Speech By

Aaron Harper

MEMBER FOR THURINGOWA

Record of Proceedings, 18 June 2020

HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Report, Motion to Take Note

Mr HARPER (Thuringowa—ALP) (3.54 pm): I move—

That the House take note of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Report No. 30, 56th Parliament—*Investigation of the closure of the Earle Haven residential aged care facility at Nerang (Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying)* tabled on 28 November 2019.

On 17 July 2019, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee resolved to undertake an investigation into the sudden closure of the Earle Haven residential aged-care facility at Nerang and into the safety and quality of care provided to the former residents at that facility. At the core of this report were 70 aged and vulnerable residents and staff who were sadly caught up in a corporate battle—a contractual dispute between HelpStreet and People Care. The residents, their families and the staff were the real victims of this terrible event. As a result, I have very little to say about one Mr Arthur Miller. The less said about that particular person the better.

The aim of the investigation was to determine what could be done to prevent such an event ever occurring again in Queensland. The committee conducted the investigation as part of our broader inquiry into aged care, end-of-life care, palliative care and voluntary assisted dying. The committee held public hearings on the Gold Coast and in Brisbane, in August and on 20 September 2019. On the committee's behalf, the Clerk of the Parliament engaged Ms Ruth O'Gorman to act as counsel assisting for the investigation. As I noted when I tabled the report, we thank Ms O'Gorman for her professional and considered approach to the investigation into Earle Haven. The report made 12 recommendations for the federal and state governments to implement.

In April 2018, People Care engaged HelpStreet to take over the running of the facility following a series of problems at the facility, which had failed audits by the federal Department of Health and Ageing. HelpStreet organised the removal of stock and equipment from the facility on the morning of 11 July. At approximately 1.30 pm, a HelpStreet staff member called triple 0 and told the operator—

We've just gone into administration and staff have gone home and it's not safe for our residents to be here anymore.

The day before the facility ceased to operate, HelpStreet removed a computer holding residents' care plans and medication records. Those records were used by staff to determine residents' daily care needs and to dispense medications. Staff from Queensland Health and the Queensland Ambulance Service attended the scene. After reviewing the situation, Queensland Health staff determined that residents could no longer be cared for safely at the facility and organised to evacuate the residents to other facilities.

Between 2006 and 2018, People Care had a number of regulatory compliance failures. It failed to meet the expected outcomes for a number of home-care standards in audits conducted by the regulator between 2007 and 2017. On each of those occasions, sanctions were imposed. In those

years, People Care had significant problems in providing a safe level of quality care to residents. In June 2019, the regulator conducted an audit of the facility that revealed that chemical restraint was being used for 71 per cent of the residents and physical restraint was being used for 50 per cent of the residents.

On the morning of 11 July 2019, HelpStreet began removing numerous items from the facility, including mattresses. Mr Bunker, from HelpStreet, informed staff that if they continued to work that afternoon they would not be paid and would not be covered by insurance. At about 1.20 pm, HelpStreet's clinical care coordinator telephoned triple 0 and advised that they had gone into administration. The Queensland Ambulance Service responded, as did the health service. The committee found that, in those circumstances, the decision made to relocate the residents was reasonable and appropriate. Although the situation was distressing for many of the residents, the efforts of the QAS, the Gold Coast HHS personnel and staff members kept the situation calm and under control.

I note the care provided by the member for Gaven and the health minister, who were there within hours of the tragic event unfolding. While the committee undertook its inquiry, as chair I noted that the compassionate and caring roles played by the member and the health minister were on display throughout. What I did also see was the member for Mudgeeraba try to make it political when it was about people in the middle of this crisis.

The committee made several recommendations, and a lot of those were around the federal government making subcontractors equally accountable alongside approved providers for meeting quality and safety standards in the aspects of care that they are subcontracted to deliver.