The Senate

Community Affairs References Committee

Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

Final report

April 2019

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Terms of Reference

(a) the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;

(b) the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;

(c) concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;

(d) the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;

(e) the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;

(f) the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and

(g) any related matters.

Abbreviations

ACFI	Aged Care Funding Instrument
ACI	New South Wales Agency for Clinical Innovation
Aged Care Act	*Aged Care Act 1997* (Cth)
Aged Care Commission	Aged Care Quality and Safety Commission
Aged Care Commission Bill inquiry	Senate Community Affairs Legislation Committee, *Aged Care Quality and Safety Commission Bill 2018 and related Bill*, October 2018
Aged Care Royal Commission	Royal Commission into Aged Care Quality and Safety
Aged Care Taskforce	Aged Care Workforce Strategy Taskforce
A healthier future for all Australians	National Health and Hospitals Reform Commission, *A healthier future for all Australians*, June 2009
AHPRA	Australian Health Practitioner Regulation Agency
AIN	Assistant in Nursing
AMA	Australian Medical Association
A matter of care	Aged Care Workforce Strategy Taskforce, *A matter of care*, June 2018
assessors	Aged Care Commission Assessors
BPSD	Behavioural and psychological symptoms of dementia
Carnell Paterson review	Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes*, October 2017
committee	Senate Community Affairs References Committee
CPSA	Combined Pensioners and Superannuants Association
Department	Department of Health
EN	Enrolled Nurse
GP	General practitioner
Health Care Commission	Australian Commission on Safety and Quality in Health Care
House of Representatives Committee inquiry	House of Representatives Standing Committee on Health, Aged Care and Sport, *Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, October 2018
Interim report	Senate Community Affairs References Committee, *Interim Report: Effectiveness of the Aged Care Quality Assessment and accreditation framework*, 13 February 2018
NDIS	National Disability Insurance Scheme
NDIS Commission	NDIS Quality and Safety Commission
NMBA	Nursing and Midwifery Board of Australia

NRAS	National Registration and Accreditation Scheme
NSQHS Standards	National Safety and Quality Health Service Standards
NSW	New South Wales
Oakden	Oakden Older Persons Mental Health Facility
Oakden report	Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian Government), *Oakden Report – Report of the Oakden Review*, April 2017
PHN	Primary Health Network
QACAG	Quality Aged Care Action Group
Qld	Queensland
QNMU	Queensland Nurses and Midwives' Union
Quality Agency	Australian Aged Care Quality Agency
RACF	Residential aged care facility
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RN	Registered Nurse
SA	South Australia
Single quality framework	Single Aged Care Quality Framework
ToR	Terms of Reference

List of Recommendations

Recommendation 1

5.13 The committee recommends the Australian Government release its consolidated response to all recommendations in key reports made in the past decade to improve aged care service delivery and regulation, and its interaction with the primary health and acute care sectors.

Recommendation 2

5.19 The committee recommends that the Australian Government clarify that residential aged care providers ultimately hold a duty of care to all residents.

Recommendation 3

5.24 The committee recommends that the Australian Government implement a clearly articulated principle that the duty of care for the regulation of all care within the aged care residential setting ultimately rests with the Aged Care Quality and Safety Commission.

Recommendation 4

5.29 The committee recommends the Australian Government establish a body with responsibility for aged care research.

Recommendation 5

5.33 The committee recommends the Australian Government continue work to expand the role of the Aged Care Quality and Safety Commission, in consultation with aged care stakeholders, to drive continuous improvement in levels of quality and safety in aged care.

Recommendation 6

5.38 The committee recommends that the Aged Care Quality and Safety Commission work collaboratively with the Department of Health, the Australian Commission on Safety and Quality in Health Care and aged care stakeholders to develop an industry model of care. This model of care should incorporate a model clinical governance framework which clearly defines the scope of personal and clinical care.

Recommendation 7

5.39 The committee recommends that the requirements for a model of care and clinical governance framework be more clearly articulated within the Single Aged Care Quality Framework, including clearly defined service outcomes expected from those frameworks.

Recommendation 8

5.42 The committee recommends that the Aged Care Quality and Safety Commission work collaboratively with the Department of Health, the Australian Commission on Safety and Quality in Health Care and aged care stakeholders to develop benchmarks for staffing levels and skills mix, which includes the requirement to roster an Registered Nurse on duty at all times, to assist residential aged care providers in staff planning and aged care assessors in regulating safe and appropriate staffing.

Recommendation 9

5.49 The committee recommends the Australian Government take action, as a matter of urgency, to ensure the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector is extended to cover the aged care sector.

Recommendation 10

5.50 The committee recommends the Australian Government investigate, as a matter of urgency, changes to ensure that the use of antipsychotic medications in residential aged care facilities must be approved by the Chief Clinical Advisor of the Aged Care Quality and Safety Commission.

Recommendation 11

5.52 The committee recommends that the Aged Care Quality and Safety Commission develop a regulatory model to oversee medications management in residential aged care facilities.

Recommendation 12

5.56 The committee recommends that the Aged Care Quality and Safety Commission work with the Department of Health and aged care stakeholders to improve the palliative care environment in residential aged care facilities.

Recommendation 13

5.59 The committee recommends that the Aged Care Quality and Safety Commission work with the Department of Health to develop mechanisms to increase the focus on wellness and reablement in residential aged care facilities.

Recommendation 14

5.61 The committee recommends the Department of Health work collaboratively with the Aged Care Quality and Safety Commission, the Australian Commission on Safety and Quality in Health Care, Primary Health Networks, residential aged care providers and medical stakeholders to achieve better integration of the aged care environment with the primary health and acute care sectors.

Chapter 1
Introduction

1.1 This inquiry was initially established in June 2017 in response to incidents of poor quality care and abuse of residents at the Makk and McLeay wards of the Oakden Older Persons Mental Health Facility (Oakden) in South Australia (SA). These two wards were classified as aged care facilities, and were therefore regulated by the Commonwealth aged care regulation frameworks. The inquiry was intended to review the critical care failures at Oakden in relation to the level of accountability that may lie with the Commonwealth aged care regulatory frameworks, which have a responsibility to ensure vulnerable aged Australians receive quality care and are protected from abuse.

1.2 The tragic incidents at Oakden have been used as a spotlight on aged care, and were recently described by the newly appointed Aged Care Quality and Safety Commissioner as 'a shock wave' which sent a 'wake-up call to providers and to consumers but also to the regulators, and that sent people to look at regulation best practice...in a more searching fashion'.[1]

1.3 However the view that the regulator and provider responses to Oakden were swift and searching is not supported by other events. In the nearly two years since the incidents at Oakden became public, much more evidence has come to light of poor care, service provider non-compliance and regulatory failures, and the Australian Government is now undertaking a Royal Commission into aged care due to 'non-compliance and abuses and failures of care'.[2]

1.4 During the course of the inquiry, the Senate Community Affairs References Committee (committee) was presented with compelling evidence which pointed to systemic issues that negatively impact the quality of aged care services, not only at Oakden but throughout Australia. This evidence pointed to failures of care within residential aged care facilities (RACFs) across a range of different areas, from personal and clinical care standards, nutrition and social inclusion, to rehabilitation and palliative care.

1.5 The substandard clinical care provided to residents of Oakden was raised as the key issue of concern in the investigation report of the SA Chief Psychiatrist, *The Oakden Report – The report of the Oakden Review*.[3] The subsequent review

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[1] Ms Janet Anderson, Commissioner, Aged Care Quality and Safety Commission, *Committee Hansard*, 15 February 2019, p. 59.

[2] Alexandra Beech, 'Scott Morrison announces royal commission into aged care'. ABC News, 16 September 2018, https://www.abc.net.au/news/2018-09-16/scott-morrison-announces-royal-commission-into-aged-care-sector/10252850 (accessed 26 February 2019).

[3] Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian Government), *Oakden Report – Report of the Oakden Review* (Oakden report), April 2017.

commissioned at a federal level, the *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson review), found that the issues that resulted in clinical care failures at Oakden were 'failures that any service could be vulnerable to' and that 'Oakden is not unique, because the characteristics and needs of its residents were not unique'.[4]

1.6 Throughout this inquiry, the standard of clinical care provided to people in RACFs stood out as a key issue of concern for the committee, particularly as an area which has lacked sufficient investigation to date.

Interim report

1.7 On 13 February 2018 the committee published an interim report which concentrated on the critical care failures at the Oakden facility, and whether the Commonwealth regulatory environment held any responsibility for those continuing care failures. In its interim report the committee found:

> Services at Oakden included appallingly sub-standard clinical and personal care, as well as abusive practices, some of which have been reported as criminal acts. Evidence of this sub-standard care was noticeable to anyone who cared to pay attention, but it seems that no-one in a position to effect change wanted to pay the required attention.[5]

1.8 The committee also identified a number of concerns that relate to the regulation of quality of care within RACFs across Australia by the Australian Aged Care Quality Agency (Quality Agency).[6] The committee found:

> [M]any of the submitters and witnesses to this inquiry have raised concerns that the oversight and regulation failures, which allowed the poor conditions at Oakden to continue for so long, are not isolated to the specialised type of service delivery at Oakden, and that the same regulatory failures can be seen more widely across the aged care sector... a significant body of evidence has been presented to this inquiry which highlights a broad range of problems with the quality oversight and regulation framework.[7]

1.9 Key issues of national concern that were identified in the interim report include:

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4 Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report* (Carnell Paterson review), October 2017, p. 39.

5 Senate Community Affairs References Committee, *Interim report: Effectiveness of the Aged Care Quality Assessment and accreditation framework* (Interim report), 13 February 2018, p. 66.

6 The Australian Aged Care Quality Agency has since merged with the Aged Care Complaints Commission into a new body, the Aged Care Quality and Safety Commission, which began operation on 1 January 2019.

7 Interim report, p. 51.

- The overall approach to compliance to minimum standards by individual providers does not support sector-wide capacity building or encourage improvements beyond the minimum benchmarks.
- There is not an accreditation process specific to aged care services with specialist elements of mental health or behavioural and psychological symptoms of dementia (BPSD) services.
- There is a clear schism in how the aged care sector defines different levels of aged care services as personal care as opposed to clinical or medical care, and therefore the level of clinical governance required for that care.
- Accreditation auditors do not necessarily have a background in clinical care, and may not be best placed to audit clinical care standards.
- Clinical governance within the aged care sector is significantly less developed than in the health care sector.
- Rates of physical and chemical restraint are too high and these practices are largely unregulated in the aged care sector.
- Workforce pressures impact on care standards, including both a lack of a suitably trained workforce as well as staffing levels within individual RACFs.
- A lack of data on quality of care is a significant barrier to ensuring an appropriate quality framework for aged care services.
- Complaints handling, by individual RACF providers and by the Commonwealth aged care regulatory regime, is done poorly and the adversarial nature does not support open disclosure and industry-wide collaboration and improvement of care standards.

1.10 The committee considers there is one overarching regulatory failure which underpins the above issues: the lack of appropriate regulation of clinical care standards within RACFs.

1.11 Further, the committee's interim report highlighted that a key cause of the lack of appropriate standards of clinical care appears to be a definitional one. There is a fundamental differing of opinion across stakeholders within the delivery of aged care services as to whether RACFs are health care related services, or merely accommodation services where residents may elect to receive (and oversee) their own health services. Views range from seeing the monitoring of clinical care standards as central to the role of the aged care regulators, to viewing aged care as an accommodation service where the provision of clinical care is outside the remit of RACF providers, as it is a professional service matter between a resident and their chosen health professional.

1.12 The committee outlined this conflict in its interim report:

> The committee notes the evidence shows this issue is not isolated to Oakden. The evidence presented to this inquiry shows there is significant conflict within the aged care sector as to the definition of the care being provided, who is responsible for providing appropriate clinical care in

RACFs, and which agencies should have quality oversight responsibility of that care.

The current impasse cannot continue and needs to be resolved.[8]

Recent reports, reviews and reforms

1.13 This inquiry has taken close to two years to come to completion. During that time there has been a significant shake-up in how RACFs operate and are overseen, and aged care has since been placed forefront in the national agenda through the establishment of a Royal Commission.

1.14 As noted in the interim report, the number of recent reviews and inquiries into various aspects of aged care service delivery is a compelling argument that the regulatory system is failing to provide adequate oversight of the aged care sector. However, it is important to assess the likely impacts of the significant reforms undertaken and still underway to establish whether these changes are likely to be successful in resolving ongoing clinical care issues in the RACF sector.

1.15 The findings of these reviews, as well as recent regulatory reforms, are summarised below as they relate to clinical care standards in RACFs.

Reviews of aged care

1.16 A number of recent reviews of aged care have investigated various aspects of aged care service delivery, and each of them has raised concerns with the standards of clinical care in RACFs:

- A 2018 House of Representatives Committee inquiry into RACFs found 'major deficiencies within the aged care sector' and made a number of recommendations to improve clinical care, such as a mandated Registered Nurse on duty at all times, expansion of data captured under indicator programs and new legislation to regulate restrictive practices.[9]
- *The Oakden Report – The report of the Oakden Review* conducted in 2017 by the SA Chief Psychiatrist, Dr Alan Groves, found service and care deficiencies such as an inappropriate model of care, clinical staff deficiencies, governance failures and inappropriate and unlawful use of restrictive practice at Oakden. The report also commented on regulatory oversight processes, finding that there were many practices at the facility 'that no accrediting body would ever endorse, if it was aware of its occurrence'.[10]

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8 Interim report, p. 56.

9 House of Representatives Standing Committee on Health, Aged Care and Sport, *Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, 22 October 2018, pp. xxi–xxiv and 133.

10 Oakden report, p. 78.

- The Carnell Paterson review, published in October 2017, made a number of recommendations regarding the regulation of clinical care in RACFs, including reforms to establish an independent Aged Care Quality and Safety Commission to centralise accreditation, compliance and complaints handling, limit the use of restrictive practices, implement unannounced accreditation visits and strengthen assessment processes.[11]
- The Australian Law Reform Commission's June 2017 report into elder abuse recommended the development of a National Plan to combat elder abuse, establishing a serious incident response scheme for RACFs, regulation of care workers and regulating restrictive practices.[12]

Recent reforms of aged care regulation

1.17 As well as a number of smaller reforms, two key reforms have been put in place to improve the regulation of the RACF sector.

Aged Care Quality and Safety Commission

1.18 As recommended by the Carnell Paterson review, on 1 January 2019 the Aged Care Quality and Safety Commission (Aged Care Commission) replaced the Quality Agency and Aged Care Complaints Commission by bringing these functions together into the Aged Care Commission. Importantly for clinical care standards, the Aged Care Commission includes the newly-established position of Chief Clinical Advisor.

Single Aged Care Quality Framework

1.19 The Single Aged Care Quality Framework (Single quality framework) will come into effect on 1 July 2019 and will become the standards by which RACF services are regulated. Of the eight standards, two are relevant to this inquiry: Standard 3 – Personal care and clinical care, and Standard 8 – Organisational governance.

More reform consultations flagged by Department of Health

1.20 In reviewing the legislation to establish the Aged Care Commission, the Senate Community Affairs Legislation Committee acknowledged that the legislative change to establish the new commission was only the first stage. Many stakeholders recommended the objects and functions of the new commission should be 'expanded beyond the current proposal to merge the existing functions of the Quality Agency and Complaints Commissioner' and that the

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[11] Carnell Paterson review, pp. xi–xiii.

[12] Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, DP 83, 12 December 2016.

Department of Health has indicated a second tranche of consultations will include discussion of 'opportunities for enhancements of the Commission'.[13]

Royal Commission into Aged Care Quality and Safety

1.21 The most significant indication that the Australian Government does not consider the recent reforms to have solved the regulatory concern, is the announcement of the Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) in response to 'a very disturbing trend in what is happening in terms of non-compliance and abuses and failures of care that have been occurring across the sector'.[14]

1.22 The Aged Care Royal Commission will investigate the quality of aged care services and the prevalence of abuse, however the Terms of Reference (ToR) do not articulate whether or not that includes clinical care provided by nurses or allied health professionals within RACFs, and may not cover either access to external health care or how the aged care sector intersects with the primary health and acute care sectors. The ToR have a strong focus on recommendations for improvements to ensure aged care services are sustainable, meet future service challenges, and are flexible and person-centred.

Focus of continued inquiry

1.23 The numerous recent inquiries and reviews described above are important in building a picture of aged care in Australia. However they have not placed an emphasis on the standards of clinical care in RACFs nationally. They have looked at 'care' more broadly to include personal care, or have investigated single critical events.

1.24 The final stage of this inquiry has focussed on the sector-wide standard of clinical care provided to people in RACFs, which remains a key concern for the committee. The ToR for this inquiry include the appropriate role of the Commonwealth aged care regulatory environment to ensure proper clinical standards within RACFs across Australia.

1.25 This final report takes into account the recent regulatory reforms and the ToR for the Aged Care Royal Commission, but notes that the reforms to date have not yet fully addressed the regulatory failures which led to the incidents at Oakden, and which have been shown by evidence to be replicated, at some level, in many RACF locations across Australia.

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[13] Senate Community Affairs Legislative Committee, *Inquiry into the Aged Care Quality and Safety Commission Bill 2018 [Provisions]*, October 2018, pp. 27–28.

[14] Alexandra Beech, 'Scott Morrison announces royal commission into aged care'. ABC News, 16 September 2018, https://www.abc.net.au/news/2018-09-16/scott-morrison-announces-royal-commission-into-aged-care-sector/10252850 (accessed 26 February 2019).

Report outline

1.26 Following this introductory chapter, this report consists of four subsequent chapters:

- chapter two discusses the delivery of clinical care within the residential aged care context, providing an overview of what is clinical care, who delivers clinical care, and who has responsibility for the standards of clinical care;
- chapter three discusses the regulation of clinical care within RACFs in its current form, noting the recent reforms to the regulator and the aged care standards and outlining the continuing concerns of stakeholders;
- chapter four discusses the intersection of aged care with external allied health, primary health and acute care sectors; and
- chapter five contains the committee's concluding comments and recommendations.

1.27 Where external issues relating to the general improvement of clinical care are raised, they will be discussed in terms of what is the regulator's role in this issue. Some high level issues of concern raised within this inquiry that lie outside the scope of the regulatory environment will be flagged for ongoing consideration in other fora.

Conduct of the inquiry

First stage of inquiry

1.28 On 13 June 2017 the Senate referred this inquiry to the committee with a reporting date of 18 February 2018 and the following Terms of Reference:

(a) the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;
(b) the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;
(c) concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other health care or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;
(d) the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;
(e) the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;

(f) the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and

(g) any related matters.[15]

1.29 The inquiry was advertised on the committee's website and the committee wrote to stakeholders inviting them to make submissions, to be lodged by 3 August 2017. Submissions continued to be accepted after this date. The committee agreed that, to protect the privacy of individuals providing sensitive material, all submissions from private individuals would be accepted as confidential, unless requested otherwise.

1.30 The committee held two public hearings, on 21 November 2017 in Adelaide and on 5 February 2018 in Canberra. The committee also held a confidential hearing in Adelaide on 22 November 2017.

1.31 An interim report, discussed earlier in this chapter, was released on 13 February 2018 and on the same day the Senate granted an extension of time for reporting until 28 November 2018. On 28 November 2018, the Senate granted an extension of time for reporting until the last sitting Wednesday in March 2019. On 5 December 2018, the Senate granted an extension of time for reporting until 3 April 2019.

Final stage of inquiry

1.32 On 22 October 2018, the committee called for further submissions by 30 November 2018, and published the following note on the website to clarify the focus of continued inquiry:

> The 13 February 2018 interim report for this inquiry focused on the aged care regulatory failures that contributed to the substandard, and in some cases criminally abusive, aged care provided to residents at the Oakden Older Persons Mental Health Facility in South Australia.
>
> To complement the work of the recently announced Royal Commission into Aged Care and the Carnell Paterson Review of National Aged Care Quality Regulatory Processes, the committee has agreed its continuing inquiry will focus on term of reference a, with an emphasis on the regulation of clinical, medical and allied health care in the aged care context.[16]

1.33 A further hearing was held in Canberra on 15 February 2019.

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[15] *Journals of the Senate*, No. 42, 13 June 2017, pp. 1384–1385.

[16] See: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality

Chapter 2
Delivery of clinical care

2.1 The standard of clinical care within the residential aged care facility (RACF) sector has been a slow-boiling issue of concern in the Australian public for some time. Reports of extreme incidents of poor care have become regular features in the media. However, these are nearly always dismissed by RACF provider groups as outlier events that do not represent the general standard of aged care services.

2.2 The incidents of poor care at the Makk and McLeay wards at the Oakden Older Persons Mental Health Facility (Oakden) in South Australia in 2016, some of which were found to be criminal matters, brought these concerns to a head and were the catalyst for a greater focus on the provision of clinical care services in RACFs and ultimately led to this inquiry.

2.3 This chapter explores recent standards of clinical care in RACFs, who delivers that care and under what kind of service model. These issues are essential to explore and understand before discussing how those clinical services should be regulated, which is the focus of this inquiry.

Clinical care in the aged care context

2.4 There is a clear schism in how different stakeholders view and describe what comprises clinical care across the RACF sector, who delivers clinical care, who is responsible for the standards of clinical care, and how those standards should be regulated.

2.5 The following section will define what comprises clinical care, explore the current clinical environment in RACFs and outline examples of recent standards of care.

What is clinical and medical care?

2.6 The terms clinical care and medical care are often used interchangeably. This inquiry report is using a broadly accepted definition of clinical care as all health care delivered by a health professional.[1] Clinical care includes medical care, which refers specifically to the health care provided by a medical

[1] Many of the health professions relevant to aged care require individual registration with, and ongoing regulation by, the Australian Health Practitioner Regulation Agency (AHPRA). These include medical practitioners, nurses, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists and psychologists. Professions not regulated by AHPRA but which may provide clinical care or assessment in residential aged care facilities (RACFs) can include healthcare workers, social workers, speech pathologists, audiologists and dieticians.

practitioner, often a General Practitioner (GP). It is important to note the Terms of Reference for this inquiry refer to both clinical and medical care.

2.7 The majority of day-to-day clinical care in RACFs is provided by nurses, both Registered Nurses (RNs) and Enrolled Nurses (ENs). The scope of practice for nurses is determined by the Nursing and Midwifery Board of Australia (NMBA), the relevant practitioner board within the Australian Health Practitioner Regulation Agency (AHPRA), and must be adhered to by nurses in order to retain professional registration. The nursing scope of practice, discussed in greater detail later in this chapter, outlines the kinds of clinical care within the aged care context that must be undertaken by a nurse, what can be delegated to a support worker and what, by exclusion, is an unregulated personal care practice.

2.8 In contrast, the difference between clinical care and personal care is not clearly defined in aged care regulatory frameworks, funding agreements or service contracts. However, personal care can be generally defined as any care which is not specifically delineated as clinical care. This issue is discussed in greater detail later in this chapter.

Current clinical environment

2.9 In reviewing the regulation of clinical care within RACFs, it is important to understand the environment in which that clinical care is being delivered. The committee received evidence that RACFs are home to communities of aged people who are frail, have chronic and complex health issues and minimal ability to access mainstream health services, and that these care needs are growing more complex every year.[2]

2.10 In 2016, the majority of people in permanent residential care were rated as having high care needs. Between 2009 and 2016, the proportion of high-care residents with complex health care needs rose from 12 per cent to 61 per cent.[3] Currently, the average Aged Care Funding Instrument (ACFI) subsidy for all age care recipients is 89 per cent of the maximum subsidy, further outlining the complex health care needs of RACF residents.[4]

2.11 The President of the Australian and New Zealand Society for Geriatric Medicine noted that admissions to a RACF are generally triggered by a health

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[2] It is worthwhile to note that the Australian Law Reform Commission made the same comments over 20 years ago in its report 'The coming of age - new aged care legislation for the Commonwealth', [p. 33] https://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC72.pdf

[3] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 5.

[4] Adjunct Professor Kylie Ward, Chief Executive Officer, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 30.

need and that medical conditions, which are often multiple and interacting, are the main reasons for older people moving into aged-care facilities.[5]

2.12 The Australian College of Nursing told the committee that the average person admitted to a RACF has significant high care needs, multiple diagnosed comorbidities and high acuity of conditions with polypharmacy, and requires a level of complex care that can only be delivered under the direct supervision of a RN.[6] The Australian College of Nursing told the committee it would 'be fair to say that older Australians are admitted to aged-care facilities due to necessity, not to choice, and often at relatively short notice'.[7]

2.13 The Australian Medical Association (AMA) has put forward the view that 'the aged care system as a whole, and its workforce, does not have the capacity, capability or systems integration to adequately deal with this growing, ageing population'.[8]

Outcomes of clinical care

2.14 Examples of poor care are often dismissed by RACF provider groups as not representative of the generally high standard of care in RACFs across Australia. The Aged Care Guild submitted that 'critical incidents are largely isolated and reflective of poor leadership and oversight of staff adherence to care standards and existing practices and procedures'.[9]

2.15 However, in recent years these individual incidents have begun to be looked at as a whole, forming a picture of a service sector that is plagued with regular and disturbing incidents of substandard care. The Aged Care Quality and Safety Commission (Aged Care Commission) told the committee:

> As a sentinel event, Oakden was a shock wave right across the sector and right across the community. It was a wake-up call to providers and to consumers but also to the regulators.[10]

2.16 Clinical care is one of the top five areas of non-compliance with the Aged Care Standards found by the Australian Aged Care Quality Agency (Quality

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5 Associate Professor Edward Strivens, President, Australian and New Zealand Society for Geriatric Medicine, *Committee Hansard*, 15 February 2019, p. 10.

6 Australian College of Nursing, *Submission 89*, p. 2.

7 Adjunct Professor Kylie Ward, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 29.

8 Australian Medical Association, *Submission 23 to the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, p. 2.

9 Aged Care Guild, *Submission 15*, [p. 2]. See also Aged and Community Services Australia, *Submission 12*, p. 4, Aged Care Guild, *Submission 15,* [p.1], Bupa, *Submission 18*, p. 3, Benetas, *Submission 61*, [p. 1].

10 Ms Janet Anderson, Commissioner, Aged Care Quality and Safety Commission (Aged Care Commission), *Committee Hansard*, 15 February 2019, p. 59.

Agency), which, as of 1 January 2019, was replaced by the Aged Care Commission. In 2016-17 the Quality Agency made 22 findings of serious risk, and in half those decisions a failure in clinical care was present.[11]

2.17 As well as being one of the top non-compliance matters found by the aged care regulators, clinical care remains the main source of complaints received by the Aged Care Complaints Commissioner.[12] Issues with the quality of clinical care were also raised as core reasons for sanctions imposed against providers managing the Makk and McLeay wards at Oakden.

2.18 The committee heard that care outcomes for RACF residents are worsening. The Brisbane North Primary Health Network (PHN) told the committee what 'we do see in our data is an increasing percentage of presentations at emergency departments by people in residential aged care requiring care'.[13] This experience is replicated across Queensland and in other states. In Queensland overall there was a 17 per cent increase in aged care residents being transported to emergency departments in the year 2016–17[14] and Victoria reported an increase of 25 per cent in similar transfers in 2017.[15]

2.19 The Queensland Nurses and Midwives' Union (QNMU) submitted that the evidence of significant numbers of inappropriate transfers from RACFs to hospitals points to a situation where RACFs lack the staffing and skills to practice effective primary health care and hospital avoidance. QNMU further cited this as an example of cost-shifting from RACFs to the acute care sector.[16]

2.20 A Department of Health (Department) study estimated pressure injuries at a significantly high 26–42 per cent of RACF residents. Within hospital systems, pressure injuries are recognised as an issue of patient safety.[17]

2.21 A national study by Monash University into premature and potentially preventable deaths in RACFs found that 15.2 per cent of all deaths of RACF residents were from external or preventable causes, almost all unintentional. Of those preventable deaths, the study found a very low incidence of death

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[11] Australian Aged Care Quality Agency, *Submission 42*, p. 13.

[12] Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report* (Carnell Paterson review), October 2017, p. 174.

[13] Ms Michele Smith, Executive Manager, Aged and Community Services, Brisbane North Primary Health Network (PHN), *Committee Hansard*, 15 February 2019, p. 39.

[14] Natasha Bita, 'Nursing home residents dumped on hospitals more than 25,000 times', *Courier Mail*, 9 April 2018.

[15] Michael Bachelard, 'Old and sick: The accelerating rate of transfers from nursing homes to hospitals', *The Age*, 9 October 2017.

[16] Queensland Nurses and Midwives' Union, Answers to written Questions on Notice (received 6 March 2019), p. 12.

[17] Combined Pensioners and Superannuants Association, *Submission 57*, pp. 8–9.

from complications of clinical care (1.2 per cent) while dying as a result of a fall was 81.5 per cent and choking 7.9 per cent.[18] As outlined in evidence to the committee, certain clinical care practices around medications mismanagement and restrictive practices can increase the risk of falls.[19]

2.22 The Older Persons Advocacy Network submitted a list of the types of RACF consumer health care issues raised with it.[20]

2.23 Dementia Australia submitted a case study from a family member:

> If Hell exists, this was it. The hallways echoed with moans and outcries from patients, begging nurses to come change them, crying from the humiliation of having to sit in their own muck and faeces for hours on end: "Help me! Please! Can anyone hear me? Please! This is no way to be!" It was horrifying. My mother's hygiene was not attended to by staff and nurses treated her like an inconvenience and a lifeless corpse. They had no respect for her well-being and treated her without dignity.[21]

2.24 These examples can be compared to the statements from the Chief Executive Officer of the Quality Agency in February 2018, that the aged care system provided overall high quality care and the regulatory system was robust:

> We believe that the Australian public can be assured that there are strong networks in government and that the public can feel assured that not only is there appropriate, safe and high-quality aged care but, if there are breaches in that system, that the complaints commissioner, ourselves and the department are all prepared to undertake our respective roles to ensure that any noncompliance or any risk is properly addressed.[22]

2.25 This inquiry will not investigate clinical care standards with a view to proving there are legitimate concerns. The committee understands that, notwithstanding the defences put forward by the RACF sector, it is now a universally accepted truth that a poor standard of care is being experienced by too many RACF residents. The committee points to the Royal Commission into Aged Care Quality and Safety, which was called because of the level of non-compliance with care standards by providers.[23]

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[18] Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, *Submission 29*, pp. 13–14.

[19] Dementia Australia (formerly Alzheimer's Australia), *Submission 20*, [p. 20] and Australian Medical Association, *Submission 23 to the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, p. 12.

[20] This list is included at appendix 3.

[21] Dementia Australia, *Submission 20*, [p. 17].

[22] Mr Nick Ryan, Australian Aged Care Quality Agency, *Committee Hansard*, 5 February 2018, pp. 3–4.

[23] Alexandra Beech, 'Scott Morrison announces royal commission into aged care'. ABC News, 16 September 2018, https://www.abc.net.au/news/2018-09-16/scott-morrison-announces-royal-commission-into-aged-care-sector/10252850 (accessed 26 February 2019).

Missed care

2.26 In addition to reports outlining the declining general health outcomes for RACF residents, a number of studies have recently been conducted to evaluate episodes of 'missed care' in RACFs. These studies attribute the increasing rates of missed care to reduced numbers of nurses as a proportion of the workforce, an issue discussed in greater detail later in this chapter.

2.27 QNMU submitted a definition of missed care alongside the results of an audit conducted to identify members' experiences of missed care episodes:

> Missed care is manifested by the difficult decisions that care staff have to make in understaffed work environments in relation to such things as pressure injury care, falls surveillance, feeding residents, mobility assistance, assisting with activities of daily living and responding in a timely manner to requests for assistance.[24]

Table 2.1 QNMU Missed care audit

Missed care issue	Percentage
Residents waiting longer than they should when they ask for assistance/help	80.49%
Not enough time to complete hygiene cares for residents	68.29%
Residents not being repositioned as often as needed	62.20%
Residents not being mobilised as often as needed	60.98%
Increased falls	57.32%
Not enough time to properly feed residents	57.32%
Not enough time to document care	51.22%
Other response or comment (please specify)	48.78%
No time for shift handover	47.56%
Increased pressure injuries	40.24%
Not enough time to attend/complete wound care	34.15%
Increased skin tears	31.71%
Medications being missed or not given at the right time	26.83%

Source: QNMU, Submission 6.1, p. 9.

2.28 The Australian Nursing and Midwifery Federation also conducted a study on staffing levels in RACFs, which included issues around missed care. The study found that, based on level of acuity and care needs, residents need four hours and 18 minutes of care per day, but the average being provided is 2 hours and

[24] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 9.

50 minutes.[25] The staffing skills mix recommended by this study is discussed in chapter three.

2.29 The AMA also submitted concerns that low staffing levels in RACFs are a cause of missed care.[26]

Committee view

2.30 The committee is highly concerned with the poor standards of clinical care being provided in some RACFs to vulnerable older Australians, who should be treated with respect and dignity. The committee remains sceptical of claims by the RACF sector that these events are outlier events, often the fault of rogue individuals, and do not represent the general standard of care. The committee notes that when these events are collated into a single body of evidence, they form a picture of an RACF service sector with an unacceptably high level of these 'individual' incidents of poor care.

2.31 The committee is highly concerned by evidence from Monash University that 15 per cent of all deaths in RACFs have preventable causes, and of these nearly 90 per cent are from falls and choking, which are associated with poor personal or clinical care. An avoidable-deaths rate of 15 per cent would be cause for outrage in any other care sector, and the aged care context should be no different.

2.32 The committee also notes the establishment of the Royal Commission into Aged Care Quality and Safety, a decision never taken lightly by governments, was in response to concerns with the standards of care being provided in some RACFs. It is now an all too common event that the standard of clinical care in some RACFs is unacceptably low and often does not afford either dignity or health and safety to individual RACF residents.

Aged care: supported accommodation or health care?

2.33 The committee heard differing views on how RACFs should be defined—as either home-like accommodation with support services, institutional care, or subacute health facilities. The different ways that stakeholders defined the type of service that RACFs provide tended to impact how the stakeholder then defined aged care as a health or personal care service, and the corresponding levels of regulation that would be appropriate.

2.34 South Western Sydney Primary Health Network (PHN) attributed much of this confusion to the aged care reforms undertaken in the late 1990s, which involve 'the removal of recognition as health care facilities when hostels and nursing homes were blended to form residential aged care facilities under the

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[25] Australian Nursing and Midwifery Federation, *National Aged Care Staffing and Skills Mix Project*, pp. 8–9.

[26] Australian Medical Association, *Submission 13*, p. 4.

Aged Care Act of 1997'. South Western Sydney PHN stated this has led to a considerable watering down of the regulation of medical, nursing and allied health services in RACFs.[27]

2.35 The Flinders University College of Nursing and Health Sciences submitted similarly that:

> Nursing and nursing care have been taken out of the language of aged care since the 1987 reforms, in a deliberate attempt to reduce costs...As such, non-nurses are providing complex and intensive nursing care and administering medications without adequate training and with very limited supervision.[28]

2.36 The Department's views on aged care appear to have changed. In August 2017, the Department submitted to the inquiry a definition of RACFs which omitted any reference to clinical care outside of providing 'access' to allied health services:

> Residential care provides care and accommodation to older people who are unable to continue living independently at home. The services provided through residential care include personal care services (help with the activities of daily living such as dressing, eating and bathing); accommodation; support services (cleaning, laundry and meals); and access to some allied health services, such as physiotherapy. For people who need almost complete assistance with most activities of daily living, residential care can provide 24-hour care.[29]

2.37 The Department later submitted to the committee a definition of RACF services in March 2019, which stated:

> Residential aged care facilities deliver a range of care and services including personal and clinical care, as well as services and supports for daily living.[30]

2.38 However, some RACF peak bodies and providers have submitted they are not responsible for any direct provision of clinical services.[31] This position is outlined in greater detail in the later section on responsibility for clinical care.

2.39 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) told the committee that although RACFs are intended to be a person's home

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[27] South Western Sydney PHN, *Submission 84*, p. 4. Reforms through the 1980s to 1990s sought to de-institutionalise aged care and emphasised values such as privacy, dignity, choice, individuality and a home-like environment. See Australian Institute of Health and Welfare, *Australia's Welfare 2001*, 23 November 2001, p. 114.

[28] Flinders University College of Nursing and Health Sciences, *Submission 102*, p. 7.

[29] Department of Health, *Submission 37*, p. 21.

[30] Department of Health, Answers to written Questions on Notice, and answers to Questions taken on Notice during 15 February public hearing, (received 18 March 2019), [p. 8].

[31] See for example HammondCare, *Submission 11*, p. 4 and Aged and Community Services Australia, *Submission 12*, p. 5.

under the *Aged Care Act 1997*, 'you can't get around the fact that there are staff who are employed by often a large organisation whose responsibility it is to run the home and to ensure that the home meets certain standards'.[32]

2.40 The Australian Commission on Safety and Quality in Health Care (Health Care Commission) told the committee that in its view, RACFs are institutional care where the provider has ultimate responsibility for all care being provided:

> There's no question about it. It's a home that's shared with many other people, so therefore it's a home that's provided in an institutional setting. Most people that are there are there because they can't look after themselves at home. So essentially aged-care facilities provide an institutional form of care.[33]

2.41 QNMU provided a similar view to the Health Care Commission that positioned RACF services as an institutional model, and submitted that '[u]nder any plausible definition of the term, a residential aged care provider…is a health service provider within the context of aged care'.[34]

2.42 Dementia Australia concurred with the view that defining RACFs as 'home-like' does not have to come at the expense of appropriate care quality standards, such as clinical governance. Dementia Australian further told the committee:

> I don't know whether you've been to a lot of residential aged care facilities... but I have never seen one where I would walk into and go, 'Oh gee, this feels like home'![35]

2.43 QNMU stated that defining RACFs as a resident's home does not negate RACF provider responsibilities to deliver quality clinical care and told the committee:

> ...we've heard providers claim many times that a residential facility is a home and not a hospital or some other kind of facility... But the physical and welcoming environment is irrelevant to the standard of health care that is required for that person...While it is important that aged-care providers make their facilities as homely as possible, it does not abrogate their duty to provide safe, high-quality care in doing so.[36]

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[32] Associate Professor Stephen Macfarlane, Chair, Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard,* 15 February 2019, p. 27.

[33] Adjunct Professor Debora Picone, Chief Executive Officer, Australian Commission on Safety and Quality in Health Care (Health Care Commission), *Committee Hansard,* 15 February 2019, p. 47.

[34] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 5.

[35] Dr Kaele Stokes, Executive Director Consumer Engagement, Policy and Research, Dementia Australia, *Committee Hansard*, 15 February 2019, pp. 22 and 27.

[36] Mr Daniel Prentice, Professional Research Officer, Queensland Nurses and Midwives' Union, *Committee Hansard*, 15 February 2019, p. 30.

2.44 The New South Wales (NSW) Nurses and Midwives Association went further and told the committee that the low standards of personal care and nursing did not meet a definition of 'home':

> [T]he definition of 'home' is talked about in terms of it being a place of safety and happiness... In January we surveyed over 1,600 of our members. Poor staffing and skills mix of all levels of work meant 73 per cent had not had time to sit and talk with someone who was lonely in the past week, around half knew someone had missed a bath because they didn't have time to assist them, 44 per cent knew someone had missed wound care and 37 per cent knew someone had been left in pain too long... These are factors that impact on whether a place feels like home or not—whether, as the definition suggests, they're places of safety and happiness.[37]

2.45 The Australian College of Nursing told the committee:

> ... the conditions we see in residents now illustrate quite clearly that aged care is health care. What we see with most aged-care facilities now is that, if they weren't called aged-care facilities, they'd be classed as subacute and non-acute hospitals, which means aged-care providers are, for all intents and purposes of what they do, healthcare providers.[38]

2.46 QNMU submitted that RACFs are increasingly being used as hospices for frail older persons with complex care needs and are arguably 'more appropriately sub-acute, non-acute care facilities, being often little different in terms of the intensity of care to that provided in a Geriatric Evaluation and Management Unit in a hospital but without the specialist clinical and multidisciplinary features of this approach'.[39]

2.47 The Aged Care Guild, a RACF provider body, told the committee there is a lack of a clear definition and goal for residential aged care and stated:

> …we haven't defined what we want out of residential aged care. As you said earlier, it is someone's home. It used to be somewhere where you would live and get the level of support you needed to continue to live in that environment with independence. But increasingly it's being looked at as an opportunity to put people who are highly complex somewhere because there are blockages elsewhere in the system. Whether it's young people with disability or whether it's people with subacute needs where there are gaps, aged care does take this role quite a lot, and that's challenging. So we've got to be able to say what the role is.[40]

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[37] Mrs Helen Macukewicz, Professional Officer, New South Wales (NSW) Nurses and Midwives' Association, *Committee Hansard*, 15 February 2019, p. 28.

[38] Adjunct Professor Kylie Ward, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 29.

[39] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 5.

[40] Mr Matthew Richter, Chief Executive Officer, Aged Care Guild, *Committee Hansard*, 15 February 2019, pp. 5–6.

2.48 The issue of appropriate service definitions was raised as a key cause of substandard clinical services at Oakden. In the review report, *Oakden Report – Report of the Oakden Review* (Oakden report), the SA Chief Psychiatrist found that the lack of an endorsed model of care 'led to a resultant further decline in services'.[41]

2.49 The lack of an appropriate model of care being in place for most RACFs is a key factor in poor clinical care standards and is discussed later in this chapter.

What are RACFs funded to provide?

2.50 Prior to admission to a RACF all residents have been assessed by an approved, clinically trained health professional as having a frailty or disability requiring continuing personal care, taking into account their medical, physical, psychological and social circumstances.[42] The *My Aged Care Assessment Manual* defines RACF services as 'Permanent Residential Care which incorporates, personal care, nursing care, or both, that is provided to a client in a residential facility in which they are also provided with accommodation'.[43] It should be noted that in disability services, accommodation providers are banned from also being service providers due to conflict of interest issues for residents. This issue is explored in chapter three.

2.51 Following admission, the RACF provider conducts an appraisal using the Aged Care Funding Instrument (ACFI) to determine the level of care to be provided to meet the resident's needs and establish the level of the Australian Government subsidy.[44]

2.52 The Combined Pensioners and Superannuants Association submitted that despite RACFs receiving funding under the ACFI for residents with high care needs, many RACFs do not provide fulltime access to a RN to deliver this care.[45] The AMA concurred with this view and submitted that RNs are being increasingly replaced with personal care workers/Assistants in Nursing (AINs) and some RACFs do not have nurses staffed after hours.[46]

2.53 South Western Sydney PHN submitted:

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41 Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian Government), *Oakden Report – Report of the Oakden Review* (Oakden report), April 2017, p. 30.

42 Department of Health, Answers to written Questions on Notice, and answers to Questions taken on Notice during 15 February public hearing (received 18 March 2019), and Approval of Care Recipients Principles 2014.

43 Department of Health, *My Aged Care Assessment Manual,* p. 79.

44 Department of Health, *My Aged Care Assessment Manual,* p. 79.

45 Combined Pensioners and Superannuants Association, *Submission 57*, p. 10.

46 Australian Medical Association, *Submission 13*, p. 4. See also Australian College of Nursing, *Submission 89*, p. 2.

> Facilities receive funding through the Aged Care Funding Instrument (ACFI) to provide nursing care and assessment, planning and treatment by qualified allied health professionals. But, we are witnessing the reduction in numbers of Registered Nurses working in RACF's and an increase in assistants in nursing and instances of untrained "aids" e.g. a "physio aid" being substituted for a qualified allied health professional.[47]

2.54 Discussion on the suitability of the ACFI funding model and the overall levels of funding for aged care and its impact on clinical care standards is contained in chapter three.

Committee view

2.55 RACFs lack a clear and consistent definition of whether or not they are, or at least include, health services. This lack of operational definition impacts all subsequent decision making on how the services should operate, be managed, be staffed and importantly, how they should be regulated, which is the focus of this inquiry.

2.56 It is quite clear to the committee that, at minimum, RACF operators are paid to provide clinical health services in addition to other personal care services, to a cohort of people with high acuity, complex health needs and minimal to nil capacity for independent management of their needs.

2.57 The committee gives weight to the view that these definitional problems had their inception in the reforms undertaken with the merger of aged care hostels, places of minimal support for residents with a large capacity for independence, with nursing homes, designed for people with no capacity for independent living. The laudable move to make nursing homes appear more homelike and less starkly clinical has had the unintended consequence of making nursing homes perform with less clinical rigour, with a reduction in overall clinical care standards, governance and regulation.

Responsibility for clinical care standards

2.58 A key theme throughout this inquiry has been the differing views from RACF providers, clinicians and regulators on what comprises clinical care within the aged care context, and who should be responsible for meeting those standards.

2.59 HammondCare, a RACF provider, did not address the issue of clinical care in its submission and instead focused on the provision of medical care. HammondCare submitted that RACFs are only responsible to assist residents in accessing the services of medical practitioners as required and therefore this was not an issue for the aged care regulator to assess.[48] In contrast, the AMA cited difficulties faced by GPs in seeing patients who are residents of RACFs, and argued that access to medical care should be an explicit regulated

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47 South Western Sydney PHN, *Submission 84*, p. 4.

48 HammondCare, *Submission 11*, p. 4.

standard.[49] Access to medical care is discussed in greater detail later in this chapter.

2.60 HammondCare did submit that RACF providers provide nursing services, but made no comment on whether they consider this to be clinical care, or how that clinical care should be regulated. In response to the premise that clinical care is only provided by external health practitioners and not by nursing staff of RACFs, QNMU told the committee that:

> ...we hear, many times, aged-care providers and their advisers claiming that nurses do not provide clinical care; that such care comes largely from general practitioners and allied health. In our view, it is a nonsense to suggest that nurses do not provide clinical care or, indeed, that residents do not need nursing care and highly skilled nursing practice.[50]

2.61 QNMU pointed to the Fair Work Commission Nurses Award 2010 which all private sector RACF providers must comply with, which described the work of a nurse as 'delivering direct and comprehensive nursing care, and coordinating services, including those of other disciplines or agencies, to individual patients, residents or clients'.[51]

2.62 QNMU further noted enterprise bargaining agreements which describe the nursing role in aged care includes responsibility to 'monitor outcomes of clinical practice; possess advanced clinical level skills; provide nursing care within the scope of clinical practice; and provide expert clinical advice relating to complex care issues'.[52]

2.63 Aged and Community Services Australia, a RACF provider peak body, submitted what appeared to be a view that changed during the course of this inquiry. In August 2017, it submitted that the aged care quality assurance framework should 'focus on the quality of aged care provided rather than the professional standards of individual medical and nursing staff which are covered by other mechanisms'.[53] Aged and Community Services Australia did not submit why it considers the quality of aged care not to incorporate the clinical care services RACFs are paid for under the ACFI. However in March 2019, it submitted that aged care regulators do in fact regulate clinical care and 'have clear powers in relation to approved providers who do not meet the

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[49] Australian Medical Association, *Submission 13*, p. 3.

[50] Mr Daniel Prentice, Queensland Nurses and Midwives' Union, *Committee Hansard*, 15 February 2019, p. 30.

[51] Mr Daniel Prentice, Queensland Nurses and Midwives' Union, *Committee Hansard*, 15 February 2019, p. 30.

[52] Mr Daniel Prentice, Queensland Nurses and Midwives' Union, *Committee Hansard*, 15 February 2019, p. 30.

[53] Aged and Community Services Australia, *Submission 12*, p. 5.

expected outcomes' of clinical care as outlined in the existing Accreditation Standards and incoming Aged Care Quality Standards.[54]

2.64 The position put forward by some RACF providers, that clinical care standards are a matter of individual professional performance, does not acknowledge that where an AHPRA investigation finds that if the organisational environment has contributed to the substandard clinical care of an individual health practitioner, it is standard practice for AHPRA to refer that issue to the relevant regulator for investigation of systemic issues.[55] In the case of aged care, that would be the Aged Care Commission, formerly the Quality Agency.

2.65 The position that AHPRA is the suitable regulator of clinical care in RACFs on the basis of individual professional standards does not acknowledge the requirement in the existing, and soon to be implemented new standards, that RACF providers have a responsibility to ensure compliance with those professional standards.[56] Chapter three includes discussion on how this responsibility is regulated.

2.66 Allied Health Professions Australia submitted that while the regulators of individual health professionals determine core competency standards and set out codes of conduct, 'they do not monitor practice, are agnostic to where individuals are employed and do nothing about individual practice until something goes wrong and a formal complaint is made. It is not in their remit to undertake quality auditing'.[57]

2.67 Allied Health Professions Australia told the committee that responsibility for standards of care lie with both the individual practitioner and the workplace environment to provide 'a system of clinical governance that assures there is continual monitoring of care quality and focuses on a system of support and continual improvement of staff'. Allied Health Professions Australia went on to state that the current regulation of individual practitioners and the accreditation of RACFs was not enough to ensure standards of care on a day-to-day basis. Allied Health Professions Australia outlined a need to be more prescriptive of minimum levels of access to care, citing this aligns with recommendations of the 2018 report of the Aged Care Workforce Strategy Taskforce (Aged Care Taskforce), *A matter of care*.[58]

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[54] Aged and Community Services Australia, Answers to written Questions on Notice (received 12 March 2019), p. 2.

[55] Australian Health Practitioner Regulation Agency, *Annual Report 2016/17*, p. 2.

[56] Leading Age Services Australia, Answers to written Questions on Notice (received 6 March 2019), p. 3.

[57] Allied Health Professions Australia, *Submission 90.1*, p. 6.

[58] Ms Claire Hewat, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 15 February 2019, p. 10.

2.68 The Older Persons Advocacy Network noted the important role the Quality Agency played in monitoring clinical care as it is often only the quality assessors who pick up gaps in care communication such as when there has not been clinical communication of the care plan to the care team.[59] The Older Persons Advocacy Network further pointed to supporting material for the new Aged Care Quality Standards which state:

> Health professionals, such as doctors, nurses and pharmacists provide clinical care. Organisations providing clinical care are expected to make sure it's best practice, meets the consumer's needs, and optimises the consumer's health and well-being.[60]

2.69 The Healthcare Commission was very clear in expressing its views and told the committee:

> ...like a hospital, a school or any other institution, an aged-care facility has duties of care to all of its residents, so the person in particular is owed a duty of care if it's someone who is very vulnerable or dependent and they need to be protected within that institutional care setting.[61]

2.70 QNMU pointed out that the Quality of Care Principles require RACF providers to ensure there are sufficient human resources to meet the residents' needs.[62] QNMU further submitted that although the existing Quality of Care Principals articulate that providers must have systems in place to ensure compliance with professional standards and guidelines, this requirement is now absent from the principles of the Single Aged Care Quality Framework (Single quality framework) and has been relegated to the Aged Care Standards Guidance Material.[63]

2.71 The Aged Care Commission provided a number of very clear responses to the committee on its position regarding responsibility for clinical care standards:

> The Commission considers residential aged care facilities to be services which deliver clinical care.
>
> Nurses (registered and enrolled) provide clinical care in residential aged care facilities, alongside medical practitioners and allied health practitioners.

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[59] Mr Craig Gear, Chief Executive Officer, Older Persons Advocacy Network, *Committee Hansard*, 15 February 2019, p. 48.

[60] Older Persons Advocacy Network, *Submission 23.1*, [p. 2].

[61] Adjunct Professor Debora Picone, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 47.

[62] Queensland Nurses and Midwives' Union, *Submission 6*, p. 6.

[63] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 17. The existing aged care Accreditation Standards and Quality of Care Principles will be replaced by the Single Aged Care Quality Framework as of 1 July 2019. These standards are discussed in greater detail in chapter three.

> The approved provider is responsible for care standards, and the quality and safety of the care provided to consumers at the residential service.
>
> The approved provider is responsible for supporting the safe practice of its individual staff.[64]

Committee view

2.72 There appears to have been greater focus placed on the clinical aspects of aged care since the critical clinical care failures that occurred at Oakden. During the course of this nearly two year inquiry, evidence suggests the attitude of RACF providers has changed, and there is now nominal acceptance that aged care does in fact include aspects of clinical care. It is disturbing that a recent view was held by some RACF providers that they held no responsibility for clinical care standards, even though this responsibility was included in the accreditation standards they were assessed by, and were supposed to be operating under.

2.73 Despite some progress, there still remains disagreement on definitional issues of clinical care. The RACF sector is clearly in need of more explicit guidance material on what comprises clinical care and who is responsible for the different aspects of clinical care standards.

RACF model of care

2.74 As outlined earlier in this chapter, the lack of an appropriate model of care was a key concern of the Oakden report, which found that this contributed to the substandard clinical services.

2.75 The Oakden report provided a definition of a model of care as:

> …Model of Care is defined as the way that health services are delivered, drawing on best practice care and services for a person, population group or patient cohort as they progress through the stages of managing a healthcare condition. A Model of Care articulates how people can access the right care, at the right time, from the right team in the right place.[65]

2.76 Throughout this inquiry, the committee received evidence from a range of expert witnesses and submitters on the model of care under which RACFs deliver personal and clinical care. Submitters raised particular concerns that there is no industry standard model of care, and many RACFs operate without a clearly defined individual model of care.[66] The informal model of care the industry operated under was referred to as a 'delegated model of care' and is described further below.

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[64] Aged Care Commission, Answers to written Questions on Notice (received 6 March 2019), pp. 1–4.

[65] Oakden report, p. 27.

[66] See for example Older Persons Advocacy Network, *Submission 23.1*, [p. 4], Australian Association of Gerontology, *Submission 82*, p. 2, Royal Australian College of General Practitioners, *Submission 95*, [p. 2].

2.77 Dementia Australia told the committee that work needs to be done to more clearly define the difference between personal care and clinical care and define who is responsible for which aspects.[67] The Office of the Public Guardian Queensland (Qld) supported this view and submitted that an appropriate model of care needs to be developed for persons with dementia, aimed at managing challenging behaviour and based on ensuring dignity and respect.[68]

2.78 The Older Persons Advocacy Network raised similar concerns and outlined the critical need for very clear guidelines to delineate where clinical care starts and finishes, as the delegated model of care involves a workforce with limited or indirect supervision from registered clinical professionals. The Older Persons Advocacy Network noted this care model also heightened the need for good clinical governance.[69]

2.79 Aged Care Services Australia, a peak body for RACF providers, told the committee that '[m]any approved providers across the sector would have in place clinical frameworks, these would range from those developed in-house through to the adoption of models based on nationally developed principles'.[70]

2.80 Bupa is one such provider which has established its own Bupa Model of Care, which comprehensively outlines delivery of care through a multidisciplinary team.[71] It must be noted however, that despite having an established model of care, Bupa has experienced a significant care deficit with 9 of its RACFs being sanctioned within a 12-month period for failing to meet compliance standards, with some identified as a 'severe risk to the health, safety and wellbeing of care recipients'.[72]

2.81 Occupational Therapy Australia identified problems with the model of care in relation to allied health professionals, citing that it is usual practice for RACFs to outsource allied health services and then confine those people to very limited roles. This severely restricts their capacity to be involved in critical preventative health issues such as environmental assessment and intervention,

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[67] Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 18. This recommendation was also made by Mr Keith McDonald, Chief Executive Officer, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 37.

[68] Office of the Public Guardian Queensland, *Submission 68*, p. 7.

[69] Mr Craig Gear, Older Persons Advocacy Network, *Committee Hansard*, 15 February 2019, p. 48.

[70] Aged and Community Services Australia, Answers to written Questions on Notice (received 12 March 2019), p. 2.

[71] Bupa, *Submission 18*, pp. 5 and 14–15.

[72] Claire Wheaton, 'Bupa's ninth aged care home sanctioned in 12 months over "severe risk" to residents', *ABC News Online*, 12 January 2019, https://www.abc.net.au/news/2019-01-12/bupas-ninth-aged-care-home-sanctioned-in-12-months/10647436, (accessed 20 March 2019).

falls management and the non-pharmacological treatment of behavioural and psychological symptoms of dementia (BPSD).[73]

2.82 Allied Health Professions Australia recommended that aged care reforms should include work to identify best practice models of care for different facilities and patient cohorts, and identify the necessary roles and staffing needed to support the needs of those residents.[74]

Informal model of delegated care

2.83 Submitters and witnesses described to the committee how day-to-day personal and clinical nursing care is delivered to RACF residents. The model was often referred to as a 'delegated model' where a registered health practitioner, generally a RN, assessed the personal and clinical care needs of the resident, determined the level of skill required to meet those needs, and delegated appropriate aspects of personal and/or clinical care to other health practitioners or to AINs.[75]

2.84 The Australian Nursing and Midwifery Federation noted that decisions about whether the personal care should be provided by a nurse or another level of worker can only be made by the RN, and must be consistent with the Nursing and Midwifery Board of Australia (NMBA) Decision Making Frameworks.[76] Decisions must be based on the characteristics of the person requiring care, the activities to be performed, and the competence, education and authority for practice of the person providing the care. The NMBA further defines work that AINs are authorised to provide as 'routine client-specific activities requiring a narrow range of skill and knowledge'.[77]

2.85 QNMU made similar observations about the requirement for RNs to evaluate the difference between clinical and personal care and noted that, under the *Health Practitioner Regulation National Law Act 2009*, only a RN is authorised to determine a resident's nursing needs, and therefore by exclusion their personal care needs. QNMU noted that the clinical assessment and care delegation by a RN is essential to ensure that the AIN does not provide care they are not qualified to perform. QNMU further noted that it is a mandated requirement by the NMBA that the RN must evaluate the outcome of the delegated episode

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73 Occupational Therapy Australia, *Submission 39.1*, p. 4.

74 Allied Health Professions Australia, *Submission 90.1*, p. 5.

75 Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 16–18, Australian College of Nursing, *Submission 89*, pp. 2–3.

76 Australian Nursing and Midwifery Federation, *Role boundaries in the provision of personal care*, February 2018, p. 1.

77 Nursing and Midwifery Board of Australia, *A national framework for the development of decision-making tools for nursing and midwifery practice, February 2018*, p. 18.

of care.[78] The Australian College of Nursing submitted that changes in NSW to remove the requirement for a RN to be present in an RACF at all time, is incompatible with nursing registration requirements that ENs and AINs are supposed to work under the direction of a RN.[79]

2.86 QNMU noted that the delegation model is a result of not enough nurses being employed to undertake the personal and clinical care requirements of RACF residents, and to address this 'aged care providers employ unregulated healthcare workers…to assist the RN'. QNMU further noted that the limited numbers of nursing staff 'forces RNs into a situation where they are prevented from complying with their statutory duties' such as evaluating the outcomes of delegated care performed by an AIN.[80]

2.87 The Older Persons Advocacy Network raised concerns with the delegation model, submitting that the majority of care in RACFs is now undertaken by 'a large, unstructured workforce of personal carers and AINs who provide direct care with no regulatory safeguards or accountability'. The Older Persons Advocacy Network has recommended the model of care should include formal supervision arrangements for these staff.[81] Discussion on the possible regulation of non-clinical staff is included in chapter three.

2.88 The Quality Aged Care Action Group (QACAG) submitted its concern with the recommendations of the Aged Care Taskforce, which promotes the role of a care manager who does not need to be a RN. QACAG pointed out that RNs cannot receive clinical supervision from a person who is not also a RN, and questioned whether a person who is not clinically trained can provide effective supervision, particularly in the areas of medication management.[82]

2.89 The issue of nursing ratios and the regulation of AINs is discussed in greater detail in chapter 3.

Clinical governance

2.90 Clinical governance is an essential component of a model of care. The Department defines clinical governance as 'a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes'.[83] The

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78 Queensland Nurses and Midwives' Union, *Submission 6*, pp. 7–8.

79 Australian College of Nursing, *Submission 89*, p. 2.

80 Queensland Nurses and Midwives' Union, *Submission 6.1*, pp. 6–9.

81 Older Persons Advocacy Network, *Submission 23.1*, [p. 6].

82 Quality Aged Care Action Group, *Submission 72.1*, p. 5.

83 Department of Health, Evaluation of the GP Super Clinics Program 2007–2008, http://www.health.gov.au/internet/publications/publishing.nsf/Content/GPSuperClinicsEvaluation-toc~discussion~progresstowardsachieving~multidisciplinarycare (accessed 6 March 2019).

Health Care Commission defined it as 'the set of relationships and responsibilities established by a health service provider, the governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes'.[84]

2.91 Many submitters and witnesses raised concerns with the lack of appropriate clinical governance in RACFs and the impact this is having on clinical standards.[85]

2.92 The Australian College of Nursing submitted that clinical governance is 'vital to ensuring clinical care is safe, effective, appropriate and person-centred' but while clinical governance frameworks are well established in the healthcare system 'there is no agreed clinical governance framework for aged care providers in Australia from ACN's understanding'.[86]

2.93 Professor Edward Strivens of the Australian and New Zealand Society for Geriatric Medicine noted that 'clinical governance is embedded in absolutely everything we do' in a health setting.[87]

2.94 QNMU told the committee that the lack of focus on clinical governance in RACFs could be attributed to the fundamental lack of recognition about RACFs being healthcare environments.[88] QNMU further submitted that the lack of clinical governance results in a system that is set up to fail because stakeholders fail to recognise the clinical risks.[89]

2.95 The Aged Care Commission presented evidence that clinical governance is an issue that is covered in the existing Accreditation Standards, and this requirement has been further strengthened in the incoming Single quality framework. These standards, and how they are regulated, are discussed in chapter three.

2.96 The Older Persons Advocacy Network pointed to the clinical governance frameworks developed by the Health Care Commission, and recommended the Aged Care Commission and its Chief Clinical Advisor undertake work to develop a similar national model for the RACF sector.[90] This work has since

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84 Health Care Commission, *National Model Clinical Governance Framework*, p. iii.

85 See for example South Western Sydney PHN, *Submission 84*, p. 4, Australian College of Nurse Practitioners, *Submission 92*, [p. 2], Victorian Department of Health and Human Services, *Submission 9*, p. 2.

86 Australian College of Nursing, *Submission 89*, p. 5.

87 Associate Professor Edward Strivens, Australian and New Zealand Society for Geriatric Medicine, *Committee Hansard*, 15 February 2019, p. 14.

88 Mr Daniel Prentice, Queensland Nurses and Midwives' Union, *Committee Hansard*, 15 February 2019, p. 32.

89 Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 8.

90 Older Persons Advocacy Network, *Submission 23.1*, [p. 3].

begun, with the Health Care Commission working collaboratively with the Aged Care Commission. This project is outlined in chapter three.

Medications issues

2.97 The complex clinical environment of RACFs, as outlined earlier in this chapter, extends to the medications environment. It has been estimated that RACF residents have an average of 3.4 to 4.5 separate diagnoses and are taking 8.1 medications.[91] Polypharmacy is defined as the use of five or more drugs, which includes prescribed, over-the-counter and complementary medicines. Polypharmacy is described by Australian Prescriber as being associated with suboptimal prescribing, is a barrier to adherence, increases risks of adverse drug events and falls, and makes it harder to obtain an accurate medical history.[92]

2.98 In this environment, medications management is a key component of appropriate clinical governance. Medications management includes: ensuring people are appropriately diagnosed and prescribed the right medications; appropriately managing polypharmacy to address contraindications; regular medication review to ensure de-prescribing occurs; medications dispensing by an appropriately qualified person; and ensuring that assistance in taking medications is done by an appropriately skilled and/or qualified person, which includes assessment of the individual patient to determine the level of assistance required.[93]

2.99 The Quality Agency submitted information on the extensive evidence it required RACF providers to demonstrate during assessment visits to show that medications are managed safely and correctly.[94] Despite this, medications management was one of the top five complaint areas reported to the Aged Care Complaints Commission, showing this is an issue of concern in RACF service delivery.[95] The Department also pointed out that although it provides a number of resources to assist RACF providers with safe medication management processes, it is the responsibility of providers to ensure medications are administered safely.[96]

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91 Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 5.

92 Sarah Hilmer, 'The dilemma of polypharmacy', 1 February 2008, *Australian Prescriber,* vol. 31, no. 1, 2008, pp. 2–3, DOI: 10.18773/austprescr.2008.001.

93 Mental Health Commission of NSW, *Submission 5, Attachment 1*, pp. 26–27, Occupational Therapy Australia, *Submission 39.1*, p. 4, Queensland Nurses and Midwives' Union, *Submission 6.1*, pp. 19–21.

94 Australian Aged Care Quality Agency, *Submission 42*, pp. 19–20.

95 Carnell Paterson review, p. 174.

96 Department of Health, *Submission 37*, p. 10.

Administering medications by unregulated care workers

2.100 Clinical organisations have expressed concern with the trend in the RACF sector of delegating some medications tasks from nurses to unregulated carers, particularly in light of the state and territory laws around medications dispensing to people with cognitive impairment.[97]

2.101 Guidance material from the Australian Nursing and Midwifery Federation outlines that the AIN role is limited to 'assisting older people with self-administering their medicines from prepackaged dose administration aids' and this is limited to older persons who have been assessed by the RN or prescribing practitioner as being safely capable of administering their own medicines. The Australian Nursing and Midwifery Federation has expressed concern that 'in some circumstances assistants in nursing...are being directed to administer medicines to residents in aged care facilities'.[98]

2.102 QNMU cited the Health (Drugs and Poisons) Regulation 1996 (Qld) which requires that carers are only able to assist with medications when asked by cognitively competent individuals.[99] The NSW Nurses and Midwives Association noted that guidelines designed for unlicensed care workers to assist people to self-administer medications were not intended for the current RACF environment of high care.[100] As discussed later in this chapter, over half of RACF residents have dementia, meaning the overall numbers of people in RACFs who are cognitively competent to self-administer is low.

2.103 Despite state and territory laws which, in some locations, allow AINs to assist with taking medications, the Combined Pensioners and Superannuants Association (CPSA) raised concerns with the increasing use of dose administration aids such as Webster packs being used by AINs. In its submission the CPSA cited a 2008 study of the packaging of dose administration aids finding packing errors in 34 of the facilities at rates between one per cent and 54 per cent, and pointed out that AINs are not trained to identify these errors or know how particular medications interact.[101]

2.104 The CPSA further pointed to the prescription of pro re nata (as needed) medications, as in NSW schedule 4 or schedule 8 pain medications can only be administered under the direct supervision of a RN. As many RACFs may not

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[97] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 19, NSW Nurses and Midwives Association, *Submission 2.2*, p. 7, Australian Medical Association, *Submission 13*, p. 9.

[98] Australian Nursing and Midwifery Federation, *Nursing Guidelines: Management of Medicines in Aged Care*, July 2013, pp. 4, 5 and 13.

[99] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 19.

[100] NSW Nurses and Midwives Association, *Submission 2.1*, p. 7.

[101] Combined Pensioners and Superannuants Association, *Submission 57*, p. 7.

have a RN on site at all times, residents are sometimes unable to access their pain medications when needed.[102]

2.105 The regulation of medication standards is made more complex as aged care regulation is a federal issue, while medication dispensing is regulated by state and territory legislation. This regulatory challenge is discussed in greater detail in chapter 3.

Medications safety

2.106 RANZCP told the committee that medication management procedures used in health settings, such as cross checking during dispensing, were often not used in RACFs and also noted that for consent purposes, families could feel pressured by the RACF to accept the prescription of psychotropic medications without properly understanding the outcomes for their family member.[103]

2.107 The Australian College of Nursing pointed to a recent study conducted by Macquarie University which selected 203 residents from 53 different facilities, and found that on a randomly selected day, these 203 residents received more than 5000 medication orders of more than 400 different medications, and stated that '"Polypharmacy" really is an inadequate word for the reality'.[104]

2.108 Occupational Therapy Australia made similar observations that, while the majority of RACFs manage medications appropriately, problems predominately arise from insufficient staffing, excessive workloads and the use of agency staff. It also noted that medication is sometimes prescribed on the basis of nursing reports, with GPs not always visiting clients prior to prescribing.[105]

2.109 Allied Health Professions Australia told the committee that overmedication is often a result of understaffing and insufficient access to appropriately qualified allied health workers, combined with poor clinical governance processes.[106]

2.110 The Older Persons Advocacy Network told the committee that often medications are prescribed as 'as required' but without a proper monitoring system of how often these are being used there is a risk of overuse of the medications.[107]

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[102] Combined Pensioners and Superannuants Association, *Submission 57*, p. 7.

[103] Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard*, 15 February 2019, p. 20.

[104] Adjunct Professor Kylie Ward, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 29.

[105] Occupational Therapy Australia, *Submission39.1*, p. 4.

[106] Ms Claire Hewat, Allied Health Professions Australia, *Committee Hansard*, 15 February 2019, p. 10.

[107] Mr Craig Gear, Older Persons Advocacy Network, *Committee Hansard*, 15 February 2019, p. 51.

2.111 The Chief Medical Officer from the Health Care Commission noted it is difficult to get a medication review done properly in a RACF.[108] The Office of the Public Guardian Qld submitted a similar view that where a doctor has prescribed a medication, the RACF will administer it without questions, without providing additional safeguards such as independent oversight or medications reviews.[109]

2.112 The Australian College of Nurse Practitioners submitted that the focus on how medications are handled loses sight of the key concern, which is 'whether the medication actually prescribed is appropriate and benefits outweigh the potential risks or harms associated with it'.[110]

2.113 The AMA submitted that a more contemporary medical records system, discussed in greater detail below, would significantly reduce the risks associated with 'polypharmacy, and in turn reduce the likelihood of cognitive impairment, delirium, frailty, falls, and mortality in RACFs'.[111]

2.114 The Health Care Commission told the committee that it has undertaken discussions regarding medications reviews in RACFs, and the community pharmacies have indicated they are keen to play a role in improving this aspect of medications in RACFs.[112]

Medical records

2.115 The issue of poor medical record keeping in RACFs was raised by a number of stakeholders.[113]

2.116 The South Western Sydney PHN told the committee of the work being done to improve the ability of clinicians to share medical records and datasets, such as 'health referrals, secure messaging, interoperable records and the like' but noted the system 'tends to break down once a person goes into a residential facility. A lot of [records in] residential aged care facilities are still paper based, for example. The linkages just aren't there'.[114]

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[108] Dr Robert Herkes, Chief Medical Officer, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 54.

[109] Office of the Public Guardian Queensland, *Submission 68*, p. 10.

[110] Australian College of Nurse Practitioners, *Submission 92*, [p.2].

[111] Australian Medical Association, *Submission 13*, p. 2.

[112] Adjunct Professor Debora Picone, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 54.

[113] See for example Dementia Australia, Answers to written Questions on Notice (received 6 March 2019), [p. 2], Australian Medical Association, *Submission 13*, pp. 6–7, Ms Lucille Chalmers, General Manager, Commissioned Programs, Brisbane South PHN, *Committee Hansard*, 15 February 2019, p. 38.

[114] Mr Keith McDonald, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 37.

2.117 The Australian College of Nurse Practitioners submitted that medical record keeping needs to be updated with a digital strategy to ensure 'appropriate and timely information is available to support decision making for frail and vulnerable' residents.[115]

2.118 Allied Health Professions Australia noted that poor record keeping may have a significant impact on the quality of clinical care provided by allied health professionals.[116]

2.119 The Brisbane South and Brisbane North PHNs submitted that the current medication records system is 'prone to clinical risk, medication errors and inefficiencies' and the 'format of the charts used in aged care complicates transmitting a comprehensive record of a resident's current treatments'. The two PHNs recommended the 'National Residential Medication Chart' be moved from a paper based system to a more modern and efficient digital system which would link doctors and pharmacists with the RACF.[117]

2.120 The Australian and New Zealand Society for Geriatric Medicine submitted that a lack of effective record keeping impacts both safety and quality of care.[118] RANZCP made similar observations and submitted that 'the standard of record-keeping is poor, often containing material that is of little clinical relevance'.[119]

2.121 The recently implemented My Health Record presents opportunities to improve the coordination of health data for individual residents. A pilot project undertaken by the Central Queensland, Wide Bay, Sunshine Coast PHN with the Australian Digital Health Agency and Benevolent Aged Care in Rockhampton found enhanced care outcomes when My Health Record is 'embedded into clinical workflows such as admission processes and medications reviews'.[120] However this would require the RACF provider to have a compatible digital health record system.

Committee view

2.122 The concluding committee view in the interim report for this inquiry stated:

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[115] Australian College of Nurse Practitioners, *Submission 92*, [p. 2].

[116] Allied Health Professions Australia, Answers to written Questions on Notice (received 5 March 2019), [p. 2].

[117] Brisbane North PHN and Brisbane South PHN, *Submission 85*, pp. 3–4.

[118] The Australian and New Zealand Society for Geriatric Medicine, Answers to written Questions on Notice, and an answer to a Question taken on Notice during 15 February public hearing (received 6 March 2019), [p. 3].

[119] RANZCP, Answers to written Questions on Notice (received 7 March 2019), p. 1.

[120] Australian Digital Health Agency, *Residential aged care gets connected through My Health Record*, https://www.digitalhealth.gov.au/about-the-agency/digital-health-space/residential-aged-care-gets-connected-through-my-health-record (accessed 24 March 2019).

> Of particular concern to the committee is the body of evidence relating to model of care issues, definitions of personal versus medical care, and clinical governance within aged care facilities.[121]

2.123 After deeper investigation, the committee remains of the view that a fundamental problem with acceptable clinical care standards in RACFs lies in the lack of appropriate rigor in the approach to planning how to deliver those services. As there is no specific industry-wide model of care and no regulatory framework which specifies how care should be delivered, the model of care used in RACFs appears to be one that has developed informally over time and appears to be largely based on finding costs-savings within the requirements of, or bypassing, the nursing scope of practice.

2.124 Not only is there no defined model of care for the RACF sector, there is no clear definition of what 'care' is, and where the lines between clinical and personal care begin and end. Without this planning, service delivery is ad hoc, inconsistent in quality, and relies too heavily on individual actors within the sector to maintain standards.

Specialist clinical care

2.125 Beyond day-to-day nursing care, RACF residents receive other kinds of clinical care from their RACF provider, including specialist nursing care, and care provided by allied health professionals such as psychology, podiatry, speech pathology and audiology. This care from allied health professionals can be provided by in-house staff or by external staff, often subcontracted from a health provider.

2.126 Allied Health Professions Australia told the committee that it believes the aged care system is failing older Australians, particularly in relation to access to allied health care which is closely linked to the maintenance of capacity and functionality for older people and is of particular importance for the clinical care standards for people with dementia and complex behaviours.[122] The Older Persons Advocacy Network also noted the limited access to behavioural advice and supports to deal with challenging behaviour.[123]

2.127 Allied Health Professions Australia further told the committee that access to allied health is not made a priority in many RACFs, and allied health staff typically work in RACFs on a part time or contract basis, 'limiting their ability to contribute to the application of appropriate clinical standards'.[124]

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[121] Senate Community Affairs References Committee, *Interim report: Effectiveness of the Aged Care Quality Assessment and accreditation framework* (Interim report), 13 February 2018, p. 66.

[122] Ms Claire Hewat, Allied Health Professions Australia, *Committee Hansard*, 15 February 2019, p. 9.

[123] Mr Craig Gear, Older Persons Advocacy Network, *Committee Hansard*, 15 February 2019, pp. 48–51.

[124] Ms Claire Hewat, Allied Health Professions Australia, *Committee Hansard*, 15 February 2019, p. 9.

2.128 However, Benetas submitted that these contract arrangements sometimes impact the ability that RACF providers have to insist on high clinical standards, as RACF providers do not have direct control over these allied health staff. Benetas submitted that there have been cases where instances of poor professional practice by these external allied health professionals have been raised by the RACF provider with their employer, but no action has been taken.[125]

2.129 This issue highlights the recommendations by Dementia Australia that 'the roles and responsibilities of aged care staff and medical practitioners as they relate to the personal care, clinical care and medical care of a resident with dementia, need to be clear, with clinical governance structures in place that underpin and enforce those roles and responsibilities'.[126] A discussion on dementia-specific care is included later in this chapter.

2.130 Bupa submitted that allied health services are vitally important to meet the health and care needs of RACF residents, and should be important factors when assessing aged care quality.[127]

2.131 The issue of regulating appropriate use and standards of allied health services is discussed in chapter three.

Palliative care

2.132 Palliative care is an important issue in clinical care within RACFs, particularly given the increasing acuity in incoming residents and the shorter length of time people are resident in RACFs prior to dying. In 2010–11, 75 per cent of the 116 481 people aged at least 65 years who died in Australia had used aged care services in the 12 months before their death.[128] The Chief Medical Officer for the Department noted that 'residential aged care has become to some extent, in part, a palliative care environment'.[129]

2.133 Pain Australia submitted that appropriate palliative care is not available in RACFs, and raised concerns with 'inadequate pain management, inappropriate hospitalisation or medical intervention, and a lack of timely and appropriate consultation over their choices regarding end of life care'. Pain Australia further submitted that ensuring high quality palliative and end-of-life care

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[125] Benetas, *Submission 61.1*, [p. 2].

[126] Dementia Australia, Answers to written Questions on Notice (received 6 March 2019), [p. 2].

[127] Bupa, *Submission 18*, p. 14.

[128] Pain Australia, *Submission 17.1*, p. 7.

[129] Professor Brendan Murphy, Chief Medical Officer, Department of Health, *Committee Hansard*, 15 February 2019, p. 62.

services in RACFs will enable more older Australians to have a good death, and facilitate the better allocation of scarce health resources.[130]

2.134 South Western Sydney PHN also raised concerns with the level of appropriate palliative care being provided in RACFs and submitted it results in 'inappropriate referrals to specialist care for people whose palliative need can be attended by a generalist team if good systems and staff training were in place in facilities'.[131]

2.135 The Clinical Director for the Health Care Commission told the inquiry that providing palliative care 'takes high intensity nursing to be able to provide that and a rapidly responsive workforce who can address people's symptom issues...and that's the crucial issue that needs to be addressed'.[132]

2.136 The AMA submitted that for palliative care, transfer to an acute care setting does not necessarily respect the needs of patients, as the acute care sector prioritises treating disease and preserving life. The AMA contended that people should be cared for in the environment of their choice and that the majority of Australians wish to die in their own home, which for many is a RACF. However, the AMA pointed out that there is a lack of resources to support this choice and recommended that RACFs have 'supporting policies in place that allows the generation of clear advanced care plans appropriate for the RACF setting, that are taken seriously and reviewed regularly'. This could be supported by 'hospital in the home-type services' provided by a Local Health Directorate.[133]

2.137 The Aged Care Guild told the committee that the key factor missing in palliative care is assessment and planning for the needs of the individual and how the family want to meet that need. These needs are broader than just clinical care needs and include supporting the family and the patient's social and emotional health and wellbeing. The Aged Care Guild went on to state that there were enormous benefits to improving home-based palliative care, because 'you can better support someone at home, give them more care, better care and more dignity through death for almost half the price that you can do it in a hospital environment and leave the hospital bed free for someone who needs elective surgery'.[134]

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130 Pain Australia, *Submission 17.1*, p. 7.

131 South Western Sydney PHN, *Submission 84*, p. 4.

132 Dr Amanda Walker, Clinical Director, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 54.

133 Australian Medical Association, *Submission 23 to the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, pp. 14–15.

134 Mr Matthew Richter, Aged Care Guild, Committee Hansard, 15 February 2019, p. 3.

2.138 The Aged Care Guild advised the committee that fixing service delivery issues in home-based palliative care would take a multidisciplinary approach involving different levels of government funding, control and engagement, and that coordination of these different government levels was critical.[135]

Pain management

2.139 Appropriate pain management was raised as an issue of concern by submitters and witnesses. The NSW Nurses and Midwives Association made a link between nursing staff ratios and pain management, noting that '[f]acilities that provided registered nurses on site at all times were more likely to be able to provide prompt pain relief and make informed clinical judgments about the appropriateness of medication administration'.[136]

2.140 Pain Australia made similar observations and submitted that while chronic and acute pain is common among RACF residents, it is poorly managed or undertreated, including the suboptimal use of analgesics.[137] As noted earlier in this chapter, the lack of a RN being on site at all times means that residents sometimes cannot access appropriate pain medications when needed.

2.141 RANZCP also noted that up to 60 per cent of people with BPSD will have unrecognised or undertreated pain.[138] The Chief Medical Officer of the Health Care Commission also noted this as an issue of concern, and told the committee that '[i]t is when people who are dementing... get an infection, have a fever or are in pain and that makes their behaviour difficult'.[139]

2.142 Pain Australia concurred with this view, and submitted that evidence shows that people with dementia are being under-treated for pain, compared with cognitively intact persons, and that this is a significant factor in BPSD.[140]

Mental Health

2.143 The Mental Health Commission of NSW submitted that older Australians living in nursing homes have some of the highest rates of depression and anxiety, yet most RACF residents are unable to access Medicare-funded psychological care due to specific exclusions in the *Aged Care Act 1997* and Medicare regulation. The Mental Health Commission of NSW argued this

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135 Mr Matthew Richter, Aged Care Guild, *Committee Hansard*, 15 February 2019, pp. 3–4.

136 NSW Nurses and Midwives Association, *Submission 2.1*, p. 7.

137 Pain Australia, *Submission 17*, p. 3.

138 Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard*, 15 February 2019, p. 22.

139 Dr Robert Herkes, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 54.

140 Pain Australia, *Submission 17*, p. 2.

exclusion constitutes systemic neglect and a denial of human rights involving discrimination on the basis of age and infirmity.[141]

2.144 Allied Health Professions Australia also raised the issue of mental health in RACFs as an issue of concern and submitted that more than 50 per cent of RACF residents have anxiety and/or depression.[142]

2.145 RANZCP told the committee that Australians over the age of 75 are the most likely to be prescribed antidepressants, benzodiazepine sedative or psychotropic medications, but are also the least likely to see a psychiatrist, a clinical or other psychologist or allied health service related to mental health. RANZCP described this further:

> So, we've got the group which is vastly overrepresented in terms of psychotropic prescriptions being the least likely people to have their care supervised by a specialist mental health practitioner, whether that's a psychiatrist or anybody else.
>
> ...
>
> The conclusion that we draw is that this polypharmacy—this overprescribing; this lack of access to mental health services—is really driven by the needs of a large group of people in residential care who have a dementia diagnosis and are receiving psychiatric medications inappropriately.[143]

2.146 The South Western Sydney PHN submitted that PHNs have recently been tasked with the co-design and delivery of psychological services within RACFs, and through this process have identified a key challenge is the lack of capacity in RACF staff to identify and adequately address the mental health issues of residents.[144]

2.147 HammondCare raised similar concerns with appropriateness of delivering specialised mental health services in RACFs, and recommended that all Older Persons Mental Health services should be delivered in sub-acute health facility settings, while dementia care for all but most severe cases could remain in RACFs.[145]

Dementia

2.148 The standard of care for people living with dementia in RACFs was raised as a major issue of concern by many witnesses and submitters. Concerns included the lack of non-pharmacological interventions being used, physical and

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[141] Mental Health Commission of NSW, *Submission 5 Attachment 1*, p. 24.

[142] Allied Health Professions Australia, *Submission 90.1*, [p.4].

[143] Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard,* 15 February 2019, p. 20.

[144] South Western Sydney PHN, *Submission 84*, p. 4.

[145] HammondCare, *Submission 11*, p. 6. See also Aged and Community Services Australia, *Submission 12*, p. 6 and Interim report, p. 68.

chemical restraint being applied indiscriminately, and the communication barriers presented by dementia not being appropriately addressed, resulting in a lack of overall clinical care such as pain management.

2.149 Dementia Australia submitted that the care and support of people with dementia is one of the largest healthcare challenges facing Australia, with more than 410 000 Australians living with dementia. Dementia is the second leading cause of death, contributing to 5.4 per cent of all deaths in males and 10.6 per cent of all deaths in females each year.[146]

2.150 Dementia Australia told the committee that over half of all RACF residents have a diagnosis of dementia, which 'suggests that dementia is core business for aged care providers'.[147]

2.151 The Office of the Public Guardian Qld submitted that dementia is different to other cognitive conditions as it is terminal and cannot always be addressed through traditional positive behavioural support or by antipsychotic medication.[148]

2.152 RANZCP pointed to best practice guidelines for managing patients with dementia which emphasise the importance of comprehensive assessments and non-drug interventions, with psychotropics as a last resort, and stated the 'current state of practice in aged care in Australia sees the reverse situation predominating'.[149]

2.153 Occupational Therapy Australia made a similar observation on best practice, but submitted that non-pharmacological interventions are primarily led by allied health professionals and this is often the professional group most under-represented in RACFs.[150]

2.154 Dementia Australia told the committee they are often given examples of care 'in which people living with dementia in residential aged care are overmedicated, physically restrained, bored, agitated or lonely'. Dementia Australia went on to outline a comment made by one of their carers:

> In another life, I inspected nursing homes. That is why I choose to keep my father at home when he developed dementia. We have seen many providers that make the minimum standards, but in those same places I have seen people time and again drugged up and tied up.[151]

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146 Dementia Australia, *Submission 20*, [p. 5].

147 Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 18.

148 Office of the Public Guardian Queensland, *Submission 68*, p. 7.

149 Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard*, 15 February 2019, p. 20.

150 Occupational Therapy Australia, *Submission 39.1*, p. 4.

151 Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 18.

2.155 The Office of the Public Guardian Qld submitted an example of a non-verbal woman in a RACF who was being held in restraints for up to 12 hours per day, was screaming all the time, had been assaulted in the chair by another resident and was on an excessive amount of medication.[152]

2.156 Pain Australia submitted that people living with dementia 'have shared stories of an aged care system unable to meet their needs with reports of incidences that span physical, psychological and sexual abuse; inappropriate use of restraints; unreported assaults; and people in extreme pain at end-of-life not having access to palliative care'.[153]

New dementia clinics

2.157 Dementia Australia submitted that the needs of people with dementia are not being fully supported through current mainstream RACF services, and demand is growing at a faster rate than the supply of aged care services. Dementia Australia recommended an approach that combines capacity building in mainstream services to provide quality care, along with the integration of specialist dementia services.[154]

2.158 This approach has recently been undertaken by the Australian Government in the announcement of $70 million per year funding to establish more than 30 specialist care units, at least one in each PHN area, to provide care for people exhibiting very severe BPSD. The Specialist Dementia Care Program will include a nationally-consistent needs-based assessment framework, and centres will provide person-centred and multidisciplinary care with formalised arrangements for regular specialist clinical input and review.[155]

2.159 The interim report for this inquiry recommended that all dementia-specific RACF services should be regulated as a health facility, echoing the concerns raised by the Health Care Commission in its recommendations to the Carnell Paterson review. However, the Health Care Commission has since advised the committee that the approach of the Specialist Dementia Care Program to incorporate specialist clinicians, including geriatricians or psychogeriatricians, will 'largely address the concerns'.[156]

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[152] Office of the Public Guardian Queensland, *Submission 68*, p. 10.

[153] Pain Australia, *Submission 17*, p. 2.

[154] Dementia Australia, *Submission 20,* [pp. 12–13].

[155] The Hon. Ken Wyatt AM, MP, Minister for Senior Australians and Aged Care, '$70 million a year to better support people with severe symptoms of dementia', *Media release*, 5 February 2019.

[156] Health Care Commission, Answers to written Questions on Notice (received 5 March 2019), [p. 4].

Restrictive practice and medications

2.160 Restrictive practice refers to 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm'.[157]

2.161 The Australian Law Reform Commission has stated that common forms of restrictive practice include detention (locking a person in a room), seclusion (locking a person in a room for a limited period of time), physical restraint (clasping a person's hands or feet to stop them from moving), mechanical restraint (tying a person to a chair or bed) and chemical restraint (giving a person sedatives).[158]

2.162 Submitters and witnesses presented overwhelming evidence of the inappropriate and indiscriminate use of restrictive practices in place of other interventions, to manage BPSD.

2.163 The Aged Care Commission told the committee of the work the regulators have done to educate the RACF provider sector on restrictive practices, including both physical and chemical restraint:

> ...we have provided and continue to provide guidance to the sector about our expectations in relation to restrictive practices. In general, we have given clear indications that they are to be used as a last resort and only after substantial consideration of alternative strategies.
>
> When they are used...they are used sparingly for as short a time as possible, and they are subject to oversight.[159]

2.164 The Department submitted information on two Australian Government funded trials aimed at reducing the use of sedative and antipsychotic medications in RACFs.[160] However, evidence presented to the committee highlights the lack of impact the work done by regulators has had on reducing rates of chemical and physical restraint.

2.165 The Office of the Public Advocate Qld submitted that 'the use of restrictive practices to manage the challenging behaviours of people supported by the aged and disability sectors has become a key human rights issue in Australia'. The Office of the Public Advocate Qld outlined that as there is currently no legislative framework to regulate these practices, the 'use of restrictive practices in aged care settings, without legal justification or excuse, is unlawful and amounts to elder abuse'. The Office of the Public Advocate Qld further

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[157] Coalition of Australian Governments, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*, 21 March 2014.

[158] Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, DP 83, 12 December 2016, p. 143.

[159] Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 57.

[160] Department of Health, *Submission 37*, p. 10.

submitted that staff using restrictive practices do not have the protections of legal immunities and are at risk of criminal prosecution for unlawful deprivation of liberty or assault, or civil claims.[161]

2.166 A significant proportion of submitters raised concerns with the overuse of psychotropic medications in RACF, with some arguing they are 'used not just to treat mental illness, but sometimes as a means of managing challenging behaviour'.[162] Allied Health Professions Australia submitted that the 'use of medication to manage challenging behaviours is a significantly more cost-effective strategy for residential aged care facilities as the cost of medication and GP's services is borne by Medicare while the use of allied health staff as part of non-pharmacological management of behaviours would need to be funded by the facility'.[163]

2.167 About half of people in aged care, and about 80 per cent of those with dementia are receiving psychotropic medications, with evidence to suggest that in some cases these medications have been prescribed inappropriately.[164] The Chief Medical Officer for the Health Care Commission told the committee that while around 20 per cent of patients who have dementia will benefit from antipsychotics the rates of prescribing were around 80 per cent, showing 'an excess of the use of antipsychotics compared with the potential benefit'.[165]

2.168 RANZCP told the committee that the over-reliance on psychotropic medications can happen for a variety of reasons, with the 'more likely' cause being 'the lack of training on proper management of behavioural disturbances in dementia that all doctors receive'. RANZCP recommended:

> This [behavioural management] training really needs to be provided to the people who are responsible [for the] medical management of people in care facilities because, at the moment, all they can do, all they have been taught to do, is prescribe. The analogy is that when all you've got is a hammer everything looks like a nail.[166]

2.169 The Office of the Public Guardian Qld submitted that it has observed chemical restraint being used without formal oversight or consideration of positive behavioural support as an alternative, and has observed it can be used in

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[161] Office of the Pubic Advocate, Queensland (Qld), *Submission 14*, p. 2.

[162] Mental Health Commission of NSW, *Submission 5 Attachment 1*, p. 25. See also Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 20, Older Persons Advocacy Network, *Submission 23.1*, [p. 9], Office of the Public Guardian Queensland, *Submission 14*, p. i.

[163] Allied Health Professions Australia, *Submission 90.1*, p. 6.

[164] Carnell Paterson review, pp. 117–118.

[165] Dr Robert Herkes, Health Care Commission, *Committee Hansard,* 15 February 2019, p. 54.

[166] Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard,* 15 February 2019, p. 20.

instances where it may be perceived as a substitute for staff shortages of appropriate training or skills.[167]

2.170 The Health Care Commission told the committee that there has been no improvement in the overuse of antipsychotics since a study they conducted three years ago, which found that in some places antipsychotic use is at 30 per cent 'yet the epidemiology of disease tells you it should only be nine or 10 per cent. We know this is now becoming profoundly concerning, because the medication actually causes more harm than benefit, and that's the message we're trying to get out to the system'.[168]

2.171 The Chief Medical Officer for the Health Care Commission noted that 'the antipsychotics not only sedate the patient but increase the risk of falls and fractures for the patient, increase the risk of the patient developing pneumonia, increase the risk of stroke and increase the chances that the resident will die'.[169]

2.172 On 17 January 2019, the Minister for Senior Australians and Aged Care (Minister), Ken Wyatt, announced draft changes to regulations to strengthen oversight of restrictive practice were 'expected to be released within weeks'.[170] On 30 March 2019, the Minister made a further announcement that he intends to make changes 'next week' in relation to physical and chemical restraint which will apply from 1 July 2019.[171] These changes are discussed in greater detail in chapter three.

Consent to restrictive practice

2.173 Dementia Australia noted that communication with families around psychotropic medications was generally poor, with limited information on what medications a resident may be on, why that medication is being used, and the processes for medication adjustment or review.[172] Dementia Australia further submitted that some individuals have expressed their concern that if consent is not granted, their relative will be sent to hospital as an emergency patient or they will be asked to leave the RACF.[173]

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167 Office of the Public Guardian Queensland, *Submission 68*, p. 10.

168 Adjunct Professor Debora Picone, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 47.

169 Dr Robert Herkes, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 54.

170 The Hon. Ken Wyatt AM, MP, Minister for Senior Australians and Aged Care, 'Aged Care Restraint Regulation to Protect Senior Australians', *Media release*, 17 January 2019.

171 The Hon. Ken Wyatt AM, MP, 'Stronger Restraint Regulations to Protect Senior Australians', *Media release*, 30 March 2019.

172 Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 22.

173 Dementia Australia, Answers to written Questions on Notice (received 6 March 2019), [p. 3].

2.174 The Older Persons Advocacy Network made similar comments and told the committee that often families did not understand why people have been put on medications, suggesting that often it could be 'to make life a little easier for the people who are working in the centre'.[174]

2.175 The Health Care Commission also raised concerns with the issue of appropriately seeking consent for using restrictive practices on a person with dementia and told the committee that RACF providers hold responsibility for the prescribed medical treatment for a person with advanced dementia, as the person has no capacity for consent. The Health Care Commission raised further concerns, citing studies which have shown that only six per cent of people on antipsychotic medications have had an appropriate consent procedure.[175]

Committee view

2.176 The concluding committee view in the interim report for this inquiry stated:

> The aged care sector appears divided in how it defines the provision of allied health or medical services, and who takes ultimate responsibility for the quality of service provision or the oversight and regulation of that health service.[176]

2.177 The committee remains deeply concerned with the standards of clinical care within RACFs, both day-to-day nursing care as well as other, more specialised clinical services. The committee notes the arguments raised that the lack of access to these clinical services is often due to funding constraints.

2.178 However, the committee also notes that many of these specialized clinical services are in fact higher level nursing practices, for which the RACF provider is paid under the ACFI to deliver. It appears that the internal governance and external regulation of clinical practice is in inverse proportion to the level of clinical speciality. Paradoxically, the more complex the care, the less oversight and regulation.

2.179 The committee is troubled with the high rates of psychotropic medications being used, and the compelling epidemiological evidence which shows this cannot possibly be for purely therapeutic reasons. Despite existing work to reduce rates, restrictive practices are still being used at alarmingly high rates, and where they are done with no clearly defined therapeutic goal and without consent, would constitute abuse and may in fact be a criminal matter. Plainly,

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[174] Mr Russell Westacott, Seniors Rights Service Member, Older Persons Advocacy Network, *Committee Hansard*, 15 February 2019, p. 51.

[175] Adjunct Professor Debora Picone, Health Care Commission, *Committee Hansard*, 15 February 2019, pp. 47–48.

[176] Interim report, p. 67.

work to date has not been successful in reducing restrictive practice to appropriate rates.

Chapter 3
Regulation of clinical care

3.1 The interim report for this inquiry made a number of comments on the aged care regulation frameworks, beyond the regulatory failures that contributed to the substandard quality of clinical care experienced at two wards of the Oakden Older Persons Mental Health Facility (Oakden) in South Australia (SA). As outlined in chapter one, these two wards were classified as aged care facilities, and were therefore regulated by the Commonwealth aged care regulation frameworks.

3.2 In its interim report, the Senate Community Affairs Reference Committee (committee) expressed its views on the need for a broader investigation of Australia's regulatory oversight frameworks for the residential aged care facility (RACF) sector:

> The evidence presented to this inquiry clearly showed that many of the circumstances that led to the substandard level of care given to residents of Oakden were not unique to that facility. Not only are there similar models of care in other facilities, many of the failures in the quality oversight frameworks are universal, in that they could occur again in relation to any aged care facility, in any location, providing any kind of general or specialised aged care service.[1]

3.3 As outlined in chapter one, the committee considers an overarching regulatory failure of aged care to be the lack of appropriate regulation of clinical care standards within RACFs. The committee considers a key cause of this to be the lack of clarity and consistent approach to how 'care' is defined and who should be responsible for different aspects of that care.

3.4 Chapter one outlined the key areas of concern relating to regulation that were highlighted in the interim report as: accreditation processes for dementia specialist services, model of care and clinical governance issues, qualifications of auditors, rates of restrictive practices, workforce pressures, quality care data, and the compliance approach lacking capacity to foster open disclosure, industry collaboration and capacity building.

3.5 This chapter will explore how clinical standards within RACFs are being regulated in the context of recent reforms, and consider how regulation could be enhanced. The provision of external medical and allied health care, and its integration with aged care regulation, is discussed in chapter four.

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[1] Senate Community Affairs References Committee, *Interim report: Effectiveness of the Aged Care Quality Assessment and accreditation framework* (Interim report), 13 February 2018, pp. 66–67.

Recent regulatory reforms

3.6 As outlined in chapter one, there have been a range of reviews and reforms of the RACF sector, including the establishment of a new aged care regulator and enacting of new aged care regulation standards. This next section will provide details on the reforms undertaken thus far to the aged care regulation frameworks, as well as provide details on the totality of recommendations for reform that have been made to date by key external reviews.

New aged care regulator

3.7 The two key independent reviews that were held into the incidents of substandard care at Oakden ultimately led to significant aged care regulatory reform, the merger of the functions of the Australian Aged Care Quality Agency (Quality Agency) and the Aged Care Complaints Commission into a single entity, the Aged Care Quality and Safety Commission (Aged Care Commission).

3.8 The first review of services at Oakden, released in April 2017, was the *Oakden Report – The report of the Oakden Review* (Oakden report) by the SA Chief Psychiatrist, Dr Aaron Groves. In addition to findings on the sub-standard services provided at Oakden, the Oakden report also commented on regulatory oversight processes, finding that there were many practices at the facility 'that no accrediting body would ever endorse, if it was aware of its occurrence'.[2]

3.9 The second key review was the Australian Government commissioned report, *Review of National Aged Care Quality Regulatory Processes* (Carnell Paterson review), published in October 2017. This review looked more broadly at the entire aged care regulatory system, and its central recommendation was to merge the two main regulatory agencies into one entity, a recommendation that has since been implemented as of 1 January 2019 with the start of operations of the Aged Care Commission.

3.10 As noted in chapter two, the new Aged Care Commissioner, Ms Janet Anderson, has described the revelation of care failures at Oakden as a 'wake-up call' which led to a number of other reforms, such as risk based regulation and unannounced accreditation visits.[3]

3.11 However, the view that the Oakden revelations were immediately viewed by regulators and providers as a 'wake-up call' is not reflected in evidence presented to this inquiry at the time. The then regulator told the committee 'do I or do my staff accept responsibility for the abuse or the neglect that occurred

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[2] Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing (South Australian Government), *Oakden Report – Report of the Oakden Review* (Oakden report), April 2017, p. 78.

[3] Ms Janet Anderson, Commissioner, Aged Care Quality and Safety Commission (Aged Care Commission), *Committee Hansard*, 15 February 2019, p. 59.

at Oakden? I don't. I don't believe that's a fair reckoning. I believe, and the law is very clear under the Aged Care Act, that it's the provider who is responsible'.[4]

3.12 This approach of deflecting of responsibility appears prevalent in the aged care sector and reflects issues raised in chapter two, where many RACF providers deflect responsibility for clinical care standards, whether they are being delivered by internal or external health professionals.

Carnell Paterson recommendations

3.13 The Carnell Paterson review did not merely recommend centralisation of existing regulatory functions, but also made further recommendations for enhancements to be made to those functions.[5]

3.14 Broadly, the key recommendations that directly relate to clinical care standards include (recommendation numbering from Carnell Paterson review retained):

Recommendation 1: Establish an Aged Care Commission board.

- This entity should include separate commissioners for care quality, complaints, consumers and a Chief Clinical Advisor.

Recommendation 2: Develop and manage centralised data-sharing to:

- Improve information sharing with acute care and mental health sectors.
- Contemporise risk indicators.
- Require RACFs to report risk incidents as they occur.
- Publish provider risk profiles.
- Share information on common non-compliance areas.

Recommendation 3: Establish a mandatory National Quality Indicators program.

- Develop an algorithm for performance benchmarking.
- Pilot additional clinical and consumer experience quality indicators.

Recommendation 6: Enact a serious incident response scheme (SIRS) for aged care.

Recommendation 7: Limit use of restrictive practices.

- Restrictive practice used should be least restrictive, last resort and subject to regular review.
- Restrictive practice must be reported to the Aged Care Commission.
- Accreditation assessments will review the use of antipsychotics.
- Antipsychotic medications in RACFs must be approved by the Chief Clinical Advisor.

Recommendation 8: Accreditation visits to be unannounced.

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4 Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency, *Committee Hansard*, 5 February 2018, p. 4.

5 Ms Kate Carnell AO and Professor Ron Paterson ONZM, *Review of National Aged Care Quality Regulatory Processes Report* (Carnell Paterson review), October 2017, pp. xi–xiii.

Recommendation 9: Assessment against standards to be consistent and reflective of current expectations.

- Strengthen capability of assessment teams.
- Clearly define outcome measures.
- Work with Australian Commission on Safety and Quality in Healthcare to develop clinical governance frameworks and guidance on clinical care measures.
- Review aged care standards every five years.
- More regular medication management reviews.

3.15 The committee notes the expertise of the authors of the Carnell Paterson review in public administration and regulation, as well as health care quality, patients' rights and the regulation of healthcare professions. The committee further notes the unfettered access the review had to the Department of Health (Department) and regulators, and the in-depth nature of the review report. The committee has used the Carnell Paterson review as a roadmap for its own inquiry into the regulation of clinical care standards.

Senate inquiry to establish Aged Care Commission

3.16 As outlined in chapter one, during the legislative process to establish the Aged Care Commission, the Department flagged a second tranche of consultations, which will include discussion of possible enhancements to the functions of the Aged Care Commission.[6]

3.17 Some of the enhancements relating to clinical care standards that were raised by submitters and witnesses to the Senate Community Affairs Legislation Committee's *Aged Care Quality and Safety Commission Bill 2018 and related Bill* inquiry included:

- Chief Clinical advisor to have a role in approving antipsychotic medications.
- Centralise information on intersections between aged care and health systems.
- Work with RACF sector to ensure adequate supply of well-trained staff.
- Improve standards of clinical governance including developing model framework.
- Undertake expanded sector education activities on regulatory functions.
- Recruit more clinically trained assessors.
- Changes to the membership of the Aged Care Quality and Safety Advisory Council to include more clinical experts.

[6] Senate Community Affairs Legislation Committee, *Aged Care Quality and Safety Commission Bill 2018 and related Bill* (Aged Care Commission Bill inquiry), October 2018, pp. 27–28.

Chief Clinical Advisor

3.18 The Aged Care Commission includes a new role of Chief Clinical Advisor. During the Senate inquiry into the legislation establishing the Aged Care Commission, this role was seen by submitters and witnesses 'as an important step forward in quality care'.[7]

3.19 The functions of the Chief Clinical Advisor were not formally enshrined in the legislation. However, during the course of this inquiry the interim Chief Clinical Advisor provided advice on actions underway to improve clinical care in RACFs. These are discussed throughout this chapter in relevant subject areas.

Retaining the accreditation approach to aged care regulation

3.20 Submitters and witnesses raised concerns that in reforms to the regulation of aged care, an opportunity was missed to change the focus of how that regulatory framework interacts with the RACF sector. The overall approach to aged care regulation in Australia is a framework focused on accreditation of minimum standards rather than seeking continuous quality improvement. Submitters and witnesses pointed to the approach of the Australian Commission on Safety and Quality in Health Care (Health Care Commission), which encompasses accreditation elements but is also focused on improving health services and lifting overall care standards of the acute care sector.

3.21 Submitters argued that the focus of the Aged Care Commission should change to be more strategically involved in overall quality improvement.

3.22 The Australian College of Nursing noted that while compliance to minimum standards is an important part of the accreditation approach, this needs to be complemented by a broader framework that promotes continuous improvement through evidence informed best practice.[8]

3.23 The interim report noted that the Carnell Paterson review found that under the accreditation system, services may prepare for accreditation cycles instead of focusing on continuous quality care.[9] HammondCare concurred with this view and submitted that the 'accreditation process has led to a compliance mentality among many residential care providers, who seek to demonstrate that their care meets the standards by following a tick-box approach'.[10]

3.24 Bupa commented that the continuous improvement approach could be enhanced and strengthened by the Aged Care Commission 'working with providers and sharing information on non-compliance themes and key

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7 Aged Care Commission Bill inquiry, p. 14.

8 The Australian College of Nursing, *Submission 89*, p. 5.

9 Interim report, p. 46.

10 HammondCare, *Submission 11*, p. 3.

learnings' and recommended an amnesty arrangement, where providers can work collaboratively with regulators on rectifying issues.[11] This last recommendation is in line with an 'open disclosure' culture as required under the incoming aged care standards, discussed later in this chapter.

3.25 The Brisbane South Primary Health Network (PHN) outlined that the shift in regulation approach needs to be similarly done at a provider level, and told the committee:

> Moving from a compliance mindset to a continuous quality improvement approach is a key workplace cultural enabler. This requires leadership and a commitment to creating a workplace culture free from fear and potential retribution for staff, visitors, consumers and their carers and families.[12]

3.26 This issue was not only raised in this inquiry, but was also raised by submitters to the legislation inquiry reviewing the bill to establish the Aged Care Commission. The Australian Medical Association (AMA) submitted recommendations to that legislation inquiry to enhance the powers of the Commission to improve aged care services, including oversight of aged care workforce issues as well as being a centralised clearing house of aged care and health information.[13]

3.27 Queensland Nurses and Midwives' Union (QNMU) submitted to the legislation inquiry that the purpose of the Aged Care Commission should go beyond centralising existing oversight functions, and should take a proactive role with the Health Care Commission to ensure consistent clinical and health care standards across all sectors, assume the functions of the Aged Care Financing Authority, act as a data clearing house for the aged care sector, and incorporate a research capacity.[14]

3.28 As outlined in discussion later in this chapter on clinical governance and restrictive practice, the Aged Care Commission appears to be making a shift in its approach to take a leadership role to guide the RACF sector to quality improvements rather than simply seeking to regulate by compliance to minimum acceptable standards of care.

Aged Care Workforce Strategy Taskforce

3.29 Another significant aged care study was undertaken soon after the Oakden revelations. The Minister for Older Australians and Aged Care (Minister) established the Aged Care Workforce Strategy Taskforce (Aged Care

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[11] Bupa, *Submission 18*, p. 6.

[12] Ms Lucille Chalmers, General Manager, Commissioned Programs, Brisbane South Primary Health Network (PHN), *Committee Hansard,* 15 February 2019, p. 38.

[13] Australian Medical Association, Submission 10 to the Aged Care Commission Bill inquiry, pp. 2–3.

[14] Queensland Nurses and Midwives' Union (QNMU), Submission 5 to the Aged Care Commission Bill inquiry, pp. 3–4.

Taskforce) on 1 November 2017, to 'develop a strategy for growing and sustaining the workforce providing aged care services and support for older people, to meet their care needs in a variety of settings across Australia.[15]

3.30 The Aged Care Taskforce released its workforce strategy report in September 2018, which identified 14 strategic actions to address current and future workforce challenges, including skill mix modelling, clinical governance, strengthening the interface to primary health and acute care, a voluntary industry code of practice and care worker accreditation.

3.31 Issues raised in the workforce strategy that are relevant to clinical care standards and regulation include:

- **Voluntary industry code of practice:** including board governance, best-practice sharing, workforce education and planning and continuous quality improvements.
- **Qualification and skills framework**: boost workforce competencies particularly for personal care workers, expand the nursing scope of practice, address emerging roles such as coordinating care, standardisation of education requirements, clearly defined competencies for each level of worker and requirements for continuing professional development.
- **Workforce planning and skill mix modelling:** reaching an industry standard based on consumer needs, individual care plans that are regularly reviewed, industry developed guidance for development of holistic care plans, establishment of a committee responsible for care compliance chaired by a director with appropriate clinical care experience, organisations publish the model of care and hours of care.
- **Strengthening the interface between aged care and primary health and acute care:** ministerial level dialogue across governments to improve funding and service design to improve access to quality primary health and acute care services, and RACF providers update workforce planning to make more effective use of combinations of functional health and clinical care providers.
- **Establish an Aged Care Centre for Growth and Translational Research:** research to improve workforce capability, care quality and effectiveness, develop a minimum data set to provide an objective benchmark for care outcomes, evidence-based models of care and providing a single industry voice on funding priorities.
- **Transitioning the industry and workforce to new standards:** establish an Aged Services Industry Council to bring the peak bodies together to enable strategic leadership across the industry.[16]

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[15] Department of Health, *Aged Care Workforce Strategy Taskforce Terms of Reference*, https://agedcare.health.gov.au/reform/aged-care-workforce-strategy-taskforce/aged-care-workforce-strategy-taskforce-terms-of-reference (accessed 23 March 2019).

3.32 As with the Carnell Paterson review, the committee notes the expertise of the Aged Care Taskforce in business, education, training and skills development, medical administration and clinical service delivery.[17] The committee notes the far-reaching nature of the Aged Care Taskforce's review and the extensive set of recommendations that look at workforce planning issues in a holistic manner. As with the Carnell Paterson review, the committee has used the work of these experts as a guide to strategically focus its own inquiry into the regulation of clinical care standards in aged care service delivery.

Charter of Aged Care Rights

3.33 Another part of the aged care quality framework designed to place the RACF resident—and all aged care recipients—at the centre of the process is consolidation of the separate rights charters for residential aged care, home care and short term restorative care into one charter to be known as the Charter of Aged Care Rights.[18]

3.34 Both the existing charters and the new consolidated Charter of Aged Care Rights articulate the rights that RACF residents can expect to enjoy, including safe and high quality services, rights to be respected and informed about their care, to have autonomy and independence and the ability to make complaints without fear.[19]

3.35 In the consolidated Charter of Aged Care Rights, which will take effect from 1 July 2019, the rights are expressed in a more minimal simplified style. Aged and Disability Advocates Australia raised concerns this may make it harder to secure residents' rights as the new rights are more nebulous and are 'open to interpretation' and warned that the new Charter of Aged Care Rights could be a step backwards:

> The generic nature of Draft Charter leaves many important principles open to interpretation. ADA Australia is concerned that aged care rights are being weakened, at a time when they should be strengthened.[20]

3.36 Under the new charter, the RACF will be required to provide a signed copy of the Charter of Aged Care Rights to each existing and new resident to make them aware of their rights. However, it is questionable whether this will have the desired affect given the vulnerability of many people living in RACFs.

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16 Aged Care Workforce Strategy Taskforce, *A matter of care*, June 2018.

17 The members of the Aged Care Workforce Strategy Taskforce are listed at Appendix 4.

18 User Rights Amendment (Charter of Aged Care Rights) Principles 2019, sch. 1.

19 See User Rights Principles 2014, sch. 1; User Rights Amendment (Charter of Aged Care Rights) Principles 2019, sch. 1.

20 Aged and Disability Advocacy Australia, *Submission to the draft Charter of Aged Care Rights*.

New aged care regulation standards

3.37 The Single Aged Care Quality Framework (Single quality framework) will come into effect on 1 July 2019 and will become the set of standards by which RACF services are regulated. Until then the current Accreditation Standards will continue to be the standards by which RACFs are assessed and accredited.[21]

3.38 The Aged Care Commission outlined the different approach to accreditation that the Single quality framework heralded:

> It is actually looking at care through the lens of the care recipient and their family...whatever their level of need—the new standards require that those needs be addressed for that individual, respecting that individual's dignity and giving them the capacity for choice as far as possible, and looking after their clinical care, their personal care, their psychosocial wellbeing, their built environment and all other aspects of the complexity which goes to providing care for them.[22]

3.39 The Aged Care Commission told the committee they have been working with the RACF sector to ensure the sector is fully aware of the new standards and the expectations around those standards.[23]

3.40 Generally, submitters and witnesses expressed support for the new standards' focus on person-centred care.[24] The Aged Care Guild noted the new Single quality framework will embed a major shift in aged care, with a focus on the consumer and outcomes for the consumer that will be 'very beneficial to not only the community but the sector overall'.[25]

3.41 Dementia Australia told the committee that the new standards place consumers at the centre of the quality process and are a vast improvement on the existing standards.[26]

Committee view

3.42 The committee strongly concurs with the guiding principle of the Single quality framework to move to person-centred care, and is pleased that RACF

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[21] Department of Health, *Single set of quality standards – the Aged Care Quality Standards*, https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards (accessed 18 March 2019).

[22] Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 58.

[23] Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 57.

[24] See for example: NSW Nurses and Midwives' Association, *Submission 2.2*, p. 3; Benetas, *Submission 61.1*, [p. 2].

[25] Mr Matthew Richter, Chief Executive Officer, Aged Care Guild, *Committee Hansard*, 15 February 2019, p. 2.

[26] Dr Kaele Stokes, Executive Director Consumer Engagement, Policy and Research, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 18.

providers, clinical organisations and residents' advocacy organisations are supportive of this change.

3.43 The committee is of the view that the change to person-centred care—which takes a more holistic view of the needs of the person—must be met with a corresponding change to person-centred regulation, where assessments of care standards are not limited by jurisdictional barriers, but look holistically at the care needs of RACF residents with a 'no wrong door' approach to issues of concern.

3.44 The committee is concerned that the new Charter of Aged Care Rights may be too brief, may not meet the needs of RACF residents and may leave their rights to be interpreted by the RACF. The committee considers that this is not desirable and that the Department may need to work with providers, advocates and RACF residents to ensure that the rights are imbued with appropriate content and that RACF residents' rights are strengthened.

Concerns with new standards

3.45 Submitters and witnesses have made a number of observations around the new standards and whether they improve the regulation of clinical care. These observations are contained in the following discussion of individual aspects of clinical care regulation.

3.46 QNMU submitted that the standards do not reflect the significant health care component in aged care and recommend that the Health Care Commission standards and national safety and quality indicators for primary health care, currently under development, should be adopted in the aged care context when completed.[27]

3.47 The Health Care Commission told the committee that it was consulted on the Single quality framework, and it felt that where the risks remain is in medication management and the transition of care.[28]

Model of care

3.48 As outlined in chapter two, a model of care encompasses all aspects of how a health or care service is delivered, including identifying what need this service is intended to address, governance and management structures, how it integrates with other services, resource allocation such as staffing levels and profiles and evaluation of outcomes.

3.49 The SA Chief Psychiatrist noted that a lack of an endorsed model of care was a significant factor in the decline of services at Oakden.

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[27] QNMU, Answers to written question on notice (received 6 March 2019), pp. 4 and 7.

[28] Adjunct Professor Debora Picone, Chief Executive Officer, Australian Commission on Safety and Quality in Health Care (Health Care Commission), *Committee Hansard*, 15 February 2019, p. 48.

> As a result of no endorsed system wide Model for [Older Persons Mental Health Services] there has been understandably, little done to define a Model that is specific for Oakden. This has led to a resultant further decline in services at Oakden Campus, which remains unclear what its purpose is.[29]

3.50 Chapter two contained discussions on the detrimental impact to clinical care standards when there is no appropriate model of care in place. Beyond critiquing the lack of an industry standard model of care, submitters and witnesses made suggestions about how this could be improved, and what such a model of care should contain.

3.51 The Australian College of Nursing summarised the critical need for greater focus on the regulation of clinical care in RACFs and told the committee that:

> ...there has been a decreasing focus on healthcare aspects of aged care, while the care needs of aged-care recipients are increasing in both acuity and complexity. Compounding this situation, there has been a shift towards an increasingly deskilled and unlicensed aged-care workforce and also a shift to a social model of aged care which has de-emphasised the healthcare aspects of care at a time when the healthcare needs of residents have never been greater.[30]

3.52 QNMU made similar comments, referring to the model of care as one that has de-emphasised the clinical aspects of residential aged care.[31]

3.53 Dementia Australia told the committee that people living with dementia want a stronger dementia specific model of care with clearly defined roles and responsibilities, and furthermore there should be clear definitions of what comprises, personal, clinical or medical care. Dementia Australia pointed to the new Specialist Dementia Care Program as proof that it is possible to develop a clear program scope and clinical principles with a staffing model that reflects the resident profile.[32]

3.54 Flinders University recommended that explicit standards of care should be established, that 'describe all aspects of care including nursing, medical, allied health, hospitality, cleaning and security services'. Flinders University went on to state that clear descriptions of standards of care will lessen the reality-expectation gap and ensure complaints are more relevant to those enforceable care standards.[33]

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[29] Oakden report, p. 30.

[30] Adjunct Professor Kylie Ward, Chief Executive Officer, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 29.

[31] Queensland Nurses and Midwives' Union, *Submission 6.1*, p. 4.

[32] Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 19.

[33] Flinders University, College of Nursing and Health Sciences, *Submission 102*, pp. 4 and 6.

3.55 South Western Sydney PHN also critiqued the Single quality framework which combines medical and personal care and is written flexibly, which is only appropriate for personal care, creating a standard for medical care which is vague and open to interpretation.[34]

3.56 The Australian College of Nursing emphasised that a model of care should include a clinical services capability framework embedded in each RACF, which must include defining the scope of practice for the workforce.[35] South Western Sydney PHN agreed with this view and told the committee it supports 'a robust quality assessment which clearly demarcates clinical and personal care'.[36]

3.57 The New South Wales (NSW) Agency for Clinical Innovation (ACI) has developed extensive guidance material on planning for and developing a model of care, which outlines that developing a model of care starts with answering definitional questions, which in essence are: what is the problem and what is the root cause of the problem? ACI further outlines that the guiding principles of a model of care are that it:

- is patient centric
- has localised flexibility and considers equity of access
- supports integrated care
- supports efficient utilisation of resources
- supports safe, quality care for patients
- has a robust and standardised set of outcome measures and evaluation processes
- is innovative and considers new ways of organising and delivering care
- sets the vision for services in the future.

3.58 ACI further states that a model of care should be 'developed in collaboration with clinicians, managers, health care partners, the community, and with patients, their carers, and or organisations that represent them'.[37]

3.59 The Aged Care Taskforce made recommendations on developing a model of care, although it referred more obliquely to a 'voluntary industry code of practice' that will 'enable the industry to define its consumer promise, standards, workforce practices and commitment to quality and safety' and would include 'integrated models of care'. The code would incorporate

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[34] South Western Sydney PHN, *Submission 84*, p. 5.

[35] Adjunct Professor Kylie Ward, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 29.

[36] Mr Keith McDonald, Chief Executive Officer, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 37.

[37] NSW Agency for Clinical Innovation, *Understanding the process to develop a Model of Care*, pp. 3–5.

elements of board governance, best-practice sharing, workforce education and planning and continuous quality improvements.[38]

3.60 The NSW Nurses and Midwives' Association commented that voluntary codes of practice was a form of industry self-regulation, which 'seems counter-productive...when the sector has failed to prevent situations such as Oakden in SA, and given the level of sanctions currently imposed'.[39]

Clinical governance

3.61 The Aged Care Commission presented evidence that clinical governance is an issue that is covered in both existing and incoming aged care standards:

> Under the current standards and indeed under the new standards to be introduced from 1 July, there are clear references to an expectation that providers will have in place clinical governance frameworks which ensure that, where clinical care is provided in the home, it is subject to protocols and policies and a clear understanding about the way things must be done.[40]

3.62 However, chapter two outlined that this element is lacking across the board in the RACF sector, despite the critical importance of a clinical governance framework in ensuring appropriate standards of clinical care and the existing accreditation requirements outlined above.

3.63 South Western Sydney PHN submitted that the clinical governance requirements in the Single quality framework are too narrow as they are 'limited to microbial stewardship, minimising use of restraints and open disclosure. The requirements of clinical governance for a vulnerable group are quite significant, particularly given care is complex and provided by multiple external providers'.[41]

3.64 Dementia Australia recommended looking to other clinical governance frameworks, such as those under the National Safety and Quality Health Service Standards.[42]

3.65 The Aged Care Taskforce looked at this issue in relation to workforce planning and recommended that 'all organisations establish an integrated care and clinical governance committee (or equivalent) to review holistic care plans and

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38 A matter of care, pp. 14 and 21.

39 NSW Nurses and Midwives' Association, *Submission 2.2*, p. 9.

40 Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 57.

41 South Western Sydney PHN, Answers to written Questions on Notice (received 6 March 2019), [p. 1].

42 Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 19.

ensure they are being delivered, regularly updated and communicated with individuals and families'.[43]

3.66 The Health Care Commission noted that there is no model framework for clinical governance in the aged care sector, which was highlighted in the Carnell Paterson review. The Health Care Commission told the committee that it has been working with the Aged Care Commission and the Department on developing one for the RACF sector, using its experience and knowledge of the clinical governance frameworks of the health sector that it oversees.[44]

Staffing levels

3.67 On first glance, evidence to the committee regarding staff to resident ratios was one where there appeared to be two very distinct and opposing views on using staff to patient ratios as a mechanism to improve clinical care outcomes. On deeper investigation, there appears to be some consensus on a way forward.

3.68 The NSW Nurses and Midwives' Union told the committee it believes the regulation framework 'has failed to draw parallels between the value of safe staffing ratios and skill mix, and quality-of-care outcomes' and with the reform of accreditation standards 'there have been no clear benchmarks set in relation to what good, safe staffing looks like for assessors to make compliance judgements'.[45]

3.69 The Aged Care Commission submitted that it 'collects information about staffing in a service to assess whether there are sufficient qualified staff to plan for and deliver care'.[46] However it did not provide any information on how, in the absence of any benchmarks, it determines whether the staff numbers are 'sufficient'.

3.70 QNMU submitted that appropriate staffing levels are included in the new Single quality framework, but the requirements are vague and there is little evidence to show it is consistently assessed as part of the accreditation process. Additionally, the Department does not appear to have developed an aged care staffing and skill mix benchmark to assist the assessors to determine what is an appropriate level of staffing. QNMU further submitted that there is little

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43 A matter of care, p. 53.

44 Adjunct Professor Debora Picone, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 48. See also Ms Maria Jolly, First Assistant Secretary, Aged Care Reform and Compliance Branch, Department of Health, *Committee Hansard*, 15 February 2019, p. 60.

45 Mrs Helen Macukewicz, Professional Officer, NSW Nurses and Midwives' Association, *Committee Hansard*, 15 February 2019, p. 28.

46 Aged Care Commission, Answers to written questions on notice (received 6 March 2019), [p. 6].

evidence that RACF providers have attempted to implement evidence based staffing and skill mix methodologies to meet the care needs of consumers.[47]

3.71 The Australian College of Nursing described situations where an agency Registered Nurse (RN) may be the only evening nurse in a facility with over 200 residents and how that impacts on the safety of practice:

> If somebody falls, you've got to leave the higher acuity area to be able to support and wait for an ambulance, so you're constantly compromised in some areas like that.

3.72 The Australian College of Nursing went on to recommend at minimum there should be pre-established nursing hours per resident per day and a mandate on one RN on site, although this should take into account the difficulties faced by rural RACFs in finding enough RNs, particularly for night duty.[48]

3.73 The NSW Nurses and Midwives' Association submitted that it is in the public interest for the government to take an active role in determining safe staffing levels, as it undertook in the staffing of childcare, and suggested that leaving this to RACF providers may not be the most protective response. The NSW Nurses and Midwives' Association further noted that the Senate inquiry into the *Future of Australia's aged care sector workforce* made similar recommendations on the planning of a minimum nursing requirement.[49]

3.74 The AMA put the issue very succinctly by submitting:

> Adequate staffing ratios alone might not ensure quality in all aspects, but inadequate staffing certainly prevents it'.[50]

Moving forward: ratios or care hours?

3.75 RACF provider groups submitted that there is no research which establishes an evidence based link between increased nurse-to-patient ratios in aged care and better patient outcomes.

3.76 Leading Age Services Australia submitted that there has been little Australian research into the effect that staffing levels and skills have on residents' outcomes, and international studies do not deliver a clear message. Leading Age Services Australia submitted a 'tentative conclusion that may be drawn

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47 QNMU, Answers to written Questions on Notice (received 6 March 2019), pp. 7–8.

48 Adjunct Professor Kylie Ward and Ms Susan Emerson, Advisor, Australian College of Nursing, *Committee Hansard*, 15 February 2019, pp. 31–33 and 35. The House of Representatives Standing Committee on Health, Aged Care and Sport *Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, recommended a mandated Registered Nurse on duty at all times.

49 NSW Nurses and Midwives' Association, *Submission 2*, pp. 5–6. See Senate Community Affairs References Committee, *Future of Australia's aged care sector workforce*, June 2017, p. xii.

50 Australian Medical Association, *Submission 13.1*, p. 2.

from available research evidence is that a higher ratio of direct care staff to residents tends to result in improved resident outcomes'.[51]

3.77 Leading Age Services Australia recommended that rigid staffing ratios may not be the best way to allocate scarce funding, and local factors such as care needs of residents, experience and quality of staff and floorplans may mean some RACFs need less staff.

3.78 The Aged Care Guild cited the Productivity Commission's 2011 report, *Caring for Older Australians* and submitted that this report 'outlined the inherent drawbacks and difficulties of mandated staffing ratios'. The Aged Care Guild went on to say that an individual model of care developed by the RACF provider that is adaptive to the needs of residents was more appropriate, and cited the Bupa Model of Care as an 'innovative model' which is 'designed to promote early intervention and treatment of conditions, and reduce unplanned transfers from aged care homes to the hospital'.[52]

3.79 However, as outlined in chapter two, this model of care promoted by the Aged Care Guild as an better alternative to staffing ratios has led to Bupa having nine RACFs sanctioned within a 12 month period for failing to meet compliance standards, with some identified as a 'severe risk to the health, safety and wellbeing of care recipients'.[53]

3.80 Aged and Community Services Australia cited two studies, both of which found that using a simple staff to resident ratio would not necessarily deliver higher quality of care, and that other factors such as quality of staff should be taken into account as well. Aged and Community Services Australia submitted it is 'supportive of a staffing ratio metric that is based on 'acuity' or 'casemix' and that is part of a suite of quality indicators that is developed in conjunction with industry'.[54]

3.81 The Brisbane South PHN agreed that staff-to-patient ratios should be based on clinical requirements and level of resident ability and needs, but went beyond RN to Assistant in Nursing (AIN) ratios and recommended this should also take into account allied health and visiting medical officers.[55]

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[51] Leading Age Services Australia, Answers to written Questions on Notice (received 6 March 2019), p. 5.

[52] Aged Care Guild, *Submission 15*, [p. 8].

[53] Claire Wheaton, 'Bupa's ninth aged care home sanctioned in 12 months over "severe risk" to residents', *ABC News Online*, 12 January 2019, https://www.abc.net.au/news/2019-01-12/bupas-ninth-aged-care-home-sanctioned-in-12-months/10647436 (accessed 20 March 2019).

[54] Aged and Community Services Australia, Answers to written questions on notice (received 12 March 2019), p. 2.

[55] Ms Lucille Chalmers, Brisbane South PHN, *Committee Hansard*, 15 February 2019, p. 38.

3.82 Allied Health Professions Australia also cautioned against hard quotas for individual professions as that approach may leave little money left over for other professions, and recommended any approach be centred on patient needs.[56]

3.83 In contrast to studies cited by RACF providers, nursing organisations cited studies which showed there is an evidence based link between care outcomes and nurse to patient ratios.

3.84 Two studies cited by nursing organisations showed that enhanced nursing levels have been found to reduce unnecessary hospitalisations in RACF residents with dementia and that high fall rates were associated with fewer nursing hours per resident per day and a lower percentage of RNs. This last study is relevant to the Monash University study cited in chapter two, which outlined that 15 per cent of all RACF resident deaths are from preventable causes, of which 81.5 per cent are from falls.

3.85 Nursing organisations cited a 2016 study by Flinders University and the Australian Nursing and Midwifery Federation which developed an evidence based staffing and skill mix model following research on the acuity of RACF residents, missed care and mapping residents' needs to develop a picture of safe staffing levels. The model did not specify a ratio, but instead called for a skill mix and minimum nursing hours based on residents' care needs.[57] The Australian College of Nursing pointed out that this staffing model would need to be considered in context of funding and financing it.[58]

3.86 QNMU told the committee that arguments positioning the nursing organisations as seeking a hard ratio of nurses to patients was misrepresenting their recommendations for an evidence-based skill mix:

> It [the research] didn't argue for a particular ratio. It asked for a skill mix and a number of hours per resident per day, which is, of course, based on the needs of those residents. If you have the appropriate nursing hours implemented and you have the appropriate skill mix, the ratio takes care of itself. It doesn't have to be a fixed number.[59]

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[56] Ms Claire Hewat, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 15 February 2019, p. 15.

[57] Mrs Helen Macukewicz, Professional Officer, NSW Nurses and Midwives' Association, *Committee Hansard*, 15 February 2019, p. 32.

[58] Ms Susan Emerson, Advisor, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 33.

[59] Mr Jamie Shepherd, Professional Officer, Team Leader, QNMU, *Committee Hansard*, 15 February 2019, p. 33.

3.87 The Aged Care Commission submitted that if there was an 'unambiguously positive correlation' between staff ratios and improvement in care quality, then it would 'merit serious consideration'.[60]

3.88 Both sides of the debate cited the Aged Care Taskforce report, *A matter of care*. Aged and Community Services Australia cited this report as stating '[s]tatic models or set staffing ratios will not...necessarily result in better quality of care outcomes'.[61] The NSW Nurses and Midwives' Union cited the same report as highlighting the lack of skill across the RACF sector at calculating staffing and staff models.[62]

3.89 What is important to note is that in relation to staffing levels, the Aged Care taskforce developed a significantly more nuanced response to the idea of staffing levels than the Aged Care Commission and stated 'the taskforce considers the industry needs to move to a standard approach to workforce planning'.[63]

Professional standards

3.90 Nursing organisations submitted that, as well as impacting care outcomes, staffing levels also impact other obligations of RACF providers outlined in Accreditation Standards, such as ensuring that staff are able to meet their professional obligations. The professional obligations of staff include RNs working within the nursing scope of practice which requires Enrolled Nurses (ENs) and AINs to work under the direction and supervision of a RN. Furthermore the nursing scope of practice requires the RN to assess any work delegated by them to an EN or AIN. The lack of a RN on site 24/7 may breach this requirement.[64]

3.91 QNMU pointed out that to encourage or direct a RN to engage in unprofessional conduct, such as a RN being unable to comply with their statutory duty or a professional standard is an offence the *Health Practitioner Regulation National Law Act 2009* and carries substantial penalties. QNMU further submitted that accreditation standards has gone backwards in this regard, as the previous requirement to have 'systems in place' to ensure compliance with professional standards is absent from the Single quality framework and has been relegated to guidance material.[65]

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60 Aged Care Commission, Answers to Questions on Notice (received 6 March 2019), [p. 6].

61 Aged and Community Services Australia, Answers to written Questions on Notice (received 12 March 2019), p. 2.

62 Mrs Helen Macukewicz, NSW Nurses and Midwives' Association, *Committee Hansard,* 15 February 2019, p. 32.

63 A matter of care, p. 50.

64 QNMU, *Submission 6.1*, pp. 16–17.

65 QNMU, *Submission 6.1*, pp. 16–17.

3.92 When asked about the obligations of RACF providers to ensure staff can maintain compliance with professional standards, the Aged Care Commission quoted the existing Accreditation Standards but did not discuss the soon to be implemented Single quality framework.[66]

Medications

3.93 Chapter two outlined that medications management was the highest area of complaint to the Aged Care Complaints Commissioner, showing that this is an area of significant concern in regulation.

3.94 The Carnell Paterson review made comment on how the regulation of medications management could be improved, and in particular recommended that the aged care regulators look to how this issue is managed in the health care sector. The National Safety and Quality Health Service Standards (NSQHS Standards), the standards by which the acute care sector is regulated, include guidance on suggested key tasks, strategies and resources that health service organisations can use to implement the NSQHS Standards. In the aged care context, there are similar guidelines and best-practice materials available, including for medications management. The Carnell Paterson review recommended that assessment of RACFs should include an expectation that consistent implementation of such guidance is necessary for providers to meet the Accreditation Standards.[67]

3.95 Chapter two contained discussions around the practice of AINs providing assistance to RACF residents to take their medications, and raised questions around whether this practice extended to residents who may be cognitively impaired, which in some jurisdictions would be a breach of local legislation.

3.96 In responding to written questions from the committee asking if assessors review whether medications are being dispensed in compliance with state and territory laws on cognitive impairment, the Aged Care Commission submitted that its role is to assess whether Accreditation Standards are met, which includes whether the RACF provides frameworks to support staff and consumers in using medicines safely and avoid medication errors.[68] By omission, this appears to confirm that the Aged Care Commission does not play a role in reviewing whether AINs are dispensing medications in accordance with the relevant jurisdiction's laws.

3.97 Chapter two also contained extensive discussions around medications safety, including the lack of medications review to combat unsafe drug interactions due to polypharmacy, the over-use of psychotropic medications as chemical

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66 Aged Care Commission, Answers to written Questions on Notice (received 6 March 2019), [p. 4].

67 Carnell Paterson review, pp. 139–140.

68 Aged Care Commission, Answers to written Questions on Notice (received 6 March 2019), [p. 5].

restraint, and the inappropriate dispensing of pro re nata (as needed) medications, which in different environments can be given either too often, or too irregularly.

3.98 In responding to written questions from the committee on whether assessors review the type of psychotropic medication residents are prescribed—as the type of psychotropic can be an indicator of inappropriate prescribing for the purpose of chemical restraint—the Aged Care Commission responded that '[a]ccountability for prescription of all forms of medication rests with the prescribing medical practitioner'. The Aged Care Commission further submitted that under the incoming Single quality framework 'services will be required to ensure that each consumer receives safe and effective clinical care that is best practice, tailored to their needs, and optimises their health and wellbeing' and where there is available guidance on best practice 'services will be expected to use this to inform their approach to care'.[69]

3.99 However, the Aged Care Commission did not indicate how assessors will review whether those available best practice guidelines are being used to deliver real-world best practice. In other words, assessors review the processes put in place by RACFs, but do not review whether those processes result in medications management for individual residents that is safe and appropriate to their needs.

Palliative care

3.100 The South Western Sydney PHN submitted that it is concerned by the omission of a palliative approach in the Single quality framework, and noted that the new standards define end-of-life care to be limited to the terminal phase of life (i.e. the hours or days or occasionally weeks when death is imminent). Other accepted guidelines define end-of-life as the last 12 months of life and include people who are living with advanced, progressive and incurable conditions, which would include dementia and people with frailty combined with co-existing conditions.[70]

3.101 The new Single quality framework provides limited guidance about the palliative care standards that can be expected from a provider. Palliative care is only referred to in Standard 2 where it notes that the organisation needs to be able to demonstrate that it offers 'end of life planning if the consumer wishes' and in Standard 3(c) which relevantly provides that the 'needs, goals and preferences of consumers nearing the end of their life are recognised and addressed, their comfort maximised and their dignity preserved'.[71]

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[69] Aged Care Commission, Answers to written Questions on Notice (received 5 March 2019), [p. 8].

[70] South Western Sydney PHN, *Submission 84*, p. 5.

[71] Quality of Care Amendment (Single Quality Framework) Principles 2018, sch. 1, item 35.

3.102 The Australian College of Nursing considers that this is insufficient because the standards do not encompass the whole of palliative care. The Australian College of Nursing submitted that a consistent framework was necessary to ensure that patients and their family members receive a consistent standard of service:

> It is the frailty and co-morbidities frequently found in aged care that make palliative care including end-of-life support so critical. There is concern that without an underpinning framework with which to hold providers more accountable, there will continue to be unacceptable inconsistency in palliative care delivery and make it harder for residents/consumers, and their families, carers and representatives, to understand what they can expect from their service provider.[72]

3.103 Instead the Australian College of Nursing advocated for 'clear and measurable standards that are specifically applicable to residential aged care'.[73]

3.104 Recommendations to improve palliative care and advance care planning were made by the National Health and Hospitals Reform Commission in its 2009 report *A healthier future for all Australians.* This report recommended sweeping changes to how health care is delivered in RACFs and specific to palliative care, recommended that RACF providers be required to have staff trained in supporting people to complete advanced care plans, and recommended governments strengthen access to specialist palliative care services with a special emphasis on RACF residents.[74]

Wellness and reablement

3.105 Where palliative care seeks to comfortably manage a person's end-of-life care, wellness and reablement focuses on increasing and maintaining a RACF residents' quality of life for as long as possible. Some submitters and witnesses raised concerns that the concepts of wellness or reablement were not adequately represented in the new or existing standards.

3.106 Dementia Australia recommended changing how the sector thinks of a home-like environment and instead advocated thinking of an enabling environment.[75] Royal Australian and New Zealand College of Psychiatrists (RANZCP) made similar observations and pointed to the funding system

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[72] Australian College of Nursing, *Submission 89*, p. 13.

[73] Australian College of Nursing, *Submission 89*, p. 14.

[74] National Health and Hospitals Reform Commission, *A healthier future for all Australians*, June 2009, p. 23.

[75] Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 22.

which is focused on how disabled a person is, which does not provide any incentive for reablement.[76]

3.107 The new accreditation standards require the organisation to 'optimise health and well-being'.[77] The Aged Care Guild suggested that this may infer a focus on rehabilitation and reablement. If this is the case, the Aged Care Guild indicated that it would be supportive of this aim, but it considered that the current ACFI would need to be adjusted to align incentives towards rehabilitation.[78]

3.108 The Australian College of Nurse Practitioners recommended that assessors could review the mobility of residents on admission to identify how long before mobility is lost, as it is common to see residents put into recliner chairs or wheelchairs because it is quicker for staff.[79]

3.109 A similar approach could be adopted with patients with mental health and cognitive issues. Dementia Australia noted that restorative and rehabilitative practices have been associated with improved mood and behaviour in people with cognitive impairments. Dementia Australia noted that this is possible when there is a clear allocation of responsibility for older people who have cognitive impairments. Dementia Australia further noted examples of the Psychogeriatric Nursing Homes in Victoria and the Psychogeriatric Care Units in Western Australia where there is an explicit focus on behavioural assessment and rehabilitation.[80]

Dementia care, mental health and restrictive practice

3.110 As outlined in chapter two, dementia accounts for a large part of the clinical care requirements in RACFs, as over half of all residents have a diagnosis of dementia. Chapter two also outlined the very high rates of restrictive practice being used in RACFs, predominantly in the form of the overuse of psychotropic medications as a form of chemical restraint.

3.111 Dementia Australia told the committee that the aged care regulation system does not appropriately place dementia care at the core of RACF services, and that it is imperative to 'make that happen in a consistent, transparent and accountable way'.[81]

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[76] Associate Professor Stephen Macfarlane, Chair, Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, 15 February 2019, p. 25.

[77] Quality of Care Amendment (Single Quality Framework) Principles 2018, Standard 3(2).

[78] Aged Care Guild, *Submission 15*, p. 18.

[79] Australian College of Nurse Practitioners, *Submission 92*, [p. 2].

[80] Dementia Australia (formerly Alzheimer's Australia), *Submission 20,* [p. 26].

[81] Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 18.

3.112 RANZCP told the committee the new Single quality framework emphasises 'the need for facilities to evidence that they use best practice in the management of behavioural disturbances and dementia', which would require a comprehensive set of interventions as a first line before any restrictive practice is implemented.[82] However RANZCP later pointed out that the relatives of the person with dementia won't necessarily know what best practice is, in order to be able to advocate for care quality.[83]

3.113 In relation to regulating the use of restrictive practice in the RACF sector, the Health Care Commission advised the level of regulation should be the same as in the health sector, particularly noting the increased expertise in the health sector to deal with issues that may lead to restrictive practice.[84] The Older Persons Advocacy Network recommended that restrictive practice oversight should mirror that used in the child protection system.[85] The House of Representatives Standing Committee on Health, Aged Care and Sport's 2018 inquiry into the quality of care in RACFs (House of Representatives Committee inquiry) also recommended new legislation to regulate restrictive practices.[86]

3.114 The Aged Care Commission told the committee that guidance on the use of restrictive practice, like any other clinically oriented practice, is expected to be outlined in the clinical governance frameworks that each RACF is expected to have in place. The Aged Care Commission further told the committee it has inserted new screening questions for restrictive practice:

> We have now inserted two specific screening questions, one in relation to the use of psychotropic medication, 'As a proportion of all residents, how many residents are currently using psychotropic medication?' and the second in relation to physical restraint, 'The number of residents subject to physical restraint as a proportion of total residents?' These are just high-level indicators which will subtly or more significantly influence where and what the quality assessor looks at in the course of their visit.[87]

3.115 However the Aged Care Commission did not provide any information on benchmarks it uses to determine what percentage of people in an RACF being

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82 Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard*, 15 February 2019, p. 20.

83 Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard*, 15 February 2019, p. 26.

84 Adjunct Professor Debora Picone, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 50.

85 Mr Craig Gear, Chief Executive Officer, Older Persons Advocacy Network, *Committee Hansard*, 15 February 2019, p. 50.

86 House of Representatives Standing Committee on Health, Aged Care and Sport, *Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australi*a, pp. xxi–xxiv and 133.

87 Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 57.

prescribed psychotropic medications would indicate potential overuse by the facility.

3.116 The Department told the committee that the Minister requested the Chief Medical Officer for the Department to convene an expert advisory group of medical, pharmacy, nursing and other clinicians to look at issues around chemical restraint, particularly workforce culture issues, and make any further regulatory recommendations to the Minister for consideration.[88]

3.117 As outlined in chapter two, on 30 March 2019 the Minister made an announcement that he intends to make changes in relation to physical and chemical restraint which will apply from 1 July 2019.[89]

3.118 The announced changes include:

- For physical restraint a provider must have informed consent of consumer or representative, except in an emergency. No such requirement for chemical restraint was flagged.
- For physical restraint, a health practitioner must assess the person before any physical restraint can be used.
- For chemical restraint, the prescribing practitioner must assess the person before chemical restraint can be used.

Box 3.1 Restrictive practice in the disability sector

The introduction of the National Disability Insurance Scheme (NDIS) Quality and Safety Commission (NDIS Commission) has seen a focus on person-centred behaviour strategies which seek to 'address the underlying causes of behaviours of concern, or challenging behaviours, while safeguarding the dignity and quality of life of people with disability who require specialist behaviour support'.

Following the endorsement of the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector by state and territory governments in 2014, the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 were developed to reduce the use of restrictive practice in the disability sector.

Under the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018, restrictive practice includes seclusion, chemical restraint, mechanical restraint, physical restraint and environmental restraint.

Registered providers who provide behaviour support to NDIS participants must comply with the NDIS Quality and Safeguarding Framework and any state or territory laws which regulate and authorise the use of restrictive practice.

In instances where an NDIS participant exhibits behaviour of concern, which puts

[88] Professor Brendan Murphy, Chief Medical Officer, Department of Health, *Committee Hansard*, 15 February, p. 61.

[89] The Hon. Ken Wyatt AM, Minister for Older Australians and Aged Care, 'Stronger Restraint Regulations to Protect Senior Australians', *Media release*, 30 March 2019.

themselves or others at risk of harm, and the use of restrictive practice is considered warranted, a registered provider must develop a behaviour support plan for the participant in consultation with the participant, their family (or carer or guardian) and the service providers who will implement the plan.

Behaviour support plans must be:

- developed by a specialist behaviour support practitioner;
- specify a range of evidence-based and person-centred strategies that focus on the needs of the individual;
- contain strategies to reduce or eliminate the use of restrictive practice; and
- lodged with the NDIS Commission.

Where restrictive practice is used, 'it must be the least restrictive response possible in the circumstances, reduce the risk of harm to the person or others, and be used for the shortest possible time to ensure the safety of the person or others'.

Registered NDIS providers who use restrictive practice must report monthly to the NDIS Commission on its use and report any unplanned or unapproved use of restrictive practice.[90]

Committee view

3.119 The committee acknowledges the extensive evidence from clinicians that a model of care and a clinical governance framework are vital to delivering safe and effective clinical services.

3.120 The committee does not intend to provide targeted comments on what specific elements are missing from the RACF model of care and what could be done to improve it, when it is clearly evident to the committee that there simply is no industry-standard model of care at all.

3.121 The committee is highly concerned with the lack of appropriate clinical governance frameworks in operation across the RACF sector, particularly in light of the evidence which shows that it is a requirement of the existing Accreditation Standards. The committee is further troubled by evidence that these requirements for clinical governance are watered down in the incoming Single quality framework.

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[90] See: NDIS Quality and Safety Commission (NDIS Commission), *Behaviour support (NDIS Providers)*, https://www.ndiscommission.gov.au/providers/behaviour-support (accessed 5 March 2019), Department of Social Services, National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector, https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector (accessed 5 March 2019), National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018, ss 6, 16, 17, 20, 21, 24.

3.122 In relation to staffing levels, the committee concurs with the views of the AMA that inadequate staffing prevents quality care. The committee further notes that without a RN on duty, medications may not always be available, nor can delegated care be monitored in a timely fashion. While this may not be necessary in all RACF service contexts, it does apply to many.

3.123 The committee is highly concerned with the oversight of medications in RACFs. There appears to be no external oversight mechanism to ensure that medications in RACFs are being managed safely, are prescribed appropriately, and are administered according to relevant laws.

3.124 The committee acknowledges the announcement from the Minister on soon to be released limitations on restrictive practice in RACFs.

3.125 The committee is of the view that oversight of restrictive practice in the aged care context cannot be any less than the oversight in any other care context, such as that used in the health or disability care context. To do so would be clearly stating that older vulnerable Australians are less deserving of protection than other groups.

3.126 Without wishing to pre-empt the advice of expert clinicians tasked with reviewing the use of chemical restraint in aged care, the committee is firmly of the view that the existing frameworks for regulating the use of restrictive practice should be extended to other service delivery contexts, wherever it is used, in this case the aged care context.

Aged Care Commission Assessors

3.127 The Aged Care Commission outlined that its approach to accreditation assessments is to seek evidence that each RACF has appropriately addressed the requirements of the Single quality framework:

> [A] fundamental expectation that we as regulators have of providers is that they have the systems and processes in place to ensure that the care that's delivered, including the clinical care, is overseen, is fit for purpose and is regulated within the home before we even come to look at it.[91]

3.128 In addition to concerns raised with the standards contained in the Single quality framework, discussed above, submitters and witnesses raised issues relating to how accreditation assessments are conducted.

3.129 Many witnesses and submitters recommended that Aged Care Commission Assessors (assessors) should have clinical knowledge and, or background. This issue was raised by both RACF providers groups as well as medical bodies.[92]

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[91] Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 61.

[92] See for example Mr Keith McDonald, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 4; Aged Care Guild, *Submission 15*, p. 19; Benetas, *Submission 61.1*, [p. 1]; Quality Aged Care Action Group Incorporated, *Submission 72.1*, p. 3; Australian College of Nurse Practitioners, *Submission 92*, [p. 1].

Leading Age Services Australia summed it up neatly and told the committee '[w]hen it comes to the lack of expertise, it's really that a clinician needs to judge the clinical performance of a facility'.[93]

3.130 RANZCP agree that assessors with a clinical background would be able to observe the way that staff interact with residents and 'you'd get far more information about the appropriateness of care by doing that than you would by reviewing the tick-and-flick tickbox situation that currently exists'.[94]

3.131 The Brisbane North PHN recommended assessors have a clinical background as this also brings a focus on quality of life and wellness to balance the clinical needs of a resident.[95]

3.132 Allied Health Professions Australia pointed out that only assessors from a clinical background would have a capacity to assess whether the appropriate clinical governance principals are being applied.[96]

3.133 Leading Age Services Australia discussed the inconsistent interpretation of quality standards, citing 'concern that some auditors may lack the expertise required for this important role' and pointed to a survey which showed over 20 per cent of respondents 'were either dissatisfied or unsure about the assessment teams' depth of knowledge and understanding of aged care or, indeed, the application of standards'. Leading Age Services did point out that the identified issues would be resolved through improved training and continued professional development.[97] Bupa echoed these concerns around inconsistency of assessors' approaches.[98]

3.134 The Aged Care Commission told the committee that some of their strongest assessors do not have a clinical background but may have performed in another regulatory environment, and that all staff have access to timely clinical advice.[99] The Aged Care Commission further outlined the recruitment and training of assessors, which included:

- Assessors are recruited to ensure an overall diverse skill background.

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93 Ms Marlene Eggert, Senior Policy Officer, Leading Age Services Australia, *Committee Hansard*, 15 February 2019, p. 4.

94 Associate Professor Stephen Macfarlane, RANZCP, *Committee Hansard*, 15 February 2019, p. 20.

95 Ms Michele Smith, Executive Manager, Aged and Community Services, Brisbane North PHN, *Committee Hansard*, 15 February 2019, p. 40.

96 Ms Claire Hewat, Allied Health Professions Australia, *Committee Hansard*, 15 February 2019, p. 13.

97 Mr Sean Rooney, Chief Executive Officer, Leading Age Services Australia, *Committee Hansard*, 15 February 2019, p. 1.

98 Bupa, *Submission 18*, p. 9.

99 Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 64.

- Assessors undertake an exam and training on entering the service, which is 'rigorous' and 'not everyone gets through'.
- Assessors have guided continuing professional development obligations.
- There is a conflict of interest protocol regarding associations with the sector.[100]

3.135 Witnesses also raised concerns that 'some members have also observed examples of behaviours of some auditors perceived to be punitive or aggressive in their engagement with providers' staff'.[101]

3.136 The Aged Care Commissioner responded to these allegations by stating 'if they weren't just a little bit uneasy about the work of my assessors, I might be uneasy'.[102]

3.137 Leading Age Services Australia noted to the committee that the *A matter of care* report by the Aged Care Taskforce recommended that building capability and competence in the aged care workforce was necessary, but equally necessary was the same workforce improvements on the regulator side.[103]

3.138 QNMU made a similar comment on building capacity and recommended the Aged Care Commission work more closely with accreditors in the hospital sector to develop a similarly effective accreditation process in the aged care sector.[104]

Data collection

3.139 The Carnell Paterson review stated:

> Intelligence gathering and effective data management is critical to ensure that the regulatory system is responsive, both to support the mitigation of risk and to rapidly detect and address poor-quality care...
>
> We consider that this comprehensive vision of data management is currently missing in aged care quality regulation in Australia.[105]

3.140 The Carnell Paterson review made extensive comment on the need for better data collection and publication for the benefit of regulators, RACF providers, clinicians and for residents and their families.[106]

3.141 The NSW Nurses and Midwives' Association submitted that there are no current clinical benchmarks that span the public, not-for-profit and private

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[100] Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, pp. 57–58.

[101] Mr Sean Rooney, Leading Age Services Australia, *Committee Hansard,* 15 February 2019, p. 1.

[102] Ms Janet Anderson, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 58.

[103] Mr Sean Rooney, Leading Age Services Australia, *Committee Hansard,* 15 February 2019, p. 7.

[104] QNMU, *Submission 6.1*, p. 15.

[105] Carnell Paterson review, pp. 82–83.

[106] Carnell Paterson review, pp. 82–104.

aged care sector, and noted that the collection of data should be used by the Aged Care Commission to inform judgments about compliance.[107]

3.142 The Royal Australian College of General Practitioners recommended aggregate measures of quality be established and be made available for RACFs to compare against, not done 'in a punitive way...but there should be feedback to individual facilities about how they sit compared to other facilities in that sort of group'.[108]

3.143 Bupa made a similar recommendation, that the regulator provide the sector with information on non-compliance themes, so the sector can work together to improve.[109]

3.144 Bupa further noted that data collection and sharing is important for continuous quality improvement across the sector, but this is hampered by reporting systems that vary greatly across the sector so data cannot be compared like-for-like. An industry-wide move to a digital environment would assist in collaboration and data sharing.[110]

3.145 The Aged Care Taskforce made recommendations on data that went beyond improving the way data is collected and published. The Aged Care Taskforce recommended the establishment of the Aged Care Centre for Growth and Translational Research to formalise collaboration between all aged care input stakeholders to support aged care workforce related research. This would include:

- a minimum data set which will provide an objective benchmark for care outcomes and assessment of the impact of interventions
- evidence-based models of care, guidelines and assistive technologies to improve workforce productivity and care quality.[111]

Quality indicator program

3.146 The Department operates the National Aged Care Quality Indicator Program for the RACF sector, which is a voluntary program that collects data on pressure injuries, use of physical restraint and unplanned weight loss.[112]

3.147 The 2018 House of Representatives Committee inquiry into RACFs recommended the program be made mandatory with an expansion of the data

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[107] NSW Nurses and Midwives' Association, *Submission 2.2*, p. 10.

[108] Dr Harry Nespolon, President, Royal Australian College of General Practitioners, *Committee Hansard*, 15 February 2019, p. 14.

[109] Bupa, *Submission 18*, p. 12.

[110] Bupa, *Submission 18*, p. 22.

[111] A matter of care, p. 84.

[112] Department of Health, *Submission 37*, p. 7.

captured, to be determined with the involvement of the aged care sector and consumer groups.[113]

3.148 The Australian College of Nursing recommended that additional indicators that should be included are restraint prevalence, falls, nursing hours per resident per day, pressure injury and preventable infection rates and nursing skills and skill mix of the workplace, which would draw Australia more in line with international standards such as the National Database of Nursing Quality Indicators.[114]

3.149 The Department told the committee the program would now be made mandatory and the indicators would be expanded to include data on medication management and falls.[115] This is in line with recommendations of the Carnell Paterson review, which stated that '[u]nlike some other countries, Australia does not have a mature quality indicator system'.[116]

Mortality audits

3.150 Mortality audits, or death reviews, were cited by submitters and witnesses as 'a really important way of looking at the service you provided and ensuring that it met the patient's needs, and it forms a part of the clinical governance structure and it feeds information back that we can learn from'.[117] The Health Care Commission confirmed that these were not currently conducted in the RACF environment in the same regular way it occurs in the health sector.

3.151 The Chief Medical Officer for the Department confirmed that a mortality index can be useful to provide indicators on clinical care, but would need to reviewed carefully due to the care environment of RACFs. The Chief Medical Officer also told the committee that unexpected deaths, or those arising from poor quality care, are supposed to be reported to the relevant coroner, but this can be hampered by death certificates which may not always be accurately completed.[118]

3.152 The interim Chief Clinical Advisor for the Aged Care Commission outlined that mortality audits in the aged care context can be complex due to lag factors,

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[113] House of Representatives Standing Committee on Health, Aged Care and Sport, *Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, October 2018, pp. xxi–xxiv and 133.

[114] Australian College of Nursing, *Submission 89*, p. 3.

[115] Ms Maria Jolly, Department of Health, *Committee Hansard*, 15 February 2019, p. 60.

[116] Carnell Paterson review, p. 41.

[117] Adjunct Professor Debora Picone and Dr Amanda Walker, Clinical Director, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 55.

[118] Professor Brendan Murphy, Chief Medical Officer, Department of Health, *Committee Hansard*, 15 February, p. 62. See also Adjunct Professor Debora Picone, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 55.

such as where a fall led to a decline in health that ultimately resulted in a death, however data does provide opportunities to improve care and eliminate or reduce clinical variance.[119]

3.153 The Health Care Commission told the committee that the Department has asked it to provide advice on morbidity and mortality audits used in the health care context that could be applied in the RACF sector.[120]

3.154 As outlined in chapter two, Monash University has undertaken extensive research into the area of preventable deaths in RACFs. While this research was hampered by a lack of quality data from the aged care sector and relied on coronial reports, it has resulted in a number of recommendations to reduce rates of preventable injury and death in RACFs. These recommendations could have been improved with appropriate data collection and publication from the RACF sector.

Committee view

3.155 The committee agrees with the views so well expressed by the Carnell Paterson review and the Aged Care Taskforce on the need for data collection. The committee believes the subsequent recommendations of those bodies, if implemented, would be important first steps to ensure that data collection supports ongoing research, clinical best-practice and consumer choice.

Regulation of AINs

3.156 As outlined in chapter two, nursing professional bodies noted that the increasing prevalence of co-morbidities within the aged population requires more complex care that, under the nursing scope of practice, can only be provided under the direct supervision of a RN. This means that personal care workers or people who have similar titles that provide traditional care elements should be considered as AINs.[121]

3.157 The Australian College of Nursing recommended that AINs be regulated under the same registration scheme as doctors and nurses, the National Registration and Accreditation Scheme (NRAS) which is undertaken by the Australian Health Practitioner Regulation Agency.[122]

3.158 The Coalition of Australian Governments (COAG) Health Council considered the issue of registering care workers under NRAS, but instead developed a

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[119] Associate Professor Michael Murray, Interim Chief Clinical Adviser, Aged Care Commission, *Committee Hansard*, 15 February 2019, p. 62.

[120] Adjunct Professor Debora Picone and Dr Amanda Walker, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 55.

[121] Australian College of Nursing, *Submission 89*, p. 2.

[122] Adjunct Professor Kylie Ward, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 29.

'negative licensing regulatory scheme' for healthcare workers in the form of a National Code of Conduct for health care workers.[123] This form of regulation does not apply high barriers to entry to practice, but allows for action to be taken against a health care worker who fails to comply with proper standards of conduct or practice.[124]

3.159 It is unclear whether personal care workers in RACFs are covered by the National Code of Conduct for health care workers. The Australian Law Reform Commission noted in its examination of the code that AINs are covered by the code. However, notwithstanding the views of nursing professional bodies, it is less clear whether a personal care worker or an aged care worker falls within the definition of a person who provides a 'health service'.[125]

3.160 The Australian Law Reform Commission considered that all aged care workers who provide direct care services should be covered by the National Code of Conduct and considered that legislation should be enacted to ensure that these workers are covered by the relevant definition.[126]

3.161 Other stakeholders considered that more stringent regulation was required. The Aged Care Taskforce considered whether personal care workers should be included under the National Code of Conduct for health care workers. Similarly to the Australian Law Reform Commission, it found that the National Code of Conduct did not extend enough to include personal care workers within its remit. In addition, it considered that National Code of Conduct itself did not meet the more stringent standards of a national registration process, because it lacks minimum training standards and continuing professional development requirements.[127]

3.162 The Aged Care Taskforce made a number of recommendations linked to an industry code of practice that would include an industry-led workforce accreditation system and centralised registration to ensure that all workers have completed mandatory police checks and are trained and accredited to work with aged care consumers.[128]

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[123] Coalition of Australian Governments (COAG) Health Council, *A national code of conduct for health care workers-Frequently Asked Questions*, p. 1.

[124] A prohibition order can be made by a tribunal. COAG Health Council, *A national Code of Conduct for health care workers—Frequently asked questions*, p. 1.

[125] Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, DP 83, 12 December 2016, para. 11.221.

[126] Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, DP 83, 12 December 2016, para. 11.221.

[127] A matter of care, p. 41.

[128] Department of Health, *Aged Care Workforce Strategy Taskforce Terms of Reference*, pp. 34–42, https://agedcare.health.gov.au/reform/aged-care-workforce-strategy-taskforce/aged-care-workforce-strategy-taskforce-terms-of-reference (accessed 23 March 2019).

3.163 The Older Persons Advocacy Network pointed to low-impact regulation of other professions such as electricians and plumbers, and wondered why there could not be regulation of aged care workers 'who are delivering such an important role'. The Older Persons Advocacy Network went on to recommend workforce regulation should address poor performers moving between employers, training standards and ongoing professional development.[129]

3.164 Bupa recommended a national registration scheme for AINs with a minimum level of qualification, but did not provide detail on how this should operate.[130]

Committee view

3.165 The committee considers that there needs to be additional regulation of personal care workers and aged care workers in RACFs. The committee notes that full NRAS registration may not be necessary, but that at minimum, people providing direct care should be covered by the National Code of Conduct for health care workers. The committee considers that a central registry may be desirable.

[129] Mr Craig Gear, Older Persons Advocacy Network, *Committee Hansard*, 15 February 2019, p. 52.

[130] Bupa, *Submission 18*, p. 7.

Chapter 4
The right environment for the right care

4.1 The fundamental purpose of the regulatory framework for aged care is to create an environment to support the delivery of appropriate standards of accommodation, personal and clinical care to the residents of residential aged care facilities (RACFs). The purpose of this inquiry, as articulated in the Terms of Reference, is to investigate how effective the aged care regulatory framework is in achieving that objective.

4.2 The aged care regulatory framework does not operate in isolation to impact the quality standards of aged care service delivery. Two key factors which also impact the quality of aged care, are the funding environment and the aged care sector's interactions with the health care sector.

4.3 This chapter explores how RACFs interact with external health care sectors and whether additional amendments to regulation or funding mechanisms are required to ensure that the person is placed at the centre of service delivery.

4.4 As outlined in previous chapters, the committee is defining clinical care as health care provided by a health professional, while medical care is the health care provided by a medical practitioner, often a General Practitioner (GP).

Integration with primary health and acute care

4.5 Leading Age Services Australia told the committee that the siloed approach to primary health, acute care, aged care and social services needs to be broken down into a person-centred 'ageing well' system:

> That view would then see supports for older people as they age around preventative health, around support for ageing well...Then when they do require clinical care or support, whether that be in their home or at a doctor's surgery or hospital or a residential care facility, that is made available to them. So the system doesn't create barriers for access.[1]

4.6 These arguments for better integration between the aged care and the primary health and acute care sectors are not new. The 2009 report by the National Health and Hospitals Reform Commission, *A healthier future for all Australians*, made recommendations for national access targets for the health system and recommended that aged care be included in reporting on 'the continuum of health services'. The report went on to make recommendations to better integrate the health and aged care systems.[2]

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[1] Mr Sean Rooney, Chief Executive Officer, Leading Age Services Australia, *Committee Hansard*, 15 February 2019, p. 4.

[2] National Health and Hospitals Reform Commission, *A healthier future for all Australians*, June 2009, pp. 5–6.

4.7 In its 2018 report, *A matter of care*, the Aged Care Workforce Strategy Taskforce (Aged Care Taskforce) developed 14 recommended actions, one of which was 'Strategic action 9: Strengthening the interface between aged care and primary/acute care' because 'integration of these systems could be achieved by taking a population health approach, which structures care systems around the needs of consumers rather than around available funding'.

4.8 The Aged Care Taskforce stated that to achieve better integration, there needs to be 'a frank discussion across the social and health care industries and all levels of government about how to restructure care and design more flexible funding mechanisms that support consumers to transition more easily between Commonwealth, state and privately funded services'.[3]

4.9 The Aged Care Taskforce made many specific recommendations on actions to achieve the goal of better integration and overall recommended the establishment of Social Care Networks, potentially to be operated by the existing Primary Health Networks (PHNs) to achieve these aims.[4]

Role of PHNs

4.10 PHNs are the central regional point for funding, planning and commissioning of primary health services in a local area with a view to better integration and coordination of the health system.[5] This is supposed to include better coordination and integration between the health and aged care sectors.

4.11 PHNs have already taken some steps to promote better integration between the health and aged care sectors. PHNs have recently been tasked with the co-design and delivery of psychological services within RACFs, but there is still capacity for PHNs to take on a broader role in establishing networks between health practitioners and RACFs.[6] The Department of Health (Department) notes that aged care is one of the six key priority areas for targeted work by PHNs.[7]

4.12 The Western Queensland PHN considers that PHNs have a role in supporting better integration and linkage across and between the aged care sector, primary health and acute hospital sector, the Aboriginal Community Controlled health sector, the National Disability Insurance Scheme, non-governmental organisations and the social care sector.[8]

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3 Aged Care Workforce Strategy Taskforce, *A matter of care*, June 2018, pp. 68.

4 A matter of care, pp. 68–72.

5 Department of Health, *Submission 37*, p. 35.

6 South Western Sydney Primary Health Network (PHN), *Submission 84*, p. 4.

7 Department of Health, *Submission 37*, p. 35.

8 Western Queensland PHN, *Submission 81*, p. 5.

4.13 South Western Sydney PHN noted that at a high level, the PHN can liaise with RACFs to ensure that there is appropriate clinical data exchange and communication between the clinician and the RACF.[9] Chapter two highlighted a project undertaken by a PHN in Queensland to integrate My Health Record into the health record keeping system of a RACF provider.

4.14 South Western Sydney PHN identified practical ways that it could assist to facilitate better interaction between primary care and RACFs:

> [W]e would help advise facilities about what would make clinical care in the facility easier—basic things like having dedicated consulting spaces; coordinating records, so that GPs can use the records, and making the records more user-friendly; working with a registered nurse on site; doing a session with patients, so they are easier to find and easier to follow, rather than leaving the GP to their own devices to find the patients.[10]

4.15 As outlined earlier in this chapter, the Aged Care Taskforce suggested that this role could be taken further with the establishment of Social Care Networks to 'better assess local aged and disability care service demands' and improve service coordination.[11] The Aged Care Taskforce suggested that this role could be added to the scope that PHNs already have, or a separate body could be established to work in concert with PHNs.[12]

Issues with current delivery of medical care

4.16 Submitters and witnesses raised a number of concerns about the current quality of medical care being delivered to RACF residents, further highlighting the need for better integration with the primary health care sector.

4.17 RACFs are funded under the Aged Care Funding Instrument (ACFI) to provide accommodation and personal care, as well as some clinical care.[13] However, as RACF residents are predominantly people with complex health care needs, they often require a great deal of clinical care beyond day-to-day nursing care.

4.18 As with other areas of clinical care in the aged care context, there are distinctly opposing views on whether medical care is an issue the aged care regulatory frameworks should be considering at all, given that RACF providers do not provide medical care under the ACFI. As outlined in chapter two, RACF providers also argue that as they are not responsible for the standards of

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[9] Mr Keith McDonald, Chief Executive Officer, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 43.

[10] Mr Keith McDonald, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 43.

[11] A matter of care, p. 72.

[12] A matter of care, p. 72.

[13] Generally, clinical care in residential aged care facilities is nursing care.

medical care, the standards of medical care should not be a matter for the aged care regulatory framework.

4.19 However, the Australian Commission on Safety and Quality in Health Care (Health Care Commission) submitted that RACF providers have a non-delegable duty of care to residents to protect the resident from harm.[14] This duty of care would extend to external medical services provided on-site in RACFs.

4.20 The Health Care Commission told the committee:

> The providers know this, so the fact that they're saying that they're not responsible for medical care or even posing these questions to you I find nothing short of remarkable. They can't hide behind an individual medical doctor's prescribing or treatment practices...when it's frequently the aged-care institution instigating the request for medical care.[15]

4.21 Furthermore, Leading Age Services Australia submitted that under the *Aged Care Act 1997* (Cth) the RACF provider is ultimately responsible for the overall care of the care recipient, although RACF providers responsibility for the quality of care delivered by visiting health professionals 'has not been tested and remains a grey area'.[16]

4.22 The Terms of Reference for this inquiry clearly provide scope to investigate how effective the aged care regulatory framework is for ensuring proper medical care standards are maintained and practised. The disagreement over the lines of responsibility for the provision of medical care in the RACF environment would indicate that the regulatory framework is not doing that well, if at all.

4.23 Older Persons Advocacy Network noted that the Clinical Governance Framework, outlined in Standard 8 of the Single quality framework, does not include accountability arrangements with visiting professionals to ensure that a facility can demand an appropriate standard of care.[17] Brisbane South PHN informed the committee that a clear process for the accountability of visiting providers, such as GPs, was necessary.[18]

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[14] Australian Commission on Safety and Quality in Health Care (Health Care Commission), Answers to written Questions on Notice (received 5 March 2019), [p. 1].

[15] Adjunct Professor Debora Picone AO, Chief Executive Officer, Health Care Commission, *Committee Hansard*, 15 February 2019, p. 47.

[16] Leading Age Services Australia, Answers to written Questions on Notice (received 6 March 2019), p. 9.

[17] Older Persons Advocacy Network, *Submission 23.1*, p. 3.

[18] Ms Lucille Chalmers, General Manager Commissioned Programs, Brisbane South PHN, *Committee Hansard*, 15 February 2019, p. 38.

4.24 The Australian Medical Association (AMA) submitted that medical practitioners are not provided with adequate access to their patients. The AMA has recommended the standards be amended to explicitly incorporate an 'access to medical care' standard to ensure that residents' medical needs are met by qualified medical practitioners.[19]

4.25 However, the Chief Medical Officer of the Department noted that Medicare evidence suggests that RACF residents receive 'good' medical review via GP visits 23 times per year, but challenges still exist in getting urgent care when a person deteriorates.[20]

4.26 The AMA cited a survey conducted in 2017 which found that one in three GPs planned to cut back or end visits to RACFs within the next two years due to inadequate Medicare fees and a lack of suitably trained and experienced nurses in RACFs.[21]

4.27 The South Western Sydney PHN reported similar issues, with GPs in its catchment area reporting they are progressively moving away from regular visits to RACFs due to logistical challenges, lack of appropriate consultation space and the availability of skilled staff, particularly RNs, to carry out prescribed treatments in RACFs.[22]

4.28 The Australian College of Nurse Practitioners submitted a similar view, stating that visiting medical staff often do not report poor standards of care, where their directives are not followed and clinical issues are not reported early.[23]

4.29 Bupa has met the challenge of limited external GPs being willing to treat RACF residents by establishing an in-house GP service.[24] The AMA discussed the provision of medical care through an on-site GP, raising concerns that this may take choice away from the patient and would impose on the GP 'an employer-employee relationship rather than having someone coming in from the outside who's able to provide independent eyes looking at the care of a patient'.[25]

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19 Australian Medical Association, *Submission 13*, p. 3.

20 Professor Brendan Murphy, Chief Medical Officer, Department of Health, *Committee Hansard*, 15 February 2019, p. 66.

21 Australian Medical Association, *Submission 13.1*, p. 2.

22 South Western Sydney PHN, *Submission 84*, p. 3.

23 Australian College of Nurse Practitioners, *Submission 92*, [p. 2].

24 Bupa, *Submission 18*, p. 5.

25 Dr Harry Nespolon, President, Royal Australian College of General Practitioners, *Committee Hansard*, 15 February 2019, p. 11.

4.30 By contrast, the Australian College of Nursing pointed out that locating GPs in RACFs would enable them to 'be much more sensitive to the nuances of how the day works, where the person is and where they want to see them'.[26]

4.31 The National Health and Hospitals Reform Commission recommended that 'funding be provided for use by residential aged care providers to make arrangements with primary health care providers and geriatricians to provide visiting sessional and on-call medical care to residents of aged care homes'.[27]

Allied health care

4.32 Allied Health Professions Australia told the committee that the work of allied health professionals is not valued by RACFs and that this leads to a lack of continuity of care and declining function among residents. However, Allied Health Professions Australia considered that the current funding model was the primary cause of RACFs' current approach to allied health care.[28]

4.33 Submitters pointed out that a number of recent reviews of the ACFI had noted the lack of support for allied health services and the effect this has had on care recipients.[29]

4.34 In its report, *A matter of care*, the Aged Care Taskforce noted that there are a number of factors that all combine to limit the availability of allied health services in an RACF. These include the limited number of allied health services and the types of services that are subsidised under the Medicare Benefits Schedule, combined with the level of subsidy and the requirement for referral by a GP. Each factor would need to be addressed in order to increase the prevalence of allied health services in RACFs.[30]

4.35 The Aged Care Taskforce also noted that there is significant confusion about what services should be funded by RACFs and what services must be privately funded by the care recipient.[31]

Care plans

4.36 The integration of externally developed care plans into RACF services was a matter raised by submitters and witnesses as an area that could be improved.

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[26] Ms Susan Emerson, Advisor, Australian College of Nursing, *Committee Hansard*, 15 February 2019, p. 33.

[27] A healthier future for all Australians, p. 23.

[28] Ms Claire Hewat, Chief Executive Officer, Allied Health Professions Australia, *Committee Hansard*, 15 February 2019, p. 9.

[29] Allied Health Professions Australia, *Submission 90*, [p. 3].

[30] A matter of care, p. 68.

[31] A matter of care, p. 68.

4.37 Before a recipient is admitted to a RACF, they must first be assessed by an Aged Care Assessment Team which considers the person's medical, physical, psychiatric, psychological and social needs to determine their eligibility and suitability for aged care services.[32] The Australian Law Reform Commission noted that assessment is one way the Commonwealth seeks to ensure that the limited number of aged care places go to people who need them most.[33] These assessments are not currently used to develop a care plan for the care recipient.[34]

4.38 The committee was advised that when a care recipient enters a RACF, their GP, who usually provides the lead in coordinating care, often does not follow the person when they enter residential aged care. Instead, the care recipient may see a number of different GPs, limiting their continuity of care.[35]

4.39 The South Western Sydney PHN explained that developing a care plan for each resident could assist in the coordination of clinical care and add to the systems that are already available through the My Health Record system.[36]

4.40 The Department advised the committee that there is a long-term vision to ensure interoperability between My Aged Care and My Health Record.[37] However, that interoperability is not yet available.

4.41 The Australian and New Zealand Society for Geriatric Medicine told the committee that a care plan developed for a RACF care participant needs to be comprehensive so that an appropriate clinical team can be wrapped around the person:

> The overwhelming importance is linking any outcomes of assessment with a management plan... It's actually about wrapping a team of health professionals and personal care workers around the individual with appropriate clinical supervision, with appropriate scope of practice and with appropriate clinical governance.[38]

4.42 These care plans can become even more important as a person moves towards the end of their lives. As noted in chapter two, palliative care is an important

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[32] Australian Law Reform Commission, *Coming of age: New aged care legislation for the Commonwealth*, Report 72, March 1995, [p. 60].

[33] Australian Law Reform Commission, *Coming of age: New aged care legislation for the Commonwealth*, Report 72, March 1995, [p. 59].

[34] Mr Keith McDonald, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 42.

[35] Mr Keith McDonald, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, pp. 42–43.

[36] Mr Keith McDonald, South Western Sydney PHN, *Committee Hansard*, 15 February 2019, p. 42.

[37] Department of Health, *Submission 37*, p. 35.

[38] Associate Professor Edward Strivens, President, Australian and New Zealand Society for Geriatric Medicine, *Committee Hansard*, 15 February 2019, pp. 13–14.

issue in RACFs and it is important that the needs and wishes of patients are respected as they enter the final stages of their life.

4.43 Submitters and witnesses to the inquiry noted that currently some people, especially those who suffer from dementia are receiving low quality care at the end of their lives.[39] Alzheimer's Australia advised that advance care planning at the time of diagnosis can allow people with dementia to express their preferences about their end-of-life care.[40]

4.44 The AMA noted that most Australians want to die in their own homes, which may include a RACF.[41] Advanced care directives or advanced care plans should be used to promote high quality patient-centred care in a way that is collaborative between the patient and the health care team.[42] The AMA told the committee that this needs to be supported by all RACFs:

> RACFs need supporting policies in place that allows the generation of clear advanced care plans appropriate for the RACF setting, that are taken seriously and reviewed regularly.[43]

Committee view

4.45 The committee concurs with the view of Leading Age Services Australia, that while parts of aged care legislation appear to confer ultimate responsibility for the care of a RACF resident on the RACF provider, there is a lack of clarity or real-world testing of this position. However, the committee strongly agrees with the position put forward by the Aged Care Guild in a previous chapter, that residents and their families don't care about jurisdictional issues or legal funding arrangements. They just want person-centred care that is appropriate to their needs.

4.46 If the goal of the new Single Aged Care Quality Framework is to provide that person-centred care, then a key change to service delivery must surely be to end the siloed approach where not only the care delivery is fragmented, but responsibility for overall care quality is avoided by the services closest to our frail elderly Australians.

4.47 The committee considers that there may be a broader role for PHNs in creating linkages between RACFs and the broader health sector to ensure that the appropriate care is wrapped around the care recipient. PHNs already have a role in coordinating clinical services and that experience in coordinating

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39 Alzheimer's Australia, *Submission 20*, p. 28.

40 Alzheimer's Australia, *Submission 20*, p. 28.

41 Australian Medical Association, *Submission 13*, p. 14.

42 Australian Medical Association, *Submission 13*, p. 14.

43 Australian Medical Association, *Submission 13*, p. 14.

services in their local areas makes PHNs well-placed to identify and coordinate Social Care Networks to benefit the RACF resident.

4.48 Care plans are important to ensure that RACF residents receive coordinated care. The committee recognises that care would be less fragmented and more clinically appropriate if each RACF resident had a care plan and there were requirements on RACFs to enable residents to review, discuss and amend their care plans to reflect the care they want and need.

4.49 The committee is concerned about the evidence it heard regarding the lack of access to GPs in RACFs and believes this is an issue that needs addressing as a matter of urgency, given the increase in acuity of residents and their need for medical care.

Funding

4.50 The overall matrix of aged care funding is an issue of great contention. Some argue there has been a reduction in 'real dollar' funding, while others argue that overall funding has either been maintained or increased. This report will not seek to make comment on past funding decisions, but will look to recommendations being made on where to go from here. The committee is also cognisant that while funding fundamentally impacts the quality of clinical care in RACFs, it has only limited relevance to the Terms of Reference for this inquiry.

4.51 The Aged Care Guild described the complexity of care funding and that it often reduces without reference to any improvements in treatments for health conditions:

> Take the example of an individual with a level of Parkinson's and with an arthritic knee. On one day they might be eligible for about $60 or $62 a day of the ACFI funding for care to support them. Overnight—bang!—someone with that exact same clinical assessment would be eligible for $48 in care support. Exactly one year later, overnight— bang!—they're eligible for $16 of care support. In that time—if you think about the system and the system being in balance—there were no medical advancements that made it easier to treat Parkinson's disease or arthritis. There were no model-of-care advancements, as far as I'm aware of, that made it easier or more expedient to treat those issues. They were as complex as before but the resources there to support them were significantly less so that is an impact at a care level, and providers have to work out then how they are going to deal with that.[44]

4.52 The Aged Care Guild also pointed out that the different funding streams often meant that larger organisations were able to cross subsidise funding from accommodation and lifestyle streams to top up care funding arrangements,

[44] Mr Matthew Richter, Aged Care Guild, *Committee Hansard*, 15 February 2019, p. 6.

which is 'good because we should continue to provide care but it is bad at the same time if it covers up the care funding issue that is in the industry'.[45]

4.53 The New South Wales (NSW) Nurses and Midwives' Association made a contrasting point, informing the committee that although aged care did require more funding 'we need to also examine how those funds are spent and utilised and look at the clinical governance around aged care. There's no use throwing good money at aged-care services for it to go straight into shareholders' coffers or for that not to be spent in an accountable way'. The NSW Nurses and Midwives' Association went on to recommend that increased funding should be tied to the best interest of RACF residents, shown through an audit trail, with some funding allocated specifically to safe staffing.[46]

4.54 Queensland Nurses and Midwives' Union (QNMU) submitted that the total RACF profit in 2018 was $1 billion, and therefore the sector has capacity to invest in improving quality standards.[47]

4.55 The Department told the committee that the recently announced additional $320 million funding for RACFs will not be specifically targeted to service delivery, but will be part of the normal subsidies that providers receive with the 'expectation' that the increased subsidies will be spent on improved care delivery.[48]

4.56 The Aged Care Guild pointed to the lack of work done to undertake a comprehensive study on the funding needed to deliver a certain level of aged care, and said that aged care works backwards by developing its care model based on funding availability, rather than developing the funding model based on care needs.[49]

4.57 Bupa also pointed to the overall lack of funding under the ACFI, and noted the indexation freeze, and said this issue is threatening the sustainability of the sector and reduces the capacity to provide high quality care to residents, and increases the chances of transfers to the more costly hospital environment.[50]

4.58 Leading Age Services Australia pointed to the *A matter of care* report by the Aged Care Taskforce which outlined that there is a gap between the output of

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45 Mr Matthew Richter, Aged Care Guild, *Committee Hansard*, 15 February 2019, p. 6.

46 Mrs Helen Macukewicz, Professional Officer, New South Wales Nurses and Midwives' Association, *Committee Hansard,* 15 February 2019, p. 34.

47 Queensland Nurses and Midwives' Union (QNMU), Answers to written Questions on Notice (received 6 March 2019), p. 11.

48 Mr Nigel Murray, Assistant Secretary, Funding Policy & Prudential, Department of Health, *Committee Hansard,* 15 February 2019, p. 56.

49 Mr Matthew Richter, Aged Care Guild, *Committee Hansard*, 15 February 2019, p. 6.

50 Bupa, *Submission* 18, p. 25.

what is considered an appropriate level of care and the input of the direct care hours per resident per day. The funding to fill that gap was costed at $3.5 billion per year.[51]

4.59 The Australian College of Nursing also raised the same funding gap and agreed it needed to be filled, but also pointed to aged care funding beyond the ACFI, such as the major refurbishment supplement, as an option for RACFs to improve infrastructure to make services more viable.[52]

4.60 Allied Health Professions Australia made a similar observation, and pointed to 'the failures of the current funding structures to support maintenance of clinical care standards.' Allied Health Professions Australia told the committee that funding appropriate access to allied health services would provide a better return on investment through greater mobility, reduced falls risks and more humane and effective management of challenging behaviours.[53]

4.61 The AMA made similar comments on Medicare funding for GPs, noting that Medicare is fixed on face-to-face consultations, while psychiatry and psychology has certain tele-health options which would be 'very suitable' options for aged care.[54]

4.62 QNMU submitted that there is a financial disincentive for RACF providers to assess residents' capacity to self-administer medications, and recommended that the ACFI should provide some degree of funding to providers for assessments, and for residents who do require assistance in taking medications.[55]

4.63 The Aged Care Taskforce suggested 'industry, individual organisations, employees and their representatives collaborate to foster a community dialogue on how to secure the funding needed to provide aged care services'.[56]

4.64 Dementia Australia discussed funding arrangements in the context of whether aged care funding arrangements established market-based competition that can drive quality improvements through consumer choice. Dementia Australia told the committee that minimal regulation only works well to underpin individualised care when coupled with a true consumer driven market,

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51 Mr Sean Rooney, Leading Age Services Australia, *Committee Hansard,* 15 February 2019, p. 8.

52 Adjunct Professor Kylie Ward and Ms Susan Emerson, Australian College of Nursing, *Committee Hansard*, 15 February 2019, pp. 34–35.

53 Ms Claire Hewat, Allied Health Professions Australia, *Committee Hansard,* 15 February 2019, pp. 9–10.

54 Dr Harry Nespolon, Royal Australian College of General Practitioners, *Committee Hansard*, 15 February 2019, p. 16.

55 QNMU, Answers to written Questions on Notice (received 6 March 2019), p. 9.

56 A matter of care, p. 66.

because the market competitiveness is what drives competition and consumer choice.

4.65 Dementia Australia told the committee that 'the aged care market is not market driven, nor are the mechanisms of transparency and comparability here for consumers to vote with their feet'.[57] Dementia Australia further recommended that should Australia's aged care system move to a co-contribution system, then there should be 'the appropriate level of transparency and tools to be able to make informed decisions about where they want to go and where they want to put their dollar'.[58]

Committee view

4.66 Funding is not an issue that is explicitly covered by the Terms of Reference for this inquiry, but the committee acknowledges it is a fundamental driver of the quality of care in aged care services. Without adequate funding, there can be no adequate levels of staff, which leads to an inability to deliver quality services.

4.67 The committee is of the view that the quality of clinical and medical care in aged care services is not of a consistent standard that any reasonable person would accept. The committee is further of the view that issues of funding and the overall viability of the aged care sector are inextricably linked to the quality standards of aged care.

[57] Dr Kaele Stokes, Executive Director Consumer Engagement, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 19.

[58] Dr Kaele Stokes, Dementia Australia, *Committee Hansard*, 15 February 2019, p. 26.

Chapter 5
Committee views and recommendations

Introduction

5.1 Residential aged care is a hybrid model of service delivery, awkwardly straddling the divide between being a health facility and support accommodation. The problem with this approach is that it is people who fall in the gap: people who are vulnerable, frail and aged, and who often lack an advocate who is both aware of their needs and is in a position to ensure their rights.

5.2 There is a lack of clarity about where the dividing line is between personal and clinical care, who should be responsible for delivering those different types of care, and who should be responsible for the standards of care. Until we solve the fundamental problem of defining what we want from residential aged care facilities (RACFs), no regulatory framework will be able to resolve these issues.

5.3 This lack of definition is not only felt at the service level, it is evident within policies, operational guidelines and funding frameworks within the Department of Health (Department) itself, which lack clarity and are often contradictory in how aged care is defined.

5.4 There has been a move to make RACFs more comfortable for residents, reflecting that RACFs are, for all intents and purposes, their home. However, it appears that this has been conflated with a move to reduce the clinical rigor of services in that 'home'. The committee strongly affirms that a lack of formality in appearance should not result in any lack of formality in clinical services.

5.5 This inquiry has demonstrated to the committee that gaps exist in the current framework for the delivery of clinical services in RACFs and that poor clinical care for older Australians who live in RACFs has too often been the result. The committee considers that the Single Aged Care Quality Framework (Single quality framework) which promotes person-centred care is a positive step forward. However, this inquiry has highlighted that much more needs to be done to promote a higher quality of care for people living in RACFs.

5.6 The committee considers that aged care stands at a crossroad. In light of the abuse uncovered at Oakden and the abuse that is being detailed by the Royal Commission into Aged Care Quality and Safety, the committee considers that it is imperative that we have person-centred care to ensure older Australians who require care in a RACF can both live and die with dignity.

5.7 The committee further considers that to get person-centred care, the sector needs person-centred regulation.

A wealth of advice

5.8 In the last decade there have been many reports and reviews into aged care, each with a series of well thought-out recommendations to improve aged care service delivery and the regulatory framework, with ideas on how to improve the interaction between aged care and the primary health and acute care sectors. These reports and reviews go back as far as the excellent report by the National Health and Hospitals Reform Commission in 2009 on how to improve and integrate the primary health and acute care sectors and the aged care sector. Many of these reviews and the key recommendations have been discussed in this report.

5.9 Most of these reviews have focused on one particular aspect of aged care service delivery or regulation. However, all have noted that aged care reform must be undertaken holistically, as each aspect is interrelated. Reviews into regulation have noted the need to update funding arrangements. Reviews into workforce supply have noted the need for increased governance and research.

5.10 There is a lack of clarity on whether the Department and the now regulator, the Aged Care Quality and Safety Commission (Aged Care Commission), have taken the advice of expert external reviews commissioned specially to solve the myriad aged care service delivery and regulation problems.

5.11 In order to ensure that the totality of reform recommendations have been appropriately captured and the interrelated nature of these recommendations has been taken into account, the committee considers that the Department should undertake a project to document the reforms currently undertaken and planned, and track these against the past decade of recommendations to improve aged care service delivery and regulation problems.

5.12 The Australian Government should then release clear advice on what progress has been made on each recommendation. This will be important both to ensure that previous good advice is appropriately acted upon and to assist in future reviews.

Recommendation 1

5.13 The committee recommends the Australian Government release its consolidated response to all recommendations in key reports made in the past decade to improve aged care service delivery and regulation, and its interaction with the primary health and acute care sectors.

Duty of care

5.14 The Department should be commended for developing the new Single quality framework standards, which have been greeted almost universally by aged care stakeholders as an important step forward in improving the standards expected in the aged care sector.

5.15 However, a remaining barrier to this person-centred care approach being fully realised is the lack of clear lines of responsibility.

5.16 As outlined by Leading Age Services Australia, there is an implication in the *Aged Care Act 1997* that RACF providers hold an ultimate duty of care towards RACF residents. This would confer an oversight responsibility for all aspects of the care provided to RACF residents, whether directly by the RACF provider or by external mechanisms. However, this implied responsibility for duty of care lacks clarity and real-world testing.

5.17 This is an important principle to enact, to take into account the vulnerability of RACF residents, particularly those with any cognitive decline. Enacting this principle would go some way to address the reality of the reduced capacity of most RACF residents to adequately self-advocate, exacerbated by social isolation and lack of active day-to-day advocates for many elderly residents.

5.18 Clearly defining that RACF providers ultimately hold duty of care for all residents would outline that RACF providers are the last line of defence for frail, elderly people who may not be able to advocate for themselves. It should also be made clear that RACF providers have an overall duty of care to report any substandard care or issues of risk, even where they do not have a direct line of responsibility to deliver that care.

Recommendation 2

5.19 The committee recommends that the Australian Government clarify that residential aged care providers ultimately hold a duty of care to all residents.

Person-centred regulation

5.20 The new Single quality framework standards place great emphasis on the responsibility for RACFs to deliver person-centred care. However there does not seem to be a corresponding emphasis on person-centred regulation.

5.21 The committee is deeply concerned by the responses from the former regulator, the Australian Aged Care Quality Agency, deflecting any responsibility for the abject failure to regulate the quality of care standards at the facility in Oakden, which has ultimately led to this inquiry and arguably been a catalyst for the Royal Commission into Aged Care Quality and Safety. The committee remains concerned by some responses from the incoming regulator, the Aged Care Commission, and from the Department. There are some instances where both entities have deflected regulatory and oversight responsibility for care that occurs within the aged care environment.

5.22 Just as there should be a clearly defined principle that RACF providers have ultimate duty of care to RACF residents, there should be a clearly defined principle that the Aged Care Commission has ultimate duty of care for the regulation of aged care.

5.23 This would take the form of the Aged Care Commission having a no-wrong-door approach to issues relating to poor care, of any kind, that occurs within a RACF. The Aged Care Commission must confirm that, where the care in question sits outside its legislated area of responsibility, another responsible entity is taking appropriate steps to ensure the standard of that care is appropriately regulated, regardless of jurisdiction. In short, if all care that occurs in an RACF is the ultimate responsibility of the RACF provider, then it is the responsibility of the Aged Care Commission to oversee that duty of care. Where there are regulatory gaps, the Aged Care Commission must fill those gaps.

Recommendation 3

5.24 The committee recommends that the Australian Government implement a clearly articulated principle that the duty of care for the regulation of all care within the aged care residential setting ultimately rests with the Aged Care Quality and Safety Commission.

Research and data

5.25 This inquiry has received a broad range of evidence to show there is a dearth of data and research to support evidence-based innovation and policy making in the aged care environment. The Department has recently increased the range of clinical data being captured and reported by RACF providers. However, advice from stakeholders indicates this does not go far enough to provide for the full range of indicator data necessary to ensure quality care outcomes.

5.26 In addition to provider-level quality care indicators, there is a lack of sector-wide data capture which can be used to highlight broad areas for clinical improvement. This includes accurate mortality data. There is a disturbing amount of evidence to show that poor quality care is contributing to the early death of some RACF residents through avoidable incidents such as falls. This has gone unheeded to date, primarily because of a culture where the deaths of RACF residents is expected. This would not be tolerated in any other care environment and can no longer go unchecked in the aged care sector.

5.27 The Aged Care Workforce Strategy Taskforce developed a comprehensive plan to establish a centre for research translation to support the strategic investment, translation and uptake of research and innovations. This was envisioned to develop a minimum data set for objective care outcomes, as well as evidence-based care innovations.

5.28 The Department should be tasked with working closely with the Aged Care Commission and the aged care sector to prepare advice to government on how to realise the recommendations to establish a research body with responsibility

for aged care research. Once established, this body should develop a plan of action for improved data capture and research.

Recommendation 4

5.29 The committee recommends the Australian Government establish a body with responsibility for aged care research.

Beyond regulation: a commission for quality and safety

5.30 During the Senate Community Affairs Legislation Committee inquiry into the bill to establish the Aged Care Commission, many stakeholders made recommendations to enhance its functions. Many of these recommendations focused on improving the capacity of the Aged Care Commission to move beyond regulating minimum care standards, to taking a role to actively drive improvement of aged care quality. The Department provided advice that additional consultations were planned for a second tranche of changes to the objectives of the Aged Care Commission. The committee strongly recommends these consultations should be prioritised.

5.31 Evidence presented to the committee indicates the Aged Care Commission has already taken steps to be actively involved in improving aged care standards. This stance is commended by the committee and should be continued and extended by the Aged Care Commission. It should continue to develop beyond the role of an accrediting agency seeking compliance to minimum standards, to truly become a commission for safety and quality in aged care. This would mean taking a role similar to that of the Australian Commission on Safety and Quality in Health Care (Health Care Commission) in actively supporting the improvement of care standards across the aged care sector, developing sector-wide clinical advice, guidelines and innovation.

5.32 The approach to drive continuous quality improvement could consider how to move the regulatory environment to one which promotes and incentivises open disclosure—potentially through an amnesty arrangement as suggested by some RACF providers—which can support early intervention to manage service problems before they become compliance issues.

Recommendation 5

5.33 The committee recommends the Australian Government continue work to expand the role of the Aged Care Quality and Safety Commission, in consultation with aged care stakeholders, to drive continuous improvement in levels of quality and safety in aged care.

A clear service framework

5.34 In chapter two, the committee outlined its deep concerns regarding the lack of clear and consistent answers to the questions about what kind of a service

RACFs are considered to be. Are they supported accommodation? Do they provide sub-acute health services? This lack of clarity leads to a fundamental question around regulation: how can you regulate a service when it is not clear what that service is?

5.35 The lack of this most basic operational definition then filters down to all service delivery planning.

5.36 Evidence from all clinical professionals and organisations has stressed the need for significant improvements to operational planning in aged care. This would entail a clearly articulated model of care and supporting clinical governance. The lack of these two operational frameworks is the key failure in aged care planning which then drives the failures in care delivery.

5.37 The committee notes the clinical governance project being undertaken by the Health Care Commission and Aged Care Commission, which will likely result in a model clinical governance framework that RACF providers can use to adapt to their individual service situations. However, there remains the issue of how the regulation framework will then assess whether that clinical governance framework is appropriately implemented and adhered to in service delivery. The responsibility of RACF providers to develop and implement a localised clinical governance framework is not appropriately defined in the aged care standards.

Recommendation 6

5.38 The committee recommends that the Aged Care Quality and Safety Commission work collaboratively with the Department of Health, the Australian Commission on Safety and Quality in Health Care and aged care stakeholders to develop an industry model of care. This model of care should incorporate a model clinical governance framework which clearly defines the scope of personal and clinical care.

Recommendation 7

5.39 The committee recommends that the requirements for a model of care and clinical governance framework be more clearly articulated within the Single Aged Care Quality Framework, including clearly defined service outcomes expected from those frameworks.

Staffing levels

5.40 The committee concurs with the views of the Australian Medical Association that inadequate staffing prevents quality care. The committee is concerned with the evidence showing the contribution that low staffing levels make to the low quality of care experienced by residents, including the unacceptably high levels of missed care episodes. The committee is further concerned with the practice whereby there is often no Registered Nurse on duty. Evidence

suggests this may result in Enrolled Nurses and aged care workers operating outside of their scope of practice. Furthermore, this can result in delays in accessing pain medication for some aged care residents and contributes to the inappropriate use of restrictive practice.

5.41 The committee notes there is a consensus view that staffing levels should be based on residents' care needs and the service context, and should be sufficient to provide an appropriate number of care hours per day from a range of appropriately qualified staff. While there are requirements in the Single quality framework standards for RACF providers to ensure appropriate levels of staff to provide quality care, there are no benchmarks for either providers to use as a guide or for assessors to use in accreditation. The committee considers that a definition is necessary to ensure proper regulation, and to ensure a Registered Nurse is always on duty to provide appropriate care and supervision, noting there may need to be some flexibility in the rural and remote service context.

Recommendation 8

5.42 The committee recommends that the Aged Care Quality and Safety Commission work collaboratively with the Department of Health, the Australian Commission on Safety and Quality in Health Care and aged care stakeholders to develop benchmarks for staffing levels and skills mix, which includes the requirement to roster an Registered Nurse on duty at all times, to assist residential aged care providers in staff planning and aged care assessors in regulating safe and appropriate staffing.

Restrictive practice

5.43 Possibly the most distressing evidence received by the committee relates to the high levels of restrictive practice being used in the aged care sector.

5.44 Evidence from legal bodies indicates that where restrictive practice is done without appropriate consent, it could be a criminal offence. At minimum, the inappropriate use of restrictive practice to address behaviours of concern, without first testing alternative interventions, is an abuse of the fundamental human rights of frail, elderly Australians. The fact that this is done routinely in so many circumstances, and it is alleged that it is done to reduce costs, is a national disgrace.

5.45 The committee is concerned by evidence that shows the rate of prescription of psychotropic medications is far higher than public health data indicates would be appropriate for purely therapeutic reasons. This indicates a disturbingly high rate of chemical restraint in the aged care sector. The committee is further concerned by the responses of the Aged Care Commission which indicate it believes this to be a matter of the individual performance of medical practitioners and not within its scope of regulation.

5.46 The committee notes the recommendation that the Chief Clinical Advisor of the Aged Care Commission must approve the use of antipsychotic medications for aged care residents, made by the review undertaken by Ms Kate Carnell and Professor Ron Paterson of the aged care regulatory regime. The committee concurs with the recommendation of this expert review.

5.47 The committee wishes to make its position quite clear: the high rates of restrictive practice within the aged care sector cannot be tolerated any longer. The current practice of light-touch regulation of restrictive practice has been proven a failure.

5.48 The committee acknowledges changes to the regulation of restrictive practice recently announced by the Minister for Older Australians and Aged Care, but does not believe these are robust enough to place appropriate limitations on the excessive use of restrictive practices in the aged care sector. The Australian Government must intervene as a matter of urgency to ensure that all restrictive practice in the aged care sector is, at minimum, compliant with the same regulation and oversight as restrictive practice in any other service context. Frail, elderly Australians deserve the same protections as anyone else.

Recommendation 9

5.49 The committee recommends the Australian Government take action, as a matter of urgency, to ensure the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector is extended to cover the aged care sector.

Recommendation 10

5.50 The committee recommends the Australian Government investigate, as a matter of urgency, changes to ensure that the use of antipsychotic medications in residential aged care facilities must be approved by the Chief Clinical Advisor of the Aged Care Quality and Safety Commission.

Safe medications

5.51 The committee is also highly concerned that the area of clinical practice that generates the most complaints, medications, is an area of practice where there appears to be little to no external oversight. The regulation of medications management has two elements: firstly to ensure that residents are prescribed the right medications, that there are no contraindications between various medications and de-prescribing reviews occurs at regular intervals; secondly, to ensure that medications are then dispensed and taken safely, that is to ensure that the person with the appropriate level of skill is overseeing the resident in taking the correct medications and is given the assistance needed to do so safely.

Recommendation 11

5.52 The committee recommends that the Aged Care Quality and Safety Commission develop a regulatory model to oversee medications management in residential aged care facilities.

Palliative care

5.53 As noted in chapter two, palliative care is a significant issue of clinical care in RACFs. The committee was deeply concerned by reports of inadequate pain management, inappropriate hospitalisation and a lack of consideration for the wishes and needs of aged Australians who live in RACFs and are nearing the end of their lives.

5.54 The committee considers that it is important that palliative care is carefully considered in the RACF setting. The committee considers that all people are entitled to have their comfort maximised and to die with dignity. However, the committee notes that there appears to be a significant variation about when palliative care should commence and what that means for aged Australians living in RACFs with progressive and incurable illnesses.

5.55 The committee considers that additional guidance may be required to ensure that all people have access to appropriate palliative care. The committee considers that RACF providers need greater support to deliver palliative care and providers should work with geriatricians, the Aged Care Commission and other stakeholders to ensure that a high standard of palliative care can be provided in RACFs.

Recommendation 12

5.56 The committee recommends that the Aged Care Quality and Safety Commission work with the Department of Health and aged care stakeholders to improve the palliative care environment in residential aged care facilities.

Wellness and reablement

5.57 The committee considers that there should be a focus on wellness and reablement for residents of RACFs to ensure that aged Australians are able to live healthy lives with the greatest degree of functionality possible. The committee understands that this may require a degree of flexibility on the part of providers and staff and requires a change in how people think about the role of RACFs.

5.58 The committee considers that maintaining healthy and functional lives should be a key consideration of RACF providers, but notes that providers may require some assistance to develop strategies to promote these goals.

Recommendation 13

5.59 The committee recommends that the Aged Care Quality and Safety Commission work with the Department of Health to develop mechanisms to increase the focus on wellness and reablement in residential aged care facilities.

Integration with primary health and acute care sector

5.60 The committee considers that the interface between RACFs and primary health and acute care needs to be better managed. The committee considers that this needs to include better access to GPs and allied health, as well as the acute care environment. The committee notes that the Primary Health Networks (PHNs) have already been working in this space to promote better coordination and integration between primary care providers and RACFs. The committee considers that this work should continue and that there may be a broader role for PHNs to play in integrating primary health, allied health care and the acute care sectors with RACFs. This integration and coordination requires action from multiple actors across the industry and related fields, the committee considers that the Department of Health should help to enable this transition to ensure that aged Australians living in RACFs receive the best care possible.

Recommendation 14

5.61 The committee recommends the Department of Health work collaboratively with the Aged Care Quality and Safety Commission, the Australian Commission on Safety and Quality in Health Care, Primary Health Networks, residential aged care providers and medical stakeholders to achieve better integration of the aged care environment with the primary health and acute care sectors.

Funding

5.62 The committee understands that many of these reforms will require funding. Funding has not been explicitly included within the committee's Terms of Reference and so it has decided not to make recommendations on this issue. However, the committee notes that it is important to consider issues surrounding clinical governance in RACFs when determining an appropriate model for funding aged care. Funding helps to set priorities and incentives. It is important that these incentives are correctly aligned and promote the behaviours and types of care that people would want for the older people in their lives.

Senator Rachel Siewert
Chair

Appendix 1
Submissions and additional information

Submissions

1 Australian Law Reform Commission

2 NSW Nurses and Midwives' Association
- 2 Supplementary submissions

3 Australian National Audit Office

4 Leading Age Services Australia
- Supplementary submission

5 Mental Health Commission of NSW
- 2 Attachments

6 Queensland Nurses and Midwives' Union
- Supplementary submission

7 Aged Care Complaints Commissioner
- Attachment

8 Australian Community Industry Alliance
- Supplementary submission

9 Victorian Department of Health and Human Services

10 Dietitians Association of Australia
- Supplementary submission
- Attachment

11 HammondCare

12 Aged and Community Services Australia

13 Australian Medical Association
- Supplementary submission
- Attachment

14 Public Advocate (Queensland)

15 Aged Care Guild

16 Australian Unity

17 Painaustralia
- Supplementary submission

18 Bupa

19 Aged Care Industry Association

20 Dementia Australia (formerly Alzheimer's Australia)
- Supplementary submission

21 Carers NSW

22 Professor Wendy Lacey

23 Older Persons Advocacy Network
- Supplementary submission

24 Law Council of Australia

25 Ms Sharon Olsson

26 *Name Withheld*

27 Office of the Chief Psychiatrist, Government of South Australia
- Attachment

28 Government of South Australia

29 Monash University
- 3 Attachments

30 *Name Withheld*

31 *Name Withheld*

32 Federation of Ethnic Communities' Councils of Australia

33 *Confidential*

34 *Name Withheld*

35 *Name Withheld*

36 *Name Withheld*

37 Department of Health
- Supplementary submission

38 *Confidential*

39 Occupational Therapy Australia
- Supplementary submission

40 Government of Victoria

41 Aged Care Crisis
- Supplementary submission
- Attachment

42 Australian Aged Care Quality Agency
- Supplementary submission

43 Royal Australian and New Zealand College of Psychiatrists
- Supplementary submission

44 Australian Health Practitioner Regulation Agency

45 *Confidential*

46 *Confidential*

47 N & C Baron & Associates
- Attachment

48 *Confidential*

49 *Confidential*

50 *Confidential*

51 *Confidential*

52 *Confidential*

53 *Confidential*
54 *Confidential*
55 *Confidential*
56 *Confidential*
57 Combined Pensioners & Superannuants Association of NSW Inc
58 Volunteering Australia
59 Australian Nursing and Midwifery Federation
60 Aged Rights Advocacy Service Inc
61 Benetas
- Supplementary submission

62 *Confidential*
63 *Confidential*
64 Ms Linda McGough
65 *Confidential*
66 *Confidential*
67 *Confidential*
68 Office of the Public Guardian
69 *Confidential*
70 Council on the Aging (COTA)
71 INSPIRED, Flinders University
- Supplementary submission

72 Quality Aged Care Action Group Incorporated
- Supplementary submission

73 Dr Anna Howe
- Supplementary submission

74 *Confidential*
75 *Name Withheld*
76 *Confidential*
77 Ms Rosemary Iloste
78 Dental Hygienists Association of Australia
79 Ms Jessica Carroll
80 Queensland Mental Health Commission
81 Primary Health Network: Western Queensland
82 Australian Association of Gerontology
83 Speech Pathology Australia
84 Primary Health Network: South Western Sydney
85 Primary Health Networks: Brisbane South and Brisbane North
86 Enrich Health Group
87 *Name Withheld*
88 Wound Centre
89 Australian College of Nursing
90 Allied Health Professions Australia

91 Australian Association of Social Workers
92 Australian College of Nurse Practitioners
93 Community and Public Sector Union
94 SA Mental Health Commission
95 Royal Australian College of General Practitioners
96 NSW Mental Health Commission
97 *Name Withheld*
98 *Confidential*
99 *Name Withheld*
100 *Confidential*
101 Australian and New Zealand Society for Geriatric Medicine
102 Flinders University, College of Nursing and Health Sciences
103 *Confidential*

Additional Information

1 Documents, from Department of Health, received 29 August 2017
2 Recommendations for prevention of injury-related deaths in residential aged care services, Professor Joseph E Ibrahim, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, from Monash University, received 21 November 2017
3 A new way of measuring long-term aged care quality and choice from the consumer's perspective, Development of a new quality-of-care measurement by Flinders University, funded by the Cognitive Decline Partnership Centre, from Flinders University, received 21 November 2017
4 Draft Position Statement: Cameras in Aged Care (September 2016), from Aged Rights Advocacy Service Inc, received 21 November 2017
5 Additional information relevant to INSPIRED Flinders University submission (number 71), from Flinders University, received 27 November 2017
6 Model developed for GP's to have a Memorandum of Understanding with Residential Aged Care Facilities, from Dr Dennis Gration, received 21 November 2018

Answer to Question on Notice

1 Answers to Questions taken on Notice during 21 November public hearing, received from Flinders University, 14 December 2017
2 Answers to Questions taken on Notice during 21 November public hearing, received from Mr Neil and Mrs Carla Baron, 14 December 2017
3 Answers to Questions taken on Notice during 21 November public hearing, received from Professor Joseph Ibrahim, Monash University, 14 December 2017
4 Answers to Questions taken on Notice during 21 November public hearing, received from Australian Aged Care Quality Agency, 21 December 2017
5 Answers to Questions taken on Notice during 21 November public hearing, received from Aged Rights Advocacy Service Inc, 9 January 2018

6 Answers to Questions taken on Notice during 5 February public hearing, received from Department of Health, 8 February 2018

7 Answers to Questions taken on Notice during 5 February public hearing, received from Department of Health, 26 February 2018

8 Answers to Questions taken on Notice during 5 February public hearing, received from Department of Health, 13 March 2018

9 Answers to written Questions on Notice, received from Office of the Chief Psychiatrist, South Australia, 8 February 2018

10 Answers to Questions taken on Notice during 15 February public hearing, received from Aged Care Quality and Safety Commission, 27 February 2019

11 Answers to Questions taken on Notice during 15 February public hearing, received from Australian Commission on Safety and Quality in Health Care, 5 March 2019

12 Answers to written Questions on Notice, received from Australian Commission on Safety and Quality in Health Care, 5 March 2019

13 Answers to written Questions on Notice, received from Allied Health Professions Australia, 5 March 2019

14 Answers to written Questions on Notice, received from South Western Sydney Primary Health Network, 6 March 2019

15 Answers to written Questions on Notice, received from Leading Age Services Australia, 6 March 2019

16 Answers to written Questions on Notice, received from Dementia Australia, 6 March 2019

17 Answers to written Questions on Notice, received from NSW Nurses and Midwives' Association, 6 March 2019

18 Answers to written Questions on Notice, received from Brisbane South and Brisbane North Primary Health Networks, 6 March 2019

19 Answers to written Questions on Notice, received from Aged Care Quality and Safety Commission, 6 March 2019

20 Answers to written Questions on Notice, received from Queensland Nurses and Midwives' Union, 6 March 2019

21 Answers to written Questions on Notice, and an answer to a Question taken on Notice during 15 February public hearing, received from Australian and New Zealand Society for Geriatric Medicine, 6 March 2019

22 Answers to written Questions on Notice, received from Royal Australian and New Zealand College of Psychiatrists, 7 March 2019

23 Answers to written Questions on Notice, received from Aged and Community Services Australia, 12 March 2019

24 Answers to written Questions on Notice, and answers to Questions taken on Notice during 15 February public hearing, received from Department of Health, 18 March 2019

25 Answers to written Questions on Notice, received from Department of Health, 18 March 2019

Correspondence

1 Letter declining the invitation to attend the public hearing in Adelaide on 21 November 2017, received from South Australian Department of the Premier & Cabinet, 13 November 2017

2 Correspondence clarifying evidence given at Canberra public hearing on 5 February 2018, received from Aged Care Complaints Commissioner, 16 February 2018

3 Information further to evidence provided at Canberra public hearing on 15 February 2019, received from Queensland Nurses and Midwives' Union, 19 February 2019

4 Correspondence clarifying evidence given at Canberra public hearing on 15 February 2019, received from Aged Care Quality and Safety Commission, 27 February 2019

Tabled Documents

1 Letter to The Hon Leesa Vlahos MP, Minister for Mental Health and Substance Abuse, dated 14 October 2016 from Mr Maurice Corcoran AM, Principal Community Visitor, South Australian Community Visitor Scheme, tabled by South Australian Community Visitor Scheme, at Adelaide public hearing, 21 November 2017

Appendix 2
Public hearings

Tuesday, 21 November 2017
Crystal Room
Stamford Plaza Hotel
150 North Terrace
Adelaide

Northern Adelaide Local Health Network, SA Health
- Ms Jackie Hanson, Chief Executive Officer

Oakden Response Oversight Committee
- Dr Thomas Stubbs, Chair

Australian Aged Care Quality Agency
- Mr Nick Ryan, Chief Executive Officer
- Ms Ann Wunsch, Executive Director, Operations
- Ms Christina Bolger, Executive Director, Regulatory Policy and Performance

Community Visitor Scheme
- Mr Maurice Corcoran, Principal Community Visitor

Monash University
- Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit

Flinders University
- Associate Professor Craig Whitehead, Clinical Director, Rehabilitation, Aged Care and Palliative Care
- Dr Suzanne Dyer, Senior Research Fellow, Department of Rehabilitation, Aged and Extended Care

Mr Neil Baron, Private capacity

Mrs Carla Baron, Private capacity

Ms Sharon Olsson, Private capacity

Aged Rights Advocacy Service Inc.
- Ms Carolanne Barkla, Chief Executive

Mr Stewart Johnston, Private capacity

Mrs Patrina Cole, Private capacity

Ms Christine Blakeley, Private capacity

Mrs Alma Krecu, Private capacity

Mrs Barbara Spriggs, Private capacity

Mr Clive Spriggs, Private capacity

Ms Maria Costa, Private capacity

Ms Deanna Stojanovic, Private capacity

Mrs Natasha Glowik, Private capacity

Mr Mark Martin, Private capacity

Monday, 5 February 2018

Committee Room 2S3
Parliament House
Canberra

Australian Aged Care Quality Agency

- Mr Nick Ryan, Chief Executive Officer
- Ms Ann Wunsch, Executive Director Operations
- Ms Christina Bolger, Executive Director Regulatory Policy and Performance

Aged Care Complaints Commissioner

- Ms Rae Lamb, Commissioner

Department of Health

- Ms Catherine Rule, First Assistant Secretary
- Mrs Lisa La Rance, Assistant Secretary
- Ms Amy Laffan, Assistant Secretary
- Ms Jo Mond, Assistant Secretary

Friday, 15 February 2019

Committee Room 2S1
Parliament House
Canberra

Leading Age Services Australia

- Mr Sean Rooney, Chief Executive Officer
- Ms Marlene Eggert, Senior Policy Officer

Aged Care Guild

- Mr Matthew Richter, Chief Executive Officer

Royal Australian College of General Practitioners

- Dr Harry Nespolon, President

Australian and New Zealand Society for Geriatric Medicine

- Associate Professor Edward Strivens, President

Allied Health Professions Australia

- Ms Claire Hewat, Chief Executive Officer
- Mr Cris Massis, Chair

Royal Australian and New Zealand College of Psychiatrists

- Associate Professor Stephen Macfarlane, Chair, Faculty of Psychiatry of Old Age

Dementia Australia

- Dr Kaele Stokes, Executive Director Consumer Engagement, Policy and Research

Queensland Nurses and Midwives' Union

- Mr Daniel Prentice, Professional Research Officer
- Mr Jamie Shepherd, Professional Officer, Team Leader

NSW Nurses and Midwives' Association

- Mrs Helen Macukewicz, Professional Officer

Australian College of Nursing

- Adjunct Professor Kylie Ward, Chief Executive Officer
- Ms Susan Emerson, Advisor

South Western Sydney Primary Health Network

- Mr Keith McDonald, Chief Executive Officer
- Mrs Amy Prince, Director of Planning and Performance

Brisbane South Primary Health Network

- Ms Lucille Chalmers, General Manager Commissioned Programs, Brisbane South PHN

Brisbane North Primary Health Network

- Ms Michele Smith, Executive Manager, Aged and Community Care
- Ms Julie Morrow, Manager, Healthy Ageing

Australian Commission on Safety and Quality in Health Care

- Adjunct Professor Debora Picone, Chief Executive Officer

- Mr Mike Wallace, Chief Operating Officer
- Dr Robert Herkes, Chief Medical Officer
- Ms Margaret Banks, Director, National Standards Program
- Dr Amanda Walker, Clinical Director

Older Persons Advocacy Network

- Mr Craig Gear, Chief Executive Officer
- Mr Russell Westacott, Seniors Rights Service member

Department of Health

- Ms Maria Jolly, First Assistant Secretary, Aged Care Reform and Compliance Division
- Ms Amy Laffan, Assistant Secretary, Aged Care Quality and Regulatory Reform Branch
- Mr Nigel Murray, Assistant Secretary, Funding Policy and Prudential
- Professor Brendan Murphy, Chief Medical Officer

Aged Care Quality and Safety Commission

- Ms Janet Anderson, Commissioner
- Associate Professor Michael Murray, Interim Chief Clinical Advisor

Appendix 3
Consumer Health Care Issues Raised with the Older Persons Advocacy Network

The most common issues raised by residents or their representatives is quality of care, specifically:

- Inadequate hydration and nutrition- typically identified by family members who notice significant weight loss.
- Conditions going unnoticed/undiagnosed until they have reached a critical stage and hospital admission is required – Urinary Tract Infections is perhaps the most common example.
- Wound care - particularly in relation to the prevention, identification and management of pressure wounds.
- Oral hygiene- residents often not supported to brush teeth daily. One residential respite client did not have their teeth brushed once during a two week stay. Lack of oral hygiene leads to other health concerns.
- Chemical restraint – often used as a behaviour management strategy before other less restrictive options have been explored.
- Poor medication administering/management – with residents experiencing long waiting times and receiving incorrect doses or medications. Some examples are:
  - Undiagnosed and untreated oral thrush resulting in resident not eating resulting in significant weight loss and not taking medication resulting in hospitalisation.
  - Long wait time for medication for Parkinson's Disease resulting avoidable hospitalisations.
  - Non-response from visual and hearing impaired resident to instruction to take medication results in medication left on bedside table and lack of monitoring of what happens to it.
- Over medication of residents – including anti-psychotic and anti-depressant medications. Residents/representatives who raise questions about their medication can receive patronising responses from clinical staff to their questions, even when medication is no longer required.
- Poor continence management. Rationing of pads can result in Urinary Tract Infections, scalding, and sores as well as a loss of dignity. Continence assessment may not be carried out by a qualified person. It is often family members who detect the need for a clinical response.
- Mental health issues – residents are often not provided with psychological supports such as counselling or therapy for issues including grief and loss,

depression, anxiety, trauma, PTSD, domestic violence, and on-going mental health disorders affecting quality of life.
- Pain medication not administered over night as no qualified staff (RNs) and have to wait till morning. Not appropriate for palliative care, chronic pain, falls where severe pain may be treated by phone order.
- Untrained junior staff telling residents to wait 15 minutes to see if their chest pain settles before calling the RN to review them
- Graduate RNs used with no experience or supervision to plan for care of older people with complex needs
- Insufficient physiotherapy to promote independence and maintain mobility, and to prevent contractures
- Speech pathologists and dieticians not routinely requested to assess for swallowing and nutritional needs; supplements available but not used to address weight loss
- General practitioners are reluctant to visit residents in aged care as cannot find trained staff to provide medical history and record signs and symptoms of change in condition
- Medical appointments cancelled in rural areas due to lack of transport to regional hospitals and centres.

In OPAN's experience, the underlying reasons for clinical care issues are:
- inadequate staffing numbers
- time constraints leading to staff taking short cuts
- inadequately skilled workers unable to monitor, assess, identify and respond to clinical issues on a day to day basis
- lack of accountability and supervision
- poor culture – "she'll be right" attitudes, carelessness, low standards. [1]

[1] Older Persons Advocacy Network, *Submission 23.1*, [pp. 9–10].

Appendix 4
Members of the Aged Care Workforce Strategy Taskforce

Table 4.1 Members of the Aged Care Workforce Strategy Taskforce

Name	Expertise
Professor John Pollaers OAM (Chair)	John Pollaers has a proven track record in leading major Australian and international companies including Pacific Brands and Foster's Group, and in his current role is working across Government to bring about major reforms to vocational education and training and aged care. This is the realisation of his vision of building a strong future for Australia by creating opportunities for people and businesses to flourish and succeed. He is a passionate advocate for education and training, the care of senior Australians and including more people with disability in work and training. John is Chair of the Australian Industry and Skills Committee, the Australian Advanced Manufacturing Council, a member of Prime Minister's Industry 4.0 Taskforce, and an advisory board member at Melbourne University's Centre for Workplace Leadership. He runs his own business and sits on an international board.
Dr Michelle Bruniges AM *Secretary, Department of Education and Training, Australian Government*	Michelle Bruniges is the Secretary of the Department of Education and Training, administering the Australian Government's interests in quality early learning, schooling, higher education, international education and research, skills and training. She has held this position since April 2016. Prior to this, she led the NSW Department of Education and Communities, and the ACT Department of Education. Michelle has held senior roles in the

	Australian Government's Department of Education, Employment and Workplace Relations. She is a graduate of the Australian Institute of Company Directors, a Churchill Fellow and a Fellow of the Australian College of Educators and the Australian Council for Educational Leaders. In 2012 Michelle was recognised for her work in public policy as a joint recipient of the Inaugural 100 Women of Influence Awards.
Dr Penny Flett AO *Pro Vice Chancellor, University of Western Australia*	Penny Flett is Pro-Chancellor and Senate member of the University of Western Australia. She is the chair of the Methodist Ladies' College (WA) and Chair of the Bravery Decorations Council. She is a former Chief Executive Officer of the Brightwater Care Group (WA) providing residential and at-home services for elderly and young disabled people. She has been a Board member of the Positive Ageing Foundation in Western Australia and the State Training Board of Western Australia. As Chair of the WA Aged Care Advisory Council, she oversaw development of a State Aged Care Plan. Penny was named Telstra Australian Business Woman of the Year in 1998.
Maria Jolly *First Assistant Secretary, Aged Care Reform and Compliance Division, Department of Health, Australian Government (from May 2018)*	Maria Jolly has expertise in a range of health programs and policy development processes. She has had experience in managing strategic policy development, the medical benefits schedule, Aboriginal and Torres Strait Islander Health, rural health, primary care policy and health workforce. Roles have been primarily in health with some time also spent in Prime Minister and Cabinet and Finance (many years ago). Maria has formal qualifications in sociology with postgraduate units in epidemiology, history, Aboriginal development and health economics.
Dr Stephen Judd *CEO Hammondcare*	With over 25 years' experience in the health care and information technology industries,

	Stephen Judd has previously held Director positions on a number of bodies including Aged Care Services (NSW & ACT) and the Community Council for Australia. He has written, edited and contributed to books on dementia care and aged care design. Stephen is a member of the Advisory Council of the Australian Aged Care Quality Agency and the Aged Care Sector Committee.
Professsor Linda Kristjanson AO *Vice-Chancellor, Swinburne University*	Linda Kristjanson is Vice-Chancellor of Swinburne University of Technology and is a Fellow of the Australian Institute of Company Directors and the Australian Academy of Technology & Engineering (ATSE). She chairs AuScope Ltd and the Victorian Comprehensive Cancer Centre. Linda was a member of the National Health and Medical Research Council from 2003-2006. In 2012 she was recognised for her research in palliative care with a lifetime achievement award by the Bethlehem Griffith Research Foundation. In 2002, Linda was named the Australian Telstra Business Woman of the Year in recognition of her entrepreneurial work in health, science and innovation.
Adjunct Professor Alan Lilly *Former Chief Executive, Blue Cross*	Alan Lilly was Chief Executive of BlueCross in Victoria from September 2016 to July 2018 and holds a concurrent appointment as an Adjunct Professor of the Australian Catholic University. He has predominantly worked in the Victorian Public Health System, including as Chief Executive of Eastern Health in Victoria for more than seven years prior to taking up his BlueCross position. A Registered Mental Health Nurse and Registered General Nurse by background, with post graduate management qualifications, he has presented extensively on matters related to recruitment, workforce development, quality and safety, and has also published articles on leadership, culture and workforce development.

	Alan is a Board Director of the Aged Care Guild, a Board Member of the Monash Institute for Health & Clinical Education Advisory Board and a member of the Dementia Support Australia Expert Reference Group. He is a Fellow of the Australian Institute of Management, an Associate Fellow of the Australian College of Health Service Management and a Member of the Australian Institute of Company Directors.
Professor Andrew Robinson *Adjunct Professor, Wicking Dementia Research and Education Centre, University of Tasmania, Director Dementia Training Australia and Principal Research and Innovation, Gravitas leadership Group*	Professor Robinson was Co-Director of the Wicking Dementia Research and Education Centre and Professor of Aged Care Nursing at the University of Tasmania until September 2017. He is recognised as a national and international leader and innovator in aged care and has led translational research and innovation projects involving a broad range of community and residential aged care services across Australia. He is an international leader in dementia education through the Wicking Teaching Aged Care Facility program and a key driver of strategic innovation in research and online delivery systems such as Massive Open On-line course (MOOC) learning platforms. He played a central role in developing the world leading Understanding Dementia MOOC and the highly innovative and successful on-line Bachelor of Dementia Care program run through the Wicking Centre. As Director of Dementia Training Australia he is leading programs to develop on-line dementia products for the aged care workforce.
Ms Catherine Rule *First Assistant Secretary Aged Care Reform Taskforce, Department of Health*	Catherine Rule oversaw policy, funding, and regulatory activities for the ageing and aged care system, including residential care, home care and the Commonwealth Home Support Program from November 2017 to May 2018. Catherine joined the Department of Health in July 2015, having held senior executive

positions in the Department of Human Services and the Australian Sports Drug Agency.

Mr Tim Shackleton
Chief Executive Officer, Rural Health West

Tim Shackleton was appointed CEO of Rural Health West in 2016, the sole agency in Western Australia dedicated to rural health workforce. He has 25 years of experience in the rural health sector. Between 2011 and 2016, he was the director of health services consulting firm Virtual Health and led a wide-range of health consultancy projects for high profile clients across Australia. Tim had previously served as CEO of the Royal Flying Doctor Service of Australia (Western Operations) and Regional Director for the WA Country Health Service in the Pilbara-Gascoyne and Wheatbelt Regions. He is immediate past chair of the Wheatbelt Development Commission and the WA Regional Development Council, and is currently chair of the WA Pastoral Lands Board.

Ms Pat Sparrow
Chief Executive Officer, Aged & Community Services Australia (ACSA)

Pat Sparrow is a social policy leader and innovator with expertise in stakeholder engagement and management. She has specific and detailed expertise in ageing policy and aged care, having worked as, and with, a diverse range of stakeholders including consumers, service providers, workforce, health professionals, corporate organisations and Government. This unique '360 degree' perspective ensures that Pat's leadership approach is strategic and nuanced, inclusive and collaborative.

Pat is currently leading Aged & Community Services Australia (ACSA) toward a new era, as a recently-transitioned national organisation and with the challenges it faces in an increasingly competitive, consumer-driven environment. She is focused on ensuring the organisation has genuine respect and influence among key stakeholders through the establishment of a strong national voice. Pat's breadth of knowledge, depth of experience and

	constructive approach enable her to achieve results that benefit ACSA members and contribute to the best possible outcomes for older Australians.
Mr Ian Yates AM *Chief Executive, COTA Australia (Council on the Ageing)*	Ian Yates serves as the COTA representative on the Aged Care Sector Committee, the National Aged Care Alliance (NACA), and various other advisory bodies. He is a member of the Aged Care Financing Authority, the Advisory Council of the Australian Aged Care Quality Agency, and was a Director of the Aged Care Standards and Accreditation Agency Ltd. Ian chaired the NACA Working Group on Workforce that advised the government during the development of the Living Longer Living Better Reforms, and Co-Chairs NACA's Blueprint and Roadmap Implementation Group. He served for 20 years as a member of the Council of Flinders University, including lengthy periods as Deputy Chancellor, Chair of the Strategic Resources Committee and Chair of the Audit Committee.

Source: Department of Health, About Aged Care Workforce Strategy Taskforce, https://agedcare.health.gov.au/reform/about-aged-care-workforce-strategy-taskforce (accessed 1 April 2019).