Review of Roy Fagan Centre

Older Persons Mental Health Services

June 2021

Office of the Chief Psychiatrist
Department of Health

Tasmanian Government

This Report has been prepared by the Advisory Panel – Standard of Patient Care – Roy Fagan Centre, established under Section 13 of the *Tasmanian Health Service Act 2018* (The Act) to provide the Secretary of the Department of Health with advice about the Standard of Patient Care at the Roy Fagan Centre in accordance with the Terms of Reference provided to the panel.

The Advisory Panel, whilst taking all care, takes no responsibility for the accuracy, completeness or relevance of the information provided in this Report and people using information provided in this Report, for whatever purpose, are advised to verify it with the Department of Health or other source and to obtain any appropriate advice.

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The observations, findings and recommendations set out in this Report are the observations, findings and recommendations of the Advisory Panel and may not reflect the views of the Crown in right of Tasmania.

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Acknowledgements: We wish to thank the family of Mr A for their invaluable help and assistance in undertaking this Review, without their help this report would not have been possible. In addition, we were aided by the staff of RFC, who to a person, were open, cooperative, and helpful, their approach made our task much easier. We wish to thank Drs Duncan McKellar, Helen McGowan, and Brett Coulson for their valuable insights into Older Persons Mental Health Services across Australia and Prof Melanie Archer from the Victorian Institute of Forensic Medicine for her guidance in respect of Forensic Entomology. Finally, we thank Anu Mahambrey, Gabby Martin, Donna Rowan, Jane Austin, Angela Proposch and Darren Turner from the Department of Health, who worked tirelessly to support the Review and provided considerable assistance with the final report.

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Ms Kathrine Morgan-Wicks
Secretary
Department of Health

Dear Secretary

In accordance with your Instrument of Establishment for the Advisory Panel - Standard of Patient Care – Roy Fagan Centre, I hereby provide you with the report of the Review of the Roy Fagan Centre and Older Persons Mental Health Service.

I bring this report to your attention in compliance with your Instrument of Appointment and section 13 of the *Tasmanian Health Services Act 2018* as the Chair of the Advisory Panel that undertook the Review of the Standard of Patient Care at Roy Fagan Centre and to provide advice to you by 15 March 2021.

Whilst the report found that, in general, the level of care and treatment was satisfactory, it found that on occasion this fell below an acceptable standard. It also found a number of areas in which improvement can be made and that a number of factors have led to the service being held back from operating at a level that might be expected of a Specialist Older Person's Mental Health Service.

The report makes recommendations that, if implemented, we believe would lead to a significant improvement in the overall level of care and treatment provided to older Tasmanians.

Yours sincerely

Dr Aaron Groves
Chief Psychiatrist and
Chairperson,
Advisory Panel – Standard of Patient Care – Roy Fagan Centre

15 March 2021

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Tasmanian Government

Ms Kathrine Morgan-Wicks
Secretary
Department of Health

Dear Secretary

In June 2021, I was informed by the family of Mr A, that a number of tragic events had occurred in the period after the Report of the Advisory Panel was provided to you.

After discussion with the family members directly affected by the contents of the report that related to Mr A, I reached agreement with these family members to modify the report and move the entirety of the Chapter that was devoted to the care of Mr A to become an appendix that should not be made public without their approval in order to minimise any further harmful effects to their health.

I confirm that this version of the report has been finalised to meet their wishes and that the content remains unchanged from the original version that I shared with them in March 2021. To remove doubt, I confirm this version of the report has no change to the material provided in relation to Mr A's care as the version provided to you in March 2021, but has been updated solely in respect of the wishes of the family of Mr A.

Yours sincerely

Dr Aaron Groves
Chief Psychiatrist and
Chairperson
Advisory Panel – Standard of Patient Care – Roy Fagan Centre

29 June 2021

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Chapter 1

1. Introduction

In late December 2020, Mr Dale Webster, Deputy Secretary, Community Mental Health and Wellbeing (CMHW) Department of Health, contacted me in my role as the Chief Psychiatrist of Tasmania and requested that I undertake a Review of the Roy Fagan Centre (RFC). He also requested that I provide advice to the Secretary of the Department of Health about an appropriate senior nurse, with experience in both mental health and general nursing, who was based outside Tasmania, and who had the appropriate skills to conduct a review of the standards of patient care.

Subsequently, Ms Del Thomson was also appointed as an additional independent member of an Advisory Panel established under the Tasmanian Health Services Act 2018 to conduct the Review of RFC.

The Review commenced on 11 January 2021, with a requirement to provide an initial report by 15 March 2021.

Comprehensively reviewing the standard of patient care in a service of this size, for a period that encompassed the previous 12 months, is challenging and required the assistance of several people, in particular the senior staff of the RFC. We are indebted to them for their prompt and helpful assistance; no request was considered too difficult and without their dedication to meeting our requests the report could not have been finished on time.

I am also grateful to all of the staff of the RFC who made themselves readily available for interviews, notwithstanding many had just completed 12 hour night shifts, now worked in different services, or were on extended leave, but were still keen to be interviewed and provide valuable insights.

This report is arranged in sections that cover the background to the review and its processes; then 3 Chapters each of which is devoted to addressing one of the Terms of Reference of the Review.

These Chapters include: An overview of the patient care of Mr A, with findings; a summary of standard of patient care of other residents in RFC over the previous 12 months, with findings; and the recent history of and planning of Older Persons Mental Health Services (OPMHS) in Tasmania, with findings.

The report is based on numerous staff interviews, some written submissions, a review of a representative selected sample of clinical files, an examination of selected policies, procedures and protocols, interviews with external Government bodies that are regularly involved with the RFC, external providers, an externally provided specialist opinion, and the observations of the members of the Review when onsite and as a formal part of the Review.

Great care has been taken to ensure all findings within the report are based directly on this material and the source material is available to Statewide Mental Health Services (SMHS) the organisation within the Tasmania Health Service that has overall responsibility for the standard of patient care provided by OPMHS and the RFC, for them to verify the observations and findings that have been made.

To ensure the anonymity of all people who provided information to the Review team, the report does not contain the details of who made which statements, or which documents, including

residents' clinical files or other correspondence that has been relied upon, unless prior permission has been provided for this to be identified in the report.

The report makes 13 main findings and 6 recommendations. The main findings are summarised as follows:

1. The standard of care provided to Mr A in the 24 hours before Christmas day 2020 was well below an acceptable level.
2. The standard of care provided to Mr A throughout the rest of Mr A's admission was at a satisfactory level.
3. The overall level of care provided to resident of Roy Fagan Centre was satisfactory
4. The Clinical Leadership of RFC acted immediately and made changes to processes and procedures, that should have been made.
5. The RFC workforce is well placed to embrace change and improvement.
6. There is no contemporary model of care.
7. There is an insufficient number and type of nursing staff for the variety and complexity of patient need.
8. There is an overall significant deficit in Allied Health Staff in the Roy Fagan Centre. This has a major significant negative impact of the level of care provided in these units.
9. The number and training of direct care staff should be reviewed once an overall appropriate level of professional and vocationally trained staff is achieved.
10. There has been inadequate attention paid to planning or prioritisation of OPMHS throughout Tasmania.
11. There has been a lack of overall investment in OPMHS, despite this program expected to see the greatest growth in demand given the ageing population.
12. The OPMHS has not been developed to include the full range of service elements.
13. The Roy Fagan Centre facility is both out of date and inadequate for some of the people who are admitted to the facility.

The summarised recommendations are as follows:

1. OPMHS should be a statewide program within SMHS and have its own dedicated leadership.
2. OPMHS should develop a comprehensive system of Clinical Governance, with dedicated resources to support this function, in line with the Tasmanian Quality Governance Framework.
3. OPMHS should be funded to deliver the full range of service elements found within a contemporary statewide OPMHS.
4. The RFC should undertake a project over the next 12 months to develop a model of care based on a new level of resourcing adequate to undertake the roles it will need to deliver in the next 10 years.
5. The Community OPMHS should develop a model of care that meets the needs of the Tasmanian community based on similar programs elsewhere in Australia.
6. OPMHS should develop a project as part of the broader Tasmanian Mental Health reforms that ensures they are able to take advantage of processes that will assist them in attracting a suitable workforce.

The report contains several Appendices, a table of Abbreviations, a Bibliography as well as a brief Document Register.

Chapter 2

2. Background

2.1. Initiation of the Review

On 25 December 2020, a woman aged in her 70s and her adult daughter went to the Roy Fagan Centre (RFC) to visit a loved one, the wife's husband and the daughter's father. He is referred to as Mr A throughout this report to protect the privacy of Mr A and his family.[1]

He had been admitted to that facility for over 2 months with the consent of his family who had been appointed as his Enduring Guardians as he was not able to provide consent to his treatment and care.

Their time together should have been a time of pleasure, to exchange gifts and be accompanied by good memories. Unfortunately, when the family went into his bedroom to change the clothes of their loved one, they discovered fly larvae within one of his socks.

They were understandably distressed. They took photos and a short video of what they found and then the family members, with the help of RFC staff, arranged for him to be transferred to the Royal Hobart Hospital, where he was assessed and later admitted for ongoing care. The events of that day triggered a chain of events that led to this Review of Roy Fagan Centre (the Review), with a special focus on the Standard of Patient Care within Older Person's Mental Health Services (OPMHS).

On 25 December 2020 after discussion within Statewide Mental Health Services (SMHS) who are responsible for the operations of the RFC, an internal record review (IRR) was initiated to investigate the circumstances of Mr A's care and treatment. This internal review formally commenced on 30 December 2020.

On 26 December, the Hon Jeremy Rockliff, Minister for Mental Health and Wellbeing (henceforth referred to as the Minister) contacted the family of Mr A by telephone, in response to an email sent by them to members of the Tasmanian Parliament. After the Minister's phone call, he contacted the Chief Psychiatrist and requested that he also speak to the family of Mr A.

On 30 December, the Tasmanian Government announced they would establish an independent external review of Roy Fagan Centre.

On that date, the Chief Psychiatrist was requested to lead the Review and to recommend a suitable and experienced Nurse with investigative skills to join the Review Team. The Chief Psychiatrist of Tasmania contacted Dr John Brayley, Chief Psychiatrist of South Australia, and sought approval for Ms Del Thomson, Clinical Risk Manager of the Office of the Chief Psychiatrist in South Australia an experienced and senior Mental Health Nurse, General Nurse and an experienced Government Investigator to undertake the role.

Subsequent to Dr Brayley's approval, Ms Thomson was appointed a member of the Advisory Panel and Dr Aaron Groves, Chief Psychiatrist was appointed Chair of the Advisory Panel, by the Secretary

[1] The family of Mr A gave consent for information to be provided in this report. All care has been taken to reduce the inclusion of personal information that would identify Mr A and the details of his medical care that form the basis for the finding are contained in an appendix which should not be publicly released as doing so is likely to cause harm to the family of Mr A.

of the Tasmanian Department of Health under section 13 of the *Tasmanian Health Services Act 2018* to conduct the review and prepare a report.

The Terms of Reference for the review are as follows:

> *Review of Patient Care – Roy Fagan Centre*
>
> *The Minister for Mental Health and Wellbeing has instructed the Secretary of Health to review patient care at the Roy Fagan Centre.*
>
> *The Review is to be conducted by a qualified person/persons independent of Statewide Mental Health Services.*
>
> *The Review is to examine the standard of patient care at the Roy Fagan Centre.*
>
> *The Reviewer should specifically examine:*
>
> 1. *the care of Patient AB[i] leading up to his admission to the Royal Hobart Hospital on Christmas Day;*
> 2. *the Safety Learning Reporting Systems incidents which identify patient care issues over the 12 months to 25 December 2020; and*
> 3. *any matters which have been the subject of an open disclosure process in the 12 months to 25 December 2020.*
>
> *The Review report is to include specific findings as to the standard of patient care provided and where appropriate recommendations for improvements in the standard of patient care.*
>
> *Initial findings (which must include reference term 1 above) of the Review will be provided to the Minister for Mental Health and Wellbeing by 31 March 2021.*

2.2. Independence of the Review

The Review was conducted through the establishment of an Advisory Panel, by the Secretary of the Department of Health under section 13 of the *Tasmanian Health Services Act 2018* (THS Act). Consequently, the deliberations of the Advisory Panel and the conduct of the Review were entirely independent of the Statewide Mental Health Services (SMHS), Tasmanian Health Service, and this report has been prepared to provide advice to the Secretary of the Department, with no other involvement of other parties outside the Advisory Panel. The Advisory Panel members consisted of Dr Aaron Groves, Chief Psychiatrist of Tasmania and Ms Del Thomson neither of whom has a direct role in relation to SMHS.

In Tasmania, the Chief Psychiatrist is employed within the Department of Health and undertakes the roles of Chief Civil Psychiatrist and Chief Forensic Psychiatrist as outlined in Chapter 3, Part 1 of the *Mental Health Act 2013* (The Act). In addition, the Chief Psychiatrist may perform other functions as agreed from time to time by the Secretary of the Department of Health and as such was appointed to undertake this review under the THS Act.

Specifically, the Chief Psychiatrist does not have direct operational responsibility for day to day patient care in the Tasmanian Health Service and is not responsible for the day to day operations of either Statewide Mental Health Services, Older Person's Mental Health Services or the RFC.

The Chief Psychiatrist does however, have powers of direct intervention (section 147 of the *Mental Health Act 2013*) as it relates to individual patients who may be within their jurisdiction. The complete wording of sections 143, 146 and 147 of that Act are found at Appendix 1.

In this Review, Ms Del Thomson was appointed under Section 13 of the THS Act as a member of an Advisory Panel and has no direct role or interest in Tasmanian Mental Health Services.

At the outset of the Review, Ms Adrienne Gibbons, Clinical Executive Director, Statewide Mental Health Services, who has overall final responsibility for the Roy Fagan Centre met with the Reviewers and undertook to provide all assistance possible to the Reviewers. Subsequently, the Nurse Unit Manager, Ms Joanne Triffitt and the Clinical Head of Service, Dr Matthew Fasnacht provided direct assistance to the Reviewers and assisted the facilitation of all interviews and any additional information that was requested.

Notwithstanding the Review, the RFC continued their internal processes of reviewing the incident involving Mr A, and made changes to the way in which they operate their service, to improve patient care.

2.3. Conduct of the Review

Formal Meetings as an Advisory Panel

The Reviewers regularly met as a constituted Advisory Panel. In total, the Advisory Panel met on 32 occasions throughout the review for a total of 80.4 hours. This involved the development of an "overall plan", the investigation phase, the clinical record review stage, the protocol and procedure review stage, and then the development of findings and recommendations.

The initial meeting was held on 11 January 2021 and finalised the "overall plan" for the approach to be undertaken during the Review. This "overall plan" was developed using the approach endorsed by the Asia Pacific Forum Guide for National Human Rights Institutions for "Undertaking Effective Investigations"[2].

It consisted of the following steps:

1) Identifications of the issues
2) Investigation plan
3) Who and How to interview?
4) Initial Preparation (Special witnesses and logistics)
5) Set up and Organisation of interviews
6) Conduct of the interviews
7) Assessment of Evidence
8) Report conclusion

The Reviewers were informed prior to their commencement, that an internal review (known as an IRR) had commenced on 30 December 2020 and was being undertaken by Statewide Mental Health Services (SMHS). This is a standard process that must occur when serious events in healthcare occur. The Review team contacted, and then met with the person (the Safety and Quality officer for SMHS) undertaking the internal review to ensure that they would continue until their IRR was concluded, without being impeded by this Review.

To establish and then fully identify the issues for investigation, the Reviewers determined they would meet with the family of Mr A to hear from them a first-hand account of the events of Christmas Day

[2] Undertaking Effective Investigations: A Guide for National Human Rights Institutions. Asia Pacific Forum of National Human Rights Institutions July 2013.

and to determine whether the family had other issues in relation to the Terms of Reference, that they wanted the reviewers to consider.

The Review determined that to have a thorough approach to the task an operational definition of Patient Care needed to be outlined. The review agreed the broadest possible definition should apply, and therefore applied the following definition:

> *<u>Patient Care</u> includes - all parts of a person's contact with the Health Service, including initial reception, admission procedures, assessment, investigations, diagnosis and treatment (including medical, nursing and allied health) discharge planning, involvement with family, direct care, assistance and attending to personal needs.*

Once the issues had been identified, the "overall plan" was to undertake the following three processes in relation to addressing the main Terms of Reference:

1. Determine the level of patient care for Mr A as follows:
    - Interview with family of Mr A;
    - Review of all available medical records of Mr A for 2020;
    - Interviews with key personnel involved in Mr A's care prior to his admission to RFC;
    - Interviews with RFC direct care staff;
    - Interviews with RFC management;
    - Examination of the Internal Review conducted by SMHS; and
    - Expert opinions on certain matters.

2. Determine the standard of patient care of residents of Roy Fagan Centre as follows:
    - Analysis of the Safety Reporting and Learning System (SRLS) for events related to RFC;
    - Review of events associated with "Open Disclosure";
    - Interviews with Executive Staff of SMHS;
    - Interviews with Clinical Leadership and Management of Older Person's Mental Health Service (OPMHS) the program that includes RFC;
    - Interviews with RFC staff;
    - Interviews with Public Guardian and Senior Guardians of the OPG;
    - Interviews with Official Visitors Program;
    - Interviews with other key informants;
    - Review of all THS and SMHS protocols, policies and procedures relevant to the RFC and OPMHS;
    - Detailed examination of Medical Records of RFC residents who received care during the 12-month period up to 25 December 2020; and
    - External expert opinion as required.

3. Determine processes that may be undertaken in relation to matters that arise that contribute to the operations of OPMHS in Tasmania.
    - Interviews with Executive and Senior Staff of SMHS and OPMHS;
    - Interviews with SMHS and Department of Health staff with roles in Health Service Planning;
    - Application of the National Mental Health Service Planning Framework (version 2) as it applies to OPMHS; and
    - Benchmarking of OPMHS resources against other Australian States/Territories.

The "overall plan" then outlined the key questions that were agreed would provide the areas of major focus during these processes.

The key questions in relation to the care of Mr A were as followed:

- What happened on the 25 December in relation to Mr A?
- What factors in relation to the staff at the RFC may have contributed to what happened to Mr A?
- What factors in the building at RFC may have contributed to what happened to Mr A?
- What factors in Mr A's condition might have contributed to what happened to Mr A?
- What foreseeably could have mitigated the events that happened to Mr A?
- Is there evidence that the level of care and treatment provided to Mr A is a concern, as a result of being a widespread or regular occurrence at RFC?
- What operational matters, if any, contributed to what happened to Mr A? and finally
- Does the care and treatment of any other resident at RFC indicate other operational matters which need to be addressed?

The key questions in relation to the standard of patient care at RFC were as follows:

- What is the overall level of patient care at RFC?
- Does the standard of care at RFC conform to what is expected of Health Care and Aged Care Standards?

The Review's processes would require many staff to provide direct, and at times detailed, accounts of what occurred at RFC. In order to have available the best information possible, the Review established, from the outset, an approach whereby staff were given an undertaking that only statements and observations that were corroborated by more than one person (or if also documented in the clinical file) would be relied upon in the report. This is in keeping with the usual standard for the evaluation and weighting of evidence in Government investigations[3].

The "overall plan" was that staff were also given an undertaking that in the preparation of this report, all care would be taken to ensure that the identity of no single individual would be possible from comments or observations contained in the report. This undertaking was given to ensure that the report is not about attributing blame. This aspect is considered by the Reviewers as the most fundamental building block for creating safe systems of care, whereby staff are full protected in coming forward and making observations without fear of later retribution. This "just culture" as it is sometime referred, is critical for being able to get a full and complete understanding of what occurs when there are health system failings.

Further meetings of the Advisory Panel considered the progress of the investigation in line with the "overall plan" and agreed on how the investigation would further proceed. The Final meetings were devoted to agreement on the findings and any recommendations.

Roy Fagan Centre Staff

After the announcement by the Tasmanian Government of the Independent Review, Dale Webster, Deputy Secretary, Community Mental Health and Wellbeing (CMHW) together with the Executive and Senior staff of SMHS, met with staff of the RFC to inform them about the Review, its Terms of Reference and what to expect, including how they could access any support that they needed.

[3] Ibid page 9.

The Reviewers arranged meetings with the full range of Executive, Senior Management, Clinical and direct care staff of SMHS and RFC. In total 53 people, including 44 staff were interviewed for a total of 36.5 hours of interview time. Some staff were interviewed on more than one occasion. In only five cases was a staff member interviewed without a support person or industrial support officer present. On each of these occasions the staff member had chosen not to have a supporter present. All interviews except one were conducted in person. The other interview was conducted by telephone as the person was on a long period of leave and was not currently residing in the Hobart.

At the commencement of each interview, the Reviewers explained their role and the powers and protections, for THS staff, that arise from sections 13 and 14 of the THS Act. Specifically, they outlined staff were permitted to share what would otherwise be confidential clinical information to the Reviewers and that they were not compelled to answer any questions if they felt uncomfortable. Staff were informed that all efforts would be made to ensure that the report would not contain any statements that could be attributed to any staff member. Without exception, staff fully cooperated with the questioning from the Reviewers and only two staff members were unable to answer a question put to them throughout the review.

The Family of Mr A.

The Review commenced with the Reviewers having an opportunity to meet with Mr A's wife and two daughters for three and a half hours, at their family home. In addition, the family gave consent to the Reviewers seeking clinical information about Mr A from a range of Health Providers who had been previously involved in providing care and treatment to Mr A. This allowed the Reviewers to have a thorough background to Mr A's medical and personal history.

The Reviewers are indebted to the family of Mr A for their hospitality, their generosity and the invaluable information about Mr A's life and other important aspects that helped the Reviewers get a proper insight of Mr A, a fundamental part of determining aspects of his care and treatment. The Reviewers are aware how extraordinarily difficult the past 2 years have been in their lives and the toll this has taken on their wellbeing.

The Reviewers are also grateful for the time and effort from the management and staff of Wellington View Nursing Home, where Mr A had been a resident prior to his admission to RFC. They provided comprehensive information about Mr A's medical and psychiatric history as well as general information about the interface between themselves and OPMHS.

The Review of RFC clinical files.

The Reviewers developed a template which was used to consistently examine the clinical records at the RFC. In order to get a representative sample of people who were residents during the timeframe outlined by the Terms of Reference, namely 26 December 2019 to 25 December 2020 (the Reference Period) the Review selected files at random from a range of possible reasons for admission to RFC. These records included:

- The file of Mr A,
- All patients in which there had been an open disclosure by RFC staff,
- A sample of residents who had been admitted to RFC under a Treatment Order in line with the Mental Health Act,
- A sample of residents who had been admitted to RFC under a Guardianship Order, issued under the *Guardianship and Administration Act 1995* (the GAA).
- A sample of residents who had been admitted voluntarily,
- A sample of residents who had multiple admissions to RFC during the Reference Period,

- A sample of residents who had very long lengths of stay in RFC,
- A sample of residents who were of a younger age, and
- A sample of patients who had included a period within the Jasmine Unit.

In total, 26 Files were reviewed, this represented about a third of all people admitted to the Mental Health Units within the Roy Fagan Centre. The Reviewers were also granted access to the Digital Medical Record (DMR) which allowed them to access relevant medical records of Mr A related to his admissions to Royal Hobart Hospital in 2020, as well as other residents of RFC, who had accessed care elsewhere in the Tasmanian Health Service.

The Review used the Structured Judgement Method[4][5] as the basis for the approach taken for the review of case records. This approach allows for a more rounded judgement on the standard of patient care when there is a mix of both good and unsatisfactory components in the phases of care. More details of this approach are found in Appendix 2.

The Review spent a total of 49 hours and 30 minutes on clinical file reviews.

On-Site visits

The Reviewers spent a total of 16 days on site at the RFC in undertaking the Review, this included one Public Holiday. During the initial phase of the Review, they conducted a tour of each of the units within RFC, as well as the Day Care Centre. Later in the Review, they revisited each of the units on at least one further occasion. The staff of RFC made the Reviewers welcome and were able to meet every request in a professional and courteous manner.

External Informants

The Public Guardian is a Statutory Officer created under section 14 of the *Guardianship and Administration Act 1995* (the GAA). The current Public Guardian is Mr Jeremy Harbottle. The Review met with Mr Harbottle and 5 senior guardians from his office for a period of 90 minutes. They were able to give the Reviewers valuable insights into their experiences, in representing people subject to the GAA, when in contact with the RFC and OPMHS. Appendix 3 outlines the role and functions of the Public Guardian.

The Principal Official Visitor is established by section 155 of the *Mental Health Act 2013*. The Manager of the Official Visitors Scheme (OVS) holds the delegated functions of the Principal Official Visitor. Mr Philip Donnelly holds this position. The Reviewers met with Mr Donnelly and 3 other Official Visitors, all of whom had conducted site visits of the RFC during the Reference Period. In addition, one of these Official Visitors prepared a written submission for the Review.

The Review was contacted by other external stakeholders and met with a specialist consultant Medical Practitioner with extensive experience working with OPMHS. This Medical Practitioner provided written material for the Review to consider.

The Review was able to examine the role of planning and development of OPMHS in Tasmania and met with key staff of the Department of Health, including the Health Planning Unit and the Mental Health Alcohol and Drug Directorate, to establish a more recent history of Clinical planning in OPMHS. In addition, the Review Team had telephone meetings with senior clinicians who have been

[4] Hutchinson A, McCooe M & Ryland E. 2015. A guide to safety, quality and mortality case note review using the structured judgement method. Bradford, The Yorkshire and Humber Improvement Academy.
[5] Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. BMJ Quality and Safety 2013

involved in service planning and reform in three mainland states (Victoria, South Australia, and Western Australia) to establish and confirm what is considered to be the most contemporary development of OPMHS in Australia.

The Review was grateful to receive staffing profiles for OPMH units in mainland states, that provide clinical services to people who have similar clinical profiles to those residents in RFC.

Document Review

The Reviewers identified several key documents that assisted the Review. First, the Review accessed and reviewed several key policies and procedures that govern SMHS and OPMHS.

In addition, the Review relied heavily on the work undertaken by the OPMH Policy Unit, Mental Health Branch NSW Ministry of Health. We are indebted to the wealth of knowledge and the leadership of this group who provide a range of high-quality documents about the planning, organisation, and design of OPMHS that are widely used around Australia to guide planning. The Review is aware these documents are used with the permission of NSW in other states of Australia. Likewise, the Victorian Department of Health has a suite of documents related to OPMHS.

In addition, the Review relied upon several other key documents developed by NSW Health, SA Health and other mainland states, as well as a similar suite of documents from Victoria.

Media

The circumstances surrounding the failure of care for Mr A were published in both print media as well as broadcast media on 30 December 2020 and in the following days.

Standard of Proof

The Review was established as an Advisory Panel under the *Tasmanian Health Services Act 2018* (the THS Act). The THS Act requires that Advisory Panel members must not:

> either directly or indirectly, record, divulge or make use of information obtained by the panel that identifies, or that could reasonably be expected to lead to the identification of, the person to whom the information relates. (Section 14).

Importantly, this section of the THS Act assists in ensuring THS staff can come forward and make statements with some confidence that they will not be identified in a public report. This is an important principle of a “no blame” or “just culture” that is a fundamental building block of safer health care systems.[6]

The Advisory Panel was mindful of establishing with all staff that it was not a disciplinary committee and would not further enquire of matters that may be disciplinary in nature, other than where it was important to establish matters that related to the standard of care and treatment which was the main focus of the Review’s Terms of Reference. Consequently, the Advisory Panel did not operate in a manner that would enquire into a matter to determine whether a burden of proof was reached as would be for formal legal proceedings.

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[6] *A promise to learn – a commitment to act: Improving the safety of patients in England*. National Advisory Group on the Safety of Patients in England. 2013.

However, it was imperative that the Advisory Panel met formally to discuss information that was discovered during the Review in such a manner to have a standard of proof in line with standards for Government Investigations. Sir Robert Francis QC, the Chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry outlined the relevant arguments relating to the determination of standard of proof that should operate when conducting inquiries and investigations, where there are similar terms of reference to this Review[7]. Notably, Francis refers to the Standard of Proof that was used in the Shipman, Bloody Sunday, and Baha Mousa Inquiries in determining the approach of this standard.

Having reviewed the elements outlined by Sir Robert Francis QC and considered the methodology outlined by the Ontario Ombudsman[8], the Asia Pacific Forum[9] and the Standards used by ACT Agencies[10] for the conduct of Government Investigations, this Review determined to adopt the following approach:

1. Findings are to be based on the material before the Review during the time of its operation (these have been outlined in this part of the report);
2. Much of what was heard by the Reviewers has been consistent and there has been no contradiction of these accounts. Where this has occurred, we have accepted the evidence that has been provided;
3. On the few occasions where issues in relation to what occurred have arisen, the Reviewers have weighed this carefully and taken the "common sense approach" of accepting what are the likely explanations and shown more caution about those explanations and views that are more improbable;
4. In some important matters, it is hard to be certain what has occurred and therefore the Review has chosen to get as much expert advice and state clearly what may have occurred.
5. The Review was careful in giving equal weighting of information provided, unless there was good reason to reject the information as inherently unreliable or implausible;
6. The Review used, wherever possible, an inquisitorial approach of asking staff "what happened?" or "what did they remember?";
7. The Review had as its primary objective to determine whether Standards of Patient Care and Treatment were in line with accepted Australian expectations and adopted standards. When this was not the case, the Review's focus was on finding systemic issues and root causes for the problem, rather than finding whether any individual was to blame; and
8. To ensure procedural fairness, all employees had the opportunity for either a support person or a union representative to be present, and were provided with a copy of the relevant clinical file to refer to during their interview, and were provided with the broad areas of questioning in advance, if this was requested. In addition, the Review informed staff that they were aware clinical notes are not a detailed account of every event that happens in relation to a patient, rather they are a summary of what occurs and that the Review was aware staff may at times only be able to recall only certain elements of what had occurred during their contact with a patient.

[7] Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary.*

[8] Sharpening Your Teeth. Advanced Investigative Training for Administrative Watchdogs. Ontario Ombudsman, Toronto Canada. 2007.

[9] Undertaking Effective Investigations: A Guide for National Human Rights Institutions. Asia Pacific Forum of National Human Rights Institutions July 2013.

[10] ACT Chief Minster's Department. Standards for the conduct of inquiries and investigations for ACT agencies. 2004.

Chapter 3

Findings:

1) ***In relation to the care provided to Mr A in the 24 hour-period preceding Christmas Day 2020, the level fell well below an acceptable standard of care[11] and should not have happened. Greater efforts should have been made, at that time, to properly address Mr A's care needs and provide him with greater dignity.***

   However, in relation to this care no single staff member or individual is at fault, rather this failure was the culmination of numerous factors, that when combined, led to an overall failing in the system of care. These factors included: insufficient resourcing; rostering practices; staff unavailability; the built environment of the RFC; other resident factors; the model of care; education and training; and staff fatigue. This is covered in more detail in the appendix to this chapter.

2) ***In relation to the care provided to Mr A throughout his involvement with OPMHS the overall level of care was satisfactory. However, we also observed that there were many examples when the care should have been better than was provided, whilst on their own each of these aspects did not have a bearing on the ultimate outcome of Mr A's heath care.***

   These included deficits relating to the involvement of Mr A's family, in particular visiting, attention to his Activities of Daily Living (ADLs) and his personal appearance and possessions, assessment, care and treatment of Behavioural and Psychological Symptoms of Dementia (BPSD) and altercations with other residents.

[11] In reference to Standards of Care, the Review has used the approach outlined in the Structured Judgement Method for Case Note Reviews widely used in the NHS. See Appendix 2.

3. The Standard of Patient Care provided to Mr A

The Review of the Roy Fagan Centre (RFC) was precipitated by the finding of fly larvae in the socks of a 78-year-old man (referred to as Mr A), who was a resident of the facility, on Christmas Day 2020. Consequently, it was the standard of patient care provided to him that was one of the major focuses of this Review.

The Review devoted approximately a half of its allocated time to examining the Standard of Patient Care provided to Mr A. The overall approach that was taken is set out in Chapter 2 of this report.

Specifically, the Review used criteria that are able to be used to categorise the standard of patient care across a continuum from well above an acceptable standard to well below an acceptable standard of care.

The standard of overall care varied throughout Mr A's admission to the Roy Fagan Centre (RFC) and thus the Review considered the period from admission until the events just prior to 25 December 2020 as one period of care and then separately considered the standard of care in the period immediately prior to that date. This was done to reflect the provision of care more accurately, during his admission to RFC.

The detailed factors which led to the findings in this chapter have been shared with the family of Mr A. They have had time to consider the findings and the appropriateness of the background detail being outlined in the body of the report.

As a result of their deliberations it has been agreed that the detail is set aside in an appendix to this chapter in such a manner that it is available to the Secretary of the Department of Health, but is not publicly available. In this way, the appendix can be used to support the findings into one of the major terms of reference of the Review and to inform any response to the report, but also to protect the family, especially their ongoing wellbeing, as well as to respect the confidentiality of any personal identifying information that relates to Mr A or his family.

Appendix 4 contains the details relating to the Standard of Patient Care provided to Mr A and Appendix 5 contains other pertinent personal details in relation to Mr A which also should not be released publicly as they would easily identify Mr A without the consent of his family.

Chapter 4

Findings:

1) ***The level of overall care provided to the residents of RFC, that were reviewed, was at a satisfactory level. However, there was significant variance between those residents who had very good or excellent care through to others where the care could have been improved.***

   The areas that need improvement include:
   - ***Documentation***
   - ***Assessment and Intake processes***
   - ***Diagnosis and treatment***
   - ***Discharge planning and involvement of families and guardians***

2) ***The Clinical Leadership of RFC immediately acted and made improvements to a number of clinical processes and procedures at the facility, rather than waiting for the outcome of the Review, this is to their credit and should be acknowledged.***

3) ***There is strong local clinical leadership and direction with a dedicated and caring workforce, that has also undergone recent renewal with new staff and an injection of new values and an improving culture. They are well placed to embrace change and improvement.***

4) ***There is no contemporary model of care for Roy Fagan Centre.***

5) ***There is an insufficient number and type of nursing staff for the variety and complexity of patient need. This is compounded by the number of casual staff, difficulties in recruiting to permanent positions, use of agency staff, rostering patterns and shift duration and the nursing model of care.***

6) ***There is an overall significant deficit in Allied Health Staff in 3 of the 4 units in the Roy Fagan Centre. This has a major significant negative impact of the level of care provided in these units.***

7) ***The number and training of direct care staff should be reviewed once an overall appropriate level of professional and vocationally trained staff is achieved.***

4. The Standard of Patient Care in Roy Fagan Centre

This chapter of the report focuses on the standard of patient care provided to other residents of Roy Fagan Centre (RFC). It is set out according to the various components that were used to define patient care in the "overall plan" and described in Chapter 2. Whilst some issues were found that are like what contributed to the overall care of Mr A, this chapter has focussed on the impacts as they related to the other residents of RFC

4.1. Methodology

The Review was required to 'determine the standard of patient care of residents of Roy Fagan Centre', and consistent with the outline described in Chapter 2 was provided with extensive access to case notes, the Digital Medical Record (DMR), the staff of RFC, Official Visitors, and Guardians.

In total, 139 people were admitted to the RFC between 26 December 2019 and 25 December 2020; however, the shortest length of stay is for people admitted to Jasmine Unit, a unit whose primary purpose is Geriatric Rehabilitation, which was not the main focus of this Review. Thus, those people admitted to the other three units, operated by SMHS, were the cohort investigated in this Review. It was not possible in the timeframe available to thoroughly explore the level of patient care to the same level as was undertaken for Mr A. Therefore, the Review determined that a representative sample would be chosen randomly.

Subsequently, the clinical records of 26 people were reviewed, representing about 25% of people admitted during that period under the care of SMHS. This included 6 people for whom a SRLS was completed and open disclosure[12] provided to family or guardians.

As previously outlined, a process was employed to ensure a consistency in the process for how the case notes were reviewed and this included:

- Determining that the admission process by nursing and medical staff was consistent with THS policy;
- Reviewing the multidisciplinary approach that was taken;
- Reviewing the regularity, timeliness, thoroughness and appropriateness of medical reviews;
- Determining whether all documentation in progress notes and on forms were consistent with each other;
- Confirming that clear problem-based management plans were in place; and
- Ensuring family, carers and guardians were engaged in the care decisions as required.

Staff interviews were also used to explore the overall standard of patient care, and staff were asked to make general comments on staffing levels, training, education, staff development and management support. During interviews many staff were also given an opportunity to make

[12] Open Disclosure is a process of providing an open, consistent approach to communicating with consumers/patients and their carer/support persons after an incident. It is a more detailed process than informing consumers/patients and their carer/support persons of an incident and may take a number of contacts to complete.

comment on the scenario whereby “if you had a magic wand, what would you change at RFC?”. There was an overall consistency in the responses received to these general questions.

The data available from the SRLS was also analysed to better inform the level of risk and types of risks within the RFC and what procedures have been implemented to improve the level of patient care.

Initial reception

The Review found that the initial reception of people into RFC was well organised and that the experience during 2020, was that people were welcomed and staff in the reception area are helpful and friendly. However, it is also apparent that people also visit RFC for appointments as outpatients and there is no suitable waiting area that maintains their confidentiality. In the main this is due to the poor entry design of the facility and this is the major shortcoming of the entry.

During 2020, the entry of RFC was also modified to allow for the screening, physical distancing and sanitisation that are the core components of Covid-19 mitigation.

The Review noted that during 2020, measures have been in place to protect the health of people in all forms of aged care and RFC has had a well organised plan in this regard since early in the pandemic. This aspect of reception has been well managed.

Admission procedures and assessment

The admission procedure at RFC has several components and it is usual for many staff to be involved in this process. The Review found that the process for seeking the consent from residents to have photographs taken was to be included in their clinical file was poorly understood by staff. Of the files reviewed almost all were incorrectly done, neither the resident (if they could consent) or their guardian or other approved person (if they can not consent) had signed the standard form. Furthermore, the policy that applies to RFC is clear that the photograph should not be taken until consent is provided. This is simply unacceptable and requires urgent action.

On admission, it is expected that a patient property form is completed that lists what is brought to RFC with the person. The form used at RFC is not the standard form used elsewhere in the THS. In addition, of the forms sighted by the Review, almost one half were incomplete or inaccurate. This should be addressed.

The Alert sheets for many residents were frequently not completed until as long as 2-3 weeks after admission. They should be commenced on the day of admission.

The admission process includes consent to access and share information with other services and organisations. Whilst many of these forms were completed accurately, in many cases this did not occur or were completed incorrectly, such as staff signing the form in the wrong area or not getting appropriate consent.

For those people who were admitted under either Guardianship Legislation or Mental Health Legislation all appropriate forms are included in the file and accurately completed. This was well performed.

The admission clinical notes are usually extensive, and this was a strength of the RFC clinical files. However, the documentation of information gathered from other sources was inconsistent, and when incomplete there was no clear outline for how this would be completed.

Medical assessments varied as a function of which staff member performed the examination. Some examinations are complete, well documented, and thorough. Others are more cursory and should have led to a more comprehensive medical assessment being performed at a later date. On at least one occasion where it was documented that a subsequent examination occurs, it did not.

The performance of cognitive testing which should be a central in any OPMHS was inconsistently performed. In some clinical files there was evidence of sophisticated and extensive cognitive and neurological examinations and this was at a very high level. In other files the cognitive testing that was undertaken was haphazard. The Review found that the RFC did not use any of the standard forms or policies developed by the THS (including those where OPMHS staff were involved in the development) for the performance of cognitive testing.

Investigations and diagnosis

The RFC takes a comprehensive approach to pathology investigations. In almost all files a good process is in place for reviewing the results of these investigations.

In very few cases, was a resident referred for an MRI or a perfusion study to try to establish a better understanding of the causes of Cognitive dysfunction. Whilst RFC has developed a close relationship with a private provider who also has a special interest and advanced skills in neuroimaging, this is perhaps under-utilized.

The diagnostic processes in RFC are generally good. There was inevitably good documentation of physical health problems and medical diagnosis. Where residents of RFC did not have cognitive dysfunction, and were admitted for a mental disorder, this was very well undertaken and, in some cases, showed very good or excellent clinical acumen.

However, in relation to the diagnostic process relating to cognitive dysfunction there was considerable variation. In some cases, there was excellent diagnostic acumen shown, with clear, concise and well thought through diagnosis whilst in other cases there did not appear to be good justification for how a diagnosis was made. Usually this resulted from incomplete assessments, and inadequate access to neuroimaging that may have helped clarify diagnosis.

Treatment (including medical, nursing, and allied health)

Throughout all of the clinical files there was a consistently high quality in the approach to the development of problem-based approaches to treatment. These were invariably comprehensive and made allowance for the treatment of a wide range of medical problems as well as a range of complex age-related problems and mental disorders. This was a clear strength at the RFC.

In addition, when residents were examined through their admission for medical problems this was also done at a high level of competence, was thorough and appropriate.

Nursing care plans and the Individual Service Plan (ISP) were of varying quality. For some people this was comprehensive, well thought through and individualised. For others it appeared more formulaic and not as well tailored to the resident. On occasion, the ISP was not updated as regularly as it should have been. The Review was left with the impression that these plans were a priority for only staff members and only for certain residents. This is an area for improvement at the RFC.

The contribution of Allied Health staff also varied. For most residents an initial assessment by one of the Clinical Pharmacists was undertaken and documented with good advice which was usually then incorporated into the management plan. Likewise, where Social Work was involved there were comprehensive notes made and these were considered to usually be of high value and pertinent to the plan for the resident. However, entries from the OT were rarely found in the clinical files. This is

not to say that the role and performance of the OT is questioned, rather their contribution is not integrated into the resident's treatment plan.

Discharge planning, involvement with family

As with other components of patient care, discharge planning varied considerably. In most clinical files there was a good discharge plan, and this was followed and resulted in good patient care.

However, there were a small number of residents in which this was not well undertaken. The issues included; lengthy delays between when a person was stable and when they were ultimately discharged as a result of poor liaison with external providers; family members not being involved at an early stage; lack of involvement of guardians at an early stage; poor liaison with external providers (such as GP or RACF); not considering whether the person's mental state had adequately settled.

Direct care, assistance and attending to personal needs

The provision of direct care was generally well done. It was apparent from staff interviews that there is an enthusiastic and good group of care assistants that enjoy their work and are keen to ensure that residents in RFC are comfortable and happy. However rostering and resourcing leads to shifts in which they are unable to fully perform all the functions of their role. This leads to many having a degree of frustration in their role. One aspect that concerned the Review was the degree to which direct care staff are fully informed and understand the importance of ensuring personal autonomy and that this should not be at the expense of compromising the resident's dignity. The Review found occasions when staff should have been more proactive in ensuring dignity was respected.

4.2. Systemic issues

Workforce: mix, resourcing levels, and rostering.

The four units at RFC provide care for four different cohorts of older persons; yet all four have the same or similar nursing profile. The Nursing hours per patient day (NHPPD) process is yet to be applied to RFC and as a result cohort of patients, that traditionally require higher staffing numbers, do not receive this. Consequently, units are staffed with a Registered nurse with perhaps an Enrolled Nurse and a Nurse Aide or Care Assistant, however it is not uncommon according to staff interviewed that this could be two Nurse Aides or Care Assistants and no Enrolled Nurse.

The Jasmine Unit was unique within the RFC, it is not a mental health unit, having been developed and staffed as a geriatric rehabilitation service as part of the RHH with staffing that includes Consultant Geriatricians, Medical staff and Allied Health staff employed by RHH. The Nursing staff are provided by, rostered and backfilled by SMHS.

At RFC, an Enrolled Nurse can write in case notes and most are able to administer medications. A Nurse Aide can write in notes but cannot administer medication. A Care Assistant cannot write in notes or administer medication. This impacts on what is required of the Registered Nurse and the Enrolled Nurse in relation to their workload and level of supervision they may need to provide.

The most clear impact is that case notes are often written by a person who may not have had any contact with the person in care provision, rather it is a 'third hand' account of the persons care for that day.

Overwhelmingly, staff reported feeling supported by local management and that their access to training was good. They also reported that some obtain their mandatory training through the RHH and not at RFC and others have training on site.

When providing support for staff, the Review noted that the Multidisciplinary Team (MDT) meetings were held on a day when Electroconvulsive Therapy (ECT) also occurs, off site at the RHH. Nursing staff are required to leave the RFC and escort the person having ECT to RHH for treatment at the same time that a nurse from the ward is expected to attend the MDT meeting. Extra staff are sometimes available to assist to ensure at least two staff are always present on the ward. This does not meet the Review's expectation of managerial support.

If a person requires a two-person assist to feed, clothe, toilet or shower, these activities of daily living (ADL) may not occur, otherwise every other resident on the ward has no access to care while staff are caring for the person who requires this level of personal care. The Review was told this can present a very distressing choice for staff to make, day after day.

The nursing staff at RFC work 12 hour shifts, with complex need consumers, face significant levels of aggression,[13] with limited at best and none at worst, access to social work, physiotherapy, occupational therapy and psychology and inadequate access to dietetics, speech pathology and wound management expertise. Yet, all staff the Review spoke to, reported RFC as a good place to work. Some staff reported support to undertake further study was provided and some had decided to specialise in mental health following their experiences at RFC. This is very encouraging finding and given the challenges faced every day in this environment these comments are all the more extraordinary.

Several staff expressed concern in relation to access to Allied Health and that a primary nurse model would be beneficial, if introduced. The Review did not hear any objection from staff, that we interviewed, to the idea of moving to an 8-hour shift configuration from a 12-hour shift except to say, "we'd need more nurses for that".

There were limited interviews with Allied Health during the Review as there are obviously, limited Allied Health and this is considered by both the staff at RFC and the Review, to be a significant concern.

Staffing rosters, numbers and disciplines were considered and comparisons to other like services were made. Consultant Psychiatrists and other Medical staffing numbers appeared to be adequate for the 30 beds that are the sole responsibility of mental health services. The access to and availability of Allied Health staff is significantly less than similar services.

For the RFC, the care team is also significantly diminished with limited access to Allied Health Services. The amount of Social Work time is less than other like services and access to Occupational Therapist (OT) assessments and sensory modulation appeared to be almost non-existent for residents on the wards.

The Review identified the level and type of staff on each unit as an important issue. The RFC has 4 different units with different cohorts of consumers, with different diagnostic profiles and problems. These can be summarised as a Unit for people with Severe BPSD (Rosewood) often referred to as a Neuro-behavioural unit (or T-BASIS in NSW), a Geriatric Rehabilitation unit (Jasmine) and a more Acute Older Persons Mental Health unit (Magnolia). The fourth unit (Heather) has a mix of residents who often have a more non acute set of clinical care needs.

[13] There were 567 reports of behavioural disturbance in the 12-month period of this review.

The needs of each group are different, the skills required to care for each group is different and the Medical, Nursing and Allied Health needs are also different. While lacking access to Allied Health, it should also be noted to prevent burnout and distress in staff, the rostering process prevents expertise development in the nursing team. The Panel believes this has a negative impact on consumer outcomes and the quality of care provided.

The shortfall in staffing numbers in RFC's 3 mental health units is significant and has an impact on health outcomes. The Review compared the staffing profile at RFC, to that of a Neuro-behavioural Unit in South Australia (Northgate House), that was established in 2017. The staffing profile at Northgate House is a proper comparison for the Rosewood unit casemix, that is most residents have Tier 6 or 7 BPSD. The Full Time Equivalent (FTE) profile for Northgate's 16-bed unit is as follows:

- Medical Officer/Psychiatric Registrar – 1.0
- Nurse Unit Manager – 1.0
- Clinical Nurse Specialist – 1.0
- Nurses – 13 Nursing Hours per Patient Day, which is configured as 7 staff on an 8-hour morning shift: 7 staff on an 8-hour afternoon shift: 6 staff on a 10-hour evening shift roster.
- Occupational Therapist – 1.0
- Social Worker – 0.6
- Physiotherapist – 0.5
- Dietician – 0.3
- Old Age Psychiatrist – 0.3
- Speech Therapist – 0.2
- Podiatrist – 0.2
- Geriatrician – 0.2
- Lived experience consultant - 0.8.
- Carer consultant who also has some governance roles – 0.6

The Review found that without a comparable level of staffing on Rosewood unit, the health outcomes of residents is unlikely to be comparable to Northgate House.

In relation to this shortfall in nurse staffing the Review heard comments such as "we were understaffed again which we're pretty used to up here", "hard when there are casuals who don't work here very often", "it's a casualised workforce, short term contracts are the most you can get", "I really like working here but I need more permanency", from RFC staff.

At the time of this Review, the RFC operates with approximately 3.6 Nurse Hours per Patient Day (Nursing hours) on day shifts and 2.4 Nursing hours on night duty, a total of 6 Nursing hours in total for the day. This compares to the 13 Nursing hours for Northgate House, 13.67 Nursing hours for the Ward 1H at the Lyell McEwen Hospital (Older Person's high dependency area) and 6.94 Nursing hours in the open area of Ward 1H OPMH acute unit.

In these OPMH units in South Australia, there is an RN / EN ratio of 70:30, in addition to the greater number of Registered and Enrolled Nurses, Lived Experience workers, and the full range of Allied Health staff.

Furthermore, in comparing staffing levels, Northgate House also has a meaningful engagement team in addition to the staffing number already outlined. This team consists of two ENs, 1.7 Allied Health Assistants and an OT, who between them cover a 7-day roster in Northgate House.

Finally in relation to staffing levels, Northgate House considers recruitment as a value based process, their team could upskill staff on the knowledge they want them to have to care for people with BPSD

if they came with the right values to ensure respect and dignity was maintained. The Review found the values expressed by staff at RFC to be consistent with the approach at Northgate.

Model of Care

The Review made several attempts to find the Model of Care (MoC) for RFC. The Review was informed by senior staff that either it did not exist or was "at least 20 years old". The Review was not provided with a MoC.

MoCs articulate how health services are delivered. They outline best practice care and services for a person, population group or patient cohort in their journey through the stages of a condition, injury or event. The aim is to ensure people get the right care, at the right time, by the right team, in the right place, first time.[14][15]

A good MoC will include principles related to evidenced based care, being person centred and collaborating with the person, their family / carers and their community and key stakeholders. It is informed by national priorities, plans and strategies and can influence future policy development.[16]

It appears to the Panel that without a clear MoC there are inconsistencies in what assessments are conducted and what pathways a person's care is expected to take at RFC. The most consistent concern found by the review, related to the person's level of aggression and a sense within RFC that if enough time elapsed, the persons behaviour will settle as their dementia worsened. The implication of this approach was that little effort needs to be given to soothing strategies for people in their care. This was noted in case notes at times as "… at least until dementia progresses."

Multidisciplinary Teams vs Multidisciplinary care

Multidisciplinary team care comprises a range of health professionals and usually involves, medical, nursing and allied health staff who participate in a team approach that involves planning of care, collaboration and communication that together addresses as many aspects of a patient's care as possible.

They further identify values that include:

- effective communication and coordination;
- respect and trust;
- solid implementation strategies; and
- transparency.

As outlined by NSW Health, "in order for a multidisciplinary team to function fittingly, roles, outcomes and modes of delivery must be clearly defined. Comprehensive policies, procedures, systems and protocols are also necessary for the development of an effective multidisciplinary team." [17]

The MDT meeting at RFC will usually last for several hours, each person is discussed, and notes are written of the meeting in a set format usually by one of the Medical staff who are present. A Social Worker (SW) is usually present and an Occupational Therapist (OT) is sometimes present. Nursing

[14] A practical guide on how to develop a Model of Care at the Agency for Clinical Innovation, Agency for Clinical Innovation, 2013
[15] Older Persons Mental Health Service, Model of Care, Northern Adelaide Local Health Network, 2017
[16] Model of Care Overview and Guidelines, WA Health Networks, 2007
[17] NSW government, Integrated care available at: https://www.health.nsw.gov.au/integratedcare/Pages/Multidisciplinary-team-care.aspx

staff are invariably present, both from the ward and one of the senior Clinical Nurse positions. The person or their Guardian is not included in the process.

The Review found that the format used for documenting the outcome of the MDT was poor and should be improved to allow for a better documentation of what is considered and what is decided. Furthermore, the RFC should consider moving the MDT so that it does not conflict with Electro-Convulsive Therapy (ECT) and thus allow for a more suitable nursing level in the units. Finally, the MDT should consider how they schedule the discussions had at the meetings to allow for an appropriate time to be spent on those residents that have the greatest care needs.

Medical staff reported in most instances they will see consumers without a nurse present and document in the case notes their assessment, plan, and changes to care. Nursing staff confirmed this, reporting they were often occupied with other residents and would often have to read the notes made by Medical staff, as they may not receive a verbal report from medical staff. The level of communication between members of the MDT needs to be improved.

Typically the best patient care provided in contemporary health settings by multidisciplinary teams, begins with the person and their family / carer who are central to the model of care, have a wealth of information that can assist the remainder of the team to know and understand the person's needs and should be engaged in the decision making of care and treatment, particularly when they are the appointed Guardian.

The Review found many case notes had clear reports detailing family involvement in care and there were regular examples of guardians being contacted for decision making; including contacting relatives who were in other countries, however others clearly did not. The RFC should consider reviewing how it develops a consistent approach to the involvement of families and carers in the approach to a person's care.

The Review found that whilst the MDT met on a weekly basis and considered each resident's care at those meetings, the way care is provided usually involves one discipline at a time. It found that there was less Multidisciplinary care than should occur.

Restrictive practice and Autonomy

Elsewhere, this Review has highlighted the importance of minimisation of restrictive practices. The elimination of seclusion and restraint has been a National Safety Priority in Mental Health since 2005, and it was a welcome sign to see that the use of restraint and seclusion at the RFC is almost non-existent. The last event at RCF was reported in 2019. This is an outstanding achievement and sets RFC amongst the best of OPMHS of its type in Australia.

In chapter 8 of the Interim Report of The Royal Commission into Aged Care Quality and Safety it is stated that 'People do not surrender their rights to mobility, personal autonomy, legal capacity and dignity when they enter residential aged care.'[18]

An open environment in which a person can move freely around and to have the right to say yes or no to an intrusive process such as being toileted and showered by another person is a right to which the staff at RFC were clearly mindful. The staff attend prevention and de-escalation training annually and have not reported any use of restraint for the period of the Review and at interview many espoused a least restrictive approach to the care they deliver that goes beyond what is usually expected of OPMHS.

[18] Royal Commission into Aged Care Quality and Safety, Interim report: Neglect, Commonwealth of Australia 2019 p 216

It is a difficult balance for staff to maintain overall safety, respect a person's right to autonomy, not engage in restrictive practice and still ensure a person's dignity is maintained and they are clean and well cared for. At times, it is possible the path of least resistance allows busy, overworked staff to move on to the next task and not engage in an altercation that may be distressing and that might take a lengthy period of time, to complete a person's ADLs.

There was good evidence of the implementation of 'Safe Wards'[19] at RFC with a number of posters and the 'discharge tree' being prominently displayed. This program is an evidenced based process to identify and reduce 'flashpoints' that can trigger distressed behaviour. When there is less distressed behaviour there is less use of restrictive practices.

It appeared to the Review that there was not consistent, ongoing use of the Safe Wards strategies and while it was not uncommon to see a service plan outlining strategies to implement when a person became agitated, the case note entry did not always match with the suggested strategies and this is an area the RFC should revisit to ensure it maintains its good performance in this respect.

The Review also found that where an OT was available to provide a sensory assessment for everyone, then more targeted and individualised strategies could be implemented to reduce agitation, injury and distress for both consumers and staff.

Clearly, attempts were made at times by staff to engage with people in their care in a meaningful way, playing cards, having discussions on topics of known interest, engaging in gardening and word games, and the consistent approach to the use of the residents preferred music are all excellent examples. What was evident however, was only nursing staff documented an activity in the person's notes. If any person attended the 'activity space' with an Activity Supervisor or OT, it was not documented in the person's case notes.

Of all the case notes reviewed by the Panel, only one OT assessment was seen, of a person who had a period of their admission in the Jasmine unit. The assessment was of an excellent standard and provided clear strategies to assist the person to self-regulate.

Documentation

The large majority of case note entries were of a good standard; they were dated, timed and signed appropriately, giving a clear report of the individuals care and management and current progress.

During the Review, several thousand clinical entries were read. Unfortunately, there were however, some instances where the standard was poor and, in a few instances, unprofessional.

Examples include a progress note made by a community team member that appeared to be a page of case notes, on which they doodled and wrote illegibly and another entry in which the staff member made disparaging comments of another medical practitioner. Some entries were gratuitous, and more care should be taken to ensure entries are necessary, objective and professional.

Many of the forms in use were not official THS medical records, including an assessment form that was included in a patient file that was from Queensland Health, and photocopies of various forms found on line, such as the Braden Scale (when a THS version already exists). The 'hygiene' form and 'Manual Tasks Care Plan' are locally produced forms and not approved as a Medical Records form,

[19] The Safewards model and associated interventions have been highly effective in reducing conflict and containment, and increasing a sense of safety and mutual support for staff and patients. The program can be accessed through Victorian Health at https://www2.health.vic.gov.au/safewards

furthermore, they were found by the Review to be of limited value in the format they are used and were also poorly completed by staff.

On more than one occasion, notes and letters related to another resident were found in the wrong case note records and the completion of the Patient Identification form was routinely incorrectly completed.

It is also of concern, as previously noted, that case note entries may be completed by a person who has had no contact with the individual during that shift, if a Care Assistant has been the main provider of care for the day. The Review found that this reflected a major concern about the way in which peers and other disciplines communicate with each other.

Communication

Communication within RFC, as with all health facilities involves verbal and written communication, may be between staff and consumers, staff and carers or guardians, between colleagues and other services, both government and non-government.

The Review found examples where the interaction between Medical staff and other members of the MDT, especially nursing staff, about a patient led to delays in interventions or nursing care. This is a problem that should be resolved as a priority.

In addition to the issue related to Nurse staffing levels as measured by NHPPD and Allied Health for the cohort of consumers at RFC, the Review found that the shift lengths (12 hours) and rostering process (monthly rotation around the four units) adds to communication issues, reduced accuracy between case notes and forms and a higher level of behavioural disturbance within the consumer group.

The provision of nursing to people with BPSD, in particular, is amongst the most physically demanding tasks in nursing care. Studies demonstrate an increase in errors due to fatigue in nurses working greater than 10 hours. The combination of the nature of BPSD nursing work, which if delivered in a least restrictive, person-centred framework, demands continual attention and physicality, with the duration of 12-hour shifts presents a risk to consumer and staff safety[20].

The Review found that in keeping with Safe Work Australia's Guide for Managing the Risk of Fatigue at Work (2013)[21] and the ANMF Policy on Fatigue Prevention[22], RFC should consider how the physically demanding nature of providing care to people with BPSD is best managed with Shifts of appropriate length.

The rotation of staff from one unit to the next each month was noted by the Review to add to a reduction in continuity of care and limit the ability for staff to develop expertise within different cohorts of consumers within RFC. While there are basic skills that are used within nursing regardless of setting and cohort, there are specific skills and knowledge required to provide good quality care to people with BPSD, for palliative care, for acute mental illness, for rehabilitation, dementia, delirium and stroke. Whilst it may be a preference that all staff have equal skills for each of these different cohorts of patients this is an unrealistic expectation and consideration of how the monthly rotation is modified and addressed this is issue. should be explored.

It is recommended that RFC transition from the use of 12 hour shifts to implement two 8-hour per day shifts and a 10-hour night shift. The use of the 8:8:10 hour shift structures, supports improved

[20] Older Persons Mental Health Service, Model of Care, Northern Adelaide Local Health Network, 2017
[21] Safe Work Australia, Guide for managing the risk of fatigue at work, November 2013.
[22] ANMF Policy – Fatigue prevention.

handover and access to regular, embedded staff education and communication, as well as increased double staff numbers at times of high unit activity. They can also help to reduce replacement costs for sick leave and covering staff attending training days.

Chapter 5

Findings:

1) ***There has been inadequate attention paid to planning or prioritisation of OPMHS throughout Tasmania.***

2) ***There has been a lack of overall investment in OPMHS, despite this program expected to see the greatest growth in demand given the ageing population.***

3) ***The OPMHS has not been developed to include the full range of service elements namely; there is no Older Person's Acute Inpatient Assessment unit and no Neuro-behavioural Unit for the assessment and treatment of people with Tier 7 BPSD, and the development of the Community Older Person Mental Health Services is at an early stage.***

4) ***The Roy Fagan Centre facility is both out of date and inadequate for some of the people who are admitted to the facility***

5. Planning of Older Person's Mental Health Services in Tasmania

5.1. Historical context

In the 1980s, in Tasmania, the reform of Mental Health Services was still in its infancy. Following the Board Inquiry into the Royal Derwent Hospital and Millbrook Rise in the early 1980s, there was a growing impetus to move toward the provision of different models of providing care with an increased focus on care provided in community rather than institutional settings.

At that time many mental health services in Australia were held in very low regard by those people who encountered them. This included not only those who were consumers, but also family members, carers, friends, volunteers and even many staff who worked in these facilities.

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

By the end of the 1980s there was a concerted effort to address these failings and this led to the establishment of two key overlapping processes. The first was the Australian Human Rights and Equal Opportunities Commissions (HREOC) *National Inquiry into the Human Rights of People with a Mental Illness* which brought down its final report in 1993[23] and the second was the agreement by all Australian Health Ministers in 1992 to implement a National Mental Health Strategy.

It was during this period of major changes both locally and nationally that decisions were made to close the Royal Derwent Hospital (which occurred in 2002) and establish the Roy Fagan Centre (which opened in 1999). [24]

Elsewhere in Australia, the reform of Older Persons Mental Health Services occurred in different ways, often with varying levels of support within the Health System and resulting in waves of innovation and reform, followed by periods of decline. One eloquent account of that pattern is that of Dr Neville Hills, an eminent Australian Older Age Psychiatrist who described the reforms of WA from the time of the Campbell and Miller report in 1982[25].

[23] Burdekin, B, Guilfoyle, M, Hall, D & Australian Human Rights Commission 1993, *Human rights and mental illness: report of the National Inquiry into the Human Rights of People with Mental Illness*, Australian Govt. Pub. Service, Canberra.

[24] Kirkby KC, Ratcliffe E, 'Psychiatry in Tasmania: from old cobwebs to new brooms', Australasian Psychiatry, 9, (2) pp. 128-132

[25] Hills, N. Public submission 688, Productivity Commission Inquiry into Mental Health and *Older Adult Mental Health in Western Australia*. Public submission to the Royal Commission into Aged Care Safety and Quality.

5.2. National Mental Health Reform

Since 1992, when all Australian Health Ministers agreed to a *National Mental Health Policy*[26], reform has been underpinned by a series of plans, statements of rights and responsibilities and funding agreements, designed to achieve a number of key reform outcomes.

Over that time, all Governments agreed to close stand-alone Psychiatric Hospitals (such as the Royal Derwent Hospital)and to mainstream inpatient services (that is to provide them on the site of General Hospitals); move services, where possible, toward greater integration between services provided in hospitals and those in the community; to ensure people's rights and facilitate recovery.

During the last 25 years, each jurisdiction, including Tasmania, has committed to reforming their specialist mental health services in line with the five agreed aims of the national policy supported by a range of nationally agreed actions outlined in five National Mental Health Plans.

However, by 2009, it became apparent that there was no clear agreement about what should constitute the optimal mix of the full range of services that should be provided. On agreeing to the *Fourth National Mental Health Plan* (4th NMHP), all Australian Health Ministers agreed that a National Mental Health Service Planning Framework (NMHSPF) would be developed to outline this optimal mix of services[27].

This NMHSPF was developed by NSW (in conjunction with Qld) with funding from the Commonwealth and oversight by a group that involved all jurisdictions. In August 2016, Tasmania was provided the later version of the NMHSPF (Version 2.1) to assist planning services that are required for this state.

Whilst the NMHSPF has certain limitations for very limited highly specific services, it is a very useful guide to planning what Mental Health Services are required for a given population. Consequently, in 2017, all Australian Health Ministers agreed that the NMHSPF will be used to inform joint regional planning under the *5th National Mental Health and Suicide Prevention Plan* (5th NMHSPP).

Brodaty's 7 Tier model and NSW OPMH planning

In the development of the NMHSPF, as it relates to people over 65 years with BPSD, there has been heavy reliance on the research undertaken by Brodaty et al.[28]

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

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

[26] National Mental Health Policy 1992, The national mental health strategy, Australian Health Ministers' Conference, Canberra.

[27] Department of Health and Ageing 2009, *Fourth national mental health plan an agenda for collaborative government action in mental health 2009-2014*, Department of Health and Ageing, Canberra, ACT

[28] Ibid page 23.

occurred prior to Brodaty's work. This is the case in most states of Australia where current OPMH inpatient units were planned and built prior to the work of Brodaty.

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

This classification is now widely accepted as the best international classification of Dementia and corresponding service needs. Since 2003, Brodaty, Draper and Low and their associates have published widely and dominated not only the national, but also international literature on epidemiological planning for people with BPSD.[29]

Figure 1

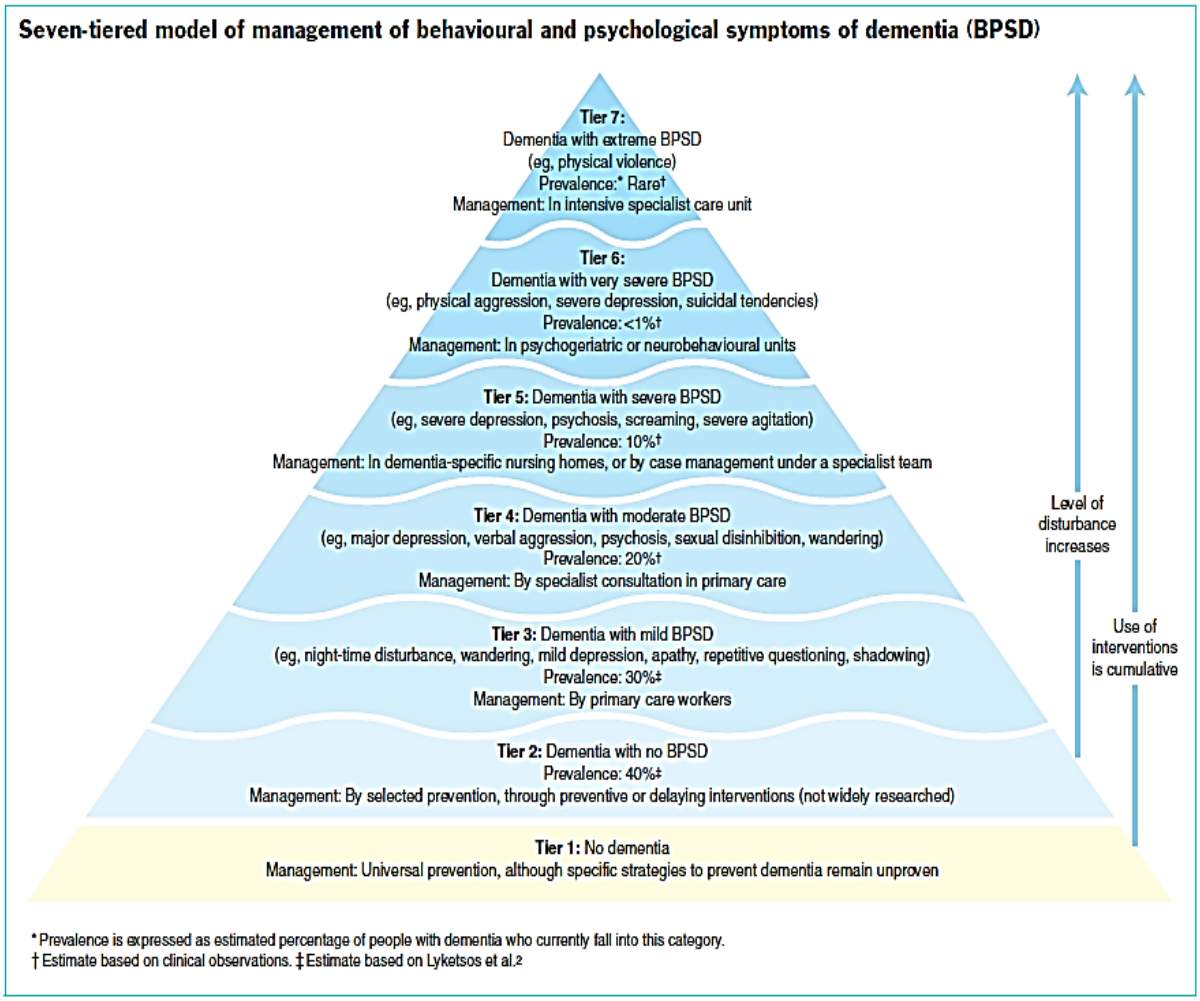

Figure 1 shows the original 7 Tier model of Brodaty, Draper and Low.

[29] The model originally described by all three authors is usually referred to as the Brodaty 7 Tier model. Throughout this report, we refer to the model as the "Brodaty model" but recognise the equal contributions of Draper, Low and others to Australia's rich knowledge about BPSD.

In addition, for simplicity we also refer to the work of Brodaty, whilst recognising that this represents the combined publications of Brodaty et al, Draper et al, as well as a number of their collaborators. Their work is now richly reflected in the wide range of Policy and Planning publications released by the NSW Ministry of Health's OPMH Policy Unit.

The Review placed special emphasis on the apex of the model (Tiers 6 and 7). The Brodaty model is careful in describing that people with BPSD Tiers 2 through 5 can successfully be managed with services from Commonwealth funded services, albeit with the support of highly specialised teams at Tier 5. However, the key consideration is the service needs of those with very severe (Tier 6) and extreme (Tier 7) BPSD. The Brodaty model clearly describes the level of interventions needed for this rare group of individuals as requiring "Neurobehavioral Units" or "Intensive Specialist Care" , or " Transitional Behaviour Assessment and Intervention Service (T-BASIS)" care types that far exceeds the level of care able to be provided by Dementia-Specific Nursing Homes.

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

The *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015* (the NSW Plan)[30] is a comprehensive outline of the relevant policy, planning and demographic context, definition of the scope and functions of OPMHS, together with an OPMHS service delivery model, an implementation plan and a reporting, monitoring and evaluation framework.

In 2011, the NSW plan was subjected to a mid-plan evaluation that also reviewed all additional literature that has become available since the development of the plan. In addition, NSW has also developed a very comprehensive clinician's handbook known as the Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia.[31] to assist all clinicians working in OPMHS to understand best practice approaches to treating BPSD.

In 2017, NSW released the *NSW Service Plan for Older People's Mental Health (OPMH) Services 2017-2027*[32]. The plan updates the first ten-year NSW OPMH plan and this Review has used this document extensively to inform best practice in OPMHS planning. The Review believes this should be a key document that informs reform of OPMH in Tasmania.

5.3. Dementia as National Health Priority

In 2006, all Health Ministers agreed to the *National Framework for Action on Dementia 2006-2010*[33] that brought together the various strategies of Australian jurisdictions in an attempt to "treat, improve the care of and delay the onset or progression of dementia".

In August 2012, all Australian Health Ministers agreed to adding dementia to the National Health Priority Areas (NHPA), recognising the increasing burden that the dementia-related illnesses would

[30] NSW Health 2006 *NSW service plan for specialist mental health services for older people (SMHSOP) 2005-2015*, North Sydney, NSW

[31] Royal Australian and New Zealand College of Psychiatrists & New South Wales, Ministry of Health 2013, *Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD): a handbook for NSW health clinicians,* NSW Ministry of Health*, North Ryde*

[32] NSW Ministry of Health. NSW Service Plan for Older People's Mental Health (OPMH) Services 2017-2027

[33] Department of Health – NSW (2006) National Framework for Action on Dementia 2006-2010

present to the Australian population, making Australia one of the first countries in the world to elevate Dementia in this way.

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

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

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

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

Since that time it has been recognised that severe and extreme BPSD has begun to fall between the cracks of the Commonwealth Aged Care system and the State funded Mental Health Care system, with the need for both levels of government to cooperate in the development of programs that cater for this small group of highly disadvantaged people and their families and carers.[34]

In 2018, the Commonwealth formed a Royal Commission into Aged Care Safety and Quality which released its final report in early 2021[35]. The status of the Commonwealth Government's response to the recommendations of *Care Dignity and Respect, the final report of the Royal Commission into Aged Care Safety and Quality* are not known at the time of writing this report. However, it is hard to see how implementation of the recommendations will not have major implications for the way in which aged care services and the mental health care of older Tasmanians is provided.

5.4. What are the Older Person's Mental Health Services in Tasmania?

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

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

In Tasmania, state-funded Mental Health Services are provided by SMHS who has responsibility for Older Persons Mental Health Services within the Tasmanian Health Service.

[34] Australian Institute of Health and Welfare (2012) *Dementia in Australia,* Australian Institute of Health and Welfare, Canberra

[35] Royal Commission into Aged Care Quality and Safety Final Report: Care, Dignity and Respect.

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

- people 65 years or over that have a mental illness or mental health problems including suicidal distress;
- people with very severe and extreme Behavioural and Psychological Symptoms of Dementia (BPSD); and
- people who may be younger but are "functionally older" and often have a combination of acquired cognitive dysfunction, complex comorbidity and are in poor health[36][37].

OPMHS are therefore provided to distinctly different groups of individuals, ranging from those with mental illnesses such as Psychosis, Depression and severe Anxiety Disorders through to people who are severely and persistently affected by challenging behaviours of Dementia such as agitation; aggression; psychosis; depression; inappropriate sexual behaviours; or are otherwise at risk of harm to themselves or others.

In Tasmania, the RFC acts as a Statewide facility for the inpatient care of people who are the focus of OPMHS. There is no other inpatient unit dedicated to the admission of people with OPMH needs.

Consequently, there is currently no Older Person's Acute Inpatient Assessment unit in Tasmania. As a result those who may otherwise access this type of service either remain in RHH in one of the Acute inpatient unit of Older People or General Wards or are admitted to the Adult Mental Health Unit, or if they are medically stable enough admitted to the RFC. No person in Tasmania currently receives Acute Older Persons Mental Health Assessment in a purpose designed, adequately staffed inpatient unit.

Furthermore, there is currently no unit designed and staffed specifically for the care of people with Tier 7 BPSD, consequently they are transferred to RFC as soon as practicable and when their medical care needs can be managed at the RFC.

OPMHS also provides a limited Consultation Liaison Service to the RHH and to some RACF in the Hobart region, however this is limited by available staff.

The OPMHS also delivers a Community Mental Health Program that focusses primarily on older Tasmanians with Mental Illness and follows up people once they have been discharged from the RFC. They are also responsible for providing the Huntington's Disease Service as part of its Community Service in Southern Tasmania.

In larger states of Australia, notably NSW, Victoria and WA, there has also been the development of several units variously referred to as Transitional Care Units (TCU) and Intensive Care Behavioural Units (ICBU) that complement the Acute OPMH services. These are required for the small number of people with the highest levels of long-term care needs that cannot be provided by the dementia specific Residential Aged Care sector. Whilst evaluations of the effectiveness and the exact role of these TCUs and ICBUs remains contested, they do provide one type of service within a spectrum of different needs and are not available in Tasmania.

[36] Tasmania has one of the highest rates of Huntington's Disease in the world with the current prevalence believed to be between 12-14 per 100,000.

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

The Tasmanian Role Delineation Framework (TRDF) and Clinical Services Profile (CSP) is the principal, government endorsed clinical service planning document for Tasmania's public health system. The TRDF and CSP have strategic importance to the health system because they have close linkages and alignment with the Service Plan and the Statement of Purchaser Intent (SOPI).

However, although in its 4th version as at 2018, the TRDF/CSP does not include any description or planning of specialists Older Persons Mental Health Services. This should be remedied.

Population based estimates of Mental Health need in Older Persons

The NMHSPF (version 2.1) has for the first time provided a range of population estimates to guide service planning for mental health, based on known Australian epidemiology of mental illness.

The NMHSPF is of greatest utility in estimating the level of the most needed service types. It has some limitations when estimating the requirements for the most highly specialised services (and therefore those provided for the lowest number of people in any given population) as these estimates are based on very low prevalence rates and thus small numbers of affected individuals.

Nevertheless, the NMHSPF predicts the number of Community FTE needed for older people services, the number of RACF beds and Acute, and Non-Acute Hospital beds needed in Tasmania.

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

Add to this the expected growth in older persons in Tasmania over the next decade, with a substantial increases in the number of people with Dementia in particular, the number of people with very severe/extreme BPSD (Tiers 6 and 7) are likely to grow much faster than the overall population of the state.

How many people in Tasmania have BPSD Tier 7?

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

The Review found that this is the number of Neuro-behavioural beds needed in Tasmania and would propose that an 8 bed Unit would be the correct capacity to deal with Tasmania's current and future need for such a service.

The Review considered the built environment at the RFC for people with Tier 7 BPSD. The RFC was planned and built without the knowledge and experience that has been gained in the last 25 years about OPMHS, especially as they relate to Tier 7 BPSD. The Review found that the RFC is inadequate to meet the needs of both people with Tier 7 BPSD and those who need an Acute OPMH Assessment unit.

Identifying the number of people with Tier 7 BPSD, is an important exercise, given the nature of their symptoms and their predicted service utilisation. People in Tier 7 characteristically are men in their late 60s or 70s who are very strong and have been so violent that they have harmed other residents

or staff. Often the cause of their Dementia is alcohol-related, Fronto-Temporal or Vascular dementia. They have often been too difficult to manage in a Hospital and special nursing homes are unsuccessful as well, staff often refuse to work with them in these settings and often no facility will accept them.

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

Such is the level of disturbance; it is usually reasonably easy to identify people with this level of symptoms, if they are in any OPMHS. At the time of writing this report it was considered that most people with Tier 7 BPSD are either in the RFC or are on the wait list to be admitted to RFC.

Other OPMHS planning considerations.

Special consideration should also be applied to certain groups that are often under-serviced. People living in RACFs have especially high rates of all mental disorders, with rates of depression estimated to be as high as 50% with many cases undiagnosed, while rates of psychosis may be up to 5%.

Aboriginal and Torres Strait Islander peoples and those within the Criminal Justice System have earlier onset of common mental health problems and Dementia related behavioural syndromes, with greater difficulty gaining access to appropriate assessment and care options. [38]

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

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

It is beyond the scope of this Review to precisely estimate the current need for transitional care arrangements for people with functional mental illness, who are aged over 65 in Tasmania. However, it is predicted, from a preliminary review of the NMHSPF (ver 2.1) and the Review team's knowledge of current OPMHS demand in Australia, that as many as 25-30 beds are needed in Tasmania, to cater for all those with Tier 6 BPSD and those people with Severe Mental Illness who need Transitional care.

The primary responsibility for the provision of this care, traditionally rests with the Commonwealth Government not the State Government, however if these options are not available, then this brings an added pressure on OPMHS and if they do not have capacity it inevitably leads to presentations to Emergency Departments and ultimately admission to Acute wards of General Hospitals, none of these settings are appropriate for the health problems of these people.

[38] Zann, S. found four times the rate in Aboriginal and Torres Strait Islanders in Nth Qld

5.5. Specialist Nature of Older Persons' Workforce.

Psychiatry

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

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

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

Since that time it is expected, within Australia and New Zealand, Psychiatrists working within this area of Specialty practice should attain Faculty endorsement through additional training that recognises that they have met additional standards of extra knowledge, skills and attitudes needed to work competently in this area.

In particular, for accredited membership of the Faculty, it is required that Psychiatrists have completed the advanced training program, resulting in the Certificate in Psychiatry of Old Age. Psychiatrists who have worked extensively in older persons' mental health or have another academic qualification are able to apply for membership of the Faculty without being eligible for accredited status.

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

These include the following:

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

In Tasmania, OPMHS currently employs four Psychiatrists who are members of the FOAP, however one is currently on a long period of annual leave. Whilst there are other Psychiatrists who are members of the FOAP, they provide services either in the private sector of other parts of SMHS. Currently there are Trainee Psychiatrists working towards FOAP status.

This current workforce shortage is a serious impediment to future service development.

Nursing

The importance of mental health nursing specific skills in older person's mental health has received attention both nationally and internationally (Heslop, Wynaden and Bramanis et al 2012[39]; and Van Leuven, 2010)[40]. It is also significant that the numbers of older adults with co-occurring mental illness and substance use disorder (dual diagnosis) are increasing worldwide. This latter group is of particular concern for they are known to experience greater rates of psychiatric relapse and poorer treatment engagement. Services are often run with higher financial costs, and care is managed for longer periods under compulsory treatment orders (Searby et al 2015).[41]

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

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

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

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

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

As noted below, whilst OTs provide specific assessments on an individuals sensory diet and potential self-regulating strategies based on that assessment, mental health nurses should be able to display a

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[39] Heslop, K, Wynaden, D, Bramanis, K, Connolly, C, Gee T, Griffiths, R & Al Omari O 2012, 'Assessing falls risk in older adult mental health patients: a Western Australian review', International Journal of Mental Health Nursing, vol. 21, iss. 6, pp. 567-75

[40] Van Leuven, K 2010, 'Psychotropic medications and falls in older adults', *Journal of Psychosocial Nursing & Mental Health Services*, vol. 48, iss. 9, pp. 35–43.

[41] Searby, A, Maude, P & McGrath, I 2016, 'Prevalence of co-occurring alcohol and other drug use in an Australian older adult mental health service', *International Journal of Mental Health Nursing,* vol. 25, iss. 2, pp. 151–158.

good understanding of sensory modulation and its use in helping those people who are dysregulated. On a daily basis it is the nursing staff who will use these strategies to soothe the consumer, improving the overall safety on the unit for staff, consumers and visitors and promoting a therapeutic environment of care.

Allied Health

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

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

Finally, the growing role of Clinical Pharmacy, Dietetics, Podiatry, Wound Care Nursing and people with lived experience in a range of role in OPMHS is increasingly recognised.

Taken together these workforce competencies were considered by the Review as essential for those working in highly specialized OPMHS in addition to those Workforce Standards outlined in the National Practice Standards for the Mental Health Workforce.[42]

The shortages of Specialist OPMH Nurses, and Allied Health staff also act as a major impediment to the development of growth of OPMHS in Tasmania.

5.6. Community Older Person's Mental Health Service

The Review was concerned about the ability of the Community Older Persons Mental Health Service to adequately follow up people, either following discharge from RFC, or as they approached discharge or even to inreach into RFC for those people known to them.

The Review was told this issue related to a general shortfall in the number of staff needed to provide services to the cohorts of OPMHS described in this Chapter. As a result the Community OPMH focus has been narrow and is not able to prioritise seeing people with BPSD.

In order for the Review to establish whether what it was told was based on an actual shortfall, it applied the current version of the NMHSP Tool to the Tasmanian population to predict how many staff are need to provide a balanced OPMHS. The Review used the NMHSP Tool to determine the workforce in Community OPMHS in 2026.

[42] Department of Health - Victoria 2013 *National Practice Standards for the Mental Health Workforce*

Table 1, shows the projected 2026 workforce broken down by discipline and the current 2021 workforce data, as at the time of writing this report, based on workforce occupancy date provided by the Department of Health.

Table 1: Required Staffing numbers according to the NMHSPF compared with actual numbers.

NMHSPF projected OPMHS workforce needs 2026			
	Projected 2026 need	**Current 2021 workforce**	**Percentage of need**
STATEWIDE	70.76	19.29	26.57%
Tertiary Qualified	*56.34*	*14.23*	23.91%
Other TQ (eg pharmacist)	-	-	
Tertiary Qualified - AHP not identified	9.30	4.80	44.44%
Occupational Therapist	4.35	-	0.00%
Psychologist	5.52	-	0.00%
Registered Nurse	26.12	9.44	35.74%
Social Worker	4.35	-	0.00%
Nurse Practitioner	6.69	-	0.00%
Vocationally Qualified	-	*0.93*	0.00%
VQ Other	-	-	
VQMH Worker	-	-	0.00%
Enrolled Nurse	-	0.93	0.00%
Peer Worker	*2.48*	-	0.00%
Consumer Peer Worker	1.41	-	0.00%
Carer Peer Worker	1.07	-	0.00%
Medical	*11.94*	*4.12*	28.30%
Psychiatrist	5.69	3.12	59.40%
Registrar	5.76	-	0.00%
Medical	-	1.00	0.00%
Junior Medical Officer	0.49	-	0.00%

The current Community OPMH workforce represents approximately 27% of the requirement for 2026. It is likely that this will be an underestimate of the workforce needed by 2026.

Furthermore, OPMHS are best placed to provide services to people with Huntington's Disease and as already reported the rate of this disorder in Tasmania is much higher than the rest of Australia. The NMHSP does not make an allowance for the unique situation in Tasmania and the Review finds that at least two FTE is required above what is currently provided to address the needs of the Huntington's Disease Service (HDS).

Chapter 6
Recommendations

The Review makes the following recommendations.

1. ***OPMHS should be a statewide program within SMHS and have its own dedicated leadership.***

2. ***OPMHS should develop a comprehensive system of Clinical Governance, with dedicated resources to support this function, in line with the Tasmanian Quality Governance Framework.***

3. ***OPMHS should be funded to deliver the full range of service elements found within a contemporary statewide OPMHS.***

4. ***The RFC should undertake a project over the next 12 months to develop a model of care based on a new level of resourcing adequate to undertake the roles it will need to deliver in the next 10 years.***

5. ***The Community OPMHS should develop a model of care that meets the needs of the Tasmanian community based on similar programs elsewhere in Australia.***

6. ***OPMHS should develop a project, as part of the broader Tasmanian Mental Health reforms, that ensures they are able to take advantage of processes that will assist them in attracting a suitable workforce.***

6. Recommendations

A Statewide Approach

The various points for and against local and statewide approaches to the delivery of healthcare in Tasmania, are beyond the scope of this report. However, it is commonplace in health planning to ensure that services are delivered in a safe way with attention to the quality that is provided. Therefore, the development of Capability Frameworks in Australia is now widely recognised as a basis for outlining which services can be provided within a quality framework.

In this regard, the Review found that OPMHS and the Roy Fagan Centre in particular, provide services which at times, will be delivered to a very small number of people. This may mean, one site will be used for the whole of Tasmania, such as a Neuro-behavioural unit. Consequently, to ensure proper access and to ensure that services are provided in a consistent and at a high quality OPMHS should be consolidated into a single statewide program within SMHS.

The Review notes that a similar recommendation was recently supported by the Tasmanian Government arising from the Child and Adolescent Mental Health Service (CAMHS) Review released in 2020. The Review considers that the reasons that apply to having a statewide approach to CAMHS is equally applicable to OPMHS and notes that the Executive of SMHS has been moving in this direction over the past 3 years.

The Review also recommends that in developing a Statewide OPMHS program, this should be led by the recruitment of a Clinical Director for this program into a role that has a significant focus on the future development of this service and the implementation of the recommendations from this report. The Review recommends that the leadership should be based on a partnership model with equal emphasis given to clinical and operational matters.

The Review found that there were many policies, procedures and clinical processes that should be reviewed and that OPMHS needed to develop models of care that are contemporary and help guide staff with how they undertake the delivery of patient care. The appointment of a Clinical Director with dedicated time that allows for the evaluation, analysis, and introduction of new processes, whilst ensuring high quality care is pivotal to this change.

As an early priority the OPMHS should develop an agreed approach on how they will adopt the recommendations in this report and include all stakeholders in changes to their service

Recommendation 1

The Review recommends that OPMHS should be a statewide program within SMHS and have its own dedicated leadership.

> ***In addition, this program should be led through the appointment of a Statewide Clinical Director, with dedicated time to ensure overall clinical standards, and work in partnership with operational management of the program.***

Clinical Governance

Throughout the Review there were numerous examples of staff being unsure how decisions were made by people undertaking managerial functions, that affected the way in which patient care is delivered. There is a high regard for local leadership within the OPMHS program at the RFC. However, the Review was concerned to hear many staff express frustration at how decisions that are at a higher level within the health system and the mental health system are made. The staff, at times appeared disconnected from the people who make these decisions. This is compounded by the lack of processes such as "Executive walk arounds" that are common, in organisations with well-developed and mature clinical processes.

The Review found that each clinical record it examined had an issue that could be improved, this was a surprise. In most cases, this was as simple as using endorsed documents rather than forms which don't fit the purpose and should not be being used. However, in other situations forms were used but this was in a non-standard way. In other cases, documents were incorrectly recorded or incomplete and at other times the use of excellent available resources was not seen in any files, as it does not appear to be a component of the OPMHS clinical pathway. Many of these improvements should be detected as part of routine clinical review and audit.

The Review found that OPMHS does not have any dedicated resource, such as a safety and quality officer (sometimes referred to as a Clinical governance officer in other states) to perform this role. If they had such a resource, it is likely that these issues would have been identified and remedied some time ago.

Two important aspects of the way OPMHS can improve its level of patient care are the use of the principles of Improvement Science and Implementation Science and both are central in excellent Clinical Governance systems. Whilst there is good evidence that clinical staff of OPMHS have a range of exciting ideas and innovations they would implement at RFC, support to make changes and a system to provide guidance or assist with implementation was not evident.

Furthermore, the Review found that several key senior staff are overwhelmed by the relentless nature of their clinical workload and consequently have insufficient time to devote to the introduction of new and improved processes.

The Review recommends OPMHS explores the approaches of the Institute for Healthcare Improvement (IHI) and devotes time to building a culture of quality improvement within all its staff. This will need the express support of leadership at higher levels within the Health system to ensure it succeeds.

The Review found that few of the key staff appeared to be aware of Quality Governance Framework in the Tasmanian Health System. Furthermore, some did not appear to fully understand the Clinical Governance system adopted by SMHS. Yet the Review was informed, that the OPMHS had one of the best Clinical Specialist Groups (CSG) within SMHS, which aligns with the Reviews finding that OPMHS is well placed to embrace change innovation and improvement.

More attention should be given to how the services achieve excellence rather than simply getting through accreditation. Whilst meeting standards is important, being able to benchmark the service against other comparable services in Australia that are considered sector leading is vital if the service is to reach the level it should be able to given the high degree of leadership within its current ranks. OPMHS should consider partnering with one or two other organisations in Australia that have similar casemix and complexity such as Northgate House in South Australia and units in NSW or Victoria.

Recommendation 2.

The Review recommends that OPMHS should develop a comprehensive system of Clinical Governance, with dedicated resources to support this function, in line with the Tasmanian Quality Governance Framework.

> ***In addition, a significant investment should be made in creating a culture of quality within the entire OPMHS. This will require dedicated resources and a specific program of training and development of skill so that all staff within OPMHS are able to contribute to and led the changes that are required to attain the quality of patient care that is expected of a Specialist OPMHS.***

A full range of OPMH service components

The Review found the development of OPMHS in Tasmania has been slow in recent years. Essentially OPMHS currently has two main elements. The first; the RFC consists of 3 inpatient units that provide services to people with entirely disparate health care needs. This centre has a Day Centre that is only able to provide services for a subset of the OPMHS target population. The second is the Community Older Person Mental Health Service, which provides care closer to where the person lives and provides a small Huntington's Disease Service. OPMHS also provides Consultation Liaison Services when it can to RHH, RACFs and other sites.

Notwithstanding the uncertainty about the Commonwealth Government's response to the Final Report of the Royal Commission into Aged Care Safety and Quality, it is inevitable that the provision of OPMHS services by the Tasmanian Government will need to address the care to those who need Hospital-level inpatient care.

In this regard, Tasmania has no Older Person Acute Mental Health Inpatient Assessment Unit. The Review found that Tasmania currently needs about 12 such inpatient beds. The Review is aware these have been planned and agreed by the Tasmanian Government for Stage 3 of the Royal Hobart Hospital Redevelopment as outlined in the report of the Clinical Planning Taskforce, and this Review supports this decision. However, that Review is aware that this is a current need which is being met by the RFC which is not designed for that purpose and does not have access to the full range of support services that are traditionally found on the site of a major teaching Hospital.

In addition, the Review found that OPMHS does not have a dedicated unit for people with extreme (Tier 7) BPSD. These units which are referred to by various names such as T-BASIS or Neuro-Behavioural Units are central to effective management of an OPMHS. The RFC was not properly designed for people with Tier 7 BPSD and is unsuitable. Consequently, the level of care that staff can provide is negatively impacted by the building in which they operate. The Review found that the current need in Tasmania is about 6 beds and this will rise to about 8 beds by the 2030s.

The Review also found that the staffing numbers, especially nursing and allied health, to provide contemporary OPMH inpatient care were too low. It is recommended that RFC is resourced at a level commensurate to patient complexity and that the application of the Nursing Hours per Patient Day reflect what is being achieved at similar benchmarked units elsewhere in Australia. It is also recommended that as part of a review of staffing, OPMHS should also address what is an optimal ratio of nursing staff they are aiming for in each inpatient unit that they operate.

The third main element of a successful OPMHS is the Community clinical service. This part of the service should have sufficient medical, clinical and case management staff to be able to make timely comprehensive assessment of people, whether that is in their own home, in a RACF, in the Four Major Hospitals in Tasmania as well as providing more specialist services such as the HDS and the provision of Day Centre Care and inreach into other institutions where older Tasmanians may need assessment.

The Review found the current staffing levels for the Community clinical service do not allow for this. To ensure any future development of services that provide overnight care are successful, the Review recommends that a comprehensively staffed Community OPMH service is developed as an early priority.

Recommendation 3

The Review recommends that OPMHS should be funded to deliver the full range of service elements found within a contemporary statewide OPMHS.

> ***Specifically, this should include the expansion of the Community OPMH service, with increased staffing dedicated to the HDS, a greater focus on following up people discharged from RFC, assessment of people with BPSD in RACF, and Consultation Liaison services in a wider range of settings.***
>
> ***In addition, the identification of a Neuro-Behavioural unit and a timeframe for development is critical. With the development of Stage 3 of the RHH some years away, the impact of this on the way services are provided at the RFC in the interim needs to be explored. We recommend that greater access to imaging and other diagnostic testing is available as a priority.***
>
> ***In the meantime, attention should be given to getting the RFC staffed with an adequate number and mix of Nursing and Allied Health Staff, and people with Lived Experience to ensure it can provide improved Health Outcomes for its residents.***

Models of Care

The Review found that there is no current Model of Care for RFC and that there did not appear to be a process that supported the development of a contemporary version. The Review is also aware that the NSW Ministry of Health, in releasing their 10-year Service plan for OPMHS43, has published their Models of Care for Acute Inpatient Units, T-BASIS and Community Services. Whilst these are high level summaries of their models to allow local interpretation the Review recommends these be used as the basis for developing locally endorsed MoCs for OPMHS in Tasmania.

The Review also found that what OPMHS currently provides was determined by its level of staffing. In developing new MoCs, it is recommended this these are developed in line with what are new (or future agreed) staffing levels so that OPMHS is seen to be "working towards" where they want to reach rather than being unable to move from what they currently provide.

[43] NSW Ministry of Health 2017. NSW Older People's Mental Health Services Service Plan 2017-2027. Sydney NSW.

The development of new MoCs should be accompanied by the development of new and comprehensive procedures and guidelines for staff and enhanced staff development to ensure the existing workforce is supported to undertake the roles that are expected in OPMHS.

During this process attention should also be applied to whether business processes within OPMHS also need review and updating to support changed clinical processes.

Recommendation 4.

The RFC should undertake a project over the next 12 months to develop a model of care based on new levels of resourcing adequate to undertake the roles it will need to deliver in the next 10 years.

In addition, these models of care should be based on contemporary models that have been recently released in Australia, such as those from NSW and SA. This development should happen in step with a process that review all the clinical operational processes and any relevant business processes.

These new clinical and operational procedures should inform a whole of service approach to staff professional development and practice improvement.

Community Older Person's Mental Health Service.

The Review was primarily focused on the RFC, however from early on, it was apparent that the role of the Community component of OPMHS was vital in the functioning of the RFC. This was not only because of its significant role in discharge planning, but also the provision of expert advice and management to a range of providers such as RACFs, and its role in preventing admission to RFC, where this is possible.

In many of the case files that were examined by the Review there was a significant involvement by the Community OPMHS either before or after the persons admission to RFC. Whilst the Review found that the level of patient care provided by the Community OPMHS was at a reasonable standard, it also found that same variation in care that was found when these people where admitted to the RFC.

The Review found that two factors led to this. The first was that the Community Mental Health Service has narrowed the scope of its target group to focus on people who predominately have a mental disorder, rather than also providing assessment advice and care for people with BPSD. Secondly there is considerable variation in the way people are case managed. The Review recommends that this be addressed through the development of the new Model of Care, in which greater attention is paid to the way in which the Community OPMHS operates.

For example, the Community OPMHS has less than one third of the staff that is projected it should have by the National Mental Health Service Planning Tool. If this is addressed, then the ability of the service to provide greater oversight of the level of care and to address provider variance can occur. Currently this is not possible without providing even less care to people than it currently provides.

The Review also found that whilst the level of care provided by Community OPMHS was at times of a very high level, the timeframes for providing written advice back to other health providers may be

months rendering the advice to be of limited use. Addressing the staffing levels should be accompanied by an expectation and measurement of improvement in communications from the service to other providers.

Finally, the expansion of Community OPMH and the adoption of a Statewide Approach is an opportunity for the OPMHS to reach and provide an appropriate level of service to a greater target group. This will require them to work closely with and in consultation with Adult Mental Health Services within SMHS.

In doing so, the Review recommends OPMHS lead a common approach to the delivery of Huntington's Disease services across Tasmania and work with other service providers within the THS to consider its place in assessment and care of people who also are at risk of the development of early onset cognitive dysfunction and symptoms associated with these syndromes. The role of OPMHS within the delivery of Memory Assessment Services or Cognitive Clinics, and Neuropsychiatric services, should be clarified as part of this process.

Recommendation 5

The Review recommends that Community OPMHS should develop a model of care that meets the needs of the Tasmanian community based on similar programs elsewhere in Australia.

In addition, it is recommended this model is developed with consideration for how a greater target group of people are seen, especially those who have recently been discharged from RFC and have BPSD, expanding services to people with Huntington's Disease across Tasmania, providing greater inreach and Consultation and Liaison services and determining its role within the provision of Neuropsychiatric services.

It is recommended that the development of Community OPMH should be informed by the recommendations related to improving clinical outcomes within an improved clinical governance system.

OPMHS reform

The Review has identified a number of areas for development and improvement of OPMH in Tasmania. If these are to be successfully implemented, it will require OPMHS to work closely with the other reform processes underway in Tasmania.

First and foremost, the Review found that there is a significant shortfall in clinical staff both for the RFC, which already experiences problems attracting staff, and in the Community OPMH service. The staff needed will either have to possess specialist skills in Older Persons MH care or be able to quickly develop them as part of staff development on the job. In addition, the Review is aware that recruitment of staff into most aspects of Aged Care, including highly specialized areas such as OPMHS is currently exceedingly challenging.

This is further compounded by the likely and imminent increase in demand for Mental Health staff both within Tasmania for current reforms, and across Australia as a result of major commitments to expanding Mental Health Services, such as those resulting from the Royal Commission into Victoria's

Mental Health System and a range of other National reforms. The current and future mental health workforce in Australia will be a highly competitive and difficult market.

The Review recommends that OPMHS lead any reforms as a Project that is embedded within the broader Tasmanian Mental Health reform program, so that they can gain the benefit from processes that support the current reforms.

The Review recommends this approach, which will enable any measures being considered in Tasmania, be adopted system wide.

Recommendation 6.

The Review recommends that OPMHS develop a project, as part of the broader Tasmanian Mental Health reforms, that ensures they can take advantage of processes that will assist them in attracting a suitable workforce.

> ***In addition, the Review recommends an approach whereby advocacy in addressing workforce issues in mental health in Tasmania, has an equity approach in which OPMH is acknowledged on the same footing as all other mental health programs.***

Chapter 7

Concluding remarks

This review was conducted after the family of 78 year old man who was a resident at the RFC was found with fly larvae in his socks. We have referred to him as Mr A. Amidst the understandable distress experienced by his family, they made public what had happened to their beloved husband and father.

The daughter of Mr A told the Review she just wanted to make sure this was looked at properly, and that it never happened again. Mr A's wife remains upset that she could not prevent this from happening to her husband.

It was, at times, a very difficult investigation. Many people were left shocked and very saddened by what had occurred. Other people's sense of pride in their service had given way to a deep sense of shame.

There is no doubt the RFC has had problems in the past. These have been recognised and significant changes have been made in the quest for improvement. The RFC has, however, a significant path ahead of them to achieve the quality of care that they aspire to deliver and that the community expects.

Central to this journey will be culture and attitude. The changes needed will be less from OPMHS which already seeks this path. Rather it is the rest of the health system and the wider community who so often find responding to aged care so difficult.

We started this Review looking for how a system might have failed someone so badly and yet we found a system that is very aware of the areas they need to improve upon, and the hopes that their words will be heard.

We hope that this report does justice to the confidence that was entrusted on us by Mr A's family, who have had only one thought in their minds; shining the light on their sadness might help others not have the same experience. We hope that with time this report helps meets your expectations.

APPENDICES

Appendix 1. Chief Psychiatrist Statutory Role as outlined in the Tasmanian *Mental Health Act 2013*

The following sections of the Tasmanian *Mental Health Act 2013* outline the Objects of the Act, the establishment of the position of Chief Civil Psychiatrist and the Functions and powers, including the power of direct intervention of that position.

12. Objects of Act

The objects of this Act are as follows:

(a) to provide for the assessment and treatment of persons with mental illnesses;

(b) to provide for appropriate oversight and safeguards in relation to such assessment and treatment;

(c) to give everyone involved with such assessment and treatment clear direction as to their rights and responsibilities;

(d) to provide for such assessment and treatment to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare;

(e) to promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices;

(f) to provide for all incidental and ancillary matters.

143. Chief Civil Psychiatrist

(1) The Governor may appoint a person to be Chief Civil Psychiatrist.

(2) The appointee must be a psychiatrist with at least 5 years' experience in practising psychiatry.

(3) The office of Chief Civil Psychiatrist may be held in conjunction with State Service employment.

(4) The Chief Civil Psychiatrist has a general overall responsibility, under and to the Minister, for ensuring that the objects of this Act are met in respect of –

(a) patients other than –

(i) forensic patients; or

(ii) persons who are subject to supervision orders; and

(b) the running of approved facilities other than secure mental health units.

146. Functions and powers

(1) A Chief Psychiatrist has the functions given to that Chief Psychiatrist by this or any other Act.

(2) A Chief Psychiatrist has –

(a) power to do anything necessary or convenient to be done to perform his or her functions; and

(b) such other powers as are expressly or impliedly given to that Chief Psychiatrist by this or any other Act.

(3) Without limiting subsection (2) –

(a) either Chief Psychiatrist may approve forms for use under provisions of this Act within his or her jurisdiction or under provisions of other Acts in respect of which he or she may have responsibilities; and

(b) the Chief Forensic Psychiatrist may authorise a person or class of persons for the purposes of Part 4 of Chapter 2 or any provision of that Part.

147. Power of direct intervention

(1) A Chief Psychiatrist has, in prescribed matters within his or her jurisdiction, the power to intervene directly with regard to the assessment, treatment and care of any patient.

Note

The exercise of a Chief Psychiatrist's power of intervention is reviewable by the Tribunal – see Division 2 of Part 3 of Chapter 3 .

(2) The power of intervention is exercisable –

(a) on the Chief Psychiatrist's own motion; or

(b) at the request of the patient; or

(c) at the request of any person who, in the opinion of the Chief Psychiatrist, has a proper interest in the patient's health, safety or welfare.

(3) However, the power of intervention is only exercisable if the Chief Psychiatrist –

(a) has made inquiries into the relevant prescribed matter; and

(b) is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.

(4) The power of intervention is exercisable by giving any person responsible for the treatment and care of the patient, as regards the relevant prescribed matter, a notice to do one or more of the following:

(a) discontinue or alter a particular practice, procedure or treatment in respect of the patient;

(b) observe or carry out a particular practice, procedure or treatment in respect of the patient.

(5) The Chief Psychiatrist, by the same or a different notice, may also do either or both of the following:

(a) issue consequential directions for the future assessment, treatment or care of the patient;

(b) direct that any decision triggering or relating to the intervention be referred, by a specified person, to the Tribunal for review within a specified time.

Note

For the review of such decisions by the Tribunal – see Division 2 of Part 3 of Chapter 3 .

(6) Nothing in this section is to be taken as authorising a Chief Psychiatrist to issue directions that are repugnant to –

(a) any provision of this Act; or

(b) a provision of any other Act; or

(c) an order, determination or direction of the Tribunal or any court.

(7) A failure by an individual to comply with a direction contained in a notice issued by a Chief Psychiatrist under this section is not an offence but does constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action against that individual.

(8) In this section –

prescribed matters means the following:

(a) the use of seclusion;

(b) the use of restraint;

(c) the use of force;

(d) the granting, refusal and control of leaves of absence;

(e) the giving or withholding of patient information;

(f) the granting, denial and control of visiting, correspondence and telephone rights;

(g) assessment and treatment generally;

(h) matters prescribed by the regulations.

Appendix 2. Safety and Quality in Patient care and the use of the Structured Judgement Review for determining the Standard of Patient Care.

In many respects, Australia has been at the forefront of the international approach to improving Safety and Quality in Healthcare. In 1995, the Medical Journal of Australia published the landmark report *The Quality in Australian Health Care Study*[44]. In 2001, soon after the publication of "*To Err is Human*"[45], *An Organisation with a Memory*"[46], "*Crossing the Quality Chasm*"[47] and the *Bristol Royal Infirmary Inquiry Report*"[48] ; the *Douglas Inquiry report into Obstetrics and Gynaecological services at King Edward Memorial Hospital* in Western Australia was released[49]. Together these reports became the impetus for a renewed approach to safety and quality in Healthcare, as well forming the basis for similar approaches to how the US, UK, Australia, New Zealand, Canada and most other countries with similar health systems went about this endeavour.

In 2000, a first paper on Clinical Governance in Mental Health Services was developed in Australia and by the mid-2000s many states had begun to consider the priorities for improving safety and quality in Mental Health Services. In 2005, the *National Safety Priorities in Mental Health: a national plan for reducing harm*, was endorsed by all Australian Governments[50]. In early 2021, a project led by Queensland Health led to national agreement of a *National Safety Priorities in Mental Health: Second Edition*[51].

By 2006, the Australian Commission on Safety and Quality in Health Care was established and this led to the development of a Charter on Health Care Rights, a Safety and Quality Framework for Health Care and an Accreditation Scheme and a set of Safety and Quality standards for Health Care. These milestones are all depicted in figure 2.

Much of this Australian work has been influenced by the work of Berwick D in the US and the UK and in turn a number of other prominent Health Care safety and quality experts[52]. Consequently, many of the tools used to improve safety and quality in these systems have saliency across all health care systems (more detail is found at the Institute for Healthcare Improvement website; www.ihi.org).

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[44] Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD. The Quality in Australian Health Care Study. Med J Aust. 1995;163(9):458-71.

[45]Kohn LT, Corigan J, Donaldson MS, editors. To Err is Human: Building a Safer Health System. Washington: National Academy Press; 2000.

[46] Donaldson L. An organisation with a memory. Clin Med (Lond). 2002;2(5):452-7.

[47] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the Twenty-first Century. Washington: National Academies Press; 2001.

[48] Kennedy I. Learning from Bristol. The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. London: 2001.

[49] Douglas N, Robinson J, Fahy K. Inquiry into obstetric and gynaecological services at King Edward Memorial Hospital 1990 – 2000. Final Report. Perth: Government of Western Australia, 2001

[50] National Mental Health Working Group (2005) National safety priorities in mental health: a national plan for reducing harm, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Commonwealth of Australia, Canberra.

[51] Safety and Quality Partnership Standing Committee meeting 26 February 2021, Item 4.3 Attachment.

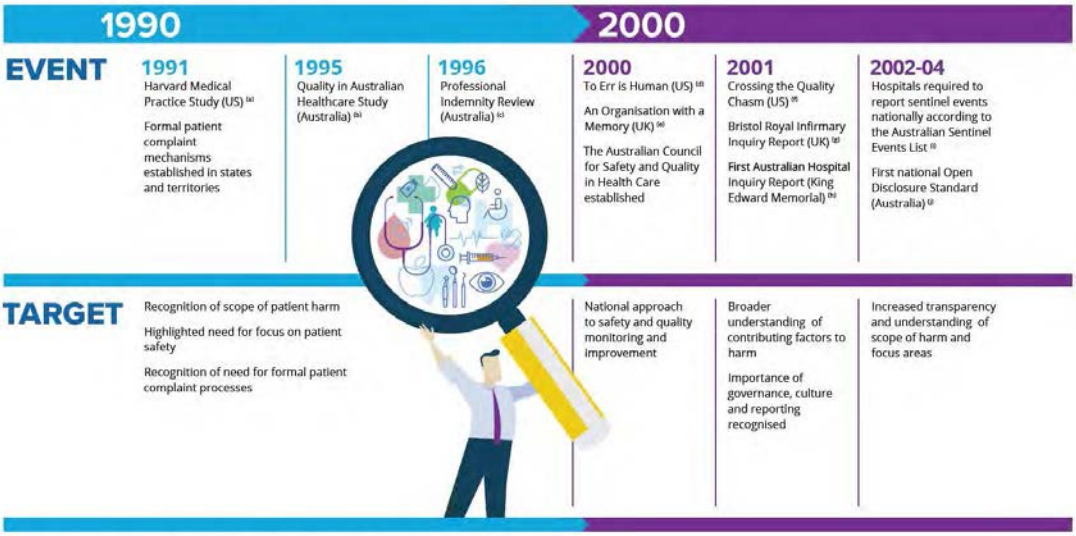
[52] Russell L, Dawda P. Lessons for the Australian healthcare system from the Berwick report. Aust Health Rev. 2014 Feb;38(1):106-8.

Figure 2: Timeline of key developments in Safety and Quality in Health Care in Australia[53]

CTH.0001.7100.0522

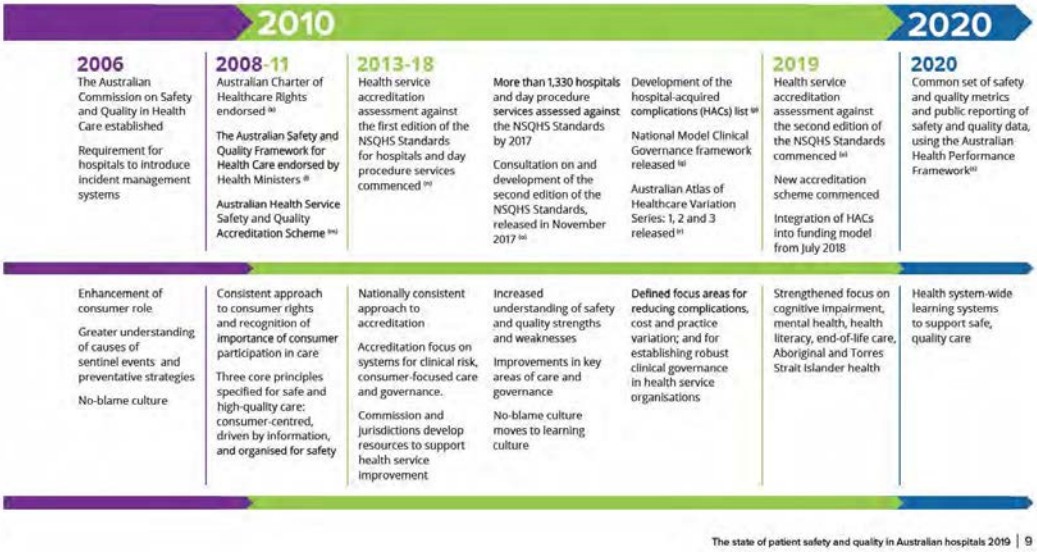
Figure 1: Summary of key developments in safety and quality in health care nationally and internationally

INTERNATIONAL AND NATIONAL SAFETY AND QUALITY MILESTONES



Source: Australian Commission on Safety and Quality in Health Care, 2019.

CTH.0001.7100.0523



The state of patient safety and quality in Australian hospitals 2019 | 9

[53] Australian Commission on Safety and Quality in Health Care. The state of patient safety and quality in Australian hospitals 2019. Sydney; ACSQHC. 2019.

In this Review, it was decided that the Structured Judgement Review[54] approach developed and used widely in the NHS in the UK would be used as the basis for case note review, which was the main method used to determine the level of patient care.

As described by Hollingworth et al, the Structured Judgement Review (SJR) approach:

> *"blends traditional, opinion-based, review methods with a standard format, requiring reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase*. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care."*

Importantly, the approach is not about finding fault, rather it is about learning about care, this is described by Hollingworth as follow:

> "The object of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process."
>
> *"A very important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case and that good care is judged and recorded in the same detail as that care which has been problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from analysis of high-quality care."*

and,

> *"Where care is unsatisfactory the purpose of the review process is not to point to individuals but to ask questions of the system in which people work. Just as importantly, it is also to ask questions about why care goes so well in a complex institution –and what can be learned from this. In order to ask these questions, there is a need to look at the whole range of care, at holistic care approaches and the nuances of case management, as well as at the outcomes of interventions."*

When undertaking the SJR approach, it is important to identify the Phase of Care, each of which is then evaluated. Traditionally, the Phases of Care that are included in a review commence with what occurs either on or before admission, and then cover each aspect through to discharge and post-discharge care and include an overall rating.

In this Review, the components of care identified in the definition of patient care on page 10, where used as the Phases of Care. A template was developed by the Reviewers and this was used to increase objectivity in determining a rating for each aspect that was reviewed for each Phase of Care.

[54] Ibid page 13.

The rating scale for each phase used in this report was as follows:

Phases of care scoring

1. Well below acceptable care–may have led to severe harm(s).
2. Below acceptable care –may have caused moderate or minor harm(s) or led to patient/family distress
3. Satisfactory care
4. Good care
5. Excellent care.

To determine the rating for each aspect of each Phase of Care, the Review referred to all nationally endorsed standards that apply to mental health services and aged care. This included the National Safety and Quality in Healthcare Standards (NSQHS), the National Standards for Mental Health Services (NSMHS), the Aged Care Quality Standards (ACQS) and a range of other standards that may have applied for specific interventions or procedures, for example ECT.

Hollingworth et al, notes that: "For the individual reviewer, scores assist in coming to a rounded judgement on the phase of care". Furthermore, they note "It should be acknowledged when talking about scoring that all review methods are based on opinion and on individual judgement. Research shows that where clinical judgement in case note review is concerned, there is about a 70% agreement between clinicians from the same specialty. Therefore, it is not unusual, when choosing to use pairs of reviewers, for some aspects of scoring on the same case to differ between the two reviewers."

In this Review, the Reviewers held lengthy discussions in relation to the scoring of each Phase of Care for each patient and had a high level of concordance in their scoring.

Any case note review depends critically on the content and the legibility of the entries in case records. In addition, evaluating the safety of care, also depends to some extent on good record keeping. Therefore, as part of the overall assessment of the standard of patient care, this Review also assessed the quality and legibility of the records, again using a 1-to-5 score.

Finally, the Review was aware of the issue of hindsight bias, where the knowledge of a particular outcome of patient care leads to a bias as a direct result of the knowledge of that outcome. To address this issue the Review ensured it took into account, that the case notes only ever record part of the care process, they are never a running commentary of everything that occurs on a particular shift, and that what reviewers know now, was not known by the patients' care team, and is usually not anticipated.

Appendix 3. Role and functions of the Public Guardian.

The statutory role of Public Guardian is established by the *Guardianship and Administration Act 1995*. The following sections of that Act outline the establishment of the role, and the functions and powers of the Public Guardian.

14. Public Guardian and Deputy Public Guardian

Subject to and in accordance with the State Service Act 2000 , persons are to be appointed as the Public Guardian and the Deputy Public Guardian and those persons may hold those offices in conjunction with State Service employment.

15. Functions and powers of Public Guardian

(1) The Public Guardian has the following functions:

(a) to foster the provision of services and facilities for persons with a disability;

(b) to support the establishment of organizations which support any such persons;

(c) to encourage the development of programmes that support any such persons (including advocacy programmes, educational programmes and programmes to encourage persons to act as guardians and administrators);

(d) to promote, speak for and protect the rights and interests of any such persons;

(e) to deal, on behalf of any such persons, with persons or bodies providing services;

(f) to represent any such persons before the Board;

(g) to investigate, report and make recommendations to the Minister on any matter relating to the operation of this Act;

(h) to act as a guardian or administrator when so appointed by the Board;

(i) to disseminate information concerning –
(i) the functions of the Public Guardian; and

(ii) the functions of the Board; and

(iii) the operation of this Act;

(j) to give advice on the powers that may be exercised under this Act relating to persons with a disability as to the operation of this Act generally and on appropriate alternatives to taking action under this Act;

(k) any other function assigned to the Public Guardian by any other Act or law.

(2) The Public Guardian has power to do all things necessary or convenient to be done in connection with the performance of his or her functions.

(3) During any illness or absence of the Public Guardian or during any vacancy in the office of the Public Guardian, the Deputy Public Guardian has the functions of the Public Guardian.

(4) Any function exercised by the Deputy Public Guardian while acting under subsection (3) is taken to have been exercised by the Public Guardian.

(5) The Deputy Public Guardian in exercising the functions of the Public Guardian is taken to have sufficient authority to do so.

(6) In the performance of his or her functions under this Act neither the Public Guardian nor the Deputy Public Guardian is subject to the control or direction of the Minister.

Appendix 4. The Standard of Patient Care provided to Mr A

(This is not to be publicly released without the consent of his enduring guardians and family)

This has been redacted for public release of the report.

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Appendix 5. Personal details of Mr A

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Appendix 6. The possible timeframe to account for the presence of fly larvae in the clothing of Mr A.

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Appendix 6. The possible timeframe to account for the presence of fly larvae in the clothing of Mr A.

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Hobart, Tasmania
December 2020 Daily Weather Observations

Most observations from Battery Point, but cloud, evaporation and sunshine from Hobart Airport.

Australian Government
Bureau of Meteorology

Date	Day	Temps		Rain	Evap	Sun	Max wind gust			9am						3pm					
		Min	Max				Dirn	Spd	Time	Temp	RH	Cld	Dirn	Spd	MSLP	Temp	RH	Cld	Dirn	Spd	MSLP
		°C	°C	mm	mm	hours		km/h	local	°C	%	eighths		km/h	hPa	°C	%	eighths		km/h	hPa
1	Tu	15.7	26.0	0	6.8		NW	93	17:48	20.3	55	7	N	11	997.3	18.2	71	7	WNW	30	992.5
2	We	7.5	18.4	11.0	6.4		W	96	03:53	11.6	50	6	W	31	1008.6	17.3	33	3	S	20	1013.5
3	Th	9.8	20.5	0	7.6		NW	50	14:48	14.4	48	6	NW	28	1016.8	18.1	54	7	WNW	22	1014.6
4	Fr	12.0	19.8	0	4.4		W	63	09:36	14.6	57	7	NW	28	1006.8	18.3	35	4	S	11	1008.0
5	Sa	10.9	21.5	0	8.0		NNW	46	14:51	16.4	58	3	N	17	1003.5	21.4	31	8	NNW	17	993.7
6	Su	11.2	16.6	8.0	5.2		NW	70	12:20	12.1	52	4	WNW	48	985.5	14.5	50	4	N	20	987.0
7	Mo	7.9	17.6	1.4	4.6		WSW	56	16:30	10.5	75	7	NW	17	992.1	15.5	48	6	SSW	9	995.9
8	Tu	7.0	17.6	0	5.0		NW	61	14:20	12.2	55	7	N	15	1008.7	14.9	53	7	NNW	35	1007.1
9	We	12.1	23.2	0	5.2		NW	61	16:58	16.8	55	7	NNW	28	1010.8	20.8	42	3	NNW	24	1008.6
10	Th	8.1	17.6	0.2	8.8		SSW	48	10:56	11.6	50	5	SSW	19	1022.6	15.4	41	5	SSW	17	1024.7
11	Fr	8.6	19.4	0.2	5.4		ESE	46	12:39	13.1	56	7	ESE	7	1031.3	16.1	60	1	ESE	24	1030.7
12	Sa	11.0	20.6	0	5.6		SE	35	15:09	15.0	62	1	N	7	1033.5	19.1	61	1	ESE	22	1029.8
13	Su	12.1	29.0	0	7.2		NE	41	12:07	17.6	55	7	NNW	22	1026.7	28.4	18	7	NNE	24	1021.0
14	Mo	15.2	33.5	0	8.0		N	50	08:19	21.0	49	1	N	24	1016.4	30.0	33	1	E	19	1011.3
15	Tu	20.7	29.4	0	11.0		SE	41	10:35	27.3	34	2	N	17	1008.9	19.0	72	4	SE	24	1012.4
16	We	11.9	15.5	0	8.4		S	31	06:01	13.3	56	7	SE	20	1022.7	14.7	56	7	SE	20	1020.7
17	Th	11.1	16.2	4.8	4.8		SSW	20	11:26	11.8	94	8	E	6	1009.7	15.2	84	7	ENE	9	1004.7
18	Fr	11.8	20.3	6.4	2.2		SW	48	16:16	15.0	81	7	NNE	6	1004.5	17.4	64	6	NW	17	1006.0
19	Sa	10.9	16.8	0.6	3.2		SW	41	08:37	14.5	42	6	SW	20	1017.2	12.2	71	6	SE	17	1018.0
20	Su	10.1	17.2	0.8	3.2		NE	30	17:28	13.0	67	8	SSW	6	1020.0	16.2	56	7	NE	11	1018.0
21	Mo	9.4	19.4	0.2	3.8		ESE	35	13:31	16.6	57	1	NE	9	1015.1	17.5	59	7	SE	22	1011.1
22	Tu	14.0	18.0	0	4.6		SSW	30	08:49	15.8	79	8	SSW	19	1008.0	16.8	89	7	SE	9	1006.8
23	We	13.3	20.3	34.0	1.4		NW	50	12:54	16.9	54	2	NNW	19	1011.6	17.1	69	7	SSW	19	1011.0
24	Th	10.7	18.4	0.8	4.4		WSW	63	12:57	13.9	52	6	NNW	13	1013.9	15.8	47	3	SW	24	1013.2
25	Fr	8.9	17.6	0.4	3.8		SSW	39	11:22	14.6	42	3	SW	15	1022.2	16.0	47	2	ESE	20	1021.3
26	Sa	9.1	23.3	0	5.8		N	46	13:11	15.7	51	2	NNW	15	1020.5	22.2	32	3	N	24	1014.8
27	Su	14.1	26.4	0	7.0		N	80	14:15	19.4	46	6	N	19	1003.6	25.9	36	7	N	37	996.4
28	Mo	7.7	20.9	3.0	6.6		NNW	35	05:50	12.5	53	1	W	2	1009.6	20.2	31	7	WNW	17	1008.9
29	Tu	11.6	22.9	0	4.0		NNW	57	05:08	17.3	49	3	NW	28	1011.7	21.3	43	7	NW	24	1012.1
30	We	10.6	21.4	0	4.8		SSE	48	12:23	16.9	59	5	NNW	15	1018.8	17.9	61	5	SSE	28	1019.4
31	Th	11.2	15.9	0.4	6.6		SSE	33	12:09	12.6	81	8	SSW	20	1026.3	14.7	60	7	SSE	19	1027.8
Statistics for December 2020																					
Mean		11.2	20.7		5.6					15.3	57	5		17	1013.1	18.3	51	5		20	1011.6
Lowest		7.0	15.5		1.4					10.5	34	1	W	2	985.5	12.2	18	1	#	9	987.0
Highest		20.7	33.5	34.0	11.0		W	96		27.3	94	8	WNW	48	1033.5	30.0	89	8	N	37	1030.7
Total				72.2	173.8																

Temperature, humidity, wind, pressure and rainfall observations are from Hobart (Ellerslie Road) {station 094029}. Cloud, evaporation and sunshine observations are from Hobart Airport {station 094008}

Conditions at Hobart Airport may be markedly different to those in the city on some days. Some cloud observations are from automated equipment; these are somewhat different to those made by a human observer and may not appear every day.

Appendix 8: Instrument of Establishment

Department of Health

Tasmanian Government

Tasmanian Health Service Act 2018

Instrument of Establishment - Advisory Panel- Standard of Patient Care – Roy Fagan Centre

I, KATHRINE MORGAN-WICKS, being and as the person appointed as Secretary of the Department of Health, in accordance with Section 13 of the *Tasmanian Health Services Act 2018*, hereby establish an Advisory Panel to provide me, and the Executive, advice on the standard of patient care at the Roy Fagan Centre in the 12 months to 25 December 2020.

The Advisory Panel will consist of two persons:

- Dr Aaron Groves (Chair), Chief Psychiatrist, Department of Health, Tasmania,
- Ms Del Thomson, Clinical Risk Manager, Safety, Quality and Risk Office of the Chief Psychiatrist, South Australia

The advice to be provided to me, and the Executive, by the Advisory Panel, is to be in the form of a report and must include specific findings as to the standard of patient care provided and, where appropriate, recommendations for improvements in the standard of patient care at the Roy Fagan Centre.

The report must include:

1. advice regarding the care of Patient X (as referred to by the Mercury Newspaper reporting of 30 December 2020) leading up to their admission to the Royal Hobart Hospital on Christmas Day;
2. the Safety Learning Reporting Systems incidents that identify patient care issues over the 12 months to 25 December 2020; and
3. any matters that have been the subject of an open disclosure process in the 12 months to 25 December 2020.

The Advisory Panel is to be provide its advice to me, and the Executive, by 15 March 2021.

Dated this 11th day of January 2021

.....

Kathrine Morgan-Wicks

Secretary

Department of Health

Page 1 of 1

ABBREVIATIONS

ADL	Activities of Daily Living
AHREOC	Australian Human Rights and Equal Opportunities Commissions
BPSD	Behaviour and Psychological Symptoms of Dementia
CSP	Clinical Services Profile
CSDD	Cornell Scale for Depression in Dementia
DBMAS	Dementia Behaviour Management Advisory Services
DCRC	Dementia Collaborative Research Centers
ECT	Electroconvulsive Therapy
ED	Emergency Department
EACHD	Extended Aged Care at Home Dementia places
FPOA	Faculty of Psychiatry of Old Age
5th NMHP	Fifth National Mental Health Plan
4th NMHP	Fourth National Mental Health Plan
FTE	Full Time Equivalent
ISP	Individual Service Plan
IDDM	Insulin-dependent diabetes mellitus
MoC	Model of Care
MDT	Multidisciplinary Team
NHPA	National Health Priority Areas
NMHSPF	National Mental Health Services Planning Framework
NHPPD	Nursing hours per patient day
OT	Occupational Therapist
OPMH	Older Persons Mental Health
OPMHS	Older Persons Mental Health Service
PHNs	Primary Health Networks
RACF	Residential Aged Care Facility
RFC	Roy Fagan Centre
RHH	Royal Hobart Hospital
SLRS	Safety Reporting and Learning System
SW	Social Worker
SMHSOP	Specialist Mental Health Services for Older People
SMHS	Statewide and Mental Health Service
THS	Tasmanian Health Service
TRDF	Tasmanian Role Delineation Framework
TOR	Terms of Reference

BIBLIOGRAPHY

A practical guide on how to develop a Model of Care at the Agency for Clinical Innovation 2013, NSW Health, Version 1.0.

A promise to learn – a commitment to act: Improving the safety of patients in England. National Advisory Group on the Safety of Patients in England. 2013.

ACT Chief Minster's Department. Standards for the conduct of inquiries and investigations for ACT agencies. 2004.

Agrell, B & Dehljn, O 1998, *The clock-drawing test*, Age and Ageing; 27: 399-403.

ANMF Policy – Fatigue prevention.

Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD), A Handbook for NSW Health Clinicians 2013, A publication by the NSW Ministry of Health and the Royal Australian and New Zealand College of Psychiatrists.

Australian Institute of Health and Welfare (2012) *Dementia in Australia,* Australian Institute of Health and Welfare, Canberra.

Australian Commission on Safety and Quality in Health Care. The state of patient safety and quality in Australian hospitals 2019. Sydney; ACSQHC. 2019.

Banerjee D, Muralidharan A, Hakim Mohammed A, et al. (June 18, 2020) Neuroimaging in Dementia: A Brief Review. Cureus 12(6).

Brodaty, H., Draper B and Low, L.F. 2003 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery', *Medical Journal of Australia, vol 178 no 5, p 231-234*

Bruno D and Schurmann-Vignaga S 2019, *Addenbrooke's cognitive examination III in the diagnosis of dementia: a critical review*, Neuropsychiatric Disease and Treatment 15 441–447.

Burdekin, B, Guilfoyle, M, Hall, D & Australian Human Rights Commission 1993, *Human rights and mental illness: report of the National Inquiry into the Human Rights of People with Mental Illness*, Australian Govt. Pub. Service, Canberra.

Clinical practice guidelines for dementia in Australia 2016, available via the Australian Clinical Practice Guidelines portal https://www.clinicalguidelines.gov.au.

Day, D. Butterworth, N. Tagat, A. Markowsky, G. and Wallman, J. Development of larvae of the Australian blowfly, *Calliphora augur* (Diptera: Calliphoridae), at constant temperatures.

Death of a Patient Guideline 2020, Statewide Mental Health Services, Tasmanian Health Service.

Dementia: assessment, management and support for people living with dementia and their carers 2018, NICE guideline.

Department of Health – NSW (2006) National Framework for Action on Dementia 2006-2010.

Department of Health - Victoria 2013 *National Practice Standards for the Mental Health Workforce.*

Department of Health and Ageing 2009, *Fourth national mental health plan an agenda for collaborative government action in mental health 2009-2014*, Department of Health and Ageing, Canberra, ACT

Dignity in Care, 2018, Central Adelaide Local Health Network, Department of Health and Wellbeing, Government of South Australia.

Donaldson L. An organisation with a memory. Clin Med (Lond). 2002;2(5):452-7.

Douglas N, Robinson J, Fahy K. Inquiry into obstetric and gynaecological services at King Edward Memorial Hospital 1990 – 2000. Final Report. Perth: Government of Western Australia, 2001.

Edmonds ME & Foster A V M 2006, *ABC of wound healing Diabetic foot ulcers*
British Medical Journal Vol 332.

Eknoyan, D, Hurley, R. and Taber K. The Clock Drawing Test: Common Errors and Functional Neuroanatomy, The Journal of Neuropsychiatry and Clinical Neurosciences. July 2012.

Experimental Estimates of the Prevalence of Elder Abuse in Australian Aged Care Facilities, Research Paper 17 2020, Commonwealth of Australia.

Fillipi, M. et al. EFNS task force: the use of neuroimaging in the diagnosis of dementia. European Journal of Neurology, 2012 19: 1487–1511.

Frontal assessment battery. Saint Vincent's University Hospital MedEl tool.

Groves A, Thomson D, McKellar D and Procter N*. (2017) The Oakden Report.* Adelaide, South Australia: SA Health, Department for Health and Ageing.

Heslop, K, Wynaden, D, Bramanis, K, Connolly, C, Gee T, Griffiths, R & Al Omari O 2012, 'Assessing falls risk in older adult mental health patients: a Western Australian review', International Journal of Mental Health Nursing, vol. 21, iss. 6, pp. 567-75.

Hills, N. Public submission 688, Productivity Commission Inquiry into Mental Health. and *Older Adult Mental Health in Western Australia*. Public submission to the Royal Commission into Aged Care Safety and Quality.

Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. BMJ Quality and Safety 2013.

Hutchinson A, McCooe M & Ryland E. 2015. A guide to safety, quality and mortality case note review using the structured judgement method. Bradford, The Yorkshire and Humber Improvement Academy.

Institute of Medicine. Crossing the Quality Chasm: A New Health System for the Twenty-first Century. Washington: National Academies Press; 2001.

Intake and Admission Protocol 2020, State Mental Health Service, Tasmanian Health Service.

International Best Practice Guidelines: *Wound Management in Diabetic Foot Ulcers*.

Wounds International 2013, Available from: www.woundsinternational.com

Jorm A & Mackinnon 1995, *A Psychogeriatric Assessment Scales User's Guide 4th Edition* (Electronic Distribution) ANUTECH Pty Ltd. Commonwealth Department of Health.

Kennedy I. Learning from Bristol. The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. London: 2001.

Kirkby KC, Ratcliffe E, 'Psychiatry in Tasmania: from old cobwebs to new brooms', Australasian Psychiatry, 9, (2) pp. 128-132.

Kohn LT, Corigan J, Donaldson MS, editors. To Err is Human: Building a Safer Health System. Washington: National Academy Press; 2000.

Malhotra A, White D. 'Obstructive Sleep Apnoea' A Seminar. The Lancet. Vol 360. July 20, 2002.

McKellar, D & Hanson J 2019, *Codesigned framework for organisational culture reform in South Australian older persons' mental health services after the Oakden Report.* Australian Health Review.

McKellar D, Renner D, Gower A, O'Brien S, Stevens A & DiNiro A 2020, *Everyone matters; everyone contributes; everyone grows: a pilot project cultivating psychological safety to promote growth-oriented service culture after the Oakden Report.* Australian Health Review.

Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary.*

Model Of Care, Overview and Guidelines, WA Government (non-dated paper).

National Mental Health Policy 1992, The national mental health strategy, Australian Health Ministers' Conference, Canberra.

National Mental Health Working Group (2005) National safety priorities in mental health: a national plan for reducing harm, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Commonwealth of Australia, Canberra.

Northern Adelaide Local Health Network Older Persons' Mental Health Service Model of Care for service reform and the interim period following the Oakden Report 2017, Government of South Australia, SA Health.

NSW Health 2006 *NSW service plan for specialist mental health services for older people (SMHSOP) 2005-2015*, North Sydney, NSW.

NSW Ministry of Health 2017. NSW Older People's Mental Health Services Service Plan 2017-2027. Sydney NSW.

Open Disclosure Policy 2019, Department of Health, Tasmanian Health Service.

Open Disclosure Protocol 2021, Department of Health, Tasmanian Health Service.

Physical Assessment Protocol 2020, State Mental Health Service, Tasmanian Health Service.

Report of the ACHS EQuIP National Organisation-Wide Survey Tasmanian Health Service – Mental Health Clinical Services 2017, The Australian Council on Healthcare Standards

Review of the Safety and Quality Systems, Leadership and Functions 2016, Central Adelaide Local Health Network.

Royal Australian and New Zealand College of Psychiatrists & New South Wales, Ministry of Health 2013, *Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD): a handbook for NSW health clinicians,* NSW Ministry of Health*, North Ryde.*

Royal Commission into Aged Care Quality and Safety, Interim Report: Neglect 2019, Commonwealth of Australia.

Royal Commission into Aged Care Quality and Safety Final Report: Care, Dignity and Respect. 2021, Commonwealth of Australia.

Russell L, Dawda P. Lessons for the Australian healthcare system from the Berwick report. Aust Health Rev. 2014 Feb;38(1):106-8.

Safe Work Australia, Guide for managing the risk of fatigue at work, November 2013.

Safety and Quality Partnership Standing Committee meeting 26 February 2021, Item 4.3 Attachment.

Searby, A, Maude, P & McGrath, I 2016, 'Prevalence of co-occurring alcohol and other drug use in an Australian older adult mental health service', *International Journal of Mental Health Nursing,* vol. 25, iss. 2, pp. 151–158.

Sharpening Your Teeth. Advanced Investigative Training for Administrative Watchdogs. Ontario Ombudsman, Toronto Canada. 2007.

Snowdon J, Rosengren D, Daniel F & Suyasa M 2010, *Australia's use of the Cornell scale to screen for depression in nursing homes*, Australasian Journal on Ageing, Vol 30 No 1 March 2011, 33–36.

Tartaglia, M. Rosen, H and Miller, B. Neuroimaging in Dementia. Neurotherapeutics: The Journal of the American Society for Experimental Neurotherapeutics Vol. 8, 82-92, January 2011.

The Patient Dignity Inventory, Available at Dignity in Care Australia http://www.dignityincare.com.au/.

Tolman J & Morrissey M 2016, *Dementia care: how we get it wrong and what's needed to get it right* Vol 5 No 1 February/March Australian Journal of Dementia Care.

Undertaking Effective Investigations: A Guide for National Human Rights Institutions. Asia Pacific Forum of National Human Rights Institutions July 2013.

Universal Declaration of Human Rights, 2015, United Nations.

Van Leuven, K 2010, 'Psychotropic medications and falls in older adults', *Journal of Psychosocial Nursing & Mental Health Services*, vol. 48, iss. 9, pp. 35–43.

Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD. The Quality in Australian Health Care Study. Med J Aust. 1995;163(9):458-71.

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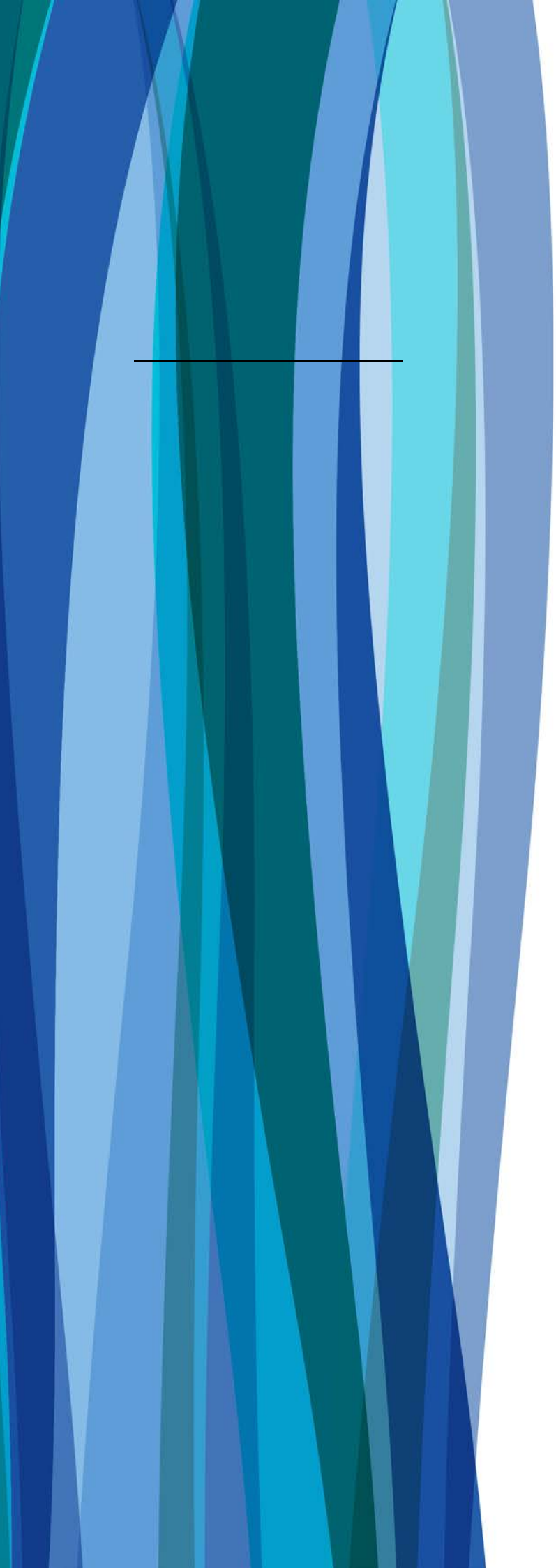

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