AUSTRALIAN NURSING & MIDWIFERY FEDERATION NSW BRANCH

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
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NSW NURSES & MIDWIVES' ASSOCIATION

BH:HMA
IN REPLY PLEASE QUOTE: Ref:17/0889
17 July 2017

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir/Madam

RE: Submission to the Inquiry into the effectiveness of the Aged Care Quality Assessment and accreditation framework

The NSW Nurses and Midwives' Association (NSWNMA) welcomes the opportunity to provide a submission to the Inquiry 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. We look forward to hearing the outcome of your consultations in due course.

Yours sincerely

BRETT HOLMES
General Secretary
NSW Nurses and Midwives' Association

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New South Wales Nurses and Midwives' Association

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

July 2017

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes Assistants in Nursing (who are unregulated), Enrolled Nurses, Registered Nurses and Midwives at all levels including management and education.

The NSWNMA has approximately 64,500 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

We currently have over 10,500 members who work in aged care. We consult with them in matters that are specific to their practice. We wish to acknowledge the contributions made by our members in preparing our comments.

We welcome the opportunity to provide a submission to this Inquiry.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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Terms of Reference

1. 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;
2. 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;
3. 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;
4. the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;
5. the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;
6. 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
7. any related matters.

Introduction

This Inquiry is set within a context of significant reform in the aged care sector and is one of a number of inquiries and consultations focusing on the future direction of aged care. Despite this, there has been a failure to address the systemic problems in aged care, and draw together the various strands that impact on safety and quality care.

Recently there have been reports on the findings of the Senate Inquiry into the future of the Aged Care Sector Workforce in Australia and a report on the Elder Abuse Inquiry by the Australian Law Reform Commission. In addition NSW has held Inquires into Registered Nurses in NSW Nursing Homes and Elder Abuse. A common theme throughout are calls for enhanced regulatory safeguards and safer staffing. Despite this there has been little progress on the recommendations, with decisions deferred to disparate departmental committees. The resulting outcome has been stagnation of decision making and accountability at all levels.

The provision of safe staffing ratios and skills mix in aged care is intrinsically linked to safety and protection against abusive practices. Any attempts to enhance safeguards through regulation will be futile unless legislative reforms also provide minimum standards for safe staffing in residential aged care facilities (RACFs). We draw your attention to the list of supporting documents produced by the ANMF and NSWNMA which should also be referred to as part of this submission (p14). These provide clear evidence of overburden at all levels within the aged care workforce and the impact on resident safety. It is hoped this Inquiry will be instrumental in drawing together the outcome of all associated findings and propose a meaningful and practical strategy for aged care.

We also attach a supplementary submission made by an aged care member, which provides insights from the workplace.

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.

The NSWNMA regularly attends Agency Meetings with the state branch of the Australian Aged Care Quality Agency (AACQA) where local and national data sets are provided. Data suggests there is a continual lack of compliance in regard to: staffing; medications management; clinical care and behaviour management. It is our view that this can be explained through a combination of the following:

- Failure of consecutive Governments to address the fundamental issue of safe staffing in residential aged care and lack of impetus to establish minimum safe staffing ratios for aged care in all states; and

- Inadequate systems for determining adequacy of safe staffing, including lack of commonwealth safe staffing methodology; and

- Inadequate regulatory processes determined by risk management that allows for the same outcomes to be reported against at each site visit, leaving large gaps between reports on other outcomes (or absence of reporting); and

- Inadequate system for assessing against each outcome upon re-accreditation of facilities and over-reliance on paper based audit and self-reporting; and

- Lack of a case-tracking system for assessing care outcomes against individual care needs.

The accreditation framework is inherently flawed with regulator performance targets more focused on reducing regulatory burden on providers[1]. Also, 'Better practice awards' offered as incentives for providers to display innovative care; which portray

[1] https://www.aacqa.gov.au/about-us/quality-agency-regulator-performance-1

this as aspirational rather than a basic regulatory requirement[2]. Both of which do little to evoke consumer confidence and promote neutrality.

The re-accreditation system relies heavily on self-reporting against care outcomes and is a largely paper-based audit. Yet accreditation may result in a licence to operate for up to five years[3]. Interim site audits conducted more regularly are likely to be more detailed, longer and use more assessors. However, they are often targeted based on intelligence about the service. This means that a set of outcomes may not be assessed against, other than through an audit based system for over three years. Some providers are also notified of audits in advance which means a true picture of the day to day operation of the home cannot be guaranteed. This leads to huge oversights in care regulation and reduces protections for workers and residents.

> ***"The managers do not care to correct the wrong doing until nearly time for accreditation then they sit down and alter the records to please the accredited personals; hence they can pass the accreditation."***
> ***Assistant in nursing - RACF***

> ***"Random audits and checks need improving as staff are told what to do and say when auditors are around. The "troublemakers" are generally not rostered on that day."***
> ***Registered Nurse - RACF***

Since accreditation audits lack depth it is unsurprising that the latest annual report by the AACQA shows that in 2015-16, more than 97% of all residential aged care facilities that went through a full audit met all expected outcomes of the Accreditation Standards, with only 13 review audits identifying concerns that the Accreditation

[2] https://www.aacqa.gov.au/providers/promoting-quality/better-practice-awards/copy_of_2016-better-practice-award-winners
[3] South Australia 'Innovation Hub' Initiative

Standards may not be met[4]. Figures from the England aged care regulator, show that 347 services were either de-registered or had their registration cancelled within the same period, took 1,090 enforcement actions and at the year-end were also in the process of taking another 777 actions[5]. Accounting for the differences in breadth of coverage; these figures still suggest under-reporting of non-compliance by the AACQA.

Changes proposed to the regulatory framework through the Single Aged Care Quality Framework to be introduced in 2018[6] support less, not more regulation of the sector. Regulation will rely more on risk assessment and indications are that there will be less definition within outcomes meaning that there will be greater chance of individual assessor discretion.

It is also concerning that revised outcomes fail to define a staffing model that will enable assessors to determine optimum staffing skills mix and ratios. It is our view that this is fundamental to ensuring high quality care as demonstrated in the findings of the Oakden Report; which recommends mandated staff training and states minimum staffing and skills mix to ensure safe and appropriate care[7]. Australian Nursing and Midwifery Federation research conducted in 2016 found that current staff hours are not adequate to even meet basic care needs[8]. Failure to ensure effective regulation of this area, and establish minimum standards to report against will no doubt lead to a continuation of the poor practices such as those displayed at the Oakden facility.

To date, there has been no consultation or indication of any changes to aged care legislation. Unless there are clear links between outcomes to be measured and legislation, assessors will have little power to take swift remedial action where concerns are identified.

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[4] https://www.aacqa.gov.au/about-us/annual-reports/annual-report-2015-2016/AACQ%20Annual%20Report%202016%20ACCESSIBLE%20WEB.pdf
[5] Care Quality Commission Annual Report 2015-16. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541546/CQC-15-16_ARA_acc.pdf
[6] https://www.aacqa.gov.au/providers/news-and-resources/single-aged-care-quality-framework/single-aged-care-quality-framework
[7] Government of South Australia (2017) The Oakden Report. Available at: http://apo.org.au/node/76130
[8] ANMF (2016) National Aged Care Staffing and Skills Mix Project Report 2016. Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

"Audits should focus on the staffing shortfalls and the resident to staff ratio - more so for the high care residents (in facilities). Management should also be made responsible for the continuation of staffing shortfalls and issues. There should be a governing body where assistants in nursing, registered nurses etc. can report the ongoing and unresolved staffing shortfalls. If management of the aged care facilities continue to ignore these issues or refuse to put measures in place to resolve these then a governing body should be able to intervene somehow. These shortfalls are directly linked with poor resident care and subsequently elder abuse. How are we expected to do our jobs successfully and efficiently with the highest standard of care when all the facility is focused on is cost cutting!"
Assistant in nursing - RACF

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.

Relatives, residents and workers are often poorly placed to raise issues of concern due to their dependence on the service provision and imbalance of power between aged care operators, care recipients and their carers. Fear of reprisal is commonly cited as a reason for inaction when concerns are felt and complaints processes must offer safeguards for workers, care recipients and their relatives.

"There needs to be protection for staff from bullying when they speak up about abuse."
Assistant in nursing - RACF

Unless complaints management is raised as a specific concern, it could be an outcome that is not explored in-depth for a minimum of three years between accreditation visits. In addition, whilst complaints are a good indicator of quality they are a reactive rather than proactive way to monitor consumer outcomes. A more appropriate way would be to ensure meaningful and independent engagement of workers, relatives and consumers throughout the accreditation cycle. Better use of data from, or meaningful engagement with, external community advocacy organisations built into formal agreements might also be of value.

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.

Whilst registered nurses have a professional duty to report issues of concern, no such requirements are placed on unlicensed care workers/Assistants in Nursing, yet the latter provide the most direct care to residents[9]. Plans to require this group to adhere to a National Code of Conduct for health care workers[10] will go some way to address this. However, each state will have determination about how this will be implemented which could be confusing for regulators of aged care; and the code remains good practice guidance rather than a statutory requirement.

Our members cite lack of action when they raise issues of concern to external agencies. In some cases, delays occur due to the referral pathways between the Department of Health, Aged Care Complaints Commission, Healthcare Complaints Commission, Nursing and Midwifery Board of Australia and AACQA. Greater legislative powers for the AACQA and more streamlining of the system for referrals, including a centralised reporting scheme would promote timely action and feedback for workers raising concerns in good faith.

[9] Australian Government Department of Health (2017) The Aged Care Workforce 2016. Available at: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/03_2017/nacwcs_final_report_290317.pdf
[10] COAG Health Council (2015) Final report: A National Code of Conduct for health care workers.

"Staff and family members report to the AACQA where there are problems. They also report to the Nurses Registration Board, but little if anything is done. RNs with complaints against them are told to be counselled and have a program of re-education, but the failing/lack of skill/personality problem still remains. This results in sites that are in jeopardy, but remain operating."
Enrolled Nurse - RACF

"The cover up in facilities would make audits difficult. Any suggestion of abuse should be investigated by independent sources. The abuse I reported involved signing a nondisclosure agreement. The AIN who was threatening a resident suffering dementia is still working."
Registered Nurse - RACF

The adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden.

The NSWNMA recently consulted members on the issue of medications handling. Findings identified widespread and systemic problems in relation to the administration of medications and lack of governance in this area. Three quarters of nurses consulted were either concerned, or unsure about the management of medicines in RACFs. Over a third of nurses consulted said that better regulation of medications by the AACQA would improve the situation.

"The time frame to administer medications safely and correctly (is too short); too many residents on too many medications (polypharmacy) and too few people to administer at a time when there are so many other tasks to be attended. The time and resources to train staff properly in medication management is often not a viable option due to staffing and funding shortfalls."
Clinical Nurse Educator - Aged Care Service

"Registered nurses have just been employed at this facility and medication management is so lax it is scary."
Registered Nurse - RACF

"There is a need for improved correlation between current training packages and regulations in aged care facilities. There are inconsistencies between facilities. Guidelines for medication management in aged care facilities need to be the same statewide NOT governed by individual organisational policies and procedures."
Registered nurse - RACF

Recent Government reform has removed the distinction between low and high care RACFs allowing people to 'age in place'. High care can now be provided in former low care provision and most people being admitted have high care needs in some form[11]. However, legislation does not stipulate minimum staffing requirements and many RACFs do not have registered nurses on-site at all times. Many are staffed either entirely by unlicensed care workers, employ registered nurses during office

[11] Australian Institute of Health and Welfare (2017) *Residential aged care and Home Care 2014–15 supplementary data*. Available at: http://www.aihw.gov.au/aged-care/residential-and-home-care-2014-15/data/

hours or have on-call arrangements which often leave people waiting to receive vital medications until suitably skilled staff can attend.

Legislation and guidelines determining best practice in relation to medication management have failed to keep pace. Guidelines designed for unlicensed care workers assisting people to self-administer medications are now irrelevant in RACFs where high care is mainly provided. This is a serious oversight that must be addressed as a matter of urgency.

As a recurring area of non-compliance reported by the AACQA it is without doubt that medication practices, such as were evident at the Oakden facility, have been inadequately addressed by existing regulatory and complaints processes.

The adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents.

We recently consulted our aged care members on the issue of elder abuse. The subsequent reports 'Who will keep me safe?' and 'Solutions from the frontline' catalogue a series of failings within the *Aged Care Act 1997* and associated regulations in regard to the reporting of serious incidents. In particular: failure to make appropriate safeguards where restrictive practices are used; failure to implement effective behaviour management plans; fear of reprisal for workers wishing to raise issues in good faith and exemption from reporting incidents where a person is cognitively impaired. A common thread throughout responses was that for effective, safe care to be provided there must be adequate ratios of staff to residents, and greater professional oversight from registered nurses.

The Australian Law Reform Commission has recently reported their findings in relation to some of these subject areas and if adopted, would go some way to address existing deficits. Collection of mortality statistics is in operation within regulatory models operation in other countries, and is a central part of intelligence

gathering about services. This is one of a multitude of ways that intelligence could be gathered between site audits and re-accreditation and it is suggested that this area is investigated as a matter of priority.

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.

Whilst ensuring safe care is everyone's business; the power imbalance between aged care providers and care recipients, relatives and workers cannot be underestimated. Many of our members cite fear of reprisal should they raise concerns and even if empowered, lack the training and education to do so. Many relatives would be unaware of how to raise concerns. They also live in fear of reprisal and feel guilt at leaving their loved ones in an aged care facility. The process of reporting adverse incidents may not only be alien to them, but if enacted, may validate feelings of guilt and helplessness.

Placing a loved one in an aged care facility is not done lightly, and is often because the person has no other choice. It is also difficult to find an aged care place and once obtained, requires a significant financial investment as security. Raising an issue that could lead to removal of that person would require significant resilience and courage given the potential financial, practical and emotional implications.

As identified in the NSW Nurses and Midwives Association papers 'Who will keep me safe?' and 'Solutions from the frontline' there have been ineffective systems for reporting of incidents by aged care providers and lack of impetus from the AACQA to take responsibility for monitoring incidents. The member submission attached with this submission provides further insights in this regard. There is over-reliance on self-reporting and lack of external governance in the management of incidents. Many aged care facilities operate on minimum staffing levels which means that remedial actions cannot be effectively implemented, for example, when implementing behaviour management plans.

There are disparate systems for the operation of aged care across states and between Federal departments. The lessons from Oakden must serve as a catalyst for change and the creation of a nationally consistent regulatory strategy for aged care that is transparent and enhances public protection.

Any related matters.

One of the perceived barriers to achieving desired changes in aged care is the lack of an overall co-ordinated Federal strategy incorporating meaningful and proportionate engagement of frontline workers. The Hon Ken Wyatt AM, MP has called for submissions to the review of the National Aged Care Quality Regulatory Processes. It is likely that the submissions to this will draw parallels with responses to this Inquiry. It is hoped this Inquiry will ensure that findings and recommendations from both reviews, are aligned.

List of supporting documents

Australian Nursing and Midwifery Council (2016) *National Aged Care Staffing and Skills Mix Project Report 2016.*
Available at:
http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

Australian Nursing and Midwifery Council (2016) *National Aged Care Survey.*

Available at:
http://www.anmf.org.au/documents/ANMF_National_Aged_Care_Survey_Report.pdf

NSW Nurses and Midwives Association (2016) *Who will keep me safe? Elder Abuse in Residential Aged Care.*

Available at:

http://www.nswnma.asn.au/wp-content/uploads/2016/02/Elder-Abuse-in-Residential-Aged-Care-FINAL.pdf

NSW Nurses and Midwives Association (2016) *Solutions from the frontline: Practical approaches to reduce the risk of abuse in aged and disability services.*

Available at:

https://issuu.com/thelampnswnma/docs/solutions_from_the_frontline

SUPPLEMENTARY MEMBER SUBMISSION

July 27, 17

ANONYMOUS SUBMISSION

I am a registered nurse and work in an aged care facility. I have been working in the aged care sector for 30 years.

I am also a member of the NSWNMA and was invited by them to add to their submission from the perspective of someone who is currently employed in the aged care sector.

I wish to raise the following points in relation to the current Inquiry-

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:

I have had direct experience of the accreditation and review process and in my view, improvement is required in the following areas to ensure safety of residents:

A. OUTCOMES OF CARE

1. FALLS

During Accreditation Inspections, the paperwork is checked by Assessors but the following also needs to be checked by them:

- The adequacy of staffing and qualified personnel during the time of incident.
- The number of registered nurses and care staff per resident at that time of incident and whether this was sufficient for supervision and assistance of residents.
- Whether there is a physiotherapist and a physiotherapist aide to assist with residents' mobility exercises.

2. USE OF PHYSICAL AND CHEMICAL RESTRAINTS

Paperwork, including consents is checked by Inspectors but the following also needs to be checked:

- The adequacy of staffing and qualified personnel during the times of use of restraint.
- How often have the Doctors reviewed these treatments.
- Whether relatives have been informed and consents been organised.

3. RATES OF WEIGHT LOSS

Standard 2.10 only states " *Care recipients receive adequate nourishment and hydration."* However assessors also need to check:

- How many staff members are available at breakfast, lunch and dinner to assist residents to eat and drink. Inspectors should check the rosters, not just look at what is happening on the day.

- What food supplementation is available? Has there been a regular supply or just purchased a week or so prior to the inspection?

- What is the menu like at breakfast, lunch and dinner? Are the food prepared fresh or frozen?

- Is the food nutritious? Have the pantry been checked for frozen prepared meals like sausage rolls? Has soup been made fresh or are the residents served tinned soup? How often are these served?

- What food preparations are made for residents who have diabetes and coeliac disease? Are there also food preparations for diabetic suppers?

- There are some residents who continue to lose weight because of their medical diagnoses.

4. PRESSURE INJURIES

Assessors should check the following in more detail to inform their assessment of this outcome:

- The availability of air pressure mattresses
- Whether the provider has supplied adequate moisturiser creams for residents.
- Who attends and reviews the wound dressings.
- Whether the Medical Practitioner is advised when a resident's skin condition is compromised.
- Whether the Registered Nurse has notified the Physiotherapist when a resident's mobility status has changed and becoming a high falls risk. Registered Nurses should then initiate changes like the setup of the room to lessen clutter, check the resident's footwear and liaise with the Physiotherapist to check the mobility aids used and to review the resident's walking ability.
- Whether the liaison with the Dietitian has taken place to review the resident's diet and food supplementation.

5. PALLIATIVE CARE

July 27, 17

Standard 2.9 states "*The comfort and dignity of terminally ill care recipients is maintained.*" In my opinion, this is not checked thoroughly and Assessors also need to ask:

- Has there been regular palliative education to all staff? What kind of education is provided?
- How many registered nurses are allocated in each shift to delegate, supervise, liaise, support and mentor?
- How many carers per resident to also enable staff to provide a dignified, quality palliative care to the resident?
- Are there mouth care equipment supplied like lanolin and mouth care swabs in their storage room?
- Does the RACF have adequate subcutaneous infusion machines?
- Has the family been supported and advised regularly by qualified staff?
- Is there the availability of pastoral support, should the family members require it?

6. INFECTION CONTROL STRATEGIES

Standard 4.7 only states "*An effective infection control program.*" In order to assess this more accurately the following areas need to be explored by assessors:

- Is there adequate Personal Protective Equipment (PPEs) and what are the outbreak strategies?
- Is there an allocated Infection Control Officer with proper training?
- Are flowcharts clearly posted?
- Has the RACF enough disposable catheter bags? How often are these catheter bags changed?
- How often are Indwelling catheters actually changed?
- Are there enough supply of alcohol hand sanitisers in the facility?
- Are there enough hand washing sinks?
- Are there enough cleaners who empties rubbish bins and cleans the RACF?
- Are carers who have been washing, toileting, repositioning residents also expected to serve food in the kitchen? If that's the case, are the carers supplied with disposable aprons, caps and gloves when handling food?
- How often are residents showered?

- How often are the aged care staff educated on infection control? Is the education 1:1, group learning or just handed a multiple choice questionnaire?

It is my experience that equipment is often in short supply and produced in time for the assessors visit, but then we run short after. This is not only my experience, but the experience of my colleagues working in other facilities.

7. CONTINENCE CARE

Standard 4.7 only states "*Care recipients' continence is managed effectively.*" This is too vague and needs to ensure outcomes are measured in the following areas:

- The protocol about the supply of continence aids.
- What continence aid products, and how many, are supplied per incontinent resident.
- Whether there are enough staff rostered on every shift to toilet residents regularly.

8. MOBILITY, DEXTERITY AND REHABILITATION

Standard 2.14 states "*Optimum levels of mobility and dexterity are achieved for all care recipients*"

- How often does the physiotherapist and physiotherapist aide take residents for walks and strengthening exercises?
- Are there enough carers to take residents for walks, as per the physiotherapist's recommendations?

In relation to points one to eight above, it is my opinion that assessors should take the time to speak to more staff and find out from them what happens day to day and be less guided by what is relayed by management and through paperwork.

Staff may feel unable to speak freely on the day for fear of reprisal as providers know who is rostered on. Perhaps an anonymous email address or similar to post feedback around the time the site visit takes place would be helpful.

B. INSPECTORS MUST CHECK THE ADEQUACY OF STAFFING OF QUALIFIED PERSONNEL LIKE REGISTERED NURSES, CARERS AND ALLIED HEALTH

- Providers should be required to demonstrate that they meet minimum staffing standards when the outcomes of care are being reviewed.
- Staffing and skills mix on morning, evening and night shifts must be inspected, not just on the day of inspection.

- Rosters must be checked for adequacy of staff, not just on the day of inspection.
- Inspections must be done at any time of the day, unannounced.

Staffing and skills mix are key performance indicators in the care of vulnerable residents in aged care facilities.

Duty Lists must be inspected to establish if carers are being required to work beyond their scope of practice. Medication administration and clinical duties must be allocated to registered nurses, NOT carers. Because of the comprehensive educational preparation of registered nurses, they have the necessary skills and knowledge to enable them to carry out assessment, planning, delivery, delegation, ongoing monitoring and evaluation of nursing care to residents. Certain regular medications are withheld by the registered nurse if adverse symptoms have been identified. Stronger analgesics are administered if a resident is suffering from excruciating pain. This is the role of the registered nurse. That is why there must be registered nurses on the floor at ALL times.

According to the Accreditation Standard1.6 - **Management Systems, Staffing and Organisational Development - Human Resource Management** - It only states "*There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards...*"

This clause does not specify clear parameters on staffing.

If a minimum staff is mandated, one registered nurse in a 120 bed facility is not adequate to attend to all clinical duties, supervise and mentor carers and students on placements, liaise with family members, allied health staff, do paperwork/ computer work and provide palliative care!

The assessment processes must ensure that there enough qualified personnel like registered nurses to attend to the clinical duties like wound care, stoma care, protocol change of indwelling and supra pubic urinary catheter tubes and urgent need to change blocked urinary catheter tubes and to change subcutaneous catheter of residents receiving palliation treatment and medication rounds.

Registered nurses, through their training and knowledge, will be able to assess a resident who will be at risk of developing pressure areas so will develop a care plan for that resident **before** that resident develops serious pressure area injuries.

Also, the nurse will liaise with the doctor and the dietitian for the consideration of food supplementation. The nurse will consider the use of a special air pressure mattress, delegate the resident's regular pressure area care and repositioning and attend to the regular monitoring of the residents' compromised skin integrity by initiating a wound chart.

The registered nurse monitors, delegates and prioritises the work on the floor in the following areas: Oral hygiene; pressure area care and repositioning; personal hygiene and assistance with meals.

The registered nurse notifies the Physiotherapist when a resident's mobility status has changed and becoming a high falls risk. They initiate changes like the setup of the room to lessen clutter, check the resident's footwear, liaise with the physiotherapist to review their walking ability, their mobility aid, their transfer equipment and how many members of staff to assist with their mobility and transfers..

C. MENU AND AVAILABILITY OF FRESH FRUITS, FOOD SUPPLEMENTATION

Adequate nutrition is vital for good physical and mental health. Assessors should match the menu with the food provided on unannounced visits and check:

- What food supplementation is offered.
- Whether fresh fruit available and easily accessible for residents.

D. MEDICATION HANDLING PRACTICES AND DRUG ADMINISTRATION METHODS

Standard 2.7 MEDICATION MANAGEMENT only states "*Care recipients' medication is managed safely and correctly.*"

SCHEDULE 4 AND 8 MEDICATIONS - STORAGE AND ADMINISTRATION

Aged Care Facilities across NSW have **varied** ways in the storage and administration of Schedule 8 (Drugs of Addiction) and Schedule 4 (Prescribed Restricted Substances)

- Some facilities have Schedule 8 drugs stored in a locked safe, administered by a registered nurse, and a witness.
- Some facilities have Schedule 8 drugs in administration aids like Webster packs, administered by a registered nurse without a witness.
- Some facilities have Schedule 8 drugs in administration aids like Webster packs, administered by carers.
- How are S4s stored and who administers these medications in residential aged care facilities?

CARERS ADMINISTERING MEDICATIONS IN SOME RESIDENTIAL AGED CARE FACILITIES

- I believe this is unsafe practice. Often these Carers are not supervised by the Registered nurse. Carers are only supposed to administer medications with the registered nurse witnessing the medication routine. Does that truly happen?

- In some aged care facilities with no registered nurses available: are carers allowed to administer Insulin injections and medications stronger than Paracetamol? I suggest an Accreditation Inspector take note of medication errors in hostels where carers administer medications.

- I strongly believe that only registered nurses and EENs who are medication endorsed must administer medications, not carers. Residents suffer from complex and chronic conditions. Their medications vary from cardiac, anticonvulsants, antibiotics, anti-coagulants, analgesia, insulin/ anti diabetic agents, anti-depressants, mood stabilisers, diuretics etc.

- Registered Nurses, through their comprehensive training, will assess residents prior to the medication administration and will notify the Medical Practitioner should there be signs of adverse effects or contraindication.

- Registered Nurses and Enrolled Nurses are required to follow a code of professional conduct, codes of ethics, guides to professional boundaries and standards for practice.

TIMEFRAME OF MEDICATION ROUND

- Are there significant delays in residents receiving their medications, especially in the morning and dinner medication rounds?

- How many residents per qualified staff member administering medications?

E. MANDATORY EDUCATION OF STAFF- ELDER ABUSE, INFECTION CONTROL AND FIRE TRAINING

Standard 1.3 only states *"Management and staff have appropriate knowledge and skills to perform their role effectively."*

- How are staff taught? However, it is vital that training is sufficient. Many staff just get multiple choice questionnaires that they can complete at home, how can this constitute adequate training?

- Do the Recruitment Agencies who supply relief staff in residential aged care facilities provide "appropriate training" to all its staff as well? Who checks their training, qualifications, reading, writing and communication skills?

- Nursing Agencies which supply workers to residential aged care facilities on a casual basis must provide proof of training attainment from verified nationally recognised Vocational Education and Training institutions.

- There must be a mandated minimum educational preparation, competency, skills and English proficiency standards and proof of training.

- All carers are supposed to be guided and supervised by health professionals such as registered nurses in residential aged care facilities.

"Recommendation 14.2 of Productivity Commission Inquiry Report, No. 53, 28 June 2011, Caring for Older Australians states "

"It must be imperative that all workers have the skills and knowledge to provide best practice quality care."

F. AVAILABILITY OF ALLIED HEALTH STAFF

Standard 2.6 only states "*Care recipients are referred to appropriate health specialists in accordance with the care recipient's needs and preferences.*"

- Is there a Psychogeriatrician who visits?
- How often has the Physiotherapist taken the resident for a walk or has been reviewed? Are there regular exercises for residents?
- Is there a Dentist who visits?
- Is there a Podiatrist who visits?
- Is there a Speech Pathologist who visits?
- Is there a Massage therapist who visits?

G. AVAILABILITY OF RECREATIONAL ACTIVITY OFFICERS

Standard 3.7 states "*Care recipients are encouraged and supported to participate in a wide range of interests and activities of interest to them.*"

- Are there an adequate number of Recreational Activity Officers in the RACF to "encourage and support residents participate in recreational activities of interest to them?
- Is there one assigned in the Dementia Unit?

H. 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

- How adequate are the responses of government agencies?
- Are complaints of families sent back or relayed back to management by phone?
- Are there follow - up *unannounced* visits from the Agency?

- What is the time frame for responses/ feedbacks to the complainant?

I. MANDATORY REPORTING AND DATA COLLECTION FOR SERIOUS INJURY AND MORTALITY INCIDENTS

I believe that adequate staffing ratios in aged care would prevent many serious injuries, particularly falls. However, there is not enough correlation between outcomes and causal factors such as adequate staffing.

J. THE DIVISION OF RESPONSIBILITY AND ACCOUNTABILITY BETWEEN RESIDENTS (and their families), AGENCY and PERMANENT STAFF, PROVIDERS, THE STATE and the FEDERAL GOVERNMENTS for reporting on and acting on ADVERSE INCIDENTS

The Carers MUST be licensed and registered so they also have some accountability and not all of the responsibility will fall on the registered nurses' shoulders.

Registered Nurses who work on the floor have a responsibility to ensure that proper quality care is given to the residents yet often there is not enough staffing and adequate skill mix! Registered Nurses attempt to work with what they have been allocated with.

Registered Nurses are expected to monitor the carers but how can you when the ratios are 1:100, for example?

The Aged Care Provider has to provide adequate care to its residents by providing adequate staffing and skill- mix in all shifts, but who monitors this?

Staffing must include enough registered nurses to supervise and mentor carers, including nursing students on placements.

I believe that nursing homes or residential aged care facilities are often like sub-acute care - between home care and hospital care. Our residents suffer from complex, chronic conditions. They often need wound care, care to ease the difficulty in their respirations, enteral nutrition care, pain management, physical, speech care, mobility care, stoma care, urinary catheter care, the management of their medication regime, and palliative care.

Our residents in aged care facilities often require daily physical assessment. Their swallowing capability, mental status and physical ability can change at any time. Are they suffering from delirium or depression? Are they suffering from pain? Their current treatment, plan and medication regime, then will need to be reviewed at any time.

There are no doctors stationed in aged care facilities every day. Hence, the need for registered nurses, qualified personnel who oversee the care of residents. There must be legally mandated ratios in aged care!

July 27, 17

Recommendation 4 of the NSW Parliament Inquiry on Registered Nurses in Aged Care released on October 2015 states *"That the NSW, through the Council of Australian Governments, urge the Commonwealth Government to establish minimum staffing ratios in aged care facilities."*

The State and Federal Governments need to adopt the staffing and skills mix methodology as per the National Aged Care Staffing and Skills Mix Project
Report 2016 conducted by the Flinders University and the University of South Australia, in conjunction with the Australian and Nursing Federation, South Australia.

K. INTERVIEWS WITH RESIDENTS, STAFF AND FAMILY MUST BE CHOSEN BY ASSESSORS AND NOT BY MANAGEMENT

L. BEHAVIOUR MANAGEMENT

Standard 2.13 states " *The needs of care recipients with challenging behaviours are managed effectively."*

Are there registered nurses working on the floor to assess residents with challenging behaviours on ALL shifts to identify/ investigate potentially contributing factors like the following:

- pain and discomfort
- delirium
- constipation
- overstimulation
- fatigue
- drug interactions or adverse effects
- depressive or psychotic symptoms
- behavioural triggers from the environment
- unfamiliar or deprived physical environment, boredom

Assessors should consider what the ratio of carers to residents in the Dementia Unit is. A resident with challenging behaviours will need 1:1 unhurried attention. They should also assess how many carers there are in Dementia units during the "Sundowning" period. In the afternoon or early evening, some residents suffering from Dementia exhibit an escalation of a variety of behaviours such as anxiety, agitation, aggression, increased pacing, disinhibition and wandering. It is also important to ensure there are arrangements for diffusing or preventing situations by using Recreational Activity Officers in Dementia Units.

- What is the ratio of staff to residents to ensure that staff and residents are safe when violent episodes occur?

- Are there proper staff training provided on how to manage challenging behaviours, not just take home multiple questions?

July 27, 17

M. AUSTRALIAN AGED CARE QUALITY AGENCY STAFFING

The current CEO responsible for the accreditation and the quality in Commonwealth funded residential, home care and industry education used to be the CEO of Aged Care Queensland, later LASA (Leading Aged Services Australia).

LASA is the national peak body representing providers of aged care services across residential care, home care and retirement living.

Therefore, in my opinion, this is not an impartial appointment and does little for consumer confidence.

References

National Aged Care Staffing and Skills Mix Project Report (2016) Willis, E., Price, K., Bonner, R., Henderson, J., Gibson, T., Hurley, J. Blackman, I, Toffoli, L., and Currie, T. *Meeting Resident Care Needs: A Study of the requirement for nursing and personal care staff.* Flinders University, University of Adelaide, ANMF