Queensland Nurses & Midwives' Union

Submission to

The Senate Community Affairs References Committee

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 practiced

Supplementary submission on the regulation of clinical, medical and allied health care in the aged care context

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106 Victoria St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
(07) 3840 1444
(07) 3844 9387
qnmu@qnmu.org.au
www.qnmu.org.au

submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Senate Community Affairs References Committee (the Committee) for the opportunity to make a further submission to the Inquiry into 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 Practiced (the Inquiry). As requested by the Committee this submission will focus primarily on the regulation of clinical, medical and allied health care in the aged care context.

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 59,000 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 care workers 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.

Summary of recommendations

1. That the Committee explicitly state that aged care is an essential element of the wider health system.
2. That minimum staffing and skill mix levels be mandated in all residential aged care facilities to achieve a minimum of 4.3 hours of care per resident per day and a staff and skill-mix of 30% RN's, 20% EN's and 50% unregulated carers.
3. That the Committee recommend the new Aged Care Quality and Safety Commission undertake further research into the missed care phenomenon following on from the issues identified in the Australian Nursing and Midwifery Federation report *Meeting*

residents' care needs: A study of the requirement for nursing and personal care staff (Willis et. al., 2016).

4. That the Committee recommend a national study into the prevalence of inappropriate transfers to hospitals from aged care facilities including the root causes and strategies to reduce the problem.
5. That all health care provided in the aged care sector (not just mental health services) must be classified as a health service and be regulated by the appropriate health quality standards and accreditation processes.
6. That the remit of the new Aged Care Quality and Safety Commission be expanded in line with the recommendations of the Productivity Commission in 2011.
7. That the Committee recommend that compliance with professional nursing standards, including the Professional Practice Framework for nurses be a mandatory requirement of the accreditation process.
8. The QNMU urges the Committee recommend that further development of nurse practitioner led models of care be undertaken across the aged care sector.
9. That the Committee recommend that it is the role of RN's and EN's only to undertake medication management and administration of medications in the aged care setting.
10. It is also strongly suggested that the Committee recommend that unregulated care workers only be authorised to assist cognitively competent recipients of aged care services in relation to medications, and that further, there be rationalisation of medicines legislation and regulation across state and territory jurisdictions to support this requirement.
11. That the Committee recommend that currently unregulated care workers be regulated under the Nursing and Midwifery Board of Australia.
12. That the Committee recommend that the framework of the Australian Health Practitioner Regulation Agency and professional boards be rescoped to include a focus on structural and system issues as part of the public protection function of this regulatory regime rather than just a focus on the individual practitioner.

Background

The QNMU believes that the predominately privately provided aged care sector in Australia is at a crisis point with the recent announcement by the Federal Government of a Royal Commission providing validation for this view. While there are many interrelated factors which have contributed, over time, to the current situation, it is the view of the QNMU that the enactment of the Aged Care Act (1997) has precipitated and facilitated an irony where there has been a decreasing focus on the health care aspects of aged care while the care needs of aged care recipients are increasing in both intensity and complexity. Compounding this situation, there has been a shift towards an increasingly deskilled, and unregulated, aged care workforce and perversely, a shift to a social model of aged care, which has de-emphasised the health care aspects of care, at a time when the health care needs of residents have never been greater (Phillips et al., 2017). This minimisation of the health care aspects

of aged care has, in the view of the QNMU, resulted in aged care being seen as a model of care on the periphery of the health care system at best, rather than a model of care within the broader health care system. Successive governments have failed to acknowledge this reality. The "Aged Care Roadmap", which takes a marketisation approach to aged care provision and providers, has further contributed to this end result. If it's not seen as health care, then ipso facto it isn't necessary to regulate, fund and resource it like health care.

In addressing the issue of the regulation of clinical, medical and allied health care in the aged care context, this submission will focus on the following areas.

- Aged care as an essential element of the health care system, rather than a separate or overlapping system
- Consistent standards of care across the health continuum
- Regulation of care provision in the aged care context.

The numerous submissions made by the QNMU over recent years in relation to aged care have been used as the basis for this paper.

Aged care as an essential element of the health care system

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. It can be argued that the term "residential aged care" is now a misnomer, with these services now 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 (GEM) Unit in a hospital but without the specialist clinical and multidisciplinary features of this approach.

Even though now a little dated, 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).

Under any plausible definition of the term, a residential aged care provider, for example, is a health service provider within the context of aged care. There are approximately twice as many residential aged care places in Australia as there are hospital beds. (Australian Institute of Health and Welfare, 2017, Australian Institute of Health and Welfare, 2018). However, without acknowledging the significant health care provision that takes place in the aged care sector, we risk creating a "parallel" health care system where levels and scope of care, skill-mix and concepts of safety and quality are considerably less than the broader healthcare sector. The QNMU is concerned that unless aged care is recognised as an essential element in the broader health care system and better integrated with other sectors such as acute care and primary care, the almost daily reports in the media of harm, substandard care and elder abuse by neglect will continue.

Recommendation

That the Committee explicitly state that aged care is an essential element of the wider health system.

Staffing and skill mix

Like any other part of the health sector, the quality and safety of care is dependent on the number and mix of staff delivering care. Sadly, the current situation for residential aged care in Australia is characterised by endemically low hours of care per day per resident compared to research based findings regarding the minimum level of care required in the residential aged care setting, i.e. 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. An audit of over eighty privately run aged care facilities across all federal electorates in Queensland in May 2018 (QNMU, 2018) identified that aged care residents received an average of 2.61 hours of care per day which is 1.69 hours below the research-based benchmark of 4.3 hours of care per resident per day with a workforce profile of (30%) RN's, (20%) EN's and (50%) Unregulated Care Workers (Willis, et al., 2016).

This average of 2.61 hours of care per day was delivered by a workforce significantly dependent on an unregulated workforce comprising of the following:

Table 1: Staffing mix as a percentage of total rostered hours

Provider Type	RN Percentage	EN Percentage	AIN/PCW Percentage
For Profit	16.58%	7.94%	75.48%
Not for Profit	15.77%	6.56%	77.67%
Grand Total	16.02%	6.98%	77.01%

These figures are consistent with those of Mavromaras et al., (2017) and confirm the shift to a carer-based model of aged care provision. As identified by Phillips et al., (2017) the reduced focus on the clinical aspects of residential aged care and shift to a workforce comprising

primarily unregulated care workers, have led to significant reductions in the number of RN's and EN's in aged care and a skill mix where the majority unregulated staff now have a limited capacity to provide the health care required. This shift to a predominately unregulated aged care workforce is also a less costly workforce, and it can only be speculated that this is again a deliberate attempt by aged care providers to reduce costs at the expense of care quality and quantity – a perverse false economy.

The long-term decline in registered nurse numbers in aged care, who lead the assessing, planning, delivery and monitoring of care, particularly complex care, as well as declines in the number of enrolled nurses, has had a negative impact on the safety and quality of care. This has led to the current situation where failures of care are reported almost daily in the media.

Currently there are no minimum staffing and skill mix requirements for RACF's. Again, it can only be assumed that these significant care hour deficits, in the face of evidence that they should be considerably greater, are more about reducing costs under the guise of management-speak terms such as "efficiency" and "flexibility" rather than any genuine attempt to meet the needs of those being cared for.

For those receiving end of life care in the residential setting the care requirement is even greater with Palliative Care Australia (2018) in the *Palliative Care Service Development Guidelines* identifying that individuals should receive 6.5 hours of care per day delivered by a mix of registered, enrolled nurses and unregulated carers. Unfortunately, the reality is much different.

Regulation of staffing and skill-mix

Unlike the acute sector where there is increasing implementation of nurse to patient ratios based on firm empirical evidence of the relationship between the quantity and quality of staff and clinical outcomes, there are only vague requirements set out in the Aged Care Act (1997) and Aged Care Legislation Amendment (Single Quality Framework) Principles 2018 regarding appropriate staffing and skill-mix in residential aged care services. The Aged Care Legislation Amendment (Single Quality Framework) Principles 2018 demonstrates this vagueness by stating in textbook bureaucratese *"the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services".* There is no clear and unambiguous indication of what this should be in practice.

As stated earlier in this submission, there is widespread evidence that aged care residents are receiving significantly less care per day than research indicates should be provided to meet their often significant and complex care needs across the biopsychosocial domains. Simultaneously, the composition of the aged care workforce is increasingly shifting towards a model where unregulated care workers comprise the bulk of the care workforce. The perverse consequence of this change, which the QNMU would argue is a deliberate strategy by aged care providers to develop a lower-skilled, low-cost workforce, is a workforce

increasingly unable to meet the complex care needs of those they care for. Both elderly residents and dedicated and hard-working Assistants in Nursing and other care staff are being set up to fail by a system that fails to recognise the complex nature of the health care required. The workforce is rendered compliant through lack of knowledge of the clinical risks inherent in the current unjust situation. The National Aged Care Workforce Census and Survey (2016) clearly identifies the decline in registered and enrolled nurses as a percentage of the residential aged care workforce.

Table 2: The decline of registered and enrolled nurses in residential aged care

Staff category	2003	2016	% Change
RN	21.0%	14.6%	-6.4%
EN	13.1%	10.2%	-2.9%
Unregulated	58.5%	70.3%	+11.8%

The long-term decline in licensed nurse numbers in aged care, who lead the assessing, planning, delivery and monitoring of care, particularly complex care, has had a negative impact on the safety and quality of that care. This lack of clinical capacity is also reflected in unnecessary transfers to emergency departments with the resulting disruption, cost shifting and use of acute resources.

Needless to say, a workforce change of this magnitude in the hospital sector would be regarded as catastrophic and trigger all manner of inquiries, investigations, planning and strategies to resolve the crisis. Yet these changes in aged care have taken place over time without any apparent sense of alarm from successive governments or regulators, with concerns raised by the ANMF and QNMU dismissed as unsubstantiated by government, regulators and providers.

Mandatory minimum staffing and skill-mix

It is the view of the QNMU (and nationally as part of the ANMF) that the only solution to reverse the long-term deteriorating staffing and skill-mix in residential aged care is the implementation of legislated minimum evidence-based staffing and skill-mix levels. These minimum requirements encompass both an average minimum hours of care per day per resident (4.3 hours) and the workforce composition needed to provide this care safely and to a high quality care based on research evidence (Willis et al., 2016).

Table 3: Skill-mix identified by the QNMU 2018 aged care audit compared to research based requirements

Staff Category as a percentage of total hours	QNMU Audit Percentage (May 2018)	ANMF Staffing and Skill-mix
Average RN%	16.02%	30%
Average EN%	6.98%	20%
Average AIN/PCW%	77.01%	50%

Recommendation

That minimum staffing and skill mix levels be mandated in all residential aged care facilities to achieve a minimum of 4.3 hours of care per resident per day and a staff and skill-mix of 30% RN's, 20% EN's and 50% unregulated carers.

Capacity to provide care and missed care

A significant negative consequence of understaffing and a deskilled aged care workforce identified by Willis et al., (2016) is the issue of missed care. 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.

Concerns by staff regarding their capacity to provide care was also identified as part of the snapshot audit undertaken by the QNMU on May 12, 2018. Data from the audit indicated that 80.5% of respondents believed that existing staff to resident ratios were not safe and limited their capacity to provide quality care. The following ranked issues provide a clear indication that the current staffing and skill mix within residential aged care facilities is directly related to a range of care issues and staff concerns.

Table 4 - Care Issues Identified

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%

Examples of issues impacting on quality of care issues identified by members working in include:

- RN's being off site and remotely on call via the telephone for a number aged care facilities
- allegations that management have received bonuses to contain costs with actions such as locking up consumables, e.g. gloves and incontinence pads and not replacing items when they run out.

These concerns simply reinforce a picture of aged care providers where the bottom line, rather than care and safety, is the primary concern.

Recommendation

That the Committee recommend the new Aged Care Quality and Safety Commission undertake further research into the missed care phenomenon following on from the issues identified in the Australian Nursing and Midwifery Federation report Meeting residents' care needs: A study of the requirement for nursing and personal care staff (Willis et. al., 2016).

Primary care and cost shifting

A particular area that the QNMU believes should be addressed as a matter of urgency relates to the capacity of aged care facilities to provide appropriate primary care services and facilities on site. According to the Queensland Health Minister, over 25,000 aged care residents were transported to emergency departments in the period in FY2016-17, a 17% increase in the past year (Bita, 2018). For example, the for-profit provider Regis has been identified in the media as a provider which, it is alleged, has a low threshold for transferring residents to emergency departments (Morton, 2018). An increase of 25% in emergency department transfers from aged care facilities has also been reported in Victoria (Bachelard, 2017). According to the Australian Medical Association (2018), in one review, a third of presentations of residents to emergency departments who subsequently returned to their RACF could have been avoided by incorporating primary care services at the facility level. Such facilities include both the physical infrastructure and the skilled staff needed, e.g. registered nurses and general practitioners. Again, the capacity of RACF's to provide primary care and to practice hospital avoidance has been significantly impacted though systemic deskilling of the aged care workforce and a model of care that deemphasises the clinical aspects of residential aged care.

An example of programs to meet these challenges include the Care coordination through Emergency Department, Residential aged care and primary health Collaboration (CEDRiC) project which has been a partnership between the University of Sunshine Coast, Nambour Hospital and the Sunshine Coast Hospital and Health Service. CEDRiC consists of two elements. These are

- the Health Intervention Projects for Seniors (HIPS) focusing on primary care coordination between RACF's and general practitioner and a nurse practitioner candidate
- The Geriatric Emergency Department Intervention (GEDI) is designed to provide better patient flow when RACF residents are treated in an emergency department and a dedicated point of contact for RACF and primary care health providers. The GEDI project has been the recipient of the Queensland Premier's Award (Customer Focus category) in 2016.

Cost savings, improved consumer satisfaction and outcomes indicate that these innovations deserve wider implementation (Wallis et al., 2017).

While acknowledging that the majority of transfers from aged care facilities are appropriate, for those third of transfers that the Australian Medical Association identifies as avoidable, it can only be assumed that aged care providers are only too happy to transfer responsibility and cost to the hospital system and underinvest in staff capacity and infrastructure. This, despite the fact, that the providers business model is primarily funded from the public purse. The result has been a significant shift in both risk and cost from the federal government to state and territory governments.

Recommendation

That the Committee recommend a national study into the prevalence of inappropriate transfers to hospitals from aged care facilities including the root causes and strategies to reduce the problem.

A key aspect of this submission is the QNMU's position that aged care (both residential and home based), must be seen as a key element of a wider healthcare system, rather than two sectors that intersect. The QNMU supports the interim recommendation of the Committee "that all dementia-related and other mental health services being delivered in an aged care context must be correctly classified as health services and must therefore be regulated by the appropriate health quality standards and accreditation processes", however we contend that this coverage should extend to all health-related aged care services. The notion that health care is somehow different in the aged care setting is plainly wrong and alignment of standards would reinforce the idea that health care must be of consistent safety and quality no matter where it is provided.

Aligning standards of care between the aged care and health care sectors

In support of the view that aged care is an aspect of health care, the QNMU maintains that consistent standards relating to safety and quality of care must be in place to help avoid the concerns expressed earlier in this submission that failure to acknowledge the core health care aspects of aged care risk the development of a two-tier system of care.

Learning the lessons from the hospital sector

In Australia, the rising awareness of safety and quality in healthcare was the driver for the establishment of the Australian Council on Safety and Quality in Health Care in 2000 which transitioned to the Australian Commission on Safety and Quality in Health Care (ACSQHC) in 2006. Scandals such as the 2005 Bundaberg Commission of Inquiry also drove the patient safety and quality of care agenda at the state and national levels.

The establishment of a single safety and quality commission and a standards-based approach has underpinned the safety and quality agenda in health care from a best practice and accreditation perspective. A robust framework of health service and clinical standards and associated resources provide a clear and comprehensive blueprint for preventing harm, improving quality, describing expected levels of care and the systems needed to make this happen.

> *The primary aim of the NSQHS Standards is to protect the public from harm and improve the quality of health care. They describe the level of care that should be provided by health service organisations and the systems that are needed to deliver such care* (Australian Commission on Safety and Quality in Health Care, 2018a).

The QNMU contends that the lack of consistency of standards across the health and aged care sectors has led to:

- chronic and widespread understaffing
- inappropriate staff and skill mix
- lack of a corresponding culture of safety and quality to that which is now well embedded in the acute care sector
- lack of reporting and transparency around the processes and outcomes of care
- a model of care that relies heavily, and increasingly, on a large workforce component of unregulated care workers at a time when the morbidity, acuity and frailty of those receiving residential aged care services is steadily increasing
- a failure of governance, regulation, and particularly enforcement, that has led to the current crisis in aged care.

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. This should not be the case and the effectiveness of existing aged care standards and associated accreditation processes have been quite rightly called into question.

While the aged care quality principles came into being at about the same time that patient safety in the healthcare sector was a rising concern, these principles were part of the Aged

Care Act, 1997. The original four standards and forty-four expected outcomes are significantly less comprehensive than the health service standards and would seem to indicate that the increasing awareness of safety and quality issues in the hospital sector did not readily inform the aged care quality principles and accreditation standards at that time, again reinforcing the idea that the healthcare elements of aged care are somehow different.

While the focus in the health sector has been on safety and quality, the focus in aged care seems to have been largely on passing accreditation rather than continuous quality improvement, and there has been no real equivalent to the patient safety movement of the hospital sector.

A set of eight quality standards have been developed to replace the original four within a single quality framework applicable to all aged care services. The ACSQHC standards have apparently been used in the development of this framework, but one must ask why the wheel has been reinvented, rather than simply adapting relevant standards. In searching the draft Aged Care Legislation Amendment (Single Quality Framework) Principles 2018 which underpins these new standards, the word “safety” only appears once for example.

Until the Aged Care Quality and Safety Commission is operational, safety and quality governance in aged care remains split between two agencies, the Aged Care Quality Agency and Aged Care Complaints Commissioner. Unlike the ACSQHC the Quality Agency also has accreditation and enforcement functions and the fact that it is an agency rather that a statutory authority of commission status would seem to reflect the relative importance of safety and quality in the health and aged care sectors respectively.

The QNMU believes that the primary aim of the NSQHS Standards should also be the primary aim of all aged care standards as well. While the aged care standards must promote choice and independence, this must not be done at the cost of the care that facilitates this very thing. The QNMU believes that any aged care standards must firmly refocus attention on these care requirements, provide clear minimum standards to a diverse range of aged care providers, and an expectation of best practice and continuous improvement rather than simply aiming for accreditation compliance. Significant sanctions, which make the price of non-compliance prohibitive, must also be in place to drive change.

While residential aged care facilities (RACFs) are not hospitals, they are places where considerable and extensive clinical care is required for a population that has significant frailty, chronic disease, co-morbidity, complex care needs and can be equated to the sub-acute, non-acute care provided in a hospital. If a patient in a hospital medical ward had contact with a registered nurse for only a few minutes in the course of an eight-hour shift, there would be public and government uproar. Yet this is the standard we currently see for an aged care recipient’s similar care needs. The QNMU believes that wherever possible, the same standards (particularly relating to clinical care and governance, including clinical governance) should apply across the acute and residential aged care sectors.

Recommendation

That all health care provided in the aged care sector (not just mental health services) must be classified as a health service and be regulated by the appropriate health quality standards and accreditation processes.

Governance and enforcement of standards

While robust comprehensive and evidence-based standards are essential to maintaining minimum levels of quality and safety, and for driving continuous improvement, they are simply tokenistic if there are no strong mechanisms to evaluate compliance by aged care providers and enforcement mechanisms to underpin it.

While a single aged care regulator will commence operations in the near future, to replace the currently fragmented regulatory regime, there has been a considerable passage of time since this was recommended by the Productivity Commission in 2011. Reasons for the delay appear to be more political than safety and quality focused.

While the QNMU welcomes the creation of the Aged Care Quality and Safety Commission, simply combining the functions of the current Australian Aged Care Quality Agency and the Australian Aged Care Complaints Commissioner into a new organisation is a missed opportunity. If a single regulatory agency is to be introduced, its functions should be of sufficient breadth to effectively regulate the sector in light of the systemic issues widely reported in a range of inquiries and reports over recent years and for which the current regulatory regime has been clearly shown to be inadequate.

As in our recent feedback to the Senate Community Affairs and Legislation Committee, the QNMU suggests the Committee consider the Productivity Commission's (2011) recommendations regarding the proposed functions of an Aged Care Quality and Safety Commission that were made as result of the *Caring for Older Australians Inquiry*. These functions are:

- quality regulation
- prudential regulation
- pricing
- information
- complaints.

Based on the recommendations of the Productivity Commission (2011), the QNMU urges the Committee to consider recommending the following additional functions of the Aged Care Quality and Safety Commission to enhance and better coordinate the regulation of the sector:

- Regulation of all aged care whether Commonwealth funded or not. Only regulating Commonwealth funded services risks creating a regulatory and standards of care gap that could potentially be exploited by unscrupulous service providers.
- The Aged Care Quality and Safety Commission must work hand-in-glove with the ACSQHC to ensure there are consistent clinical and health care standards across all sectors. The ACSQHC is a mature organisation with considerable expertise in standards development and the QNMU maintains that there must be consistent health care standards irrespective of where care is delivered.
- The Commission must work closely with the accrediting bodies in the hospital sector such as the ACHS to develop a similarly effective accreditation process in the aged care sector. It must be remembered that the current crisis has occurred under the watch of the Australian Aged Care Quality Agency which has responsibility for accreditation.
- The new Commission must have broad and strong investigative and enforcement powers. The QNMU argues the existing aged care regulatory agencies have failed to adequately regulate the sector, and that regulatory failure has contributed to the current aged care crisis.
- The Commission must have a prudential and financial regulatory and reporting role to ensure the significant level of government funding given to aged care providers is spent on care and services and not used to generate profit via complex and opaque company or organisational arrangements. This may be achieved by rolling the function of the Aged Care Financing Authority into the Commission to achieve a more integrated approach.
- The Commission must act as a data clearing house for the aged care sector and set reporting requirements across safety, quality, operations and finance.
- The Commission must incorporate a research capacity rather than having a separate entity as recommended by the Aged Care Workforce Strategy Taskforce Report (2018). The aged care sector lags the acute sector in the development and application of research and this capacity must be a core component of the planned Commission to drive change in the sector.

Consideration should also be given to how aged care standards are developed and updated. Currently these standards are contained in subordinate legislation to the *Aged Care Act (1997)*. An alternative approach would be to give the Aged Care Quality and Safety Commission responsibility for the development of aged care standards and give these standards the force of law through the *Aged Care Act (1997)*. Such an approach would ensure that development, review and updating of standards would not be part of a legislative cycle and would remove this vital regulatory mechanism from the political arena to an independent authority.

Recommendation

That the remit of the new Aged Care Quality and Safety Commission be expanded in line with the recommendations of the Productivity Commission in 2011.

Issues relating to the regulation of clinical, medical and allied health care in the aged care context

The following reiterates the original submission to the Committee made by the QNMU in August 2017 and relates primarily to the nursing and unregulated carer component of the aged care workforce.

Nursing practice framework

The *Health Practitioner Regulation National Law Act* (the National Law), enacted in all states and territories establishes the Nursing and Midwifery Board of Australia (NMBA). The NMBA regulates the nursing profession within its remit under the National Law. The codes and guidelines developed by the NMBA as part of its regulatory function create the nursing professional practice framework, which includes the mandated obligation for nurses to practice in accordance with professional nursing standards.

The *National Framework for the Development of Decision-making tools for Nursing and Midwifery Practice* (NMBA, 2013) requires that the RN undertake a risk management process when assessing if an activity can be delegated to an unregulated carer and involves the RN considering a range of criteria in order to make this decision. This is particularly relevant to the aged care sector, given the high proportion of unregulated care workers who provide direct care.

For the nursing profession, clinical and professional standards are the foundation of contemporary, evidence-based practice. When a resident is admitted to an aged care facility, it is because they require a level of care that can only be provided in a hospital or residential care setting. Prior to admission, each resident has been assessed as having a significant self-care deficit that requires nursing and personal care on an ongoing basis. Under the current regulation of health practitioners, governed by the National Law, the only entity authorised to provide this type of care autonomously is the RN. While the role of the aged care provider is to ensure that the appropriate infrastructure and human and material resources are available to meet the care needs of residents, it is the exclusive role of the RN to ensure that each resident's health and personal care needs are assessed, their care is planned, interventions are documented and implemented, and outcomes evaluated.

The reality of nursing practice in the aged care context

The *Aged Care Act 1997* (Cth) and now superseded accreditation standards set out in Schedule 2 of the *Quality of Care Principles 2014* (Cth) state that providers must have "systems in place" to ensure compliance with professional standards and guidelines. This requirement now appears to be absent from the Aged Care Legislation Amendment (Single

Quality Framework) Principles 2018 and seems to have been relegated to the Aged Care Standards Guidance Material (2018) for these new aged care quality standards. These instruments describe the obligations for providers of commonwealth funded aged care services. However, they do not articulate how nursing and care staff must provide care to residents. It is our belief that this significant regulatory gap is deliberate and fundamentally relates to a lack of valuing of the contribution of nursing in favour of cost containment. This articulation is only found in the codes and guidelines of the NMBA and in the Council of Australian Government (COAG) National Code of Conduct for Healthcare Workers. The QNMU believes that there has been a widespread failure of aged care providers and regulators to ensure that their organisations provide the infrastructure and work conditions for nurses to comply with their professional obligations.

As described earlier in this submission, the number of RN's and EN's working in aged care has declined precipitously. In a somewhat circular process, aged care providers have employed increasing numbers of unregulated care workers, commonly known as assistants in nursing or personal care workers, to assist nursing staff. However, irrespective of their title, nursing and personal care only occur when delegated by an RN. The NMBA's codes and guidelines do provide for the delegation of nursing tasks to competent unregulated care workers by the RN, however there are a number of factors to consider before and after this delegation takes place. An unregulated care worker cannot provide personal care autonomously because only the RN is authorised under the national law to determine the resident's nursing needs and by extension, their personal care needs. As a result, unregulated care workers require direction from the RN, under direct or indirect supervision, to assist the resident.

The process of assessment, decision-making and appropriate delegation to competent staff resides with the RN and no unregulated care worker can perform care they are not qualified to perform. EN's are employed to assist the RN by practicing nursing within their scope of practice, as delegated and supervised by the RN. Unregulated care workers assist the RN by providing *routine client-specific activities requiring a narrow range of skill and knowledge* (NMBA, 2013).

While it is a mandated requirement that the RN must evaluate the outcomes of all delegated care, and personally assess that the care was provided correctly and with the intended outcome, the reality is that the decreasing numbers of RN's in the aged care sector make this obligation extremely difficult or impossible. For example, the aged care audit undertaken by the QNMU in May 2018 suggested that most of the 83 facilities audited only had one RN onsite overnight. The occupancy of facilities audited ranged between 32 to 264 residents.

It would be nonsensical to suppose that an RN would be able to comply with their professional obligations regarding delegation when they may have over 100 residents to care for. Nor does the current aged care regulatory/accreditation regime appear to offer any relief. Aged care facilities continue to be accredited in the face of obvious disregard of the professional standards requirements of RN's being met and the sub-optimal staffing and skill-

mix levels that drive this situation in the first place. The QNMU emphasises that to encourage or direct an RN to engage in unprofessional conduct by forcing them into a position where they are unable to comply with their statutory duty or a professional standard, e.g. the standards for quality nursing care, or the principles for delegation and supervision of nursing, is an offence under s.136 of the National Law and carries substantial penalties. Sadly, this situation seems to be conveniently overlooked by regulators and providers. The QNMU asserts that the Australian Aged Care Quality Agency is failing to appropriately assess compliance with nursing professional standards and guidelines in relation to nursing care as evidenced by:

- unregulated health care workers administering medications to residents who do not have the capacity and competence to self-administer
- single RN's being responsible for large numbers of aged care residents, sometimes in an off-site capacity, with no reasonable expectation of being able to evaluate delegated care
- EN's practicing without appropriate supervision by an RN
- unregulated care workers providing care without RN supervision or without care outcomes being evaluated by the RN.

Recommendation

That the Committee recommend that compliance with professional nursing standards be a mandatory requirement of the accreditation process.

The role of Nurse Practitioners

In addressing the regulation of clinical, medical and allied health care in the aged care context, it is also appropriate to consider the impact that models of care can play in relation to the safety and quality of care. One such area is the expansion of Nurse Practitioner models of care across all practice environments in the aged care sector. The *National Evaluation of the Nurse Practitioner — Aged Care Models of Practice Initiative* (Davey et al., 2015) found a range of positive outcomes from nurse practitioner models of care, which included:

- improved access to primary care for older people though filling service gaps and supplementing general practitioner services
- the provision of new and expanded services and the development of innovative delivery models
- a range of models across sub-acute care, primary care and primary health
- reduction in unnecessary hospitalisations
- education and skill development for the aged care workforce
- coordination of care. The CEDRiC HIPS project previously mentioned is also an example of the contribution of nurse practitioners to model of care innovations.

Recommendation

The QNMU urges the Committee recommend that further development of nurse practitioner led models of care be undertaken across the aged care sector.

Unregulated care workers

As earlier identified, there has been a significant change in the aged care workforce composition with unregulated care workers now comprising over 70% of the workforce and decreasing percentages of RN's and EN's. This workforce deskilling trend has occurred in the face of rising acuity and intensity of care requirements for those receiving residential aged care services. As a result, the aged care workforce is increasingly unable, and ill-prepared, to meet the health care needs of those in their care as Nurses with degrees and diplomas are substituted for by unregulated carers with Certificate III or IV based qualifications, knowledge and skills, or perhaps no formal qualifications at all. In any other part of the health system such a trend would be met with alarm, failed accreditation, undoubtably some regulatory response and an urgent intervention aimed at increasing the number of nurses.

It is also the view of the QNMU that this workforce composition change has been pursued by aged care providers as part of a cost minimisation strategy to achieve a low-cost, compliant workforce and abetted by inaction from successive federal governments and aged care regulators.

An example of the consequences of this deskilling and substitution strategy is that of medication administration.

Medication Management

The QNMU, and the Australian Nursing and Midwifery Federation (ANMF) nationally, are disturbed by the widespread trend in the aged care sector of moving medication related tasks from RN's and EN's to unregulated carers. It is the policy of the ANMF and QNMU that all aspects of medication management in aged care must be undertaken by RN's and EN's (AMMF, 2013). The role of unregulated carers must only be in assisting cognitively competent clients to take prescribed medications when they request assistance to do so.

This position and the medication guidelines for nurses, developed by the ANMF and the Royal College of Nursing Australia, constitute a professional guideline for nurses, are supported by the Commonwealth Department of Health previously under Schedule 2, Part 2, Item 2.2 of the *Quality of Care Principles 2014* (Cth) and now in the *Guidance and Resources for Providers to support the new Aged Care* Quality *Standards (2018),* and should be assessed for compliance in accreditation audits, though the QNMU has no confidence that this occurs in practice.

Under the current *Health (Drugs and Poisons) Regulation 1996* (Qld), carers are only able to assist with medications when asked to do so by cognitively competent individuals. While

assistance is not defined, the QNMU believes a reasonable definition of medication assistance means:

- reminding and/or prompting a resident/client to take the medicine, or
- assisting (if needed) with opening of medicine containers for the client/resident at his/her request and direction, or
- bringing packs of medicines to a person at their request so that the person can take the medicines, or
- reading labels aloud to the client/resident and advising the time (e.g. "3pm") at the request of the person who is going to take the medicine, or
- ensuring the resident/client has a drink to take with his or her medicines.

The QNMU believes that a number of aged care providers go well beyond this definition through the use of "medication competent" personal care workers.

While aged care facilities are not hospitals, it is the position of the QNMU that significant, and increasing, levels of clinical/health care takes place in aged care facilities due to the needs of residents in terms of their diagnoses, co-morbidities, medication requirements, level of frailty and dependence. It is important to point out that while an older Australian is waiting for an aged care bed in a hospital they will be assessed for, and receive, significantly higher levels of care as a routine than they would when they finally receive their place in the aged care facility down the road from the hospital, despite their care needs not changing over the course of a short trip from one facility to the other.

During the course of a three-year nursing undergraduate degree it is likely that students undertake hundreds of hours of theoretical and practical learning relating to pharmacology. This knowledge is what both the Australian Nursing and Midwifery Accreditation Council (ANMAC) and the Nursing and Midwifery Board of Australia (NMBA) regard as a minimum standard for safe medication management practice by registrants.

The QNMU is extremely concerned that aged care providers and the Age Care Quality Agency believe that unregulated carers who have completed a course such as *HLTHPS006 Assist clients with medication*, as part of a Certificate III or IV course, can substitute for the skills and knowledge of a registered or enrolled nurse. Compared to the extensive pharmacological knowledge and training of an undergraduate nursing degree, an example of the HLTHPS006 course content is identified below.[1]

- Theory: 3 Hours

[1] ALACC Health College Australia (2018), Medication Administration competency for Care workers, retrieved from http://www.alacchealth.edu.au/medication.html

- Skills Training: 3 Hours
- Assessment (comprising self-directed study): 14 Hours
- Assessment Assistance: 10 Hours
- Practical Placement Experience: 50 Hours.

To believe that somehow eighty hours of training can in some way substitute for hundreds of hours is unsafe and unsustainable. Anecdotally, the QNMU also receives reports of carers receiving significantly less training prior to "assisting" residents with medications. As with other parts of the broader health care system, quality use of medicines principles and medication safety standards must apply (Australian Commission on Safety and Quality in Health Care, 2018b; Australian Government Department of Health, 2011).

For older Australians, polypharmacy is an issue with research indicating those in residential aged care taking an average of 8.1 medications (Willis et al., 2016). Research undertaken by Macquarie University indicates that 85% of aged care residents were prescribed 5 or more medications, 45% were on 10 or more medications and 4% were on 20 or more medications (Westbrook, 2017).

Medication management is also one of the top five complaint areas reported to the Aged Care Complaints Commissioner (2017). This, and the vulnerable nature of those in RACF's and their significant medication use, highlights that medication management is a critical clinical process in aged care, just as it is in the acute sector. If medication related errors and adverse events remain a high risk in the acute sector despite the availability of highly trained staff, comprehensive standards and wide-ranging medication safety processes, it is hard to believe that transferring medication administration tasks to unregulated carers will maintain safety in aged care.

Recommendation

That the Committee recommend that it is the role of RN's and EN's only to undertake medication management and administration of medications in the aged care setting.

It is also strongly suggested that the Committee recommend that unregulated care workers only be authorised to assist cognitively competent recipients of aged care services in relation to medications, and that further, there be rationalisation of medicines legislation and regulation across state and territory jurisdictions to support this requirement.

The issue of medication management highlights the need to have effective levels of nursing staff to provide services such as medication management and why unregulated care workers must be subject to a regulatory regime to ensure the safety of residents and quality of care.

Regulation of care workers

It is the policy position of the ANMF that unrelated care workers must be regulated under the Nursing and Midwifery Board of Australia. As described in this submission, nurses are subject to a regulatory regime in relation to their practice and conduct. To argue that the majority of aged care workers should not be, is in the view of the QNMU, a nonsense.

Low wages, poor working conditions and a lack of career pathways are an acknowledged issue for unregulated aged care workers (Aged Care Workforce Strategy Taskforce, 2018). The QNMU believes that the currently unregulated component of the aged care workforce is essential to aged care delivery, however not at the expense of other groups such as nurses. This is why a restructuring of the direct care workforce is a core element of the ongoing ANMF "Ratios for Aged Care" campaign which advocates for a 30% RN, 20% EN, 50% Carer workforce composition.

While the QNMU supports the development of improved career pathways and educational preparation for these workers, we disagree strongly with the tenor of the Aged Care Workforce Strategy Taskforce report *A Matter or Care – Australia's Aged Care Workforce Strategy* (2018) which appears to marginalise nursing to a specialised role within aged care, rather than acknowledging the centrality of nursing to this sector, with the implication that an increasing level and complexity of care will be provided by non-nurses presumably by under-mining or cannibalising the nursing scope of practice.

While the QNMU believes that care workers should have a rewarding and appropriately remunerated career pathway, our stance is that a clinical progression path already exists through established nursing training pathways, and given the significant and increasing frailty and care requirements of those receiving aged care services, it would seem incongruous to develop another health care professional category that duplicates the nursing role, when one already exists. Certainly, the significant cultural and health related circumstances that drove the development of the Aboriginal and Torres Strait Islander Health Practitioner role for example (a regulated profession under the AHPRA regulatory framework), are not present in the aged care sector. The time, effort and resources required to develop a nurse substitute role in aged care would be better spent on re-establishing the central role of nursing in the sector.

Recommendation

That the Committee recommend that currently unregulated care workers be regulated under the Nursing and Midwifery Board of Australia Professional Practice Framework.

The role of the NMBA

A core function of the Nursing and Midwifery Board of Australia (NMBA) within the national law framework is protection of the public, in part through the development of standards. While it is appropriate that individual registered and enrolled nurses be investigated, and if

necessary sanctioned, for breaches of professional standards, it is the belief of the QNMU that the remit of the NMBA to protect the public must extend beyond a narrow focus on the individual practitioner to include the broader context in which practice takes place.

It is critical to patient and resident safety that the NMBA works to ensure that practice environments across all care sectors contain the conditions where standards can be met. It could also be argued that all nurses are members of the public in addition to being registrants, and that protection extends to the practice environments in which they work. Of all the sectors where the QNMU has membership, the issues of resident safety and the quality and quantity of care are of gravest concern and must also be of concern to the NMBA in relation to its core mission of protecting the public.

The QNMU would urge the Committee to encourage the state and national NMBA Boards to take a broad perspective regarding protecting the public, particularly the elderly as one of society's most vulnerable groups, to help address the systemic issues that often make it very difficult for registered and enrolled nurses in the aged care sector to meet the practice standards set out by the NMBA.

While the NMBA's capacity to directly influence these structural issues may be limited, it is the expectation of the QNMU that the national and state Boards, as statutory authorities, would take all opportunities to articulate the issues of unsustainable workloads, missed care, decreasing skill and staff mix as well as resident safety and quality of care to all stakeholders with the aim of mitigating these problems endemic to the aged care sector.

At the state level, we of course realise that it is the role of Queensland's Health Ombudsman to investigate health system and service issues. However, we are of the view that the NMBA has a direct and crucial role in advising the Health Ombudsman on the evidence base for nursing practice, in all sectors, and where the provisions of the NMBA's Codes and Guidelines for the profession, which require mandatory compliance by all nurses, are not being accommodated by aged care service providers.

Recommendation

That the Committee recommend that the framework of the Australian Health Practitioner Regulation Agency and professional boards be rescoped to include a focus on structural and system issues as part of the public protection function of this regulatory regime rather than just a focus on the individual practitioner.

Medical and Allied Health

While this submission has focused on nursing and unregulated carers, the QNMU acknowledges the vital role of medical and allied health practitioners in aged care, and the issues and barriers to practice that these groups also experience. Issues identified by the Australian Medical Association (AMA) around Medicare Benefits Schedule (MBS) funding for

aged care medical services, access to nursing staff when medical staff visit aged care facilities and staffing levels and skill-mix mirror the QNMU's concerns (AMA, 2018).

Conclusion

The aged care sector is at a critical juncture. Years of government, regulatory and provider inaction and complacency have produced a crisis situation and a pending Royal Commission process that will undoubtably further highlight the workforce issues, failures of care, resident safety risks and elder abuse seemingly endemic to this sector.

Urgent actions to mitigate the current crisis include:

- explicit recognition by the government and regulators that aged care is a core element of the health care system and not a separate consideration that provides inferior care and outcomes
- the urgent need to have consistent standards of care across all health sectors including aged care coupled with robust governance and regulation
- minimum staffing and skill-mix levels as identified in the ANMF "Ratios for Aged Care" campaign
- recognition that professional nursing standards and guidelines are essential to safe nursing practice which must be enforced in aged care work environments
- regulation of the currently unregulated care workforce via the Nursing and Midwifery Board of Australia Professional Practice Framework.

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