly technical nature and small volume of the service type that is required (for example Cardiac Transplant Units, or Forensic Mental health Inpatient Units). In Australia, this is usually outlined in planning documents such as Clinical Services Capability Frameworks (CSCF) which outline the minimum requirements for the provision of safe high quality services of a particular type.

The South Australian CSCF, in relation to OPMHS, does not include a service type for the type of service needed at Oakden, that is, there is no consideration for any subacute or non-acute Older Persons' Mental Health Inpatient Units.

### **Mental Health Planning in South Australia.**

During the 1990s, South Australia commenced its mental health reform in line with the directions of the National reform agenda. This involved the closure of Hillcrest Hospital and the devolvement of its services to more appropriate settings. However during this time the inpatient services within the Oakden facility, part of the closing Hillcrest Hospital were among those that were not replaced by contemporary services.

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<sup>4</sup> This is discussed in more detail in the following chapter

In 2001, the Department commenced a series of reforms, during which time there was a renewed focus on providing more contemporary OPMHS. This led to the development of a proposal to redevelop Acute OPMHS on General Hospital sites in keeping with the National Mental Health Strategy.

By the middle of that decade it was determined SA required 70 Acute Older Persons Mental Health Inpatient beds to be provided across Adelaide to cover the Acute inpatient needs throughout the state. These are now provided at the Lyell McEwin Hospital (LMH), The Queen Elizabeth Hospital (TQEH) and at Ward 18 of the Repatriation General Hospital. It is planned to move the beds associated with Ward 18 into a new purpose built unit at the Flinders Medical Centre (FMC) by the end of 2017.

However, it was not until 2007 that the State Government agreed to a set of funded recommendations that indicated the direction of the future state-wide reforms in mental health. This set of recommendations from a report of the Social Inclusion Board (SIB), titled *'Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012'* commonly known as "The Stepping Up Report" is considered the only State-wide Mental Health Plan in SA under the National Mental Health Strategy.

"The Stepping Up Report" made one specific reference in relation to specialised OPMHS. This recommendation did not address either the issue of provision of OPMHS to Tier 6 and 7 BPSD or the transitional care needs of older people with severe mental illness.

The recommendation of the SIB was as follows:

**Recommendation 31**

South Australia must have a clear plan of action for the future management of long-term aged residential care that is consistent with good practice and contemporary policy. A focus on earlier intervention is required, ensuring that people at risk and needing specialist services are identified and given priority access to services. Partnerships with the Commonwealth and aged care providers are essential to deliver a scalable and sustainable response.

"The Stepping Up Report" does not appear to have examined the detail of the NSW Plan (outlined earlier in this chapter) and does not appear to have had the benefit of the considerable academic and planning expertise within NSW (but also found in Victoria, Qld, ACT and WA) and their published plans. This would appear to be the reason the SIB report did not consider these elements when developing its recommendations concerning OPMHS in SA.

The Review considers this lack of consideration of OPMHS developments in other states, where this was informed by the release of the Brodaty model in 2003, as an important gap in planning. This gap has led to uncertainty about the role of specialised OPMHS in SA, since that time.

However, in early December 2007, after the implementation of "The Stepping Up Report" recommendations began, a process to plan for further OPMHS commenced within SA. This included the development of a draft State-wide Model of Service for OPMHS and planning for the range and quantity of State-wide OPMHS needed to complement Acute OPMHS and allow for the replacement of the Oakden facility.

However, there is no record that either the Model of Service for OPMHS or the planning of OPMHS was endorsed by the SA Department for Health and Ageing (DHA), despite the Review finding numerous reports, options papers and draft business cases within archived departmental files.

As a result in 2012, SA Health considered the key practical elements of the SIB proposal as it related to OPMH extended care beds as follows:

- reduce the high number of aged mental health extended care beds;
- transfer these to the Non-Government Organisation (NGOs) aged residential care sector; and
- harvest significant savings from the transfer and apply such savings to support
  - Good Quality high dependency facilities and models of service (including in-reach) located within the mainstream residential aged care sector
  - Early intervention services to enable a broader cohort of older people with mental health problems to remain in the community or general residential care and avoid escalation to being physically located within the specialist system.

The Review was unable to find any consideration through this planning process, of services that would manage very severe and extreme BPSD (that is Tier 6 and 7), which as outlined earlier in this chapter are critical in providing a continuum of care across all Tiers of the Brodaty model.

Furthermore, the Review found no mention of any consideration of either the Brodaty model, planning from other jurisdictions, or consideration of what was the evidence in relation to these types of service needed by people with Tier 6 and 7 BPSD. As people with this level of BPSD represent a significant proportion of existing residents of Oakden this is a critical omission.

During 2014, the DHA undertook extensive state-wide planning to transform the SA Health system. This process has seen substantial re-location of health services and devolvement of services to where they should be best provided. During the *Transforming Health* process the planning of Mental Health services focussed primarily on Adult services and further planning of OPMHS was not extensively undertaken.

In 2014, there was a commitment to establish a South Australian Mental Health Commission (SAMHC). The SAMHC commenced in October 2015 and its inaugural Commissioner appointed in July 2016. The SAMHC is currently undertaking the development of a new ten-year State Mental Health Strategic Plan. This plan is expected to be completed by October 2017. It is not clear whether the SAMHC's plan will address the future needs for clinical services across SA.

In the absence of either clear decisions or directions about the future of services that will be provided for older people with severe mental illness and transitional care needs, or with Tier 6 and 7 BPSD during the past decade, the Oakden Facility has continued as the only service for this significantly disadvantaged group of people on behalf of all Local Health Networks (LHNs) in SA.

### **Population based estimates of Mental Health need in Older Persons**

The NMHSPF (see page 13) has for the first time provided a range of population estimates to guide service planning for mental health, based on known Australian epidemiology of mental illness.

The NMHSPF is of greatest utility in estimating the level of the most commonly needed service types. It has some limitations when estimating the requirements for the most highly specialised services (and therefore those provided for the lowest number of people in any given population) as



these estimates are based on very low prevalence rates and thus small numbers of affected individuals.

Nevertheless, the NMHSPF predicts the number of Community FTE needed for older people services, the number of RACF beds and Acute, and Non-Acute Hospital beds and an indication of the number of Transitional Care Unit beds.

Mental Illnesses are common in people over the age of 65. It has been estimated that 12.85 % of people experience a diagnosable mental disorder with 2.0% having a severe disorder. In addition, 1.4% of 65 year olds have Dementia (whether a result of Alzheimer's Disease, Vascular dementia, Lewy Body Disease, Picks Disease or Alcohol-related Brain Damage). However, the prevalence of Dementia rises quickly after this age, rising to 10% of those aged 80-84 and 20% of those aged 85-89.

As the population of South Australia grows over the next decade, there is likely to be substantial increases in the number of people with Dementia and in particular, the number of people with very severe/extreme BPSD (Tiers 6 and 7) are likely to grow much faster than the overall population of the state.

For example, the number of people over the age of 65 in 2016 was 302,847 and this will increase by 27.65 % to 386,588 by 2026, whilst the state population growth is only 8.82% (See Table 1).

#### **How many people have BPSD Tiers 6 and 7?**

The Brodaty Tiered model for BPSD predicts that 0.4% of people with Dementia will have Tier 6 (very severe) levels of disturbance whilst an additional 0.1% will experience Tier 7 (extreme) severity symptoms. Using these rates the modelled prevalence of Severe Persistent and Challenging Behaviours that define Tier 7 of the Brodaty model, would predict that SA currently has 26 people who are Tier 7, with this rising to 34 people by 2026.

Identifying the number of people with Tier 7 BPSD, is an important exercise, given the nature of their symptoms and their predicted service utilisation. People in Tier 7 characteristically are men in their late 60s or 70s who are very strong and have been so violent that they have harmed other residents or staff. Often the cause of their Dementia is alcohol-related, Fronto-Temporal or Vascular dementia. They have been too difficult to manage in a Hospital and special nursing homes are unsuccessful as well, staff often refuse to work with them in these settings and often no facility will accept them.

Brodaty described the need for a highly secure specialised unit with a large staff ratio, for those with Tier 7 BPSD and that the number of people is so small that only one unit in each state is likely to be needed.

Such is the level of disturbance; it is usually reasonably easy to identify people with this level of symptoms if they are in any OPMHS. At the time of writing this report it was considered that there are 14 people with Tier 7 in Oakden, and another 4-6 in Acute OPMH units in General Hospitals, a setting that is unsuitable for the longer term care they need. There appears to be a further small number of people with Tier 7 BPSD, in dementia specific RACFs (awaiting transfer to a more appropriate treatment setting). The presence of people with Tier 7 BPSD in these latter two settings has a significantly disruptive impact on other residents.

It is therefore estimated that the actual number of people with Tier 7 BPSD in SA is at least 20 and this is consistent with the number predicted for South Australia, by the Brodaty model.

People with Tier 6 BPSD are more frequently encountered than those with Tier 7. It is estimated there would be 104 people living in SA. Brodaty outlined that people with Tier 6 will generally be found in one of three different settings as follows:

- special care units with highly trained staff (often referred to as Transitional Care units (TCU)) where they are likely to stay for many months before being able to return to mainstream dementia care these units are widespread in Victoria, NSW and WA;
- acute Older Persons Mental Health Units, where they may be for a few weeks prior to stabilisation and referral to a TCU; and
- special Wards of General Hospitals often where they are being assessed or treated for super-imposed delirium and once this abates they may be referred to a TCU or back to a mainstream RACF.

#### **Other OPMHS planning considerations.**

Special consideration should also be applied to certain groups that are often under-served. People living in RACFs have especially high rates of all mental disorders, with rates of depression estimated to be as high as 50% with many cases undiagnosed, while rates of psychosis may be up to 5%. Aboriginal and Torres Strait Islander peoples and those within the Criminal Justice System have earlier onset of common mental health problems and Dementia related behavioural syndromes, with greater difficulty gaining access to appropriate assessment and care options.<sup>5</sup>

The issue of older consumers living with enduring mental illness, such as schizophrenia, is also recognised as an area of need where consumers have experienced higher levels of comorbid age-related health problems, greater difficulty with access to services and increased risk of homelessness, inappropriate placement in acute wards, placement in settings primarily designed for management of dementia, poor medical and end-of-life care, or missing out on service provision altogether. In keeping with these difficulties, the life expectancy for a person ageing in the context of schizophrenia is 20% less than the general population.

There is a need to provide high quality care, including options for rehabilitation and transitional care for older people with mental illness, such as schizophrenia, who have difficulty accessing mainstream aged care options.

It is beyond the scope of this Review to precisely estimate the current need for transitional care arrangements for people with functional mental illness, who are aged over 65 in South Australia. However, it is predicted, from a preliminary review of the NMHSPF (ver 2.1) and the Review team's knowledge of current OPMHS demand in SA that as many as 90 beds are needed in SA, to cater for all those with Tier 6 BPSD and those people with Severe Mental Illness who need Transitional care.

As already noted, currently Oakden is the only service in SA that provides services for three groups of people; those with Tier 7 BPSD; those with Tier 6 BPSD with Transitional care needs; and people with Mental Illness (not arising from Dementia) who are severely affected and have transitional care needs. It provides these services on behalf of all 4 geographically aligned Local Health Networks that cover the State.

The Review was able to obtain the population estimates for SA from the Department of Planning, Transport and Infrastructure (DPTI) to use to estimate the number of people with Tier 6 and 7 BPSD.

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<sup>5</sup> Zann, S. found four times the rate in Aboriginal and Torres Strait Islanders in Nth Qld



In a series of reports, Deloitte Access Economics (DAE) has presented estimates of the prevalence<sup>6</sup> and incidence of dementia both in NSW and in Australia<sup>7</sup>. These estimates, based on a series of studies, as well as the estimates of Brodaty et al, were subsequently agreed by the National Modelling group developing the NMHSPF, as the most accurate estimates of rates of Dementia for Australia.<sup>8</sup>

The Review has used the DPTI population projections together with the known Australian epidemiology (based on the DAE) and the agreed prevalence of Dementia from the NMHSPF to calculate the number of South Australians with Dementia and to predict the number of people with BPSD by Tier from 2016 until 2031.

Table 1 shows the population projections for SA until 2031, with calculated rates of people with Dementia based on the known prevalence of Dementia in Australia by age, and from this the projected number of people with BPSD at all levels of the 7 Tier model.

**Table 1: Estimates of people with dementia with BPSD applied to SA population projections, 2016 to 2031, by tier<sup>9</sup>**

Population/Tier	Estimates and projections for June 30			
	2016	2021	2026	2031
Total population	1,715,299	1,791,767	1,866,715	1,936,812
Population aged 65+ years	302,847	343,220	386,588	423,294
Population aged 75+ years	136,817	157,613	190,042	218,940
Projected number with dementia	26,868	30,443	34,290	37,546
Projected dementia incident cases	10,102	11,263	12,893	14,117
<b>Projected number of people with dementia with BPSD</b>				
Tier 3: Dementia with mild BPSD	8,007	9,072	10,218	11,189
Tier 4: Dementia with moderate BPSD	5,319	5,776	6,789	7,434
Tier 5: Dementia with severe BPSD	2,660	2,888	3,394	3,717
Tier 6: Dementia with very severe BPSD	104	116	136	150
Tier 7: Dementia with extreme BPSD	26	29	34	38
<b>Total dementia with BPSD</b>	<b>16,016</b>	<b>17,881</b>	<b>20,571</b>	<b>22,528</b>

The Review considers the estimates from the NMHSPF to be a useful predictor of the number of Tier 7 state-wide ICBU beds that will be needed. In practice it is likely that in SA the number of beds needed will be approximately 80% of the total number of people with Tier 7 BPSD.

### Specialist Nature of Older Persons’ Psychiatry.

In 1996, the World Health Organisation and the World Psychiatric Association released a consensus statement regarding Psychiatric care in the elderly. In this statement they highlight that:

<sup>6</sup> Prevalence refers to the total number of people who have a particular condition at a specified point in time

<sup>7</sup> Caution should be used in interpreting the prevalence of Dementia as the late presentation to Health care and the under-reporting in the National Health Survey as well as the household component of the Survey – Disability, Ageing and Carers (SDAC) can lead to underestimates of cases

<sup>8</sup> The lack of reliable National data, required DAE to use meta-analysis similar to that used by the AIHW to develop reliable rates. Another approach to calculating prevalence using the Alzheimer’s Disease International rates published in the World Alzheimer Report 2009, produce rates of Dementia in SA in 2021 that are almost equivalent to those derived from DAE, with the ADI rate being slightly higher than the DAE rate.

<sup>9</sup> Source of population projections – Population projections for South Australian, Feb 2016 release, Department of Planning, Transport and Infrastructure, Government of South Australia

*“Psychiatry of the Elderly is a complex Discipline...” and “it is indispensable that competencies, specific care and structures adapted to Old Age Psychiatry, be solidly developed”.*

In January 1999, the Royal Australian and New Zealand College of Psychiatrists recognised the highly specialised nature of Older Persons Mental Health when it formally established the “Faculty” status of Old Age Psychiatry (FPOA).

Since that time it is expected, within Australia and New Zealand, Psychiatrists working within this area of Specialty practice should attain Faculty endorsement through additional training that recognises that they have met additional standards of extra knowledge, skills and attitudes needed to work competently in this area. In particular, for accredited membership of the Faculty, it is required that Psychiatrists have completed the advanced training program, resulting in the Certificate in Psychiatry of Old Age. Psychiatrists who have worked extensively in older persons’ mental health or have another academic qualification are able to apply for membership of the Faculty without being eligible for accredited status.

The FPOA continues to take an active role in the development of a range of documents, produced in partnership with various state and national governments, which outline best practice in the management and provision of services for Older Persons mental health problems.

These include the following:

- *Psychiatry services for older people* (position statement 22, October 2015);
- *Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD) - A handbook for NSW Health Clinicians* (May 2013);
- *Relationships between Geriatric and Aged Care Psychiatry services* (position statement 31, November 2012); and
- Priority must be given to investment that improves mental health of older Australians (position statement 71, November 2011).

The RANZCP, with input from the FPOA, has contributed to the development of policy around dementia as a NHPA through submissions including the following:

- Submission to the National Framework for Action on Dementia 2013-2017; and the
- Submission to the Inquiry into care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD).

### **Specialist Nature of Older Person’s Mental Health Nursing**

The importance of mental health nursing specific skills in older person’s mental health has received attention both nationally and internationally (Heslop, Wynaden and Bramis et al 2012<sup>xiii</sup>; and Van Leuven, 2010)<sup>xiv</sup>. It is also significant that the numbers of older adults with co-occurring mental illness and substance use disorder (dual diagnosis) are increasing worldwide. This latter group is of particular concern for they are known to experience greater rates of psychiatric relapse and poorer treatment engagement. Services are often run with higher financial costs, and care is managed for longer periods under compulsory treatment orders (Searby et al 2015).<sup>xv</sup>

Falls risk assessment with elderly ambulant populations with a history of severe mental illness is highly relevant to consumers at Oakden. Nursing practice should incorporate preventative interventions that account for the episodic nature of mental illness and associated behavioral and cognitive disturbance.

The mental state of an older consumer might change significantly during a single admission, from being isolated, withdrawn and immobile, to being expansive, independent, and ambulant. Mental Health Nurses must have a thorough knowledge of the assessment of these mental states and the factors which may contribute to these changes in order for them to provide appropriate and timely interventions.

Specialist education in understanding the nature, scope and consequences of mental illness must be combined with general nursing skills to provide a framework for the review of falls risk specific to older consumers with longstanding mental illness and/or associated dementia processes. In such instances, the following indicators of mental state should be taken into account (e.g. a change from dependency: independence, increased paranoid ideation, or elevation of mood). Additional factors include the increased risk of orthostatic hypotension (associated with many psychotropic medications) and fluctuating changes in nutrition make the addition of lying and standing blood pressure monitoring over a number of days for at-risk consumers, an essential addition to a mental health nursing specific set of skills.

Additional mental health nursing considerations for more vulnerable, frail and potentially violent elderly consumers include the careful assessment of mobility aids. Working in collaboration with other disciplines, mental health nursing skills are needed to help mitigate the risk of a mobility aid being used as a weapon or for protection by a consumer experiencing psychosis or another form of perceptual disturbance.

Working closely with mental health nurses, physiotherapy assessment of the consumer's balance, gait, muscle strength, and functionality, along with planned interventions, such as low-impact exercise programs, can help reduce anxiety whilst simultaneously working to rebuild the person's mobility confidence and strength.

### **Specialist Nature of Older Person's Mental Health Allied Health**

During the last 10 years there has been the rapid development of special interest groups and professional chapters devoted to Older Person Mental Health with disciplines such as Clinical Psychology, Occupational Therapy and Social Work. These developments reflect the highly individual skills needed amongst Allied Health Professions in dealing with older consumers with mental health issues.

The roles of allied health practitioners in providing best-practice mental health and dementia care for older consumers is well-supported by research and practice guidelines. For instance, occupational therapy has taken the lead internationally in developing specialist sensory modulation therapies that support management of BPSD and improvement in quality of life for people with dementia. The role of physiotherapy is central to rehabilitation and the optimisation of mobility and functioning in aged care and therefore essential in settings such as Oakden campus that are required to provide holistic care, within a mental health framework. Physiotherapy is the most appropriate discipline to lead a falls prevention program

Taken together these workforce competencies were considered by the Review as essential for those working in highly specialized OPMHS in addition to those Workforce Standards outlined in the *National Practice Standards for the Mental Health Workforce*.<sup>xvi</sup> This should equally apply to all Medical, Nursing and Allied Health staff in OPMHS.

## 4. History of Oakden

### History of Hillcrest Hospital

Prior to the commissioning of Oakden Campus in 1982, the Hillcrest Hospital had been in operation for 53 years. Originally called the Northfield Mental Hospital, it was proclaimed in April 1929, and was built to accommodate South Australia's mentally ill and to provide them with therapeutic occupation in a farm-like setting.

However it is reported that “In reality, the inmates of Northfield lived within a custodial system for more than thirty years which saw many of them become institutionalised and highly dependent upon an authoritarian regime. The stringencies of the war years only escalated the overcrowding problem and Northfield's facilities continued to deteriorate as it tried to accommodate more and more patients - young, elderly and infirm, suffering from a range of mental conditions”.

By 1964, the Northfield Mental Hospital was renamed as Hillcrest Hospital, a decision which reflected the changing attitudes and approaches to those in need of psychiatric assessment and rehabilitation. The renaming was an attempt to reduce the stigma associated with Mental Institutions.

Over the next two decades, Hillcrest Hospital was bolstered by additional State funding, which transformed the old pattern of custodial limited care, replacing it with a form of community care in which people could be treated in their own social setting and provided with adequate services after they left the Hospital.

Hillcrest Hospital Closed in 1992.



Administration Block, 1935

In November 1982, the then Minister for Health, the Hon Dr John Cornwall opened the Oakden building at Hillcrest Hospital. At the time it opened, it was referred to as a Psychogeriatric Unit and functioned as a purpose built facility for older persons with a mental illness. This new unit was a

significant improvement on the dormitory-style facilities that had been provided previously. The building is now 35 years old and the difference in what would be constructed today is substantial.

The original consumers were older people, with a history of mental illness for whom there was difficulty in finding a place in the Residential Aged Care sector. At that time, the development and provision of high quality Residential Aged Care Facilities (RACF) with sufficient expertise to assist people with the most significant levels of disability from mental illness and BPSD was in its early days.

In the 1980s, Hillcrest Hospital was utilising a functional streaming model of care, whereby people within the Hospital resided in Units that had similar diagnostic pictures. This meant that there were units that had people with Schizophrenia separated from people with Alzheimer's type Dementia.

At the time Oakden was built, the adjacent unit, Mason House, was constructed with a similar design and layout even though the target groups that would use the different units were dramatically different. This was a common planning method of that period, whereby units for Older people were created as if they were Adults with no other special needs.

In 1985, the Psychogeriatric Unit, which served elderly members of the community (65 years and over) who had Mental Illness or BPSD. The Unit operated two community teams covering the eastern and north-eastern-regions of Adelaide. The elderly consumers were cared for and treated in an acute assessment ward and four long stay wards. About half the consumers at the time suffered from an organic brain disease, such as Alzheimer's disease, while the remaining consumers suffered from a variety of mental illnesses not associated with Dementia. At that time the units were as follows:

- Howard House – 30 beds: An acute facility where elderly consumers were assessed and treated;
- Clements House – 27 beds: A long stay ward that care for elderly female consumers with Alzheimer's disease;
- Albert Zweck House – 17 beds: A long stay ward that catered mainly for elderly men with Alzheimer's disease;
- Makk House – 27 beds: A long stay ward that catered mainly for elderly men with Alzheimer's disease; and
- McLeay House – 22 beds: A long stay ward that specialised in the treatment of elderly consumers with severe Alzheimer's disease, where incontinence and chronic severe confusion had become a major problem.

Thus a total of 123 Older persons mental health beds, of which 93 were sub-acute or non acute beds, existed at the site, for a population catchment of 642,500 people.

The mainstreaming of mental health services in South Australia began in the early 1990s as a key priority of National Mental Health Reform, and with the closure of Hillcrest Hospital in 1992, Howard House, the Oakden building and the nearby forensic services in James Nash House, were the last remaining services on the Hillcrest site. There remained only four units in the Oakden complex; namely Makk, McLeay, Clements and Zweck.

By the 1990s, the staff consisted of Mental Health Nurses and Enrolled Nurses, typically with up to five on each unit at a time and easy access to Occupational Therapy, Social Work, Psychology and Physiotherapy with Medical provision from a Consultant Psychiatrist and other specialist medical staff.

In 1998, a decision was made to seek Commonwealth accreditation for Makk and McLeay as nursing home beds.

This was a key turning point. From that time, what had been an entirely State funded Specialist OPMHS was now an entirely Commonwealth funded service, for these two units that were attempting to provide the same range of specialist services with a lower level of overall funding. It is unknown what happened to the State recurrent funding of Oakden from that time onward.

Following this decision, Personal Care Assistants were introduced at Makk and McLeay, in line with other RACFs and the Enrolled Nurses were encouraged to complete Diplomas of Nursing to allow them to undertake higher skills such as administering medication.

A snoezelen room<sup>10</sup> was provided within Oakden, a sensory garden was utilised and each unit had an Activity Supervisor who provided an activity program over extended hours to ensure access to activities in the later part of day. This room is no longer established for that purpose.

Some clinical services were sourced through Howard House, which provided the acute aged care assessment service and facilitated access to Geriatricians, extra medical cover and other allied health services.

In 1999, a series of concerns led to the then Acting Chief Executive Officer of North West Adelaide Health Service, David Coombes, to organise a review of the Quality of Care for Older Persons Mental Health Services at Oakden. The review was undertaken by Fab WebConsulting. The review made a number of recommendations about the organisation and funding of Older Person's Mental Health Services on the Oakden Campus including one that led to Howard House being relocated.

With the establishment of Makk and McLeay as Commonwealth nursing-home beds the concept of people having tenure ('beds for life') combined with no entry fee and no charge on medications (unlike non-state run RACFs), meant that transitioning people through to mainstream residential aged care facilities understandably became difficult.

Governance at Oakden consisted of a monthly meeting, chaired by the Director of Mental Health and included staff from Howard House, Oakden and the community older person's mental health team. The agenda included reviewing incidents and audits; planned training for implementing new procedures and protocols; and preparing for 'unannounced visits' from the Commonwealth Auditors.

In 2001, initial discussions were facilitated between the State Government and Aged Care and Homes (ACH) Group, a not for profit organisation and residential aged care provider. Throughput was slowing and this was mostly attributed to the issue that as nursing home beds, Makk and McLeay represented a permanent placement, unlike the previous State model from the 1990s.

At that time the real possibility that Oakden had a limited life as a state government run facility began to permeate through the staff.

In the early 2000s, a particular client with Huntington's disease was being cared for and his behaviour was considered so risky, that an area of the building between Makk and McLeay was

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<sup>10</sup> snoezelen – a concept developed in the 1970s in Holland, the term is a contraction of the Dutch verbs "snuffelen" (to seek and explore) and "doezelen" (to relax). A snoezelen room is a relaxing space that provides a multi-sensory environment that can help to reduce agitation and anxiety, engage and delight the user or stimulate reactions and encourage communication



refurbished specifically to care for him. Later, this area will be routinely referred to in clients notes and at meetings, as the 'BIOS' area.

The first indication that Oakden may have been experiencing quality issues was in 2001. From that time until 2007, Oakden was only accredited for 12 month periods, apart from one 2-year accreditation period. These periods of accreditation that were less than should have been achieved should have raised attention.

However, following the Commonwealth review of Oakden in December 2007, the facility failed 25 of the Commonwealth's 44 standards for aged care and sanctions were imposed. ACH Group entered into a joint partnership with the Health service to assist with the operations of the services through until 2010.

At that time the Health Service commissioned an external review that took place in February 2008. This report will be referred to as the Stafrace and Lilly report and is discussed in more detail in **Chapter 7**.

In 2010, the facility returned to the full responsibility of the local Mental Health Services with Commonwealth funding for Makk and McLeay. At that time Oakden was found by the Aged Care Safety and Accreditation Agency to have met all 44 standards.

In the late 2000s, a fourth unit at Oakden, Zweck House was closed and Howard House moved off site to a new building at the Lyell McEwen Hospital (Ward 1H). This added to the staff's convictions that the service would close and as a result it is reported that attracting new staff was increasingly difficult. Anyone who wanted permanent, secure employment did not consider Oakden a viable option and staff reported a sense of inevitability that both their workplace and their employment were limited.

From 2010, the Review heard that requests for maintenance of the building and replacement of broken, damaged or new equipment from staff were regularly responded to with statements such as;

*'there's no funding for that', 'borrow it from next door', 'it's not going to happen in this financial year'.*

The Review was also told that there was pressure on all areas of mental health to operate within their budget; any allied health taking leave were not back-filled, and when some key staff members resigned they did not appear to be replaced. More detail is contained in **Chapter 7**

After the closure of Zweck House and the movement of Howard House, the entrance to the Oakden service was moved such that visitors to the Unit then needed to walk past the plant room and at times the sewerage truck when this was on site emptying the septic tank.

In the period prior to the commencement of the Review, NALHN had assumed the management of Oakden OPMHS and it is understood there had been a decision to request from private operators to take over the management of at least certain parts of the service such as the Makk and McLeay Nursing Home.

The following Chapters of the report provide the detail of the consideration on each of the terms of reference of the Review including findings and recommendations as well as timeframes where this is possible.

# Chapter Five

## Model of Care

*“Care as the person and their family knew it, ended when they entered Oakden”. Multiple sources*

*“If he was cared for properly it did not matter what the place looks like. But he was not cared for properly”. Family of a former resident of Oakden.*

*“The hospital told us there was nowhere else to go except Oakden, when we got there the Oakden staff said there was nowhere else for him to go except Oakden, but how can there be nowhere else to go?” Family of a former resident of Oakden.*



## 5. Term of Reference - Model of Care

The Review team was asked to consider, review and make recommendations about the:

- current Model of Care, and whether there are variations in practice to the model and if the model is aligned with current best practice standards for delivery of care for older persons with a mental illness.

### Consideration of Models of Care

The terms, “model of service” or “model of care” are often used interchangeably to refer to documents with the same meaning. In this Review we have used the term Model of Care (MOC) unless it is used otherwise in the name of a specific document. For this Review a Model of Care is defined as the way that health services are delivered, drawing on best practice care and services for a person, population group or patient cohort as they progress through the stages of managing a healthcare condition. A Model of Care articulates how people can access the right care, at the right time, from the right team in the right place<sup>11</sup>.

It is generally considered best practice in the development of a MOC that it should take into account underlying challenges in service provision that create the case for changes from an existing MOC. It should be developed as a consumer-centred workable plan that is based on best available evidence with the capacity to be supported by both Health Service Executives and stakeholders. It is common for the development of a MOC to be supported by a Business Case and consideration of a resourcing strategy that will facilitate the sustainability of the MOC.

An endorsed MOC should outline the risks to implementation and address these in the context of an articulated governance structure. It should consider how any new MOC will discontinue aspects of services superseded by changes. Implementation of a new MOC will require a communications plan and building of frontline capacity and engagement from managers and staff. It should provide a framework for evaluation of outcomes that will feedback in to continuous improvement and recurrent review of the MOC to ensure continuing relevance, efficiency and effectiveness.

### Is it the right care at the right time from the right team?

Prior to 2012, there does not appear to have been a MOC developed for OPMHS in South Australia. In August 2012, the Executive Leadership Group of the Older Persons Mental Health Service (OPMHS) endorsed a Model of Service for the South Australian metropolitan area entitled “Maximising the Mental Health of Older People”.

The processes that led to the development of this MOC, began in December 2007 when the then Director of Mental Health Operations in SA Health established an OPMHS project team and Reference Group. This process also led to the development of the *State-wide Older Persons Mental Health Future Service Model* (Draft, December 2008).

<sup>11</sup> NSW Agency for Clinical Innovation, Understanding the process to develop a Model of Care 2013

This document did not progress to endorsement by SA Health and consequently remains a proposed Model that has had limited implementation and its status is not well understood even within OPMHS in SA.

The Review was unable to identify any documents that outline the reasons the MOC was not endorsed by SA Health. At the time, the Model was developed to respond to changes in national policies, guiding mental health reform and state initiatives including *The Generational Health Review* and *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*.

The unendorsed Model was framed within an approach that aligned with a person-centred approach to service delivery that placed consumers and their carers as active participants in decision-making and choices about services. It articulated commitment to consumer rights, consumer-focused principles and a recovery approach as defined in the *National Standards for Mental Health Services 2010*,<sup>xvii</sup> which was informed by the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK.<sup>12</sup> The Model articulated a number of underpinning principles including; the uniqueness of the individual; having real choices; fostering recovery oriented attitudes and rights; dignity and respect; partnership and communication and evaluating recovery.

The Model proposed a single specialist service, with a continuum of components, including acute inpatient care, in-reach to community and residential aged care facilities and packages of care, centred around and coordinated by the Community Mental Health Team (CMHT).

It articulated a number of elements that are relevant to the delivery of services through the Oakden Campus. In particular, the Model described the use of Transitional Care Units (TCUs) and Intensive Care Behaviour Units (ICBUs). These were defined as follows:

- TCUs were to be units allowing step-up from community and mainstream RACFs or step-down from acute inpatient units with an average length of stay (ALOS) of three to six months.
- ICBUs were to be slow stream units providing support for older consumers who cannot be managed by the mainstream aged care residential sector, even with specialist support, due to the level of behavioural and psychological symptoms associated with their mental illness. The anticipated ALOS was 18 months.

This description of TCUs and ICBUs appears likely to have been based on the development of TCUs and ICBUs in NSW during the early 2000s, as exactly the same terms are used to describe identical target populations. These elements (TCUs and ICBUs) are outlined in the endorsed *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015*.

The SA Model identified that TCUs and ICBUs would provide high dependency but recovery-focused environments of specialist care during clinical transitions for complex needs older consumers. It was proposed that, ideally, TCU and ICBU beds should be available in each Local Health Network (LHN) in order to provide these services closer to consumers' families, carers and communities.

The Model proposed the development of contractual arrangements between the state government and the NGOs involved, in which the NGO would host the service, while the OPMHS would continue to manage admission and discharge processes and provide extensive control over assessment, care planning, therapy, medication management, research and education through an in-reach model led by the Community Mental Health Team (CMHT).

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<sup>12</sup> Note Australia has subsequently endorsed a National Framework for Recovery based on these principles

The Model also proposed that CMHT staff would work in TCUs and ICBUs on a sessional or continuous basis as required. The Model offered no description of how these changes would be implemented or whether they were achievable or sustainable. Whilst the Review was able to find a number of draft Business Cases that had been developed to support the implementation of the unendorsed MOC it could find no evidence that any funding was made available to implement the model.

The Model was consistent with “The Stepping Up Report” recommendation in delineating the objective that extended care aged mental health beds, outlined in the Model as the transitional service beds (TCUs and ICBUs), should be outsourced to the non-government residential aged care sector. This aspect of the proposal differs substantially from the NSW model in which ICBUs are considered highly specialised units run by the State Public Mental Health System for people with Tier 7 BPS of Dementia.

In line with the reasons outlined in Chapter 3, the Review does not accept the view Tier 7 services can be provided by the Non-Government Sector. Furthermore, whilst there exists in Australia a small number of Tier 6 services that are operated entirely by the RACF sector these are heavily subsidised by the State Government (in addition to the Commonwealth subsidy that is received) to ensure the person with Tier 6 BPSD has access to the full range of highly trained multi-disciplinary staff needed to ensure safe, high quality care.

These Tier 6 services are usually developed with very clear Memoranda of Understanding between the RACF provider and the State that indicates the level of State funding needed to provide a suitable package of care and clarify access to State based services (including out of hours access to on-call Consultant Psychiatrists) so that if the placement fails there is a clear pathway for the person to return to a State OPMH facility. This would be required as a minimum to underpin the success of these services.

In many states notably Victoria, these Tier 6 services utilise facilities built and owned by the State and run as a joint partnership between the RACF provider and the State OPMHS which provides the majority of the most specialist trained staff.

Currently, there are no specific Tier 7 only services provided by RACFs in Australia.

The Review considers the evidence in NSW, Victoria and WA, supported by the evidence outlined by the Brodaty model in that ICBUs for people with Tier 7 can only be operated by State Services. It is unclear to the review why the unendorsed SA MOC had based its Model solely on the “The Stepping Up Report”, and consequently took such a different direction about TCUs and ICBUs when they had already been in place for nearly 7 years in NSW and had already been subject to an external mid-term evaluation of their effectiveness.<sup>xviii</sup>

One possible explanation is that the rationale was as follows:

“It is intended to operate ICBUs and TCUs in partnership with NGOs with aged care experience. This partnership model reflects the principles of the mental health reform agenda for OPMHS.” (Found on page 29 of the MOS).

However, the Review can find no other description of a mental health reform agenda for OPMHS in SA, other than the National Mental Health Reform (NMHR) agenda. The Review does not believe the NMHR agenda proposes States move toward providing highly specialised hospital type services by NGO aged care providers.

The Model, though not endorsed has continued to inform broad aspirational objectives for the Executive of OPMHS in LHNs, with little evidence of advancement towards a workable application in practice in any LHN. This may well be as a result of it being unendorsed.

As a result of no endorsed system wide Model for OPMHS there has been understandably, little done to define a Model that is specific for Oakden. This has led to a resultant further decline in services at Oakden Campus, which remains unclear what its purpose is within a State-wide system of OPMH services.

As such Oakden has continued to provide services that should be consistent with TCUs and ICBUs, on behalf of the State, without a plan that supports the level of resources it needs to provide such a service.

This is compounded by a widespread view, held by the staff, which the Review heard repeatedly, that Oakden (in particular Makk and McLeay Nursing Home), is a place for the rest of the consumer's life. This resulted in an attitude among staff that there was less effort and emphasis that needed to be placed on managing the consumer's challenging behaviours as there was little prospect that any improvement would help facilitate their discharge. This became a self-fulfilling prophecy for many in Oakden.

The Review team was repeatedly informed by a variety of staff of statements made by Mental Health Executive members during the last five years, stating that investment in resources at Oakden was not made because the service was to be outsourced to a private provider. The Review also heard that staff believed this was likely to be unsuccessful as the most severely unwell residents in Oakden were unable to be managed by these services.

During that same period, progress with the outsourcing of the service was not achieved, while the Review was told resources at Oakden diminished and attention to quality improvement in care was not sufficiently undertaken<sup>13</sup>. No implementation plan was developed identifying what sort of services or infrastructure would be required in order to achieve engagement from an NGO provider.

The Review expected that a MOC that describes how a service for Tier 7 should operate would need to outline the service philosophy, pathways in and out of the service, its partnerships, a detailed staffing profile and describe how the built environment will promote a safe service system. In addition, the model would need to describe the full mix of all staff that are required.

The Review also had expected that the MOC would describe those same aspects but from the perspective of shorter average lengths of stay for those people who would address the transitional care needs of people with Severe Mental Illness and complex enduring disability and those with Tier 6 BPSD.

The only reference to a MOC that could be found at Oakden was in materials that the Review discovered within the OPMHS training topics for Orientation and Induction of staff<sup>xix</sup>. The Review accepts that this is an important opportunity for new staff to be aware of the Model of Care in a service. However the material provides only a brief overview of the MOC and appears to be designed for a different purpose rather than any attempt to outline a MOC.

Consequently the Review ultimately found no MOC that related specifically to Oakden.

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<sup>13</sup> More detail on this is included under the Quality and Safety of Care TOR

In addition the Review was able to form a clear view about the range of services that are provided at Oakden.

### **What is Oakden?**

Oakden is not a Nursing Home.

Oakden is, and has always been a Specialist Older Person's Mental Health Service for South Australians with Severe Mental Illness including those arising in the context of Dementia, for 34 years.

During almost half of that time, a significant part, but not all of the facility, has also been funded by the Commonwealth as an Aged Care Facility. This has led to confusion at all levels of the Health System in South Australia.

Whilst part of Oakden, has "Nursing Home" status under Commonwealth Aged Care Funding arrangements, it has always been an integral part of the continuum of State-operated Specialist OPMHS. The referral pathway is primarily from SA Health acute OPMHS to a system that is run by SA Health. The service is for those people who have the most severe problems which mean they could not be provided assistance by any other Commonwealth funded Dementia Specific Facility in SA.

This interaction between Commonwealth funding and State operation is complex but has been successfully implemented elsewhere in Australia and is considered an important element of how services are provided, in particular for people who have Tier 5 and 6 BPSD.

This issue is critically important because without a proper understanding of the interplay between what funding is available under the Commonwealth's Aged Care Programs (as identified by the Aged Funding Instrument (ACFI)) and what top-up funding is needed from the State to provide quality services there will be as has occurred insufficient resourcing.

Furthermore, as outlined earlier in this chapter, whilst it is appropriate that the State not remain in the sector providing Aged Care Services that can be provided with great expertise by the Commonwealth RACF sector, it is critical that as in other States it remains the provider of those services that cannot be provider otherwise.

This crucial issue is not captured in any MOC in South Australia.

### Finding 1:

The Review makes the following finding in relation to the Model of care at Oakden:

- It was unable to find a satisfactory, specific MOC that has been developed for the types of services provided at Oakden, in particular, this issue was not satisfactorily addressed in the unendorsed 2012 Model of Service for OPMHS.
- There has been no clear articulation of the cohorts for whom services on the Oakden Campus are to be provided and how this should be achieved with regard to staffing profiles, resources or infrastructure.
- Further, expectation of a CMHT-led, in-reach model as described in the unendorsed 2012 Model has not been supported by the degree of commensurate change within the

resources; skills and capacity; or changes in practice; within the OPMHS community teams that would be necessary, if the changes aspired to in the Model were to be achieved.

- As a result, the Model described in 2012 has been unable to prevent ongoing deterioration in the Oakden service. This is as a result of two factors; namely the Model was not endorsed, is largely unknown in the OPMHS sector and it has not been implemented in a systematic manner; and secondly it identified aspirations that have not been supported by further strategic planning, resource allocation or investment.
- The Executive of OPMHS in all LHNs has relied on the 2012 Model. This has contributed to the deficits now evident at the Oakden Campus because of the disconnection between an unfunded aspirational document and the real-world challenges of the service, when no process to identify the resources needed to implement a new model is made.
- All other LHNs have continued to rely on the Oakden service without having made any arrangements to provide sub-acute and non acute Tier 6 and 7 BPSD services and Transitional Care for older consumers within their own catchment areas.
- The unendorsed 2012 Model of Care as it relates to both Tier 6 and 7 BPSD is not in keeping with International or National Best practice and in particular is not supported by the best practice examples in New South Wales, Victoria and Western Australia.
- The Model of Care that is provided at Oakden is not in keeping with current best practice for the people they intend to serve who have functional mental illness and there is no relationship between best practice for people with Tier 6 and 7 BPSD and what is currently provided.

In summary, Oakden is not providing the right care, at the right time from the right team.

#### **Recommendation One:**

**SA Health should develop a specialised contemporary Model of Care that addresses the State's obligation to provide high quality care to people over 65 years of age who live with the most severe forms of disabling mental illness and for those people with the most severe and extreme Behavioural and Psychological manifestations of Dementia.**

- **This Model should be developed as a partnership between all LHNs across the state and be led by suitably qualified clinical experts in the field of Older Person Mental Health. It should involve the full range of possible partners to such a model including, but not limited to, Consumers, Carers, Experts in Geriatric Care, referrers, staff, the RACF sector and other providers of BPSD services.**
- **The Model should draw reference from the NSW plan for specialised OPMH and by those providing similar services in Victoria and NSW.**
- **The Model should rely on detailed population-based planning, taking into consideration but not being bound by the NMHSPF version 2.1.**

- **The Model should be supported by a Business case that identifies the funding needed to implement the new model and take proper account of the need for funding to allow the transition from the current service to a future model.**
- **The Model should identify the range of service needed across the continuum of care; between services provided in a person’s home (including Hospital in the Home), those in other residential settings, acute inpatient services, and transitional care; that will allow for the proper care to Older South Australians who experience BPSD or who have Severe Mental illness. It is estimated that SA currently has need of between 60 and 90 Transitional care beds.**
- **The model should identify as a priority the site(s) for a purpose built unit for People with Tier 7 BPSD and that unit(s) be constructed in consideration of the full range of services needed to provide high quality safe care. It is predicted unit(s) currently require 21 beds and will need 24 beds by 2021.**
- **The Model must take into account how to jointly operate services that are funded with Commonwealth Aged Care Funding and State Specialist Mental Health funding for people with BPSD, when they cannot be provided with service through the privately operated Residential Aged Care sector.**

**The review recommends this process commences immediately and that the responsibility for progressing this be shared by all LHNs and should not be considered the sole province of NALHN.**

#### **Is it the Right place?**

The appropriateness of the infrastructure of the Oakden facility was considered by the Review, as part of considering the model of care and its alignment with best practice.

In 1993, The Australian Human Rights and Equal Opportunities Commission (HREOC) reported on its National Inquiry into the Human Rights of People with Mental Illness.<sup>xx</sup> This Inquiry, often referred to as the “Burdekin Inquiry” reported that many public psychiatric facilities were gravely inadequate and antiquated. They were reported as being alienating environments and even new units were poorly designed and cramped. The report criticised units for elderly people as depressing and intimidating with a lack of privacy and inadequate toilet and bathing facilities.

Since then, and particularly throughout the 2000s, Older Person MH facilities have been designed using guidelines that attempt to ensure a person’s safety and dignity, self-esteem, and comfort and promote autonomy.

The Review examined the available published literature on the adverse effects of the infrastructure of OPMHS on the mental health of its residents.

The available evidence shows:

- That violence in OPMHS is associated with the following factors; high social density, lack of privacy, loss of control, cognitive dysfunction, crowding and involuntary status.



- Furthermore, female consumers in mixed gender units are vulnerable to threats, harassment and abuse and of those residents experiencing fear and distress 74% are women. It is vital for elderly females to be protected from fit strong men with Tier 7 BPSD.
- There is evidence that some consumers of mental health units who have been traumatised during their hospitalisation have lasting harm. In Australia, it was found that one in three people interviewed after discharge from an OPMHS unit reported feeling frightened, unsafe, disgust or embarrassment, powerlessness and a sense of intrusion. Others reported loneliness, isolation, and restriction of their movements. Where these consequences resulted from the design of the units and contact with other residents it delayed recovery.
- In designing OPMHS for those who are at highest risk of harming others, the factors in the built-design considered most significant in mitigating this risk are as follows; significantly more space, direct access to enclosed gardens, quiet areas, sensory rooms, activity and games areas, avoidance of corners and long echoing corridors. In bedrooms the use of louvre type observation panels, bidirectional opening doors, homely and safe fixtures are all recommended.

In relation to the operations of OPMH units it has been shown that the mixing of functional impaired and cognitively impaired consumers tended to have a negative impact on those with functional impairments and contributed to low staff morale. Where these types of residents are segregated the wards are quieter and calmer, staff have higher morale and greater job satisfaction (Craig 2008).

Furthermore, Garling (2008) recommended that there should be an increase in the provision of same sex wards. This is likely to promote greater safety, higher satisfaction, more socialised behaviour and quicker recovery.

The importance of establishing home-like environments is significant. It has been widely proposed that small facilities (7-10 beds), with private rooms and bathrooms, and a residential kitchen with communal dining areas are desirable for longer term care of people with even very severe BPSD.

The Review has identified the following factors as of primary importance in creating a best practice setting for providing treatment in Older Person's Mental Health Services:

- temperature, efforts must be made to avoid both very hot and very cold areas;
- humidity, dry conditions that mitigate the development of various respiratory and skin conditions should be maintained;
- air quality, the provision of fresh air, good ventilation and neutral odours;
- smells, should be natural and in-offensive;
- sound, should be regulated for the individual needs appropriate to all consumers;
- colours, there should be efforts to provide bright colours and to avoid muted colours blue and bluish grey in particular;
- lighting, should be soft, indirect and full spectrum, with the aim of ample natural daylight noting that sunlight may be therapeutic;
- textures, should be promoted throughout the built design;
- furnishings, soft furnishings with round edges wherever possible to avoid injury;
- wall coverings, need to be sensitively and carefully chosen and culturally grounded;
- artwork, should be considered in the light of emerging evidence about its calming effect in some people with BPSD;
- window treatments, should be soft and promote visibility into outdoor areas;



- bulletin boards in rooms, that help the consumer identify their own areas and indicate a connection to their life story;
- open space, without the use of long echoing corridors;
- numerous windows with views of nature, that promotes the consumers access to outdoor areas;
- exercise areas and long meandering walking tracks, designed to allow several consumers to be in an area but not encroach on one another's personal space. For many, access to a sensory garden is critical;
- personal safety zones, acknowledging that for many individuals experiencing psychosis their zone is many metres larger than for a person not experiencing a psychosis;
- industrial grade carpet rather than vinyl is being promoted as a safe and reliable option, taking into account the need to quickly manage incontinence where this occurs;
- soundproofing, in common areas promotes a more acceptable environment;
- multi-Sensory Rooms; are now considered standard practice throughout Mental Health Units to reduce agitation, arousal and the likelihood of violence;
- memory boards with photos are located at the entrance to residents' bedrooms to help them identify their private space;
- residents have a direct line of site from their bed to the toilet, promoting independence;
- direct line of sight from threshold of bedrooms to sunrooms, living rooms and kitchen, to help assist decision making and prompt way-finding;
- bedroom doors on different sides of the corridor are offset to minimise the likelihood of residents entering someone else's room;
- colour-coded hot (red) and cold (blue) taps for safety; and
- toilet seats that contrast in colour to the bowl to promote independent toileting.

### **What we found**

What we found at Oakden does not meet best practice in most respects.

Oakden has areas such as the BIOS area that is unbearably hot in summer and would promote the likelihood of dehydration. In several areas, the Review found damp areas, poor ventilation and highly perfumed odours being used to mask offensive background smells.

During the Review, the television was often very audible showing material that was inappropriate for residents. It was reported to the Review by several family members, that on weekends it was usual for the television to be on a station showing horse racing that was considered by the family to be more for the entertainment of the staff than the consumers.

Bedrooms are poorly designed for elderly people and the placement of doors promotes consumers bumping into one another.

There is poor access to outdoor areas, which are in any event, is in a state of poor upkeep, and not designed in a way that would ensure consumers can wander without falling as a result of uneven surfaces.

The Review found a number of issues that are not of an acceptable level for the only State-wide Specialist Older Persons Service.

The current entry into Oakden is adjacent to the plant room and is unwelcoming and when the septic tanks are being emptied it is very unpleasant and distasteful. The previous entry to the building is more appropriate but now rarely used.

**Image 1: Entry to Oakden**



On entry to the Oakden facility, a much cluttered board gives directions to the particular unit you are looking for. This creates an impression that the facilities design is chaotic. For elderly people who can become confused, this is confusing.

**Image 2: Directions Board**



The Review team found the purpose of the Board unclear as it intended to achieve a number of different purposes, none of which it did well.

It was of concern that the reception area is a significant distance from the entry and that it is easy to get lost before finding the reception, whilst also allowing the possibility of access that is unobserved.

At times during the early stages of the Review, members of the Team were met by staff who did not enquire the purpose of our presence within the facility and seemed unconcerned about who was in the facility.

The environment for consumers in their living areas is generally bland, uninviting and not home-like. It also has televisions mounted well above eye level especially for older people who would be seated.

Walls are not decorated in any way that would break the appearance.

Furniture in these areas has square corners that promote injuries if a person falls, these should be avoided wherever possible.

Floors are finished with linoleum and whilst this is a consideration for those people who may be incontinent, it creates an institutional atmosphere rather than being home-like and increases the impact if a consumer should fall.

**Image 3 and 4: Living Areas**





The units have long corridors that are a poor design feature for people with severe BPSD. It promotes those who are agitated and pacing quickly to gather speed and leads to a greater likelihood of bumping into other confused consumers.

**Image 5 and 6: Long Corridors.**





This was an example of poorly maintained doors and walls, which are unsatisfactory in a unit of this type. The Review found there was an unacceptable level of maintenance throughout the Facility. Subsequent images also reflect this issue.

**Image 7: Door, door jambs and walls**





The following photo is of a chair, that the Review was informed by a staff member, had been cleaned that morning. On the left edge of the chair (right side of this image) is evidence of faecal soiling that was still visible. This image also shows the lack of maintenance to walls, furniture with sharp corners that leads to a high likelihood of injury.

**Image 8: Soiled Chair and damaged wall.**



Image 9 shows probable possum urine stains on the ceiling in one unit.

**Image 9: Ceiling**



This image shows a filing cabinet rusting to the floor in the office.

**Image 10: Filing cabinet.**



Much of the specialised furniture was damaged, ripped or in very poor condition. Much of it was no longer in use and should have been removed and replaced. Instead there was a stockpile of unused equipment stacked into a store room.

**Images 11 and 12: Damaged Chairs**





In addition, the Review found a range of chairs, such as the one shown in image 12, that were badly damaged and either still in use or had been awaiting replacement for some time. Note in Image 11, the wall linoleum has peeled back and not been repaired.

The openings through sliding doors were poorly maintained and represent a tripping hazard.

**Image 13: Sliding doors**





Images 14, 15, 16 and 17: Outdoor areas





The Review team found the outdoor areas to be neglected and posing a falls risk to consumers. Getting into these areas was difficult as sliding doors were also in a poor state of repair. Even the area in the best state of repair (image 17) has very little appeal.



The following images show an entry point into the roof space where it is likely possums enter. It is likely other vermin may also be present. The outside post has rotted and been painted over.

**Image 18: Roof with uncovered hole which can allow entry to vermin.**



**Image 19: Outside post:**



Images 20, 21 22 and 23: Kitchen area





The Review found that Kitchen staff had to manage with damaged, antiquated or broken equipment and in cluttered surroundings, with leaking pipes and rotted dirty shelves.

The consumers' environments are confusing with doors the same colour as the walls and directly opposite each other. This is known to add to intrusive behaviour.

In addition, photos of the consumer are used to aid their orientation and help them find their bedroom, however they were placed much higher than most people would look at. It appeared to be a greater aid for staff to identify not for consumers to identify their room. Image 24 has faces shaded to ensure confidentiality and privacy.

Images 24 and 25: Area outside bedrooms.





**Images 25 and 26: Bedrooms**



The bedrooms are generally unappealing and have few of the personal possessions of the consumer that would be comforting or assist the consumer to identify the area as their own.

The 'BIOS area' is particularly stark and inappropriate.

**Image 27: The Bios Area**



By way of comparison, the Review found that the quality of the infrastructure in the facilities providing services to people with Tier 6 and 7 BPSD in Victoria and NSW was vastly different.

The following images are provided with the kind permission of Mr John Nadjarian of Hammondville in Sydney NSW and Associate Prof Kuruvilla George at the Peter James Centre in Melbourne, Victoria.

The Peter James Centre is a state owned and operated service that receives Commonwealth funding to provide care to people with Tier 6 BPSD. In addition, the centre gets additional funding through the State's mental health program to the local health service which operates the facility.

Victoria has a range of such State operated services that are aimed at people who have Tier 6 BPSD. In addition, Victoria has services for people with Tier 7 BPSD. Together, with their Acute Older Person's Mental Health Inpatient units, they establish the full range of services needed to provide a continuum of residential inpatient care for the highest tiers of BPSD.

This allows for a smooth transition between services designed and staffed specifically for the corresponding level of severity BPSD, as this changes during the progression of a person's dementia.

The Dementia Care Cottage at Hammondville is privately owned and operated by HammondCare to provide a Residential Aged Care facility receiving Commonwealth and state funding to provide care to people with Tier 6 BPSD.

HammondCare also provides the Commonwealth Government funded Severe Behaviour Response Team in South Australia.



Across NSW, Victoria and Western Australia there are a number of examples of services that are jointly funded through State and Commonwealth funding that provide contemporary high quality services for people with severe and very severe BPSD.

These facilities have been designed consistent with the principles outlined on pages 33-35.

The following images give examples of what can be provided and are in stark contrast to what is provided at Oakden.

The Linden Unit at Hammondville is entered through a domestic looking front door, assuring friends and family that their loved one will be at home here.

**Image 28: Entrance to Hammondville unit**



The corridors are wide and bright with natural light entering them and carpet is used on the floor.

This is not just to recreate a domestic feel, the available evidence shows carpeted floors assist in reducing injury from falls without increasing the risk of falls.

In image 29, the walls are decorated with motifs that make the appearance home-like. It also shows corridors with small angles that break the flow of the corridor. This contrasts with those in Oakden, that are long, unbroken and institutional.

**Image 29: Walls in Hammondville.**



**Image 30: Doors and Walls of different colour.**



Image 30, shows a bedroom door that is a different colour to the wall, helping to ensure consumers can differentiate a door they can enter, from doors that are the same colour as the wall (such as the exit door) to discourage them entering through the door.

A collage of pictures relevant to the person is on the wall next to their room. This may be pictures of them when they were younger, their loved ones, places they have been to and activates they engaged in.

In image 31, there can be seen that through the dining/lounge room window, residents look out at a familiar domestic scene, a veranda and pergola area, lawn and clothes, that are washed on-site hanging on the line.

**Image 31: Outdoor area**



The Review was informed the bedrooms and outside areas were accessible to the consumers at all times, unlike Oakden. A well designed garden path led the person around the 'backyard' where they could re-enter the house through a different door from what they left the building.

In sections of the corridors, a 'nook' is created to encourage residents who like to walk and pace, to have a place to sit and rest.

**Image 32: Sitting nook**



The lounge areas, are created to look domestic with a fire place and arm chairs, the television is set at a 'domestic' height, not up on the wall where many consumers are unable to see it, as occur at Oakden.

**Image 33: Lounge area**



At the Peter James Centre, the Northside unit is older and contained within a larger facility and yet a more domestic feel is still able to be obtained.



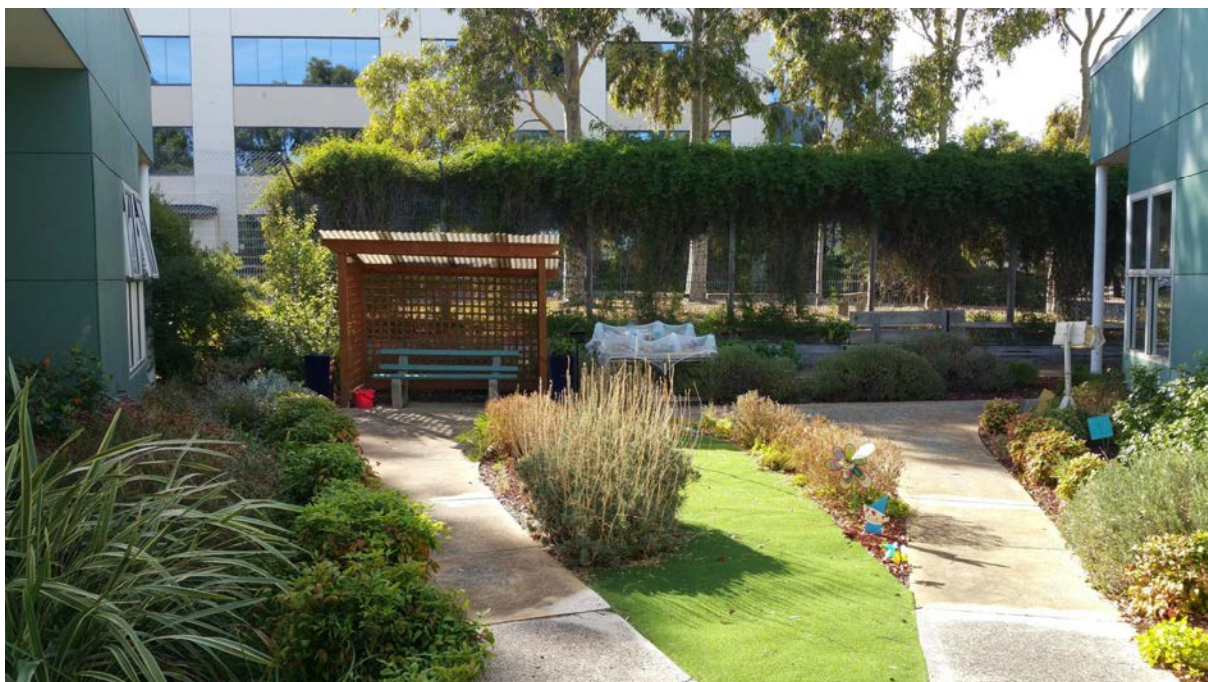
The dining area is separate to the main living area of the unit. The tables are round to prevent injuries caused by knocking against sharp edges and it looks out onto a well-kept and inviting 'pergola' area adding to the homely feel.

**Image 34: Dining Area.**



A number of outside areas were available and accessible to all consumers. This well maintained outside area had a path that meandered around a variety of plants to provide a range of sensory stimulation for consumers and an option for visiting with friends and family.

**Image 35: Outdoors**



This decorated wall, one of a number within the facility, has an array of posters of people who might have had meaning to the consumers during their life. This type of wall is a conversation starter, it is stimulating, breaks the boredom of a hospital environment and can be easily changed and updated depending on current consumer interests and backgrounds.

**Image 36: Wall**



The 'snoezelen' room was accessible 24 hours a day as a place in which consumers could self-regulate. It had a range of items catering to sound, smell, tactile and visual senses enabling staff to use calming strategies specific to the individual. The myth that to calm a person they need a 'low stimulus environment' was rejected by the Review.

**Image 37: Snoezelen Room**





Finding 2:

The Review finds 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.

- Oakden was not well designed or modern for the time it was built and is now entirely unsuitable for its current purpose. It meets none of the expectations of a modern mental health service for older consumers with severe and incapacitating mental illnesses.
- The substandard quality of the infrastructure is likely to have led to considerable difficulty providing appropriate management of the most severe challenging behaviours of Dementia. Furthermore, the infrastructure has led to low morale and frustration among staff and led to some visitors becoming distressed by the environment in which their loved one has to reside.

**Recommendation Two:**

**The Review recommends that in developing a new Model of Care the Oakden facility is not considered an appropriate facility for the provision of either a State-wide Specialist Intensive Care Behavioural Unit for consumers with Tier 7 BPSD or for the provision of Transitional Care Units for people aged over 65 with Severe Mental Illness or Tier 6 BPSD. When considering the provision of services that replace Oakden the following should apply in relation to infrastructure:**

- **The development and commissioning of new purpose built facilities needs to be completed prior to the full de-commissioning of the Oakden facility.**
- **The commencement of the capital planning for the purpose build replacement of Oakden should occur immediately.**
- **Facilities will be required to cater for a non acute longer stay unit for people with Tier 7 BPSD with pods no more than 8 beds, sub-acute transitional care units (TCUS) for people with Tier 6 BPSD and separate TCUs for people with severe functional mental illness.**
- **Neither the Tier 6 nor Tier 7 services should be considered a bed for life.**
- **Those people in Oakden who can transfer the Residential Aged Care Sector should do so.**
- **During the period before a replacement facility is available, concerted efforts should be put in place to substantially improve the physical amenity of the facility both inside and out.**

**Capital planning should commence immediately with an aim of decommissioning Oakden at the earliest possible time.**

# Chapter Six

## Staffing Model

*“When you come into the ward sometimes you can’t find any staff”  
– Family of a resident of Oakden.*

*“I am concerned that at times there does not seem to be enough staff. Guardians report that when they visit, it can be hard to find staff as they are all with one person.” - The Public Advocate.*



## 6. Term of Reference - Staffing Model

The Review team was asked to consider, review and make recommendations about the:

- current staffing model and whether this aligns with the optimal staffing required for the Model of Care;

### **Consideration of Staffing Profiles.**

Staffing profiles vary considerably between differing types of mental health units throughout Australia. In part, this is based upon local factors such as industrial agreements which specify amongst other factors the Nursing Hours per Patient Day, determined by levels of acuity for patients on a particular ward.

This makes comparison difficult unless units of similar size and patient complexity are either closely matched or broadly equivalent.

In 2008, Queensland published Optimal Staffing Profiles (OSP) for the full range of mental health inpatient units and community based teams within its state public mental health services. These were used as the basis for the national standardization of Optimal Staffing Profiles for each different service contained within the National Mental Health Service Planning Framework (NMHSPF). In this way, an agreed OSP would exist that catered for the differences, for example, that should exist between an Acute Inpatient Unit for Children and Adolescents, compared to a non-acute unit for adults with rehabilitation needs or a Mother and Baby Unit for someone with a Post-Partum Psychosis.

As part of this process a range of Inpatient Units catering for the needs of consumers over 65 years of age were identified with associated OSP for the NMHSPF. Each jurisdiction agreed to the staffing profiles for each team-based or unit-based element of the taxonomy contained within the NMHSPF.

The OSP were designed with the specific purpose of providing Clinical Planners with an indication of the level and the mix of clinical staff needed for each specific Mental Health Inpatient Unit contained within the Taxonomy of the NMHSPF. Whilst some units may have more staff than is suggested in the OSP, it was considered strongly undesirable to have less staff than the OSP.

These OSPs can then be used to indicate the minimal required level of the full mix of staff required for each type of different mental health unit.

### **What we found.**

At the commencement of the Review, we requested from NALHN that they make available documents in relation to the staffing model at Oakden, as at 1 January 2017. This would provide the Review with an indication of what was available during 2016 to consider this Term of Reference. However, as noted in Chapter 5, the lack of an identified Model of Care means it is not easy to compare the staffing levels against any relevant OSP.

The Review requested the following information to inform our analysis of the alignment with OSPs:

- a full list of staff, the Full Time Equivalent (FTE) and the discipline profile;
- a list outlining each staff members valid relevant screening checks;
- details of the mandatory training schedules;
- detail of any non-mandatory training that was attended or provided during 2016; and
- the number of notifications of elder abuse that were logged with the Office for the Aging (OFTA) during 2016.

### 1. FTE and discipline profile

The Review was provided with a spreadsheet of the staffing by Full Time Equivalent (FTE) for three cost centres coinciding with each Unit within the Oakden Facility. This spreadsheet showed the substantive and actual FTE and the indicated vacancy rate for nursing staff and patient care assistants only.

The information provided showed a variation between the FTE in the substantive budget for Oakden compared with the actual staff who had been employed in both the Nursing and Patient Care Assistants role. The variation consisted of a smaller FTE (3.9) of nursing staff and a larger FTE (1.67) of Patient Care Assistants.

The table below shows the variation in nursing FTE. The table outlines a higher number of nursing staff at the Registered Nurse (RN) level and a lower number of Enrolled Nurses (EN) than was in the substantive FTE.

**Table 2: Oakden Nursing FTE**

STAFF	Substantive	Actual
RN 3	3.0	3.0
RN	26.4	27.4
EN	22.8	17.9
<b>Total</b>	<b>52.2</b>	<b>48.3</b>

The lower number of actual nursing staff documented is consistent with comments received by the Review team such as “ENs are often replaced by carers”. The total substantively funded FTE of clinical staff was calculated at 52.2 based on the information provided.

A separate list provided included the following staff working on site:

- IPC nurse
- Dietitian
- Transitional Care Coordinator
- Senior Project Officer
- Nurse Manager
- Senior Medical Practitioner
- Clinical Director
- Consultant Psychiatrist
- Personal assistant
- Administration staff

No information was provided on the FTE or role of these people at Oakden and it was clear from comments made to the Review that most staff had no notion of what allied health staff they might have access to. However, on the most generous estimation that all of these positions are fully established the total Clinical FTE is 56.3 FTE (48.3 with 8 from the above list).

The Review was not able to identify anyone who personally identified as being the Nurse Manager or Senior Project Officer from their site visits and interviews with staff and no staff member was able to say with confidence what the FTE of any of these people were. This is not to say that these positions do not exist, rather that no one at Oakden was able to identify this for the Review.

The Review was informed that a physiotherapist was available to consumers at Oakden OPMHS. It was noted that a part time social worker was employed for a short period of time in 2016, as well as manager of Leisure and Lifestyle with 3 assistants; for whom the total FTE was unknown.

The Review was also informed that the current staffing levels are based on the Nursing Hours per Patient Day as defined by the current Nursing / Midwifery Enterprise Agreement 2010<sup>14</sup> (NMEA) that is 4.3, 3.25 and 3.2 for Clements, Makk and McLeay respectively.

In comparing these staffing levels, the Review considered the OSP within the NMHSPF for the service type, Non-Acute Intensive Care Hospital Unit for Persons aged over 65 (NA IC Hosp 65+). The framework outlined that the level of Clinical Staffing required is 1.62 FTE per bed.

On the basis that Oakden when fully occupied, currently has 62 commissioned beds (this had been 64), the NMHSPF would suggest Oakden requires 100.4 FTE clinical staff. Therefore the shortfall may be as high as 44 FTE at the level of funding in January 2017.

An alternative way of considering the extent of the current staffing profile is that 56.3 FTE would, if guided by the NMHSPF OSP for NA IC Hosp 65+, be sufficient for only 35 beds.

The Review considered alternative ways of applying the NMHSPF OSPs to the Oakden facility, as a better way of capturing the number of staff needed in line with the current case-mix.

The Review was able to identify that 14 consumers within Oakden are currently displaying Tier 7 BPSD. This alone would require 22 staff (14 beds at 1.62 FTE per bed). If all other consumers required the lowest level of FTE for a service type within the NMHSPF, which is 1.28 FTE per bed, then the remaining 35 consumers present in Oakden at the time of the report (as Oakden is not operating at full capacity) would require a further 44.8 FTE. This would bring the total estimated FTE currently to 66.8 FTE.

Put another way, using the most conservative estimates from the NMHSPF, the Review believes that the FTE available at the commencement of the Review would be at least 10.5 FTE short of what is required for even the currently significantly reduced occupancy within the facility.

Whilst comparisons are difficult, in that Oakden does not provide services that are arranged in a manner consistent with the NMHSPF, it was apparent to the Review that Oakden has insufficient

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<sup>14</sup> Dept. of Premier and Cabinet, SA Government, Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2010

Nursing Staff for the type of consumer that is likely to be within the unit, if the NMHSPF is used as the comparator.

In relation to Medical resources needed for Oakden, this was also difficult to determine without an agreed model of care and a full analysis of the case-mix for the service. However, from the information provided to the Review, and an analysis of the current case-mix in Oakden, it is clear there is a significant Medical shortfall currently. This shortfall would lessen once the full range of appropriately trained members of a full multi-disciplinary team is in place that could ensure Specialist medical staffing levels are optimal.

However, the Review considers the requirement for Consultant Psychiatrist would be 0.6 FTE at current occupancy levels if all other resources are in place. That is, this is an estimate of the long term requirement for Consultant Psychiatrists.

There is however, a significant current shortfall in FTE of Consultant Psychiatrist which will need to be provided whilst the significant backlog of clinical requirements for all consumers in Oakden is met.

The Review was informed of the difficulty encountered by junior medical staff managing the number and range of tasks confronting them on a daily basis. These included attending to frequent falls, management of complex medical issues, deteriorating patients, complex mental health needs and routine tasks for up to sixty patients.

The junior medical staff also had to undertake tasks that would have been completed by allied health practitioners in a functioning multidisciplinary team; however this was not possible due to the lack of these staff. These medical officers' responsibilities were typically undertaken in isolation, with limited supervision or support and without adequate clinical resources or information.

This contributed added challenges to efficiency for medical staff who would find themselves called to see patients with nursing staff unable to provide knowledgeable handovers and with clinical records being simultaneously insufficient in useful detail but overly voluminous in length, reflecting the long admissions of many patients (This is referred to again in Chapter 7). Medical staff felt that their efforts to advocate for improved resources, including staffing numbers, was not heard by the OPMHS Executive.

Finally, the Review is aware that during February and March, 2017 there has been a significant increase in the number of Medical and Allied Health staff, of all disciplines that has complemented the existing staffing levels. It is probable the overall increase in staffing and the multi-disciplinary staffing model together with a reduced occupancy has led to more satisfactory levels of staffing at Oakden. This was not the case in 2016.

## **2. Appropriate Screening**

Staff who are employed at the Oakden facility are required to undergo an employment screening when commencing employment with the service. The specific type of screening is dependent on the unit they are employed in as the facility receives funding from both the Commonwealth Government for Makk & McLeay and from the South Australian Government for Clements ward.

The *Aged Care Act 1997* provides the legislative framework for Commonwealth funded RACF services. The Principles of the Act require that organisations funded by the Commonwealth to provide RACF services should be satisfied that a person providing those services has not committed a

precluding offence. In order to meet this requirement, SA Health requires employees working in Makk and McLeay to undertake an Aged Care Sector Employment Screening, the screening is provided by the Department for Communities and Social Inclusion (DCSI) on behalf of the South Australian Government. The screening must be completed prior to the person commencing employment and every three years during the period of their employment.

For staff working in Clements ward, which is a South Australian funded unit, and not subject to the *Aged Care Act 1997*, they are required to undergo a Vulnerable Person related screening prior to commencement of their employment.

The information provided by NALHN demonstrated that all staff were up to date with their required screening and the dates for when staff were due to undergo an updated screening was also clearly documented.

### **3. Training**

SA Health employees have mandatory training requirements which vary depending on local requirements, service setting and professional disciplines. The information provided to the Review, listed 14 different trainings topics. The list provided was noted to be incomplete as there was no information provided for one unit.

The Review noted that there were only two topics considered mandatory training by the service that had a 100% completion rate. It was of particular concern that training for 'Child Safe Environments' had a near 100% completion rate while other more relevant training such as 'non-violent crisis intervention' had zero completion on one unit and only 26% on another.

The Review was not provided with any information on staff attending non-mandatory training. However, the Review is aware of two Oakden staff who attended non-mandatory training facilitated by the Chief Psychiatrist in 2016. This calls into question either the reliability of the information held by Oakden or the concern that staff are attending non-mandatory training outside of employment endorsement.

The Review found that the training and skills of nursing staff is clearly inadequate based on the lack of completion of mandatory training and no evidence of a framework of performance development to enhance and encourage skill development. This is despite a number of comments during interviews on accessing online training, such as "there's only one computer in each ward and there is always a nurse using them doing SLS or online training."

The Review requested information on the rate of completion of Professional Review and Development (PRD) of staff in Oakden. From the information provided, a number of staff in Oakden, possibly close to 50%, have not completed their PRD.

### **4. Elder abuse reports**

Under the *Aged Care Act 2007*, the Australian Government introduced compulsory reporting of alleged or suspected elder abuse (for those in Commonwealth Aged Care Services) and the Australian Nursing and Midwifery Federation position statement states<sup>15</sup>:

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<sup>15</sup> ANMF Position Statement – Compulsory reporting of abuse in aged care settings for nurses and assistants in nursing, 2014

*'Registered nurses, enrolled nurses and assistants in nursing are required to report any suspected or actual abuse of an older person. They must report to their employer or directly to the Police or the Department of Social Services.'*

Furthermore, in 2015 the South Australian Minister for Ageing released the *Strategy to Safeguard the Rights of older South Australians Action Plan 2015-2021* (the Action Plan)<sup>xxi</sup>.

As part of endorsing this Action Plan Local Health Networks (LHNs), agreed to implement the TOP 5 tool (see page 19 of the Action plan).

In addition, the LHNs committed to "building a culture of dignity in care throughout service delivery."

Therefore, the Review expected that older persons' services would have a process in place to determine, escalate and report possible incidents of elder abuse. Despite there being an incident of actual assault on a consumer in Oakden that was reported to the police, the Review found no evidence of any elder abuse reports being completed.

This raises serious concerns about whether the staff at Oakden have sufficient knowledge about their statutory obligations to report Elder Abuse and if not, why not?

This is an issue that has to be addressed as a matter of priority. The provision of any services for older people is underpinned by the assumption that they are safe. There must be zero tolerance for any abuse. As stated on page 8 of the Action Plan:

*'The South Australian Government upholds that the abuse of an older person is unacceptable. It is never justified.'*

However, as no South Australian legislation with specific provisions protecting the rights of older people exists, South Australia has developed a Charter of Rights and Freedoms of Older People to support the Strategy. The 7 domains of this Charter of rights are:

- Dignity and self determination
- Liberty and Security
- Equality and non-discrimination
- Minimum standards of living and care
- Privacy and Family
- Social Participation
- Freedom of thoughts, conscience, religion and expression.

In addition, SA Health has developed its own Departmental Strategy for Safeguarding Older People. However SA Health does not foresee or deal with the issue of Elder Abuse within its own services or by its own staff.

The Charter of rights seem to be unknown to the majority of staff of Oakden, nor does there appear to be an awareness of the Strategy or Safeguarding and there should be a requirement that all staff fully understand and appreciate their duties in this important matter. It is a minimum basic competency for staff working in this area.

## 5. Staff Rostering

The Review was concerned about whether the use of 12 Hour shifts for nursing staff was appropriate.

When nursing staff work a 12 hour shift at Oakden they are subject to prolonged exposure to consumer distress and in many instances, behavioural disturbance. Longer days in physically and demanding work environments contribute to the problem of fatigue and performance decrements.

The Review holds concerns specific to Oakden; an environment where interpersonal conflict between staff is known to be high. The use of 12-hour shift rostering may lead to additional fatigue which can, in turn, lead to further reductions in work performance, especially in the long term. Shorter shifts help create a buffer where there are fewer prolonged exposures to people requiring complex care, as well as increased numbers of staff working actively at the point of care.

### Finding 3:

The Review makes the following finding in relation to staffing models:

- It was unable to establish a true and accurate staffing profile or FTE which restricted the Review's ability to accurately comment on this Term of Reference with the certainty it desired.
- It was also restricted in its ability to address the adequacy of staffing as a consequence of the previous finding, that there was no defined and endorsed model of care for the service, to compare the staffing to.
- A preliminary analysis of the provided staffing model against the Optimal Staffing Profile from the NMHPSF for a service of this type found it did not meet the levels that are required and that the mix of disciplines is incorrect.
- Staff were not provided with adequate opportunity to meet their mandatory training requirements, let alone access desirable training to assist them in caring for and improving services for the consumer cohort. While just over 50% of staff had completed a Performance Review and Development, what may have been included as 'Development Activities' is not clear.
- There is a lack of attention to ensuring staff are able to prevent and respond to Elder Abuse.
- The available staffing profile showed a reliance on Personal Care Assistants and a shortage of trained Mental Health Nurses. This was most apparent in the small number of Enrolled Nurses, Assistants in Nursing and Registered Mental Health Nurses. However this apparent shortfall is more profound when taking into account the poor levels of skill and training of many of the Nursing staff.
- The provided staffing profile showed a marked shortfall in Allied Health staffing levels. Over several years, Oakden has had insufficient access to Social Work, Occupational Therapy, Psychology and Clinical Pharmacy services that would be critical for ensuring the service provided a high level of safe care.

- The Medical staffing levels of Oakden, in particular Consultant Psychiatrists, are significantly short of what is determined adequate for a service of this type. The level of Consultant Psychiatrist input into the service should be at a level of 0.6 FTE in the medium term depending on the Model of Care that is finalised. However this minor shortfall in Consultant Psychiatrist input is magnified by the long term shortfall that has existed for many years.
- The result of such a shortfall is a marked reduction in the number of specialist interventions and an overall lack of specialised treatment plans which leads to a significant difference to the level of specialised care provided.

### Recommendation Three

The Review recommends that during the development of a new Model of Care for Specialist OPMHS in South Australia (Rec 1), significant consultation should be undertaken to identify the optimal mix of the full range of members of a Multi-Disciplinary service that is needed to provide adequate care for the defined target group for this service. This should include consideration of the following:

- the need to be advised of the adequate staffing levels, together with the level of demonstrated workforce competencies that are required to provide service benchmarked against relevant services in other jurisdictions, in particular NSW and Victoria that currently have viable effective services;
- that there should be a comprehensive approach to determining the full range of knowledge, skills and attributes within the workforce to ensure staff are able to provide high quality and safe services;
- mandatory training should be appropriate, it is imperative to understand elder abuse, safeguarding rights and the principles of trauma informed principles, it currently more important than understanding “Child Safe Environments”
- that in the transition period between Oakden as it is currently and a finalised staffing model for the range of replacement services, the following indicative minimum staffing levels of non-nursing staff should be provided:
  - 1.0 FTE Consultant Psychiatrist (that holds FPOA accreditation)
  - 2.0 FTE Junior Medical Officer
  - 0.2 FTE Geriatric Medicine (Registrar level or Equivalent)
  - 1.0FTE Consumer or Carer Consultant
  - 1.0 FTE Senior Occupational Therapist
  - 0.5 FTE Occupational Therapist Assistant
  - 1.0 FTE Social Worker
  - 1.0 FTE Physiotherapist
  - 0.4 FTE Clinical Psychologist;
  - Consumer and Carer consultants (which could apply across the entire NALHN OPMHS); complemented by
  - Sessional access to Podiatry, Dental therapy, Dietetics and Speech Therapy;
- in addition, the occupational therapist must be qualified in sensory assessment and modulation and that all staff is trained in sensory modulation and trauma informed care in addition to having immediate access to their mandatory training requirements;



- a program to support better education, training, skills development and competency as well as a framework for clinical supervision is developed and delivered that incorporates as a minimum, elements related to comprehensive patient assessment and care planning, the Fundamentals of Care, person-centred evidence based care, cultural safety and competency and clinical documentation requirements;
- the Education program should contain a specific focus on the following Australian Commission on Safety and Quality in Health Care Standards in the context of the Older Persons Mental Health Service; preventing and controlling healthcare associated infections; medication safety; clinical handover; preventing and managing pressure injuries; recognising and responding to deterioration; and preventing falls and harm from falls; and further to this
- the Review recommends 8 hour day shifts with a 10 hour night duty, consistent with the SA Nursing Enterprise Agreement, to improve patient care and staff access to training and development opportunities.

This recommendation should align with the development of a new model of care.

# Chapter Seven

## Quality and Safety of Care

*“I strongly suspect that the lack of appropriate treatment and compassionate care in this state government facility contributed to his deteriorating ill health and ultimately led to his demise” -Family member of former Oakden Resident.*

*“He had bruises but no one could tell us why” - Family member of an Oakden Resident*

*“Apathy pervades the building” – Committee member.*

*“The Clinical Governance Committee is essentially a whingefest” - Committee member.*

## 7. Term of Reference - Quality and Safety of Care

The Review was asked to consider, review and make recommendations about the

- current risk management and risk mitigation practices being undertaken to ensure they align with SA Health standards and national best practice in care for older persons with a mental illness;

### Consideration of Clinical Quality and Care.

This term of reference required the Review to consider how the clinical risks were managed and mitigated at Oakden. Ultimately, meeting the highest level of clinical care should be the aspiration of all Health Services. However time and again, reviews of health services, around the world, are released that bring to the surface, failings in the systems that are supposed to ensure this does not occur. The Review considered that the widest possible interpretation of this area should be taken and consequentially this chapter has been titled Quality and Safety of Care in recognition of this scope.

#### 1. The International Context.

Prior to 1995, it was generally considered that the principal responsibility of the Boards of Health Services in the United Kingdom was to ensure financial management and to reach an acceptable level of patient safety.

However, as a result of the revelations that arose during that year at the Bristol Royal Infirmary, relating to the high mortality rate in Paediatric Cardiac Surgery, the National Health Service (NHS) ultimately established an investigation in 1998 into the failings in Bristol<sup>xxii</sup>.

In many respects the initial inquiry and the subsequent investigation of the service, gained such international attention because for the first time it exposed that failings in the health system can occur, in the absence of proper controls, even in the most prestigious Hospitals.

Important findings from the Investigations of Donaldson included:

*“a lack of leadership”, “an old boy’s culture”, a lax approach to safety secrecy about performance, lack of monitoring by management, and a unit that was “simply not up to the task”.*

By 1999, the United Kingdom the NHS required its Boards to assume responsibility for the quality of care equivalent to their other statutory duties.

Around that time the term Clinical Governance was used by the NHS and referred to:

*“a framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”.*

This concept was developed to embody three critical attributes namely; recognisably high standards of care, transparency in the accountability and responsibility for those standards, and a constant drive for improvement.

In the NHS, the following elements were considered central to the Clinical Governance Frameworks.

- Education and training;
- Clinical Audit;
- Clinical Effectiveness;
- Research and Development;
- Openness;
- Risk Management; and
- Information Management.

Over the next decade, the NHS released a number of important policies and national reports that established the current systems to ensure comprehensive Clinical Governance systems are in place.

However in 2011, the United Kingdom was yet again tackling another major tragedy in Health care. The now notorious Mid-Staffordshire tragedy, which was reported on by Francis in 2013, detailed some 1700 pages and over 290 recommendations related to the failings of Clinical Governance in the Mid-Staffordshire NHS Foundation Trust.

Ultimately, this led the UK Government and the NHS to commission Prof Don Berwick to lead the National Advisory Group on Safety of Patients in England in producing their landmark report: *A promise to learn- a commitment to act.*

This report, more than any other, has detailed the fundamental problems behind why good systems still fail and what should be done to provide solutions to these problems.

The Review believes no analysis of failures of Clinical Governance would be complete without beginning by reiterating the problems found by Francis in the Mid-Staffordshire report, as summarised by Berwick, and then looking at the applicability of the proposed solutions.

The Review has used this analysis of Mid-Staffordshire's failings as the basis for our descriptions of what we found in Oakden for reasons that will become apparent in this chapter. The following is the Review's summary of Berwick's report.

The Problems were described in this way:

- 1. Patient safety problems exist everywhere.** Like every other health system in the world there are repeated defects in patient safety and too many people suffer.
- 2. Staff are not to blame.** Whilst there are a few exceptions the vast majority of staff wish to do a good job, reduce suffering and be proud of their work.
- 3. Incorrect priorities do damage.** The prime directive should be "the needs of the patient come first".
- 4. Warning sounds abound and are not heeded.** Loud and urgent signals were muffled and explained away.
- 5. Responsibility is diffused and therefore not clearly owned.** When so many are in charge, no one is.
- 6. Improvement requires a system of support.** The system should be devoted to continual learning, top to bottom and end to end.

- 7. Fear is toxic to both safety and improvement.** Better not to know can become the order of the day.

The Solutions to these problems were described this way:

- 1. Recognise with clarity and courage the need for wide systemic change.** Everyone must acknowledge the need to improve.
- 2. Abandon blame as a tool.** Whilst misconduct merits censure, errors do not warrant punishment.
- 3. Reassert the primacy of working with patients and carers to set and achieve goals.** Patients and carers must be at the centre of all we do.
- 4. Use quantitative targets with caution.** The primary role is better care, targets are merely a tool en route to this end. When the pursuit of targets is the over-riding priority the focus may become too narrow to ensure best care.
- 5. Recognise transparency is essential and expect and insist on it at all levels and with regard to all types of information.** Everyone should be free to state openly their concerns about patient safety without reprisal.
- 6. Ensure responsibility for safety and improvement are vested clearly and simply.**
- 7. Give the people career-long help to learn, master and apply quality control, improvement and planning.**
- 8. Make sure pride and joy in work, not fear infuse the health service.**

Berwick states that in the end-

“culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.”

In the United States of America, the proponents of Clinical Governance have likewise adopted a similar approach to that in the UK, as outlined in several key documents such as the 2002 American Institute of Medicine, *Crossing the Quality Chasm, A New Health System for the 21<sup>st</sup> Century*.<sup>xxiii</sup>

## 2. National Context

In Australia, the adoption of Clinical Governance processes in Health Services gathered momentum from 2001 onward, as the full impact of the Donaldson report on the Bristol Royal Infirmary got international attention. For example, the first Clinical Governance Framework for Mental Health appears in 2002 in Western Australia, based on the then 7 pillars of Clinical Governance.

This was closely followed by a number of other Clinical Governance Frameworks released by State Governments.

By 2006, all Health Ministers had agreed to the establishment of the Australian Commission on Safety and Quality in Health Care (ACSQHC) to lead and coordinate national improvements in safety and quality in health care.

In September 2011, Health Ministers agreed to the National Safety and Quality Health Service (NSQHS) Standards that had been developed by the ACSQHC. The Standards are designed to protect the public from harm and to improve the quality of health service provision. They describe the systems required to ensure the minimum standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational and developmental

goals. The 10 Standards are a nationally consistent statement about the level of care consumers can expect from a health service.

The national accreditation scheme was also endorsed in 2011 and this is designed to ensure all health services are measured against the national standards to ensure public confidence that quality care is provided.

In 1996, the first set of voluntary National Standards for Mental Health Services (NSMHS) was released. These were updated in 2010, to reflect the changes in delivery and focus of Mental Health Services and are applicable across a broad range of mental health services. This includes bed-based and community mental health services, those in clinical and non-government sectors, those in the private sector and those in primary care and general practice.

In 2017, the ACSQHC released its National Model Clinical Governance Framework for consultation. This draft Framework will outline the broad expectations of all health services in Australia, in relation to Clinical Governance

### **3. South Australian Clinical Governance Policy**

In South Australia, the Department for Health and Ageing's Safety and Quality Unit (S&Q) is responsible for leading the development of the policy, procedures, guidelines and processes that underpin SA Health's goal of providing safe high quality accessible health care.

The S&Q has endorsed a 2016-2018 work plan that outlines the 6 key priorities to be addressed by LHNs in SA. These are as follows:

- Priority Area 1 Patient safety
- Priority Area 2 Partnering with patients, consumers and community
- Priority Area 3 Quality cost and value
- Priority Area 4 Supporting health professionals to provide safe and high quality care
- Priority Area 5 Safety Learning System (SLS)
- Priority Area 6 Communication strategy to support safety and quality

This work plan describes a three year rolling work schedule that provides a detailed account of 67 actions that are to be implemented across SA Health during that time. In addition, a process of tracking progress has been developed that is designed to ensure all Health services can outline their progress under this work plan.

In addition, S&Q has released a number of resources to assist Health Services in meeting mandatory accreditation against the NSQHS Standards.

The Review placed primary importance on the resource that accompanies Standard 1, which outlines the departmentally-endorsed Governance arrangements expected in all Local Health Networks (LHNs) as the expectation for Oakden.

The Review also considered the *CALHN Review of the Safety and Quality Systems, Leadership and Functions*.

This report was commissioned by CALHN as a "review of the systems in place to support staff to provide the best evidence based care, learn from adverse events and provide the community with assurance about the safety and quality of their care".



The Final Report of this review, released in October 2016, made the following finding:

*“Within the current arrangements, clinical governance seems to be viewed as something separate to clinical practice and something that somebody else ‘does’ rather than being a system for supporting clinicians to engage in monitoring and improving their practice, and providing safe care; this has resulted in limited clinical leadership of and engagement in the safety and quality systems.*

*There is no shared definition of what good care is or looks like; consequently, roles and responsibilities with respect to safety and quality are not clear, and functions are focussed on compliance activities (rather than improvement) and are fragmented and not well understood.*

*Systems, processes and policies to support compliance functions are well developed; however, this is at the expense of the systems needed to support accountability, assurance and improvement to drive consistently safe, high quality care across the Network. In the absence of these systems, professional accountability for demonstrating the provision of safe, quality care for every patient appears inconsistently enacted across the organisation. While there seems to be an abundance of data available, it is not generally well used largely due to systems which are not well integrated making it difficult to obtain data in a way that is meaningful and useful particularly at the clinical service level.*

*Patient safety systems are not seen as contributing to a whole of organisation approach to clinical improvement. The incident reporting system is the dominant patient safety system in use, however it is not clear how the data collected are used to understand care or drive improvement. Similarly, patient feedback is not presented in a way which drives understanding and improvement of patients’ issues. Improvement loops are often not closed and the sharing of lessons learned across the organisation is limited.*

*Patients or consumers are not readily visible within the safety and quality systems. They are not generally involved in governance or the planning and design of services but are limited to having their voice heard via complaints, feedback and a consumer committee which is not yet fulfilling its potential.*

*Patients express frustration with the difficulty of raising issues and the impersonal way in which they are managed.*

*An insight into how staff view the quality of care provided across CALHN is demonstrated through a strongly negative Net Promoter Score achieved in response to a survey question asking how likely it would be that they would recommend the care and treatment provided by CALHN to a family member, friend or colleague. This response was reflected during discussions with many who were interviewed.*

The Review had good reason to use these findings as a context as it undertook the Review at Oakden, as will be shown later in this Chapter.

#### **4. Northern Adelaide Local Health Network**

The Clinical Governance system in NALHN at the time of the Review is outlined in the document *Northern Adelaide Local Health Network Governance Framework* (version 1.0 dated 10/2105).

The Foreword of this policy sets the scene in this way;

NALHN “aspires to achieve high levels of health and wellbeing for all members of the community it serves.” It concludes thus, “Governance can only work if it is part and parcel of the culture of the organisation...” and “Everyone must know and act on their responsibilities.”

The Review considered these to be important statements, which set the clear expectations of all staff, in NALHN, including those at Oakden.

## **What we found**

### **1. Leadership**

The Review, interviewed the Executive Leadership of NALHN who reiterated the primary importance of Clinical Governance to the overall outcomes they expect in their LHN. As a team they presented a united and compelling vision for the service, which they expected to be put into effect through a series of delegations to each of the Clinical Divisions within the LHN.

Thus it was clearly stated by the NALHN Executive, to the Review their expectation that the Clinical Director of Mental Health Services in NALHN was ultimately accountable for the Clinical outcomes of the entire Mental Health Program.

However, the Review heard that these reporting arrangements have only been in place since the end of 2015. Prior to that time, the line of reporting was from the Clinical Director of the Older Person’s Mental Health Service (OPMHS) to the Executive Director of Mental Health (now titled Director of Strategy and Operations). At that time, the Clinical Director of Mental Health did not have a direct supervisory role of the Clinical Director of OPMHS.

The Review heard that the delegation of Clinical responsibility now cascades from the Clinical Director (now referred to as the Divisional Director) to the Clinical Lead for the Older Person’s Mental Health Service who has overall accountability for the Oakden facility and its clinical outcomes.

Throughout the Review, staff from the different clinical units of Oakden were unable to give an account of the Clinical Governance processes in place at Oakden. Whilst most could state that there was a Clinical Governance meeting they were unable to say what it did and whether it made a difference to what happened within the units. These staff were unclear whether that overall responsibility ultimately was vested with the Medical lead or the Nursing lead or both at the same time.

The Review was able to inspect the minutes of the OPMHS Clinical Governance (CG) Committee meetings. They shed little light on how the CG Committee actually addressed major clinical issues. The Minutes from the Committee meetings do not give the reader a proper understanding of who is responsible for what, and whether actions are being completed. It was troubling that on at least one occasion in 2016, there was insufficient attendance by members for a quorum (out of a possible 21 attendees). Furthermore of the total number of meetings that should have been held only about a half took place.

The Review is clear, if it is not possible to know from the written records, what has been discussed, what is agreed to be done, and by whom, and what is the outcome that is expected, then it is

unlikely that the process will achieve the outcomes that are desired. This was borne out by members who attended the meetings.

The Review heard from members of the CG Committee and the following are examples of statements about how it functions:

*“that most attendees did not know the fundamental principles of Clinical Governance”, “that there was an absence of leadership”, “Poor chairmanship”, “nobody was held accountable, actions were not followed up”, “reporting lines are unclear, escalation is unclear”, “that apathy pervades the building”, “that if you ask them to do anything they get agitated”, and “it is essentially a whingefest”.*

The Review was disturbed to find that many members of the CG committee were not aware of their responsibilities as outlined in the NALHN Governance Framework. This shortfall in commitment at the highest level of senior leadership within the OPMHS has consequently lead to little or no understanding of Clinical Governance at lower levels within the organisation.

The results of this failure are captured in the organisational phrase “the fish rots from the head”<sup>xxiv</sup>. This is an apt view of the collective organisational leadership as it related to Oakden.

However in this case, the failure of Clinical Leadership and thus Clinical Governance is complicated by another well recognised issue in failing clinical systems, who is actually responsible?

Throughout the Review and from almost all we interviewed there was no consistent view of who was in charge of clinical outcomes in Oakden. The more we asked the more we heard people say it was someone else. The Review went around and around hearing that it was someone else who was at fault.

One senior staff member said that after reflection “I failed. I did not do my job properly”. We did not hear anyone else, who might have had a role to play, say that they should have done anything different. This in itself is telling.

At the core of this was a structural problem. As shown in **Chart 1** (below) there was unacceptably high levels of challenging behaviour; worrying data on increased use of restraint, falls and other injuries; medication errors; and as shown elsewhere assaults and poor clinical outcomes.

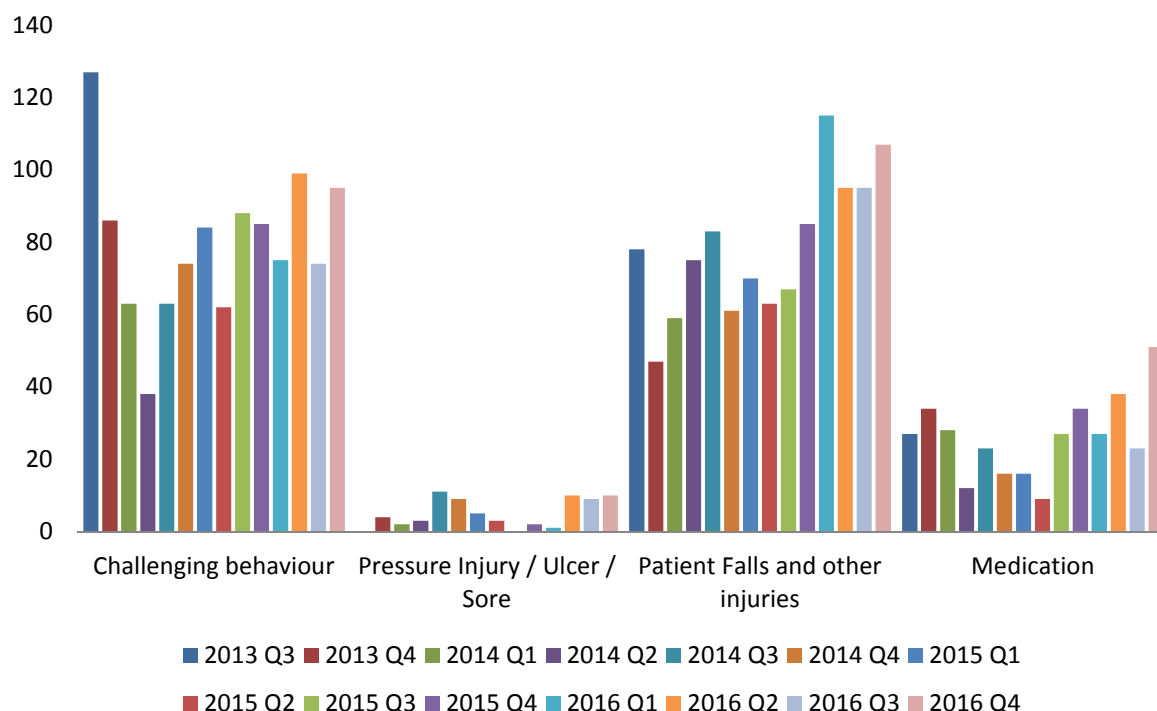
Despite all the evidence, there has been a failure of staff at all levels, particularly senior levels, to ask why?

The Review found that in many ways, it had become a situation of people taking aim at others they perceived to be responsible. The result had been a circular firing squad with no one working to solve the problem. Many have stood by, incurious and disinterested, and watched it happen.

The Review found that at Oakden, the extension to Francis’s warning that “if so many are in charge, then no one is” should be “if so many could have taken charge, then no one will.”

Chart One: Oakden Incidents by Level 1 and Date Quarter

## Oakden Incidents by Level 1 and Date Quarter



The Review also heard of leadership decisions that negatively impacted on the Governance at Oakden. Multiple examples were provided of repeated urgent requests for additional resources that were denied. This was best captured by the following quote from a staff member:

*“Stop asking for things you are not going to get”*

This type of concern was also highlighted to the Review by the Public Advocate who is appointed as the guardian for 9 people in Oakden who are all “protected people” under the *Guardianship and Administration Act 1993* (GAA). The Public Advocate expressed it in this way in her written submission to the Review:

*The Office of the Public Advocate (OPA) has concerns about Oakden that include, the use of restrictive practices, reports of assaults, lack of knowledge of some staff about legislation, lack of clarity about unlawful detention, staffing ratios, limited inclusion programs, lack of stimulation, excessive noise an inability to access their own bedrooms, reports of physical abuse by staff, activities being cancelled and that requests by staff for equipment and supplies for therapy and activities being declined because of funding. (Summary of submission by Public Advocate)*

## 2. Accreditation

One of the major focuses of the CG meetings appeared to be on the then forthcoming November 2016 accreditation by ACHS of NALHN against the NSQHS Standards.

The Minutes indicated to the Review that Oakden appeared unprepared for accreditation against these standards and that the focus was on ensuring staff knew what to say during accreditation, rather than knowing how a service should provide high quality care.

The Review found that Oakden has developed a culture of making periodic attempts to meet different accreditation standards, even if these were barely met, rather than embracing a culture of continuous quality improvement that is seen as one of the core features of good clinical governance.

The Review also became concerned about the manner in which services can achieve accreditation (even if some standards are only met in part) and yet any detailed analysis of clinical performance would raise very serious concerns about whether the standards are indeed being met.

Having made a detailed review of clinical records (covered in more detail later in this Chapter), that in some cases go back as far as 2005, the Review did not find an appreciable difference in the overall level of clinical outcomes over that entire period. Put another way, the problems in 2016 are seen as far back as one looks.

The Review heard from many sources, including some through the media, that significant problems were known as far back as 2007 at Oakden when it first failed to meet certain Commonwealth Standards. At that time, the external review by Stafrace and Lilly pointed to some of the reasons for these problems. This Review has confirmed that these problems remain and that by enlarge, they have been present throughout the last 10 years.

The Review heard and saw evidence that Oakden became better at knowing how to produce documents and records that Accrediting Bodies and Surveyors wanted to and expected to see; and better at ensuring staff knew what to say. However, it became no better at providing safe or better quality care.

Oakden, as a system, has missed the point of why there are standards and that the aim of standards is to point a system toward what is to be achieved at all times to provide quality care, because it is important, rather than only when it is being accredited.

In short, Oakden had forgotten that “the needs of the patient come first” and had not heeded Francis warning that “Incorrect priorities do damage”.

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.

### **3. Concerns about Clinical documentation.**

The Review conducted a detailed review of multiple files between 27 January and 24 March 2017.

Ultimately, the clinical record of a person is one of the most important reflections of what has happened during the provision of their Health Care. At its most fundamental, the clinical record is relied upon when Courts and Coroners need to determine what has occurred. Clinical records need to meet standards and those that do not are a window into the system and those providing the care.

Throughout the examination of the files, the Review discovered a number of major issues.

Many staff made clinical entries that were of little clinical value. In some files, clinical terms were clearly used in a manner that was inaccurate and suggest the staff member did not know the term properly. Furthermore, a number of file entries contained words that are colloquialisms such as “wandersome”.

In some cases, many days went past without any entry that had any clinical relevance. More disturbing was the use of either pejorative language to describe certain behaviours or language that indicates the writer implies the person has acted deliberately, for example:

*“sits and acts as if he has not been spoken to”* in an entry for a person with very severe dementia.  
*“foul language less today”* in an entry of a person with severe fronto-temporal dementia.  
*“he had his usual day, several periods of shouting and throwing himself on the floor”*  
*“he went to the couch and fell over”*  
*“spent the day wandering around the ward*  
*“... just wants to fight”*  
*“making wailing noises”.*

Another concern was that notes were often internally contradictory, implied what had happened was the fault of the person or that they deserved what happened to them, examples include

*“wanders around with eyes closed, fully dependent on RN for all care”*  
*“does the client speak clearly in any language no, does the client speak clearly in English, yes”*  
*“ambulating freely with help of nurse”*

The Review found multiple clinical entries that referred to various terms such as “tends to lie on the floor”, “puts themselves on the floor” and “floor time”. The Review could not understand what this meant. On direct questioning, the Review was informed of a very disturbing account of what constituted “Floor time”. It occurred when during staff interactions with certain consumers, the staff would leave the consumer on the floor in considerable distress if they had formed a view that intervening to assist the person was not needed immediately, for whatever reason.

This is among the most abhorrent approaches to providing care to severely disturbed consumers that any of the Review had encountered in well over 110 years of collective practice. It simply lacks any humanity.

Time and again such documentation of “floor time” was found in the clinical files, in one instance as long ago as 2010. The Review team can find no reason for such a practice to ever occur in an OPMHS and requested immediate action be taken by the Nursing management of Oakden. This was put into effect within one day.

This was an example of the type of issue that no accrediting body would ever endorse, if it was aware of its occurrence.

The Review not only found errors in the use of terms, poor documentation standards, inaccurate and misleading observations, and the use of pejorative and demeaning language, it also found that clinical files were not considered by Senior Specialist staff when considering the persons clinical progress.

One example is as follows:



In this case, the Review found contrasting information contained in the case notes about deteriorating clinical care and inaction at the time of the weekly clinical review meeting, convened by the senior psychiatrist and senior nursing staff. In the following instance, the clinical file evidenced physical and mental deterioration of a consumer over a 12 day period, culminating in two falls within hours of being clinically reviewed:

Date	Randomly Selected Case Note Documentation [name withheld]
5/7/16	Consumer "Agitated".
6/7/16	Consumer "Restless, trying to get out of chair, trying to get out of bed".
7/7/16	Consumer "Agitated and requiring pelvic restraint. Resistive during ADLs. Trying to come out of chair". Dietician Review: "6.7kg of weight loss in recent weeks. Was 66.1kg. Now 59.38 kg. Additional notes:
9/7/16	Consumer "Needs assistance with meals. Needs X2 staff to go to the toilet".
10/7/16	Consumer "Restless, requiring restraint. Trying to come out of a chair".
10/7/16	Consumer "Agitated. Overturned a table. Unsettled. PRN medication administered".
11/7/16	Consumer "Requiring restraint".
<b>12/7/16</b>	<b>Morning Clinical Review Meeting: Consumer "Eating and drinking well. Mobilising independently. Mood bright and less confused. Continue current management".</b>
12/7/16	Consumer "Fall".
13/7/17	Consumer "Fall. PRN medication administered three times".

The above information sourced from the consumer’s clinical file, sits in stark contrast to the summary findings of the weekly Clinical Review Meeting “Eating and drinking well. Mobilising independently. Mood bright and less confused. Continue current management”.

It is of deep concern to the Review how the Clinical Review meeting could reach the conclusion to continue current management for a consumer who, in the last few days had fallen, required PRN medication, was losing weight, showed signs of agitation, confusion and restlessness. Such a conclusion raises serious questions about the process of reviewing the clinical care; the adequacy of the governance arrangements; consumer oversight; interpretation of clinical data; and care planning in response to physical and mental deterioration.

If this entry is a correct summary of what was discussed as the clinical status of the consumer, then no one present could have taken into account any of the contemporaneous entries of all other staff on the unit. If the entry is not what was discussed, then serious questions should have been raised. That there appears no process to check the veracity of entries is a significant clinical governance failure.

The Review also heard from several medical staff, who had provided visiting services at Oakden, that there was almost no value in perusing the file for background, because there was very little in the clinical files that were meaningful and much of what was in the file, they could not rely on. Some went as far as saying they could not know with confidence, whether some staff knew how to take basic observations, such as lying and standing blood pressure readings, correctly.

In summary, the clinical files were inadequate of poor quality and insufficiently reviewed for a specialist service. This is the responsibility of and should have been remedied by the senior staff of each discipline.

In relation to clinical deterioration, the Review commends the 2014 ACSQHC publication *Recognising and Responding to deterioration in mental state: A scoping review*. This should be well known to Mental Health Services and those responsible for Clinical Governance.

Following the management – Initiated changes in February 2017, a number of clinical files were re-reviewed. The clinical files now contain extensive and detailed assessments by the new attending Consultant Psychiatrist with detailed management plans. In addition most files now contain comprehensive assessment from Geriatric Medicine. Both of these changes lie in stark contrast to what was found prior to the changes.

#### **4. Oversight of Clinical Care**

The Review was concerned about the documentation of assessments made by Consultant Psychiatrists. The number that was found was much lower than expected. The assessments that were found in files during 2016 seemed to be short in detail and do not reflect the severity of the conditions the consumers were experiencing.

The clinical files examined had entries from the Medical Officer in Oakden, but there were very few entries from any Consultant Psychiatrist in what is a highly specialised service for people with severe BPSD. This is considered by the Review as unsatisfactory.

In one file, the only Consultant Psychiatrist entry was made in relation to assessments required under the *Mental Health Act 2009*.

The entries that summarised discussion at Clinical review meetings were uniformly written and signed, by either the medical officer or one of the senior nursing staff. The Review believes these should be sighted by the Consultant Psychiatrist on most occasions, to ensure the clinical file properly reflects the Specialist contribution to the Treatment and Care Plan.

The Review found little evidence of a sufficient supervisory model for clinical care throughout all levels of all disciplines in Oakden. The Review heard from many people that, Oakden did things in a particular way and had always done it this way, as “they knew how to do this best”. The evidence in relation to the overall standard of care did not support this view that care was either contemporary or best practice.

There seemed to be a poor understanding among staff, as evidenced by the case files, in regards; modern falls mitigation, the use of trauma informed principles to avoid the use of restrictive practices, wound care, pain management, assistance with activities of daily living, management of wandering, the use of sensory modulation, management of agitation and arousal, management of disturbed sleep-wake cycles and the nursing management of common medical problems including how to undertake common medical procedures.

This was compounded by an approach to addressing these problems which was essentially nursing only. The Review heard from staff that they did not know or understand what role various other members of the traditional multidisciplinary team could add to the effective management of these complex clinical problems. For example, some senior nursing staff on direct questioning did not know what an Occupational Therapist could do with respect to sensory assessments and their role in avoiding the use of restrictive practices.

In addition, the Review found numerous examples in clinical files in which it would be expected that other members of a Multidisciplinary team would have been critical in the overall management of the individual concerned. This included the lack of input from Social Work, Geriatric Medicine, Speech Pathology, Clinical Psychology, and Clinical Pharmacy.

The Review was concerned about the level of nursing knowledge among the Nursing staff of Oakden and believes there needs to be a long-term strategy to remedy these shortfalls in knowledge and skill is required.

The level of knowledge relating to the modern management of BPSD falls well below that expected to be found in a Specialist OPMHS.

As a result, the Review formed a clear view that Oakden was making little or no use of clinical audit to determine whether its performance and outcomes could be improved or to determine what factors may have been leading to poor outcomes. What was needed was a system devoted to continuous learning, top to bottom, end to end. What was in place was a system with little interest in learning that did not think it could improve; resting in the belief it could do no better.

### **5. Patient-Centred care.**

The Review found staff had a poor understanding of what constitutes Patient (or alternatively person/consumer) Centred Care. Patient-Centred Care is defined as health care that is respectful of, and responsive to the preferences, needs and values of patients. Therefore it should be respectful, comforting, supportive, informative, accessible, coordinated and developed in partnership with families, carers and the wishes of the patient.

At the fundamental basis of Patient Centred care is dignity.

First launched in 2011, the ten SA Health endorsed *Dignity in Care* principles are designed to change the culture within health services to ensure patients are treated with dignity and respect. These principles summarised as follows:

1. Zero Tolerance of Abuse.
2. Show the same Respect you would want for yourself or a member of your family.
3. Treat each person as an individual.
4. Enable people to maintain independence, choice and control.
5. Let people express their needs and wants.
6. Respect privacy.
7. Let people complain without fear of retribution.
8. Engage families and carers as partners.
9. Maintain people's confidence and self-esteem. and
10. Relieve loneliness and isolation.

The full detail of these principles are found at **Appendix Ten**

In addition, the Review considers SA Health's strategic priorities for Nursing as central to what should be expected to be found among nurses at Oakden. The first of these is "Caring with Kindness": This should mean that services:

1. Identify/ construct and implement a framework that transforms the way that fundamental care is delivered at the bedside.

2. Create and redesign care processes to reflect a truly person centred approach.
3. Inform models of care to reflect the essence of caring and kindness.

The Review heard and saw examples where the care did not closely meet either of these sets of principles. For example, there were consumers who were not treated with respect, left soiled and un-bathed, were not adequately fed and hydrated, confronted with a “show of force” to undertake routine tasks of daily living, mocked, ridiculed, spoken to as if they are children, dressed inappropriately, left unkempt, and treated with little personal dignity.

As one family member put it:

*“They put him in someone else’s clothes. He was staggering around the corridor in revolting clothes. A man with mental problems- stripped of his own clothes, without his own clothes. ‘Where are his clothes?’ I would ask. ‘They are getting labelled’, was the reply. This went on for weeks. The day he left Oakden he left still wearing someone else’s clothes. He was a proud man. He was proud about his appearance”.*

While this did not occur to all people on every occasion, there were countless examples provided and clinical files that reflected such attitudes. On some occasions, the Review team witnessed such interactions between staff and consumers whilst in the Oakden facility.

The solution can only ever be that consumers are at the very centre of what we do, they are the very reason we do what we do. The threshold must be that everything you do today is what you would want to have happen if it was your most loved one.

This does not occur in Oakden at all times.

## **6. Staff availability.**

The Review heard repeatedly from families, visitors and external informants, that they attended the ward and no staff were visible and were not available to assist the family member. This was explained by staff to be a result of all staff on the ward being required to attend to a single consumer.

This situation should never occur. That it does occur reflects a failure in the monitoring of care. That it continues, without being addressed, is more concerning. Either staff need to be trained in how to provide assistance with Activities of Daily Living in a more specialist way that requires less staff or satisfactory staffing levels needed to be assured. It is possible in some scenarios that both remedies may apply.

The Review was also told the manner in which staff were allocated roles at the beginning of each shift, contributed to this problem and that it was also a cause of conflict between staff on certain shifts. How this had a negative impact on the culture is covered in more detail in Chapter 8.

Staff gave varying accounts of the way they managed challenging behaviour, with dramatic differences of approach. The failure to adopt consistent evidence-based techniques that work effectively with BPSD is further support of the need to provide adequate staff education, training and clinical supervision, as well as the need for specialist input in behavioural support plans.

The Review was concerned about whether the use of 12 Hour shifts for nursing staff contributed to the inability to have suitably trained staff. This should be dealt with during the consideration of the Model of Care and the appropriate staffing profiles as recommended in Chapters 5 and 6.

### **7. Injuries sustained in Oakden**

The Review discovered that in each of the first 10 files that it examined, all consumers had been injured. The nature of these injuries is documented in the clinical file as arising either from another consumer or in one case from a staff member (this staff member was reported to the Police and subsequently his employment was terminated). In addition, there were numerous accounts of injuries sustained by staff members while assisting consumers.

This level of injury, even in units mainly concerned with people who have Tier 7 BPSD, is deeply concerning. Even more concerning to the Review, was the approach by the service, which had taken no actions, before the start of the Review, to address this serious issue. This was considered by the Review as a serious failure to monitor clinical outcomes and to learn from its clinical incidents. Indeed, the Review found very little evidence that Oakden has developed a “Learning Culture” in which the analysis of readily available information is used to improve the clinical outcomes of those in Oakden.

Such a level of injury demands serious re-consideration of the approach in places where the injuries occurred, with the involvement of the most highly trained staff in revising the approach to management. Instead, Oakden continued to rely heavily on the use of medications to ameliorate this behaviour, despite their limitations, and heavy reliance on the use of mechanical restraints, despite their known risks.

In some situations the Review was also informed of consumers who had effectively been detained in an area of the facility in which they could not leave and where no other person would be present with the consumers. This constitutes seclusion. However, these episodes of seclusion were not being routinely reported as is mandated in SA.

This is not only a serious breach of reporting it shows a secretive approach to performance and an unwillingness to be scrutinised, both of which show a failure to acknowledge the need to improve. It was said, on more than one occasion by staff of Oakden, that there was no way in which things could be improved with respect to these outcomes. The Review rejects these statements unequivocally.

The use of restraint to prevent injury was stated to be because of how severely affected the person was affected by Dementia. This pattern of blaming of patients to account for poor and potentially harmful practices is a disturbing example of therapeutic nihilism. They no longer knew what to do, they appear not to have known where to turn to get the expert advice they needed, so they stopped asking.

### **8. Falls**

The Review was provided with considerable detail about the rate of falls within Oakden. A number of issues were identified. Falls are common and a number of them have been un-witnessed. Some staff did not appear to have a sophisticated understanding about how this could be prevented or minimised. Many held the view the only effective tool was the use of restraints in particular pelvic restraint.

This runs contrary to modern management of falls. In particular most evidence shows the regular use of restraint (even for short periods) can lead to significant muscle weakening and increase the likelihood of subsequent falls.

The Review points to the 2009 publication of the ACSQHC, *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals* which makes the following note (page 100):

*There is no evidence that physical restraints reduce the incidence of falls or serious injuries in older people. However, there is evidence that they can cause death, injury or infringement of autonomy. Therefore restraints should be considered the last option for patients who are at risk of falling.*

This excessive use of pelvic restraints is addressed in Chapter 9 in more detail.

A number of previous attempts to have Oakden consider this evidence was met with rejection of such ideas and re-iteration that their approach was appropriate. This is a feature of organisations that are closed to new evidence, and cannot incorporate new approaches when they are challenged about the prevailing norms in their practice.

## **9. Quality Use of Medication.**

The Review examined the manner in which medications were used at Oakden. The Review accepts that there is no perfect system in place that has resulted in the elimination of all medication errors in health care settings.

However since 2000, when Australia's National Medicines Policy was endorsed, the National strategy for the Quality Use of Medicines (QUM) has been a central aspect that underpins the Policy.

In SA, *Continuity in Medication Management; a Handbook for South Australian Hospitals*, sets out the expectations for ensuring that best systems are in place.

It outlines that SA Health services should have proper processes of medication management in place that prevent as many errors as is possible and minimises the effects of any errors that occur. These are represented in Figure 1.

Best practice use of medication in OPMHS is vital in order that there are minimal unintended consequences from prescribing. The *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults* often referred to as the Beers List are guidelines that help to improve QUM in older people. The Beers List emphasises the importance de-prescribing unnecessary medicines to avoid polypharmacy, drug interactions and adverse reactions. Whilst the criteria do not replace good professional judgement they serve as a good guide.

The pattern of prescribing, at times showed little understanding of these principles. There were multiple examples of polypharmacy and the continued use of medicines after they should have been ceased.

In relation to Oakden, the systems that should ensure best use of medicine fell well short of what is required. The consequence of this is poor performance in relation to the QUM and a resultant level of medication error that is too high which leads to harm to consumers. This was not being identified as a major issue of concern. It should have been as the following case illustrates.



Figure One: The Medication Management Cycle.



The case relates to a significant error in the prescribing, transcribing and administration of an Antipsychotic Medication used in the treatment of BPSD.

In the case reviewed, the consumer received 10 times the dose of medication that was intended. This occurred sequentially for the midday dose for three days.<sup>16</sup>

There were multiple points at which this error and its impacts could have been averted. These include but are not limited to the following; greater diligence at the point of prescription and later transcription; regular review of prescribing patterns and administration by Clinical Pharmacists; proper understanding of mental state changes and clinical deterioration by those administering; proper consideration of the likely impact of dosages that are in error, effective communication between medical and nursing staff about treatment plans that involve changes in dosage; proper checking at the point of administration; and prompt availability of Medication Handbooks that can guide clinical staff.

<sup>16</sup> The Review is aware that the details in this part of the report potentially identify a person whose identity has been made public through the media. The Review sought permission from the person’s family to include this case in the report with full knowledge that the inclusion of this detail will have the unintended consequence of identifying the person involved.

The consumer involved had a clear deterioration in their mental state over the period of time they were administered excessive medication. This was an avoidable harm. However their care was also accompanied by a number of other deficits that make it difficult to determine the effects that can be attributed solely to this medication error.

During the Review, another case in which it was stated a resident had been given 10 times the intended dose was raised. This was a case involving an over administration of Insulin and could have had serious consequences. This incident was not reported as required in the Safety Learning System (SLS). This is a serious issue and raised the possibility to the Review; How many other incidents have not been reported and why not?

What the Review was told was that this particular medication error was very clearly known to those involved and to the person who informed the Review. Among the range of possible reasons that may explain this failure, are possibilities such as fear of reprisal, deception (not wanting to get caught), embarrassment, collusion, shame, ignorance, and expectations from a system that does not want to “dob” someone in. Whatever the reason, none are acceptable if the system is one that supports self-disclosure as a way of learning from mistakes to improve care.

However that is not the system at Oakden. The Review heard one staff member being threatened by another with the words “you would not want to report me to AHPRA”.

Oakden does not have that type of culture needed to promote safety. As was highlighted by Francis, “Fear is toxic”. Instead of using knowledge to learn, Oakden did not want to know.

The Review also examined files in which the combination of certain medications, doses and even the clinical indication for the use of the medication was questionable. These issues would be addressed by the inclusion of Clinical Pharmacy services within the Clinical model for the services at Oakden.

It is unclear to the Review why the involvement of a Clinical Pharmacist has not been embraced at Oakden. The considerable benefits of a Clinical Pharmacist are essential to improving medication outcomes.

## **10. Incontinence and Personal Hygiene.**

The Review was provided with many examples in which families and external informants raised concerns about consumers having been incontinent and their hygiene not being addressed. These reports were numerous. In addition, staff confirmed that on occasion, certain consumers were attended to less frequently because they were considered more likely to be combative when being assisted with ADLs.

Comments such as:

*‘[consumer name withheld] has sat in wet pads while eating because no staff were available to change him’ or  
‘[consumer name] was smelly, it was embarrassing to take him out’, ‘my mum has had shit in her hair’* were not uncommon statements from family members.

The Review was also told some consumers did not have their dental hygiene adequately addressed and in some case consumers teeth were not cleaned.

This is an entirely unacceptable approach to take with consumers; it does not maintain their dignity.

### **11. Benchmarking/Clinical Audit**

One of the easiest ways in which a Clinical Governance Framework can assure continuous improvement in quality is the collection and auditing of Performance Indicators and Clinical Indicators.

The Review did not find any concerted efforts had been made to use Indicators at Oakden and benchmark them with other similar services in Australia and then to use this information to let staff know about the performance of its clinical processes. There are a number of equivalent services in other states that could have been asked to benchmark indicators as a means of Oakden improving its clinical outcomes.

Such an approach would have led to an earlier realisation that the use of restrictive practices in particular, is far in excess of similar services. This should have led to improved processes and better overall levels of care.

### **12. Responding to incident reporting**

The Review considered the reporting of incidents at Oakden into the Safety Learning System (SLS) where a key purpose is to ensure 'organisational learning from incidents, including near misses and system failures, to eliminate or reduce future risk'.<sup>17</sup>

The Review found that many incidents were logged by staff. This included 411 falls incidents, 139 medication incidents and 3115 restraint and seclusion incidents for 2016. What was not found was evidence that the incidents were appropriately reviewed on an individual basis or as aggregated data.

Every fall should be reviewed to determine why it occurred and what could be done to prevent another incident. The data revealed that in only 21% of incidents the risk factors were considered, 29% had existing falls assessments completed and yet, of the 60 people who experienced a fall, 80% of them experienced more than one and 25% had 10 or more falls.

Reviews of restraint and seclusion incidents were repeatedly completed by use of a 'cut and paste' method, including dozens of incidents where the person's name was misspelt in the same way and the managers comments in hundreds of incidents was either:

- 'Restraint safety monitoring initiated during period of restraint. Daily care needs met during period of restraint. Restraint released hourly as per protocol'. or
- 'Consumer safety maintained.'

This overall attitude is one of indifference. It was as if completing an SLS was purely a means unto the end of getting a tick in a box, rather than being the basis to a serious consideration of why it needed to be eliminated.

The Review found 139 medication incidents reported for 2016 and only two were found to have a reference to documenting or communicating agreed actions to prevent a recurrence. This further highlights the failure to adequately monitor, review and follow up on incidents affecting consumers' care.

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<sup>17</sup> SA Health Incident Management Policy Directive, 2011

These examples highlight a significant lack of critical thinking and reflective practice.

### **13. Clinical Risk Management.**

This chapter has highlighted a number of concerns about Oakden’s Clinical Risk Management, most notably the areas in which very little if any real approach was in place.

However, the Review was aware of an example which best exemplifies the fundamental issue of governance.

In this example, it was ultimately determined that there was a substantial clinical risk that needed to be placed on the Risk Register for NALHN. In placing this on the Risk Register, the owner of the risk needed to determine what treatments and controls would be applied, put these in place and monitor for the reduction of the risk.

However, what occurred was the proposed treatments were not implemented in full and sometime later the risk was removed from the Register on the basis that the Risk had been managed and no longer applied. All those at Oakden that the Review interviewed, have stated that they believed the risk remained, that it was unchanged and that there was no consultation with those who originally raised the risk to see if it had been ameliorated, before it was removed. The Review believes the risk was still in place when it commenced but has since been managed.

This whole approach to raising and retiring risks on registers needs to be approached in line with best practice. It currently falls short of the desired approach.

#### **The Stafrace and Lilly report**

In February 2008, Oakden had been found to be non-compliant with some of the Aged Care Standards and as a result the then administering health service Central Northern Adelaide Health Service (CNAHS) commissioned a report from experienced Specialist Older Person Mental Health Service Providers, Assoc Professor Simon Stafrace and Mr Andrew Lilly<sup>xxv</sup>.

Whilst some of the findings of that review have been addressed since 2008, a number of findings were not addressed and were also found by this Review.

The following are the findings of the *Stafrace and Lilly report* that have not been addressed and which this Review also found:

1. “The Standard of meeting documentation was variable and did not provide the reader with a clear indication of the discussion and the actions required.”
2. “Some items are simply lost” and the review was “not confident that important matters were being adequately monitored through to resolution or implementation”.
3. “Staff reported not being kept informed of what is happening in a timely manner.”
4. “Overwhelming feeling that purchasing protocols had paralysed action and that there was a pressing need to purchase essential items.”
5. “No systemic approach to or framework for Quality improvement, risk management and clinical governance.”
6. “No plan to guide implementation, monitoring and evaluation of clinical improvement activities”
7. “Clinical audits had not been routinely undertaken.”

8. "Report of minimal specialist medical input into residents care."
9. "KPIs not routinely monitored, therefore no oversight of key clinical processes relevant to the population."
10. "Data on skin integrity, falls, episodes of aggression, infections and medication errors not used in a cycle of Continuous Improvement."
11. "Management of behavioural disturbance is a low priority as the resolution of these behaviours and subsequent discharge is not seen as a realistic goal."
12. "No sense that behavioural management was a primary focus and some people had not been seen medically for 5 years."
13. "Majority of residents are left with little stimulation or engagement in meaningful activity."

The Review was confronted by the situation whereby so many of the findings from the *Stafrace and Lilly Report* remain unchanged in 2017.

This apparent lack of attention and failure to take any sufficient action to address serious issues presented by an external review strongly suggests the service has not developed a learning culture and is not open to external scrutiny.

Both of these factors that permeate the culture of Oakden will not change without significant and clear actions to address the underlying issues.

#### Findings 4:

The Review found that there was a failure of governance, particularly clinical governance, at the Oakden OPMHS. This failure was across all components of a Clinical Governance Framework.

Specifically the Review finds:

- warning signs such as the rate of injuries, medication errors, excessive mechanical restraint, numerous falls, unexplained bruising, failed accreditation, poor documentation and unidentified clinical deterioration were present but the signs were not heeded;
- responsibility for clinical outcomes was not owned, there was no one who was clearly in charge;
- the priorities at Oakden were never clear to staff, but they did not include putting consumers at the centre of care and ensuring high quality and safe care, furthermore there was no clear definition of what good care was the focus became about compliance and accreditation not improvement;
- leadership was poor, those in charge did not take the actions needed to have a system in place that would deliver good governance, in particular they did not seem to either know or appreciate what NALHN Executive leadership expected of them, they seemed to think it was someone else's role;
- staff were frightened to report when things went wrong, they thought they would be blamed and many senior staff thought it better not to know, this is a fatal flaw;
- staff continued to make the same mistakes as there was no culture to learn by these mistakes;

- the education, training and professional development that should underpin excellent care was seriously deficient and focussed in areas that are out of date and irrelevant, areas such as trauma informed care, sensory modulation, falls prevention and safeguarding against elder abuse are critical;
- there were no identifiable process to support greater clinical effectiveness;
- open disclosure was rare, and external scrutiny was not encouraged;
- there was failure to properly resolve clinical risk when it was (rarely) appropriately raised and this led to a subsequent reluctance to raise it again, staff felt helpless and that the situation was hopeless;
- standards of care were poor but not closely monitored, as a result there were no systems of continuous improvement, this was not seen as a priority;
- professional accountability was weak, inconsistent and led to some staff not being sanctioned for unacceptable behaviour;
- considerable information contained within SLS and a range of other systems was not used to improve care. It was treated as if it were a chore rather than a source of important data to drive change; and
- information from families and carers was not sourced as actively as it should have, complaints were managed as something that needed to be covered over as part of the nature of the work the service must do rather than as a source of important information to aid improvement.

These findings are entirely consistent with the findings of Francis in Stafford and provide another example that is consistent with what was found in the review of Clinical Governance in Central Adelaide Local Health Network in 2016.

#### **Recommendation Four**

**The Review recommends that NALHN must establish a new clinical governance system at Oakden.**

**This Clinical Governance system should include the following features:**

- **it should comply with the current NALHN governance framework and be accountable to the Divisional Director Mental Health. This position should ensure the appointment of a suitably qualified clinical head that is the single point of clinical accountable to them for the outcomes at Oakden;**
- **the clinical head should be part of the development of the new model of care and develop a clinical governance system at Oakden that is part of an overall system that covers all specialist Older Persons Mental Health Services in South Australia from community, to acute to long stay sub-acute and non-acute units;**
- **it should be informed by the National Model Clinical Governance Framework developed by the ACSQHC and address each of its elements;**



- it should feature a focus on ceasing blame, encouraging openness, promoting the use of data and information to drive improvement, embracing continuous improvement and placing patient care as a priority, and bringing pride back into the provision of services at Oakden;
- it should also promote transparency, encourage staff to state openly their concerns, give all staff assistance to achieve the expectation of life-long learning, in order that a culture of safety and quality is created; and
- it should be developed in partnership with the other LHNs in order that as South Australia moves toward a system that integrates services for people with very severe and extreme BPSD and long term needs with severe mental illness there is a consistency of approach.

**This recommendation should be implemented immediately in the knowledge that change will require 3-5 years to make a sustained difference.**

# Chapter 8

## Culture

*“Many of us are depleted and defeated...given up fighting to make change. ‘What’s the point?’ NALHN are not trying to create new positions. It’s a dumping ground. Over the years we are getting more complex people to manage. We need more mental health nurses, not geriatric nurses”. – Staff member of Oakden*

*“One staff member refused to talk to another for the entire shift. This was just not helpful for patient care. I was requesting a BP to be done – but it could not be done if it is not communicated to others that it is required”. – Staff member of Oakden.*

## 8. Term of Reference - Culture

The Review was asked to consider, review and make recommendations about the:

- cultural practices currently occurring in Oakden.

### **What we considered.**

In every organisation, there are cultural norms, values and practices that distinguish that organisation and that often evolve over time.

The culture of an organisation will often consist of a shared set of assumptions, values, principles, beliefs and expectations that will determine for many people within that system how they behave whilst in that organisation.

The culture is often a product of the history of that organisation and can in certain settings be transferred from other organisations if a number of staff has previously shared a certain culture.

Culture within organisations is often identified as either strong or weak, based on the degree of alignment between the way staff respond and the values of the organisation. However Social researchers have described a number of different cultural styles within organisations including; Cultures based on fear; Cultures based on bullying; Tribal Cultures; which were considered by the Review as being of important consideration.

Whilst a dominant culture often prevails it is usual to find one or more sub-culture that may exist.

### **What we found.**

Whilst it is important to acknowledge that some of the staff of Oakden are passionate, professional and dedicated staff who have worked for long periods in a service that has the considerable difficulties we have outlined throughout this report, with an unwavering commitment to the consumers in the facility, this is considered by the Review to be an exception.

These are exceptional people and are seen that way by the families who come into contact with them regularly, they did well, they did their best and they made things better, but they are not the dominant culture of Oakden.

Before long it became clear that the Review needed to understand this using an ethnographic approach.

In doing so, we found that there was not only a dominant culture that was readily identifiable, there were also a small number of sub-cultures. These will be outlined below.

Early on in the Review, we came across use of the phrase "boss on floor" as a distinctive form of insider communication. As a cultural practice, "boss on floor" is a phrase used by nursing staff to communicate to each other that a person in authority (for example, an external assessor, official visitor, protected person's guardian or senior SA Health employee) was in the building and/or on the ward. Upon hearing the phrase staff would be expected to act in ways that would reduce the

likelihood of being scrutinised. The phrase is telling in terms of reducing external scrutiny. It has specific meaning largely known only to those who use it.

From the very first days that the Review spent on site at Oakden, it was confronted with a series of behaviours and beliefs within the staff which were confirmed time and again by those relatives, visitors and external informants that spoke to the Review.

Many of the practices at Oakden contribute directly and indirectly to the distress of staff, consumers, their carers and family members.

The Review will outline the various aspects that characterise the culture through the use of direct reference to statements made to the Review. For example, the Review noted relatives concerns for staff workload in the following way:

*“Food for residents comes from Regency Park. It arrives cold. Staff then need to heat it up, cut it up. Its ‘stone cold’ [and] give to already difficult to feed people. Cold food is not good at all.*

*And then there is the septic. It’s still on septic. They [referring to management] don’t want to spend the money.”*

*“The cleaners do a really good job”.*

The Review noted that there are staff at Oakden who are clearly motivated to provide care and do what is possible to provide comfort to consumers. One interviewee expressed the following:

*“I have seen some committed nursing staff... dedicated, enthusiastic, they relate to the person, can tell you a lot about the person, but they don’t have the time to give [consumers] stimulation. They are running all over”.*

Another saw it this way:

*“The manager was sympathetic to the issues we raised about getting more staff, better resources, but said ‘no money, no money’. They did not push the need for more staff any further. It was not considered a priority to push”.*

The Review noted this commitment to care and empathy towards the idea that additional resources are needed. However, for a range of complex reasons, including cultural practices and traditions of the past, there was diminished opportunity for positive change. The cultural norm of “no money” left many (both staff and some families) feeling despondent as the following example makes clear:

*“Many of us are depleted and defeated... given up fighting to make change. ‘What’s the point?’ NALHN are not trying to create new positions. It’s a dumping ground. Over the years we are getting more complex people to manage. We need more mental health nurses, not geriatric nurses”.*

The Review also saw a range of significant cultural practices at play that prevent progress being made across a number of fronts. In particular, the old verities of nursing practice and manual handling from a bygone era remain; as a legacy of a stand-alone hospital where some staff had their initial training half a century ago, there are additional practices such as the style of interpersonal

communication, that impact directly upon the physical and mental health of consumers and staff who care for them.

The Review identified the following workplace practice and culture concerns:

- staff discontent, bickering and interpersonal conflict;
- the HR practice of removing poor performing nursing staff from elsewhere within the service, and requiring them to work at Oakden as part of individual disciplinary procedures;
- employment of overseas trained nurses with narrowly defined practices, skills and knowledge;
- seclusion, restraint and rough handling practices transported from mid-late 20th Century Glenside Hospital (and possibly from Hillcrest Hospital);
- the often repeated statement, “There is no money for Oakden, so don’t ask for anything”;
- the often repeated statement, “Oakden will soon be taken over and managed by a NGO provider”; and
- secrecy and inaction surrounding poor performance of staff.

The combined elements of the above have had an organising effect that guide how those living and working within the Oakden facility interact with each other.

These are now outlined in more detail.

### **1. Staff Bickering and Conflict**

Several people told the Review about ‘staff bickering between each other’, “low morale” and “a toxic culture”. Many made reference to overseas trained nurses working at Oakden because “when they arrived in Australia, management realised they did not have adequate qualifications to work in other areas of mental health’.

The default employment option was to have overseas trained nurses work within the Oakden campus. Many told the Review that several of these nurses have English as a second language and experience some difficulty communicating with their Australian born counterparts.

The Review was told this was sometimes linked to interpersonal conflict. One interviewee saw it this way: “There are lots of foreign nurses... (Their) understanding of everyday working language and speaking English is not always that good”.

Although raised as a concern the Australian Health Practitioner Regulation Agency (AHPRA) assesses applications for registration from internationally qualified nurses and midwives on behalf of the Nursing and Midwifery Board of Australia under governance arrangements provided through Health Practitioner Regulation National Law. Individual states and territories are responsible for the final decision on each application. The Review finds that internationally qualified nurses have much to contribute to the consumers at Oakden, particularly with South Australia’s changing cultural mix in the coming decades.

The worker-to-worker team environment was described as “toxic” and “disrespectful”. Efforts had recently been made to create a respectful team environment through staff development. Topics such as ‘Working Respectfully as a Team’ have been initiated by Human Resources (HR) to help change professional culture. It was not apparent to the Review that this had made any impact. It was not clear that the culture was being measured in such a way to determine whether any interventions had made any difference.

Several interviewees told the Review that additional equipment and resources – including provision of Allied Health staff, would not be forthcoming as there was “no money”, and “Oakden was going to be put out to tender, eventually taken over and managed by a non-government organisation (NGO)”.

Lack of available finances was linked (in part) to explanations surrounding why resources and equipment were not provided. By drawing attention to these conversations, interviewees told the Review of a subsequent “lack of stimulation for the residents”; “No occupational therapy or even music therapy would be provided”, and “The Princess chairs being shredded and not replaced”. One interviewee summarised it this way: “There is no money being put into the place”.

Such a message around lack of funding and resources and the eventual running of the facility by a NGO provider had become institutionalised into the social and working life of Oakden. It has also become enmeshed with interpersonal conflicts and lasting feuds between clinical staff, an example of a situation brought to the attention of the Review team by way of interview.

On this occasion, interpersonal conflict between staff came to a head when a broken sphygmomanometer was not going to be repaired. A junior member of staff told the Review that despite best efforts to obtain working equipment; the message from senior staff was always the same: “the broken equipment was not going to be repaired or replaced because the service has no money”. Feeling upset about how this request was responded to, led to a feud between the staff member and manager that eventually widened to involve others.

Staff felt unfairly treated when told by their manager that if they needed to check a blood pressure reading; they would be required to leave the ward and borrow equipment from elsewhere. Staff told the Review this generated feelings of anger and resentment towards their manager and contributed to unsafe practices with staff being required to leave the ward understaffed especially during the night shift. A sphygmomanometer is an inexpensive mandatory medical device, why it became such an issue is hard to fathom.

The Review was told that the staff member who initially raised the issue of broken equipment began to feel targeted and victimised by their manager. This was expressed through roster changes being done without consultation with the staff member, spreading of malicious rumours and being ignored in daily interactions. Feeling intimidated and bullied, the stress levels for the staff member rose dramatically. The staff member subsequently became anxious and depressed and obtained mental health counselling and support from a health professional external to SA Health. The Review was disturbed by this entirely unavoidable outcome.

## **2. Interpersonal Conflict**

The Review also found that interpersonal conflict situations appear to be made worse by two intersecting issues. Firstly, there is a preoccupation of dealing with matters in-house. Conflicts and tensions were not limited to requests to repair or replace broken equipment. For some staff communications between them had completely shut down. The Review was told of a “negative workplace culture, where staff members would not speak to each other for the entire shift”. The Review noted that such behaviour places consumers at risk, for example:

*“One staff member refused to talk to another for the entire shift. This was just not helpful for patient care. I was requesting a BP to be done – but it could not be done if it is not communicated to others that it is required”.*



The second aspect was secrecy and inaction. The Review was told that a former Nursing Director (who was in place in 2016) had instructed a junior staff member to not report an allegation of professional misconduct of a nurse working at Oakden to the Australian Health Practitioner Regulation Agency (AHPRA). The message given to staff by the Nursing Director was, “We will handle all of this in-house”. The consequence was a feeling among staff that anyone can get away with things they should not, and why would you bother letting people know it is not good enough, no one will do anything about it.

The Review is deeply concerned that such behaviour is an example of a type of secretive and self-serving style of culture that was both so pervasive and so widely condemned in most reviews of the factors that led to widespread human rights violations in Mental Institutions from the 19<sup>th</sup> Century onward.

Alongside internal staff processes of secrecy; family members and carers were also incorporated into this situation. The Review was told:

*“My Mother had been in there for 2 days and was given a double dose of medication – she was sent to the Lyell Mac – when I met with the staff I suggested that one nurse should give the medication and another nurse should mark the chart to stop the mistakes from happening – I was told by the psychiatrist there were not enough staff to do that”.*

*“Two young nurses witnessed a senior nurse stomping on my Dad whilst he was restrained – the nurses were scared to report it because of possible ramifications. In speaking with others, they all had concerns about this man (nurse)”.*

In instances where complaints were made known to authorities, inaction continued:

*“Even when we reported to the police and the nurse subsequently pleaded guilty to aggravated assault, the staff member was not at work but paid for 12 months while an investigation was undertaken by the police. The staff member had been reported to AHPRA but management couldn’t remove the staff member – it took an aggravated assault”.*

*“I made 4 separate complaints about [name withheld by Review]”.*

### **3. Rough Handling**

Many informants told the Review of their concerns about repeated rough handling of consumers, and overall very poor performance of nursing staff. The Review was told that the service was “very reliant on pelvic restraint” as something that “was automatically used with consumers”. The Review was also told that the level of restraint used at Oakden was “off the scale”. The Review heard reports of deeply concerning occurrences of rough handling of consumers and grossly inappropriate conduct. Examples given included:

- “forcibly placing a person in a chair”;
- “aggressively washing of a consumer’s genital areas”;
- staff assaulting consumers;
- staff threatening the wife of a consumer;
- a staff member asking a female client “to paint their toenails”;
- a staff member with a drug problem. Found with a fentanyl patch for personal use; and
- staff leaving a consumer unattended on the floor, documenting it as “floor time”.

The Review was told by some within Oakden that the rough handling of consumers and other aggressive actions are needed in order to keep the upper hand. These staff also viewed these actions as an effective way to get the job done. In many instances, the 'job to be done' was to prevent falls using pelvic restraint (Chapter 7 has outlined that this is incorrect).

Such practices originated in mid-late 20th Century psychiatric settings and are sanctioned by silence and inaction. Worse still, when senior management abrogate responsibility in addressing these practices they effectively sanction such behaviour. If the end always justifies the means and there are no consequences for poor behaviour, then dangerous practices prevail. Such individuals make poor leaders, because in addition to their own unsafe and unsatisfactory performance, they are not able to take action to cease unsafe and unprofessional practice, motivate others or encourage junior staff to do their best.

In demonstrating the impact of the above practices on consumers, family members expressed it this way:

*"My Father was in the toilet and there were 2 male nurses on either side of him, each with a foot on his foot and holding his wrists. A female nurse started to clean him from behind and he was startled and tried to get up – he was embarrassed".*

*"I don't know who is who – no-one wears a name tag or a uniform".*

#### **4. Disrespectful Behaviour**

A medical staff member told the Review of how they were spoken to by a nurse at the time of the nurse undertaking a medication round. The Doctor had wanted to review a medication chart but the response was that the nurse stated loudly:

*"Don't you dare come near my medication charts – GO AWAY!"*

Staff also described their witnessing "verbal abuse and demeaning behaviour from staff towards clients" resulting in "diminished autonomy, that does not represent a contemporary and trauma informed approach" an example was:

*"In comparison to a healthy culture with language and engagement that fosters self-determination, hope and a focus on resilience based strategies that would be considered as contemporary language, there is a culture of demeaning language and engagement. For example, staff would say to a client who was often left on the floor [so called 'floor time']: 'only children behave like that'... 'Get up off the floor, don't be so childish'; 'Do you want dinner...well grow up and get up off the floor'."*

The Review was told that:

*"There [has been] no attempt to train the nurses. Nothing was done. No one from above acted. The culture is permeated from above [and] when you complain about it you look like you are pathetic".*

The Review, in meeting with families discussed the experience of carers and relatives and the way they tried to make meaning out of what was happening to their loved one. The Review heard from carers and relatives in this way:

*“Oakden is one of the most depressing places you can visit”.*

*“I leave the ward and feel scared for my husband”.*

*“I have visited after hours on many occasions and I have seen some disgusting things – things that should never happen”.*

*“I am taking my Mum to the dentist, last time she went she had shit in her hair and on her hands and on the chair – they should be ashamed of themselves, how can they call themselves nurses”.*

*“Are all the staff replacing these experienced staff suitably qualified – my Mum 2 years ago had a male catheter tried to be inserted into her for 2 hours for a urine specimen – she was screaming for 2 hours”.*

*“It breaks my heart every day I go and see my Mother – Mum now has a bedsore – the chair is all ripped, she is wearing odd socks and looks like a hobo”.*

*“When I asked about showering and bathing I was advised that it is only every 4 days and a wipe down in between. I asked them if it could be done every other day. Now he has to have a bath and it is once every 4 days”.*

*“In Makk and McLeay, we are not actively involved in any care plan review – we are only notified or spoken to when things go wrong”.*

*“My Mother is in a nursing home in Adelaide – every 6 months I get a letter inviting me to meet with them for a patient review – it only takes half an hour but they ask if I am happy with everything etc. There is nothing like that here”.*

These quotations emphasise the powerful and ever-present links between carers and family caught up in the experience of fear, frustration, and emotional distress in Oakden.

## **5. Loss of possessions**

The Review was also told of the unexplained disappearance of clothing, property and personal finances. For example:

*“Loss of residents clothing constantly”:*

*“I brought in a hip protectors for my Mum, I got them from the RAH, they cost \$120 – they have disappeared”.*

*“My Mothers money has gone missing – when I asked the staff about it they told me they have “Pay Days” – they (the resident) are given money and they sign for it – in an A4 book that has patient signatures in it”.*

The Review referred the matter of unexplained loss of residents clothing, personal property and personal funds to the Internal Audit division of the Department for Health and Ageing for appropriate action.

### Finding 5

The Review found that there was a dominant culture in Oakden.

This culture was characterised by, poor morale, disrespect and bickering, secrecy, an inwardly looking approach, control, a sense of entitlement and indifference. This culture led to a loss of dignity and of rights for those in Oakden, both consumers and staff.

There was also a sub-culture of those who cared. They respected and valued the consumer and sought to value this at all time. This group are a small minority, who are unlikely to last long in Oakden before the influence of the dominant culture takes over.

As is often the case, the dominant culture makes it very difficult for those who want good things to flourish. Instead they are become more frustrated, eventually needing to either leave, because they cannot conform to the dominant culture, or because they can no longer protest and not be heard, or leave. For many, they leave rather than become “acculturated”, for others who may have no other options; they slowly become part of the system.

A number of senior staff are standard bearers. They have an inordinate influence on the culture of Oakden; they are the people who have made Oakden what it is today, a service much like those of the 1980s, and to some extent an extension of the culture from mental institutions of the middle of the last century.

There is however a number of staff at middle levels of seniority that have been at Oakden for less than three (3) years. Some of them are part of the solution for Oakden; they are the future and need to be encouraged as part of a new future.

Changing the culture of Oakden will take time; the primary focus should be on patient care and allowing people to take pride in their work.

The management- initiated introduction of a number of senior staff, a range of Allied health staff, an increase in specialist staff as well as a clear expectation that things will change has had an immediate positive impact. This may be temporary if a concerted approach to changing the culture is not put in place.

Furthermore, attention to a number of matters that might lead to disciplinary action, has led to a change in those who are leading what happens in Oakden.

### **Recommendation Five**

**The Review recommends that NALHN needs to ensure the significant introduction of people in senior leadership positions at Oakden that can drive the change in culture required to one that has as its core principles the values of dignity, respect, care and kindness for both consumers and the staff that work there. This will need:**

- **the introduction of new staff who must be immediately visible and requires processes in place so that any deviation from this culture is handled appropriately;**
- **the development of a program that addresses the culture and has components that include, introducing respectful behaviours, team building and effective team work, values**

based leadership, providing and receiving constructive feedback, effective problem solving and positive communication;

- inclusion of the Nursing and Midwifery Board of Australia Code of Ethics, adoption of the Dignity in Care Principles and Safeguarding against Elder Abuse;
- a strong engagement of Industrial bodies and Human Resources Management who must be part of a solution to Oakden, the balance between supporting those who have the attributes to work in a new culture at Oakden and ensuring those that do not, can find alternatives will be critical;
- a number of staff who are critical to success will need support to engage in an agenda of changing the culture at a time when many staff will feel under enormous pressure;
- support of senior executive positions in NALHN as well as other LHNs who have an equal responsibility for improving the outcomes of people who need to access Oakden service; and
- other LHNs supporting NALHN by recognising that Oakden is a state-wide service and that they should contribute to the solution. This could take the form of encouraging Oakden staff to participate across all parts of the OPMHS program rather than being confined to Oakden.

The Review considers the adoption of these recommendations to build a new positive, consumer-oriented, culture will take many months to develop and longer to become firmly established.

# Chapter Nine

## Restrictive Practices

*“The use of restraint is known to increase the risk of a person falling and incurring harm from that fall.” -SA Health*

*“There is no evidence that physical restraints reduce the incidence of falls or serious injuries in older people. However, there is evidence that they can cause death, injury or infringement of autonomy.*

*Therefore restraints should be considered the last option for patients who are at risk of falling.” – The Australian Commission on Safety and Quality in Health Care, 2009.*

“



## 9. Term of Reference – Restrictive Practices

The Review was asked to consider, review and make recommendations about the:

- use of restrictive practice, to ensure it is in line with the *SA Health Restraint and Seclusion Reduction Policy Directive* and *Restraint and Seclusion in Mental Health Services Policy Guideline*.

### Consideration of Restrictive Practices

In 1815, a British Parliamentary Inquiry into “Madhouse” as they were referred to at the time found, amongst other things, that the excessive restraint of people was one of the “Basic Evils” of the time. Whilst this report was some 200 years ago, it remains a major concern that has not yet found a remedy.

In 1998, the Hartford Courant shed light on some 142 deaths that occurred in the United States during or shortly after psychiatric and other developmentally disabled patients had been secluded or restrained during the previous decade.

This led to the US establishing a National Centre for Trauma Informed Care (NCTIC) as a technical expert centre to support the National Association of State Mental Health Program Directors, with the aim of eliminating the use of Seclusion and Restraint in USA.

In 2006, Australia ratified the UN Convention on the Rights of Persons with a Disability (CRPD). In 2016, the WHO developed a draft Quality Rights Initiative which aims to improve the quality of care in mental health and related services and to promote the human rights of people with psychosocial, intellectual and cognitive disabilities, throughout the world.

As part of this initiative the WHO reiterates that:

*Secluding or restraining people violates many human rights, for example the right to be free from violence and abuse, the right to be free from torture, cruel, inhuman and degrading treatments, the right to integrity of the person and the right to privacy.*

*These rights are protected by many Human Rights Instruments including:*

*The Universal Declaration on Human Rights;  
The International Covenant on Civil and Political Rights;  
The UN convention on Torture and Other Cruel, Inhuman and Degrading Treatments or Punishment; and  
The UN Convention on the Right of Person with a Disability (CRPD).*

Furthermore, the UN Special Rapporteur on Torture has called for “an absolute ban on seclusion and restraints”.

In 2005, as part of the National Mental Health Strategy, all Health Ministers agreed to the *National safety priorities in mental health: a national plan for reducing harm*. This is the first and only nationally agreed plan to reduce harm in mental health settings in Australia. The plan aimed to

‘Identify, avoid, or reduce, actual or potential harm from mental health care delivery in all environments in which it is delivered.’

The plan has four priority areas identified, one being ‘Reducing [the] use of, and where possible eliminating, [the use of] restraint and seclusion’.

As part of the implementation of this plan the Commonwealth Government provided funding to States and Territories as part of “The National Beacon Project”. This involved study tours to various services and systems in Europe and North America and the identification of ‘beacon sites’ in which participants from the study tours would apply principles of best practice in an attempt to eliminate seclusion in these sites.

The National Beacon Project was complemented by an annual conference devoted to sharing experiences about how to successfully reduce or eliminate restrictive practices. This initiative is still supported nationally, and is about to hold its 11<sup>th</sup> Annual forum as the premier meeting that shares best practice as a way of facilitating continuous improvement toward the National goal of eliminating where possible all seclusion and restraint.

At the conclusion of the National Beacon project in 2009 the recommendation for the national adoption of the six core strategies, developed by the NCTIC was endorsed by all Australian Jurisdictions. This is outlined in the National Documentation Outputs report 2009<sup>xxvi</sup>.

In South Australia, there has been a concerted effort for many years, led by successive Chief Psychiatrists to reduce and where possible eliminate restrictive practices. This has been based on the six core strategies which are:

- leadership towards organisational change;
- use of data to inform practice;
- workforce development;
- use of seclusion and restraint prevention tools;
- consumer and carer roles in inpatient settings; and
- debriefing techniques.

SA Health has endorsed the Restraint and Seclusion in Mental Health Services Policy Guideline (Restrictive Practices Guideline), developed by the Office of the Chief Psychiatrist, in 2015, using the six core strategies as a structural basis for the policy.

The Restrictive Practices Guideline has an accompanying toolkit that includes specific information on tools such as the use of activity programs, sensory modulation, debriefing and the use of personal safety plans (also referred to as comfort tools).

These guidelines use the nationally endorsed definitions for seclusion, mechanical and physical restraint that are taken directly from the national documentation project.

In May 2016, SA Health in partnership with the University of South Australia co-sponsored a week-long series of workshops and train-the-trainer sessions, delivered by two senior members of the NCTIC, as part of a process of re-invigorating the States level of response toward eliminating restrictive practices across all Mental Health Settings.

Two staff members of Oakden attended the workshops, and have attempted to introduce aspects of the training into practice at Oakden. One of the staff members reported to the Review, a reluctance

in Oakden staff to consider the introduction of evidence based strategies as proposed by NCTIC and endorsed by SA Health until the commencement of the Review.

### **What we found**

All mental health units in SA have been asked to enter their incidents of restraint and seclusion on a standalone database utilising the agreed national definitions of restrictive practices since 2009.

Although the *Stafrace and Lilly report* (see Chapter 7), noted the excessive use of mechanical restraint in 2008, the significance and seriousness of the excessive rate does not appear to have been understood by any staff at Oakden.

After that time, there were only four reports of restraint recorded for Oakden between 1 July 2009 and 30 June 2013. It is entirely implausible to believe that Oakden went from a situation of excessive Mechanical Restraint at the time of the 2008 report, to almost no restraint without any strategy to achieve such a reduction, only to return to an extreme rate in 2014. The Review rejects this as a possibility.

Instead, the Review has no doubt that the rate of mechanical restraint remained high (and unacceptable) from at the latest 2008, but in all likelihood at any time from the past until the present.

The under-reporting that occurred until 2014, represents a significant failure to appreciate the seriousness of restraint as stated by the UN and as agreed in Australia both in CRPD and also as a National Safety priority in mental health.

It is as though Oakden believed these issues did not apply to them, when the reality is; they applied more than in any other setting in SA.

For the sake of the record, it is worth noting the episodes of mechanical restraint that were reported over the years 2009-2013 as there was only 4 reports. These occurrences of restraint all occurred within McLeay and were as follows:

9 April 2011; mechanical restraint (jacket) for 10 hours 10 minutes duration on a 79 y.o. man. Reason given was 'To facilitate medical and nursing procedures considered mandatory for managing patient's condition'

25 October 2011; lap belt restraint of a 72 y.o. man of 10 hour duration. Reason given was 'To facilitate medical and nursing procedures considered mandatory for managing patient's condition'

21 December 2011; jacket restraint on a 90 y.o. man for 6 hours. Reason given was 'To facilitate medical and nursing procedures considered mandatory for managing patient's condition'

14 and 15 July 2012; 80 y.o. woman 1 hour and 2 hours, respectively with a lap belt. Reason given was 'To facilitate medical and nursing procedures considered mandatory for managing patient's condition'

In SA, during the National Beacon project, the state-wide priority had been on the reduction of seclusion within adult mental health services however, reporting by all services was encouraged and

it was expected that services would report back to the state-wide Committee (SMHQIC see below) that had been established by the then Chief Psychiatrist to oversee the reduction of restrictive practices.

From 1 July 2013, reporting of restraint and seclusion was moved from the stand alone database to the Safety Learning System (SLS) and the then Chief Psychiatrist issued under s90 (2) of the *Mental Health Act 2009* a standard on reporting restraint and seclusion<sup>18</sup>. This made reporting of all forms of restraint and seclusion mandatory.

Despite this mandatory requirement the reporting from Oakden was almost non-existent until a clarification from the then Chief Psychiatrist through the State-wide Restraint and Seclusion Minimisation Working Group in April 2014. Put another way despite a legislated requirement Oakden did not comply with mandatory reporting requirements. It was as if Oakden simply believed rules did not apply to them, and that they had no interest in what was considered a mainstream and sector wide safety priority.

In May 2014, the State-wide Mental Health Quality Improvement Committee (SMHQIC) noted the high numbers of restraints within NALHN. These were almost entirely accounted for as arising from Oakden.

In June 2014, further clarification of the correct interpretation of Restraint led to more reliable and valid reporting of the extent of Restrictive Practices in Oakden by NALHN.

Although this led to a small reduction in incidents from September 2014, there was no further reduction and in March 2015 the Chief Psychiatrist wrote to the NALHN CEO requesting:

“... further unpacking of this increase by NALHN to identify underlying factors and if determined appropriate to inform the development of a quality improvement plan.”

The Chief Psychiatrist requested a response by May 2015 and this was received in June 2015 giving explanation that the use of restraint was as a result of:

- ‘Agitated behaviour’
- ‘Restless sleep patterns’
- ‘Episodes of hyperactivity’

The Review considers none of these to be a satisfactory explanation for the use of mechanical restraint in a specialist Mental Health setting under any circumstances

Further to this, NALHN stated:

*‘OPMHS has a developed internal data base on restraint that clearly identifies and monitors clients that have restraint insitu (sic) as a response to their assessed physical safety needs. This information is utilised by the restraint minimisation committee when reviewing clinical care. From a system and process perspective the risk of using restraint is assessed and a plan of care is documented, authorised by the medical officer and agreed to by clinicians and the relative or carer.*

*To comply with the Aged Care Accreditation standards and in line with the Commonwealth guidelines on restraint decision making tool, the client’s management plan clearly identifies application and hourly release of restraint, skin integrity checks, alternatives tried and*

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<sup>18</sup> SA Health (2015) Restraint and Seclusion – Recording and Reporting - Chief Psychiatrist Standard

*evaluation of restraint in assisting client wellbeing. These indicators are fed back through the Restraint Minimisation Committee, and reviewed as part of the OPMHS quality reporting mechanism.'*

And they requested that SMHQIC:

*'Note that OPMHS has well established systems and processes which meet Commonwealth Aged Care accreditation standards, and that moving forward planning through the Restraint Minimisation committee to bench mark the use of restraint for safety with outside organisations is an objective to be met over the next 6 months.'*

However, no further correspondence was received at the end of that six month period and no evidence of benchmarking was received despite this being discussed at each monthly SMHQIC committee.

On 3 June 2016, the Chief Psychiatrist under section 90 (4) of the *Mental Health Act 2009* requested an opportunity to inspect to Oakden in order to determine the reasons for the unacceptable use of restrictive practices. The visit occurred on 30 June 2016.

A clear definition of seclusion was reiterated at the visit and strategies to assist in reducing the use of restraint and seclusion were provided by email correspondence from the Chief Psychiatrist to senior Oakden staff on July 11, 2016. This included:

- asking for a full OT assessment and sensory assessment on any person who is being transferred from 1H, SE or Ward 18 before accepting the transfer;
- looking at education for all staff on an understanding of sensory modulation and importance;
- choosing a mental health nurse as a champion who can do a sensory modulation course / spend some time with an OT somewhere for experience, which they could then bring back to Oakden;
- considering if the allocation you have for psychologist time can be converted to OT position as an interim measure; and
- reviewing the data collected to see what may be useful in demonstrating your need for an improved environment, appropriate staffing and upskilling and training. For example, is there a difference in the restraint use on people who are recent transfers from 1H, SE or Ward 18, can you compare PRN and restraint use pre and post transfer, and whether some restraints are used more on certain days?

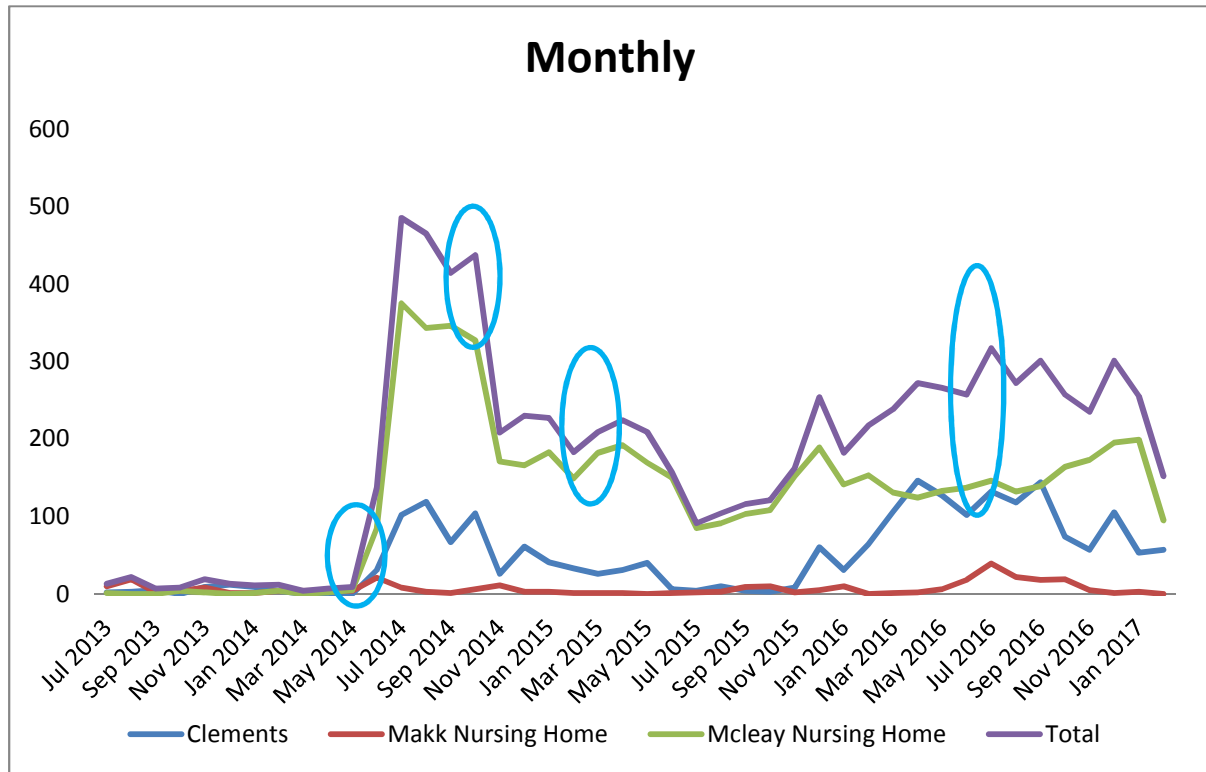
Despite this advice no formal reply was received.

The Review compared the reporting of restraint and seclusion with the SA Health Restraint and Seclusion Reduction Policy Directive (RSRPD) and Restraint and Seclusion in Mental Health Services Policy Guideline (RSMHSPG).

In addition, the Review has identified the extent of the use of Restrictive Practices in Oakden from the time they began correctly reporting in May 2014 until the beginning of the review. This time series shows restraint and seclusion use by month and identifies the points at which clarification

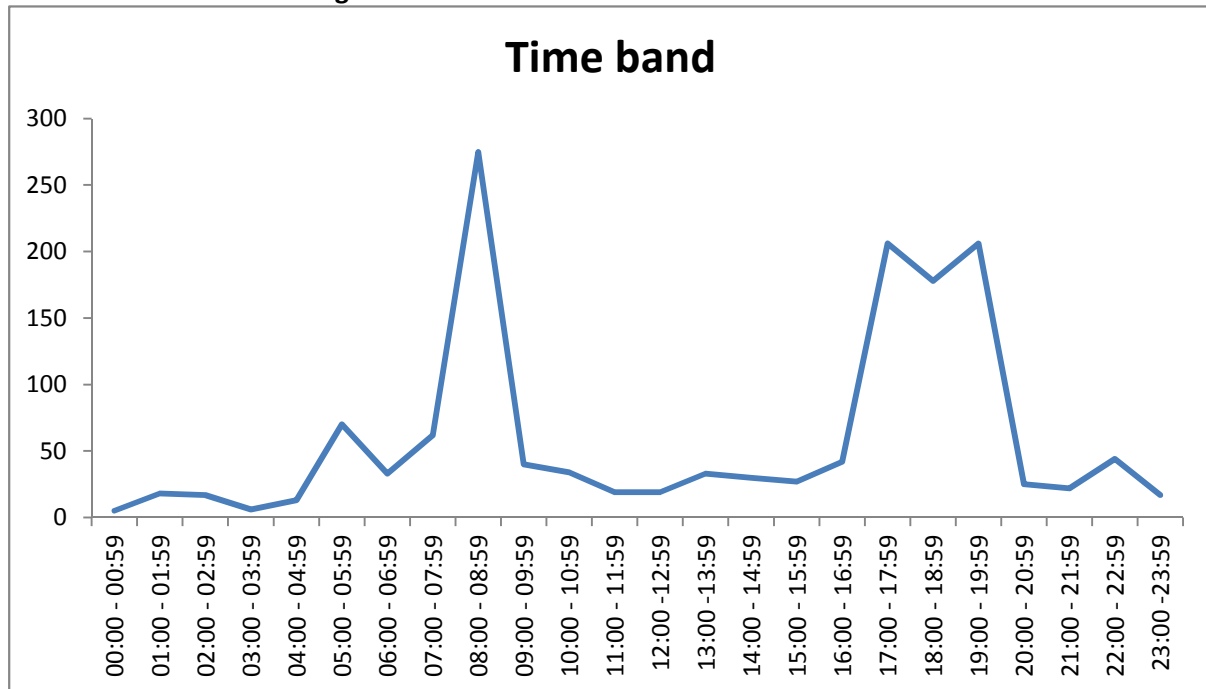
with Oakden led to either the reporting or incidence of mechanical restraint altering as outlined previously (Chart 2).

**Chart 2: Restrictive practices at Oakden**



Data source: SLS

**Chart 3: Time band showing the commencement of Restrictive Practices.**



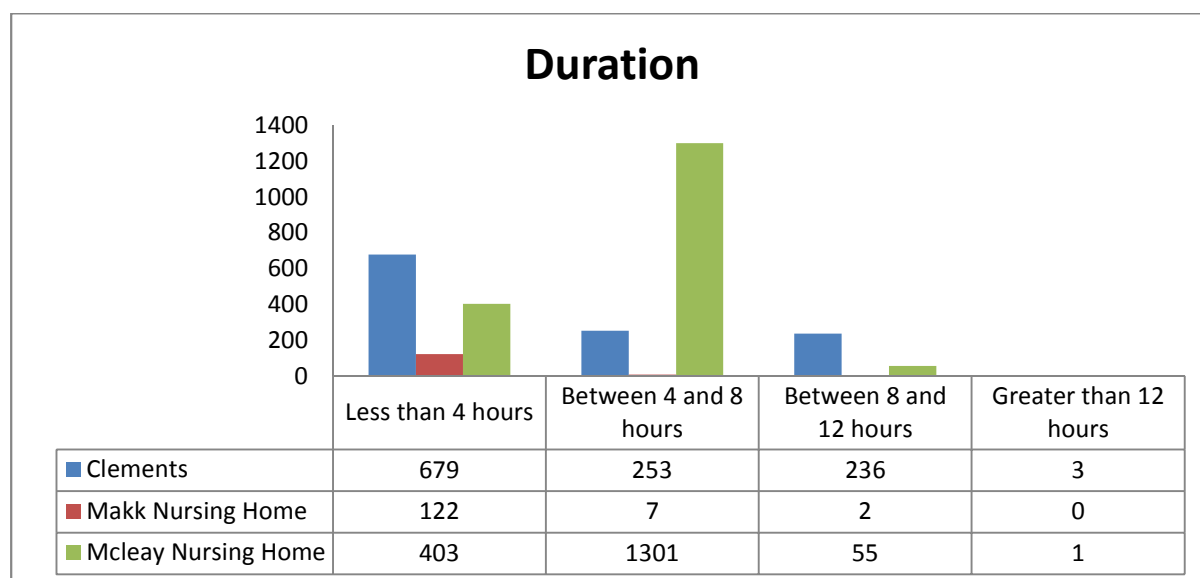
Data source: SLS



Of concern to the Review was the finding that most incidents of restrictive practice commenced in the early morning (around breakfast time) and or around dinner time. The Review believes this strongly suggests the use of Restrictive Practices is not “as a last resort” as required, but as a routine management tool as described in Chapter 8.

Up to 60% of incidents last longer than four hours. This duration of restraint is not consistent with any reasonable efforts being made to minimise the use of the restrictive practices. For example, in some states a limit of three hours is placed by law on the use of any restrictive practice.

**Chart 4: Duration of Restraint in Oakden.**



**Data source: SLS**

A definition fact sheet was supplied to all LHNs in December 2014 to assist with improved accuracy in reporting and understanding by staff of what constituted restraint.

The SMHQIC monitors the changes in mental health safety indicators in SA each month. Each LHN has a member of this committee whose role includes participation in the development of system wide monitoring of these indicators and the development of strategies to mitigate indicators that deviate from targets and benchmarks.

The Executive Director Mental Health, NALHN was the representative on SMHQIC, however was rarely able to attend the meetings in 2015 and arranged for the attendance of a proxy for some of the meetings. This lack of engagement by senior management of mental health in NALHN with state wide processes is an indication of the lack of transparency that existed at Oakden.

The Review heard from a number of staff who reported that several consumers needed between four to seven staff to attend to activities of daily living (ADLs) and this would entail physically restraining the person. During these interviews no staff members were able to recognise that excessive force might be being used and that alternatives could be employed to make the experience less traumatic for the consumer and themselves.

The SLS is the tool through which the reporting of events, that raise safety concerns, are both reported and managed at the point of care. The SLS does not include, as one of its options, falls prevention for the person reporting the use of mechanical restraint as the explanation for an

episode of the use of mechanical restraint. This is because it is not a valid reason to restrain a person. The use of restraint increases the propensity for a consumer to subsequently fall.

Despite this staff of Oakden routinely reported in notes that the reason for the use of mechanical restraint was that consumers were at risk of falling.

For example; a person that completed a Safety Assessment & Restraint Authorisation Form, clearly stated the reason for use of mechanical restraint as *'Increased falls risk with history of recurrent falls.'* In short, the Oakden facility continued to use an approach that increased the likelihood of falling in someone who had a history of recurrent falls.

That no process existed at the service level to address the incongruous nature of their treatment is considered by the Review to be a serious failure of clinical governance.

There should have been no doubt that this approach was in error, this was previously outlined on page 84 of this report.

The requirement to not use restraint as a means of preventing falls is reiterated in the Falls Risk training provided through the SA Health Safety and Quality Unit, the RSMHSPG and the Decision-making Tool: supporting a restraint free environment in Residential Aged Care. These policies clearly stated that:

*'The use of restraint is known to increase the risk of a person falling and incurring harm from that fall.'*

The Review examined the reasons given within SLS to account for the use of restraint. In 82% of incidents, the reason given is 'unintentional harm to self', when the reason is most likely to have been used by staff as an attempt to prevent falls.

Staff of Oakden completed a Safety Assessment & Restraint Authorisation Form in line with Commonwealth requirements, for episodes of mechanical restraint. This form lists alternatives that should be considered and or tried as follows:

- Lowered bed;
- Floor mattresses;
- Reduction of excess stimulation;
- Provision of meaningful activity;
- Avoidance / removal of resident from situation that triggers behaviour that may necessitate use of restraint;
- Increased monitoring e.g. patient specialling;
- Sensor alarms, personal matts / door alarms;
- Massage;
- Aromatherapy; and
- Other alternatives.

The very limited consideration by staff, as evidenced by documentation, for the use of alternatives to mechanical restraint, indicates that mechanical restraint was inappropriately being used as a default to manage a range of challenging behaviours rather than as an option of last resort.

For example, it was found that most forms were endorsed with the alternative 'reduction of excess stimulation' and that no other strategies were considered.

The Review found it most likely that ‘reduction of excess stimulation’ was a euphemism for seclusion. This is supported by entries in a number of clinical files that indicated people spent time ‘in the BIOS area’, ‘cared for in the BIOS room’, ‘Client continuously nursed in the BIOS room’ and or ‘re-directed him to a low-stimulus area’.

The Review has examined the area referred to as the BIOS room and considers the use of this room as a clear example of seclusion. The Review was also made aware an area in Clements ward that was being used for some time during 2016 to seclude a consumer, under the misguided belief that it was “time out” which did not in their view require mandatory reporting as seclusion. This was incorrect.

As part of each consumer’s assessment in Oakden, staff complete a form known as the ‘Weekly Lifestyle Planner’, a Commonwealth requirement, at morning and afternoon activities. This form outlines a number of activities the person likes and implies they are attended to each day.

These strategies could have been used as part of the approach to reduce agitation, improve their response to assistance with ADLs; and as an alternative to restraint, however there was no evidence that it was done, as part of the daily activities, let alone considered as an alternative to restraint.

Despite the completion of the Weekly Lifestyle Planner, there was no evidence found during the Review’s consideration of the clinical entries of 17 sets of case notes, that these forms were even occasionally used to inform prevention of restraint.

It was also evident to the Review, that staff had little or no training in the use of reduction tools, sensory modulation or prevention strategies in keeping with the *SA Health Restraint and Seclusion Reduction Policy Directive* and *Restraint and Seclusion in Mental Health Services Policy Guideline* or other national documents referred to previously in this chapter.

The Review finds that the use of mechanical restraint was contrary to all SA Health policies.

## **The Legislative framework.**

### **1. Detention.**

In South Australia, there are two main Acts of Parliament that deal with the way in which people may be subject to detention. They are the *Mental Health Act 2009* (MHA), which applies to people who have mental illness and the *Guardianship and Administration Act 1993* (GAA), which applies to people who have impaired decision making capacity other than from a mental illness. (The GAA is the primary legislation for people with impaired decision making capacity with other causes but it can also apply to people with a mental illness).<sup>19</sup>

The MHA establishes the regime under which a person may be detained in an Approved Treatment Centre (ATC) for the provision of involuntary treatment. The authorisation of an ATC may be determined in such a manner that it only applies to a specified portion of the facility. That is, one part may be an ATC for the meaning of the Act and a different part may not.

All of the Oakden facility is gazetted as an ATC, under section 96 of the MHA. This allows for a person with Mental Illness to be treated under the Act, anywhere within the facility. It should also

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<sup>19</sup> The *Criminal Law Consolidation Act 1935*, also applies in relation to “forensic patients” who are rarely admitted to Oakden

be noted that a person with a Mental Illness can be treated as a voluntary patient within an ATC, without the use of the MHA, if they can be treated in this less restrictive way.

A person, who is detained as a “patient” subject to the MHA, must be provided treatment in accord with the principles of the Act. These require amongst other things the following (underlining has been added for emphasis):

*section 6 (i) Should receive a comprehensive range of services of the highest standard for their treatment care and rehabilitation, with the goal of bringing about the recovery as far as is possible, and*  
*section 6 (ii) Retain their freedom rights dignity and self respect ... and that*  
*section 7 (h) Mechanical bodily restraints and seclusion should only be used as a last resort for safety reasons and not as a form of punishment or for the convenience of others.*

That is, in SA the *Mental Health Act 2009* should be used only when there is no less restrictive viable option available to provide for comprehensive, high quality services that retain the persons’ freedom and dignity, and allows for mechanical restraint only as a last resort and not for punishment or the convenience of others.

The GAA is an Act that allows for the authorisation, as a last resort, for a person’s detention (under section 32), if they have impaired decision making capacity other than from mental illness,.

Under the GAA, people who have impaired decision making capacity by virtue of Dementia can be subject to a detention order. However, the GAA does not allow for a person to be subject to detention under section 32, if they are in a ward that is primarily for the treatment of mental illness within an ATC. This means that the GAA cannot be relied upon, as the legislated basis for the detention of a person in any ward in Oakden whilst that ward of Oakden is an ATC and used primarily for the treatment of mental illness.

## **2. Restrictive Practices.**

The use of restrictive practices such as Seclusion or Mechanical Restraint, even if for the purposes of providing medical treatment, should only occur with lawful authority.

The three ways in which this can occur in South Australia are as follows:

1. By informed consent, either by the person or someone who has substitute decision making powers, such as a parent, guardian, or if authorised by the “Consent Act” or through an advance care directive;
2. By a Court, such as through its *parens patriae*<sup>20</sup> jurisdiction or by the Youth Court (both are either rare or not applicable to Oakden); or
3. Through Statute, such as occurs under the GAA and the MHA (see previous section this page)

The GAA allows for the authorisation of the use of reasonable force for the purpose of ensuring the proper medical treatment, day-to-day care and wellbeing of the person. Thus the GAA can permit the use of certain restrictive practices, such as seclusion and mechanical restraint under certain circumstances.

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<sup>20</sup> *Parens Patriae*, meaning “parent of the nation” is a term in law that applies when courts take the role of protecting the best interests of a person who cannot do this on their own behalf.

The Review found numerous instances of people who were either voluntary within the meaning of the MHA, or not subject to a section 32 order under the GAA, who were restrained, secluded or detained. There is confusion among staff at Oakden about the proper application of the MHA and the GAA as regards both detention and the use of restrictive practices and the need for a lawful authority to do so.

For example, the Review heard of a consumer who was refused access to a garden area, despite not being subject to any legal order, and numerous instances of consumers not subject to any legal orders, nor consent from a substitute decision maker, who were restrained and or secluded.

These examples not only demonstrate the lack of understanding of the MHA by some staff, it contravenes the principle of least restrictive practice and in some instances, is likely to have been implemented for the convenience of staff and at times for punishment.

#### Finding 6

The Review found that staff working at Oakden did not have the sufficient level of training which would allow them to understand the requirements and restrictions associated with the use and monitoring of restrictive practices.

This lack of training led staff to exercise powers in the use of restrictive practices that were beyond those outlined in the relevant legislation framework.

The Review makes the following finding in relation to Restrictive Practices:

- There has been a failure at Oakden to implement an action plan that utilises trauma informed principles and is consistent with the 6 core strategies and the SA Health Restraint and Seclusion Reduction Policy Directive, the Restraint and Seclusion in Mental Health Services Policy Guideline and Toolkit;
- There has been ongoing, repeated use of restrictive practices at Oakden that has contravened legislation, national standards, state policy and local procedures and likely implemented for staff convenience and or used as punishment;
- There was a lack of leadership towards changing restrictive practices demonstrated by failure to respond to requests or support staff who were attempting to implement positive change;
- When data was eventually collected, as required, it was not used to inform practice or encourage reflection of current practices;
- Staff were not presented with opportunities to engage in training that focused on prevention and de-escalation and or the use of prevention tools;
- There was a lack of reflective practice including the debriefing of staff, consumers or carers following the use of any restrictive practices, this is known to assist in preventing further incidents;

- Consumer and carer roles were not used at Oakden to assist in promoting a consumer centred approach; and
- It is noted that there has been a dramatic decrease in the use of restrictive practices following the recent introduction of management initiated activities.

#### **Recommendation Six**

**The Review recommends that NALHN immediately develop and implement an Action Plan which is based on Trauma Informed Principles and the six core strategies developed by NCTIC.**

**This Action Plan should:**

- **be introduced as soon as possible, and ensure compliance with the *SA Health Restraint and Seclusion Reduction Policy Directive* and *Restraint and Seclusion in Mental Health Services Policy Guideline*;**
- **ensure all staff are aware of the legislative basis for restrictive practices;**
- **feature targets for markedly reduced rates of restrictive practice to be achieved, with milestones along the pathway to this outcome that can be achieved, within the next 3 months;**
- **enlist the assistance of expertise from a range of disciplines that can help rebuild a new approach to the management of severe and persistent challenging behaviours of dementia;**
- **be subject to external peer-review by those who operate similar services where restrictive practices are either rare or have been eliminated; and**
- **include an expectation that unannounced inspections from the Chief Psychiatrist and their office staff will occur to examine restrictive practices.**



## 10. Conclusion

This report is the culmination of a review that has taken 12 weeks. During that time, the Review was immersed in a system that gave all members of the Review little comfort. For each of us, we saw aspects of a mental health system that we had thought confined to history. Sadly, this was not the case.

Many times we were asked “How is it going, it must be hard?” In part, this reflected natural curiosity. But for some, this question was part of a collective knowledge that in some small way they knew that there was something wrong at Oakden, but they did not know what it was and what should be done.

For one member of the Review it brought back a strong association from the past. They had a close relative develop severe early onset Alzheimer’s disease and be admitted to a Psychiatric Hospital in 1982, the same year Oakden opened. For them, the care they saw in 1982, elsewhere for their relative, bore little resemblance to what happens at Oakden today. How could Oakden exist in some parallel world, unable to embrace modern patterns of care? Yet this is what has happened. For Oakden the world has stood still.

The impact of being a stand-alone service, away from the scrutiny of peers, believing one has been cast adrift, and repeatedly faced with evidence of having a limited future with no one championing the cause for change cannot be underestimated.

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.

## Appendix One

### Terms of Reference



Government of South Australia  
SA Health

## TERMS OF REFERENCE OLDER PERSONS MENTAL HEALTH SERVICES – OAKDEN CAMPUS

<b>PURPOSE</b>	To conduct a review of the older persons mental health service at Oakden Campus Oakden with the purpose of making recommendations about the management, culture and standards of care in 2016.
<b>KEY POINTS TO NOTE</b>	<ul style="list-style-type: none"> <li>• The older persons mental health service at Oakden Campus provides transitional and extended care for mentally ill older residents with challenging behaviours.</li> <li>• The wards located at Oakden are known as Makk, McLeay and Clements and attract 55 Commonwealth bed licences.</li> <li>• The Clements ward is a state-wide transitional care service providing a holistic, multi-disciplinary, short term rehabilitation service, following an acute admission. It provides 24 hour specialist mental health care for residents who require mental health nursing support and rehabilitation support to enable residents to move to a residential care facility, other supported accommodation, or their own home.</li> <li>• The Makk and McLeay wards provide a statewide specialist mental health and geriatric residential care for its residents, whose challenging behaviours have prevented them from residing in mainstream aged care facilities.</li> </ul>
<b>REVIEW TEAM</b>	<p>The review team will consist of:</p> <ul style="list-style-type: none"> <li>• Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing</li> <li>• Professor Nicholas Procter, University of South Australia</li> <li>• Dr Duncan McKellar, Central Adelaide Local Health Network</li> <li>• Ms Del Thompson, Clinical Risk Manager, Office of the Chief Psychiatrist</li> </ul>
<b>ROLE of REVIEW TEAM</b>	<ul style="list-style-type: none"> <li>• The review will be limited to the Older Persons Mental Health Service at Oakden, focussing on that service during the 2016 calendar year.</li> <li>• The team will consider, review and make recommendations about the:             <ul style="list-style-type: none"> <li>○ current Model of Care, and whether there are variations in practice to the model and if the model is aligned with current best practice standards for delivery of care for older persons</li> </ul> </li> </ul>

	<p>with a mental illness.</p> <ul style="list-style-type: none"> <li>○ current staffing model and whether this aligns with the optimal staffing required for the Model of Care;</li> <li>○ current risk management and risk mitigation practices being undertaken to ensure they align with SA Health standards and national best practice in care for older persons with a mental illness;</li> <li>○ cultural practices currently occurring; and</li> <li>○ use of restrictive practice, to ensure it is in line with the <i>SA Health Restraint and Seclusion Reduction Policy Directive</i> and <i>Restraint and Seclusion in Mental Health Services Policy Guideline</i></li> </ul>
<b>GOVERNANCE</b>	The report of the review will be submitted to the Chief Executive Officer, Northern Adelaide Local Health Network
<b>TIMEFRAME</b>	The panel will aim to conclude the review within 8 weeks after interviews with staff have concluded.

## Appendix Two

### Mental Health Act 2009 – Chief Psychiatrist

#### Division 2—Chief Psychiatrist

##### 89—Chief Psychiatrist

- (1) There will be a position of Chief Psychiatrist.
- (2) The Governor may appoint a senior psychiatrist to the position of Chief Psychiatrist.
- (3) The terms and conditions of appointment to the position of Chief Psychiatrist will be as determined by the Governor.

##### 90—Chief Psychiatrist's functions

- (1) The Chief Psychiatrist has the following functions:
  - (a) to promote continuous improvement in the organisation and delivery of mental health services in South Australia;
  - (b) to monitor the treatment of voluntary inpatients and involuntary inpatients, and the use of mechanical body restraints and seclusion in relation to such patients;
  - (c) to monitor the administration of this Act and the standard of psychiatric care provided in South Australia;
  - (d) to advise the Minister on issues relating to psychiatry and to report to the Minister any matters of concern relating to the care or treatment of patients;
  - (e) any other functions assigned to the Chief Psychiatrist by this Act or any other Act or by the Minister.
- (2) The Chief Psychiatrist may, with the approval of the Minister, issue standards that are to be observed in the care or treatment of patients.
- (3) Any standards issued by the Chief Psychiatrist under this section will be—
  - (a) binding on any hospital that is an incorporated hospital under the *Health Care Act 2008*; and
  - (b) binding as a condition of the licence in force in respect of any private hospital premises under Part 10 of the *Health Care Act 2008*.
- (4) The Chief Psychiatrist will—
  - (a) have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act 2008*; and
  - (b) be taken to be an inspector under Part 10 of the *Health Care Act 2008*.

##### 91—Delegation by Chief Psychiatrist

- (1) The Chief Psychiatrist may delegate a power or function of the Chief Psychiatrist under this Act to a particular person or to the person for the time being performing particular duties or holding or acting in a particular position.
- (2) A power or function delegated under this section may, if the instrument of delegation so provides, be further delegated.

- (3) A delegation under this section—
- (a) may be absolute or conditional; and
  - (b) does not derogate from the power of the delegator to act in a matter; and
  - (c) is revocable at will by the delegator.

## Appendix Three

### Biographical Statements

**Dr Aaron Groves** commenced in the role of Chief Psychiatrist of South Australia in February 2015. The role of Chief Psychiatrist in South Australia as defined under S90 of the *Mental Health Act 2009* (the Act) includes the promotion of continuous improvement in the organisation and delivery of mental health services, monitoring the treatment of voluntary and involuntary inpatients as well as the administration of the Act.

In this role, Dr Groves is leading the implementation of the use of trauma informed practices in mental health service settings, initiatives to reduce the use of restraint and seclusion and the implementation of a new approach to suicide prevention known as 'Connecting with People'. At a national level Dr Groves is the South Australian member of the Mental Health Drug and Alcohol Principal Committee, the Safety and Quality Partnership Standing Committee and the Board of *beyondblue*.

Dr Groves' previous appointments include, Director of Mental Health, Queensland (same as the Chief Psychiatrist) from 2005-2012 and the Chief Psychiatrist and then Director of Mental Health for Western Australia from 2001-2005. During this time Dr Groves was involved in the development of the Third and Fourth National Mental Health Plans and a number of components of the National Mental Health Strategy. In particular, he Chaired the Safety and Quality Partnership Standing Committee that developed the 'National Safety Priorities in Mental Health: a national plan for reducing harm'

**Professor Nicholas Procter** PhD MBA GradDip Adult Ed BA CertAdvClinNsg RN, is Chair: Mental Health Nursing and leader of the Mental Health and Substance Use Research group at the University of South Australia. For several years he has conducted independent mental health service reviews and evaluations in both Australia and overseas. He has researched and published widely in the area of older person's mental health, including contributions to all three volumes of the *Encyclopaedia of Elder Care* (Springer: New York). As a three time recipient of the University Chancellor's Award for Excellence in Community Engagement, and author of *Mental Health: A Person Centered Approach* (Cambridge University Press, 2014), being closely connected to practice drives research innovation. With Cambridge University Press the oldest publishing house in the world, it was the first mental health nursing title by this publisher in 500 years. A second edition is currently in preparation. Professor Procter is a licenced trainer with the UK based *Connecting with People* suicide prevention and mitigation program, and has completed advanced training as a Psychological Autopsy Investigator with the American Association of Suicidology.

**Duncan McKellar** is a consultant older persons' psychiatrist working with the Older Persons' Mental Health Service in the Central Adelaide Local Health Network. He is a Fellow of the RANZCP and a member of the Faculty of Psychiatry of Old Age (FPOA). He currently represents the FPOA as a member of the RANZCP SA Branch Committee.

In his current role he works in an integrated model providing clinical care to older people in the community and in the acute older persons' inpatient mental health unit at The Queen Elizabeth



Hospital. He has previously worked as a consultant psychiatrist with Eastern Community Mental Health, adult services.

Duncan has a keen interest in helping older people and their families manage ageing well. He also has an interest in palliative care and in 2014 won the Faculty of Psychiatry of Old Age scholarly project prize for his research exploring old age psychiatrist's perspectives on working with people approaching the end-of-life.

**Del Thomson** is a Registered Nurse and Mental Health Nurse. She has worked in the public health system since 1980 and specifically in mental health since 1989, across central and southern Adelaide, in inpatient and community settings, adult and older persons services. She is an experienced clinician who has delivered direct care, managed teams, developed and delivered education and training, facilitated consumer and carer involvement in services and represented mental health both locally and nationally.

In 2007 she was the Project Lead representing Southern Adelaide for the National Beacon Project; reducing and where possible eliminating the use of restraint and seclusion in mental health, including participation in the study tour visiting comparative facilities in the United States. In 2009 Del commenced work in the then Mental Health Unit and assisted in the implementation of the *Mental Health Act 2009* and development of the first Office of the Chief Psychiatrist (OCP) in South Australia under Dr Margaret Honeyman AM.

As the Senior Project Officer for the reduction of restraint and seclusion Del was and remains the SA representative on the National Restrictive Practices Working Group and the National Seclusion and Restraint Data Working Group.

Currently Del is the Clinical Risk Manager for the OCP. She has assisted, as the SA representative in the Australian Commission on Safety and Quality in Health Care (NSQHS) review of Medication Safety and Clinical Deterioration in mental health and has extensive experience in the investigation of complaints and incidents as a delegated inspector under the *Mental Health Act 2009*.

## Appendix Four

### Letters to Families of Consumers at Oakden



**Government of South Australia**  
**SA Health**

Office of the Chief  
Psychiatrist

8th floor  
CitiCentre Building  
11 Hindmarsh Square  
Adelaide SA 5000  
PO Box 287 Rundle Mall  
Adelaide SA 5000  
DX 243  
Tel 08 8226 1091  
Fax 08 8226 6235  
ABN 97 643 356 590  
[www.health.sa.gov.au](http://www.health.sa.gov.au)

Dear

#### **Open Letter to Families, Carers and Friends of People who resided in Oakden Older Persons Mental Health Service in 2016**

I have been given your details as someone who may wish to provide information to the team I am leading undertaking the review into the Oakden Older Persons Mental Health Service (OPMHS). I hope, that by now, you will be aware that a review of care provided at the Oakden OPMHS service has commenced.

I would like to invite you to attend a meeting in relation to this review. The meeting has been scheduled for:

**Tuesday the 14<sup>th</sup> February at 9.30AM**  
**Public Advocates Office**  
**Level 7, ABC Building**  
**85 North East Road, Collinswood**

The review of mental health services at Oakden has been commissioned by Ms Jackie Hanson, the Chief Executive Officer of the Northern Adelaide Local Health Network. As Chief Psychiatrist, I have some powers under s90 of the *Mental Health Act, 2009* to conduct independent reviews and investigations of any mental health services and facilities in South Australia.

In this instance I have a review team to assist me. The team consists of:

- Professor Nicholas Procter, Chair of Mental Health Nursing in SA and Head of Mental Health Nursing at Uni SA.
- Dr Duncan McKellar, Psychogeriatrician from Central Adelaide Local Health Network.
- Ms Del Thomson, Clinical Risk Manager of the Office of the Chief Psychiatrist

The review involves a four week period during which we will be gathering information from a variety of sources to be followed by an eight week period of collating, assessing and writing up our findings. We will be considering the model of care being used; staffing levels, risk management and risk mitigation processes and whether any use of restrictive practices such as restraints used, are in line with best practice and current SA policy.

I would strongly value your comments on the quality of care you believe has been provided, both positive and negative; the information you receive in relation to your loved ones progress and care; the quality and timeliness of response to any concerns you may have raised and; any other information you believe the should be raised with the review team.

If you are unable to attend on February 14<sup>th</sup>, please contact Del on 70871246 or email [del.thomson@sa.gov.au](mailto:del.thomson@sa.gov.au) and we can arrange a time to suit you or you may wish to provide a written response.

This can be forwarded via email to [del.thomson@sa.gov.au](mailto:del.thomson@sa.gov.au) or by post to: Aaron Groves, Chief Psychiatrist, P.O. Box 287, Rundle Mall, Adelaide, SA, 5000.

Best Wishes

**Dr Aaron Groves**  
**Chief Psychiatrist**

01/02/17



File: 2011-09272  
Ref No:eA962068

Dear

**Update to Families, Carers and Friends of People who reside(d) in Oakden Older Persons Mental Health Service in 2016**

I wrote to you on 9 February 2017 about the Oakden Review of Mental Health Services for Older People I would like to update you about the review.

As you may recall I had arranged for us to have an opportunity to meet on 15 February 2007. On that day, Dr Duncan McKellar, Psychogeriatrician from Central Adelaide Local Health Network, Ms Del Thomson, Clinical Risk Manager of the Office of the Chief Psychiatrist and I met with 17 family members, friends and carers of people who are or have recently resided at Oakden Campus.

We were joined by Ms Lydia Dennett, Chief Nurse and Midwifery Officer of South Australia and two officers from the Office of the Public Advocate.

At the commencement of the meeting, Ms Jackie Hanson, Chief Executive Officer of the Northern Adelaide Local Health Network (NALHN) who commissioned the review, addressed the group to inform those who could make the meeting of changes to the Older Persons Mental Health Services that she has already implemented. This includes the provision of a Clinical Pharmacist to assist with the complex prescribing of medicines for people with dementia and / or a mental illness and other physical illnesses. In addition, Ms Hanson advised that she has engaged senior clinical nurses to provide focused clinical leadership after hours and on weekends. In addition she has committed to individually look into any matters from friends or relatives of residents in Oakden and she provided a fact sheet which I have attached to this letter about how to make contact.

My whole team is very grateful for the time those present at the meeting spent with us. While the feedback and issues raised at the meeting highlighted some positive examples of staff care and compassion many experiences shared were distressing and at times disturbing to all present. I cannot thank those who attended enough for their willingness to share their stories openly and honestly with us.

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In addition I have also received some individual feedback in person from two carers, a written submission, emails with examples and comments and phone calls from others. These have also been valuable contributions that will assist with the review.

I have attached the Terms of Reference for the review and I encourage you to continue to send in any information you believe would be relevant to the review. This can be forwarded via email to [del.thomson@sa.gov.au](mailto:del.thomson@sa.gov.au) or by post to: Aaron Groves, Chief Psychiatrist, P.O. Box 287, Rundle Mall, Adelaide, SA, 5000.

For those who would like an opportunity to meet with the review team please contact Del on 70871246 or email [del.thomson@sa.gov.au](mailto:del.thomson@sa.gov.au) and we can arrange a time to suit you.

I hope to conclude the review and provide a report to Ms Hanson and the Minister for Mental Health and Substance Abuse in early April 2017.

Best Wishes

A handwritten signature in black ink, appearing to read 'A. Groves', written in a cursive style.

**Dr Aaron Groves**  
**Chief Psychiatrist**

20/02/17



## Appendix Five

### Document Register

#### Occupational Health and Safety

Document ID	Document Title	Date of Document
CP-OKREV-002	WHS Leisure and Lifestyle Checklist	11 February 2016
CP-OKREV-003	WHS Vehicle Inspection	11 February 2016
CP-OKREV-014	WHS Admin Checklist	14 October 2016
CP-OKREV-022	Attachment 4 – Makk & McLeay Re-accreditation Audit	2 February 2016
CP-OKREV-028	Copy of Clinical and Nursing Checklist	26 August 2016
CP-OKREV-050	Northern MH WHS&IM January 2017 Report	17 February 2017
CP-OKREV-051	WH Clinical& Nursing Checklist	13 February 2016
CP-OKREV-052	WH Clinical& Nursing Checklist	7 August 2016
CP-OKREV-062	WSSI Work Kitchens	13 June 2016
CP-OKREV-092	Oakden Risk Report – Inadequate Medical Staff	July 2014
CP-OKREV-093	Final Audit Report Challenging Behaviour NALHN – email	24 June 2016
CP-OKREV-094	WHS Injury Prevention Internal Audit Report – Challenging Behaviours	20 May 2016
CP-OKREV-095	WHS Injury Prevention Internal Audit Program – Challenging Behaviour	February 2016
CP-OKREV-096	WHSIM Internal Audit Feedback Questionnaire	
CP-OKREV-097	Final Audit Report Remote or Isolated Work Safety NALHN – email	13 November 2015
CP-OKREV-098	WHS Injury Prevention Report – Remote or Isolated Work Safety	3 November 2015
CP-OKREV-099	WHS Injury Prevention Internal Audit Program – Remote or Isolated Work	September 2015
CP-OKREV-100	WHS Corrective Action Request 1 – Remote or Isolated Work	13 November 2015
CP-OKREV-101	WHS Corrective Action Request 2 – Remote or Isolated Work	13 November 2015

#### Accreditation

Document ID	Document Title	Date of Document
CP-OKREV-004	Briefing to MHSA from CEO NALHN re Commonwealth Accreditation –Word version	31 January 2017
CP-OKREV-005	Briefing to MHSA from CEO NALHN re Commonwealth Accreditation – PDF	06 February 2017
CP-OKREV-029	Copy of Letter NALHN Makk & McLeay Revised Allocation	13 February 2017
CP-OKREV-030	Copy of Revised Schedule of Conditions Makk & McLeay 15 Places	1 March 2017
CP-OKREV-031	Copy of Revised Schedule of Conditions Makk & McLeay 40 Places	1 March 2017
CP-OKREV-037	Makk and McLeay Nursing Home Commonwealth Outcome of Audit	2 March 2016
CP-OKREV-046	NALHN-315895 Not Met Report	2 December 2016
CP-OKREV-001	Draft Review-Mental Health	1 February 2017

## Legislation

Document ID	Document Title	Date of Document
CP-OKREV-006	Aged Care Accountability Principles 2014	24 June 2014
CP-OKREV-013	Additional Guidance – Care and Services in Aged Care Homes	Not dated
CP-OKREV-015	Aged Care (Transitional Provisions) Principles 2014	27 June 2014
CP-OKREV-057	Sanctions Principles	20 June 2014
CP-OKREV-061	User Rights Principles 2014	23 June 2014

## OPMHS Committee Papers

Document ID	Document Title	Date of Document
CP-OKREV-007	Action Plan – OPMHS Governance Committee	11 April 2016
CP-OKREV-008	Action Plan – OPMHS Governance Committee	8 February 2016
CP-OKREV-009	Action Plan – OPMHS Governance Committee	12 September 2016
CP-OKREV-010	Action Plan – OPMHS Governance Committee	14 November 2016
CP-OKREV-011	Action Plan – OPMHS Governance Committee	24 October 2016
CP-OKREV-012	Action Plan – OPMHS Governance Committee	9 November 2015
CP-OKREV-016	Agenda OPMHS Governance Committee	9 November 2015
CP-OKREV-017	Agenda OPMHS Governance Committee	8 February 2016
CP-OKREV-018	Agenda OPMHS Governance Committee – word version	11 April 2016
CP-OKREV-019	Agenda OPMHS Governance Committee – pdf version	11 April 2016
CP-OKREV-020	Agenda OPMHS Governance Committee	14 November 2016
CP-OKREV-021	Agenda OPMHS Governance Committee	24 October 2016
CP-OKREV-040	Minutes OPMH Governance Committee	12 September 2016
CP-OKREV-041	Minutes OPMHS Governance Committee	24 October 2016
CP-OKREV-042	Minutes OPMHS Governance Committee	11 April 2016
CP-OKREV-043	Minutes OPMHS Governance Committee	8 February 2016
CP-OKREV-044	Minutes OPHMS Governance Committee	9 November 2015
CP-OKREV-045	Minutes OPMHS Governance Committee	14 November 2016
CP-OKREV-053	Minutes Residents and Reps Meeting	15 April 2016
CP-OKREV-054	Minutes Residential and Reps Meeting	13 January 2016
CP-OKREV-055	Minutes Residential and Reps Meeting	6 July 2016
CP-OKREV-056	Minutes Residential and Reps Meeting	19 October 2016

## Human Resources

Document ID	Document Title	Date of Document
CP-OKREV-034	Job and Person Specification – Nursing Director	2 July 2014
CP-OKREV-035	Job and Persons Specification – Nursing Director Clinical Practice	2 August 2011
CP-OKREV-048	NALHN MHD CPC JP Inpatient Units	14 November 2014
CP-OKREV-049	NALHN MHD CSC J&P Inpatient Units	14 November 2014
CP-OKREV-060	Updated Clinical Director Job and Person Specification	1 November 2015
CP-OKREV-058	SMP MDP4G Job and Person Specification	2014
CP-OKREV-032	Discussion Paper MH Division Leadership Restructure	15 December 2016
CP-OKREV-136	OPMHS Training Topics – Core and Elective	March 2017



## Union Submissions / Copy of documents provided by Union representatives

Document ID	Document Title	Date of Document
CP-OKREV-063	Copy of Letter to SASMOA re Aged MH Services Consultative Committee	6 March 2009
CP-OKREV-064	Copy of CNAHS Presentation MH Aged Care Transitions	13 February 2009
CP-OKREV-065	Agenda Aged Mental Health Care Services Consultative Committee	18 March 2009
CP-OKREV-066	OPMH Service Reforms Major Milestones Draft	Not dated
CP-OKREV-067	Letter to SASMOA re Older Persons Mental Health Reform Consultative Committee	1 March 2011
CP-OKREV-068	Older Persons Mental Health Reform Consultative Committee Terms of Reference Draft	April 2011
CP-OKREV-069	Contacts for the Older Persons Mental Health Services Reform Consultative Committee	March 2011
CP-OKREV-070	Older Persons Mental Health Service Reforms Presentation – OPHMHS Consultative Committee	17 March 2011
CP-OKREV-071	Older Persons Mental Health Services Reform Major Milestones Draft	Not dated
CP-OKREV-072	OPMHS Staffing in Adelaide Health Service	Date obscured
CP-OKREV-073	OPMHS Staffing in Adelaide Health Service	May 2011
CP-OKREV-074	Minutes - AHS Older Persons Mental Health Services Reform Consultative Committee	6 May 2011
CP-OKREV-075	Minutes - AHS Older Persons Mental Health Services Reform Consultative Committee	17 June 2011
CP-OKREV-076	Papers Older Persons Mental Health Services Reform Consultative Committee	19 August 2011
CP-OKREV-077	Minutes - AHS Older Persons Mental Health Services Reform Consultative Committee	18 November 2011
CP-OKREV-078	OPMHS staff in Adelaide Metro Mental Health Directorate	August 2011
CP-OKREV-079	Comparison of Current OPMHS Community Staffing with 2017-18 Final Build Up	Not dated
CP-OKREV-080	Letter to SASMOA – re Consultations with Southern OPMHS on Future Staffing for Community Team	1 February 2012
CP-OKREV-081	Mental Health Services for Older Persons Staffing	Not dated
CP-OKREV-082	Letter to SASMOA – Older Persons Mental Health Service Model of Service	11 April 2012
CP-OKREV-083	Letter to SASMOA – Older Persons Mental Health Service Model of Service	1 August 2012
CP-OKREV-084	Minutes - AHS Older Persons Mental Health Services Reform Consultative Committee	24 August 2012
CP-OKREV-085	Minutes - AHS Older Persons Mental Health Services Reform Consultative Committee	8 February 2013
CP-OKREV-086	Letter from SASMOA to David Davies re Older Persons Mental Health Service Reform	13 May 2013
CP-OKREV-087	Letter to SASMOA re Older Persons Mental Health Reform	3 June 2013
CP-OKREV-088	Letter to SASMOA re Older Persons Mental Health Reform	20 May 2014
CP-OKREV-089	Email from SASMOA to Leonie Nowland re OMHS Consultative Communications documents	12 May 2014

Document ID	Document Title	Date of Document
CP-OKREV-102	Draft Memo – Medical Risks at Oakden Campus	7 July 2014
CP-OKREV-103	Risk Register - Draft	Not dated
CP-OKREV-104	Aged Mental Health Care Services – Consultative Committee – TOR Final Draft Approved	15 April 2009
CP-OKREV-105	Oakden Staff Survey Results	12 March 2012
CP-OKREV-106	EOI – Delivery of Non-Acute Inpatient Services for Older Mental Health Consumers	Not dated

### Submissions by Family Members of Residents & Consumer Feedback

Document ID	Document Title	Date of Document
CP-OKREV-107	Submission – C Doran	12 February 2017
CP-OKREV-025	Consumer Feedback 2015-16 General Listing Report	30 December 2016
CP-OKREV-026	Consumer Feedback 2015-16 Pie Chart by Subject	30 December 2016
CP-OKREV-027	Consumer Feedback by Location Exact – Graph	30 December 2016

### Documents received from CVS

Document ID	Document Title	Date of Document
CP-OKREV-115	CVS Report – Visit to Oakden OPMHS	18 January 2016
CP-OKREV-116	CVS Report – Visit to Oakden OPMHS	15 February 2016
CP-OKREV-117	CVS Report – Visit to Oakden OPMHS	21 March 2016
CP-OKREV-118	CVS Report – Visit to Oakden OPMHS	28 April 2016
CP-OKREV-119	CVS Report – Visit to Oakden OPMHS	23 May 2016
CP-OKREV-120	CVS Report – Visit to Oakden OPMHS	22 June 2016
CP-OKREV-121	CVS Report – Visit to Oakden OPMHS	25 July 2016
CP-OKREV-122	CVS Report – Visit to Oakden OPMHS	26 August 2016
CP-OKREV-123	CVS Report – Visit to Oakden OPMHS	19 September 2016
CP-OKREV-124	CVS Report – Visit to Oakden OPMHS	27 October 2016
CP-OKREV-125	CVS Report – Visit to Oakden OPMHS	17 November 2016
CP-OKREV-126	CVS Report – Visit to Oakden OPMHS	14 December 2016
CP-OKREV-127	CVS Report – Visit to Oakden OPMHS	19 January 2017
CP-OKREV-128	CVS Report – Visit to Oakden OPMHS	16 February 2017
CP-OKREV-129	Copy of email from NALHN to CVS	18 July 2016
CP-OKREV-130	Copy of email from CVS to NALHN	6 September 2016
CP-OKREV-131	Copy of email from NALHN to CVS	15 September 2016
CP-OKREV-132	Copy of email from CVS to NALHN	10 October 2016
CP-OKREV-133	Copy of email from CVS to NALHN	21 November 2016
CP-OKREV-134	Copy of email from CVS to NALHN	16 January 2017
CP-OKREV-135	Copy of email from CVS to NALHN	31 January 2017

Document ID	Document Title	Date of Document
CP-OKREV-023	Clements Daily Stats Sheet	1 March 2017
CP-OKREV-024	Clements House Consumer Journey Board	14 March 2017
CP-OKREV-036	Makk House Daily Stats Sheet	1 March 2017
CP-OKREV-039	McLeay Daily Stats Sheet	1 March 2017
CP-OKREV-110	Clements House – Daily stat sheet	19 February 2017
CP-OKREV-111	Makk House – Daily stat sheet	19 February 2017
CP-OKREV-112	McLeay House – Daily stat sheet	13 February 2017

<b>Document ID</b>	<b>Document Title</b>	<b>Date of Document</b>
CP-OKREV-059	Toryzn D – Oakden Throughput	31 December 2016

CP-OKREV-033	Australasian Health Facility Guidelines – Part B	1 March 2016
CP-OKREV-038	Internal Audit Report – Management of resident fees – Oakden Campus	28 October 2016
CP-OKREV-047	NALHN Governance Framework	October 2015
CP-OKREV-090	Oakden OPMHS Internal Memo Inappropriate documentation	8 February 2017
CP-OKREV-091	Anonymous Letter	24 November 2016
CP-OKREV-109	Northgate Powerpoint	
CP-OKREV-113	Email from Chief Operating Officer – Christmas and New Year Arrangements across NALHN – copy attached to RD email	13 December 2016
CP-OKREV-114	NALHN Bed arrangements – attached to RD email	December 2016

## Appendix Six

### *Mental Health Act 2009 – Principal Community Visitor & Community Visitor Scheme*

#### **Division 2—Community visitor scheme**

##### **50—Community visitors**

- (1) There will be a position of Principal Community Visitor.
- (2) There will be such number of positions of Community Visitor as the Governor considers necessary for the proper performance of the community visitors' functions under this Division.
- (3) A person will be appointed to the position of Principal Community Visitor, or a position of Community Visitor, on conditions determined by the Governor and for a term, not exceeding 3 years, specified in the instrument of appointment and, at the expiration of a term of appointment, will be eligible for reappointment.
- (4) However, a person must not hold a position under this section for more than 2 consecutive terms.
- (5) The Governor may remove a person from the position of Principal Community Visitor, or a position of Community Visitor, on the presentation of an address from both Houses of Parliament seeking the person's removal.
- (6) The Governor may suspend a person from the position of Principal Community Visitor, or a position of Community Visitor, on the ground of incompetence or misbehaviour and, in that event—
  - (a) a full statement of the reason for the suspension must be laid before both Houses of Parliament within 3 sitting days of the suspension; and
  - (b) if, at the expiration of 1 month from the date on which the statement was laid before Parliament, an address from both Houses of Parliament seeking the person's removal has not been presented to the Governor, the person must be restored to the position.
- (7) The position of Principal Community Visitor, or a position of Community Visitor, becomes vacant if the person appointed to the position—
  - (a) dies; or
  - (b) resigns by written notice given to the Minister; or
  - (c) completes a term of appointment and is not reappointed; or
  - (d) is removed from the position by the Governor under subsection (5); or
  - (e) becomes bankrupt or applies as a debtor to take the benefit of the laws relating to bankruptcy; or
  - (f) is convicted of an indictable offence or sentenced to imprisonment for an offence; or
  - (g) becomes a member of the Parliament of this State or any other State of the Commonwealth or of the Commonwealth or becomes a member of a Legislative Assembly of a Territory of the Commonwealth; or
  - (h) becomes, in the opinion of the Governor, mentally or physically incapable of performing satisfactorily the functions of the position.

- (8) The Minister may appoint a person to act in the position of Principal Community Visitor—
  - (a) during a vacancy in the position; or
  - (b) when the Principal Community Visitor is absent or unable to perform the functions of the position; or
  - (c) if the Principal Community Visitor is suspended from the position under subsection (6).

## **51—Community visitors' functions**

- (1) Community visitors have the following functions:
  - (a) to conduct visits to and inspections of treatment centres as required or authorised under this Division;
  - (b) to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body;
  - (c) to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act;
  - (d) any other functions assigned to community visitors by this Act or any other Act.
- (2) The Principal Community Visitor has the following additional functions:
  - (a) to oversee and coordinate the performance of the community visitors' functions;
  - (b) to advise and assist other community visitors in the performance of their functions, including the reference of matters of concern to the Minister, the Chief Psychiatrist or any other appropriate person or body;
  - (c) to report to the Minister, as directed by the Minister, about the performance of the community visitors' functions;
  - (d) any other functions assigned to the Principal Community Visitor by this Act or any other Act.

## **52—Visits to and inspection of treatment centres**

- (1) Each treatment centre must be visited and inspected once a month by 2 or more community visitors.
- (2) 2 or more community visitors may visit a treatment centre at any time.
- (3) On a visit to a treatment centre under subsection (1), the community visitors must—
  - (a) so far as practicable, inspect all parts of the centre used for or relevant to the care, treatment or control of patients; and
  - (b) so far as practicable, make any necessary inquiries about the care, treatment and control of each inpatient; and
  - (c) take any other action required under the regulations.
- (4) After any visit to a treatment centre, the community visitors must (unless 1 of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the community visitors think appropriate.

- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.
- (7) A community visitor will, for the purposes of this Division—
  - (a) have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act 2008*; and
  - (b) be taken to be an inspector under Part 10 of the *Health Care Act 2008*.

### **53—Requests to see community visitors**

- (1) A patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act may make a request to see a community visitor.
- (2) If such a request is made to the director of a treatment centre in which the patient is an inpatient, the director must advise a community visitor of the request within 2 days after receipt of the request.

### **54—Reports by Principal Community Visitor**

- (1) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the work of the community visitors during the financial year ending on the preceding 30 June.
- (2) The Minister must, within 6 sitting days after receiving a report under subsection (1), have copies of the report laid before both Houses of Parliament.
- (3) The Principal Community Visitor may, at any time, prepare a special report to the Minister on any matter arising out of the performance of the community visitors' functions.
- (4) Subject to subsection (5), the Minister must, within 2 weeks after receiving a special report, have copies of the report laid before both Houses of Parliament.
- (5) If the Minister cannot comply with subsection (4) because Parliament is not sitting, the Minister must deliver copies of the report to the President and the Speaker and the President and the Speaker must then—
  - (a) immediately cause the report to be published; and
  - (b) lay the report before their respective Houses at the earliest opportunity.
- (6) A report will, when published under subsection (5)(a), be taken for the purposes of any other Act or law to be a report of the Parliament published under the authority of the Legislative Council and the House of Assembly.

## Appendix Seven

### Community Visitor Scheme Reports 2016-17

Date of Visit	Summary of Issues and/or Concerns Raised	Summary of Outcome
18/1/2016	One staff member on suspension while under SAPOL investigation Limited allied health – no psychologist, OT	
15/2/2016	High level of incident reports for seclusion, restraint No development on obtaining an OT	
21/3/2016	Allied health – still no OT or psychologist Communication issues with staffing as 2 senior staff have gone on leave	Allied health matter raised by a staff member who is attempting to rectify it No further information on staff member on suspension
28/4/2016	Allied health – still no OT, psychologist or SW	No further information on staff member on suspension
23/5/2016	Allied health – no progress on filling psychologist, SW, OT Second staff member suspended Concern about initial level of care provided to consumer who had been recently been transferred	No further information on staff member on suspension
22/6/2016	Staff commented that communal areas in Clements large, noisy, not conducive to quality care Consumer concerns – bruising, locked in room, toileting Allied health positions remain vacant	[name withheld] responded immediately: origin of bruising unknown but did not appear consistent with rough handling; moving consumer to unlocked room was attempt to settle him but practice ceased when he became agitated; the longest he has gone without toileting is one hour. CVs satisfied with responses. No further information on two staff members on suspension 0.4FTE psychologist position to be advertised shortly 0.4 and 0.6FTE have become available for OT and SW respectively Transitional Care Coordinator has been instrumental in placing consumers in mainstream aged care facilities



Date of Visit	Summary of Issues and/or Concerns Raised	Summary of Outcome
25/7/2016	<p>Consumer concerned he was not assisted to go for walks Allied health – no OT or SW on site</p>	<p>[name withheld<sup>21</sup>] explained consumer requires assistance from 2 staff members for walks; some staff are hesitant due to receiving injuries from consumer. Consumer's 'favourite' staff assist daily where possible.</p> <p>Allied health – physio from LMH visits weekly, alternating between Clements and Makk/McLeay. Transitional Care Coordinator continues to place consumers in mainstream aged care facilities where appropriate. No action taken on OT, SW positions. Psychiatrist position advertised but not filled.</p>
26/8/2016	<p>3 patients observed with bruising on their heads caused by falls, personal/hygiene needs One patient not dressed appropriately (not wearing a bra – missing) Lack of allied health besides dietitian Inadequate staffing levels to meet high needs patients' requirements 3 staff remain suspended</p>	<p>[name withheld] to [name withheld], 15/09/2016<sup>22</sup>: OT: Currently referring individual consumers for OT assessments to Ward 1H OT for assessment on a needs basis.</p> <p>SW: Currently reviewing funding to source a Social Worker for Oakden Campus. Transitional Care Coordinator has been successful with organising Aged Care placement for many consumers and residents.</p> <p>Physio: Oakden Physiotherapist is due to return from maternity leave in November 2016. Referrals currently being made through 'Therapy solutions'. Enquired with the Lyell McEwin Physio department to seek additional supports. Currently awaiting response.</p>
19/9/2016	<p>Lack of stimulation and diversionary therapy due to inadequate staffing levels Falls occurring unobserved due to staffing levels Environment run-down, needs upgrading Lack of allied health besides part-time</p>	<p>A/CSC negotiating with union to change shift times to increase staffing levels during day</p> <p>No further information about three staff who have been suspended</p>

<sup>21</sup> All names contained within this table have been withheld by Review.

<sup>22</sup> There was only one occasion during 2016 where a written response was provided by NALHN to concerns raised by the Community Visitor.

Date of Visit	Summary of Issues and/or Concerns Raised	Summary of Outcome
	dietitian No car attached to the facility Carer feedback not resolved	
27/10/2016	Low staffing levels = reduced interaction and meaningful activities Cultural needs unmet – lack of interpreters, cultural connection for Indigenous consumer Environment sparse and tired One visiting room also used for storage (unsafe) Consumers observed with bruises from falls	Staff advise no resources available to make improvements for issues raised
17/11/2016	Limited allied health support – no OT, SW, psychiatrist Blood stains observed on a consumer’s pillow (followed up during visit) Inadequate staffing levels	Filling SW position is now on the radar. Physio gap being filled one day a week through NALHN.  Blood stains – consumer had fallen previously and blood had come from a wound on patient’s head.
14/12/2016	Building tired, needs updating	
19/1/2017	2 staff members currently suspended	
16/2/2017	Environment’s ambience/atmosphere still listed as not conducive to quality care	Issues described are referred to PCV for information

## Appendix Eight

### Guardianship and Administration Act 1983

#### Division 3—The Public Advocate

##### 18—The Public Advocate

There will be a Public Advocate.

##### 19—Appointment of Public Advocate

- (1) The Governor may, by notice published in the Gazette, appoint a person to be the Public Advocate.
- (2) Subject to this Act, the terms and conditions of appointment and employment (including salary and allowances) of the Public Advocate will be as determined by the Governor.

##### 20—Term of office of Public Advocate etc

- (1) The Public Advocate will be appointed for a term of office of five years and, on the expiration of a term of office, is eligible for reappointment.
- (2) The office of Public Advocate becomes vacant if the Public Advocate—
  - (a) dies; or
  - (b) completes a term of office and is not reappointed; or
  - (c) resigns by notice in writing to the Governor; or
  - (d) is removed from office by the Governor under subsection (3).
- (3) The Governor may remove the Public Advocate from office for—
  - (a) mental or physical incapacity to carry out official duties satisfactorily; or
  - (b) neglect of duty; or
  - (c) dishonourable conduct.

##### 21—General functions of Public Advocate

- (1) The functions of the Public Advocate are—
  - (a) to keep under review, within both the public and the private sector, all programmes designed to meet the needs of mentally incapacitated persons;
  - (b) to identify any areas of unmet needs, or inappropriately met needs, of mentally incapacitated persons and to recommend to the Minister the development of programmes for meeting those needs or the improvement of existing programmes;
  - (c) to speak for and promote the rights and interests of any class of mentally incapacitated persons or of mentally incapacitated persons generally;
  - (d) to speak for and negotiate on behalf of any mentally incapacitated person in the resolution of any problem faced by that person arising out of his or her mental incapacity;

- (e) to give support to and promote the interests of carers of mentally incapacitated persons;
  - (f) to give advice on the powers that may be exercised under this Act in relation to mentally incapacitated persons, on the operation of this Act generally and on appropriate alternatives to taking action under this Act;
  - (g) to monitor the administration of this Act and, if he or she thinks fit, make recommendations to the Minister for legislative change;
  - (h) to perform such other functions as are assigned to the Public Advocate by or under this Act or any other Act.
- (2) In performing his or her functions the Public Advocate is not subject to the control or direction of the Minister.
  - (3) The Public Advocate may establish committees for the purpose of providing him or her with advice in relation to the performance of any of his or her functions.

## **22—Public Advocate may raise matters with the Minister and the Attorney-General**

- (1) The Public Advocate may, at any time, raise with the Minister and the Attorney-General any concerns he or she may have over any matter arising out of or relating to the performance of his or her functions under this Act or any other Act.
- (2) If the Public Advocate so requests, the Attorney-General must cause a report of any matter raised by the Public Advocate under subsection (1) to be laid as soon as practicable before both Houses of Parliament.
- (3) The annual report furnished by the Public Advocate under this Act must include a summary of any matters raised by the Public Advocate under subsection (1).

## Appendix Nine

### Media

Date	Media Item
17/1/2017	ABC Television Adelaide airs a story about an elderly man being given 10 times the amount of prescribed medication and left with unexplained bruises whilst an inpatient at Oakden. The patient's family, the Minister for Mental Health and Substance Abuse, Principal Community Visitor and SASMOA Senior Industrial Officer are all interviewed as part of the story. The story is also carried in brief during the night's regular news updates.
18/01/2017 – 19/01/2017	ABC (891) radio carries numerous news stories with 'grabs' from the 17/1/2017 7.30 Report story.
15/02/2017	ABC Radio Adelaide airs a story about the appointment of more senior staff after hours and on the weekend, including the appointment of a pharmacist. The Minister for Mental Health and Substance Abuse's statement about the appointments is included in the story.
27/02/2017	ABC Television Adelaide airs a story about the suspension of three SA Health workers at Oakden. The story references a leaked report by a concerned staff member in 2014 demonstrating inadequate medical staffing numbers at Oakden. The Premier's statement about the staffing levels, Minister's response about what action was taken after the report was made by the staff member and comments from the Shadow Health Minister features in the story.
27/02/2017-28/02/2017	ABC Radio Adelaide carries numerous news stories repeating 'grabs' from the ABC Television Adelaide story, as aired 27/2/2017.
28/02/2017	ABC Television Adelaide airs television story about Oakden, focussing on the leaked report, suspension of staff, and changes made to the facility post commencement of the Review.
01/03/2017	The Advertiser features an article about the suspension of three Oakden staff, including a statement from the Minister for Mental Health and Substance Abuse, and referencing the Minister for Health's statement in Parliament about the suspensions.
21/03/2017	ABC television airs a story about Oakden, and in particular, the failure of Oakden to achieve Commonwealth aged care standards. The story features an interview with two consultants who were engaged at Oakden in 2008 to bring the facility up to standard after it failed to achieve Commonwealth aged care standards in 2008.
22/03/2017	ABC Radio Adelaide airs a story about Commonwealth sanctions against Oakden, including 'grabs' from two consultants who were engaged to bring Oakden up to standard in 2008.
29/03/2017	Both ABC Radio Adelaide and ABC website feature stories about additional staff being appointed at Oakden to bring it up to standard following a Commonwealth audit of the facility, and resulting sanctions.
05/04/2017	ABC television and ABC website reports Federal Senator Nick Xenophon says Oakden should be closed down. Stories include excerpts from wife of former patient of Oakden about the care her husband received whilst an inpatient at Oakden.
06/04/2017	ABC television and ABC website reports the family of an elderly resident killed at Oakden in 2008 says the Government has swept the story under the carpet.

## Appendix Ten

### National Mental Health Policy & Planning Documents

Mental Health Statement of rights and responsibilities 1991

National Mental Health Policy 1992

National Mental Health Plan 1992-1998

Medicare Agreements 1993-1998

Second National Mental Health Plan 1998-2003

Australian Health Care Agreements 1998-2003

National Mental Health Plan 2003-2008

Australian Health Care Agreements 2003-2008

National safety priorities in mental health: a national plan for reducing harm 2005

COAG National Action Plan for Mental Health 2006-2011

National Mental Health Policy (revised) 2008

Fourth National Mental Health Plan 2009-2014

Mental Health Statement of rights and responsibilities (revised) 2012

Roadmap for mental health reform 2012-2022

National Mental Health Service Planning Framework

## Appendix Eleven

### SA Health Dignity of Care Principles



# 10 Dignity in Care Principles

*Dignity in Care matters to us.*

1. Zero tolerance of all forms of abuse.
2. Support people with the same respect you would want for yourself or a member of your family.
3. Treat each person as an individual by offering personalised service.
4. Enable people to maintain the maximum possible level of independence, choice and control.
5. Listen and support people to express their needs and wants.
6. Respect people's privacy.
7. Ensure people feel able to complain without fear of retribution.
8. Engage with family members and carers as care partners.
9. Assist people to maintain confidence and a positive self-esteem.
10. Act to alleviate people's loneliness and isolation.



## Appendix Twelve

### Bibliography

- Australian Commission on Safety and Quality in Health Care *Australian Charter of Healthcare Rights*
- Australian Institute of Health and Welfare 2012 *Dementia in Australia*
- The Bristol Royal Infirmary Inquiry 2001 *Learning from Bristol the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*
- Brodaty, H., Draper B and Low, L.F. 2003 Behavioural and Psychological Symptoms of dementia: a seven-tiered model of service delivery, *Medical Journal of Australia*, 178 (3), p 231-234
- Committee on Quality of Health Care in America, Institute of Medicine 2001 *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*
- Commonwealth of Australia 2003 *National Mental Health Plan 2003-2008*
- Commonwealth of Australia 2009 *Fourth National Mental Health Plan – An Agenda for Collaborative Government Action in mental health 2009-2014*
- Commonwealth of Australia 2010 *National Standards for Mental Health Services 2010*
- Department for Health and Ageing 2017 *Criminal and Relevant History Screening Policy Directive*
- Department of Health UK 2008 *High Quality Care for All: NHS Next Stage Review Final Report*
- Department of Health NSW 1983 *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled Report*
- Department of Health - Victoria 2013 *National Practice Standards for the Mental Health Workforce*
- Department of Health and Ageing 2012 *Decision-Making Tool: Supporting a Restrain Free Environment in Residential Aged Care*
- Department of Health and Ageing 2012 *Decision-Making Tool: Supporting a Restrain Free Environment in Community Aged Care*
- Department of Health – NSW 2006 *National Framework for Action on Dementia 206-2010*
- Dobrohotoff, J. T. and Llewellyn-Jones, R. H. 2011 'Psychogeriatric inpatient unit design: a literature review', *International Psychogeriatrics*, 23 (2), p 174-189
- Draper, B., Jochelson, T., Kitching, D., Snowdon, J., Brodaty H. and Russell, B. 2003 'Mental health service delivery to older people in New South Wales: perceptions of aged care, adult mental health and mental health services for older people', *Australian and New Zealand Journal of Psychiatry*, 37 (6), p 735-740
- Heslop K., Wynaden D., Bramanis K., Connolly C., Gee T., Griffiths R., Al Omari O. 2012 Assessing falls risk in older adult mental health patients: a Western Australian review, *International Journal of Mental Health Nursing*, 21(6):567-75.
- The Mental Health Act Commission 2008 *Risk, Rights, Recovery: Twelfth Biennial Report 2005-2007*

The Mid Staffordshire NSH Foundation Trust Public Inquiry 2013 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*

National Advisory Group on the Safety of Patients in England 2013 *A Promise to learn – a commitment to act: Improving the Safety of Patients in England*

National Mental Health Seclusion and Restraint Project (NMHSRP), National Documentation Outputs, 2009

New South Wales Department of Health (2006) *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015*

New South Wales Ministry of Health (2013) *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD)*

New South Wales Ministry of Health (2013) *National Mental Health Service Planning Framework*

New South Wales Ministry of Health (2016) *National Mental Health Service Planning Framework V2.1*

New South Wales Ministry of Health (2012) *Specialist Mental Health Services for Older People (SMHSOP): Acute Inpatient Unit Model of Care Project*

Royal Australian and New Zealand College of Psychiatrists (2011) *Priority Must be Given to Investment that Improves Mental Health of Older Australians – Position Statement*

Royal Australian and New Zealand College of Psychiatrists (2012) *Relationship between Geriatric and Aged Care Psychiatry Services – Position Statement*

Royal Australian and New Zealand College of Psychiatrists (2013) *Inquiry into care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia – submission*

Royal Australian and New Zealand College of Psychiatrists (2013) – *Submission to the National Framework for Action on Dementia (2013-17)*

Royal Australian and New Zealand College of Psychiatrists (2015) *Psychiatry Services for Older People Position Statement*

SA Health (2016) *Good Practice Guidelines to Prevent Abuse of Older South Australians*

SA Health (2015) *Restraint and Seclusion – Recording and Reporting - Chief Psychiatrist Standard*

SA Health (2015) *Strategy to Safeguard the Rights of Older South Australians: Action Plan 2015-2021*

Sally, G.(1998), 'Clinical Governance and the drive for quality improvement in the new NHS in England', *British Medical Journal*, 317(7150), p 61-65

Searby, A., Maude, P., McGrath, I. (2016) Prevalence of co-occurring alcohol and other drug use in an Australian older adult mental health service, *International Journal of Mental Health Nursing*, 25, (2): 151–158.

Stafrace, S. and Lilly A. 2008 Report on the Review of the Makk and McLeay Nursing Home

UK Inquiry into Mental Health and Well-Being in Later Life (2007) *Improving Services and Support for Older People with Mental Health Problems: the second report from the UK Inquiry into Mental Health and Well-Being in Later Life*

The University of New South Wales and NSW Health (2007) *NSW Health Facility Guidelines: Post Occupancy Evaluation Guideline*

Van Leuven, K. (2010) Psychotropic medications and falls in older adults, *Journal of Psychosocial Nursing & Mental Health Services*, 48(9): 35–43.

- 
- <sup>i</sup> The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*
- <sup>ii</sup> Burdekin, B, Guilfoyle, M, Hall, D & Australian Human Rights Commission 1993, *Human rights and mental illness: report of the National Inquiry into the Human Rights of People with Mental Illness*, Australian Govt. Pub. Service, Canberra.
- <sup>iii</sup> National Mental Health Policy 1992, *The national mental health strategy*, Australian Health Ministers' Conference, Canberra.
- <sup>iv</sup> National Mental Health Strategy 2003, *National mental health plan, 2003-2008*, Commonwealth of Australia, Canberra.
- <sup>v</sup> Australian Health Disaster Management Policy Committee & Australia, Department of Health and Ageing 2009, *Fourth national mental health plan an agenda for collaborative government action in mental health 2009-2014*, Department of Health and Ageing, Canberra, ACT
- <sup>vi</sup> Department of Health 2013, 'National mental health service planning framework (NMHSPF)' (archived in the National Library of Australia, Australian Government Web Archive), Department of Health, North Sydney.
- <sup>vii</sup> Department of Health 2016 *National Mental Health Services Planning Framework (NMHSPF) V2.1*
- <sup>viii</sup> Brodaty, H., Draper B and Low, L.F. 2003 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery', *Medical Journal of Australia*, vol 178 no 5, p 231-234
- <sup>ix</sup> New South Wales Department of Health & NSW Health 2006 *NSW service plan for specialist mental health services for older people (SMHSOP) 2005-2015 NSW, a new direction for mental health*, NSW Department of Health, North Sydney, NSW
- <sup>x</sup> Royal Australian and New Zealand College of Psychiatrists & New South Wales, Ministry of Health 2013, *Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD): a handbook for NSW health clinicians*, NSW Ministry of Health, North Ryde
- <sup>xi</sup> Department of Health – NSW (2006) National Framework for Action on Dementia 2006-2010
- <sup>xii</sup> Australian Institute of Health and Welfare (2012) *Dementia in Australia*, Australian Institute of Health and Welfare, Canberra
- <sup>xiii</sup> Heslop, K, Wynaden, D, Bramanis, K, Connolly, C, Gee T, Griffiths, R & Al Omari O 2012, 'Assessing falls risk in older adult mental health patients: a Western Australian review', *International Journal of Mental Health Nursing*, vol. 21, iss. 6, pp. 567-75
- <sup>xiv</sup> Van Leuven, K 2010, 'Psychotropic medications and falls in older adults', *Journal of Psychosocial Nursing & Mental Health Services*, vol. 48, iss. 9, pp. 35-43.
- <sup>xv</sup> Searby, A, Maude, P & McGrath, I 2016, 'Prevalence of co-occurring alcohol and other drug use in an Australian older adult mental health service', *International Journal of Mental Health Nursing*, vol. 25, iss. 2, pp. 151-158.
- <sup>xvi</sup> Department of Health - Victoria 2013 *National Practice Standards for the Mental Health Workforce*
- <sup>xvii</sup> Commonwealth of Australia 2010 *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra
- <sup>xviii</sup> Health Policy Analysis 2011 *Evaluation of NSW Service Plan for Specialist Mental Health Services for Older People*, NSW Ministry of Health, Sydney
- <sup>xix</sup> OPMHS Training Topics – Core and Elective sourced from
- <sup>xx</sup> Department of Health NSW 1983 *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled Report*, Department of Health NSW Division of Planning and Research, Haymarket NSW
- <sup>xxi</sup> SA Health (2015) *Strategy to Safeguard the Rights of Older South Australians: Action Plan 2015-2021*
- <sup>xxii</sup> The Bristol Royal Infirmary Inquiry 2001 *Learning from Bristol the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*

---

<sup>xxiii</sup> Committee on Quality of Health Care in America, Institute of Medicine 2001 *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*

<sup>xxiv</sup> Garratt R. *The Fish Rots from the Head: The Crisis in Our Boardrooms: Developing the Crucial Skills of the Competent Director*. 2011

<sup>xxv</sup> Stafrace, S. and Lilly A. 2008 Report on the Review of the Makk and McLeay Nursing Home

<sup>xxvi</sup> National Mental Health Seclusion and Restraint Project (NMHSRP), National Documentation Outputs, 2009