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TRANSCRIPT OF PROCEEDINGS

O/N H-1037319

THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner

IN THE MATTER OF THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

CAIRNS

10.04 AM, TUESDAY, 16 JULY 2019

Continued from 15.7.19

DAY 37

MR P. ROZEN QC, counsel assisting, appears with MR R. KNOWLES and MS B. HUTCHINS
MR G. KENNET SC appears with MR B. DIGHTON for the Commonwealth of Australia

COMMISSIONER TRACEY: Before I call on you, Ms Hutchins, I should note that Commissioner Briggs is unable to be with us today. She is very unwell and she will read the transcript of the hearing when she has recovered. Yes, Ms Hutchins.

MS HUTCHINS: Thank you, Commissioner. Our first witnesses today is a panel of chefs who have experience of working in aged care facilities. I call the next witnesses, Nicholas Hall, Timothy Deverell and Lindy Twyford.

<LINDY MAREE TWYFORD, SWORN [10.05 am]

<TIMOTHY JOHN DEVERELL, AFFIRMED [10.05 am]

<NICHOLAS MICAEL ZANE HALL, AFFIRMED [10.05 am]

MS HUTCHINS: Thank you. Now, Mr Hall, could you please state for the transcript your full name.

MR HALL: Nicholas Micael Zane Hall.

MS HUTCHINS: And you have prepared a statement for the Commission.

MR HALL: Yes.

MS HUTCHINS: For our records, it's WIT.0215.0001.0001. Is this a copy of your statement now dated 4 July 2019?

MR HALL: Yes.

MS HUTCHINS: Have you had an opportunity to read over your statement before giving evidence today?

MR HALL: Yes.

MS HUTCHINS: And do you wish to make any changes to the statement?

MR HALL: No.

MS HUTCHINS: And to the best of your knowledge and believe, are the contents of your statement true and correct?

MR HALL: Yes.

MS HUTCHINS: I tender that statement.

COMMISSIONER TRACEY: Yes. The witness statement of Nicholas Michael Zane Hall dated 4 July 2019 will be exhibit 6-43.

EXHIBIT #6-43 WITNESS STATEMENT OF NICHOLAS MICAEL ZANE HALL DATED 04/07/2019 (WIT.0215.0001.0001)

MS HUTCHINS: Mr Deverell, please state your full name for the transcript.

MR DEVERELL: Timothy John Deverell.

MS HUTCHINS: And, Operator, please go to WIT.0216.0001.0001. This is a statement dated 19 June 2019. Did you prepare the statement for the Commission?

MR DEVERELL: Yes, I did.

MS HUTCHINS: And have you had the opportunity to read over the statement before giving your evidence today?

MR DEVERELL: Yes, I have.

MS HUTCHINS: Do you wish to make any amendments?

MR DEVERELL: No.

MS HUTCHINS: And to the best of your knowledge and belief, are the contents true and correct?

MR DEVERELL: They are.

COMMISSIONER TRACEY: Yes, the witness statement of Timothy John Deverell dated 20 June 2019 will be exhibit 6-44.

EXHIBIT #6-44 WITNESS STATEMENT OF TIMOTHY JOHN DEVERELL DATED 20/06/2019 (WIT.0216.0001.0001)

MS HUTCHINS: And, Ms Twyford, could you please state your full name for the transcript.

MS TWYFORD: Lindy Maree Twyford.

MS HUTCHINS: And have you prepared a statement for the Commission?

MS TWYFORD: I have.

MS HUTCHINS: Operator, Document WIT.0270.0001.0001. Is this your statement dated 28 June 2019?

MS TWYFORD: It is.

MS HUTCHINS: Have you had the opportunity to read over your statement before giving evidence today?

MS TWYFORD: I have.

MS HUTCHINS: Do you wish to make any amendments?

MS TWYFORD: No.

MS HUTCHINS: To the best of your knowledge and belief, are the contents of your statement true and correct?

MS TWYFORD: They're true and correct.

MS HUTCHINS: I tender that statement.

COMMISSIONER TRACEY: Yes. The witness statement of Lindy Maree Twyford dated 11 April 2019 will be exhibit 6-45.

EXHIBIT #6-45 WITNESS STATEMENT OF LINDY MAREE TWYFORD DATED 11/04/2019 (WIT.0270.0001.0001)

MS HUTCHINS: Starting with you, Mr Hall, you have been a chef for over 30 years.

MR HALL: Yes.

MS HUTCHINS: And paragraph of your statement identifies that from .1999, you have worked as a chef in Australia both in permanent and contract positions over a range of large commercial kitchens, including aged care facilities.

MR HALL: Yes, that's true.

MS HUTCHINS: And between 2013 to 2015, you worked as a chef manager and trainer for a company that provided food services to a residential aged care facility.

MR HALL: That's correct.

MS HUTCHINS: And for the purposes of today, rather than naming that provider, we will refer to them as a food services company.

MR HALL: Yes.

MS HUTCHINS: And how many residents were at that facility where the food services company provided the food services?

MR HALL: It was up to about 120. 100 were full-time residents and 20 to 25 were temporary residents that were coming in and out of hospital.

MS HUTCHINS: And what did your responsibilities include in that role?

MR HALL: Compiling menus, getting the menu choices from the residents, ordering, catering, taking care of all the food service attendants, making sure the food went out on time and overseeing the whole catering operation.

MS HUTCHINS: And then from November 2017 to April 2018, you worked as a chef manager for an aged care provider that ran its food services on site; is that correct?

MR HALL: That's correct.

MS HUTCHINS: How many residents were at that facility?

MR HALL: There was 80 residents, and we also catered for a wing for temporary people that were coming in for dialysis on a daily basis.

MS HUTCHINS: And what did your responsibilities include in that role?

MR HALL: Overseeing the entire kitchen, all the food service attendants, cooking, catering, dishes, cleaning, receiving stock and everything to do with the cooking.

MS HUTCHINS: Mr Deverell, you held executive chef management positions for most of the past 30 years.

MR DEVERELL: Correct.

MS HUTCHINS: And 11 of those years have been in aged cared facilities on either a full-time or contract basis.

MR DEVERELL: Yes.

MS HUTCHINS: And what did your role typically involve?

MR DEVERELL: So I would be hiring the staff, training the staff, doing the rosters, ordering the food, supply contacts, checking the meal quality, making sure

paperwork has – is all done, following a food safety program, doing any amendments to the food safety program, liaising with the rest of the nursing home in terms of the nursing unit managers, attending family meetings, getting complaints, dealing with the complaints, working out new procedures, new solutions to fix the problems.

MS HUTCHINS: And what numbers of residents would you typically be cooking for?

MR DEVERELL: Normally around 100 to 150. The last place was 250.

MS HUTCHINS: And, Ms Twyford, you currently work in a residential aged care facility; is that correct?

MS TWYFORD: Correct.

MS HUTCHINS: And you've worked there for 33 years.

MS TWYFORD: Yes, that's correct.

MS HUTCHINS: And you started as a general services officer.

MS TWYFORD: I did.

MS HUTCHINS: And your current role is a hospitality food safety manager.

MS TWYFORD: Hospitality manger, yes.

MS HUTCHINS: Yes. And how many years have you been in that role for?

MS TWYFORD: Between 16 years, 17 years.

MS HUTCHINS: And so how did you transition from your role as a general service officer to your current role as a hospitality manager?

MS TWYFORD: I was asked to – would I like to cook, so I did, and I made my way up through there, through the – put myself through TAFE, business catering advanced certificate and then went into the role of cooking.

MS HUTCHINS: And how many residents are in your facility?

MS TWYFORD: 65.

MS HUTCHINS: And what does your role typically involve?

MS TWYFORD: Overseeing the catering, the menus, liaising with the residents, food safety, liaising with the catering – the hospitality – sorry, the nursing care manager and the GM, and just typical running of the kitchen.

MS HUTCHINS: And you mentioned that you have put yourself through training through a business catering advanced certificate.

MS TWYFORD: That's correct.

MS HUTCHINS: What does that certificate involve?

MS TWYFORD: It involves all the parts of the chef role, all the – all the cooking, accounting, all the operations of catering business.

MS HUTCHINS: Do you think that training has provided you with the information that you need to be able to do your job well now?

MS TWYFORD: Absolutely. It was a definite good beginning for that.

MS HUTCHINS: And, Mr Deverell, what training qualifications to you hold?

MR DEVERELL: I've got Certificate 4 commercial cookery. I've got a HACCP certificate, external food safety auditor certificate, Train the Trainer Certificate 4, and a Diploma in banking and finance.

MS HUTCHINS: And do you think that those qualifications have prepared you for the demands of working in residential aged care facilities?

MR DEVERELL: No.

MS HUTCHINS: What do you think was lacking in that training that would be helpful?

MR DEVERELL: So the aged care industry, a lot of – lot of food is served now. Some residential places, up to 70 per cent are on texture-modified diets. Nowhere during any of my training did I receive anything on texture-modified diet.

MS HUTCHINS: And, Mr Hall, what are your training and qualifications?

MR HALL: New Zealand general catering certificate. I was trained in the army in New Zealand. After I moved to Australia, got a Certificate 3 and 4 in commercial cookery. I also hold a HACCP certificate, food safety certificates.

MS HUTCHINS: And do you think that training has prepared you for the demands of working in residential aged care?

MR HALL: No. It's the same view. You get no training on texture modifications, fluid – thickened fluids, and nothing prepares you for that kind – that side of it, and the – what would happen – you don't get told what would happen, if a resident gets fed the wrong texture modification or liquid.

MS HUTCHINS: Yes. And did the training cover issues relating to specific nutritional needs for elderly people?

MR HALL: No.

MS HUTCHINS: How about in both of your experiences?

MR DEVERELL: No. And when I went through commercial cookery, they didn't even mention aged care. So nutritional needs weren't discussed at all.

MS HUTCHINS: Yes, and - - -

MS TWYFORD: There's ongoing training through the industry with speech pathologists on texture-modified foods, with the dietitians. There's other areas of training with – in dementia and what foods they eat. There's – that's, like, training our staff and myself as well.

MS HUTCHINS: Sure. Thank you. And you mentioned as well, Ms Twyford, that the residential aged care facility you work in assists with training and career pathway development.

MS TWYFORD: Absolutely, yes.

MS HUTCHINS: Is that something that you see as being important to achieving good food outcomes for residents?

MS TWYFORD: Absolutely. Yes. Yes. They're very good with that. They always look at improving the training for staff to enable them to do their work.

MS HUTCHINS: And, Mr Hall, in your experience, has additional training been something that has been offered by the facilities or providers you have worked for.

MR HALL: It has if you can call it training. It's usually a half-hour session that the staff will do at home on a computer. There's no trainers provided. There's no examples. There's no actual teaching. It's just read and tick and flick.

MS HUTCHINS: What's the type of subject matter that would be covered in those training sessions?

MR HALL: Some of them would be texture modification. But yet again, no one is taught actually how to do it manually. Elder abuse, and just general subjects like that. Mainly it's just so they can tick it off to say that we have trained our staff and – the training is very minimal.

MS HUTCHINS: What do you think would be more advantageous in terms of training?

MR HALL: A proper TAFE course where, for the food service attendants especially, and the chefs, when they actually get to learn the different texture modifications, how to prepare those modifications and thicken liquids, things like that.

MS HUTCHINS: Mr Deverell, in your roles have you been responsible for menu planning.

MR DEVERELL: I've been involved in menu planning but normally it gets taken out of my hands.

MS HUTCHINS: Do you know what the food budget is that's usually required to be worked within?

MR DEVERELL: Yes, I do. They normally give me a food budget to work within, yes.

MS HUTCHINS: And what is that, what is your experience, what kind of budgets have you been given?

MR DEVERELL: So it varies hugely. Top of the range, good places are between $14 and $17 per resident per day. At the other end of the scale, it's around $6.50 to $7 per resident per day.

MS HUTCHINS: Yes. And if you are given a budget of around $14 to $17 a day what are the types of foods you are able to provide for residents.

MR DEVERELL: Normally we get better cuts of meat. You've got better quality vegetables, you are using less processed food, you're buying less food in so you are able to make food fresh, like a lasagne, for instance, you can make it from scratch. You've normally got more labour along with that food budget as well and so you can prepare everything properly the way it's traditionally meant to be made.

MS HUTCHINS: And when you have a budget more around the $7 a day mark, how does that impact on the type of food you are able to provide?

MR DEVERELL: Well, you are normally getting secondary cuts of meat. Normally, the vegetables are second – second quality. You know, you have to throw a certain portion out because you have to order a carton to get in under your food budget. Because you are throwing a certain percentage out, you are giving less to the residents. So they end up with smaller portion sizes. The protein content is normally smaller in those places. Yes, it's not good.

MS HUTCHINS: And is there a difference in the amount of fresh or frozen foods that you are able to use in both of those circumstances.

MR DEVERELL: Yes, so like I said, at the top end of the scale you're using a lot of fresh produce. At the bottom end it's normally processed, packet or frozen food that you are using.

MS HUTCHINS: Mr Hall, across the facilities you have worked in, have you been involved in menu planning?

MR HALL: Yes.

MS HUTCHINS: Yes. And what is the typical type of budget that you've been required to work within?

MR HALL: For outside caterers, it's usually around $6.25 a day and that's not real money because you are ordering through their in-house system which is inflated prices so they can get a rebate at the back end of the year. So for instance, if I was ordering for one example, gluten-free bread wasn't on the in-house system, I was going down to the supermarket to buy that, and it was $4. Once the catering institution had put that loaf of bread into their system I was paying $8 for it.

MS HUTCHINS: So when you were working for that particular catering provider were you required to order through that type of system when food was available on it?

MR HALL: 99 per cent of the food was ordered through that system, yes.

MS HUTCHINS: And what was the typical budget that you were working with, when you were working in-house at the facility?

MR HALL: I believe it was about $7.20 a day.

MS HUTCHINS: And what were the types of food that you were able to prepare for residents on that type of budget?

MR HALL: Well, it wasn't great, that's for sure. You know, you are having to cut corners, you are having to use frozen foods, you are having to use processed foods just to feed the residents. And at the end of the meal if the resident was still hungry and they wanted more food there was no more food to give them. They would be rationed down. So if you were making, say, rissoles for 80 people they would supply five kilos of mince. So you've got to extend that out with, say, grated carrot, breadcrumbs and that kind of thing, just to make sure that every resident had two rissoles and there's nothing left over.

MS HUTCHINS: Ms Twyford, you note in your statement that at your facility you have $16 per resident per day for the budget.

MS TWYFORD: That's correct.

MS HUTCHINS: And what type of food are you able to serve with that amount?

MS TWYFORD: Examples of it we might have fillet mignon, salt and pepper squid, seafood baskets, good quality meat. We have a combination of fresh and frozen because there are some good products of frozen foods, but I'm really lucky that the facility – that the utmost importance is the food.

MS HUTCHINS: And in instances where you do need to serve frozen food do you note that there is a difference in the quality of the types of frozen foods that you are able to provide?

MS TWYFORD: Yes and no. I think it's the way it is cooked. I think that – we have things like combi ovens and I suppose the – we have mostly fresh vegetables and it might be only peas and beans that are frozen.

MS HUTCHINS: In your witness statement, you note, for example, if you need to buy party pies you are able to buy more like the top of the market one which has got real meat. What kind of difference does that make to what the cheaper options may be?

MS TWYFORD: Well, I think when you purchase party pies, we do things like pulled pork, beef cheeks, and chicken and leek, and I think it's better quality meats in there for them but it's also the way it's presented to the resident at dinner time. If the facilities can afford it, it's putting it on a nice plate with sauces and its presentation to them.

MS HUTCHINS: Sure. And when you hear of the experience of the other gentlemen on the panel that they've been working with budgets at around $7 a day, do you think you would be able to provide such good quality food if you were working within that type of budget?

MS TWYFORD: No, I don't, no.

MS HUTCHINS: Mr Deverell, in your statement, you identify a number of instances of unsafe or substandard food preparation practices that you've witnessed in residential aged care facilities. What do you think are some of the worst examples you've seen?

MR DEVERELL: Reusing food that's already been out served to the resident and come back to the kitchen. They use that for the texture modified diets. Reheating textured modified food in a cold bain-marie. Texture-modified food is high risk. Not storing food correctly. I've had one place where the fridge temperature for the whole day was 14 degrees. I reported it to the manager and they said under the food safety plan they only have to take the temperature once a day, and they did it at midnight. At midnight, it was four degrees, but the food was in the danger zone for the whole day. So, yes, I could go on, there's endless examples.

MS HUTCHINS: Yes. You noted also maggot-infested rubbish stored between serving trolleys.

MR DEVERELL: Yes.

MS HUTCHINS: Is that something that would be a common occurrence or - - -

MR DEVERELL: No, that was an unusual occurrence, and that kitchen was the dirtiest kitchen I've been in. That's in a quite up-market residential aged care facility where the catering is contracted out to a third-party caterer. And the manager told me that they'd had staffing issues, and the staff literally had walked out, but they didn't get anybody else in to take the rubbish out or clean the kitchen. They had no cleaning chemicals in the kitchen at all to clean anyway. All the containers were empty. The fridge was full of rotten food. We could have filled a box trailer, eight by five with a cage, with the rotten food from the cool room that we pulled out. The chicken was green, the sausages were green, they expected to use them that day.

MS HUTCHINS: And Ms Twyford noted the importance of the way that food is served to residents, particularly, say, the use of crockery. I note in your witness statement you indicate that something you've observed is food served on disposal plates.

MR DEVERELL: Yes.

MS HUTCHINS: Is that something you come across often?

MR DEVERELL: With the third-party caterers it is, because, normally, they have cut the labour back and they have no labour to clean, so it's just easier to serve everything on disposable plates covered with plastic and then when it comes back it just goes in the bin.

MS HUTCHINS: Mr Hall, when you were engaging in menu planning, at either of the jobs that you've referred to in your statement, did you find there was much flexibility and variety in the menus that you could create?

MR HALL: Not at all. A lot of aged care facilities now are using one system and that system is all dropdown boxes for – that you – when you're compiling the menu and those dropdown boxes are very restrictive. A lot of the time you might only have two or three choices for a meal, and you've really got to work through and juggle it around so the meals aren't that repetitive at all, but it is pretty impossible.

For a season, or three months, we will do a four-week rotating menu. That will be done three times during that season. And we try to make it – try to change it up a bit. But it is very, very repetitive and I found different items have started appearing on that system that only come from one supplier. So I have a feeling that that supplier and the system, they are working together. So there's some kickbacks involved there.

MS HUTCHINS: So, in effect, you are restricted to creating menus based on the food that was available to you in this system?

MR HALL: That's correct. And there was no area in these dropdown boxes where you can say, okay, I want to do shepherd's pie that night and I'll enter that in. That wasn't available at all; you had to juggle it around.

MS HUTCHINS: How often would you see the same meal being repeated to residents?

MR HALL: Sometimes twice a week. So, you know, when you're looking at a three-month period, that's, you know, eight times in a month, 24 times in three months, it gets a bit boring.

MS HUTCHINS: And Mr Deverell, what's your experience in terms of the repetition of meals?

MR DEVERELL: Yes, I actually see it more than twice a week. Sometimes three or four times a week, especially the party pie option or a hot dog option of a night-time, which is normally a cocktail frankfurt. That is quite often repeated because it's cheap and they don't need to have a chef on site at the time to distribute that, to cook that.

MS HUTCHINS: And Ms Twyford, what's your experience in terms of the repetition of particular meals?

MS TWYFORD: Not all that – no, we don't repeat a lot. I suppose when we do our menus we ask the residents, we have surveys, we have resident meetings, their requests. They have favourites like roast dinners and silverside and cutlets, and the party pies of an evening and things like that. And that's because that's what they like. And the reason that they like that is – and that's why we provide the food that we do. It might be repetitive in some cases but it's what they request. So we provide that for them.

MS HUTCHINS: And Mr Deverell, in your experience, has there been much resident input in menu design?

MR DEVERELL: No. Normally, the menu goes out and then when the residents complain, that's when we get their input and then we make changes according to their input but it's normally a menu goes out first.

MS HUTCHINS: What would be common complaints that you receive?

MR DEVERELL: Normally, it will be that they don't like the food item. So we might be – we might have a stir-fry on and we're in a predominantly Greek or Italian nursing home and they don't like the stir-fry. So it will be something along those

lines or they don't like the choices. Sometimes you will end up with fish two or three days in a row. They don't like that either. So, yes.

MS HUTCHINS: Mr Hall, what types of complaints would you usually hear?

MR HALL: Yes, the same. If it's – if, you know, if you've got a predominantly Anglo-Saxon-type clientele – and, yes, they don't want a curry, and they don't want a stir-fry and that kind of thing. But, you know, when you go through the dropdown boxes sometimes that is all that's available on that day because you have already used the other items on the preceding day or following day so you've got to juggle it in there. And the main complaint that I would get would be about the temperature of the food.

MS HUTCHINS: And why is that?

MR HALL: Because the facilities I work for won't pay the money to have a hot box. The trolley will go on to a trolley that's open-air, just a tray. Like, we preheat the plates, but they only stay hot for so long and then they're covered with a plastic cover. And if they're – you know, and if there's – quite a few residents that need to be fed, then the last 50 per cent of the residents are getting a cold meal.

MS HUTCHINS: And for those that aren't aware, what's a hot box?

MR HALL: Just a big metal container, heater with shelves that plugs in, that has a fan, just like a portable oven on wheels and, you know, that you could wheel around that keeps its temperature, keeps the food at a safe temperature - - -

MS HUTCHINS: Yes.

MR HALL: - - - and a desirable temperature for what you want to eat.

MS HUTCHINS: Yes. And is the use of a hot box something you would recommend to be fairly standard practice?

MR HALL: It should be mandatory.

MS HUTCHINS: Mr Deverell, what's your experience in terms of the delivery of food in the residential aged care facilities and whether there's systems or equipment in place to ensure that the residents get their meals at the right temperature?

MR DEVERELL: It varies hugely between facilities. At the top end, we had a hot-and-cold unit. We put one tray of food in there, hot on one side, cold on the other side, and that gets wheeled around the to the residents so they get both a hot and cold meal at the proper temperature. And then you go to the bottom end where they will have just food on a tray – as Nick was saying, just food on a tray on an open trolley wheeled around. They have limited staff to distribute the meals. And by the time

we've plated up the food and the resident gets it, could be 30, 40 minutes later, and by then, the food is cold. So – yes.

MS HUTCHINS: Ms Twyford, what types of systems or processes do you have at your facility in relation to service of food?

MS TWYFORD: We have the hot box. We have crockery with lids on it. We have – there's a limit to the staff, when it's prepared, this is for tray service. We contact the care staff and they come in to put the meal out. So it's not cold, because that can be an issue. We serve the residents in the dining room, just like a restaurant service so that it isn't cold.

MS HUTCHINS: Yes, and you note in your statement, just in relation to the calling of the care staff - - -

MS TWYFORD: Yes.

MS HUTCHINS: - - - that that's a matter of as each resident is ready to eat, they will be called so the food is - - -

MS TWYFORD: That's correct.

MS HUTCHINS: - - - served directly to that resident. Is that correct?

MS TWYFORD: That's correct. That's when there are feeds and they have to be fed. So we put a system in place that when that resident – when the care staff is ready, they come to the kitchen. We make sure that the tray is ready and then we put the food hot on to the tray for them to take individually. They finish that resident and they come back. And if there's an issue, they ring the kitchen and we wait.

MS HUTCHINS: And you mentioned also the use of crockery for your residents. I understand that you have a special type of crockery that you use; is that correct?

MS TWYFORD: Yes, I have different special types of crockeries. One is a comfort plate. Sometimes a resident who needs aids, they put plastic guards on plates if they try and assist with feeds. We have found a comfort plate that is a bit higher at one end that allows the resident to feed themselves without looking different, without being singled out as having to have assistance, and that's brought many a tear to the eye of those that are able then to not look different. And the other thing is there's – on the cups, there's coloured spots to enable the sight-impaired resident to know where to put the cup, and then it won't spill. There's a higher lip. There's quite a few advantages. And it's made the lives of our residents really special for eating time.

MS HUTCHINS: Yes. How important is it to those residents to be able to maintain the independence of eating through the use of those types of those aids?

MS TWYFORD: Very important. Very, yes. It's made their – as I said, one gentleman, when he used it, he cried and said how he wasn't different any more. He felt special.

MS HUTCHINS: And turning to the matter of involvement of dietitians or nutritionists in menu design, in your experience, Mr Deverell, have nutritionists or dietitians been involved in the menu design process?

MR DEVERELL: The dietitian is not involved in the menu design. I've not had that happen yet. What happens is normally the menu is prepared and then it gets sent to the dietitian for approval. Normally they are looking for the balance, making sure there's enough chicken, beef, fish, vegetarian options, protein options throughout the week. They're looking for that sort of balance.

MS HUTCHINS: Yes. And are there any limitations on the effectiveness of these reviews based on the menus?

MR DEVERELL: Yes. They always put a qualifier on the bottom of their covering letter to say that they were limited in what they could assess in terms of the nutritional value of the menu. They don't receive any recipes, so they don't know what the portion sizes are, whether we're giving 20 grams of chicken or 100 grams of chicken. They don't know whether we're using processed food or fresh food because they haven't seen a recipe. And they don't see how we're plating it up, how we're presenting the food. They don't see any of that.

MS HUTCHINS: And are the menus that have been reviewed by the dietitians followed by the kitchen?

MR DEVERELL: No, not always. Sometimes there's – incorrect food is ordered so you don't have the food there to prepare the menu item, so you will change the – substitute a food item in there, and normally it's with a cheaper or a lesser option. So the third-party caterers do that quite often. They don't follow the menu and they substitute in that menu. So even though the menu has been approved by a dietitian, it's not being followed by the chefs because they haven't got the stock.

MS HUTCHINS: Do you have anything to add to that, Mr Hall, in your experience?

MR HALL: Yes, the nutritionists are there just solely so – in my experience, so the home or the third-party facility can say, "We have a dietitian or a nutritionist, have a look." But when I was at the aged care provider, I think I saw her once a month for one hour and I think it was once every two months one hour when I was – when I was at the third-party caterer. It's just there so they can say, "We have a nutritionist that will come in and that," but they don't have time. They don't sit down with – if they were really doing this properly, they would be sitting down with the resident, they would be weighing the resident to see how much weight is being lost because that's the biggest thing. You see residents wasting away because they're not getting enough food and, yes, it's – it's just a joke.

MS HUTCHINS: And, Ms Twyford, what's your experience in terms of dietitian involvement in menu design at your facility?

MS TWYFORD: Yes, I have good relationships with the dietitians. We have our menu reviewed by an external dietitian and she asks – she has been into the facility, she has looked at the work flows, she has looked at the menus. She has looked at how the recipes are produced. She asks for two pages sent to her about everything that's in those recipes, the portion sizes, the ingredients, how it's cooked. We also have dietitians come in regularly to the facility, if there's a resident that needs reviewing, they will review it, then the dietitian will come and speak with myself or the catering staff so they're all on board to know the changes in the diets for that resident. And if there's any concerns that the staff have, they can talk with the dietitian and it's put on board. And the nurses, RNs are involved as well.

MS HUTCHINS: Yes. And is the dietitian involved in providing direction as to how the food is actually cooked?

MS TWYFORD: Yes. Yes, she will look at that. She will advise and see how we cook it, what we add to the cooking ingredients and everything. Yes, they are.

MS HUTCHINS: You also note in your statement that you have built a relationship with the Food Safety Authority.

MS TWYFORD: Yes, I have.

MS HUTCHINS: Why is that important?

MS TWYFORD: Well, when the Food Safety – they first came into place, the changes that Aged Care had to put in place to make the food safe, they provided roadshows. And you could see that there was some difficulties with that at times with, you know, the changes. So I thought, well, to get a rapport with them and if there's any sort of concerns I have with being able to provide the food safe for the resident to eat, it was good to get their, you know, I suppose, knowledge.

MS HUTCHINS: Yes.

MS TWYFORD: And I've become, yes, quite good friends with them and can ring them any time if I have a concern.

MS HUTCHINS: The Commission has heard evidence previously to the effect that many facilities are concerned about providing food to residents which might be considered risky for fear of breaching their obligations under the food safety regulation. Is that something that you've been able to work through with the authority?

MS TWYFORD: Yes, absolutely, with the authority, and our third-party auditor is brilliant and regularly ringing saying, "Look I want to serve this food. How can we go around it? How can we work with it?" And, yes, they're on board.

MS HUTCHINS: And what are some examples of the types of foods that you would be having those conversations around?

MS TWYFORD: Let me think. The – I suppose, soft cheeses and salamis and things like that, soft eggs, and they say, you know, "Yes, you can. No, you can't." Rockmelon, things like that. And there's – all through the training – we have extensive training with our third-party auditor, and so the staff are quite aware of what they can and can't do and what provides food safety.

MS HUTCHINS: Thank you. And, Mr Hall, what's your experience been with the Food Safety Authority or the auditing process in general?

MR HALL: Yes, you've got to keep your kitchen clean. You've got to keep it up to standard and – yes. And at all times, they can walk in. Yes. But I've found the checks aren't often enough. You don't – they should be able to walk in at any time. You're usually warned. So, therefore, the facility will put an extra couple of cleaners on the day before to keep up the appearance. But they've cut the hours back of the food service attendants and all that so much that they are literally running around trying to complete their tasks in the time and they don't have time to clean the kitchen properly.

And then they're warned that an auditor, or how someone from the council, is coming in to check and then, you know, they're just doing it to keep up appearances. And on that note, you were saying before about the high-risk foods. There's no need to worry about it if there was enough labour. You know, the elderly, they love, like, steak and kidney pies and lambs fry and bacon, but they're seen to be too risky. Whereas if you've got a chef there serving it and he's there all day, there's no problem with that.

MS HUTCHINS: So in your experience, are those types of foods avoided because of, I guess, the man hours that it would take to be able to provide them safely?

MR HALL: Yes. And if it's for a dinner, most of the time they don't want a chef there past – I would start at 7 in the mornings sometimes, so I would finish at 3 or 4 in the afternoon and it would be a food service attendant serving and heating the evening meal, rather a chef being there because they don't want to pay for a chef for those hours, and so, therefore, there would be no high-risk food served at that time.

MS HUTCHINS: Thank you. And, Mr Deverell, do you have anything further you would like to add in relation to your experience on either of those matters in terms of auditing or the service of risky foods?

MR DEVERELL: So I'll actually concede that the Food Authority works better and their auditing process works better in regional areas in New South Wales than it does in the city. In the city, the Food Authority come out, they – to a new facility and they do two inspections in 12 months. And if you pass both of them, then they hand you over to the food – to a third-party auditor. You never see the Food Authority again. I've never come across them anywhere else in Sydney re-inspecting a place that's currently being done by a third-party auditor. Even though they say they do 10 per cent, I've never seen it.

The third-party auditors, normally they don't want to correct anything because they are hired directly by the aged care home and they want the business next year, so they're not going to be hard on you. They will pass things. Normally, that third-party auditor is responsible for the food service training of the staff, so that – he's never going – or the auditor will never criticise his own work if the staff are getting it wrong. So I have a huge issue with a third-party auditing system.

MS HUTCHINS: Yes. And a question for the panel for whoever would like to start first: how important do you think food is to a resident's happiness?

MR HALL: It's everything. It's what they look forward to at the end of the day. It's what they look – what they get up for in the morning. It's what they look for – you know, a lot of other things have been cut, you know, their outings, games. All these things are going by the wayside to save money. So at the end of the day, the food, it's the number 1 thing for them.

MS HUTCHINS: And in terms of your own job satisfaction, Mr Hall, when you're providing food to residents that you think they don't like because of complaints and the level of the budget, how does that impact on your job satisfaction?

MR HALL: It impacts greatly. If you've got to go and face the residents once a month for a resident meeting, you know, you cop it from them and the families and that. You try your best. The last – when I was – the last facility I was at, the last couple of meetings there were no complaints about the food, and that's the first time there had been no complaints about the food in five years. And that's because I'm doing extra hours unpaid in my time.

MS HUTCHINS: Mr Deverell.

MR DEVERELL: Yes. So the whole resident's day is structured around their meal periods. It's the one thing that they get to look forward to every day. The bus outings, the shopping trips: those sort of things are intermittent. But the meals are constant. So their happiness and getting a decent meal is huge. It's very important to them.

MS HUTCHINS: And when you're working within a budget of $7 a day, is that the type of food you would want to eat yourself?

MR DEVERELL: No.

MS HUTCHINS: And, Ms Twyford, how important is the food experience to your residents?

MS TWYFORD: Well, if I can refer to the paragraph here that I see the impact and the importance good food has on a resident. The residents love little things. It's huge for the resident. It might be little things for us but huge to them. My attitude is that we're there to make the place their home, and I will go above and beyond to accommodate their needs and requests. Nutrition is vitally important to both physical and emotional wellbeing because malnourishment will lead to wounds or bedsores. And to them – like, it's a social site in the dining room. They come down. They sit with the other residents. They are very much involved in talking to us about the food and the changes of their diet. So it gives them importance and independence.

MS HUTCHINS: And, Mr Deverell, in terms of food preferences and allergies, in your experience, is that communicated well between staff on the floor and staff in the kitchen?

MR DEVERELL: It could be better. There's not enough use of technology. Everywhere I go, it's normally paper-based and you're waiting for somebody to carry the paper to the kitchen, and hopefully they update the records in the kitchen and get it right. It can be a bit hit and miss, and we rely a lot on the staff knowledge. Staff will pick up, "Oh, that resident can't have that item." So we're relying on a lot on that.

MS HUTCHINS: Yes. And you've mentioned in your statement the use of a lot of agency staff and staff turnovers in your kitchen.

MR DEVERELL: Yes.

MS HUTCHINS: Does that make managing allergies or preferences more difficult?

MR DEVERELL: Yes. Because we haven't got the right information in a kitchen, an agency chef coming in won't always know where to look. It's different from kitchen to kitchen, how they collate that information or present it to the kitchen. So the agency chef doesn't know what to look for. They can go looking for it. They can miss it. Sometimes it's not easily found and the agency chef has to just, like, I call it wing it and hope they get it right.

MS HUTCHINS: Mr Hall, in your statement, you note at paragraph 26 that at the aged care facility you worked at there was a higher percentage of residents on cut-up preferences for their meals. Why do you think there was such a high percentage at the facility?

MR HALL: Well, when I was at the previous provider, 120 residents, there might be three or four residents on cut-up meals. At the aged care provider, there was 75 per cent of the kitchen, and I asked, "What's going on here? This can't be right." And I was told by nursing staff that the aged care facility, which was supposedly not-for-profit, gets more funding from the government if the resident is on a cut-up diet. I had residents coming to me going, "I don't want my food cut up. I can do it myself." But I had no say over that because it's done through the nursing staff. It's not – the doctor hasn't – the doctor should be the one that signs that off, but it was done from director of the – the manager of the facility, through the nursing staff, and then that would be told to the kitchen and we have to do as we're told.

MS HUTCHINS: And, Ms Twyford, how important do you think the management or leadership is at a facility is to achieving good food outcomes?

MS TWYFORD: Very important. You mean as far as myself as manager or higher management or - - -

MS HUTCHINS: Starting with higher management.

MS TWYFORD: Okay. Higher management.

MS HUTCHINS: What kind of impacts does that have on your ability to provide the types of outcomes you would like to for residents?

MS TWYFORD: Everything. From the CEO down, I'm very, very lucky because to them it's important that the food we serve to residents is excellent. And I think that also that – as far as the other side of the management, that the staff have the knowledge and the equipment in the kitchen to be able to provide the job well, to serve the food. And that's just what we were saying before. We have a paper register but a software system in the kitchen that the staff are able to see that's updated as needed, and weekly.

And I think it's also important that the staff have – to know where to go to – the information for that. We don't have agency in our kitchen at all. We're lucky there. But I know that if anyone was to come in the kitchen, the information is there to enable them to be able to work in that kitchen. And as I said, we've been able to do that because of our management.

MS HUTCHINS: Yes. And in terms of providing good outcomes generally to your residents in terms of the quality and type of food that you're able to provide to them, how key is the level of staff involved at the facility and also the quality and training of that staff?

MS TWYFORD: Very, very important. We have ongoing training all the time. The staff, our staff there are asked to know the residents, to talk with the residents after every meal, or when they can, to know every little thing about their likes and dislikes, their allergies. Get to know them as part of their family, just not as coming

to work to work with them, and that is important. And the resident knows that they're cared for, that the staff genuinely want to do the right thing by their food.

MS HUTCHINS: And, Mr Hall, in your experience, you've mentioned previously staffing pressures. Would you have the time in your role to speak to the residents and get to know their preferences and get to know them?

MR HALL: It's impossible in the hours that you're given. And further to that last comment, my catering manager at the aged care facility had never worked in a kitchen, had never worked with food her whole life. She had worked in a laundry, yet she is overseeing the kitchen. She didn't have a clue about what she was doing. But I'm taking guidance from that person. A chef has to be qualified and we have to show our qualifications. I think a catering manager should have those – that kind of standard as well.

MS HUTCHINS: What observations would you like to make, Mr Deverell, in relation to the necessity for adequate staffing numbers and training of staff?

MR DEVERELL: Yes, so the training, I would like to see dedicated aged care training for food. There should be a course. We should have separate qualification, and that would cover modified diets. I think from the Royal Commission's point of view, if we can come out with that, I would be happy. I would be jumping over the moon. In terms of staffing numbers, it's really hard to specify a staffing ratio because every facility and every kitchen is different. They're all doing food in a different style. Some are doing bain-marie service, some are doing tray service. So the staffing ratios are different for each one. So it's very hard to specify ratio. But, in general, definitely needs to be more staff on the ground.

MS HUTCHINS: And, Mr Hall, in your statement, you suggest that a change you would like to see in residential aged care facilities is a food ordering system which would involve integration of a number of different people that are relevant to the care of someone in a home and their food preferences. What type of thing do you have in mind?

MR HALL: I see a system that oversees everything, that the government can have a look at, that local government can have a look at to make sure that the residents are being fed correct food. Right now, the doctors should have input. So – and take into account medication, because no one has taken that into account with food, because some residents are on different medication with different foods. It will react with them, and no one has taken that into account at all. And I think it should be taken into account – there should be suppliers then – so that the prices are fair and they're not rigged towards the third-party caterers, and that you can show that the right amount of food is being served to the resident.

If the resident is sick or has dementia and can't order their own food, then an alert can be sent to the family because the family knows what they want and they could order their food for that portion of time, and feedback from the resident themselves.

"How was the meal? Was it hot? Was it tasty?" You know, and that – there needs to be oversight. At the moment, the system that is in place is just an absolute joke. Someone that's allergic to peanuts can order a peanut butter sandwich. And I made that aware to that company five years ago, and still nothing has been done. No red flag comes up. And you're – we are listing the allergies and intolerances on the system, yet they can still order a meal that will kill them.

MS HUTCHINS: And you note in your statement that in your experience where food is not eaten, this isn't recorded by the kitchen.

MR HALL: No, it's not recorded by the kitchen at all. You know, especially with a third-party contractor, the reason the third-party contractors are there, in my eyes, is because the facility is too lazy to do it themselves. They don't want to know about the food. They just want to pay the money, get the residents fed, and then they can wash their hands of any responsibility. So they don't want to know if the resident isn't eating their meal or not. They don't care about it. They just – they just will just push it on to a third-party caterer who will do it for the lowest price, and that's it. They don't want to know about it.

MS HUTCHINS: Ms Twyford, in your statement you highlight the importance of the attitude of staff that you have working with you. How does the staff directly impact on the experience for residents?

MS TWYFORD: Well, if the staff's attitude isn't positive, then it doesn't – the resident feels like they're not wanted to be there. I think the staff need to want to be there. They need to be happy. They need to be interested. They need to have good knowledge, as we said, with the training. And yes, that does impact because the residents' experience in the dining room is an important – to their day.

MS HUTCHINS: And you provide an example in your statement of an instance where staff, I guess you could say, have gone above and beyond what might be expected of staff within, I guess, the allocated hours of work. Do you want to describe that example for the Commission?

MS TWYFORD: Was that Jack or - - -

MS HUTCHINS: Sure.

MS TWYFORD: Okay. So when I first started in aged care, I was working in another facility and it was Christmas morning and I saw this one resident named Jack sitting on the bed with his hat and his jacket and his little brown bag, and he was going home. His family were picking him up. He was really excited. So he said he wouldn't be there for lunch. Is that okay there? I went down morning tea time and he was still sitting on the bed with the same little bag, nearly ready to go, and I said, "Would you like a cup of tea?" "No, mate," he said, "it's all right. They're coming. It's fine. You know, I'm going." I said, "Okay."

We monitored it during the day. Lunchtime, Jack was still sitting on his bed. No one had came. Offered him lunch and he still said, "No, no." You could tell that his level of excitedness had dropped a bit, but we still monitored it. By the end of the day walking out, Jack was still sitting there, the family hadn't come. So the staff – myself and the staff around, we didn't go home. We – Jack was starting to get undressed and we said, "No, no." We got him together, we said, "Let's go." We provided Christmas hats and food and everything to make his Christmas a good one and to take – try and take from his mind that he was forgotten. And that was the staff. They stayed back. We all did.

MS HUTCHINS: And in your experience, Mr Hall, how important is the staff attitude to trying to achieve good outcomes for residents?

MR HALL: It's everything. When I was at the third-party contractor, I remember Anne Marie, she had been there for 20 years. She loved the residents. And the same at a later job. There was – there were a couple staff there had been there over 20 years and they absolutely loved the residents. They were their friends. They treated them like a member of their family. But as their hours got cut more and more, and more and more pressure got put on them, you could see their interest in the job just dropped because they knew they were just a number. And it was sad, because they really did love the residents, but they were just pushed to the breaking point, really.

MS HUTCHINS: And, Mr Deverell, have you found also that the, I guess, circumstances in which you have been working under budgetary pressure or inadequate numbers of staffing, as you said, how does that impact on your attitude to the job and the feeling of satisfaction or otherwise that you have?

MR DEVERELL: Yes, you can tell whether food has been made with love or not. And when the staff are under pressure, because there's a shortage of food or a shortage of labour, the food suffers. It's not as good a quality, not as much care goes into it. Corners get cut, it just gets put on a plate. There's no dressing it up. Nobody cares about the presentation. It's definitely issues with low food cost and low labour.

MS HUTCHINS: There's no further questions from me, Commissioner.

COMMISSIONER TRACEY: Thank you. One of the matters that we've been hearing evidence about, resident satisfaction, revolves around timelines, and the rigidity with which some institutions have, for the time breakfast is served, the time lunch is served, the time dinner is served, people complain that, "That's not like it is at home. That's what makes us feel we're in an institution. When I'm at home, I was able to have my breakfast at 8.30, 9 o'clock because that suited me. That's what I was – but now I'm in this institution, I can't do that." Is there scope, consistent with good practice, as far as sanitary and other matters are concerned, for meals to be more flexibly produced for individual people?

MR HALL: I definitely think that that is available, but at the moment the way – because it's a race to the bottom at the moment, who can provide it at a lesser cost,

food satisfaction and that, they throw these words around like they mean something to these companies, but they don't. They're just racing to the bottom to see who can feed for the lowest amount of cost. Yes, I think that if a resident doesn't want to get up at 8 o'clock in the morning, get up at 7.30, they should say, "I'm going to have a sleep-in today. Can I have my breakfast at 9.30?" But that's not available. You know, I was trained in the army and they said this is what that seems like. And, yes – and the hours are being cut back from especially the food service attendants so much.

One of the saddest things I saw was when I – I would start at 5am at one site so I could do the home baking, and that made a huge difference because the residents would wake up to freshly baked scones, and the smell of it throughout the residence made a huge difference. But at night, we used to have a staff member stay till 8 o'clock and clean up the supper dishes once they came back, the trolleys came back. The third-party operator cut that out, cut that right out. The staff were finishing at 7.

I walked in one morning and the trolleys had been returned in front of the kitchen, half-eaten food and cold cups of coffee and everything. They hadn't been cleaned. And a resident with dementia was helping themselves to it. They were eating the old food from the night before. And that's purely to save a tiny amount of money. For an 80-bed resident, when you're – when they're paying half a million dollars each to move in, they've got $40 million, and yet they're saving 50 bucks a shift and they've got $40 million of their money in the bank. It's just not right.

MR DEVERELL: Now, I – there's two things there in terms of being able to give residents meals when they choose. One is the labour cost. There's definitely – there's a meal compression which I mention in my statement, where they compress all the meals to maximise their labour cost or minimise their labour cost. That's a huge factor. The second one is we're working with constraints in terms of food safety.

So in New South Wales, we've only got – technically it's two hours, but they tell us 90 minutes from when the food leaves the kitchen to when it has to be returned to the kitchen. So if we don't have enough labour to do, say, two meal periods, do a staggered dining, they've only got 90 minutes so the resident has to eat it. If we start the first one at 12, the last one has to finish by 1.30. That's under the legislation. That's under – what we're working with. So there's two constraints there. One is the labour, and nobody wants to spend the labour. And the other one is the Food Authority.

MS TWYFORD: We do have set meal times. However, the resident doesn't have to come down. We do have the flexibility. If they want to stay in their bed, the catering staff is let known by the care staff and they stay there. They come down when they're ready. And they want to have breakfast, they have breakfast. Some sleep in until 9.30. Some sleep 8 o'clock. The changes at the moment is from – the agency is asking us to do these things, but we're already doing it, as are a lot of other

facilities. I do agree with other – some places have problems with it, but we're not finding that. We're finding that it's working quite well.

COMMISSIONER TRACEY: Thank you. Anything arising out of that?

MS HUTCHINS: Only a further point of clarification with Ms Twyford. You've included in your statement also that should a meal – should a resident want food outside of the standard meal times, that will be made available to them also.

MS TWYFORD: Absolutely, yes. Yes.

COMMISSIONER TRACEY: Thank you. Thank you all for giving us of your time and very considerable experience of catering in aged care institutions. It's a matter that looms large in the quality of care for elderly people, and it's important to know what can and can't be done to improve the lot of those people, and it's for that reason that we've asked you to give evidence and for which we are very grateful to you for having done so. Thank you very much.

MS TWYFORD: Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until 11.20.

<THE WITNESSES WITHDREW

ADJOURNED [11.05 am]

RESUMED [11.22 am]

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Commissioner, I call Maggie Beer AM.

<MAGGIE BEER, AFFIRMED [11.22 am]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Please state your full name for the transcript.

MS BEER: I'm Maggie Beer.

MS HUTCHINS: And you have prepared a statement for the Commission.

MS BEER: I have, indeed.

MS HUTCHINS: For our records, it's WIT.0202.0001.0001 and you have a copy of that statement before you - - -

MS BEER: Yes.

MS HUTCHINS: - - - dated 21 June 2019.

MS BEER: Yes.

MS HUTCHINS: Have you had an opportunity to read over the statement ahead of your evidence today?

MS BEER: Absolutely.

MS HUTCHINS: Do you have any changes you would like to make?

MS BEER: Not changes, just additions.

MS HUTCHINS: Sure. And to the best of your knowledge and belief are the contents of your statement true and correct and the opinions in it opinions which you hold?

MS BEER: Yes, absolutely.

MS HUTCHINS: I tender that statement.

COMMISSIONER TRACEY: Yes. The witness statement of Maggie Beer dated 21 June 2019 will be exhibit 6-46.

EXHIBIT #6-46 WITNESS STATEMENT OF MAGGIE BEER DATED 21/06/2019 (WIT.0202.0001.0001)

MS HUTCHINS: Now, Ms Beer, you appear today in your capacity as – your association with the Maggie Beer Foundation.

MS BEER: Yes.

MS HUTCHINS: And you have had a long involvement in the Australian food industry. Your career spans farming, food production, television presenting and writing, and in 2010 you were awarded the Senior Australian of the Year.

MS BEER: Yes, I was.

MS HUTCHINS: And in 2011 the South Australian of the Year.

MS BEER: Yes.

MS HUTCHINS: You were appointed a Member of the Order of Australia for your service to tourism and hospitality.

MS BEER: Yes.

MS HUTCHINS: So what is the Maggie Beer Foundation and why was it established?

MS BEER: The Maggie Beer Foundation was established to further the food in aged care, to be able to – to be able to give the pleasure that is needed as well as nutrition and it's simply – it actually happened because I was asked to speak to 1000 CEOs of aged care during the year of being the Senior Australian. So I saw great and terrible, to be able to prepare my talk, and that is what led me to forming the Foundation.

MS HUTCHINS: Yes. And you note in your witness statement also that you had an experience with an aunt that was in a residential aged care facility.

MS BEER: Yes. I was a Sydney girl before my time in the Barossa, and an aunt of mine – and given that I'm nearly 75, you've got to remember it's a long, long time ago – but it was just the most terrible thing that I saw and I had nothing that I could do at that time. But now I have got a platform.

MS HUTCHINS: What were the types of things you saw in relation to your aunt's experience when it came to food?

MS BEER: My aunt didn't want to eat anything. Lost all the weight because the food was without a smell. It was institutionalised food in its most basic form. And there is no room for institutionalised food, but you have to work very hard not to.

MS HUTCHINS: In terms of the needs of older Australians for their diet, what are some of the characteristics of older Australians which can affect their nutritional needs?

MS BEER: Well, their loss of taste as they age is something that we have to – we have to cope with, but we have ways of – we have ways of making up for that with the smells of home cooking, even no matter how big the home is, and it's a home to me, not a facility. And if I think of a home, that's what I want to see and smell. And then it's a case of every meal, every bite of sustenance should be of goodness but flavour first. Flavour, goodness and pleasure. Without those three things in equal

measures they don't have enough to look forward to to get up in the morning. And that is just so vital that we provide that.

MS HUTCHINS: And how important do you think the role of food is for older Australians, particularly those living in residential aged care facilities?

MS BEER: It's the thing that drives them. I feel we've heard this morning, it's the one thing that is, if you like, that immediate satisfaction. It's not just for young to have that. They – it's the thing that is left for them most but without the energy that comes from good food, they don't have the will to, or the physicality to be involved. So the protein requirements that are so essential. But what is so important is to want to live, and to have a good life and food being the – to me it's the centre of the plate. But there are so many things that go around it. It's not just the food. It's the care. It's the feeling of home. It's the dining experience. It's the gardens. It's every single thing. But food is the centre and everything can emanate out from that if it's done as it can be, should be, must be.

MS HUTCHINS: You touched on earlier the poor food experience you saw with your aunty and, in particular, the institutionalisation of food.

MS BEER: Yes.

MS HUTCHINS: What are some of the features of that, that you have seen?

MS BEER: Well, it's the lack of scent, the lack of aromas, the lack of interest in food. How – and if a resident is not seduced by the food, they're not getting any nutrition because they don't want to eat it. And so it's – you have to step back and think how can you imprint into a home the things that are going to make a difference for the resident in terms of – and particularly the aromas of food, so the saliva can be stimulated instead of dry mouth. All of those things. And there are also emotional cues; there are emotional cues that are really important.

MS HUTCHINS: Yes. And are there some ways in which aged care facilities now are preparing their food which takes those types of factors away from the experience?

MS BEER: Look, there are so many people in aged care working so hard and trying to do the very best they can. But without – I will get back to the question – so, and there are really good places and we should be shouting them from the hilltops and giving them the kudos they deserve. And then we need to give the cooks and chefs that want to do really well, we have to give them the support of the CEOs, we have to give them the knowledge, we have to give them the training. I've gone off on a tangent. Please go back to the question.

MS HUTCHINS: The question was, what are the types of ways in which food is prepared in some aged care facilities which takes away those beneficial elements of the food experience that you were just describing.

MS BEER: Well, there is – the issue of the food just not having the right flavour and ingredients. There is – we have a huge percentage of food being cooked, chilled and coming in from commissaries, if you like. And so that final putting together of the food that has come in a plastic bag – and I'm not saying that you can't; you can do good food that way. But if you don't add to that, if you don't have satellite kitchens with some onions being cooked in butter or bacon, the smells – bring the smells in. It's lacking in scent and aroma. And they're the emotional cues but they're also – everybody wants to smell proper food. Without the right budget for the right ingredients, you cannot make good food with bad ingredients.

MS HUTCHINS: We heard earlier today from a chef panel that some facilities are providing their chefs with a budget of around $7 a day for meal provision. Do you think that this amount is adequate to be able to prepare the type of food you would like to see people eating?

MS BEER: Absolutely not. It's not possible, because they will have to – as has been discussed, processed foods, frozen food, frozen vegetables, fish that is usually frozen and imported, not even Australian. It's just impossible.

MS HUTCHINS: Yes. And what budget do you think is a reasonable amount that would be able to produce the type of food outcomes you would like to see.

MS BEER: All right. The minimum I would see would be $10 and $10, $10.50 is the minimum but that's when everything single thing is right. That's when you have a passionate cook or chef that knows how it costs no more money to be able to do things from scratch if they have a garden and if they have the processes in place that they can use the garden. But that's when every single thing is right. But $14, you can do really good food. But we also – we have experience from cooks and chefs that have been through our training programs, the masterclasses, that have gone into a home with a $10.50 budget, taken over the same budget as they went into, and the food had been dreadful and – at $10.50, but now, eight months into their position, they are doing beautiful food at the same budget. So it is not just budget, but you cannot do it without budget.

MS HUTCHINS: Yes. And you mentioned that a lower budget of around, say, $10.50 might produce good food provided everything else was right.

MS BEER: Yes.

MS HUTCHINS: And you mentioned, say, the availability of a garden that is producing fresh fruit and vegetables.

MS BEER: Yes.

MS HUTCHINS: Also a passionate chef.

MS BEER: Yes.

MS HUTCHINS: Is there anything else that you would say really helps to contribute to the environment being just right for good food outcomes?

MS BEER: Yes, the holistic approach of the whole of the home where everyone is invested in doing things so beautifully but none of that can happen without the basic – if you are lucky enough to get a really good passionate chef as we have heard go into a home and be given the freedom and the support of the CEO, the champion, if you like, to help, we can do that 10.50. But there is so much where it needs to be every part of a home – from the nurses, the carers, the dietitians, the health professionals, the management all have to be part of supporting each other.

And what I've seen in all the cooks and chefs – and we've trained 260 – now, it doesn't sound like a huge number, but they have then influenced in that train the trainer. But what we know from them is often they have no confidence because they're not respected and they're paid so little. And they need this attention, if you like, and skill to show, this is what I can do. They need to be shown what is possible if they don't have huge training behind them. And it's – but it won't happen unless there's a champion within the home and it has got to be from the leadership and it has got to be the whole.

MS HUTCHINS: Yes. And in relation to the staff training you've just referred to, is that a reference to the face-to-face masterclasses that the Maggie Beer Foundation provides?

MS BEER: Yes, it is.

MS HUTCHINS: Could you provide a bit of an explanation for the Commission about what that program is?

MS BEER: Yes. We have three masterclasses a year where we bring 30 cooks and chefs together, all around Australia. We take turns going around Australia. And for two days – in the past it was once, it was even three, but two days of absolutely – absolute immersion in what is possible, and skill. And so it's actually not only the skill of the cooking but the challenge. We put them through mystery boxes in kitchens where they have to work in teams and work with each other. We have our nutritionist or dietitians come in. We have experts in leadership. We pool together all the things that we think it's necessary that they learn so they know, and we give them that pride in themselves that they are the person that can make the most change. If they come in with this knowledge and inspiration and ideas and also the sharing with the other cooks and chefs. Everyone has the same problems. And they have strength in sharing ideas and sharing problems.

MS HUTCHINS: And do you think, generally, there's adequate training available for chefs and cooks working in aged care facilities?

MS BEER: Absolutely not. You know, to be a cook or a chef in an aged care home it is much more complex than a cook who does commercial cookery and goes out to

be in a restaurant or a café or restaurant except for at the highest level. It is more complex.

MS HUTCHINS: Why is that?

MS BEER: Well, it's that because of dealing with vulnerable people. So often high care, the onset of dysphagia in so many, the inability to swallow that needs a totally different way of cooking, in terms of food that those people can cope with. So it's specialised and there is no training.

MS HUTCHINS: Yes, and your masterclass is open to cooks, managers and CEOs at facilities?

MS BEER: We separate the CEOs. So it's only in the last two years that we've brought the CEOs into it. So it's open to cooks and chefs and we give – we have a lot more applications than we have places. So we give preference to the cook and the chef rather than the manager. And then we have the last day, we bring in the CEOs. And, really, I'm there to advocate on behalf of the cooks and chefs, and – with the CEOs and what is possible, if they show the leadership and if everybody cares as much as I know – I know so many people do.

MS HUTCHINS: Flinders University has undertaken an evaluation of the masterclass.

MS BEER: Yes.

MS HUTCHINS: What are some of the findings of that evaluation?

MS BEER: It has been terrific for us to have Flinders evaluate every class that we have had over four years – four years – the fifth year. And because the feedback comes to us of how the masterclasses have given them – the cooks, not only knowledge but confidence. And that when they go back into their home, they also have – because we have shared so much with them and given them so much time, they have the respect of the other members of the team where they weren't respected before. They were considered the lowest of the low, quite often. They – we join them up as a group where they can continue to ask questions of us and ask questions of each other.

They write us – I have – I have piles of letters and emails of saying how they went back and they made change. They threw out the packaged foods. They made stocks from scratch. They used fresh vegetables. So the feedback from Flinders is giving us the fact that we are, I guess, getting through to them and seeing it not only just straight after the masterclass but three months on, six months on. So it's this groundswell of knowledge that is being evaluated. And the introduction of foods that are going to make a huge difference from their health. The use of pulses and everything that could possibly give flavour.

MS HUTCHINS: And I understand the Maggie Beer Foundation will soon launch an online skills-based training course.

MS BEER: Yes.

MS HUTCHINS: Why is that course being launched and what's the need that it is seeking to address?

MS BEER: Well, the course is so needed because in one-on-one masterclasses, I can't do enough to get around Australia to every – I would like to, you know, because I know I can energise and give ideas but the Federal Government gave us 500,000 for our first session – section of skills-based training which we're going to do. And the first – we've actually identified 45 different modules we would like to present over a three-year period. The first year is 11 modules.

MS HUTCHINS: Operator, could I please ask you to bring out paragraph 28 of the statement. Just the table that sits under that paragraph, please.

MS BEER: Yes, thank you.

MS HUTCHINS: So are these the modules you were just referring to?

MS BEER: Yes, these are the modules we were referring to because we had to have a base to start. What happens in aged care is there's a huge difference between the training that is already there. You have really experienced chefs that have come out of the fine dining even, and often because they're burnt out and they want a life. And you've got them and they come in with a passion and they want to bring about change.

You have, as we have heard before this morning, you have cooks that fall into the position because they were the dishwasher and the cook left. I mean, that happens a lot, particularly in regional areas. And then you have cooks that are trained in the basic commercial cookery but nothing in the very specific needs of the complexities of aged care. So that is not available anywhere, which is why we're tackling this. But we did try for two years to get it up with TAFE.

MS HUTCHINS: Yes. And in general terms could you provide an overview of the types of things, say the first four categories under the cooking essentials - - -

MS BEER: Only four.

MS HUTCHINS: - - - in terms of cover. I mean, what are the issues that you've seen in cooks that come to you for training and what are these subjects seeking to address?

MS BEER: Okay. Well, because of this incredible diversity of skill that comes, we really have to have something as basic as a pan-frying module. Now, that might

sound so simple that it's ridiculous but, you know, that principle of not crowding in the pan, getting the butter hot and nut brown first for full flavour, deciding which ingredients benefit most from pan-frying. The right pan, the right heat. The fact that it doesn't stay at that heat all the time. It sounds so basic but that is – if you don't know how to do that, then you can't really cook because you need colour and flavour.

MS HUTCHINS: And is that type of information tailored specifically for the environment they might be faced with in an aged care facility?

MS BEER: Yes, it's tailored for the environment of the home that cooks in-house.

MS HUTCHINS: Yes.

MS BEER: But it's also really important for those that have the cook chill delivered by a larger food service organisation because if they – we have to live with that. They're there. I would rather them not but they're there. And – but by pan-frying the last parts of a meal, even if it's only tomatoes in butter because it's going to be added to the side and get the scent so, yes, it is essential – pan-frying.

MS HUTCHINS: That's the type of information that you touch on as well in the working with the cook chill finishing stages?

MS BEER: Yes, I do. I do.

MS HUTCHINS: Yes.

MS BEER: Yes.

MS HUTCHINS: Before, you touched on the importance of food presentation which presumably is part of the next module as well.

MS BEER: Yes.

MS HUTCHINS: Why do you see the food presentation as being important to food outcomes for people in residential aged care facilities?

MS BEER: We know that as we age, we lose more taste buds and that – saliva, we're more likely to have dry mouth like when we are nervous, and the saliva can be stimulated by aromas first but, secondly, by the eye. The look of a beautiful meal can stimulate saliva. It was really interesting to learn, Lindy this morning talked about the plate that was designed so it was higher one end to allow the dignity of the diner. Now, you have those in the top list restaurants, you know, those special plates that all seem very funny. But the plate being the right plate, not white on white. So someone with less eyesight can see quite simply, an edge around the plate. So all of the design of the crockery, the balance, the meal not being too big too, so as to overwhelm the diner, because if you are not being active, you actually have a lesser

appetite, that make every bite count. And the way it's presented, we all know that. We love – we eat with our eye, they often say and we do, eye and nose.

MS HUTCHINS: And in relation to the module keep it simple, keep it fresh: gardens.

MS BEER: Yes.

MS HUTCHINS: What is the type of material that is covered in that module?

MS BEER: Well, keep it simple, I noted about stocks earlier and that's one of the things we talk about with every cook and chef that comes through. Now, in a restaurant, you would roast your bones and you would roast the vegetables. But you can make a brodo, a cook or chef in an aged care can just put it all in and put it on a simmer and that's the base of something so simple and it's going to make all the difference in flavour. Having fresh herbs from the garden and, yes, it is possible. So many cooks and chefs have been told it's not, and that needs to be debunked.

MS HUTCHINS: Told by the facilities they work for?

MS BEER: Well, because their manual does not allow for it whereas when you speak to – if you have the processes in place and it's part of your manual, the way you look after what comes in from the garden, of course it is. But there are Chinese whispers that happen in kitchens.

MS HUTCHINS: So when you refer to the manual, is it in your experience that chefs have come to you and said the relevant facility policy or procedures don't allow for me to have that garden.

MS BEER: Don't allow for me to have a garden to have any vegetables out of the garden, to even have fresh herbs. And we have to debunk that and to do that with our one-on-one training we bring in a very experienced third-party auditor who has come through from a chef. And so it's really good to have – and soft eggs. You know, the things that are possible, if you have the processes in place. But, for instance, making scrambled eggs and putting cream into them instead of milk or water, and I know cream might not have that much, as much protein as, say, the eggs but it's the lusciousness and putting in fresh herbs. It's just making a pesto. We need to oomph the flavour of food in every single way we can. So keeping it simple is just that, the things to share, because people want ideas. They are working very hard without – without respect and without people to bounce off, bouncing off people.

MS HUTCHINS: Do you find the cooks and chefs that come to your training sessions are there on their own accord or with the support of the provider or a bit of both?

MS BEER: Absolutely both. We have a lot that come on their own. The first couple of years we were able, with support of a large business, to give scholarships and they were people that really – they just cared so much and we were able to bring them in on that. But there are a lot now – we're having groups of homes come to us and say, "Will you especially design for the whole of our group" you know, like 30 homes. And we are doing that but it does take a huge – I can't do that with everybody.

MS HUTCHINS: Certainly. And in relation to the next category of modules, important needs, how important is it to specify or make sure that a menu is tailored for a particular individual's needs and desires?

MS BEER: Yes, well, you know, that is – to lose choice in life is a terrible thing. And if you have a budget as restrictive as those that we have been hearing about, there is no possibility of having that choice, because that amount of money just does not allow for it, because choice will cost more. But having said that, there are ways of stepping back and thinking how could I do differently. And, for instance, I would like to come to breakfast later from a comment this morning, so – but choice – choice requires a lot of thinking and planning, and knowledge and that's why it's a holistic thing. Everybody has to be involved in this, including families, including the residents expressing their choices.

MS HUTCHINS: And what you like to say in relation to breakfast.

MS BEER: Well, what I want to say in relation to breakfast is one of our people in our orbit in an aged care home in a country town, not far from the Barossa, went away thinking how important choice was because we talk of this. And so what she did was to bring all of her staff to have a breakfast that was a buffet breakfast that ran between 7 and 9.30 and that she and her staff came in their pyjamas so they could encourage the fact that the residents don't have to be all showered and primped if it works for them. Let them come in their pyjamas, too. That's what I mean by thinking of it as your home. It is their home. So how can we bring in matters of home. So that's what I wanted to say.

MS HUTCHINS: Thank you. And back to the pilot modules, high energy and protein; why is this considered to be an issue worthy of, I guess, the attention of the first 11 modules?

MS BEER: Well, it is – I've learnt so much from the nutritionists and dietitians and Flinders University, of just the fact that as we age, we need more protein than even when we're young. Now, that's not readily known in the community, let alone in kitchens and we need a whole program in the community to talk about that, and the needs that are so different. And without the protein – and not just protein, amino acids and more technical things – how the muscle waste is so extreme. So how do you have energy to be involved? And if you are not involved and you are just a passive recipient, I don't feel we're giving – you can't be giving the resident the chance to be connected to their life to the end of their life.

MS HUTCHINS: Thank you. In relation to the Texture Modification A and B, we have heard this morning from the chefs panel of the lack of training around texture modification. We have also heard in evidence before the Commission last week about a lack of variety in the meals that are available.

MS BEER: Yes.

MS HUTCHINS: How important is it to try to serve texture modification meals that are appalling to the residents and what are ways in which you could do that?

MS BEER: Okay. Well it's just essential because of the number of residents, you know, with dementia or dysphagia or both and coming in at high care now, much older, it is – and there's, as we've heard, there's no training in this. So we have really focused tremendously on that with great support from Peter Morgan-Jones and from Hammond Homes who, in fact was very integral for me getting involved in all this because of the work that he was doing. But there is the thinking that it is not – moulds are really important to have food that is shaped like, say, just even say a carrot that has been mashed and put into the shape of the carrot. So there is that recognition factor. And so if that is on the plate, that is one thing.

And it's really important but, of course, if your moulding takes more time and it takes an investment, and often it's also frozen to be able to push out. But there are other ways as well. And we are continually learning from people. And, for instance, one very qualified chef who came into aged care – very young, about 30, and had dysphagia herself because of an operation – and she put herself through, "Okay. How can we do this without the investment of moulds?"

And to see her preparing the food with all of the butter and garlic and onions and fresh herbs and then pureeing it and using moulds because that is when you must put the flavour in – so it's not just to have it textured modified. There are mousses; there are ..... or silky custards; there are so many ideas and we need to share those ideas, but we need a variety of colours and flavours and we need to put as much flavour in as possible.

MS HUTCHINS: And in relation to the last two modules, we've spoken briefly already about the sensory thresholds for taste and aromas, is there anything further you would like to add in relation to the importance of - - -

MS BEER: Flavour is everything. Flavour with aroma, along with the goodness, the nutrition and – will give the pleasure, and it can be done. But there's a lot of work to do.

MS HUTCHINS: Yes. Thank you. And in relation to the dining environment, what are the types of measures that you encourage people to put in place?

MS BEER: To think of even a large dining room, how can you give some intimacy. And that can come with lighting and colour and vitality, how can you create a mood.

Every home is different. And – but we have been working with design students from the University of South Australia who put themselves into this position and came back to us with so many ideas of how you put colour and photography that meant something to the residents on the walls, to bring – bring – the small things.

Like, if you were at home and you want flowers on the table, make them edible in case they're eaten. But it's – when you can have a dining room where you are looking out but the ambience, the room temperature, the lighting needs to be bright – there's a dichotomy there, it needs to be bright to be able to see for those that are losing sight, yet soft lighting and soft music is evocative of better times. But there is so – often it's the little things but it's putting yourself in the position of seeing it as a home, yes.

MS HUTCHINS: And in relation to other activities of the Maggie Beer Foundation, you also engage in advocacy, is that correct?

MS BEER: Yes.

MS HUTCHINS: And what does that work involve?

MS BEER: Well, the advocacy is all about spreading the word of what is – spreading the word and making people think, with government departments, we spend a long time putting in submissions to the Federal Government. The other piece of advocacy that's tied up with tying in with research is the fact that – working with other organisations like SAMRI in South Australia and the CSIRO, people who – organisations that can see us as we're the conduit for the practical end of science. And so that advocacy is truly important. But so is spreading the message.

MS HUTCHINS: Yes. And, Operator, if you could please pull out the last paragraph on the bottom of page number 10. So the at this part of your statement, you detail a number of common complaints that you receive from people, and it says:

> *The nature of these complaints are around choice, quality, lack of flavour, colour texture, variety, nutritional content, smell, lack of fresh and seasonal produces, chef skill, extensive use of packet and pre-packaged goods, the cook/chill model, food safety restrictions and commonsense.*

How do you feel when you receive these types of complaints?

MS BEER: It's a terrible thing. These letters, these letters are often so personal and they deal with a family member or the person themselves in the aged care home. And it just breaks your heart because it doesn't have to be like that. It should never be like that. We have a responsibility to give a good way of life for those in aged care and in the community, by the way, those elderly living on their own. And to change it, we need everyone involved.

MS HUTCHINS: What do you think are the main systemic issues that are causing these types of food outcomes for people?

MS BEER: Lack of training. Lack of training, lack of respect and lack of salary too. We were asked to be on a panel to choose a chef as an exec chef for a home, quite a substantial home with three different operations, and all of the things that we heard from our chefs this morning, the things that cook or chef had to do as well as cook and the salary was 54,000. So there's that lack of respect in the industry that they are faced with. It's the low wage. There's the lack of support often, and lack of – lack of the latest thinking as well.

MS HUTCHINS: Yes. What do you mean by that exactly?

MS BEER: The latest thinking about the need for dairy in the elderly, about the fact that they shouldn't be having no fat, low-fat anything, that diet cordials should never be used. Packet – that's the – they're the issues that they need a conversation to be happening. The amount of protein. It's much harder – a restaurant chef does not have to balance a meal over a week. It's a celebration, if you like. But a cook or chef in a home has got to make so many right decisions and not everyone has a nutritionist or a dietitian to help them, and they're not being – well, just the issue of, I think low-fat diet and preservatives, all of those things, they're not conversations that are being had.

MS HUTCHINS: Yes. And do you think there's adequate, I guess, guidelines or directions available put out by, say, the government that would help direct chefs in, you know, who nutritional content they should be aiming for in their meals?

MS BEER: No, I don't. And when I can – if I could find my note. In the current standards and guidelines of 2014, just taking (a), meals of adequate quality and quantity, adequate is not enough for people who don't have choice, who have had hard lives and we have a responsibility to look after and give them pleasure as well as health. You can't – there's nothing there about emotional wellbeing, the quality of life they deserve. And so there has to be – there's community and government understanding of the difference that we need to make and can make and must make.

MS HUTCHINS: Yes. And so what are the types of things you would have liked to have seen in the new standards?

MS BEER: What I would have liked to see in the new standards is a system to gather residents' feedback on their food experiences, and that requirement to meet a satisfactory level for accreditation. But, you know, there is the issue of subjectivity. You know, some people think one meal is good enough. So it's a very tricky thing to put into a standard, but we need to be – to have a proper food accreditation standard with – where you have every part, the dietitians, nutritionists, other professionals to incorporate. It's really important that they incorporate flavour – flavour, appetite and pleasure thoughts to have wellbeing. It's – nutrition is not enough on its own. It's absolutely essential, but it is not enough. So – but there has to be that holistic way.

And guidelines developed for the best dining practice too. You know, simple things. They're not complex. But we need more.

MS HUTCHINS: Yes.

MS BEER: We need research.

MS HUTCHINS: Yes. And while we're on the topic of the Aged Care Quality Standards - - -

MS BEER: Yes.

MS HUTCHINS: - - - standard 1 relation to consumer dignity and choice.

MS BEER: Yes.

MS HUTCHINS: Do you think currently across the board, residents are provided with dignity in choice in the type of foods that they're provided?

MS BEER: No. No, they're not in – look, there are – I have to come back to the fact that there are really good homes out there. We know that. But dignity, independence can only come if you have dementia from, for instance, being able to have finger food, not to be ostracised because you can't use a knife and fork. It's so – it's – it's so important. And it's not there, not in the standards.

MS HUTCHINS: Yes. And we touched on earlier this issue of food that's perceived to be risky and whether that might be, you know, contrary to food regulations or outside of the scope of what - - -

MS BEER: Yes.

MS HUTCHINS: - - - a particular provider might want their staff to be cooking for the residents. What's your view in relation to that issue?

MS BEER: That's the lowest common denominator for me. And with training, with respect – with the trained staff on in the evening as well. We heard this morning. It's all of these – perhaps there are some foods – I mean, not for me but – I would even have pate. But if food is looked after properly of the right quality, because the quality of the food has a lot to do with the risk of it, to be able to give the soft eggs, to be able to have the meats, to think that we can't give liver, pan fry, there isn't a cook on at night, to pan fry liver that is so good for them, so full of iron and it's a memory of their childhood, it's just – it all can happen with training.

MS HUTCHINS: Yes. And do you have circumstances as well where chefs or cooks come to your master classes and describe that they would like to put into place particular food measures but it's not possible because of the other staff that's available in the facility?

MS BEER: Yes.

MS HUTCHINS: For example, people responsible for feeding.

MS BEER: Yes, absolutely. When they first come, we ask them to put up and we put up on the board all the impediments that they see, and then we try and tackle them. And that is a major one. Those that have staff that don't want to shift, they don't want to change, they've always done it this way. But part of that is the lack of leadership of knowing how important it is to have beautiful food and the outcomes of beautiful food for – it's just the resident, it's the positive energy that transmits through everyone in the home. But if the cook or the chef is given respect and training, then – and that holistic approach where everybody has to be on board to make this change that we're looking to make.

MS HUTCHINS: And what are some of the major impediments you see?

MS BEER: Budget. Budget and training and attitude are the main impediments, and the lack of knowledge, which is different from training. Lack of knowledge, to touch on again, of the importance to wellbeing that this can make. There are many people who seafood as just fuel, and they're never going to be able to be part of this. And so that is finding the right people. There are – we come across so many cooks and chefs that also there is another impediment. They are so busy filling in forms and doing things other than cooking without support that they're no longer getting that connection with their resident.

Now, they all say in their way, the statement they all make to me is, "If I can see my oldie," and they say that with great warmth and care, "and I know that I have pleased them, this is – makes my job worthwhile." But they are so often now being excluded from that direct contact because of the amount of regulations and the amount of other duties that the cook and chef other than cooking have to do.

MS HUTCHINS: Yes. And in relation to your comment about the attitude for some people that food is fuel - - -

MS BEER: Yes.

MS HUTCHINS: - - - I know a matter that you've raised in your witness statement is the use of supplements.

MS BEER: Yes.

MS HUTCHINS: Yes. So what's your view about the use of supplements?

MS BEER: Well, supplements are often needed, and those that come in very fragile from the community or those that haven't been eating because they haven't – they don't like the food, and so supplements are essential but – in those cases, but supplements can be about real food, and it's – it is so easy to put extra eggs and

cheese and butter through the vegetables with herbs. There is so much we can do just in cooking terms to make – instead of using a packet mix for a custard, to make a crème anglaise with a very simple stick blender and full of cream and eggs and vanilla and put into a combi, and it's so beautiful and luscious. That's what supplements should be.

MS HUTCHINS: And do you think there's enough focus when, say, a dietitian or a nutritionist is considering someone's, I guess, nutritional requirements for the importance of flavour and enjoyment in the meals?

MS BEER: I've come across those that absolutely feel that way, and we work with Flinders University with a dietitian who is passionate about food. If you put a dietitian or a nutritionist that has all of the science that they need to be able to impart and this love of food and flavour, that's where – but it's not in all.

MS HUTCHINS: And in terms of recommendations that you may wish to make to the Royal Commission?

MS BEER: The recommendations, well, is that other than that what we've put into the report which I've sort of touched on?

MS HUTCHINS: Certainly. So in your statement, you touch on a few matters which we've already addressed - - -

MS BEER: Yes.

MS HUTCHINS: - - - being the inclusion of the food experience, outcomes in food accreditation standards, a desire to increase training - - -

MS BEER: Yes.

MS HUTCHINS: - - - in the workforce, and also an increase in wages.

MS BEER: Yes.

MS HUTCHINS: What are some other key matters that you would like to highlight?

MS BEER: Well, I think we absolutely need research on the relationship between food, emotional and physical wellbeing in aged care to assist providers so they can be shown on a plate just what – rather than hearing anecdotally from a person like me who feels it so strongly. But funding for the establishment of research into the expertise and design of food in aged care. You know, and that doesn't have to be a university such one. But research into taste changes in food because of the lack of saliva flow. These are research that is really needed in the community.

But, also, there needs to be a campaign, a campaign for society as a whole, to understand the importance of food, of eating well as we age for health, the how and the what, and understanding the social aspects of loneliness and isolation that lead to depression and – depression, malnutrition. But they're the big things over and above. But there are other things that – things – raising the status of cooks and chefs, having the CEOs with the leadership to lead the change as a champion and having a salary ladder for cooks and chefs as they get more experienced is so really – is so really important. And – but I did have a few things. An impediment I forgot to bring up, can I bring it up now?

MS HUTCHINS: Certainly.

MS BEER: There are some states with government buying policies that the homes, that many of the homes are limited to having to use the food that they put out for tender and accept the cheapest ingredients and that is Parliament, State Parliament dictating that that's what they should do. And so we'll always have imported frozen fish and frozen vegetables as a norm because they're cheaper. And so there needs to be a way of encouraging agriculture to link in with aged care and seeing that our ingredients should be Australian, because it just makes so much sense. Food safety auditors, debunking myths. Sorry; I had so many notes because I was scared I would forget something.

MS HUTCHINS: That's perfectly fine, and I think you've covered the ambit of the questions that I wanted to ask today, Commissioner.

COMMISSIONER TRACEY: If you want a minute or two to go through your notes - - -

MS BEER: Yes, could - - -

COMMISSIONER TRACEY: - - - to find the missing bit, feel free to do that.

MS BEER: Thank you. I've got here just ideas, ideas to share. We all know that the gut of elders is a problem with so many medications and often the diet that they're on without choice, and we know that it disturbs the gut biome. I also know as a cook that fermented foods – and a nutritionist would say the same thing – is so good for them, but we have to be having foods that are familiar. But this is the idea. If you make a water kefir, it tastes like ginger beer, and that's of their childhood. And that's just an example of how we pool all these ideas that are not going to be in a book. And there are so many ideas, like the plate this morning.

And the other one, I know there will be very few homes that will have a filet mignon, right, but a cook or a chef that is – has been given training in the use of secondary cuts of meat, long, slow cook that they're so luscious you could eat with a spoon, will give so much more – I mean, it will give equal amounts. It is – in a filet mignon, it's texture, not flavour, you know, and it's posh, and it's great for those that can have it. But they are available with the right cooking methods for the right

ingredient. We can do things inexpensively if we look at every single thing. And the big thing is the training that we are going to do is not a dry training.

And by that, I mean there's a lot that I learnt is when you're training and you're bouncing off of someone and, "I'm going to do each of the ones with other experts so there's energy and interest and the knowledge that the foundation and myself feel that these people are so important and we can give them what they need to make more change than anyone else." And so, to me, that training is so essential and, of course, that's only the first year. Yes.

MS HUTCHINS: Thank you.

COMMISSIONER TRACEY: Ms Beer, you have treated us to a special masterclass this morning for which we are most grateful. Your enthusiasm for the work of the foundation is both palpable and infectious. I note that it is a decade now since you were invited to be the guest speaker at the meeting of CEOs of aged care facilities.

MS BEER: Yes.

COMMISSIONER TRACEY: And I would be bold enough to suggest to those organising this year's meeting that the time is probably ripe for another invitation. You will be preaching, I think, to some of the converted.

MS BEER: Yes.

COMMISSIONER TRACEY: But there will have been new appointments in that period and there will still be some who remain to be convinced.

MS BEER: Yes.

COMMISSIONER TRACEY: So I ask that those who are monitoring these proceedings and have responsibility for issuing such invitations to please note what has just been said.

MS BEER: Thank you.

COMMISSIONER TRACEY: Thank you again for your insights into such an important aspect of the care of our elderly.

MS BEER: Thank you, Commissioner.

COMMISSIONER TRACEY: The Commission will adjourn until 1.15.

<THE WITNESS WITHDREW

ADJOURNED **[12.22 pm]**

RESUMED **[1.18 pm]**

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Commissioner, I call the next panel of witnesses: Dr Sandra Iuliano, Robert Hunt and Sharon Lawrence.

<SANDRA IULIANO, SWORN **[1.19 pm]**

<ROBERT JOHN HUNT, SWORN **[1.19 pm]**

<SHARON LAWRENCE, SWORN **[1.19 pm]**

MS HUTCHINS: Dr Iuliano, could you please state your full name for the transcript.

DR IULIANO: Sandra Iuliano.

MS HUTCHINS: And you have prepared a statement for the Commission dated 28 June 2019.

DR IULIANO: Yes, I have.

MS HUTCHINS: For our records it's WIT.02024.0001.0001. Do you have a copy of that statement before you now?

DR IULIANO: Yes, I do.

MS HUTCHINS: Are its contents true and correct to the best of your knowledge and belief and the opinions are the opinions that you hold?

DR IULIANO: Yes, they are.

MS HUTCHINS: Yes. And I understand you would like to make a number of corrections to that statement which are set out in document WIT.0204.0002.0001.

DR IULIANO: Yes.

MS HUTCHINS: Commissioner, I tender those documents.

COMMISSIONER TRACEY: I'm sorry. What was the amendment?

MS HUTCHINS: They're contained in a document, Commissioner, which is document reference WIT.0204.0002.0001. The amendments are in the nature of rectifying a couple of typographical areas in relation to the footnoting.

COMMISSIONER TRACEY: They're the only amendments?

MS HUTCHINS: Yes, Commissioner.

COMMISSIONER TRACEY: Yes, very well.

MS HUTCHINS: And that amendment document is dated 16 July 2019.

COMMISSIONER TRACEY: Yes. The witness statement of Dr Sandra Iuliano dated 28 June 2019, as corrected in the corrigendum dated 16 July 2019 will be exhibit 6-47.

EXHIBIT #6-47 WITNESS STATEMENT OF DR SANDRA IULIANO DATED 28 JUNE 2019, AS CORRECTED IN THE CORRIGENDUM DATED 16/07/2019 (WIT.0204.0002.0001 and WIT.0204.0002.0001) AND ITS IDENTIFIED ANNEXURES

MS HUTCHINS: Thank you, Commissioner. Now, Mr Hunt and Ms Lawrence, you have prepared a statement, a joint statement for the Commission?

MS LAWRENCE: Yes, we have.

MR HUNT: We have.

MS HUTCHINS: Operator, please bring up WIT.0205.0001.0003. Is this your statement dated 20 June 2019?

MS LAWRENCE: Yes, it is.

MR HUNT: Yes, it is.

MS HUTCHINS: Have you had the opportunity to read over your statement before giving evidence today?

MR HUNT: We have.

MS LAWRENCE: Yes.

MS HUTCHINS: Do you wish to make any changes to the statement?

MS LAWRENCE: No.

MS HUTCHINS: And to the best of your knowledge and belief, are the contents of your statement true and correct and the opinions in it opinions which you hold?

COMMISSIONER TRACEY: Yes.

MS LAWRENCE: Yes.

MS HUTCHINS: I tender that statement.

COMMISSIONER TRACEY: Yes, the witness statement of Mr Robert Hunt on behalf of the Dietitians Association of Australia dated 20 June 2019 will be exhibit 6-48.

EXHIBIT #6-48 JOINT WITNESS STATEMENT OF ROBERT HUNT AND SHARON LAWRENCE ON BEHALF OF THE DIETITIANS ASSOCIATION OF AUSTRALIA DATED 20/06/2019 (WIT.0205.0001.0003)

MS HUTCHINS: Thank you, Commissioner. Now, Dr Iuliano, you are a qualified nutritionist with a PhD in Nutrition and Exercise Psychology, a mMaster's Degree in Human Nutrition and a Bachelor of Applied Science in Human Movement.

DR IULIANO: Yes. It's actually exercise physiology.

MS HUTCHINS: Exercise physiology. Thank you. And since 2001 you have been employed as a senior research fellow at the Department of Medicine in the University of Melbourne.

DR IULIANO: Correct.

MS HUTCHINS: What was your professional experience prior to this role?

DR IULIANO: Generally lecturing in nutrition and exercise physiology and consultancy work as a nutritionist.

MS HUTCHINS: And you have published a number of publications during your career relating to improving nutritional care and nutritional quality of food provision in residential aged care. These are listed at annexure A to your statement. In broad terms what are the types of matters that you are investigating?

DR IULIANO: Mainly, looking at nutrition and how it can influence the outcomes of residents such as falls and fractures and their overall health and all the work has been using a food-based approach instead of using a pharmaceutical or supplement approach, so it's using foods.

MS HUTCHINS: Mr Hunt, you are currently the chief executive officer at the Dietitians Association of Australia.

MR HUNT: I am.

MS HUTCHINS: You have held this role since May 2018.

MR HUNT: I have.

MS HUTCHINS: Your professional background is that you hold qualifications as a Certified Practising Accountant you hold and a Bachelor of Commerce and Accounting.

MR HUNT: I do.

MS HUTCHINS: And prior to working with the Dietitians Association of Australia what is your professional experience?

MR HUNT: Over my career I have held numerous senior management roles in membership and professional organisations, including the likes of the Australian Medical Association, the Hearth Foundation and the like.

MS HUTCHINS: And what is the Dietitians Association of Australia?

MR HUNT: Well, the Dietitians Association of Australia has several main functions. Importantly, as a self-regulating profession, dietitians are covered under what is called an accredited practising dietitian program which I will touch on in a moment. The other role we play is as a voice of nutrition. And we have both roles run together: regulatory and the professional organisation, and a public advocate for nutrition.

MS HUTCHINS: And how many members does your association have?

MR HUNT: Our membership is thankfully growing. We have now 7000 members across the country.

MS HUTCHINS: And you referred just now to accredited practising dietitian. Who are accredited practising dietitians and what does this qualification mean?

MR HUNT: Accredited practising dietitians are health professionals who have dedicated their life to nutrition. They see themselves as one of the strongest advocates for nutrition in our community. It is a credential. It's a hard-fought credential. APDs, as they are known, Accredited Practising Dietitians, are all – they are all nutritionists. They do a Bachelor of Nutrition, and then those who choose to go on to do a Master's level qualification in – that centres around clinical environments. So these health professionals are incredibly qualified and, as I said earlier, are passionate about nutrition and I would go so far as to say the only health

professionals in the community that are dedicated solely to nutrition. So we take great pride and thank the Commission for this opportunity to be here. It's very important for us.

MS HUTCHINS: Certainly. And who is the APD credential recognised by?

MR HUNT: The APD credential is recognised by the Australian Government through the Medicare system. The APDs are able to apply for and use a provider number through the Medicare system. They're also recognised by the Department of Veterans Affairs and also importantly through the National Disability Insurance Authority and working in the NDIS.

MS HUTCHINS: And what settings do APDs work in?

MR HUNT: Well, they work across a number of areas. Obviously, the first would be in the hospital setting, both private and public; also, in private practice, running their own businesses in nutrition support; academia, as my colleague to my left would be. Also, importantly in the food industry, there are quite a number of dietitians working very hard to influence the supply of, and the formulation of, food in this country.

MS HUTCHINS: Thank you. And Ms Lawrence, you are an Accredited Practising Dietitian?

MS LAWRENCE: Yes.

MS HUTCHINS: So you completed a Bachelor of Health in Nutrition and Dietetics.

MS LAWRENCE: Yes.

MS HUTCHINS: From the University of Newcastle.

MS LAWRENCE: That's correct.

MS HUTCHINS: And for the last 10 years you've been employed as a Commonwealth Home Support package APD.

MS LAWRENCE: Yes. So it's actually a Commonwealth Home Support Program.

MS HUTCHINS: Yes. And what does that role involve?

MS LAWRENCE: So that role has two significant roles. One is supporting the nutrition and dietetic needs of the frail aged living in the community. The other role is supporting aged care providers who support frail aged in the community, being that meal services such as Meals on Wheels or carers that go into the home to support clients. It's supporting their needs and their education and skill level around nutrition as well.

MS HUTCHINS: And what do you see the role of dietitians as in providing care for elderly people either in their homes or in a residential aged care facility setting?

MS LAWRENCE: Sure. I see there being four main roles, and I guess the most important one is our role in supporting individual care. So that's quite an important role where we would undertake quite an in-depth comprehension nutrition assessment taking in all factors that may be contributing to poor nutrition for the individual, whether that's in the community or in the home. Our other area is working side by side with the food service system. It's really important that we work together. As we have heard today, we need the chefs and the cooks to implement our recommendations. We need to work together. We need to be one force.

The other area that dietitians work in is in the area of quality. So whether that's around undertaking audits around food service systems using, say for example, the Dietitians Association of Australia has a manual audit tool that we use in residential facilities. It could be undertaking audits around nutrition risk whether that is malnutrition screening. It could be assessing documentation, and it could be waste – plate waste audits, those sorts of things.

And our final area is around education and training. So because, you know, our careers are solely based around nutrition and dietetics, we have such a capacity to be able to educate and train aged care workers, everyone from food service providers to aged care providers to aged care assessors like ACAT and RAS, working with Allied Health Assistance, working with carers, working even with other dietitians and other health professionals in around educating the importance of nutrition in aged care.

MS HUTCHINS: And in terms of assessment, what does nutrition risk screening involve, and what are the types of nutritional risks that you look out to identify?

MS LAWRENCE: Sure. So nutrition risk screening should be a very simple process. It's quite different to a nutrition assessment. A nutrition assessment is a very in-depth, comprehensive process. Nutrition risk screening needs to be simple and quick. So what we're trying to identify are the main risks that are going to indicate if somebody is likely to be at risk of malnutrition. So we're looking for things like unintentional weight loss, how much weight they've lost over a period of time and changes in their appetite. Things that are likely to consider the type and amount of food that they may consume.

MS HUTCHINS: Dr Iuliano, why is nutrition important, particularly for elder Australians?

DR IULIANO: Yes, look, nutrition is – it's basically people's health and wellbeing through the foods they eat. And, really, what it's doing is it's – nutrition is about providing the building blocks so that they can build, grow and repair their body and also all the nutrients so that they can actually maintain all their bodily processes. So it's vital for every aspect throughout the ages, especially in the elderly.

MS HUTCHINS: And are the nutrition needs for older Australians different to the general population?

DR IULIANO: Yes, look, you find as people get older, their nutritional needs go up, and those with – that are frail, their needs are probably even higher still. Most of my works looked at protein and we know their protein needs are higher relative to younger adults. And the other aspect is also that there – we need to consider how much they can actually eat as well. So we need to ensure that what they're eating is of good nutritional value because they are not going to eat as much especially in the aged care setting where they're not active, their whole intake is lower so every mouthful needs to have some kind of benefit to them.

MS HUTCHINS: And are there studies that have shown how much the increase in the need for protein is in the elderly?

DR IULIANO: Yes, look, there has been some work done. It's still – look, it's still not crystal-clear, but the suggestions – at the moment, it's about one gram per kilogram body weight. So for a 60-kilogram person, that's about 60 grams of protein. It's suggested about 1.2 to 1.5 grams per kilogram body weight. So what we know in Australian residential aged care, the average is about .8. So if we go to the top end of recommendation, it's just over half of what they should be getting.

MS HUTCHINS: And what is malnutrition in general terms?

DR IULIANO: Yes. Look, malnutrition, basically, it's an imbalance. And so it's a deficiency in the nutrients that we need in order to be able to function and go through all the normal body processes. So, relative to protein, it is lack of protein and lack of energy, which is the two key drivers that we see that's in the residential aged care setting.

MS HUTCHINS: And have the studies that you've been involved in or others you are aware of indicate prevalence of malnutrition in aged care facilities?

DR IULIANO: Yes, we've actually documented the prevalence in one of our main trials, and it was 68 per cent of residents are malnourished or at risk of malnutrition in residential aged care.

MS HUTCHINS: And, Ms Lawrence, do those figures accord with your observations in relation to the extent of malnutrition in residential aged care facilities?

MS LAWRENCE: Yes, definitely. So there's been quite a significant amount of research completed around residential aged care where it does range anywhere from one in two, to two in three residents are malnourished. When we look into the community, what we find is that the risk of malnutrition is approximately 30 per cent of free-living elderly people in the community. And if we extrapolate that, that's equivalent to 1.14 million older Australians that are at risk of malnutrition. Those

who are actually malnourished, it's roughly around the eight per cent mark. So we're looking at just over 300,000 older Australians that are actually malnourished living in the community.

MS HUTCHINS: What are some of the challenges that people face in achieving adequate nutrition?

MS LAWRENCE: There's numerous challenges. So I guess the most obvious challenge which we've talked about today are the physical challenges, the physiological challenges with the changes that we experience as we age, whether it be taste, whether it be changes in gut function, changes in smell, increase in morbidity. There's also changes around psychosocial circumstances.

So increasing risk of depression, grief and loss, but also the affordability of food, being able to afford food, the living arrangements that change that also impact on our older Australians. There's the community belief, which is really mis – unfortunate, I should say, around believing that it's okay for our older Australians to be underweight. It's not okay. And it's a belief that we really need to debunk.

But, as Maggie highlighted this morning, is that there's also a lack of awareness of what our changing nutrition needs are as we age. Our needs are different, and I guess the public aren't aware of what those needs are, which is quite challenging. One of the other areas that makes it challenging to achieve nutrition in older people is the underutilisation of dietitians to help people where they do have special needs, where they do have increased needs.

MS HUTCHINS: And, Mr Hunt, do you think the current system encourages the proper screening of elderly people in relation to what their nutritional status is both in the community and in residential aged care facilities?

MR HUNT: It would be our position ..... that absolutely not. There's no desire to do so. There's no requirement to do so. And where it is done, the issues, one of the key issues is that the people doing the assessments are not necessarily holding the right training to identify – ask the right questions or ask the questions, sorry, and then deal with the responses to ensure that they're getting the right information. There would be many in our profession and, in fact, in the health system that would suggest that because of the demographic we're talking about, "Why don't we screen them all for malnutrition?" It would be easier.

MS HUTCHINS: And, Dr Iuliano, your statement identifies a number of adverse clinical outcomes which are associated with inadequate nutrition. I would like to ask you about a number of these in turn. You identify that one effect of malnutrition is an increased incidence of falls.

DR IULIANO: Yes.

MS HUTCHINS: Why is it that that happens?

DR IULIANO: Generally, what you find is when people are malnourished, and especially with protein, energy malnutrition, they lose muscle mass. When they lose muscle, they lose muscle strength, and poorer strength. They're more likely to fall, so it's related often to their function and lack of function.

MS HUTCHINS: Yes. And, Ms Lawrence, would you agree with that observation in relation to instances of falls?

MS LAWRENCE: Definitely. Definitely. I completely agree that – that loss of muscle mass. We need our muscles to hold ourselves together. It's one of the core functions, but it also impacts on not only falls but also on strength - - -

MS HUTCHINS: Yes.

MS LAWRENCE: - - - and also on aerobic function. There are so many other factors that malnutrition contributes to falls.

MS HUTCHINS: Yes. And it's also been noted that the effect of malnutrition can increase incidences of fractures. Is that something you have noticed also?

MS LAWRENCE: Yes. Well, that definitely comes as a result of falls. Yes. Yes.

MS HUTCHINS: And in relation to the effect of malnutrition on pressure ulcers and sores, what's the connection between the issue of pressure ulcers and the time that it takes to heal? How crucial is that?

DR IULIANO: Yes, with – again, the protein as a key factor – there's other nutrients as well – basically, the skin tissue is made of protein. So if we don't have enough protein, we actually can't repair the skin. So, therefore, they're more likely to get pressure sores. We also know that as people start to lose weight, that padding aspect is no longer there. So there's a greater pressure on the skin, which then also again can't heal. And we also know that the immune system is compromised. So often what happens is that they get an ulcer or a pressure sore and they actually get an infection because they're less able to resist the infection, and also that the actual wound stays their longer. So the costs overall go up because the wound is bigger and the wound stays there longer as well.

MS HUTCHINS: Thank you. Operator, please go to the statement of the Dietitians Association of Australia, to the bottom of page 9, and pull out the statistics that are set out at subparagraph (l). So Ms Lawrence, could you please just walk the Commission through the findings that you set out here in relation to the consequences for elderly clients losing body mass.

MS LAWRENCE: Yes. So even just a small change in lean – changes in lean body mass, being loss of muscle, has such a significant impact in the overall health and wellbeing of an older person. So 10 per cent change. So if you think of somebody who is, for example, 100 kilos, if they lose 10 kilos, most people will say, "That's

great," but it's not. It has – if they are losing it unintentionally, it impacts their immune system, it increases their risk of infection, as Dr Iuliano has just said, and it increases their illnesses around – from bacteria and viruses.

Further to that, a 20 per cent loss of muscle mass, we're looking at changes in our body's ability to repair wounds. As I explained earlier, it increases – decreases strength, increases weakness and it elevates our infection risk again. A loss of 30 per cent of muscle mass makes it too hard sometimes for a person to sit up to be able to consume a meal. So we're looking at total loss of muscle mass here, and even sometimes it makes it hard for individuals to swallow because muscles are required for the swallowing process.

Muscles are little required for the cardiac output, the renal output, the functions of our gut, the functions of our liver, etcetera. So we're looking at multi-systemic issues here to a point where we see a loss of 40 per cent lean body mass is actually fatal. And so we're looking at higher risks of pneumonia and, as previously explained, multiple organ failure.

MS HUTCHINS: And what impact may malnutrition have on a person's cognitive abilities?

MS LAWRENCE: There are – poor nutrition has been related – I guess poor nutrition is not only protein and energy, there are other nutrients and micronutrients, and what we can – what we know is that particular nutrients that we may be deficient in can mimic changes in our cognitive status. We know that there is growing evidence around changes in the gut biome and cognitive changes. We also know that dehydration, so inadequate hydration, can also impact on the cognitive status of an older person, their risks of developing delirium as a result of that. So there are multiple changes that can happen.

MS HUTCHINS: Yes. And you also note in your statement that dehydration can impact on short-term memory.

MS LAWRENCE: Definitely. Definitely. That's what I just – yes. That's what I just talked about, that it impacts the cognitive status of a person.

MS HUTCHINS: Thank you. And we've touched on, just a moment ago, the prevalence of malnutrition amongst Australians' elderly. What rate of malnutrition really would be an acceptable rate? Are there because of just the nature of people's conditions that it might be that it's unavoidable, or do you think that it would be a realistic goal to ensure that no one is malnutritioned in residential aged care facilities or in the community generally?

MS LAWRENCE: We would like there to be no malnutrition present. It's – we – when most people talk about malnutrition, they relate to third world countries. Here we have, and even across – this isn't just an Australian issue. This is a global issue, that malnutrition exists in our older people across the world. We shouldn't be having

that, just like we shouldn't have malnutrition in our third world countries. If anything, yes, there's – because of physiological changes, changes that you see around disease processes, there's going to always potentially be an increase in nutrition risk. But where we can minimise the progression to malnutrition, that would be our ultimate aim.

DR IULIANO: I just think it's a difficult number to quantify. It's about minimising the risk in the individual as to the best of our ability. And in residential aged care setting, that involves everybody being able to minimise the risk in that resident, who is somebody's mother or father.

MS HUTCHINS: Thank you. Dr Iuliano, you've recently been involved in a large-scale study that involved 60 residential aged care facilities. What was that study endeavouring to ascertain?

DR IULIANO: Yes. So what this trial was, it was basically a food-based approach and what we looked at is improving the nutrient intake in the residents, and it had 60 facilities and what we did is we worked with the food service staff, so similar to the chefs that were here earlier giving evidence, and we incorporated just milk, cheese and yogurt as a source of dairy as a source of protein and calcium into the menus and what we were able to do was improve their nutritional status. So we were able to maintain good nutrition in the residents. And when I say residents we are talking about 4000 in total.

So 2000 residents received the additional food, and we also did it over a two-year period which shows that you can do it over the long-term as well. So it's not a short-term trial in a short number of people. Key outcomes obviously with fractures, falls, but then we had, looking at function we looked at muscle. We looked at quality of life as well because we want to see if we improve their nutritional state if their quality of life is equally improved which is important as well.

MS HUTCHINS: Operator, please bring up the statement of Dr Iuliano and go to page 5 at paragraph 21 there's a number of subparagraphs under that, from (a) to (g), I would ask you to please call out. Your statement identifies that – the study you've just referred to now has identified a number of barriers to adequate nutrition as a result of that study. I would like to discuss some of these in turn with you. Of these factors that you've identified and listed here for the Commission, which ones do you think are the most important, I guess, to recognise as having an impact on the food outcomes?

DR IULIANO: Look, I think if you look at it, there's a systemic problem. So with that systemic problem comes a lot of these other issues that I've raised. The systemic problems that we identified with the food service set-up in residential aged care was one which has been brought up by Maggie and the chefs, the lack of education in the food service staff. So some food service staff may have got to their position not through training but through attrition. So they happen to have been in the kitchen and a chef leaves so they get put into that position. So they don't have

any knowledge. They're doing the best they can but they actually don't have knowledge. So there's no standard of nutrition, of education across food service staff.

MS HUTCHINS: Would you like to see some kind of mandatory minimum application?

DR IULIANO: Absolutely. I think if people are going to work in aged care and work with the elderly that we need some kind of standardised national education that they must achieve in order to work in that field because without it – it's a very specific group of people. It's like paediatrics; we don't just suddenly work in paediatrics with children, you have to be qualified and specialised. It's the same; they're as vulnerable as the children so it's the same scenario.

MS HUTCHINS: Yes. Mr Hunt, I see you nodding.

MR HUNT: Yes. Well, only to agree; education is the key to all of this, recognising the skills that are in the aged care environment. Cooks and chefs – we have heard some terrific testimony this morning from those chefs about how they are screaming out for this sort of support. It's training but it's also recognition of the roles of each of these components in this care environment. You've got support workers who are really fantastic people, have no training whatsoever in even the most basic alerts around nutritional issues with their carers. So it's absolutely fundamental. And you've seen it through our witness statements and throughout: education is a really important component.

MS HUTCHINS: Yes. And the next factor that we see listed here is a lack of funding allocated for food, which is clearly a matter the Commission has heard a lot of evidence about today. What observations could you make, Ms Lawrence, in relation to the food budgets that you see allocated to residents?

MS LAWRENCE: I have to say I was rather astounded to hear some of the dollars that have been attached to food in the residential setting. I completely agree that we need to be focusing on providing good quality food and that may come with changes to budget. My biggest concern is that often the food service system is seen as a completely different component of aged care, whereas food service is part of clinical care. It's part of the health and wellbeing of the individual resident. So it needs to be equally funded to support that care of that kind. It's not an auxiliary service at all.

MS HUTCHINS: Yes, and in relation to – we will return to the matter that you've just raised shortly, but just in relation also to the lack of funding allocated to food, what observations could you make about the availability of resources or funding for people in the community who might be relying on the government or, you know, social services to be able to receive adequate food and adequate nutrition?

MS LAWRENCE: There's not a lot of support there at all. Whilst the Commonwealth Home Support Program does fund funded food services such as

Meals on Wheels and other food service, the dollars attached to that are minimal to be able to provide sufficient quality foods. The issues around food security, around access and affordability and availability limits the older person being able to access, you know, nutritious food.

MR HUNT: If I could add to that, out in the community, you know, there's a lot of fantastic providers out there doing – and one, of course, comes to mind for all of us who have been around in Australia for a while, Meals on Wheels. You know, they have to – and excuse the pun, sing for their supper on a regular basis, like every 12 months. How can you plan – in the millions of meals that they roll out every year, yet they spend half their time justifying their next funding round. That is no way to have a long-term – particularly long-term plan, particularly when we want to stop the flow of aged malnourished people from the community, from their own homes, into residential and then downstream in the more costly end to public hospitals.

MS HUTCHINS: Yes. And in your experience, Ms Lawrence, or in your experience of what you have heard from your members, Mr Hunt, is there a need for elderly people living in their homes receiving aged care services in their home, is there a need at the moment for greater provision of meals?

MS LAWRENCE: I guess, yes, there is but it's very much an individual basis. So, you know, I work with clients who are able to be sufficiently supported by their carers and family members. But there are other older people living in the community who are reliant upon meals. But, unfortunately, the meals that are provided to them may only be delivered once a day, but what happens to the other two meals? So I guess there are issues that – around not only the quality of the meals that are being provided but the quantity of the meals that are being provided, and it's really not encompassing the whole nutrition wellbeing of the client.

MS HUTCHINS: And, Dr Iuliano, the next factor you have identified in your statement as a barrier to adequate nutritional food in residential aged care facilities is the lack of flexibility with food ordering and production, what's this a reference to.

DR IULIANO: Yes, what we've noticed – traditionally, the food will be ordered and cooked at a facility and what we are seeing is that often the ordering is now centralised at a main office. So, therefore, there's a set-up between an aged care provider and a food distribution company. And so if they're limited in the choices of food that are on the foods available, then those foods are just not available to the chefs in the ground floor.

So, as an example, if they wanted to add cheese to a particular meal, if that isn't on the ordering system, they can't order it. And they're not in a position to be able to order it themselves. So what it's doing is it's limiting the number of choices of foods that can be ordered. And the menus are the same. The menus are now being centralised and provided to all the facilities. So it's very difficult to accommodate all the individual needs and desires and wants of residents and cultural differences if there is one menu that's meant to suit all residents in those facilities across Australia.

MS HUTCHINS: Yes. And a further barrier that you identify at 21(f) is that menus are not quantitative.

DR IULIANO: Yes, so what often happens is a menu is written and – but there is no actual quantities of food. So, for example, if it is a serving of meat there's no actual quantity. The example I gave there is cheese and biscuits which is a really good snack that can be provided to residents. So it can either be provided in a lovely cheese and biscuits or crackers that they can help themselves to, or it could be a quarter of a slice of processed cheese on four crackers. So very, very different. So when you look at a menu and it says cheese and biscuits, that sounds great and potentially it can be a fantastic snack but in reality, how it's actually presented to the residents can differ quite substantially. They're not quantified. If we can't quantify how can we judge if that food is appropriate or not.

MS HUTCHINS: Ms Lawrence, is this an issue that you have encountered?

MS LAWRENCE: Definitely. Quantifying is really important and when dietitians are assessing – completing menu audits, it's really important for us to know what the quantity that is actually being served as well as the ingredients that go into a meal, as well as the recipes and the way that food is produced or cooked. All of those factors are really important for us as dietitians so that we then have – if we know that, we then have the confidence in the menu to be able to say to our resident that, "Okay. These are your specific needs. This menu can meet those needs." But at this moment, we can't say that because we don't know the quantities that are being produced, we don't know the ingredients, we don't know what the recipe is, we don't know what changes are being made. So we don't have that confidence to be able to say, "Can we actually meet your individualised ..... can we customise this to your needs?" It's really quite challenging when we are disengaged from that process.

MR HUNT: But none of that means that what goes through that process can't be delivered as Maggie Beer said earlier, in a fun and tasty and attractive way.

MS LAWRENCE: That's right.

MS HUTCHINS: So what would you suggest needs to be done differently to be able to have better input in this process?

MS LAWRENCE: It would be ideal and it would be great for chefs and cooks and dietitians to work together, side by side so that we develop our nutrition standards, we are there together to develop recipes that meet the needs of the residents, whether it's around nutrition, whether it's around taste, whether around senses, to be able to source ingredients that are appropriate for the older persons. And, of course, we have got older people that have special dietary requirements as well.

So we have to be really selective in choosing ingredients, but also bringing in seasonal fruits and vegetables is really important. Working together to support the

memories and the emotional and spiritual and cultural needs of older people living in residential care is really – it's what we can do together to make a change.

MR HUNT: It's the respect of the roles within the aged care environment. You've got some fantastic people in there, health professionals. We heard from a couple of chefs this morning, how frustrated they were about what they saw and what they had to deal with. We have got 7000 health professionals dedicated to nutrition who share that frustration, and it's joining the dots. You know, it's really, you've got nurses there. You've got support workers. Joining the dots, respecting each part of that process.

MS HUTCHINS: Yes. And, Dr Iuliano, a further factor that you have identified is a lack of documentation around the recipes and the ingredients that are actually involved. How does this cause problems?

DR IULIANO: What we found in our work is that many don't work to a recipe. So if a recipe is provided it could be nutritionally adequate but if that recipe is not followed we have got no idea of what is being provided, and what we have noticed over the duration I've been working in residential aged care over a 10-year period, is if I get a particular meal what we are finding is the meat content and the dairy content, so the high protein foods, the content is less. So a casserole is now being supplemented with other perhaps less nutritious components instead of the meat. And I think the chefs alluded to this as well. They were using cheaper cuts of meat.

And so, really, what we are doing is compromising their intake. So if we look at dairy serves, it's gone from two, it should be four, down to one. If we look at meat serves, it's gone from two a day down to one. So we're compromising on the foods on which will provide the nutrients that would then correct a lot of the problems we're seeing in residential aged care.

MS HUTCHINS: Do you have anything further you would like to add in relation to factors that are leading to instances of malnutrition, particularly in relation to residential aged care facilities first?

MS LAWRENCE: Yes, so for residential aged care facilities, I guess one of the factors that I think is contributing to malnutrition is that there's a lack of governance of nutrition care within facilities. There's no framework to work to, there's no standards, there's no policies. There's nothing to guide the cooks, the chefs, the care providers, the nurses, the management, CEOs, there's nothing to guide them through this process around what is the most appropriate form of nutrition care in residential aged care.

MS HUTCHINS: Certainly. And I note that your association commissioned a scoping project, The Development of Nutrition and Menu Planning Standards for Residential Aged Care Facilities in Australia and New Zealand. What did that project involve?

MR HUNT: It looked at a review of all the literature around menu planning and, from that, made some recommendations, went to the association. And, really, the findings of that scoping was that there were no standards. There was no source of truth. There was no one central repository of that sort of guidance that was required. And what came out of that was DAA's work on – sorry, the Dietitian Association of Australia's work on this menu audit tool.

MS HUTCHINS: Dr Iuliano, in relation to guidelines that are available for chefs, say, in residential aged care facilities, do you think there's adequate guidance out there for chefs or cooks to know what it is they should be endeavouring to be providing?

DR IULIANO: Yes, I think, look, it's a hard one because unless they've got the knowledge to apply it, it's really difficult. So in Australia, we've got the Australian Guide to Healthy Eating which gives them a framework of servings of foods that they should be providing. That's for the healthy population. There are other guidelines in Victoria. For example, the Department of Human Services had guidelines for menu items which kind of takes into account that older frail people can't eat as much. But what we found even with those guidelines is that they're not even met.

So even though these guidelines are perhaps smaller, lesser guidelines in terms of volume of food, even they're not being met. So I think unless the guidelines' levels of nutritional care is mandated, a guideline is there to be guided but it doesn't have to be used. And our experience from our research has shown they're actually not being used.

MS HUTCHINS: Because the guidelines currently are not mandatory.

DR IULIANO: They're not mandatory, so they're suggestions. And, look, some places do a fantastic job. But if you look at the average, the average is below requirement. So for the few that are doing a great job, there's a lot that aren't doing a good job at all.

MS LAWRENCE: And, certainly, that's our experience also in community care. We recently developed the national meal guidelines for funded food services in the community and, again, they're guidelines and there are barriers to actually implementing those guidelines, but they're not mandated. So there's no – what's the word – reason, I guess, for services to actually meet those guidelines if they can't do it.

MS HUTCHINS: Thank you. Returning now to factors that may impact on a person's ability to get adequate nutrition, particularly in the aged care setting, how important is the role of staff that are involved in, say, feeding residents that are unable to feed themselves?

DR IULIANO: Yes, look, the – I'll go with the literature to start with and then I'll go down to practical. The literature shows that a resident needs about half an hour for a meal in order to be able to achieve adequate intake. So that's actually physically feeding the person. What's happening – again this is the systemic problem – is that staff are overworked and they actually don't have the time to feed the residents, and so, therefore, I often look at in a facility when we have family members feeding, it takes time away for a resident, for staff to actually feed another resident.

So the – we forget a meal should be enjoyable. It shouldn't be just nutrition shoved into the mouth, and that's often the case simply because there's not enough time to do it. So some of the programs that have been put into place is actually freeing up all the staff during meal times so that the staff can actually sit with the residents and feed and assist with feeding. We found even sitting with residents can increase their intake. So that's actually not even physically feeding them but just being with them. So some places look at splitting the lunchtime so that staff are available, freeing up staff time.

I think we need to get down to these practical things of what we can do to improve the – not only just the nutritional intake but the whole eating experience for these people. You know, having physically done it, it's not nice to see people have food just shoved down their throat simply because there's not enough time to engage with that person and actually enable them to enjoy that meal as well. So I think that – as I said, back to those systemic problems which need repair.

MS HUTCHINS: Mr Hunt have you had a similar observations - - -

MR HUNT: Absolutely.

MS HUTCHINS: - - - by your members?

MR HUNT: Absolutely, right across the board. And many of our members go into sanctioned sites to report on them. But just picking up my colleague's comments there, moving the next step is around that feeding, for want of a better word, process, is data collection, collecting what did they eat, how much did they eat. You know, we've had stories – and you may have heard them in the Commission earlier – where trays of food go into a room and half an hour later the carer comes back and collects it and the food is still on the tray. No questions asked, "Oh, Robert must have been not – he must not have been hungry," and that tray goes back and there's no feedback around it, and it's so easy to do. And – but, of course, with data, you have to then be able to collect it, analyse it and deal with it. And it's not hard. And we heard earlier from the chefs that these – all these facilities or most of these facilities have some access to technology. It's not that hard to do.

MS HUTCHINS: And, Ms Lawrence, in your experience, as a matter of practicality, if you have a client and you've assessed them as having some issue of

being malnutritioned, what are some of the examples of the types of measures that you would recommend that they put into place?

MS LAWRENCE: Sure. Sure. So our first line of interventions is food first. It's so important for every Australian but our older Australians to receive their nutrition from food. In the event that the food that's being provided to them isn't going to meet their specific needs, our next line of defence would be fortifying those foods with food ingredients. So it could be adding extra cream, butter, margarine to increase the kilojoule content. It could be adding egg or legumes or skim milk powder – milk powder into foods to increase the protein content. So it's adding food into food to make it worth more, that every little mouthful is worth more.

Only after – sorry. Some of the other interventions that we might recommend could be a medication review. It could be referral to another health profession such as a speech pathologist to assess chewing and swallowing. It could be a referral to a dentist to look at dentition issues. It could be multiple referrals there. The other – the next line would be considering – after all of that has been exhausted, would be then considering oral nutrition supplements. And I guess oral nutrition supplements, there's a purpose for them, there's a place for them, but they need to be implemented in a way that they are going to work. So they should never replace a meal. They should be there to supplement what's already there to meet the needs of that older person.

MS HUTCHINS: And, Dr Iuliano, what's your view on the use of supplements in the diet of the elderly?

DR IULIANO: You know, as Sharon has mentioned, they do have a purpose, but I think the literature indicates over the long-term, they're not effective. So over the short-term, I can put weight back on a person by giving them a supplement. But over the long-term, they're not effective.

MS HUTCHINS: Why is that?

DR IULIANO: Well, we find compliance goes down. So if you're – so if you imagine the cost, if we just go to simple cost, if I'm producing meals that aren't being eaten, there's a cost involved. The person loses weight. I then put them on a supplement that they're not consuming. There's two costs now, neither of which have been effective. So the key thing is, often the trigger is weight loss. So when we see a resident lose weight, there's this trigger of, "Let's act on it," whereas I think if you look – correcting weight loss is much more difficult than preventing the loss in the first place.

So what – the approach that we're taking is all residents receive adequate nutrition so that the weight loss doesn't commence. And then in the case where it does, you can then address it. But at the moment, nutrition in aged care is what it is and we're only addressing the issue when weight loss is occurring, which now it appears that it's occurring and it's only triggered over a – there's a particular formula. So if we don't

see weight loss occurring within a three-month period, that person is left alone, whereas what we see and what we've noticed in our work is the weight loss is creeping. So over a year, there is a substantial amount of weight loss, but one of it occurred within that three-month period in order for that resident to be flagged.

MS HUTCHINS: Yes.

DR IULIANO: And that weight loss is happening because their energy protein, malnourished. So I'm saying prevent it by just providing adequate food.

MS HUTCHINS: Yes. And in studies or generally, have you observed what common practices in relation to who pays for the supplements?

DR IULIANO: I'll talk in the residential aged care setting. There's two ways it can be paid for. If it's prescribed or suggested from the clinical care staff, it comes out of the clinical care budget. If it's a supplement that's added to the foods, it may come out of the food service budget. So it's very mixed. I know in the community setting it's different again. But if you look at the cost of supplements, it's probably cheaper to feed them than it is to add a supplement. So I think the food-first approach is probably the best approach and an approach that they can relate to because people forget food is a visual thing, it's an emotional thing. So giving a person a supplement may not necessarily induce the desire to eat, but perhaps putting a meal in front of them that they remember and recognise may make them want to eat.

MS HUTCHINS: Ms Lawrence, when you create a nutrition plan for a client that is in a residential aged care facility, who is responsible for ensuring that that plan is then followed?

MS LAWRENCE: Yes, so a nutrition plan would be communicated to not only the food service staff but also to the respective nursing staff as well. So, unfortunately, dietitians don't get to follow through on those plans, and so we rely on the nursing staff, the carers and the food service staff to follow through on those recommendations.

MS HUTCHINS: Yes. And what role does a general practitioner play in that process?

MS LAWRENCE: That can vary. Look, we've had reports from members where we've had general practitioners overrule the recommendations of dietitians, which is very sad. We – you know, there are some general practitioners that are extremely supportive of our recommendations, but, yes, I guess there's a real fifty-fifty chance of what you're going to get there. I think you've had other - - -

MR HUNT: Yes, well, look, the Royal Australian College of General Practitioners at their admission have said that GPs could do a lot more in this space but they don't have time. You know, they're incredibly busy with their – what are the say sayings – see a million – two million patients a week. So again, I go back to joining the dots

and respecting each other roles and how we can do that. Certainly GPs have a role to play, particularly in medication prescribing and the likes. But again, it's about the team approach, and they don't have time. You don't see a GP up in an aged care facility very often at all because it's lost time for them to get to the aged care facility, do what they have to do and get back, and when you've got other health professionals that work in that team approach.

MS HUTCHINS: Mr Hunt, Ms Lawrence touched earlier on a current feature of the system which is a separation of nutrition care from food services, which is often called hotel or hospitality services. In the experience of your members, does this have practical consequences for a dietitian's ability to fulfil their role in ensuring adequate nutrition for residents?

MR HUNT: I think we've heard quite a bit of that today. There's no – the connection is broken. Some places, and we heard this morning that there's a couple of providers that have it, but the – in the main, our members report that the connection is broken. And just to pick up the issue of this food, the plan, the nutrition plan, a physiotherapist in an aged care facility will prescribe – or put in place a management plan for some sort of muscle or whatever treatment. He or she will then manage that treatment right through to the process. Whereas in the process with dietitians they're called in where there's a trigger, where there's a red flag or something and they will put a plan in place. But then they have no ability to participate and ensure that that is developed right through to food service.

MS HUTCHINS: And Ms Lawrence, in the community setting, what access do elderly Australians currently have to nutrition-related services?

MS LAWRENCE: There's inconsistent access to dietitians or nutrition-related services in the community. So whilst I am one of the very few Commonwealth Home Support Program dietitians, we know that across Australia that there are some jurisdictions that don't have any Commonwealth Home Support Program dietitians. Where there are dietitians under the program, they're more likely to be concentrated in the metropolitan areas. So we don't see them extending out to the rural regional areas. This then falls back on to the health system in older Australians needing to access a dietitian through the health system. But, again, across Australia, we have multiple health systems and quite often you don't see dietitians working in – well, they're not employed in the community space. They tend to be employed more in the hospital space within our health systems.

So the next option then is to access a dietitian via a GP under the Medicare chronic disease management plans, and this is really interesting because whilst you can access a dietitian under these plans, the whole group of allied health professionals are only allocated five interventions in a calendar year. So if an older person needs podiatry twice a year, if they need to see a physiotherapist once a year, that only leaves two sessions for a whole year for that person to see a dietitian. Often the dietitians, whilst it's Medicare-orientated there is an above out-of-pocket fee that can sometimes be charged to the older person. And then the final option if all of those

are exhausted is to access a dietitian privately either through private health insurance or for the person to pay for it themselves. So it's actually quite hard to access dietitians in the community but yet the workforce is there to support it.

MS HUTCHINS: And, Mr Hunt, the lack of access, or limited access that people living in the community may have to dietitians because of the limitations on funding through Medicare or elsewhere, how do you think this impacts upon that person's ability to live in the community?

MR HUNT: Well, there's absolutely an impact. Within the Medicare system at the moment the item numbers that dietitians can access to do that screening, to identify, to put those plans in place, is shared with a multiple of other allied health professions. There are five services, so everyone in this room can access five services through their Medicare for all of those allied health. And the issue is that there's not enough to go around and certainly the data is showing that other allied health professions get access to that before dietitians. And so you have this small snowball becoming a bigger snowball, becoming an avalanche of malnourished people in the community, aged community, moving through the system.

MS HUTCHINS: And Mr Hunt, in relation to, I guess, other matters that dietitian involvement – sorry, other matters that you advocate for in terms of dietitians' involvement, you note in your witness statement that you see that there's a role for dietitians in the accreditation and quality process part of the equation.

MR HUNT: Yes. Yes, absolutely. And it comes back to in the accreditation process you have assessors going through the process that have very little or no nutrition training.

MS HUTCHINS: So what role would you see for a dietitian being involved in part of that process?

MR HUNT: Well, I go back to my opening statement. You are dealing with thousands and thousands of health professionals who have dedicated their life and career to one thing: the science of nutrition and the clinical application of that. So you would be mad not to include those people as part of the team in that process. And that moves on to general education and training in the aged care sector. It's madness that they're not – this valuable resource that this community has got is not accessed.

MS HUTCHINS: And, Dr Iuliano, is there any observations you would like to make in relation to the role that more specialised trained people might be able to have in the role of the auditing process in aged care facilities?

DR IULIANO: Yes. Look, I think if you step back, unless we establish minimal standards or minimal requirements in which they can benchmark the facility or the aged care provider to, it doesn't matter how qualified our accreditors are. So I think what we really need to do is step back and say, well, if it's nutrition, what are the

minimal requirements or the adequate requirements that we need to see to ensure that all the residents are achieving proper nutrition. Then you can then say, well, who is qualified or what skills do they need to be able to quantify that. I think we need to go back that step. The current system is not mandatory. And it's not encouraging people to provide better nutrition for the residents.

And through the work we've done I'm seeing it getting further and further from adequate and, as the data showed with the costs, less and less is being spent on it. So the importance of food nutrition needs to be perhaps given its right place because, really, once they're nutritionally inadequate and they're malnourished every other cost is going to go up because of their care needs, etcetera. So it is the centre and I think it needs to be provided with its appropriate recognition. At the moment it's not recognised as an integral part of the health of the resident, the person, and I think once that is recognised its importance will be seen.

MS HUTCHINS: Ms Lawrence, in your statement you raise the issue that there's a lack of oversight as to what happens when, say, a recommendation is made by a dietitian under the current system where you might make a recommendation and then there's a lack of oversight as to what actually happens on the grounds in the residential aged care facility. How might those issues be addressed?

MS LAWRENCE: So my suggestion would be, again, around that governance and accountability framework; that we need to raise the profile of dietitians within the aged care arena. We need to ensure that there are, as Dr Iuliano is saying, there needs to be minimum standards. We need to have – whether it's policies or frameworks that addresses the issues around screening and assessment, developing care plans, what the basic level of need is around the meal time environment and assistance with eating and drinking and education – we need that governance around all of those issues.

And then we need to ensure that there's some form of understanding that everybody knows what their role is when it comes to nutrition, because the nutrition is a multi-professional, yes, responsibility, that everybody has a part in this. But we also – we all need to know what our roles are and we all need to know what each other's roles are so we can complement each other. So I feel there needs to be a greater area of development around understanding that.

MS HUTCHINS: Yes. And in relation to the Aged Care Quality Standards which have just come into effect, it has been observed that a number of these standards will be relevant to managing food and nutrition-related risks. Is there anything further you would like to say in relation to the standards specifically? Perhaps I will start with you, Ms Lawrence?

MS LAWRENCE: Yes. So there's a lot of focus on the new aged care standards around how it will be applied in a residential setting. My greatest concern is how it's going to address the nutrition needs of older Australians in the community. Currently the guidelines are very subjective. There's little guidance around nutrition

– food and nutrition within there, for assessors. And where there is guidance, it's more towards the residential setting and less within the community setting. But yet the guidelines – the standards cover the community setting as well.

MS HUTCHINS: Mr Hunt, do you have anything you would like to add to that?

MR HUNT: They're too loose. They're open to interpretation. But they're along the road. But we need to work – we need to do better.

MS HUTCHINS: And what would you like to see, when you refer to we need to do better?

MR HUNT: Well, I think my colleague was going to come in there.

DR IULIANO: I think what we are failing to address is the standards are resident-focused. So what we should be focusing on is the resident and their needs and are their needs being met, not getting the resident and putting them into a system and moulding them to a system. So we have got to go back the other way. So back to what the chefs were saying, we need to look at the timing of meals. We need to look at the accessibility of foods outside of meal times. When, what, how. And I think those are the factors. We need to actually consult with the residents as to what they want. I don't think a single system in terms of, you know, if we do have a menu that it's going to address the needs of all the residents. So maybe we need to look at how we can change that so that residents are given their appropriate choices.

And I think that's where the difficulty will lie. And unless there's an incentive to actually get those systems in place, I think we're going to maintain the status quo which to me at the moment is not appropriate, and it's inadequate because basically these residents are malnourished and they're starving to death, and what it is about quality of life so that they can actually maintain the best quality of life to the point of death.

MS HUTCHINS: And we have discussed a lot today, issues around malnutrition. Do you think, as a starting position, enough has been done just to maintain the health of residents that are currently, have adequate levels of nourishment?

DR IULIANO: No, no. I think – I find it quite sad that many residents have to rely on family members bringing in food in order to achieve the foods that they want and achieve the nutritional status that they want. I think prevention is better than trying to deal with malnutrition. So what we need to address are all the residents not just simply those that are losing weight. We need to look at prevention to prevent that happening and also just quality of life so they actually get to enjoy their food and their meals because currently what is happening is, yes, I have a nutrition focus but I also have a food focus and what we are failing to remember is that food is important to them. And when we make that food tasty and nutritious and meaningful to them, they will eat it. And if they eat it, they stay nourished. So I think we need to really address how we are delivering food to older adults in residential aged care.

MS HUTCHINS: What do you see as being some of the biggest types of issues with the type of food and the way it's being delivered in the residential aged care facilities you have studied?

DR IULIANO: Look, currently what we are seeing is the shift away from quality foods. We are seeing a shift away from the high protein, so the dairy foods and the meats. We are seeing less protein-based foods in meals. We are seeing more discretionary foods, so cakes and sweets and things like that that fill them up but is not nutritionally sound. We're seeing a greater consumption of that occurring. So I think what we need to do is go back and say, well, what are the minimal standards of nutrition that we should be giving to these people and they've got access to it.

So it shouldn't be part of extra services. It should be just a basic right to receive those foods. And then – and that should be across the board across all aged care facilities, not simply those that are doing a great job.

MR HUNT: You have to remember, though, counsel, that food is not nutrition unless it's eaten. So there's a process here where, again, you have to join the dots. The quality of the food, the way, the excitement and the passion that comes from food but it isn't nutrition unless it's eaten.

MS HUTCHINS: Ms Lawrence, what observations could you make about the ability of residential aged care providers to implement the recommendations that you might make as part of someone's nutrition plan?

MS LAWRENCE: Look, I believe that at this moment they don't have the capacity to do that just because they don't have the skill and knowledge to be able to do that. And I feel that dietitians are able to support the food service staff, the cooks and the chef in regards to upskilling them in their knowledge around the specific needs of the older person, the changing needs of the older person and how to manage specific needs, whether it be somebody who requires a specialised diet or texture-modified diet. I feel that we're able to support the services to do that, but at this stage that's not there. It's not available.

MS HUTCHINS: And in terms of the current audit system for residential aged care facilities, I know we've touched on this briefly, but do you have a view, Dr Iuliano, about whether auditors are well-equipped to properly assess whether nutritional needs are being met by residents in facilities?

DR IULIANO: The current system, as I mentioned before, if we don't quantify a menu, all we can to do is look at it. And if we don't know what we are not looking for, then how can we judge if it's okay? So I think what we need is people who can at least quantify what's on a menu. The menu needs to be quantifiable. We need to see what's happening. So it's one thing to have a fantastic menu, but if the residents aren't eating it then we need to look at what's actually being consumed by the residents. What's delivered, what's consumed. That kind of system isn't difficult. As mentioned earlier, there is technology that can help with that kind of system.

So if only half of every meal is being eaten, then the nutrition is lacking simply because they're not eating it. And then it's like, "Why aren't they eating it?" I think what we're not doing is ongoing down those next levels. "Why aren't they eating it? What is it about the food that is causing them not to eat?" and then addressing it backwards.

MS LAWRENCE: And I guess it's more than what is – it's not only about, "What is it about the food?", but it's, "What else is happening for that person at the time?" So it's do – are there – are there changes around grief and loss? Are there changes around social circumstances? Are there changes around the physiological changes, like, have they got, you know, oral thrush? Have they got poor dentition? So it could be – so going down the why, why, why, we're not doing that. We're not doing that enough to actually get to the nitty-gritty part of why our residents and our older Australians aren't consuming adequate nutrition.

MS HUTCHINS: And in terms of being able to assess whether, say, a person in a residential aged care facility is having adequate nutrition, do you have any observations about the use of food and hydration logs that are kept sometimes in facilities and whether, in your experience, these are done properly to be able to perform assessment about whether they're getting adequate intake?

MS LAWRENCE: Whilst a dietitian may recommend a food and fluid log, there's a skill level that comes with recording these logs. So as we've said earlier, it needs to not only be around not just a list of what's consumed, it also needs to be quantified, the amount that's consumed, or what has been left, it all needs to be quantified for us to be able to make a full assessment of whether they're meeting all their requirements or only half of their requirements.

I guess it also then comes back to, "How does that relate to what they would have been provided, what they would have consumed if they ate the whole lot?" So some – as dietitians, sometimes we don't know the nutrient value, the energy value, the protein value of what they were consuming in the first place, let alone knowing from those logs if that met 25 per cent, 50 per cent, 75 per cent.

DR IULIANO: I think from our – my observation from the work that we've done, there's a disconnect between the food production and the food consumption. So in a nutshell, many of the facilities now have kitchens that are quite a distance to the location at which it's eaten, the dining room. So the food is produced and it's usually the care staff that clean the plate that can tell us whether a food was eaten or not. So unless that's relayed back to the kitchen, there is a disconnect. So what we really need to do is reconnect those two things so that the kitchen is aware when food is eaten or note eaten.

Often if you need to find information, it's the care staff that tell you about the resident because they're the hands-on people that actually see what the resident is doing, what they're eating and not eating, and I think it's back to that team approach. We need to get everyone back on the same page to bring all the staff together,

clinical staff, food service staff, back together so that the nutritional care of the resident is met.

MR HUNT: If she could speak from the public gallery, I'm sure Maggie would say the chefs or cooks would want to know. If they're really passionate about their job, they're being recognised for their part of the team – I don't know about anyone else here, but when I do some cooking I really like feedback. So that's really important. And again, it's about these join-the-dots. It's actually a team approach.

MS HUTCHINS: Yes. And we spoke earlier about the effect that food budgets may have on a facility's ability to provide sufficient nutrition to a resident. Dr Iuliano, in your statement, you detail at paragraph 27 the cost of – identified in the study of $6.08 per resident per day. What was that figure obtained from?

DR IULIANO: So they actually looked at food purchasing costs across the number of facilities, and from that research – that was done by Dr Cherie Hugo and it was in Australia, which is good. Where possible, we use Australian data. What we found is the actual costs were going down, so – which means that they're actually spending less. Now, this is a mean cost. And as we mentioned, the food service manager showed that her budget I think it was $14, which is fantastic. But I think at a $6 budget, it would be very difficult to meet the nutritional needs of a person with that amount of money. And perhaps what needs to be done is to actually model how much money it does cost and, therefore, that becomes minimal benchmark of budgetary allocation to food, because $6 would not be enough.

MS HUTCHINS: No. And you observe in your statement that this is about a third of the average daily household expenditure in the community, which is around $17.25.

DR IULIANO: Yes.

MS HUTCHINS: Is that is right?

DR IULIANO: Yes. That was taken from the Australian Bureau of Statistics. So what we've looked at is, you know, what is spent. And that amount is only for purchasing of food. That doesn't include eating out. So what we're saying is that that's simply just purchasing. So, really, a $6 budget is almost impossible to meet nutritional needs of a person with $6 a day. So what we need to do is work out how much is the minimum. And even if it is matching the national standard for older adults, at the least we do that.

MS HUTCHINS: And you note also that the six-dollar-odd figure is less than the money currently spent in Corrective Services, which is $8.25; is that right?

DR IULIANO: Yes. So it's the same thing. One thing we fail to remember is when someone is residential aged care, they don't have access or have limited access to other food. So they are under the – you know, the guidance of that aged care

provider. And if they're not providing, they do not have access to other food unless they have family members that bring it in. So, really, it's about that provider ensuring that what they're providing is adequate.

MS HUTCHINS: Thank you. Do you have any further observations you would like to make in relation to the average cost of food in residential aged care facilities?

MS LAWRENCE: Only just to echo exactly the same comments, is that the small amount that's actually spent on a resident per day, I totally agree. There's no chance that we could meet the overall nutrition requirements of a healthy person, let alone a frail, older person whose needs, nutrient needs are even more extensive than a healthy older person.

MR HUNT: I would make two very quick comments. One, counsel, you should also note the doubling of the cost of supplements in the same report. And also – and I'm sure the Commission – well we gave you a lot – I'm sure you're getting a lot of statistics. But you multiple that cost by your number of residents in aged care compared to the cost of them going into public hospitals because they're malnourished and need that sort of attention. As an accountant, the numbers do stack up, that we need to go back a step.

MS HUTCHINS: Yes. Today, you've each given evidence about a range of recommendations for improvements to the current system. What do you think is the most important matters that you would seek the Commission's attention to in relation to change in this area? Perhaps I will start with you, Ms Lawrence.

MS LAWRENCE: For me, I believe there needs to be a stronger governance and accountability framework around the provision of food and around nutrition across both residential and community settings. We've got such a huge gap in the community to be able to support the nutrition needs, and I guess the aim of supporting residents in the community is to prevent them or to minimise their chances of going into residential care.

Older people want to age in their homes. They want to age at home. So why don't we have a system that supports that process to ensure that their risks of nutrition don't escalate to a point where they become malnourished, where they become more frail and become more dependent on others for their care and enter into aged care facilities? So I feel that we really need to look at the whole governance approach. There is no national nutrition policy at all that encompasses the nutrition needs of the older person. So I feel that that's something that we need to look at.

MS HUTCHINS: Mr Hunt, in relation to the lack of a national nutrition policy in Australia, what do you think should be included in any such policy?

MR HUNT: So my colleague touched on aged care nutrition policy, but the dietitians and the dietitian/nutritionists profession has been advocating for some time for a national nutrition policy because, at any metric, we have an epidemic. We have

an epidemic in obesity. We have an epidemic in nutrition being a risk factor for so many of the chronic diseases that are all going one way: up. And then we talk about in the aged care sector. We have a silent – we have had a silent, faceless abuser in the aged care sector for years.

It has been tragic around what we've seen in terms of the safety of residents. But for years and years and years, this silent, faceless abuser called malnutrition has been around. So what – certainly from the national nutrition policy is – absolutely whatever the Commission can do to encourage governments and the community to elevate nutrition to its rightful spot in our health prevention strategy. It is a human right. It absolutely should be at the top of the tree.

DR IULIANO: I think the final area, I think many people that work in aged care are wanting to do the right thing. I don't think it's all about, you know, not caring. There are many that do care, but many are not informed. So I think that minimal educational standards for staff so that they're at least equipped to be able to produce the correct foods, to understand what those foods are, to recognise when someone is not well, to be able to react to people appropriately if they're not eating and what they need to do. So I think, you know, in a sense, it's the three areas. It's the education, it's the policy and then it's the monitoring of what's actually happening. I think those three together would make a very big difference to residential aged care and community care for nutrition.

MS HUTCHINS: Thank you. Commissioner, I have no further questions.

COMMISSIONER TRACEY: Thank you, Ms Hutchins. Thank you very much for your evidence. There's just one matter I want to pursue, and that is this. You've given evidence about falls causing fractures. I just wonder whether it's not also the other way around, whereby somebody with brittle bones has a fracture and, therefore, a fall.

DR IULIANO: I've got the evidence for that. 95 per cent of fractures occur from a fall. So you will get that few per cent that do get up from a chair and fracture and fall, but 95 per cent of fractures are other way around. They fall - - -

COMMISSIONER TRACEY: The other way around.

DR IULIANO: Yes. And you're correct, they are extremely fragile, so it doesn't take a lot for that bone to break.

COMMISSIONER TRACEY: Yes.

MR HUNT: And, Commissioner, as I said, downstream, the costs of that far outweigh the costs of the fixing the problem up here where the – so we don't have as many. We can't stop them all, but there is absolute without-a-doubt evidence that a lot of that can be prevented through better nutrition.

COMMISSIONER TRACEY: Yes. Well, nutrition is emerging as one of the major matters that are central to the wellbeing of our elderly citizens in this country, both in nursing care but also in home settings, and we are indebted to you for your expert evidence about this and I can assure you that your recommendations will be taken on board when it comes time to make recommendations to government. Thank you very much.

DR IULIANO: Thank you.

MR HUNT: Thank you.

COMMISSIONER TRACEY: The Commission will adjourn until 3 o'clock.

<THE WITNESSES WITHDREW

ADJOURNED [2.45 pm]

RESUMED [3.05 pm]

COMMISSIONER TRACEY: Yes, Mr Rozen.

MR ROZEN: Commissioner, the next witness is Adrienne Lewis, and Ms Lewis is in the witness box.

<ADRIENNE ALEXIS LEWIS, SWORN [3.05 pm]

<EXAMINATION-IN-CHIEF BY MR ROZEN

MR ROZEN: Ms Lewis, can I please confirm for us your full name for the transcript?

MS LEWIS: Adrienne Alexis Lewis.

MR ROZEN: And it's Adrienne, spelt A-d-r-i-e-n-n-e.

MS LEWIS: That's correct.

MR ROZEN: All right. And Ms Lewis, for the Royal Commission, you have made a witness statement dated 18 June 2019?

MS LEWIS: Yes.

MR ROZEN: And I see you have a copy of that in front of you. And the code here is WIT.0246.0001.0001, and the first page should be on the screen that you can see to your left there, if that helps you. Have you had a chance to read through your statement before coming along this afternoon to give evidence?

MS LEWIS: Yes.

MR ROZEN: Is there anything you would like to change in the statement?

MS LEWIS: No.

MR ROZEN: And are its contents true and correct?

MS LEWIS: Yes.

MR ROZEN: I tender the statement of Adrienne Lewis of 18 June, Commissioner.

COMMISSIONER TRACEY: The witness statement of Adrienne Alexis Lewis dated 18 June 2019 will be exhibit 6-49.

EXHIBIT #6-49 WITNESS STATEMENT OF ADRIENNE ALEXIS LEWIS DATED 18/06/2019 (WIT.0246.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR ROZEN: Ms Lewis, if I can start by asking you a little bit about yourself. You currently are the project manager, aged care for the service planning unit of the South Australian Dental Service?

MS LEWIS: Yes.

MR ROZEN: What is the South Australian Dental Service?

MS LEWIS: It's the government dental provider in South Australia for children and adults.

MR ROZEN: Okay. When you say the "dental provider", it provides dentistry services to citizens.

MS LEWIS: Yes, to children and adults in South Australia.

MR ROZEN: And what does the service planning unit do?

MS LEWIS: The service planning unit looks at what services the Dental Service needs to provide and sort of in the area of aged care, it has had quite a focus on that. It also looks at what sort of dental clinics, where they need to be positioned, etcetera.

MR ROZEN: Right. Does the Dental Service provide dental services in residential aged care settings?

MS LEWIS: Yes.

MR ROZEN: So there are dentists employed, are there, by the service that go to residential aged care facilities?

MS LEWIS: Yes, but only in a very limited capacity and we have two models that we use.

MR ROZEN: Yes.

MS LEWIS: So - - -

MR ROZEN: Do you want to just briefly tell us what they are, please.

MS LEWIS: So one has been a model whereby SA Dental Service supports private dentists and it's a small group, it has essentially been a demonstration project and it was a collaboration between the ADA, which is the Australian Dental Association and SA Dental Service looking at how to support the delivery of services into residential aged care. So these private dentists are supported by a scheme, so a payment and the provision of portable equipment, which SA Dental Service maintains and couriers out to participating residential aged care facilities. But as I said, it's a demonstration project and it's a very limited project due to funding. The other service we offer is dental domiciliary care and we have two teams, northern and south, that do that. And they visit residential aged care facilities but really on a sort of emergency call-out basis.

MR ROZEN: I see.

MS LEWIS: And I guess sort of with the caveat there that people that can get to the dental clinic are encouraged to get to a dental clinic, and for people to be eligible to have public dental care they must have a concession card. So there must be a pension card or a health care card.

MR ROZEN: Right. Do you know if other states, state governments offer similar services in aged care settings?

MS LEWIS: Yes, there are a variety of models and Peter Foltyn gave a bit of an example of those in his witness statement. But it is an area that I guess every state is grappling with how to provide a service in that context.

MR ROZEN: Yes. All right. We might come back to some of those topics in a moment. I just wanted to get some sense of the work that you do. We will see in a moment that in your capacity as project manager, you have worked on some specific projects to do with more broadly oral health care in relation to the older population both in a residential setting and in a home care setting.

MS LEWIS: Yes, to support non-dental health professionals, improve oral health in those settings.

MR ROZEN: All right. That might be just a good opportunity to clarify that. You said non-dental health professionals. There's a distinction in your statement between dentists and dental technicians in one category and then this other category. Can you just expand a little bit for us what you have in mind when you talk about non-dental oral health professionals.

MS LEWIS: I guess not everybody – not all older people see a dentist. They may see them – or their relationships may be once a year or maybe never with a dentist. But they're cared for by a lot of other health professionals, so doctors and nurses and speech pathologists and physios, occupational therapists so they can build up long-term relationships with these people who are responsible for monitoring and assessing their health status, and supporting and guiding and enabling older people. So the rationale behind sort of building the oral health capacity of this non-dental group is to raise the profile of oral health so they can do the assessments so they can do oral health planning, oral health delivery of oral – basic oral health care and dental referral as indicated with an assessment.

MR ROZEN: We will come back to a couple of those. Before I press on with that, I need to ask you a little bit more about yourself. You professionally are a registered nurse.

MS LEWIS: Yes.

MR ROZEN: And you've worked in that capacity, presumably, as a nurse?

MS LEWIS: As a nurse for a very long time, yes.

MR ROZEN: In acute health setting or in aged care settings or both?

MS LEWIS: Mainly in acute care, private and public.

MR ROZEN: Right. And you've got a number of other qualifications which I won't take you through, they're set out in paragraph 8 of your statement. But you are also a member of the Australian College of Nursing.

MS LEWIS: Yes.

MR ROZEN: And you are visiting research fellow with the Adelaide Nursing School at the University of Adelaide.

MS LEWIS: Yes.

MR ROZEN: And it's there that you have nearly completed a PhD.

MS LEWIS: Completed a PhD.

MR ROZEN: You have completed a PhD.

MS LEWIS: Just waiting for conferral.

MR ROZEN: Right. So we can't quite call you Dr Lewis?

MS LEWIS: A couple of weeks.

MR ROZEN: Soon, no doubt. What is the subject of the PhD thesis?

MS LEWIS: I was exploring the factors that affect the implementation and sustainability of improving oral health in the community aged care setting.

MR ROZEN: Right. Okay. And in your statement – perhaps if paragraph 10 could be brought up. It's on page 2, there's a section headed Mary's story, and without necessarily reading it, but you can read it if you would like to, you say that was an inspiration to you in setting about doing a PhD, which is obviously a very big task. What was it about this particular story that so inspired you?

MS LEWIS: I guess the story, it was that something so simple as having a clean mouth can make quite an impact on somebody's life and really how within nursing care, some of the basic fundamentals of care, and it's the simple things that prevent bad things happening.

MR ROZEN: Yes.

MS LEWIS: And Mary's story actually came from the Better Oral Health in Residential Care project that I worked on, and so this project looked at improving oral health capacity of nurses to do assessments, and plan care, helping care workers to deliver that care, and we also had a visiting dentist on this particular site. And so this is one of the stories from the nurses with that. And I guess Mary's story – and I will read it out.

MR ROZEN: Please do.

MS LEWIS: So:

As Mary aged, she underwent a hip replacement and was diagnosed with health problems, heart problems and began a slow decline into dementia. Her family could no longer cope with her care needs and she entered a residential aged care facility. At first, this was just hostel care, but eventually, at 90 years old, she was placed in high care. Mary, at this stage, had been in the facility for seven years and no one had checked inside her mouth. She was unable to do most things for herself. Her dentures clacked around in her mouth and she was losing weight, and she cried a lot. And to the staff, this was just how Mary was; she vocalised, and she cried a lot.

The facility's RN did an oral health assessment and discovered that in addition to loose dentures, Mary had sore and bleeding gums, a build-up of plaque and tartar on her dentures and a dry mouth most of the time due to her medications. After the assessment, staff were able to improve Mary's oral health by increasing their care of her dentures, using Polident to secure the dentures in our mouth, disinfecting the dentures regularly and using Curasept Gel on her gums and Kenalog on her ulcers. Care workers encourage Mary to eat more and to drink more fluids. They applied Carmex to her dry lips.

Improvements in Mary's oral health came quickly. Her ulcers healed. Her gums no longer bled. She reported no pain. She started to gain weight. And best of all, she no longer cried. The staff were absolutely astounded by this, and one of the staff members said to me, "What is another word for guilt?" One nurse said, "We should have been doing this years ago."

MR ROZEN: And what strikes me from the story, and also from reading your statement, is that a simple check of oral health can have such a profound effect on health generally and, very importantly, quality of life for an older person.

MS LEWIS: Yes.

MR ROZEN: And that – as I read your statement, that's a theme that runs through it, that, really, the steps necessary to ensure oral health are quite simple and inexpensive steps. Is that a fair observation?

MS LEWIS: Yes.

MR ROZEN: Now, I should have said at the start – you've already mentioned Dr Foltyn's name. Thank you for reminding me. We did give you Dr Foltyn's statement. He gave evidence in Sydney, and the evidence he gave covers somewhat similar ground to the topics that we have invited you to give evidence about here. And you have referred in your statement a number of places to evidence that he has given. I won't take you specifically to those. But I take it, in general terms, that you broadly agreed with the observations that you made and the evidence that he gave in Sydney.

MS LEWIS: Yes.

MR ROZEN: And I think you indicate you actually know him professionally.

MS LEWIS: Yes.

MR ROZEN: Yes. Perhaps if I can just start by asking you to address the question which appears at the top of page 3 of your statement, and that is, what is the importance of oral health in a person's health and quality of life in aged care?

MS LEWIS: I guess we've talked earlier today about the importance of the eating experience, and I guess I need to say it all starts with the mouth. So in terms of quality of life, there are multiple problems with poor oral health. So it affects an older person's ability to eat and enjoy their meals. It can impact on their chewing, their food choices and sense of taste.

MR ROZEN: Sorry. I might just stop you there if I could - - -

MS LEWIS: Yes.

MR ROZEN: - - - because we heard evidence from the gentleman who was sitting in the middle of the panel – I've forgotten his name, I'm sorry – just earlier, who was talking about food going back, you know, a plate of food being placed in an elderly resident in an aged care facility. We've heard this several times during the course of the Commission. And you would, no doubt, encourage staff to make inquiries about why food is uneaten because, of course, it might be due to pain associated with chewing.

MS LEWIS: Yes. We've mentioned a few times about joining the dots.

MR ROZEN: Yes.

MS LEWIS: So it's about comprehensive care and seeing what the connections are.

MR ROZEN: Is that a phenomenon that you have experienced, that is, someone either not eating at all or not eating much because of painful gums, for example, or sore teeth?

MS LEWIS: Yes. So if it interrupts meals – so I guess there are a number of issues. It can be because there's dental pain.

MR ROZEN: Yes.

MS LEWIS: So it's painful to chew. It could be lack of teeth. So they've got chewing incapacity. It could be dry mouth that's causing a lack of taste and - - -

MR ROZEN: Yes.

MS LEWIS: - - - no appetite or difficulty swallowing. And apart from the aspect of eating, there's also, you know, people that – it affects a person's appearance. So, you know, they find it embarrassing to smile and laugh. It can affect their speech, bad breath. People don't want to come up and give you a hug or a kiss.

MR ROZEN: Yes.

MS LEWIS: So it's quite debilitating, really.

MR ROZEN: Yes. And you make that – you make the point in paragraph (b) there at 15 of the ability of poor oral health to impact, for example, on sleep patterns as well.

MS LEWIS: Yes, sleep patterns and change of behaviour in people with dementia.

MR ROZEN: Yes. And we've had considerable evidence in the Commission about behaviour in people afflicted with dementia being addressed by medication or other forms of restraint. And no doubt, you would encourage investigation of behaviours which may well be related to pain generally but, of course, specifically - - -

MS LEWIS: Dental pain.

MR ROZEN: Dental pain, yes. And I take it that's once again a phenomenon that you've seen - - -

MS LEWIS: Yes.

MR ROZEN: - - - in your work. You use the expression at paragraph 16 of "the mouth acting as a portal for disease," and I might ask you to expand on that, please.

MS LEWIS: So I guess we tend to forget that the mouth is part of the body.

MR ROZEN: Yes.

MS LEWIS: So, you know, as I said, with eating, it starts with the mouth, but also oral health and disease are closely linked. So when I use the term "a portal for disease", so we've got tooth decay and gum disease. It can contribute to oral infections. So if there's an infection in the mouth, it can go in the bloodstream and spread to other parts of the body. So there can be bacteraemia or septicaemia. Also having bacteria in the mouth, it can be inhaled and you've got aspiration pneumonia.

MR ROZEN: Yes, which you refer to at paragraph 18. You said a moment ago – you made a reference to forgetting that the mouth is part of the body, and perhaps if I could just ask you to expand on that. I take that to mean not literally but rather there is a perception in the community generally, I think it's fair to say, about health matters associated with mouths to be the province of dentists, rather than any other sort of health professional. Is that – am I on the right path there in terms of - - -

MS LEWIS: You're on the right path, but it happens within the professions as well.

MR ROZEN: I see.

MS LEWIS: So we've had a lot of talk about nutrition today but not a lot of talk about that it could be the mouth that's causing people not to eat.

MR ROZEN: Yes.

MS LEWIS: And the same with changes in behaviour with dementia. It would be a whole lot of other things rather than thinking that it's the mouth.

MR ROZEN: Yes.

MS LEWIS: And so a lot of the assessments, even a comprehensive assessment by a GP or a nurse may forget to even look in the mouth.

MR ROZEN: Yes.

MS LEWIS: So yes.

MR ROZEN: You were asked at the foot of page 3 to identify common oral health problems that are prevalent in residential aged care settings, and I take the ones you've mentioned, that is, aspirational pneumonia can occur in a residential aged care setting just as it can in any other situation, presumably - - -

MS LEWIS: Yes.

MR ROZEN: Yes, but you identify on page 4 a number of other specific matters for the Commission's information. And I want to ask you about the reference at paragraph 21 to retention of natural teeth, and if I could ask you to expand on that. That's a change we've seen in recent years, is it not?

MS LEWIS: Yes. And before I say that, I guess a lot of the conditions like tooth decay, gum disease, dry mouth and thrush and cancers, they're all interrelated and they all exacerbate existing medical conditions. So they shouldn't be seen in isolation. They have a knock-on effect and they are made worse by not looking after the mouth. So when it comes to the retention of natural teeth, in the past in aged care, people would have expected people to have full dentures, no teeth and full dentures. There has been quite a generational change now and we're seeing less and less of that and quite rapidly in the population. So one would expect people to if not have all of their natural teeth but to have some natural teeth supported by restorative dental work, and by that the mouth becomes quite complex.

MR ROZEN: So a couple of things there. Firstly, what is the reason for that change? Why do we now see more older people with full or partial sets of teeth,

whereas a generation ago it was more likely to be dentures? What do we – how is that explained?

MS LEWIS: Advances in modern dentistry.

MR ROZEN: Right.

MS LEWIS: Fluoride in the water - - -

MR ROZEN: Yes.

MS LEWIS: - - - and societal expectations.

MR ROZEN: Yes. So all of that, one would assume, they're positive developments but they bring with them new challenges, and perhaps if you could explain what those challenges are.

MS LEWIS: So while retaining your teeth – I certainly hope to keep my teeth for as long as I can – I know it's going to improve my quality of life for all of the reasons that we spoke about before.

MR ROZEN: Yes.

MS LEWIS: But it also increases the risk of tooth decay and gum disease. So – and with having a more complex mouth, and also the presence of polypharmacy and dry mouth that also have an effect on the health of the mouth, I need to maintain good care of my mouth, and I also need to be able to access a dentist for preventative treatments.

MR ROZEN: And the difference there is with dentures, they're to be taken out overnight and placed in water perhaps. The care needs are somewhat less; is that right? Or different.

MS LEWIS: Well, the care needs are less and they are also different because - - -

MR ROZEN: Yes.

MS LEWIS: - - - dentures also have risks attached to them which probably they were neglected in the past, to be honest with you.

MR ROZEN: Yes.

MS LEWIS: Just going back to the complex mouth, particularly an advancement has been implants, and the risk of not maintaining good oral health is diabolical with diabolical failure of the implant. So having a stud in the gum in the bone, if there's an infection there, it's serious.

MR ROZEN: Yes, because the infection can go through to the bone. Yes. Okay. And in your experience, how have residential aged care facilities adapted to those changes? Is there an issue there about the preparedness for the residential aged care sector to address that change in oral health of the residents?

MS LEWIS: I'd have to say no.

MR ROZEN: No.

MS LEWIS: I'd have to say no. I think there's a lack of insight into the high-risk consequences of poor oral health.

MR ROZEN: Right. And what do you put that down to? Is that due to ignorance or staffing, or what's the explanation for that?

MS LEWIS: I think there are multi-factors - - -

MR ROZEN: Yes.

MS LEWIS: - - - that are responsible for that. As I said, I think there's a lack of insight and that comes from education. On the other hand, people may well say that the mouth is really important to general health and quality of life, but yet in practice it's not happening. And we know out of all of the care, the fundamentals of care that are given to older people that oral health is probably the most missed.

MR ROZEN: Just to clarify, when you talk about oral health, obviously, brushing teeth regularly is a part of that. Are there other dimensions?

MS LEWIS: Yes. People often refer to mouth care or oral care.

MR ROZEN: Yes.

MS LEWIS: I prefer to call it oral health care because it's more than brushing teeth. It is about diet. It is about prevention of dry mouth, etcetera.

MR ROZEN: Right. So when you talk about diet – you do deal with this in your statement – you talk about the importance of reducing the consumption of sugary foods, for example. I think there's an expression "tooth-friendly food" - - -

MS LEWIS: Yes.

MR ROZEN: - - - which, obviously, is really the link back to some of the evidence we've heard earlier today, isn't it, about the importance of healthy food not just for general health but for oral health as well? Is that right?

MS LEWIS: Yes. It's more the frequency of consuming food.

MR ROZEN: Yes.

MS LEWIS: So every time we eat something we have an acid attack in our mouth. So a healthy mouth can cope with, you know, breakfast, morning tea, lunch, afternoon tea and dinner, quite comfortably. Somebody that has got a dry mouth is more vulnerable, so the acid attack – it takes longer, double the time to recover from that. So if somebody has a dry mouth and has retained their teeth and they are snacking on food or sugary drinks continually through the day, their mouth is in a constant acid bath.

MR ROZEN: You deal with the phenomenon of dry mouth which you have mentioned a few times; xerostomia – is that the correct pronunciation, and you note that it is a common issue and we have heard quite a bit about it, particularly in the context of being unable to produce saliva and then unable to consume foods in a way that is comfortable. And you've identified in paragraph 24 some of the causes of the phenomenon of dry mouth. I take it, it's not something that is necessarily associated with ageing, it's not inevitable.

MS LEWIS: No, it's not inevitable but people that are ageing and the comorbidities that they have are probably at a higher risk, and it's particularly around the polypharmacy, the medications that they are taking.

MR ROZEN: Yes. So I wanted to ask you about that. That's another link with a topic that has been explored in the Royal Commission; that is, that particular medications can have the effect of causing the mouth to become very dry. And it's another example of what you talked about earlier, the need to join the dots; that is, it's important to know that if a resident in an aged care setting is taking a particular medication and that's likely to result in dry mouth, then steps presumably need to be taken to address that, to ensure their quality of life.

MS LEWIS: So that might be when a nurse is doing an oral health assessment when somebody is coming into a residential aged care facility or even starting a package that there is somebody that is reviewing that. So whether it's the nurse or the GP or if we are looking at comprehensive care that's it's the pharmacist that is reviewing that.

MR ROZEN: Yes. In relation to that, we have heard in the Commission a lot of evidence about care plans of various descriptions. There might be a care plan addressing wound care, a care plan might be concerned with avoiding pressure injuries. It might be concerned with falls risk, for example. We have seen some examples of care plans addressing oral health but perhaps not that many. Is that an issue here as well, that there isn't enough attention to ensuring oral health by way of a formalised care plan that for example would monitor a phenomenon like dry mouth. That's something I suspect you would be advocating.

MS LEWIS: Ideally, yes, that would be great. But, as I said, some of the problems with actually doing care plans and the attitudes towards oral health – well, it may be

in the care plan but it doesn't necessarily mean that it's going to be actioned for many reasons. So when I mentioned we need to put the mouth back in the body, oral health for some reason is seen as something that is optional. Often it's seen, oral mouth care is like a task associated with grooming, or hairstyling. So when their work practice is rushed for time, it is something that can be missed. It's not seen as an equal priority to a lot of other things. And it's also the mouth can hide missed care quite easily unless there's a lot of pain or there's excessive bad breath but it can hide missed care.

MR ROZEN: Well, as it did in Mary's case for a number of years, it seems. At paragraph 27 of your statement on page 5, you identify some of the costs associated with oral disease and you say that it imposes a significant burden on the health care system. So at the same – and I won't go through the figures, they're there set out for us. But at the same time as you've told us that attending to oral health care can be a relatively inexpensive exercise, because it just requires attention, essentially, and some time obviously, the costs of not attending to oral health care are quite significant, I take it, from those figures.

MS LEWIS: And I guess with oral care, it's not – the poor oral health is not associated with ageing. A lot of the conditions like tooth decay, gum disease, can be prevented by good oral health. They can be prevented by good care, good daily care, prevented or managed, and timely dental referral. So these hospitalisations are preventable.

MR ROZEN: At paragraph 34 of your statement on page 6, you give us some examples which I will ask to be brought up on the screen of – examples of poorly maintained dentures and unclean natural teeth. Perhaps if the denture photo could be brought up. It's tab 90 in the general tender bundle, ALE.0001.0001.0001. Just while that is coming up – that's it. Can you tell us about this photo, please, Ms Lewis.

MS LEWIS: This is dentures that have not been cleaned.

MR ROZEN: Yes.

MS LEWIS: And a person was wearing them.

MR ROZEN: And is that a common phenomenon in your experience, albeit that there's a smaller number of people wearing dentures as you're explained.

MS LEWIS: A smaller number wearing dentures, but I guess the problem with partial dentures is that they don't get removed and there's so much calculus around them, people would think that they were natural teeth.

MR ROZEN: I see. And do you think that – you would be guessing, I suppose, but that might be the explanation for this case.

MS LEWIS: Yes. These dentures have not been cared for and have not been taken out of the mouth. So you can see how uncomfortable they would be.

MR ROZEN: Yes. And is this a case you have some particular familiarity with? Or why have you drawn our attention to it?

MS LEWIS: Just an example of what is seen in residential aged care. So not so much the dentures but the next photograph of an unclean mouth is probably more what we would see.

MR ROZEN: More common. Perhaps we will go to that, then. Tab 91, please, in the general tender bundle. And this is an example of poorly cleaned teeth in an elderly resident in an aged care facility.

MS LEWIS: Yes. And within this facility there was a dentist, there still is a dentist and a hygienist that go there once a month and they've attended to this person, and after one visit like four weeks later this is what they found. So we were having – so this facility was having the services of dental care but to me this is saying that the mouth was not, not my problem, it's the dentist's problem so there's missed care.

MR ROZEN: Right. It's an unintended consequence of having a dental visiting program, perhaps, that it's seen to be someone else's - - -

MS LEWIS: Someone else's problem.

MR ROZEN: Yes, I see.

MS LEWIS: And I guess here when you look at the missed care particularly for this person, you can see, you know, their tongue is sore. Their gums are red. You know, with the dental plaque there, the risk of aspiration pneumonia is quite high and this would be very uncomfortable, and this is more likely to be somebody that has got dementia.

MR ROZEN: You make reference to the Aged Care Quality and Safety Commission's new standards which we did ask you about and this is at paragraph 38 of your statement. You say like Dr Foltyn, who gave evidence about this matter in Sydney, you are concerned about the extent to which the new standards will ensure appropriate attention to oral health. Can you expand on what the concern is there?

MS LEWIS: First of all, I would like to qualify. I think the new standards are excellent in the way that they're encompassing residential aged care and home care. I think that's very positive. My concern is more around how evidence-based oral care is going to be measured. What are they using as their evidence base for a start, and how is it going to be measured and what information is going to be provided to consumers, particularly under the umbrella of consumer-directed care or informed consumer-directed care.

MR ROZEN: Yes. So a bit like the last witness on the panel who was referring to a concern about the application of nutrition standards in the context of home care. There is that theoretical – or certainly it's applicable to the home care setting, the concern is how it's to be applied and how compliance with the standard is to be measured, if I'm understanding you.

MS LEWIS: Yes.

MR ROZEN: Yes. If that we could go to paragraph 43 of your statement, please, I want to ask you a little bit about a project that you are involved in, which builds on work that Dr Foltyn referred to, that is ,the Better Oral Health in Residential Care Program and you explain at paragraph 43 by reference to that, that you were involved in development of the program and you specifically draw our attention to the better oral health in residential project report. What I'm particularly interested in asking you about is the adaption of that work to the home care setting which you had some involvement in. Can you just explain to us the background to that, what you were trying to achieve in applying that to the home care setting.

MS LEWIS: So, with the residential aged care project, it was promoting a multidisciplinary approach to oral health care. So as I said, four processes about oral health assessment, care planning, actioning of that care plan, and timely referral for dental care. So the residential aged care project was very successful, and we saw good improvements in oral health and building the capacity of the workforce up. So within the home care setting, particularly with the reforms and the development of the changes in the home care packages and knowing that 80 per cent of care in the future is predicted will take place in the community and 20 per cent in residential aged care. So this was really looking at translating that to fit the community aged care context.

MR ROZEN: So building on the success of the residential care program but tailoring it to a home care setting.

MS LEWIS: Yes.

MR ROZEN: And perhaps if we could bring up an example, not an example but a product of that work that you've drawn our attention to. It's at tab 92. This is the Building Better Oral Health Communities Project summary document. And this is one aspect of the work that resulted from that project.

MS LEWIS: This was a project summary.

MR ROZEN: Yes.

MS LEWIS: And the branding there with the toothbrushes was similar to that of the residential aged care, and the toothbrushes were quite significant because they – as I said before, oral care or tooth-brushing is associated with grooming where in this

context it's a tool. So a bent toothbrush can be used as a retractor. A bent toothbrush can be used to clean behind teeth so it's a tool.

MR ROZEN: Yes. If we can turn to page 5 of that document please, the code is .0005 in the top right-hand corner, just back a couple of pages, please. And if we could just increase the size of the two paragraphs under the heading Background on the left-hand column. This page sets out a summary of the project and it's a useful way of the Commission understanding it. We see that there's a reference there to future estimates predicting that 80 per cent of formal aged care is to take place in the home setting. That's an observation you made a moment ago. And we know from a lot of the evidence that we have heard in the Commission and a lot of empirical work that there's a strong desire for people to age in their own homes. And so the work here is built on that expectation that people's desire will be matched by appropriate funding.

And I say that because we have heard a lot of evidence about that not being the case presently that people, for example, are assessed for level 4 home care packages but there's often considerable delay associated with their delivery. Is that relevant to the application of the policy – sorry; of this project, rather.

MS LEWIS: Yes.

MR ROZEN: How so?

MS LEWIS: So I guess within this project, it's about building the capacity of the home care staff to actually be able to assess and monitor somebody in their home. So we talked about nutrition before. Has the care worker noticed that there's more food not being eaten, left in the fridge, in the bin when they're coming to assist with meal preparation, etcetera?

MR ROZEN: Yes.

MS LEWIS: So, I guess, a lot of the work within aged care looking from a care worker or nursing perspective, and I guess with other professions too, we tend to concentrate on the task and time rather than thinking and linking what we're doing to the bigger picture. So this project, particularly with the presence of aged care workers, so care workers going into homes that aren't supervised by registered nurses, they are actually the eyes and ears of the organisation. So they're quite key in being able to recognise if something is going wrong. So not only about oral health but a whole lot of other conditions as well.

MR ROZEN: Yes.

MS LEWIS: But the focus of this was to raise the awareness of oral health and its importance.

MR ROZEN: And you explain to us in your statement at paragraph 47 that various resources were produced as a result of the project. Can you summarise what the outputs were of the project, the practical situation.

MS LEWIS: I guess there can be a double-up between the two projects. So with the residential aged care, there were a lot of resources that were developed and that was a national rollout of training.

MR ROZEN: Yes. Dr Foltyn gave some evidence about that, didn't he?

MS LEWIS: Yes.

MR ROZEN: Yes.

MS LEWIS: And from that training there was a sort of cascade of other training that was available. So the Aged Care Channel also mirrored that work and also with the community aged care work there were resources that were pertinent to the context. So there's a difference between aged care in the community, so the resources were adjusted to fit that context. Also with the community services and health industry skills council, with the residential aged care, they developed a whole set of competencies around it, but they became electives rather than core components.

MR ROZEN: Yes.

MS LEWIS: And so I guess what I'm saying is there are a lot of – the resources are available. It's how they're used. And with the national rollout and there has been a lot of examples of one-off training, not only in Australia but around the world. And while they initially improve care, their long-term sustainability has been elusive.

MR ROZEN: Right.

MS LEWIS: So I guess what I'm saying, we've got fantastic resources, they've been well-received. We get very good feedback from educators and students of nursing and care workers, but education alone is not going to make the change.

MR ROZEN: It sounds like there's some similarities with this area to the area of palliative care. We had some evidence in Perth in our hearings there about the lack of sustainability of a number of specific projects that have been put in place to achieve improvements in the standards of palliative care in aged care facilities. You said a moment ago education alone is not enough to lead to sustainable outcomes. What more would you say is needed?

MS LEWIS: Systems change.

MR ROZEN: Yes.

MS LEWIS: And the last speakers sort of mentioned some of the aspects about system levels change, and I think with the literature around sustainability is that there are a number of factors that come into play with this. So people need to have some coherence or they need to have some sense-making about what they need to do. So staff need to understand the aims and the benefits, plus they need to know how it works and what their role and responsibility is. So, with the nutrition, we were talking about, like, the shifts and the cooks and the dietitians and that type of thing.

MR ROZEN: Yes.

MS LEWIS: So that can be sort of translated into, you know, GPs, nurses, care workers, and other aspects of comprehensive care, like physios, OTs, that type of thing. So people need to understand what they're doing, what their - - -

MR ROZEN: Yes.

MS LEWIS: - - - aim is and what their role is. There needs to be some engagement. So there needs to be encouragement and reminding, and this needs to be facilitated. And it's both a role and a process. So there needs to be some mechanism where that's facilitated.

MR ROZEN: Sorry. If I just interrupt you there. Are you talking about those matters happening at the – if we're talking about residential aged care, at the provider level? Is that what we're - - -

MS LEWIS: I think it can be - - -

MR ROZEN: Or - - -

MS LEWIS: - - - translated into multi-levels.

MR ROZEN: Yes.

MS LEWIS: So it could be a systems level, it could be an organisational level, it could be at an education level or on the floor level.

MR ROZEN: Yes.

MS LEWIS: And so – sorry. What did I say? People need to make sense of what they're doing.

MR ROZEN: Yes.

MS LEWIS: They need to be engaged. There needs to be collective action, and again that needs to be facilitated. People need to be working together. So if we're looking at comprehensive care, staff need to be working together, professions need to be working together. And there needs to be some reflexive monitoring. So and that

is – and we've talked about – a few people have talked about this, about systematically collecting information, whether it be by formal mechanisms or whether it's individual appraisal about, "Was that delivery of care good enough? What could I do different next time?" And that - - -

MR ROZEN: Sorry. If I just stop you there. Does that link us back to the oral health care planning they spoke about earlier? Is that – so the importance of monitoring, for example, a person's eating habits, is that relevant to that work?

MS LEWIS: Yes, and I'd have to say with – particularly if oral health is in care plans, I think it is very rarely actively monitored. As I said, it becomes optional if it's bumped off by a higher priority. But there's no follow-up whether it's been done or not.

MR ROZEN: Yes.

MS LEWIS: And there's no reprimand whether it's been done or not.

MR ROZEN: Sorry. I interrupted you.

MS LEWIS: And I guess getting back to the monitoring, whether it be auditing and particularly linked to risk management processes, which oral health is very rarely linked to risk management.

MR ROZEN: You expand on this issue on page 13 of your statement, if I could ask that be brought up. You identify for us, both in respect of residential care and home care, the importance of a multidisciplinary approach, and that's again a theme the Commission has heard evidence from a number of witnesses in different areas of care. So I suppose the starting question then is why as a multidisciplinary approach important for achieving oral health improvements?

MS LEWIS: Because I think there are very many players in, when we are looking at roles and responsibilities - - -

MR ROZEN: Yes.

MS LEWIS: - - - particularly who does what in the residential aged care setting. We know – and the home care setting – we know it's a care worker that will be actioning care plan and doing the – or supporting the person to clean their teeth or clean their dentures. But, really, the role of assessment is – particularly in the residential aged care setting is a registered nurse or maybe the GP on admission to a residential aged care facility.

MR ROZEN: Yes.

MS LEWIS: And then the planning around that would be from the registered nurse. And then the highlighting of whether it needs to go to – be referred to a dentist. And

particularly when I said about the dry mouth, the medication chart, whether that's a general practitioner or pharmacy review.

MR ROZEN: Yes.

MS LEWIS: The aged care setting is quite different. The care coordinators don't tend to be nurses. They are usually people that have a certificate qualification in aged care.

MR ROZEN: Yes.

MS LEWIS: And I guess there's sort of conundrum between a delivery of a service or is it a delivery of care? So it's quite a different context to aged care.

MR ROZEN: The training of personal care workers has been a constant theme in the evidence the Commission has heard. Are you able to enlighten us about whether personal care workers are adequately trained in relation to matters concerned with oral health? Is that an area that you've had cause to examine?

MS LEWIS: Yes. Both in residential aged care and the home care setting, there's - - -

MR ROZEN: Yes.

MS LEWIS: - - - a lack of knowledge. But also within the curriculums of the undergraduate or entry-level nursing and the aged care certificates, there's also a lack of oral health content.

MR ROZEN: Right.

MS LEWIS: And I guess my experience, particularly with the home care setting, the amount of time that is available for education is bereft. It's getting less and less. And it's almost like it's too late. And there's the expectation that it's already a work-ready skill and it's a personal care task. They should know what they're doing.

MR ROZEN: Can I ask you, it's an expression you use on your statement. Can I ask you expand on the notion of a "work-ready skill." What do you mean by that?

MS LEWIS: The expectation from home care providers or aged care providers or hospitals is - - -

MR ROZEN: Yes.

MS LEWIS: - - - that when somebody has finished a qualification, they should have the skills to be able to do their job.

MR ROZEN: Right. Without any further training.

MS LEWIS: Without any further training.

MR ROZEN: I see. And you – if I understand you correctly, you're saying that's a misconception in relation to - - -

MS LEWIS: Yes.

MR ROZEN: - - - the area that we've been discussing.

MS LEWIS: Yes. And I would say with the other professions, for example, medicine and allied health, there isn't a lot of oral health content within their curriculums either.

MR ROZEN: Yes. Earlier on in your evidence, I asked you about the role of dentists and I want to return to that now, if I could. That multidisciplinary team, you did mention dentists. Are dentists important in relation to oral health care, firstly, in the residential aged care setting? You're nodding. I - - -

MS LEWIS: Yes, they're an important part of the delivery of oral health care.

MR ROZEN: Yes.

MS LEWIS: But they can't be there every day to be brushing people's teeth, so I go back to the role and responsibilities of different people - - -

MR ROZEN: Yes.

MS LEWIS: - - - within the environment, and I do describe what I think an oral health team could be. It's not only the dentist. It could be the oral therapist or the dental hygienist. There's also the dental technicians as well. So they also have a role to play in their scopes of practice as well.

MR ROZEN: Yes.

MS LEWIS: So, you know, a dentist is responsible for the dental treatment, and I suspect a pathology and forming dental plans with a hygienist and therapist does a lot of preventative work.

MR ROZEN: Yes.

MS LEWIS: And the dental technician is more dentures.

MR ROZEN: You give some explanations for the lack of visiting by a dentist to residential aged care facilities including inadequate rooms to work in at residential aged care facilities. Is that a particular problem, in your experience?

MS LEWIS: Yes. And the program that I am involved in, it's a continual problem. It's interesting, as I said, in one instance, you know, dentists are in hairdressing rooms, hairdressers' rooms. They can be in lunch rooms with – sharing with physiotherapists and yet there's people lunch and utensils on the sink and the dentist is drying to do some clinical work in a clinical environment. And there's almost a lack of respect or, again, a lack of insight into what this care is.

MR ROZEN: Yes.

MS LEWIS: And I guess it's the siloing of care. It comes back to this task and time a bit and that things are in their different silos and professions are in their different silos. But certainly, the lack of support that I've seen from residential aged care facilities for having a dentist visit. I'm surprised that some of the dentists are still visiting. And again, I think it's also – I gave the example of a facility wanting to charge the dentist for the hire of the room - - -

MR ROZEN: Yes.

MS LEWIS: - - - and also charge for a care worker to be supporting a resident, you know, getting residents from the room to where the dentist is, as a service and that people could just book into reception if they want to see a dentist. So that notion of service versus care or comprehensive care, that there has been a separation.

MR ROZEN: You have explained to us that part of the reason for carers not necessarily attending to oral health include a perception that oral health is part of grooming generally. Are there other reasons for there being a lack of concern on the part of care workers or lack of attention by care workers in relation to oral care? For example, specifically with dementia patients, are there particular problems that you're aware of?

MS LEWIS: Again, it can come back to a lack of knowledge and skill about how to support somebody with dementia around oral care. But there's - - -

MR ROZEN: Yes.

MS LEWIS: - - - often the fear of being bitten - - -

MR ROZEN: Yes.

MS LEWIS: - - - or the fear of hurting the person. And I guess with a lot of the management techniques around that are, it is about making somebody feel very safe - - -

MR ROZEN: Yes.

MS LEWIS: - - - and participating in the care. And so the principles are the same no matter what the task is, but it is about the approach.

MR ROZEN: It's another example, isn't it, of the joining the dots as you said earlier, that is, if a care worker is not sufficiently understanding of the features of dementia, then they may well not attend to the oral health concerns of a person suffering from dementia, whereas a better understanding of the right techniques to encourage a person to open their mouth, for example, might achieve a better outcome. It's an example of the sort of holistic nature of the task, isn't it?

MS LEWIS: Yes. So if someone came towards me and shoved a toothbrush in my mouth, I would be fighting back.

MR ROZEN: Yes, of course. But if it was preceded by a discussion, an explanation, encouragement.

MS LEWIS: Miming and encouragement, yes.

MR ROZEN: It might be quite different. Now, you've identified – and you've already touched on this, I must say, you have identified in your statement towards the end some areas – this is on page 15 of your statement, towards the bottom of the page. You were asked by the Commission staff what, in your opinion should be done to improve the oral health of residents in residential aged care facilities and also aged care in the home. And you indicate that you strongly believe there needs to be a multi-level and multidisciplinary strategy. And you've talked about the importance of attention being focused at the system level, firstly, and this relates to the accreditation standards. Can you just expand on what is it about the Accreditation Standards that you think needs to be attended to so as to achieve better outcomes in respect of oral health.

MS LEWIS: Just before I go into that, it's really about shifting the perception of oral care as a low personal task priority to something that, when we're looking at the avoidance of hospital and the implications for general health that it is a low cost infection control intervention and out of hospital strategy for the aged care sector. But within the aged care standards and, you know, I've mentioned this before, it needs to be clearly articulated what the evidence is, what is evidence-based oral care - - -

MR ROZEN: Yes.

MS LEWIS: - - - for organisations to follow.

MR ROZEN: Over the page, you talk about the importance of building the health workforce's oral health capacity and you've already discussed that in relation to medical, allied health, nursing and care worker qualifications. Is there anything you would add to that?

MS LEWIS: Dietitians.

MR ROZEN: Dietitians, yes. Indeed. And then you refer to priority dental pathways for older people in the public system, at paragraph (d). Can I just ask you to expand on what you mean there.

MS LEWIS: I guess that is more in relation to older people need to be seen as a priority and not be on a waiting list for months to years before they're seen.

MR ROZEN: Yes.

MS LEWIS: And that's particularly in the public system. So if somebody could get to a clinic, they might be on a waiting list for a year before they're seen. As I said, if somebody can't get out to a clinic, they're reliant on a dentist being able to do some onsite dental treatment and we know we haven't got enough dentists doing that so they may well not be seen at all.

MR ROZEN: So you can't have an oral health strategy built around ready access to dentists, necessarily. Is that - - -

MS LEWIS: I think this is trying to improve the access to dental treatment.

MR ROZEN: Yes.

MS LEWIS: Yes, and so I guess with that, the public sector hasn't got the capacity to do that. So it really does need to be a public/private collaboration and even around particularly the Australian Dental Association has been promoting a pensioner dental scheme where people have got a choice. That's a voucher, a bit like the child benefit scheme. So we have got both groups, very vulnerable groups, the very young and the very old have got priority access.

MR ROZEN: And if there was one or maybe two particular areas that you would encourage the Commission to focus on in relation to improving the oral health of elderly citizens in aged care settings and home care settings, what would you target as the priority areas or priority tasks?

MS LEWIS: That's really difficult because I think it has to be done at a multi-level.

MR ROZEN: Right. You can't just pick a couple of - - -

MS LEWIS: You can't just pick one.

MR ROZEN: Yes. It has got to be the full suite.

MS LEWIS: Yes. It's a bit like the processes that I've been talking about, doing an oral health assessment. It's no good doing an assessment if you can't get dental treatment. If you've found that you need to refer and there's no dentist there. Or you can have access to a dentist, but nobody is doing the daily care. So it does have to be a suite and it does have to be done at multi-levels and coordinated, I guess. So, you

know, with the organisational level we know the importance of having commitment and leadership. As I said, with oral care, it needs to be unbundled from personal care and seen as infection control strategy to get the recognition and so it is part of the quality and safety processes and that reflects of monitoring and risk management strategies within an organisation.

I guess some of it, too – and we keep talking about joining the dots, it is about getting the sectors to work together and communicate together. So I would say with the aged care sector and the dental sector there's really no communication. They don't understand one another. And, of course, at the practice level we have been talking about the skill sets that are needed, and the reporting of competencies and the education.

So I know with oral health, I have never seen it as mandatory training. I – very rarely is it in induction programs. So it's a matter of, you know, as I said, it's a work-ready skill. Is it a matter of testing people's competencies when they start in a job. And I guess at the consumer level older people, too, think that oral health is something that happens when you grow old, poor oral health is, and that it takes a lesser priority over other care needs, and that's a misconception. So at a general population level there needs to be increased literacy around oral health and self-care.

MR ROZEN: Yes. Thank you very much. Commissioner, they're the questions that I have for Ms Lewis.

COMMISSIONER TRACEY: Thank you. Dr Lewis, as your evidence has made clear, fashioning an oral health regime to take the place of the disarray that confronts the Commission at the moment is not going to be easy but your evidence has certainly provided a good deal of guidance as to where the salvation of the system lies. Thank you very much for giving that evidence.

MS LEWIS: Thank you.

COMMISSIONER TRACEY: You are excused from further attendance.

<THE WITNESS WITHDREW [4.07 pm]

MR ROZEN: Commissioner, the next witness is Dr Frances Batchelor and she is in the hearing room. I would ask her to step into the witness box.

<FRANCES ANNE BATCHELOR, SWORN [4.08 pm]

<EXAMINATION-IN-CHIEF BY MR ROZEN

MR ROZEN: Dr Batchelor, could I ask you to state your full name for the transcript, please.

DR BATCHELOR: Frances Anne Batchelor.

MR ROZEN: I know you've been waiting patiently today to give evidence and we are very grateful for that. Dr Batchelor, for the purposes of the Commission, have you made a witness statement dated 26 June?

DR BATCHELOR: I have.

MR ROZEN: Do you have a copy of that in front of you?

DR BATCHELOR: I do.

MR ROZEN: It's WIT.0267.0001.0001. You've now got it in stereo in addition to having it in front of you, you've got it on the screen just to your left there, if that assists. There is one small typographical error that I know we have previously discussed, in paragraph 6 on page 2, in the second sentence. You see that it starts with the word "there", it seems to be missing "are" after the word "there", so it should read:

There are many known risk factors –

is that right?

DR BATCHELOR: That's correct.

MR ROZEN: You would seek to make that change.

DR BATCHELOR: Yes, I do.

MR ROZEN: All right. Are there any other changes that you would seek to make to the statement?

DR BATCHELOR: No, there aren't.

MR ROZEN: Okay. And is the remainder of – is the statement otherwise true and correct?

DR BATCHELOR: Yes, it is.

MR ROZEN: I tender the statement of Dr Batchelor, Commissioner.

COMMISSIONER TRACEY: Yes. Subject to the minor amendment just identified, the witness statement of Frances Anne Batchelor dated 26 June 2019 will become exhibit 6-50.

EXHIBIT #6-50 WITNESS STATEMENT OF FRANCES ANNE BATCHELOR (SUBJECT TO MINOR AMENDMENT ABOVE) DATED 26/06/2019 (WIT.0257.0001.0001)

MR ROZEN: Thank you, Commissioner. Dr Batchelor, you are in the first place a physiotherapist.

DR BATCHELOR: Yes, I am.

MR ROZEN: And you have some 30 years experience, both as a research and a clinical physiotherapist.

DR BATCHELOR: Yes, I do.

MR ROZEN: I'll just ask you a little about your clinical experience. Can you tell us what that was? I assume that's past tense.

DR BATCHELOR: No, it's still current.

MR ROZEN: It continues. Right.

DR BATCHELOR: Yes. So I've worked for over 30 years in the fields of gerontology and neurology in acute and rehabilitation settings predominantly, both in Australia and overseas. And I continue to work as a clinical physiotherapist in a rehabilitation setting on a casual basis.

MR ROZEN: Right. And the rehabilitation setting, I take it that's not a residential aged care facility.

DR BATCHELOR: No, it's not.

MR ROZEN: Okay. Do you have any clinical experience of working in residential aged care?

DR BATCHELOR: So as part of my role at the National Ageing Research Institute we run a whole suite of education and workshops for residential and community aged care providers. So the experience, while not directly working myself as a physiotherapist in residential aged care, I have a lot of experience in understanding the sector and the issues facing staff in the sector.

MR ROZEN: We will come that in a little more detail in a moment. I take it from that you mean to provide training about falls risks, for example, it's necessary to have some understanding of a particular aged facility and the problems that they are facing.

DR BATCHELOR: Yes, that's right.

MR ROZEN: I understand. So is that sort of indirect knowledge that you are talking about.

DR BATCHELOR: Correct.

MR ROZEN: You mentioned a moment ago that you work at the National Ageing Research Institute where you are the director of clinical gerontology and a senior research fellow. How long have you fulfilled those roles at the National Ageing Research Institute, NARI.

DR BATCHELOR: Yes, that's right. So I completed my PhD in 2010 and since then I've been employed as a research fellow. But over the last three years I've been the Director of Clinical Gerontology and a Senior Research Fellow at NARI and that involves running a program of work that focuses on a number of areas but including falls prevention, physical activity, and the like.

MR ROZEN: I will ask you a bit more about those in a moment, too. Firstly, I don't think we have had a witness from NARI and it sound like it's very important to the work of the Commission. Can you tell us a little about the National Ageing Research Institute. Firstly, where is it?

DR BATCHELOR: It's based in Melbourne. We are an independent medical research institute. We are affiliated with the University of Melbourne but we are separate from it. We have been around for 40 years. Our main aim really is to improve the lives of older people, specifically through the translation of evidence into practice. So it's at that translational end of research.

MR ROZEN: Yes. And an example of that is that you use the research to provide training to residential aged care facilities and their workers.

DR BATCHELOR: Yes, that's right. So what we would do is assist residential aged care providers and workers to understand and interpret the evidence as it relates to the particular group of people they're caring for.

MR ROZEN: Yes. Going back to NARI for a moment, what funding sources do you have? Where does the funding come from?

DR BATCHELOR: Yes, we have a range of funding. We receive some funding from the Victorian Government, Department of Health and Human Services. We undertake some research that's competitive funding through the Federal Government, so Department of Health. But we also have a range of other competitive funding through the National Health and Medical Research Council and also receive philanthropic grants for particular work. In addition, sometimes we are contracted to undertake evaluation of services. So aged care services through providers both in metropolitan and regional areas.

MR ROZEN: Right. That's the training function you spoke about a little earlier.

DR BATCHELOR: Evaluation and training, yes.

MR ROZEN: Yes, I see. And how many full-time researchers are there at NARI, do you know?

DR BATCHELOR: So we have got about 40 individual staff; that probably encompasses about 25 full-time equivalent staff.

MR ROZEN: Right. Okay. So it's quite a sizeable research organisation.

DR BATCHELOR: Yes, and we have a multidisciplinary background. So we have, obviously, a physiotherapist - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - occupational therapists and sociologists, social workers and medical staff as well.

MR ROZEN: Right. Is it the only such dedicated ageing research institute in Australia?

DR BATCHELOR: Yes, it's.

MR ROZEN: And - - -

DR BATCHELOR: It's the only independent medical research institute focused solely on ageing.

MR ROZEN: Yes. And are there overseas equivalents, to your knowledge?

DR BATCHELOR: Not in the same format, I don't believe so.

MR ROZEN: Right. Okay. On page 2 of your statement, if that could be brought up on the screen, please, you could give a summary of NARI and then you were asked the question about the quay risk factors for falls. If we could turn to that, please. And we asked you about the key risk factors for older people living in the community and also older people living in residential aged care facilities and older people in hospitals. Firstly, are the answers different?

DR BATCHELOR: Well, risk factors are common across all settings - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - with regards to individuals. But how they play out is different in different settings.

MR ROZEN: Can you give us an example of that?

DR BATCHELOR: So, for example, an older person, one of the risk factors for falls, obviously, is problems with balance - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - and walking. So an individual at home may be able to walk safely in their own home by using furniture to support them. If that same person is admitted to hospital, the environment is different.

MR ROZEN: Yes.

DR BATCHELOR: And so even though the falls risk factor is the same, the interaction with the environment, where there may not be furniture that someone had hold on to, there's increased distance for that person to walk, for example, to the bathroom it's an unfamiliar environment. That means that risk factor is more relevant in that situation - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - and more likely to lead to a fall.

MR ROZEN: Yes. So we had a case study yesterday of an elderly lady who was legally blind but, on the evidence, was quite good at negotiating her way around her home, no doubt because of familiarity with where the furniture was and so on. But within days of entering a residential aged care facility, she had had a fall, and then a further fall a few weeks later, and then ultimately a fall that led to her being hospitalised. I take it that your research would be – that that scenario is not unique in relation to residential aged care settings.

DR BATCHELOR: No, no, it's not unique. And what we also know is that these periods of transition when - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - an individual moves from one setting to another exposes that person to an increased risk of falls. So whether it's from home into residential aged care, for example, respite, or it's from home to hospital or from residential aged care to hospital, any change in environment is associated with an increased risk of falls.

MR ROZEN: And that's because of the reasons we have already discussed, presumably, that is, the furniture is in different places and so on, but it might also be because of the unsettling effect for an elderly, particularly, say, an elderly person with dementia, of the change in the setting. Is that right?

DR BATCHELOR: That's right. Cognitive impairment can play a large role.

MR ROZEN: Yes.

DR BATCHELOR: But also in circumstances where residents may be needing to go to hospital, it might be because they're unwell, may have increased confusion or delirium, and so are particularly vulnerable in that situation due to medical reasons as well as the environment. So here we see, really, the interaction from – of individual factors with the particular environment that that person is in.

MR ROZEN: Yes. Yes. And you've included in your statement what I take is a pretty comprehensive list of risk factors relating to individuals. This is at paragraph 6 of your statement, and we can see it on the screen there. I won't take you through each of those, but we – one I do want to focus on is about two-thirds of the way down the list, incontinence. Do you see that, under medications?

DR BATCHELOR: Yes.

MR ROZEN: We've heard some evidence in the earlier part of this hearing in Darwin about the particular challenges associated with the management of incontinence. What is it about incontinence that presents as a falls risk, not immediately obvious, but if you could explain that for us, please.

DR BATCHELOR: Sure. So incontinence plays a role in two ways. The first way is that, really, for older people there's an increase incidence of urge incontinence or the need to go to the toilet quickly. And older people – or any person for that matter – the desire to avoid an incontinent episode will often outweigh the need to wait for assistance, if someone is, for example, unsteady or needing help with their walking.

MR ROZEN: Yes.

DR BATCHELOR: So they might feel the need to go to the toilet, they might call for assistance but they're not sure how long it's going to take for that assistance to arrive.

MR ROZEN: Yes.

DR BATCHELOR: And so instead of waiting, which might be the safe option, they might take themselves to the toilet and, therefore, expose themselves to the risk of falls. The second way is if an incontinent episode has occurred, so urinary incontinence, for example - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - in the bathroom, that poses a slip hazard.

MR ROZEN: Yes, I see. On page 4 of your statement, if you go to that, please, down the bottom at page 19, you were asked the question about the relationship between falls prevention and fall-related injury prevention. And if I could just ask

you to clarify for us that distinction between preventing falls and preventing injuries from falls. It's a significant difference, is it not?

DR BATCHELOR: Yes. So a fall can occur, and not all falls result in injury but there is an argument to suggest that because falls are quite frequent, particularly in residential aged care, that some people suggest that instead of focusing efforts on preventing falls, we should focus efforts on preventing injury.

MR ROZEN: Yes.

DR BATCHELOR: But I would argue that we need to do both.

MR ROZEN: Presumably, the best way to prevent an injury is to prevent the fall in the first place.

DR BATCHELOR: To prevent a fall in the first place.

MR ROZEN: Yes. Yes.

DR BATCHELOR: The other aspect of that is that even falls that don't result in injury can have negative impacts for individuals. So that can lead to or be associated with things like a fear of falling, which can lead to then an individual further restricting their activity, which then goes into this downward spiral, if you like, of restricted activity, decreasing strength and balance and then further increasing falls risk. And another aspect of that is restriction of activity can also then be associated with things like social isolation and loneliness. So not just physical impacts but also those very personal impacts as well.

MR ROZEN: Before moving on to the research which I want to ask you about, a question that is has come up from time to time in the Commission is whether the rate of falls presents as a useful quality indicator for a residential aged care facility. And we know, for example, in Victoria and certainly publicly funded aged care settings there is a requirement to report regularly on falls. Is that a matter that you're able to assist the Commission on?

DR BATCHELOR: So I think it's important to measure rates of falls, but it should be said that a measure of falls, a number of falls rate is a fairly crude measure because this type of data is subject to a lot of noise and fluctuation, sort of on a week – potentially on a week-to-week basis, but also we know seasonally rates fluctuate up and down, and they can also be influenced very strongly by particular individuals in a residential aged care facility. So - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - if there's a resident who has very recurrent falls, that can tend to skew the data to increase the falls rate. And you can imagine if that resident then was transferred to hospital, the falls rate would then suddenly drop.

MR ROZEN: Yes.

DR BATCHELOR: So while I think it's an important measure, it's not the only measure.

MR ROZEN: Right. In the example that you've given, the resident going to hospital would have the effect of reducing the numbers, but it wouldn't tell you anything about whether falls were being better managed at that - - -

DR BATCHELOR: That's - - -

MR ROZEN: - - - facility at all.

DR BATCHELOR: That's correct.

MR ROZEN: Yes.

DR BATCHELOR: So I believe that we should also be considering process measures and the degree to which appropriate falls management has occurred and response, both for prevention and if and when a fall occurs.

MR ROZEN: So a more nuanced measure relating to falls might be an appropriate quality indicator.

DR BATCHELOR: Yes, I think so.

MR ROZEN: Right. Is there a related question – and I'm thinking about the evidence the Commission has heard about chemical restraints, for example, being used which essentially can have the effect of stopping a person moving at all – that might reduce the incidence of falls but not necessarily in a way that ought to be encouraged?

DR BATCHELOR: So I think this is one thing that there's a real tension around this whole area, because every movement is inherently risky. So if, for example, a resident moves from chair to bed, that's an inherently risky move.

MR ROZEN: Yes.

DR BATCHELOR: Walking is inherently risky. So I don't think that it's feasible or appropriate to aim for a zero rate of falls because, as you imply, that would mean that there may be covert or even overt restraint that is limiting someone's ability to move.

MR ROZEN: Yes. At paragraph 24 in your statement, you say:

> *In comparison to the community setting, there is a relative lack of robust evidence about what works to prevent falls in residential aged care.*

And I'd like to unpack that a bit, if I could, starting with the community setting. So implicit there in that sentence is that there is some robust evidence about what works to prevent falls in the community setting. Can you tell us in general terms what that is.

DR BATCHELOR: Sure. So we know that in – for older people, so people over the age of 65 who are living in the community, that we have very robust evidence that exercise, particularly exercise that consists of gait – sorry, strength training and balance exercise at a dosage of about 50 hours, so two hours a week for 25 hours, is effective at reducing falls.

MR ROZEN: Sorry, two hours a week for 25 weeks?

DR BATCHELOR: Yes, correct.

MR ROZEN: Yes.

DR BATCHELOR: So that is very robust evidence.

MR ROZEN: Yes.

DR BATCHELOR: We have that, really, from multiple sources now, including good evidence from randomised controlled trials and as well as meta-analyses where those randomised controlled trials are combined to provide the highest level of evidence.

MR ROZEN: Yes.

DR BATCHELOR: The highest level of evidence.

MR ROZEN: So that's quite clear in the community.

MR ROZEN: Yes.

DR BATCHELOR: But it's not the case in residential aged care settings.

MR ROZEN: Well, we'll come to that research and why that is, but are there other things that work to reduce the risk of falls in the community? For example, we've heard that vitamin D can be – vitamin D supplements can be of assistance in reducing falls risk. Is there research that backs that up in a community setting?

DR BATCHELOR: Well, vitamin D is quite a complex situation.

MR ROZEN: Yes.

DR BATCHELOR: There's different forms, different doses. So what we probably can say is that it's effective in reducing falls in people with low vitamin D.

MR ROZEN: I see.

DR BATCHELOR: And you're more likely to find those people in residential aged care compared to the community.

MR ROZEN: Turning then to the lack of evidence, because it's obviously of considerable significance to the work of this Commission because we've heard so much evidence about initiatives that are implemented on a regular basis – and you'd be more familiar with this than us, I think – about attempts to reduce falls risks, so changes to bed heights, for example, or exercise regimes through physiotherapists and so on. Your statement very helpfully gives us an insight into the state of the research, and you do it by reference to the Cochrane review of interventions, which you've referred to as the highest level of evidence available, at paragraph 24. So perhaps if I could start by asking you to explain to us what a Cochrane review of interventions is. What does that mean?

DR BATCHELOR: Sure. So a Cochrane review is a particular type of systematic review and meta-analysis - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - that follows a certain very robust methodology. And what it involves is evaluating particular interventions in particular settings and, obviously, we refer to residential aged care in this instance.

MR ROZEN: Yes.

DR BATCHELOR: And what a Cochrane review does is search through – very systematically search through databases for randomised control trials that are evaluating the intervention and outcome under consideration.

MR ROZEN: Right.

DR BATCHELOR: And then what the review will do, and normally there are multiple authors of a review - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - is combine, where appropriate, the results of certain randomised control trials to actually increase then the power of making recommendations about whether an intervention is effective or not.

MR ROZEN: All right. Which brings us to the particular Cochrane review that you have drawn our attention to, which happens to be a very recent piece of work from last year.

DR BATCHELOR: Yes.

MR ROZEN: 2018. And you have provided it to us, at tab 134 of the general tender bundle, if that could please be brought up on the screen, and, firstly, we see from the front page that this is a product, as you say, of the Cochrane Database of Systematic Reviews, and this particular one is entitled Interventions for Preventing Falls in Older People in Care Facilities and Hospitals. And then there's a series of authors that are identified there. Is this an Australian piece of research or is it an international - - -

DR BATCHELOR: No, this is an international piece of research, but, obviously, it involves Australian studies and includes Australian authors as well.

MR ROZEN: You told us that it's a meta-analysis and by that I take it you mean it looks at a very broad sweep of research that is being done and seeks to combine the results of that so as to provide a more robust evidence base is; that's essentially the idea?

DR BATCHELOR: Yes, the combination is done where it's appropriate. So they don't seek to combine results from studies where the intervention is – is not similar, if you like.

MR ROZEN: I see, so you are comparing apples with apples.

DR BATCHELOR: Apples with apples, yes.

MR ROZEN: Yes, I understand. And we see that it's not just concerned with aged care facilities. It also is concerned with the hospital setting but we will see in a moment that the data is actually separated. So conclusions are reached that are specific to aged care settings.

DR BATCHELOR: That's correct. And in this instance care facilities does refer to what we would term residential aged care.

MR ROZEN: Yes, okay. Thank you, that's very helpful. So if we can go to page 2, please. We see an abstract – sorry, it is the next page, actually, I think. Native page 2, it's page 5 in the document. Helpfully for us right at the bottom of the page there is – if you can just scroll down to the bottom please, operator – there is a plain language summary which for the uninitiated is always a pleasure to see because it's quite a technical document, is it not, Doctor.

DR BATCHELOR: Yes.

MR ROZEN: Yes. And we see that the heading there Interventions for Preventing Falls in Older People in Care Facilities and Hospitals, and we have to scroll down to the next page to get the summary. If we could just focus on the first two paragraphs there, the review question and the background if they could be highlighted. We see the question that was being approached was:

How effective are interventions designed to reduce falls in older people in care facilities and hospitals.

And then there is a bit of a discussion about falls and the importance of falls that can obviously result in death and injury. In relation to injury, I should have asked you this a moment ago, the injuries resulting from falls can be direct in the sense that someone breaks a bone when they fall.

DR BATCHELOR: That's right.

MR ROZEN: But it's also the case that there can be indirect injurious consequences from falls. We saw this in the case study yesterday where a fall resulted in a direct injury, a broken wrist, but then when the elderly resident who had the fall went to hospital, she sustained a heel injury, and then in the last week's case study in Darwin, similarly the resident who had been injured and broke her hip, went to hospital and also sustained a heel injury which became very much more serious.

DR BATCHELOR: Yes.

MR ROZEN: From your experience, is that quite a common thing?

DR BATCHELOR: So we can have direct injury as a result from a fall but then we can have negative consequences, even in the absence of injury such as death. The fall seems to trigger this downward spiral.

MR ROZEN: Yes.

DR BATCHELOR: Yes. And sometimes that's a result of care processes not being adequate. There's a huge number of factors involved in that but in a lot of circumstances, the fall should not result in that downward spiral. I believe there are appropriate interventions and strategies that can be put in place that would prevent or at least minimise that scenario.

MR ROZEN: You explained this to us before about a fall potentially having the effect of making – of someone losing confidence, moving less, become being more infirm and so on. Is that - - -

DR BATCHELOR: That's right.

MR ROZEN: And I think what you are saying to us, properly managed there's nothing inevitable about that progression.

DR BATCHELOR: That's correct.

MR ROZEN: If we can go back to the research, we see in that section, background, that there are many types of interventions in use which are identified there, including exercise, which we have already discussed, medical interventions that include

vitamin D supplementation. Once again we have made brief references to that. Reviews of the drugs that people are taking, and if I could just stop there. Reviews there mean not just reviews but alterations to pharmaceutical regimes based on such a review.

DR BATCHELOR: That's right. So when medication review is referred to, really the aim behind that is to decrease the use of particularly psychoactive medications. So it's review and management, not just simply review.

MR ROZEN: Yes. So going back to the identified interventions that are frequently used, there's environment or assistive technologies including bed or chair alarms, and once again that's something we have heard a deal about in the Royal Commission. And then changes to beds is another example, using low beds so that there's a smaller distance to travel. Social environment interventions that target staff members and changes in the organisational system. What is being referred to there, Doctor?

DR BATCHELOR: In terms of how care is organised, the social environment interventions refer to these organisational systems in structures and models of care.

MR ROZEN: Right. And then finally there's a reference to multi-factorial interventions, which is presumably a combination of two or more of the identified interventions.

DR BATCHELOR: Yes, that's right. So we distinguish between two types there. One is multi-factorial interventions that are based on individualised falls risk assessment and management. So different residents would have different interventions put in place in that scenario based on their individual falls risk factors. There's also multiple interventions where the same type of intervention is provided to all residents. So it might be four things that are applied equally to all residents.

MR ROZEN: Yes. And the authors go on to say:

> *Falls are reported in two ways in our review. One outcome is the rate of falls which is the number of falls and the other outcome is the risk of falling which is the number of people who have had one or more falls.*

The first category or first way of reporting falls is self-explanatory but can you just expand on the concept of the risk of falling: what is being measured there?

DR BATCHELOR: So the risk of falling is really referring to the proportion of people who have had one or more falls. So if there were 100 residents and 50 fell then there's a .5 risk of being a faller, if you like to use that term, which we – is often used but not necessarily the ideal term.

MR ROZEN: Right. It's another one of those terms like wanderers, that perhaps
- - -

DR BATCHELOR: Correct.

MR ROZEN: - - - connotes certain things - - -

DR BATCHELOR: That's right.

MR ROZEN: So they're the interventions which were the subject of this research or this examination of the research. And before we look at the outcomes of the research, are they all interventions which, in your experience, in residential aged care settings in Australia, are they all interventions that are utilised to your knowledge?

DR BATCHELOR: Absolutely. So in residential aged care settings they employ a number of different interventions, including things like bed or chair alarms but often implementing technology such as smart floors, a range of different exercise types.

MR ROZEN: Yes.

DR BATCHELOR: There's a number of strategies being trialled across the sector.

MR ROZEN: Yes. And that observation, I have to tell you is entirely consistent with the evidence the Commission has heard about the way providers seek to address falls risk. So if we can go back a bit lower down on the page please, we get a summary of the outcomes. About halfway down we see a heading, firstly, Quality of the Evidence which I need to ask you about. So perhaps before I do that, sorry, the previous paragraph, Study Characteristics. So we can see that this is a very extensive piece of work that looked at 95 randomised control trials involving, as we can see, 138,164 participants.

DR BATCHELOR: That's across both settings.

MR ROZEN: That's a combined total. Thank you. That's what I was going to ask you. Of the 95, 71 trials involving 40,374 participants were in care facilities, and we can ignore the outcomes in relation to hospitals were the numbers are greater although the number of trials was smaller because of course presumably hospitals are much larger generally than aged care settings.

DR BATCHELOR: That's right.

MR ROZEN: The authors then indicate that on average the participants were 84 years of age in care facilities, and if I could just stop there. That's broadly consistent with the evidence the Commission has heard about the average age in Australian - - -

DR BATCHELOR: That would reflect the profile – the age profile in Australian residential aged care facilities.

MR ROZEN: And the gender breakdown, is that consistent again?

DR BATCHELOR: Yes, I would expect that is consistent.

MR ROZEN: Three-quarters women, one-quarter men.

DR BATCHELOR: Yes.

MR ROZEN: And then if we can go to the next paragraph please, operator, which deals with the quality of the evidence and I want to ask you a little bit about this. It said:

The majority of trials were at risk of bias mostly relating to a lack of blinding.

Can you help us with that.

DR BATCHELOR: Sure. When we look at evidence in randomised control trials, what we need to make sure is that there isn't bias within the study. So for example, if the participants in the study know that they're either in the intervention group or the control group, that can influence outcomes. Again, if the assessors who are examining the outcomes of the trial – so we're looking at the outcomes, the outcome variables, if they're aware of group allocation, so either intervention or control, that can introduce bias into how outcomes are reported. And it's often unconscious bias. They are not deliberately trying to alter the results but it's just an effect of knowing what group the participants are in.

MR ROZEN: Now, for those of us that are not as actively involved in research as yourself, if we could just break that down a little bit. The way these studies were done that are the subject of this meta-analysis, presumably involved a certain cohort within a given residential aged care facility being divided into two groups where one group was the subject of a particular intervention, it might be a vitamin D supplement being given to them, and the other group were not the subject of that intervention. Their falls risks were just addressed in whatever normal way was being done in that facility. Is that broadly how the studies would have been - - -

DR BATCHELOR: Broadly, but what we see most in the research around residential aged care is that the study arms, if you like, the groups, are randomised by facility. So individual residents at a facility don't receive one or the other. It's – they're grouped according to facility. But if I can just give an example about blinding, for example, we do this – not I, but it's done when we have drug trials, where you get a placebo and the active ingredient. So the person taking the drug doesn't know which one they are getting so the participant is blinded in the situation.

Whereas in studies such as evaluating the effects of exercise, the participant will know if they're in the exercise group, obviously, because they're doing the exercise program. Whereas the ones who are in the control group are not doing the exercise program. So while blinding is an issue in randomised control trials in these settings and with these types of interventions, sometimes it can't be avoided.

MR ROZEN: Yes, I was about to ask you about that. The drug trial, the classic drug trial scenario where one group is getting a placebo and the other group isn't presumably will produce very high-quality evidence.

DR BATCHELOR: That's right.

MR ROZEN: Right. In the residential aged care facility in this sort of trial, it doesn't seem to necessarily lend itself to that sort of type of research for reasons that are - - -

DR BATCHELOR: That's right. I think but there – in really well-designed studies there are attempts to control for those factors. So sometimes an intervention might be exercise, for example, then the control group will receive a similar intervention that's not exercise based but goes for the same amount of time, for example, a social type of intervention.

MR ROZEN: I see. We see from the report that you've drawn our attention to that this lack of blinding means that most of the evidence, with some exceptions, but most of the evidence that was examined was considered to be at a very low or very low quality.

DR BATCHELOR: So for some of the work there are not just issues around blinding but issues to do with collection of outcome measures, of things like data that's missing, so not fully reporting data for all participants, and they're all things that are taken into consideration when rating the evidence as low or very low. So it's rated in a very structured manner according to a checklist - - -

MR ROZEN: Right. And I - - -

DR BATCHELOR: - - - by the authors.

MR ROZEN: Yes. And I take it they're terms of art, "low" and "very low quality evidence." They have a particularly meaning for the researchers.

DR BATCHELOR: That's right, yes.

MR ROZEN: Is the low quality of the evidence, for the reasons that we have discussed, balanced to some extent by the quantity, the scale of the work that was done here? Is that relevant to the – to - - -

DR BATCHELOR: Some of the work – some of the studies have very low participant numbers, so - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - it would be much harder to draw individual – to draw inferences from those individual studies. That's why the Cochrane review, where appropriate, combined studies - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - to enhance the sort of participant pool. But sometimes studies can't be combined if they're, as I mentioned before, an intervention that doesn't relate to another type of intervention. So I think, off the top of my head, one study is looking at whole-body vibration and its effects on falls.

MR ROZEN: Yes.

DR BATCHELOR: We cannot necessarily combine that with a simple exercise intervention.

MR ROZEN: So because of the reputation of the Cochrane review, we can assume without necessarily investigating it that that work has been done by the authors. They have excluded studies that are not apples, they're pears or they're oranges, and what we're left with are things that can properly be combined - - -

DR BATCHELOR: Absolutely.

MR ROZEN: - - - in a way that gives a reliable outcome.

DR BATCHELOR: A very robust summary of the evidence.

MR ROZEN: Yes. Okay. So with all that in mind, if we can then turn to look at the findings, specifically looking at the next paragraph, number 2, with the heading Care Facilities. And we see there that the four interventions, or four of the – I think there were more than four in the list that I looked at.

DR BATCHELOR: That's right.

MR ROZEN: Why have these four been identified as you understand it?

DR BATCHELOR: So these are the four types of interventions for which there are studies that could be combined. So they haven't included in this list single types of intervention where there was, for example, only one study of that type.

MR ROZEN: Okay. If we can start then with the effective exercise which was the one that – it was the one area that you identified where there was very robust evidence in the community setting, and one would expect intuitively that it wouldn't be that different in the aged care setting. If it works in the community and works well, then one would think that it would work maybe not as well, but it would work in the aged care setting.

DR BATCHELOR: Well, I think what's quite sobering about the summary, this lay summary, if you like, of evidence of in relation to residential aged care is that we don't have very good-quality evidence for those interventions as in terms of exercise. So, really, what we saw was that exercise doesn't impact on the rate of falls in residential aged care.

MR ROZEN: Yes.

DR BATCHELOR: Now, the exercise included in those interventions isn't necessarily at the same intensity and dosage and type as community-based interventions. So that might be one reason for this result. And bearing in mind exercise has other benefits, what we're considering here is exercise's effect on falls and risk of falls.

MR ROZEN: Yes.

DR BATCHELOR: In terms of medication, again - - -

MR ROZEN: Sorry. Just before we leave exercise, because it is something I would like to focus on because, I must say for me it seems to be counterintuitive that the exercise doesn't reduce the falls risk or doesn't appear to make any difference or little difference as is explained there. You've given your view about why that might be, and I just want to explore that a little bit more. Is what you're saying that those 25 two-hour-a-week sessions that the community research tells us can reduce falls risk might not be implemented with the same sort of rigour in an aged care setting?

DR BATCHELOR: Yes, so some – the studies have various exercise programs.

MR ROZEN: Yes.

DR BATCHELOR: Some as short as 12 weeks, for example.

MR ROZEN: I see, yes.

DR BATCHELOR: Some with durations that were less than those two times 25 hours.

MR ROZEN: Yes.

DR BATCHELOR: We have seen some emerging evidence in the last year of an exercise program that's been evaluated in the Australian context where they actually did do six months of exercise training two times a week for one hour - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - including the types of exercise that we know are effective in community-dwelling older adults. So - - -

MR ROZEN: As weight-bearing?

DR BATCHELOR: So strength training.

MR ROZEN: Yes.

DR BATCHELOR: So progressive resistance training, as well as balance training. And this particular study did find 55 per cent reduction in the falls rate in the intervention group. So in this study, they did a six-month exercise intervention and then a maintenance program for six months.

MR ROZEN: Right.

DR BATCHELOR: So it does seem that there's emerging evidence that if we can increase the dosage to sufficient levels - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - provide the right type of exercise, that this may potentially bring about reductions in falls. What we're unsure of is the effects in people with moderate cognitive impairment.

MR ROZEN: I see.

DR BATCHELOR: So I just put a minor caveat on that.

MR ROZEN: Okay. That Australian study that you've referred to combined, I guess, with what we know about what works in the community, is that informing the advice that you're giving to aged care providers presently?

DR BATCHELOR: Well, we still don't have enough evidence in the Australian context to - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - actually make that recommendation as to those number of hours and the content. I think that study to which I'm referring to, known as the SUNBEAM study - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - needs replication in other facilities so that we can have more confidence in those results.

MR ROZEN: All right. Back to the Cochrane review, the second intervention that was examined was medication review and, as you explained to us earlier, that's to be

understood as meaning review and, where indicated, alteration to medication regimes. Once again, made little or no difference to the rate of falls.

DR BATCHELOR: Nor the risk of falling.

MR ROZEN: Nor the risk of falling. Thank you.

DR BATCHELOR: So often this will – this may come about because there are studies with mixed outcomes. So there might be one study that shows a positive impact, other studies that show a negative impact - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - no difference between the intervention and control group. And when combined, their conclusion is that it was no better than usual care.

MR ROZEN: Neutral.

DR BATCHELOR: Neutral result.

MR ROZEN: Okay. Thirdly, vitamin D, which we addressed before, and here there is some good news. The study indicated that prescription of vitamin D probably reduces the rate of falls but probably makes little or no difference to the risk of falling. So it reduces numbers but not necessarily the likelihood of people falling.

DR BATCHELOR: Yes. So interpretation of this sentence is that if you're likely to fall, vitamin D probably doesn't make a difference to that.

MR ROZEN: Right.

DR BATCHELOR: But it decreases the rate of falls that an individual might have.

MR ROZEN: Consistently with the evidence you gave earlier, the population that was included in those studies generally had low vitamin D levels previously. So they were coming off a low base, in other words.

DR BATCHELOR: They were coming off a low base. That's correct.

MR ROZEN: Right. So in those – for that cohort, vitamin D supplements are, it would seem, amenable - - -

DR BATCHELOR: Something to be, yes, considered.

MR ROZEN: Considered. Right.

DR BATCHELOR: Correct.

MR ROZEN: And that suggests, doesn't it, that a provider that wants to give residents vitamin D supplements ought to do it in quite a nuanced way in the sense of perhaps first investigating their existing levels to maximise the chances of it being successful.

DR BATCHELOR: Yes, I would agree with that statement. And again, bearing in mind we're talking about falls prevention here. So vitamin D has a range of other effects as well.

MR ROZEN: Right.

DR BATCHELOR: So in this situation, we're really talking about the effects in relation to falls prevention.

MR ROZEN: Okay. The other effects of vitamin D, are you suggesting they might be negative effects or - - -

DR BATCHELOR: I think most of the studies show no adverse effects from - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - vitamin D. But, obviously, prescribing vitamin D supplementation needs to be undertaken in conjunction with the resident's medical professional.

MR ROZEN: Yes. And, finally, the multifactorial interventions which we discussed earlier similarly made little or no difference to either the rate of falls – sorry, there's uncertainty about the effect on the rate of falls but little or no difference to the risk of falling.

DR BATCHELOR: So the uncertainty is because they didn't find a difference in outcomes between multifactorial interventions and control condition but also in relation to the fact that the evidence was very low quality as assessed by the authors.

MR ROZEN: Leaving the Cochrane review and going back to the evidence that is in your statement, you indicate at paragraph 31, at the top of page 7, not surprisingly in light of that evidence, that there is an urgent need for further high-quality research to determine effective interventions to prevent falls in residential aged care facilities.

DR BATCHELOR: That's right. At the moment, as I mentioned before, there are a whole range of different interventions and strategies being implemented within aged care settings and, as we've now heard, that evidence base is actually quite low.

MR ROZEN: Yes.

DR BATCHELOR: So we really – some of these strategies may or may not work. We just don't know in terms of evidence. So we really need to understand which

strategies are effective when evaluated in proper studies and which strategies may be not worth implementing.

MR ROZEN: Yes.

DR BATCHELOR: So resources directed elsewhere.

MR ROZEN: Yes. You don't, however, throw your hands up in the air and saying nothing can be done whilst such research is carried out.

DR BATCHELOR: No. In the absence of robust evidence, I think there is a number of things that need to be addressed.

MR ROZEN: Yes.

DR BATCHELOR: We really need to improve the individualised assessment and, importantly, the management of falls risk factors, particularly those that are modifiable.

MR ROZEN: Right.

DR BATCHELOR: So we shouldn't just say that falls are an inevitable part of ageing and that - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - they are all going to happen. We really need comprehensive falls risk assessment and then management of those falls risk factors in a timely manner. And so one of the gaps we see is that falls risk factor assessment can often be relatively static. So it might happen when someone enters residential aged care - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - and then on a three-monthly basis or if and when a fall occurs. But it's not responding in a dynamic way to the changes that we might see in residents' functional and health status.

MR ROZEN: So could you give us an example from your experience of that being done well, of those sort of adaptions to change in terms of the management of a falls risk.

DR BATCHELOR: So when it's done well, frontline staff are able to pick up subtle fluctuations in a resident's performance.

MR ROZEN: Yes.

DR BATCHELOR: Whether it might be increased unsteadiness compared to how they usually moving around in the facility. And if that's done well, then that's fed back and then we have multidisciplinary, you know, reassessment - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - and then implementation of the strategies. So it's this care planning that involves the implementation that's crucial. It's not just a tick-the-box, "Okay. We've done the falls risk assessment." It's taking that next step to ensuring the strategies are implemented.

MR ROZEN: I just want to pick up something you just said about the importance of care workers who are invariably the frontline observers of residents in aged care. You make the point that increasing the number of staff can have an effect on reducing falls risk, and we can understand that if more staff are available to assist a resident to get to the toilet, for example, that's an obvious example, isn't it, of how more staff can reduce falls risk?

DR BATCHELOR: Yes, I believe there needs to be increased knowledge and skills within frontline staff.

MR ROZEN: Yes.

DR BATCHELOR: But imagine the situation at night where a care worker is assisting someone to the toilet and someone else calls for assistance. It doesn't matter how much knowledge or skills they have, they can't be in two places at the one time. So they will need to make a decision about whether they leave the resident who they're with - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - and go to the other resident and weigh up, you know, a challenging decision to make. So I do believe that we need increase staffing resources as a way of reducing falls within residential aged care.

MR ROZEN: Is there also a qualitative dimension to that? And by that I mean – and you've already alluded to this – the importance of training and experience to pick up what might be subtle indicators that a person's falls risk is increasing.

DR BATCHELOR: I think there needs to be training on those subtle indicators, but - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - I think there needs to be broader training as well. So we need that granularity, but we also need, really, a comprehensive overview and an

understanding of how falls risk factors interact with other issues, and we've heard a lot about joining the dots.

MR ROZEN: Yes.

DR BATCHELOR: So falls aren't in isolation from other issues such as nutrition - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - even oral care, as we've heard today.

MR ROZEN: Yes.

DR BATCHELOR: They're all interrelated. And if we can support staff to offer truly person-centred assessment and care - - -

MR ROZEN: Yes.

DR BATCHELOR: - - - then I think that will go a long way to prevention of falls but also joining the dots for those other issues.

MR ROZEN: Yes. Is there another aspect of that being this: that we've heard that the provision of truly person-centred care, we have heard in the evidence in the Commission, often is reliant on continuity of staffing; that is, staff that are familiar with particular residents, get to know them well, are more likely to pick up those subtle signs and, as you say, connect the dots. Is that another dimension to this?

DR BATCHELOR: Yes, look, I believe that's the case but, obviously, we can't always have continuity of staff. So, in that situation, the communication is very important and the mechanisms that allow that communication to happen.

MR ROZEN: You have very helpfully listed for us the areas that you think need attention, even in the absence of the sort of robust evidentiary base that you've talked about. Can I just ask you about the one that appears at paragraph 38:

> *Implementing improved systems for collection of comprehensive clinical data and enabling tracking and reporting of data in real time.*

Can you assist us and expand on that, please, Doctor.

DR BATCHELOR: So often what we see in relation to falls prevention is completion – for example, when a fall has occurred, we see completion of perhaps a falls incident report which might happen in one system. We have documentation about care and care planning and progress notes that might happen within another system. But often what we don't have is integration of those systems to be able to

understand where we have variation in overall factors that relate to falls, location of falls, for example, but also in relation to individuals.

So I think that if there was better integration of data from multiple sources that enables tracking of fluctuations in real-time so that staff could be proactive in addressing particular issues, that would go a long way to improving falls prevention because I think one of the limitations is that data is often collected or information about residents, to put it in a different way, is often collected at certain time points. For example, monthly or resident of the month might come up every three months. And I don't think it's timely enough in order to detect changes and respond to those changes.

MR ROZEN: We've seen in some of the case studies that we have looked at, Doctor, that what often appears in the progress notes is little more than:

Resident had a fall. Family member notified. Move on.

DR BATCHELOR: So there's a lot of information that's held, you know, perhaps in people's heads and is not documented, and if there was a system that better was enabled to capture information and share that information, it would enable also families, residents and staff to be able to better make informed decisions and take action, proactively rather than reactively.

MR ROZEN: Yes. So information that might be significant to record could be the location of the fall.

DR BATCHELOR: Yes.

MR ROZEN: The activity that the resident – whether they go to the toilet or not, for example, might be of assistance and, presumably, you could come up with a number of others, I'm sure.

DR BATCHELOR: That's right.

MR ROZEN: And then that data could be analysed.

DR BATCHELOR: And it could be analysed for different facilities, for different areas of that facility rather than being this one size fits all approach. In the absence of robust evidence, we really need that local context because of the interaction with the individual and their environment to understand what is happening at a very local level.

MR ROZEN: Presumably that sort of more detailed data source would be of assistance not just to a provider in seeking to manage a falls risk but also to an external regulator, for example, which is an examining an accreditation or some other regulatory intervention. That sort of information, if the regulator was able to interpret it properly, could be of assistance as well.

DR BATCHELOR: Yes, I think with checks and balances it could be of assistance in that circumstance.

MR ROZEN: All right. In relation to that, I want to finally ask you about paragraph 40 of your statement. You were asked about the quality standards, the new quality standards which at the time of your statement were due to commence but of course they have now commenced a fortnight ago, and your attention was drawn to standard 1 which talks about the dignity of risk and you were asked about the potential impact of the application of standard 1 and you make the point that the standard has direct relevance to falls prevention. But reading the last sentence of paragraph 40 you say:

> *The extent to which the new standards will influence falls prevention in residential aged care will depend on tolerance of risk from aged care organisations, residents and residents' families.*

Can I just ask you to expand on what you're talking about there, please, Doctor.

DR BATCHELOR: So as I mentioned before, any kind of movement is inherently risky. And I think often there's an expectation – we know that falls can be a trigger for people entering residential aged care and sometimes there's an expectation, particularly from family members, that once that person who may have fallen a lot at home goes into aged care that they will stop falling but as I have indicated previously the falls risk factors remain the same, largely, and it might even be that the person entering aged care might be at increased risk of falling.

MR ROZEN: Yes.

DR BATCHELOR: So I think there really needs to be conversations with or involving the resident, their families and staff at aged care facilities about how much choice the resident can have in moving around, what that might mean in terms of the risk of falls and the risk of injury, and what the implications are for the residential aged care provider as well, because obviously they are in a difficult position of potentially exposing themselves to risk if a resident falls and has an adverse outcome. So it's really around this tolerance of risk, what are we prepared to tolerate, to enable people to choose to move freely around in the safest possible manner.

MR ROZEN: Yes. Now, finally, Doctor, I just want to ask you about two aspects of other evidence that the Royal Commission has heard and ask you to comment, if you are able to. Firstly, we had some evidence last week from Catherine Maloney who is the acting CEO of an organisation called Services for Australian Rural and Remote Allied Health. It's an organisation representing physiotherapists and other allied health people working specifically in rural and remote regions, and she talked about the increasing importance of allied health assistants who she explained were workers that have cert IV qualifications but work, as the name suggests, as assistants to physios and other such allied health professionals. Do you have experience of allied health assistants working in the context of falls prevention?

DR BATCHELOR: Yes, I do.

MR ROZEN: Could you tell us a bit about the potential for – or their role and your observations of their work.

DR BATCHELOR: So I think there is potential to consider the role of allied health assistants in falls prevention particularly in under-resourced areas but I will say that the status of residents is becoming more complex. So we really need to recognise that caring for older people receiving residential aged care is a highly specialised area. So I do believe that physiotherapists and occupational therapists, dietitians, you know, and highly trained health professionals do play a very key role, but I think we could explore how allied health professionals could provide potentially something that is economically a little more efficient, under the direction of those trained health professionals. So we don't know the answer to that yet but I think it's something that should be explored.

MR ROZEN: The other question concerns some evidence which I think you were in the hearing room when it was given, that was Dr Iuliano sitting on your left earlier.

DR BATCHELOR: Yes.

MR ROZEN: And you will recall that Commissioner Tracey asked her a question or asked the panel a question about whether it's the falls that lead to the fractures or is it weak bones that lead to falls. Her evidence was that primarily it's falls that lead to fractures in 95 per cent of cases, I think was her evidence.

DR BATCHELOR: Yes, I concur with her evidence. The vast majority of fractures are the result of a fall, not the other way around.

MR ROZEN: Thank you. All right. That's very helpful, thanks a lot. Commissioner, they're the questions that I have for Dr Batchelor.

COMMISSIONER TRACEY: Thank you, Dr Batchelor, we have obviously got a long way to go in countering the problems associated with falls that are experienced by elderly people. But you've certainly highlighted the major areas of research that need to be done in order to improve that position, and the Commission is extremely grateful to you for coming and giving us the guidance that we need to work out a regime that hopefully will – I don't think we will ever achieve a complete prevention of falls but we need to go a lot further than we're at at the moment. Thank you very much.

DR BATCHELOR: Thank you.

<THE WITNESS WITHDREW [5.11 pm]

COMMISSIONER TRACEY: Mr Rozen, 10?

MR ROZEN: 10 is the time I am told is appropriate, Commissioner. Yes.

COMMISSIONER TRACEY: Good. The Commission will adjourn until 10 am tomorrow morning.

MATTER ADJOURNED at 5.11 pm UNTIL WEDNESDAY, 17 JULY 2019

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