



# Submission to

The Standing Committee on Health, Aged Care and  
Sport

Inquiry into the Quality of Care in Residential  
Aged Care Facilities in Australia

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submission

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## **Introduction**

The Queensland Nurses and Midwives' Union (QNMU) thanks The Standing Committee on Health, Aged Care and Sport (the Committee) for the opportunity to make a submission to the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia.

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 57,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

While not an aged care service provider or consumer organisation, the QNMU actively represents members working in the aged care sector at an industrial and professional level, and also draws on the considerable experience the organisation has gained as a stakeholder in safety and quality improvement in the acute health sector. The QNMU believes that its aged care membership base makes the organisation a stakeholder in any debate regarding the quality and safety of aged care services. As a member led organisation which advocates for nurses and unlicensed careworkers in aged care, member feedback consistently identifies a range of endemic and systemic issues which impact on the safety and quality of care provided and which effect those receiving and providing care. These issues include staffing and skill-mix, working conditions, governance and regulation, funding and training. Again, the QNMU thanks the Committee for the opportunity to provide feedback to this inquiry.

## **Background**

For the QNMU, as an industrial and professional organisation, the safety and quality of aged care services is of the highest priority for those providing and receiving care. Recent inquiries, media reports, complaints by those receiving aged care services and research, have raised serious concerns regarding the safety and quality of these services (Ibrahim et al., 2017, Willis et al., 2016). In Australia, aged care services are a public good, funded predominately by the public purse and largely delivered by the private sector.

As identified by Phillips et al., (2017) the proportion of those aged care residents requiring high levels of care has dramatically increased from 13% in 2009 to 61% in 2016 with aged care facilities increasingly acting as hospices for frail older Australians with complex care needs. As succinctly described by the Royal Australian College of General Practitioners (RACGP, 2006):

*Older people in residential aged care are the sickest and frailest subsection of an age group that manifests the highest rates of disability in the Australian population. The prevalence of chronic conditions among residents in high care is estimated to be 80% sensory loss, 60% dementia, 40-80% chronic pain, 50% urinary incontinence, 45% sleep disorder, and 30-40% depression. Annually 30% of residents have one or more falls and 7% fracture a hip.*

Older Australians, particularly those receiving residential aged care services are characterised by significant care needs, multiple diagnoses, comorbidities and polypharmacy. It has been estimated that on average they have 3.4 to 4.5 separate diagnoses, 6 comorbidities, and are taking 8.1 medications (Willis et al., 2016). Research also points to a rising trend of avoidable and premature death in Australian aged care facilities (Ibrahim et al., 2017).

Recent care issues identified at the Oakden Facility in South Australia as well as a number of inquiries and reports over the last decade have pointed to a disparity in terms of safety and quality of care between the hospital and aged care sectors.

In Australia, there are approximately 94,000 hospital beds, distributed across the public and private sectors, providing care to those with acute and chronic health conditions that can't be managed in other health care settings. In contrast, there are over 250,000 residential aged care places for an increasing frail, chronically unwell and dependent population who are essentially cared for outside of the mainstream health care system but who have significant health care needs. This care is provided without the robust governance, safety and quality standards, staffing, skill mix and clinical infrastructure, accountability, reporting, and funding arrangements accepted as essential to the effective and efficient operation of the hospital sector.

Simultaneously, there has been a shift towards an increasingly deskilled, and unregulated, aged care workforce and perversely, a de-emphasis on the health care aspects of aged care in favor of a social model of aged care at a time when the health care needs of residents have never been greater (Phillips et al., 2017). It is little wonder then that the care and safety issues identified almost daily in aged care continue to occur largely unabated.

Sadly, the current situation for residential aged care in Australia is characterised by:

- increasing levels of complex care requirements;
- an apparent deemphasis on the health care needs to aged care residents despite increasing frailty and care needs of the residential aged care population;
- endemically low hours of care per day per resident compared to research based findings regarding the minimum level of care required in residential aged care, e.g. 4.3 hours of care per resident per day (Willis et al., 2016). QNMU members have reported situations where it appears that residents are receiving less than half this level of care on average per day;

- falling percentages of registered and enrolled nurses and increasing numbers of unregulated careworkers resulting in deteriorating skill and staff mix within the aged care workforce. This loss of qualified nursing care is occurring despite the sector achieving a \$1.1 billion net profit and an average EBITDA per resident per annum of \$11,134 (Aged Care Financing Authority, 2017);
- poor wages and conditions and high workloads which often result in missed care and difficulty attracting nursing staff;
- lack of a regulatory regime that will provide standards for practice and a scope of practice for the majority of the aged care workers, who currently function as unlicensed healthcare workers;
- a complex, and apparently fragmented, regulatory environment spread between the Commonwealth Department of Health, the Australian Aged Care Quality Agency (AACQA) and the Aged Care Complaints Commissioner (ACCC);
- a funding model (the Aged Care Funding Instrument) that has significantly outlived its usefulness and urgently needs to be replaced by a sustainable alternative such as an activity based funding model where the costs of care are reflected in a realistically determined “efficient” price;
- current levels of governance, standards, reporting and transparency that are simply not comparable to the hospital sector and which lag considerably behind the significant improvements in safety and quality achieved in the hospital sector by many years;
- an apparent lack of political will on the part of the Commonwealth Government to regulate the aged care sector to a level commensurate with the level of funding provided by the public purse to a largely private provider dominated and commercially driven sector. Inaction by successive governments since the enacting of the Aged Care Act (1997) has now resulted in a “as you sow, so shall you reap” situation characterised by an increasingly widespread view of aged care in crisis.

### **Response to the inquiry terms of reference**

Please find below the QNMU response to the inquiry terms of reference including recommendations and other issues that the organisation feels are relevant for consideration.

### **Terms of Reference One**

#### **The incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistle blowers**

As identified by the Australian Law Reform Commission (2017), abuse of those in residential aged care can be committed by paid staff, other residents, family members or friends and encompasses:

*...a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. It can take various forms, such as physical abuse, psychological or emotional abuse, financial abuse, sexual abuse, and neglect.*

The QNMU also contends that the notion of mistreatment should also include the concept of “unintentional neglect” which the QNMU believes stems primarily from the continuing and systemic deskilling of the aged care workforce and decreasing levels of care (both in terms of the skill of those providing the care and the hours of care provided), that continue unabated in the residential aged care sector. The impact of these trends, while simultaneously the care requirements of those receiving residential aged care increase, is considerable and undoubtedly contributes to the burden of harm experienced by aged care residents. The following points are made.

Australian research has clearly established that on average, aged care residents require over four hours of care per day (Willis et al., 2016). Unfortunately, the QNMU has all too often identified instances where aged care residents routinely receive less than half this amount of care per day delivered by a workforce that is ill-equipped in terms of training and supervision to meet the increasingly complex health and care needs of those in their care. Inadequate quantity and quality of care can have many harmful consequences and results from a decreased capacity of staff to provide safety surveillance in a care hours depleted environment. These consequences include:

- increased levels of falls which often lead to harm, and as identified by Ibrahim (2017) are the leading, and increasing, cause of preventable death in residential aged care;
- harm perpetrated by residents on residents due to lack of surveillance time and unregulated staff without the intervention skills of licensed nurses. Resident on resident harm has been identified as an emerging issue requiring further research in the Australian context by Murphy et al., (2017);
- increased rates of pressure injuries when staff have insufficient time to undertake mitigation strategies such as frequent turns and continence management;
- resident weight loss and nutritional deficits resulting from rushed or insufficient time for staff to feed/assist residents which has a progressive and cumulative impact on a residents' nutritional status;
- increased medication errors (and resulting harm) as medication administration tasks are moved from medication-qualified nurses to care workers who may have had no more than one-hours' instruction and simply don't have the pharmacological knowledge to undertake this task safely. Ironically, any health practitioner who proposed the idea of unlicensed careworkers administering medications in the hospital sector would be ridiculed and perhaps even investigated as to their competence as a practitioner, yet this practice of unqualified carers administering

medicine is an increasing trend in aged care where the medication risks associated with co-morbidity and frailty are arguably much higher.

### **Standards, Adverse Events and Key Performance Measurement of Safety and Quality Outcomes**

Another source of harm, though almost always unintentional in nature, are adverse events that occur during the course of care. While the identification, reporting, management and investigation of adverse events which cause temporary or permanent harm or death has long been recognised as an essential patient safety process in the hospital sector, the aged care sector has yet to make significant progress in this area. Without the systems and processes in place to respond effectively to individual adverse events and use aggregate data to identify systemic trends and issues, the capacity of the aged care sector, and regulators, to keep aged care residents safe will be compromised.

Like the acute health care sector, i.e. public and private hospitals, a foundational concept in aged care must be the safety of residents. Iatrogenic harm is now a well-recognised phenomenon with approximately 10% of patients in the acute sector receiving a hospital acquired diagnosis (Duckett, 2016). It is not unreasonable to assume that the residential aged care environment has, at least, similar levels of harm.

Within residential aged care, clinical care is a significant component of overall care delivered. In 2016, the percentage of aged care residents with high care needs across all Aged Care Funding Instrument (ACFI) domains (activities of daily living, behaviours and complex care needs) was over fifty percent (Australian Institute of Health and Welfare, 2017). That residents of aged care facilities have complex needs is supported by the evidence from a sample population which identified on average they have 3.4 – 4.5 separate diagnoses, 6 comorbidities and are taking 8.1 medications (Willis et al., 2016). Supporting the highly clinical nature of residential aged care and the need for robust safety surveillance, reporting and remediation processes, is the latest ACCC report on complaints which identified the following top five complaint areas:

- Health Care - Medication administration and management;
- Health Care - Falls prevention and post fall management;
- Personnel - Number/ratio;
- Personal Care - Personal and oral hygiene;
- Consultation and Communication - Lack of consultation/communication (Aged Care Complaints Commissioner, 2017).

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is the standards setting body for the acute health care sector, yet there is no comparable body for the aged care sector. We note here that in July 2015 the AACQA notified the QNMU in writing that the current Standards are made by the Minister and that *“it is not within our (the Agency’s) remit*

*to make standards or to mandate particular matters or methods to be practised by care homes in order to meet the Standards”.*

There are also no standards for aged care equivalent to the comprehensive clinical and EQuIP National Standards for the acute sector. While a draft set of Aged Care Quality Standards has been recently released, these appear to be far less robust and comprehensive than the standards operating in the acute sector and fails to recognise the significant clinical care required by most aged care residents (Australian Government Department of Health, 2017). While a range of comprehensive and robust accreditation standards exist for the acute sector, via the ACSQH, in relation to such events as falls, pressure injuries, medication safety, clinical deterioration and infection management, there is no corresponding set of standards for the aged care sector. In the acute sector, all health jurisdictions have comprehensive surveillance, monitoring and investigative processes in place to identify and respond to episodes of harm. These processes are now well developed and reflect the recognition that patient safety is a key organisational imperative.

The aged care accreditation process has also been called into question and has been the subject of recent inquiries. Again, there seems little comparison between accreditation processes accepted as the norm in other health care sectors and those undertaken by the AACQA for the aged care sector.

Given the vulnerable nature of this large group of Australian citizens and the current inadequate safety and quality accreditation and reporting of this sector, development and implementation of a mandatory, comprehensive and transparent safety and quality indicator program is an essential and pressing need.

Unfortunately, resident safety in the aged care sector does not have the same profile. While there is mandatory reporting of suspicions or allegations of reportable assaults, the ACCC for complaints relating to quality of care, as well as the AACQA with an accreditation role, this safety framework seems poorly developed in comparison to the acute sector. Providers maintain internal incident reporting systems but there is no attempt at sector wide reporting other than a fledgling Residential Aged Care Quality Indicators program for pressure injuries, restraint and unplanned weight loss.

That a more comprehensive focus on resident safety is required is supported by the recent research undertaken into premature deaths of nursing home residents which demonstrates an increasing incidence of external causes of deaths in residential aged care over the period 2001 – 2012, particularly those related to falls (Ibrahim, et al., 2017). The robust incident investigation processes such as root cause analysis used for events that result in permanent harm or death that are a feature of the acute sector are also absent from the residential aged care sector, with the effect that systemic issues impacting on resident safety are not systematically reviewed and responded to.

The current voluntary aged care quality indicator program consisting of three indicators (pressure injuries, use of physical restraint and unplanned weight loss) is demonstrably inadequate and is indicative of the considerable lag compared to processes in the health care sector that have been established for many years.

At a minimum, the following quality and safety indicators should be mandated, collected and publicly reported as a starting point. The Victorian government uses the *Quality indicators in public sector residential aged care services* data set (Victorian Department of Health, 2015). Adoption of these indicators and associated definitions would promote consistency of data across jurisdictions and save considerable time and resources in development of a national set of indicators which would be the same or similar.

The Victorian model consists of five indicators which involve a total of thirteen data items:

1. Pressure injuries – Stage 1, 2, 3, 4 as well as unstageable and suspected deep tissue injury;
2. Falls and falls-related fractures;
3. Use of physical restraint – intention to restrain, use of physical restraint devices;
4. Use of nine or more medicines;
5. Unplanned weight loss – consecutive weight loss and significant weight loss.

In light of recent research on inadequate staffing and skill mix and missed care in aged care (Willis et al., 2016) we also suggest the following indicators be included in any aged care safety and quality reporting regime:

1. Average hours of care per resident per day;
2. Percentage of staff categories providing direct and indirect care to residents
  - a. RNs
  - b. Enrolled Nurses (EN)
  - c. Assistants in Nursing (AIN) / Personal Care Workers (PCW).

### **Whistle Blower Protection**

The following reflects the QNMU submission to The Joint Committee on Corporations and Financial Services Inquiry into Whistleblower Protections (2017).

Although there may be a broad understanding of the term “whistleblowing”, there remains fundamental ambiguity and confusion about who can make a disclosure, the type of matter being disclosed, where the individual can make a disclosure, to whom it can be made and the circumstances in which they can access protections. These factors are exacerbated in the health and aged care sectors where a raft of legislation, codes of practice, standards and regulations govern clinical practice.

Nurses and midwives must be registered with the Nursing and Midwifery Board of Australia (NMBA), and meet the NMBA's professional standards in order to practice in Australia.

Professional standards define the practice and behaviour of nurses and midwives and include:

- codes of conduct;
- codes of ethics;
- guides to professional boundaries;
- standards for practice/competency standards.

The Codes of Conduct for nursing and midwifery outline the profession's commitment to respect, promote, protect and uphold the fundamental rights of people who are both the recipients and providers of nursing, midwifery and health care.

They are supported by, and should be read in conjunction with the:

- *Code of Professional Conduct for Nurses in Australia;*
- *Code of Professional Conduct for midwives in Australia;*
- *Code of Ethics for Midwifery in Australia;*
- *Code of Ethics for Nursing in Australia;*
- *Registered nurse standards for practice;*
- *National competency standards for the midwife;*
- *Enrolled nurse standards for practice;*
- *Nurse practitioner standards for practice.*

Under the *Code of Ethics for Nursing* (NMBA, 2013a) quality nursing care involves nurses accepting accountability for the standard of nursing care they provide, helping to raise the standard of nursing care, and taking action when they consider, on reasonable grounds, the standard of nursing care to be unacceptable. This includes a responsibility to question and report what they consider, on reasonable grounds, to be unethical behaviour and treatment.

Further, nurses must take steps to ensure that not only they, but also their colleagues, provide quality nursing care. In keeping with approved reporting processes, this may involve reporting, to an appropriate authority, cases of unsafe, incompetent, unethical or illegal practice. Nurses also support colleagues whom they reasonably consider are complying with this expectation (NMBA, 2013a).

Nurses' primary responsibility is to provide safe and competent nursing care. Any circumstance that may compromise professional standards or any observation of questionable, unethical or unlawful practice should be made known to an appropriate person or authority. If the concern is not resolved and continues to compromise safe and competent care, nurses must intervene to safeguard the individual and, after exhausting internal processes, may notify an appropriate authority external to their employer organisation (NMBA, 2013b).

These documents, together with other published practice standards (e.g. decision-making frameworks, guidelines and position statements), provide a framework for accountable and

responsible nursing and midwifery practice in all clinical, management, education and research areas.

It is the position of the QNMU that nurses and midwives should be free to speak out against poor professional practice, misconduct or corruption identified during the course of their employment without reprisal. Nursing and midwifery, like many other professions have high levels of employment mobility. For that reason, consistent public disclosure protections should exist across all health and aged care sectors and across state and federal jurisdictions.

### *Internal Disclosure*

The QNMU endorses the *Whistleblowing* policy of our peak body, the Australian Nursing and Midwifery Federation (ANMF, 2017). According to that policy, health and aged care managers who receive complaints or reports of misconduct, corrupt conduct or criminal conduct must manage the complaint in accordance with relevant legislation and the organisation's policies and procedures.

Employers have an obligation to ensure they comply with any relevant whistle-blower legislation (State, Territory and Commonwealth). Legislation provides legal protection against reprisals in some circumstances, for example the *Corporations Act 2001* for private sector disclosures and in Queensland the *Public Interest Disclosure Act 2010* for state public sector disclosures and *Health Ombudsman Act 2013* which provides a system for dealing with complaints and other matters relating to the health, conduct or performance of health practitioners and the services provided by health service organisations.

Section 275 of the *Health Ombudsman Act Qld 2013* gives protection to a nurse or midwife reporting unethical treatment or behaviour to the Health Ombudsman. This section applies to a person who, honestly and on reasonable grounds, gives information to the Health Ombudsman, a staff member of the Office of the Health Ombudsman or an authorised person for the purpose of a health service complaint. The person is not subject to any liability for giving the information and no action, claim or demand may be taken or made of or against the person for giving the information.

Depending on the circumstances, it may be that a disclosure to a prescribed entity or person is inappropriate or unworkable. In such circumstances, the person wishing to make the disclosure has no option available to them.

More concerning is that this type of process potentially excludes a person who has disclosed information about improper conduct from protection merely because that person has disclosed the information to the wrong person or entity. Given the array of regulatory bodies within the health and aged care sectors, such an occurrence is quite possible. For example, a nurse may disclose information to a regulatory agency such as the ACCC and find themselves without appropriate protections. In our experience, nurses and midwives seeking to disclose information may be unfamiliar with the reporting process for the relevant agency.

We advise nurses and midwives who make a complaint or report or who are the subject of a complaint or report to seek support and advice from the QNMU in the first instance. In that regard, the QNMU believes whistle-blowers should be permitted to make a disclosure to a third party.

We therefore seek stronger statutory protections in the private, public and not-for-profit sectors to ensure nurses and midwives are able to comply with their ethical standards of practice. We support stronger whistleblowing protections in the private and aged care sectors so that whistle-blowers' identities are kept confidential, there are penalties for employers who fail to investigate properly when an individual or group of individuals make truthful assertions and there are protections of whistle-blowers from reprisal.

### *Aged Care*

The QNMU and the ANMF have consistently raised the need for greater protection of employees in the aged care sector who wish to raise issues in relation to the quality of care provided to residents of aged care facilities.

Aged Care providers receive substantial sums of Commonwealth funding. There is a public interest in ensuring that providers disperse these funds for the benefit of residents and to provide the highest quality of care. Since 2016, the 'independent' ACCC investigates any complaint relating to a Commonwealth subsidised residential or home-based aged care services. Consumers can make a complaint, anonymously if they choose, about any area that impacts their health, safety or wellbeing, such as the care they receive, living conditions, how they interact with the staff or their daily lifestyle (ACCC, 2016).

This leaves staff vulnerable to allegations possibly from an anonymous source over a range of matters related to aged care.

Although presently there are mandatory reporting requirements in relation to reportable assaults, many aged care employees are reluctant to make complaints related to the quality of care, poor facilities, resident neglect or the misappropriation of public funds because the potential for making such complaints may result in the termination of their employment, a reduction in the number of shifts or hours or other less favourable treatment.

Legislation should provide nurses working in aged care with protection for disclosures they make in relation to poor facilities, resident neglect or the misappropriation of public funds. This should extend to all aged care providers.

### *Disclosure to Third Parties*

As a union, we encounter members who have felt it was either unsafe or ineffective for them to make a disclosure within their organisation, or they had confronted serious obstacles in doing so. There are circumstances where whistle-blowers need clear and accessible pathways to disclose information to third parties in certain circumstances when internal disclosure systems are ineffective.

The ability for whistle-blowers to raise their concerns with a third party be it the media, members of parliament, non-government organisations or unions creates a powerful incentive for organisations to act according to prescribed legislation and standards. This is particularly so in the health and aged care sectors where licensed nurses are subject to extensive regulation.

It is a core function of trade unions to protect and advance workers' rights and conditions of employment. Unions and other third parties themselves should be immune from reprisal action in the event they decide to act on the disclosure or make the information public. We suggest that not only does the person making the disclosure need protection but also the third party.

### **Recommendations**

1. The regulation of aged care be amended to include provisions mandating nursing ratios that allow RNs to comply with their statutory duties. Using the evidence-based research conducted by Flinders University and University of South Australia, that ratio of Residents to RNs must be a maximum of 20 Residents to each RN.
2. As a safety net, there must be amendments to aged care regulation to include provisions mandating a minimum of one RN on each aged care residential worksite at all times to enable RNs and ENs to comply with their professional standards.
3. The regulation of aged care be amended to include provisions mandating the number of nursing and care staff rostered on shift must be able to provide nursing and personal care hours per resident per day at a minimum of 4.3 hours, on average.
4. The regulation of aged care be amended to include provisions mandating a skill mix of 30% RN, 20% EN and 50% AIN so quality care can be provided by all categories of staff and missed care (abuse by neglect) will be minimised, if not eliminated.
5. The regulation of aged care be amended to include provisions mandating that aged care regulation must be read in conjunction with the *Health Practitioner Regulation National Law Act 2009* (National Law).
6. The Accreditation Standards be amended to include explicit provisions mandating that relevant nursing professional standards are audited by accreditation assessors with respect to compliance by the provider.
7. The Accreditation Standards be amended to include explicit provisions mandating that any resident who does not have mental capacity to self-administer their medicines will have their medicines given to them by a registered nurse or enrolled nurse with medication qualification.
8. That a compulsory and standardised reporting mechanism/system be developed to manage the reporting and management of all adverse events which result in temporary or permanent harm or death.
9. That a standardised and mandatory approach be developed and implemented for the management and investigation of all serious adverse events that occur in residential aged

care with mechanisms for data sharing between regulatory agencies and the identification of trends and issues requiring regulatory intervention.

10. That a compulsory national aged care safety and quality key performance indicator program be developed and implemented as a matter of urgency.
11. That the Committee explore options and make recommendations regarding comprehensive best practice whistle-blower protections for present and former aged care workers across all segments of the aged care sector.

## **Terms of Reference Two**

### **The effectiveness of the Australian Aged Care Quality Agency, the Aged Care Complaints Commission and the *Charter of Care Recipients' Rights and Responsibilities* in ensuring adequate consumer protection in residential aged care**

An essential element of the government's responsibility for aged care is the implementation of robust regulatory and control mechanisms (e.g. complaints handling, incident reporting and follow-up, standards and governance) as part of this overall responsibility and recognition that there is more to aged care than just funding. While instruments such as the Charter of Care Recipients' Rights and Responsibilities are important documents that highlight the respective responsibilities of aged care providers and recipients of care, they are no substitute for appropriate legislative and regulatory control mechanisms. It is also of concern that this charter may be used against residents and their significant others, e.g. should they complain, rather than providing any modicum of control over provider behaviour.

In Australia, the provision of residential aged care is a public good largely provided by the private sector ranging from charities, not-for-profit organisations and for-profit providers. Some residential aged care is provided by state governments. The funding and regulation of aged care falls primarily under federal jurisdiction via the *Aged Care Act (1997)*. While it is likely that state government do have capacity to legislate/regulate the provision of aged care services within their jurisdictions, there has been a general reluctance for state governments to do so.

Currently, governance responsibilities for aged care are shared between the Commonwealth Department of Health, the AACQA and the ACCC. This division of responsibility is emblematic of the failure of successive federal governments to implement robust standards and enforcement mechanisms regarding the safety of aged care residents as part of overall governance of aged care. Highlighting this failure has been inadequate surveillance the ACQA, as demonstrated by the most recent accreditation issues at the Oakden Aged Care Facility, a lack of comprehensive standards, and a paucity of transparency requirements for providers in relation to how the significant public contribution to aged care funding is spent, particularly in relation to the those factors known to directly influence resident safety, e.g. staffing and skill mix levels.

In 2011, the Productivity Commission recommended that establishment of an independent Aged Care Commission to regulate the aged care sector and separate the policy functions of the Commonwealth Department of Health from a regulatory function. The QNMU believes that such a body would replicate the success of the ACSQHC for the hospital sector. Unfortunately, these recommendations contained in the *Caring for Older Australians Report* (Productivity Commission, 2011) were not comprehensively acted on. It is the view of the QNMU that the current situation in aged care has in part resulted from the failure of successive national governments to implement robust governance mechanisms for aged care, e.g. an Aged Care Commission. Recent enquiries which have called into question the effectiveness of the current disjointed aged care governance and regulatory bodies only highlights the need for a single, independent and penultimate body to regulate the aged care sector.

### **Recommendations**

1. That an independent Aged Care Commission, as the peak regulatory body for the aged care sector and comparable to the functions of the ACSQHC and incorporating the functions of the AACQA and ACCC, be established.

### **Terms of Reference Three**

#### **The adequacy of consumer protection arrangements for aged care residents who do not have family, friends and other representatives to help them exercise choice and their rights in care**

It is view of the QNMU that further can be done to protect older Australians who do not have significant others to support them when they access aged care services. The following are suggested.

#### **Protecting older Australians from Abuse**

The Australian Law Reform Commission report, *Elder Abuse—A National Legal Response* (2017) contains recommendations across a range of areas including aged care, aimed at protecting older Australians from abuse. The QNMU urges the Committee to incorporate these recommendations into its deliberations and final recommendations.

#### **Advocacy**

Advocacy on behalf of consumers is an essential component of any complex system. Feedback received on many occasions by the QNMU suggests that navigating the aged care system by older Australians, and their significant others, can be daunting in its complexity. Two potential approaches should be considered.

1. In conjunction with the States and Territories, the Commonwealth fund an Aged Care Ombudsman/Commissioner Office to assist consumers of aged care as they encounter issues in dealing with this complex system. It is anticipated that this

Ombudsman/Commissioner role would work in a co-regulatory capacity with the current ACQA and ACCC (or future regulatory body such as an Aged Care Commission) in a similar way to existing coregulatory models in other parts of the health care system, e.g. the Queensland Office of the Health Ombudsman. A state based approach is suggested as this brings the function closer to those who would use the system and acknowledges that each state and territory jurisdiction has its own idiosyncrasies.

2. Funding for advocacy services must be increased. Again, the experience of the QNMU is that significant advocacy resources are required to assist older Australians to effectively utilise the aged care system, and while advocacy organisations working in this space are highly effective, they do have capacity and funding constraints such that people do still fall through the cracks. Failure to fund advocacy services to assist those using the aged care system is simply false economy which leads to poor outcomes for individuals and ultimately increases the funding burden for all.
3. A requirement of any funding must be that the advocacy group is independent and not subject to influence by other organisations. Specific consideration should be given to Primary Health Networks, locality based advocacy services and special needs areas such as advocacy services servicing culturally and linguistically diverse communities.

### **Advanced health directives**

Another area where the commonwealth can assist older Australians in making choices about their aged care is the area of advanced health directives. These documents identify a person's wishes in relation to existing and future health issues and decisions, provide consumers and healthcare workers with certainty in relation to the care they receive and help to prevent the often significant cost and resource utilisation associated with futile health interventions that can result when the consumer has limited or no capacity to make decisions about their own care. The QNMU suggests the Commonwealth coordinate and fund a campaign to maximise the use of advanced health care directives in residential aged care. Elements of this campaign would involve:

- information resources and education for aged care consumers and their significant others regarding the process and benefits of advanced health directives;
- education for aged care workers on the impact of these directives on care of individuals;
- exploring how completion of an advanced health directive may be incorporated into the Aged Care Assessment Team (ACAT) process;
- education for healthcare workers in the broader health system regarding advanced health directives, particularly as hospitals are a feeder system for those awaiting placement in an aged care facility;

- liaising with state based guardianship authorities to maximise the use of advanced health directives for those individuals who do not have family, friends or other representatives;
- ensuring that residential aged care providers have systems in place to ensure that all care staff are aware of resident advanced health directives and provisions. For example, ensuring that such systems are in place and used, could occur through the accreditation process.

### **Professional Standards**

It is the firm belief of the QNMU that much work needs to be done to develop more robust care standards for the aged care sector that are comparable to those in the hospital sector. Development of enforceable standards of care are a critical consumer protection mechanism. In addition to these standards, the QNMU believes that aged care providers have an obligation to ensure that professional standards are supported and complied with, e.g. Nursing Professional Standards. These standards are another essential consumer protection mechanism.

While current agreements between providers and consumers incorporate issues such as fees and charges, the QNMU suggests that these agreements should also identify that the provider and staff will support and adhere to professional standards of practice, i.e. best practice. It is also essential that all such agreements must be clear, concise and in plain language to help protect consumers from manipulation, confusion and deception.

### **Legislation**

An increasing feature of the aged care sector, particularly noticeable in the for-profit segment is the “vertically integrated” nature of service provision that encompasses retirement living, community services and residential aged care. However, while governance of aged care services falls largely within the federal jurisdiction, the regulation of retirement living services is state based. As recent media exposés have identified, there is concern that older Australians are open to exploitation as they move from their homes to retirement living schemes. The QNMU suggests that the Commonwealth consider negotiating with the states and territories to introduce a national approach to the regulation of retirement villages and similar services that would address issues such as fees and charges, and any provider conflict of interest concerns, as consumers transition from retirement living to residential aged care.

As the aged care sector proceeds down the course outlined in the Aged Care Roadmap and a consumer directed care (CDC) model becomes embedded and potentially moves to the residential aged care segment, the QNMU is concerned that without effective regulatory oversight, this “quasi-market” approach risks exploitation of consumers through excessive fees and charges as providers seek to maximise profits, e.g. through excessive entry and exit fees which eat into the consumers funding budget. Ideally, the QNMU believes that providers

should not be able to charge entry or exit fees, however at the very least these should be regulated and capped so that they are a nominal impost only.

### **Recommendations**

1. That all relevant recommendations from the Australian Law Reform Commission report, *Elder Abuse—A National Legal Response* (2017) be incorporated into the work of the Committee and be reflected in any recommendations made.
2. In conjunction with the States and Territories, the Federal Government consider a state/territory based Aged Care Ombudsman/Commissioner scheme, to assist those dealing with the complexities of the aged care system, to work with other regulatory arms of the aged care sector using a coregulatory approach.
3. That the Federal Government explore options for increased funding and resourcing of aged care advocacy organisations to support aged care service recipients and their significant others to successfully navigate the aged care system.
4. That the Committee consider options for increasing the use of advanced health directives in residential aged care.
5. That the Committee explore regulatory mechanisms for ensuring that professional standards are supported and complied with by aged care providers, either as part of the aged care accreditation process or via the contractual process between providers and recipients of care.
6. That the Federal Government explores options for establishing consistent national laws for the regulation of retirement living schemes.
7. That the Accreditation Standards in the *Quality of Care Principles 2014* be amended to explicitly state that nursing professional standards and guidelines must be complied with.
8. That Division 66 of the *Aged Care Act 1997* be amended to explicitly state that the sanctions imposed upon residential care providers who fail to meet any Accreditation Standard expected outcome can include fines or financial penalties.

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## **Legislation**

Aged Care Act 1997

*Corporations Act 2001*

Health Ombudsman Act 2013 Qld

*Health Practitioner Regulation National Law Act 2009* (National Law)

*Public Interest Disclosure Act 2010*