



# Royal Commission into Aged Care Complaints Submission

28 September 2018

Independent Advocacy in the Tropics Inc. ("IATI") including all registered Business Names, is a community organisation formed in 1989 then incorporated in 1991, to provide advocacy support for people with disability of all ages, genders and cultural identities. *We provide a quality service accredited under the National Disability Advocacy Standards for both Individual and Systemic Advocacy.*

### The Need for Advocacy

People with a disability are in particular need of advocacy because they often experience or are vulnerable to discrimination, neglect, exploitation and/or abuse. This is particularly so for the elderly with or without a disability.

People with disability are just as valuable as any other human being regardless of what they do or don't do. They need the same things that all people need to live well in this world; their own place, sense of belonging, love and affection, safety. We are all connected within a community and in our world and people with disability must be fully included in this. People with disability should not be separated, segregated or isolated. They should be able to make their own decisions, make mistakes, have courage, be fearful, be likeable, be unpleasant just as any other person. This is everyone's basic human right.

### PAST EXPERIENCES:

I have witnessed in my eight years of attending residential aged care facilities (RACF) in Townsville and surrounding areas, insufficient staff levels to adequately care for the residents both aged and young and more so for those with disabilities. There is also a gap in the skills of the staff, and there are some staff who should not be working in the sector. As an Advocate, I experience a resistance from the facilities and/or staff to external assistance – apart from supports and community visitors. It is as though there is a culture in some facilities to close ranks so as not to risk of being identified and reported for poor care, possible abuse and mismanagement. Some facilities who had young people with disabilities (YPIRAC) would create alliances with external service providers or not support them in providing their contracted services. And even not allowing residence to be taken into the community due to what they perceive are 'behaviour' issues. It was easy to keep a resident in a room all day with only minimal contact i.e., mealtimes, bathing and bedding changes.

### GREATER ISSUES EXPERIENCED:

#### Client 1 :

Basic care where continence aids are not changed from overnight which then had a flow on affect where the pads were so full, they kept falling down. This same client has recurring UTI's. Client had untreated head lice for 2 weeks and as a result, support workers would not work with her and she lost her community access. Same client was admitted to this RACF for a short rehabilitation period after breaking her ankle in a Health facility where she was receiving mental health treatment. She was admitted at the age of 47 and now, at the age of 53, she is a permanent resident of this RACF and is immobile due to not receiving the physio and rehabilitation recommended on her discharge from hospital. Client has been sexually and physically abused in this facility. Client has had personal belongings taken from her room and advises of staff going through her wardrobe of a night removing any treats she may have bought herself during the day. I have witnessed a breakfast tray left for her as she was late getting out of bed. She was told to eat the food before she was given lunch...this was 11.30am and the food had been left for her at 7.30am. Where is the food safety rules? There are many more negative experiences I have witnessed and experience with this client, aged 53.

### Client 2.

A non-verbal, paralysed person aspirating was not seen by staff since 7:00am in the morning. On my arrival at 4:00pm, the client was in such distress as she was suffocating, that action was taken but within a couple of days she died. She was aged 51.

### Client 3.

A client with a mental illness was visiting her mother daily in a RACF's dementia unit. Client was noticing bruises on her mother and when her mother's thumb was dislocated, she reported it to the staff but it was not investigated. The matter was referred to Qld Police Service. Client also phoned the Aged Care Complaints. This RACF had then turned the blame onto my client, the daughter, and accused her of causing the bruises and dislocated thumb.

Another incident occurred, and my client made a complaint to the staff, and as a result Qld Police were called and escorted my client off the facility and had her admitted to a mental health unit. My client had never been an inpatient in a mental health facility as her mental illness was minor and treated. On her discharge from the mental health unit, she was restricted to visiting her mother only 2 hours per day.

When her mother was in her final days, this 2 hours was not relaxed. Client's mother passed away on her own, my client was not notified until after she had passed and my client was so distressed at not being able to be by her mother's side. This was a cruel and unnecessary act and not one of compassion and empathy which would have been expected of a facility supposedly run by professionals. My client's Involuntary Treatment Order from her admission was revoked soon after.

## 1. Do you have feedback on issues the Royal Commission should consider in relation to the specific listed areas?

### **The quality of care provided to older Australians, and the extent of substandard care:**

I would recommend a ratio system for staff to resident. A minimum number of staff rostered for nights and weekends to be mandatory. People working in the sector need to have specific training, specialised training. The skill level has to be of level greater than a registered nurse, but not a medical specialist. There needs to be a middle ground. This training needs to be implemented asap. Overseas nursing staff to be upskilled, and all staff to be trained in behaviours, whether it is dementia, intellectual or any neuro related illness. General Practitioners who have the contract to provide medical care in these homes to have a set contract period – 3 years. GP's must visit a resident within a one month period.

I strongly recommend a spot visit by a team of medical professionals regularly. I say a team, because if one person arrives for a spot check, the word of the visit would spread to the units and any issues or poor practices can be covered up. A team could go to each unit unannounced and check on residents and their care.

Another issue is also staff numbers. Many residence are able to do a lot of things for themselves but because they are "slow" they are forced to be hand-fed, unceremoniously dressed and/or bathed or put in a wheelchair to move them quickly for the sole reason that there are not enough staff to afford them the time to be able to do this themselves. Stripping people of the ability to do for themselves leads to loss of dignity, the will to try, a loss of self-worth and ultimately the loss of the will to live.

**The challenge of providing care to Australians with disabilities living in residential aged care, particularly younger people with disabilities;**

People with disabilities require substantial care and staff need to be rostered to meet the needs of the person. NDIA and RACF pass the responsibility to each other, and the person with the disability is the one missing out. Ensuring a quality of life to the person is paramount, whilst their daily needs are being met. A ratio of staff to the person is required.

**The challenge of supporting the increasing number of Australians suffering dementia and addressing their care needs as they age;**

Government need to research other countries way of caring for people with dementia. Some countries build small villages which offer conveniences ie shops, bakery, hairdresser, parklands. People with dementia do not need to be locked in wards, tied to chairs and other restraining devices, but allowed to walk freely in an environment which is safe and has medical staff on standby should they be needed.

**The future challenges and opportunities for delivering aged care services in the context of changing demographics, including in remote, rural and regional Australia**

Funding has to be provided to regional, rural and remote areas to build appropriate culturally-minded facilities to allow a person to live in the environment where there is a more holistic approach to services recognising the role of extended family and the community. It is not acceptable to move people from their land because of lack of appropriate facilities and care. Consideration must also be given more fully cater to and understand the cultural significance of aging for those from the CALD community who already face many challenges and barriers in fully integrating into their communities.

**2. Are there any other areas that should be considered by the Royal Commission?**

Young People in Nursing Homes with disabilities receive funding from National Disability Insurance Scheme. As part of their plans, there is a 'back office' figure of approx. \$80,000 added to their core supports. I have been advised that this figure is given to Dept of Health for the RACFs to care for young people with disabilities.

My enquiries have determined that this money is never given to the Aged Care facilities and Dept of Health staff member have advised they do not see this money.

If these funds are provided to the RACFs, this would in fact assist in staffing levels and have a positive impact through the facility. Staff would have the time to give adequate personal care and assist with meals. Staff training ongoing would see long term benefits to all residents, and to the moral of the staff.