Australian Nursing and Midwifery Federation submission to Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021 - 3 November 2021

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 300,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities. With regard to care of older people, ANMF members work across all settings in which aged care is delivered, including over 45,000 members who are currently employed directly in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors (acute, residential, community and in-home care), depending on their health needs. Being at the forefront of aged care, and caring for older people over the twenty-four hour period in acute care, residential facilities and the community, our members are in a prime position to make clear recommendations to improve legislation that seeks to enhance the quality and safety of Australia's aged care system.

The ANMF welcomes the opportunity to provide feedback on the *Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021* (the Bill). Our submission makes comment on a number of key issues regarding the Bill and it's associated amendments including; clinical governance, implementation of a new funding system (the Australian National Aged Care Classification model 'AN-ACC'), regulation and screening of personal care workers, extension of the Serious Incident Response Scheme to home care, enhanced information sharing requirements, increased financial and prudential oversight, the

independent health and aged care pricing authority, the restrictive practices amendment, and the registered nurses 24/7 amendment.

IMPROVED LEGISLATED REQUIREMENTS FOR CLINICAL GOVERNANCE, LEADERSHIP AND EXPERTISE

Schedule 5 of the Bill amends the Aged Care Act and the Quality and Safety Commission Act to improve the governance of approved providers of Commonwealth-funded aged care. Schedule 5 of the Bill aligns with Recommendations 88 to 90 of the Royal Commission, which noted the importance of good provider governance arrangements to the provision of high-quality care for consumers. The ANMF strongly agrees that the aged care sector must have legislated requirements to demonstrate quality clinical governance through effective clinical leadership and expertise at all levels.

As recognised in the Bill's explanatory memoranda; "Clinical skills and expertise are critical, given a provider's core business is providing services to older Australians who have been assessed as requiring additional care and or support to ensure their safety, health, wellbeing and quality of life." We agree that clinical governance must become an essential element of the overall organisational governance of any nursing home. It is both a provider responsibility and regulator responsibility to ensure effective clinical governance is in place to ensure the safety and wellbeing of aged care recipients.

The ANMF considers that reform of governance arrangements across the aged care sector is vital, however we highlight that strong and specific requirements are necessary for ensuring clinical/health care expertise and experience among the membership of providers' governing boards, commissioners, executive group, and staff.

In the subsection 63-1D(2)-b the Bill states that it is the approved provider's responsibility to ensure at least one member of the governing body of the provider has experience in the provision of clinical care. Also, at subsection 63-1D(4) the Bill states that where provider governing bodies have fewer than five members or where determination under section 63-1E that the responsibility set out in that paragraph does not apply in relation to the provider is in force at that time. In these cases, the ANMF takes an opposing view and regards it to be essential that any approved provider that offers or provides aged care must have clinical experience and expertise on their governing body. Further, the base requirement for only one member with "experience in the provision of clinical care" seems insufficient based on the degree to which clinical care and expertise are part of the core business of aged care providers. At the governing board level, these requirements for clinical governance are insufficient and unlikely to result in adequate clinical governance expertise on many provider boards especially for smaller providers with fewer than five board members. We recommend that the governing bodies of aged care providers should comprise members whose integrity, skills, and independence enable them to act, first and foremost, in the best interests of the people receiving that care. This necessitates the involvement of individuals with specifically professional clinical skills and experience in the form of a clinical care governance committee.

IMPLEMENTATION OF THE AUSTRALIAN NATIONAL AGED CARE CLASSIFICATION MODEL (AN-ACC)

The Bill will finalise implementation of the Australian National Aged Care Classification (AN-ACC) model from 1 October 2022. Schedule 1 amends the Aged Care Act and the Transitional Act to enable the introduction of the AN-ACC, to replace the Aged Care Funding Instrument (ACFI) as the residential aged

care subsidy calculation model from 1 October 2022. Schedule 1 of the Bill responds to the Royal Commission's Recommendation 120. The new funding model will link calculation of a variable amount of residential aged care subsidy to each care recipient's AN-ACC level. It will also link calculation of a fixed amount of subsidy to the characteristics of residential aged care services. This fixed component will be the same for all residents at a service and will be higher for services in remote locations and certain specialist services, in recognition of higher fixed operating costs.

The ANMF strongly supports the decision to implement a new funding model to replace the ACFI model and considers the proposed AN-ACC model to be a promising replacement providing that it is properly resourced and carefully implemented. Importantly, however, it must be noted that while the AN-ACC model provides a suitable alternative funding measure for residential aged care it is not a model for determining safe staffing requirements. The AN-ACC aged care funding model, a case-mix model, groups aged care consumers with similar levels of complexity and care needs which, in turn, can be used to explain the relationship between care need, activity and cost. The AN-ACC will not however provide for staffing allocation and assignment at a facility level on a daily or weekly basis as would be achieved by the ANMF's proposed staffing model.[1] We strongly recommend that a new funding model should not be implemented before a suitable staffing model has been mandated.

The AN-ACC tool is designed to identify the case mix of each Australian nursing home, and if implemented as proposed, would ensure that facilities' case mixes are updated regularly. These case-mixes, which define government funding thresholds, and which are also (initially) separate from staffing and care planning could be used to guide recommended staffing levels and skills mixes to provide the required care. Providers could then be required to publish their staffing and skills mixes and demonstrate how they have aligned these with the changing needs of their residents. If this occurred in the context of mandated minimum staffing levels and skills mixes, the public would then be informed of where providers were understaffing in relation to their residents' needs. An additional requirement that is recommended would be to hold providers accountable to the allocation of government funding that is provided upon the basis of AN-ACC assessments. Briefly, AN-ACC proposes that a baseline 50% of government funding would be provided to cover the shared care needs of residents. Additional funding that would be designed to cover the individual care needs of residents would also be provided based on the results of external assessments of individual residents. It would be desirable for providers to publicly and transparently demonstrate how this funding is used to deliver both shared and individual care to residents in part by ensuring best-practice staffing levels that align to the needs of residents.

[1] Willis, E., K. Price, R. Bonner, J. Henderson, T. Gibson, J. Hurley, I. Blackman, L. Toffoli and T. Currie (2016). Meeting residents' care needs: A study of the requirement for nursing and personal care staff, Australian Nursing and Midwifery Federation [Online]. Available: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf (Accessed 1 Nov 2021).

REGULATION AND SCREENING OF PERSONAL CARE WORKERS

Regulation and Screening of Aged Care Workers

Schedule 2 of the Bill proposes to amend the Aged Care Act and the Quality and Safety Commission Act by establishing the legislative authority for nationally consistent pre-employment screening for aged care workers of approved providers to replace existing police checking obligations.

Schedule 2 of the Bill responds in part to Royal Commission Recommendation 77 which recommended the establishment of a national registration scheme for the personal care workforce by 1 July 2022.

Schedule 3 of the Bill responds in part to Recommendation 77 of the Royal Commission by proposing the establishment of authority for nationally consistent pre-employment screening for aged-care workers and governing persons of approved providers. It also establishes a Code of Conduct, which is designed to ensure poor behaviour of approved providers, workers and governing persons is held to account. It also responds to Recommendation 103 relating to introducing banning orders as one of a wider range of enforcement powers.

A national database of cleared and excluded individuals is proposed to support employment decisions in aged care and, through mutual recognition arrangements with the National Disability Insurance Scheme, across the care and support sector more broadly.

The above proposals go in part to Royal Commission Recommendation 77, which refers to the personal care workforce. The Bill proposes a pre-employment screening scheme and code of conduct that would apply to 'aged care workers'. It is proposed that the Aged Care Quality and Safety Commission Act be amended to include a definition of 'aged care worker' as follows:

> ***Aged care worker*** of an approved provider means:
>
> (a) an individual employed or otherwise engaged (including on a voluntary basis) by the provider; or
>
> (b) an individual:
>
> (i) who is employed or otherwise engaged (including on a voluntary basis) by a contractor or subcontractor of the provider; and
>
> (ii) who provides care or other services to the care recipients provided with aged care through an aged care service of the provider.

This definition captures all classifications of employees, contractors, subcontractors or volunteers employed or engaged by approved providers. As such, it is not confined to personal care workers, but also includes registered and enrolled nurses, and other registered health practitioners.

Both registered and enrolled nurses are subject to a registration scheme under the Health Practitioner Regulation National Law (the National Law), administered by the Nursing and Midwifery Board of Australia

(NMBA)/ Australian Health Practitioner Regulation Agency. In order to practice as a registered or enrolled nurse, a person must be registered in accordance with the NMBA. In order to be eligible for registration, a person must have successfully completed an Australian Nursing and Midwifery Accreditation Council accredited program of study, approved by the NMBA. For a registered nurse, the approved program of study is a three-year Bachelor of Nursing degree and for an enrolled nurse, an eighteen-month Diploma of Nursing.

Both registered nurses and enrolled nurses must meet the NMBA's registration standards when first registering and renewing their registration, including with respect to criminal history (including an international criminal history check), professional indemnity insurance, recency of practice and continuing professional development.

Both registered nurses and enrolled nurses are also required to comply with the NMBA professional standards including the Codes of Conduct and can be sanctioned for failure to meet the requisite standards. The registration scheme includes mechanisms for reporting misconduct, serious misconduct and conditions that may impact a nurse's capacity to practice safely. Nurses found to have breached the code of conduct or to be otherwise unfit to practice are subject to sanctions, including imposing conditions on registration, suspension, or cancellation of registration.

The ANMF considers that it is not necessary to include health practitioners, who are currently subject to the National Law registration scheme, in the proposed screening and code of conduct as these measures are already met, and exceeded, pursuant to the National Law.

Inclusion of registered and enrolled nurses in the screening scheme and applying a code of conduct in addition to the existing registration scheme, which includes the requirement to meet standards set in codes of conduct, would result in unnecessary duplication and regulatory burden. Similarly, the definition of governing person captures registered health practitioners, including registered and enrolled nurses. The ANMF notes that the Government has not agreed to implement the Royal Commission's Recommendation 77 to regulate personal care workers through an Australian Health Practitioner Regulation Agency (AHPRA) model. An important feature of ensuring the capacity and capability of the aged care workforce to deliver safe, quality care is to establish a registration scheme for unregulated aged care workers. The ANMF strongly recommends that care workers must be subject to a registration scheme.

Regulation through registration of care workers will provide greater opportunity for care workers to articulate into nursing and other health professional qualifications as well as into higher level certificate qualifications and relevant training packages. The ANMF notes the benefits of registration of the nursing profession, which ensures registered nurses and enrolled nurses are adequately educated to enter the workforce, meet ongoing professional development requirements to maintain registration and are subject to investigation and sanction if reported for failing to meet professional conduct standards. By contrast, the ANMF submits that the lack of regulation of the care workforce increases the risks associated with substandard training, lack of ongoing training and development and lack of accountability for conduct that falls short of required standards. Any regulation that establishes a registration scheme for care workers must be designed to protect the public and recipients of aged care. Any scheme must be accessible to the

public so as to provide confidence that loved ones are being cared for by suitably trained and skilled people.

The ANMF has significant concerns regarding Schedule 2 and 3 of the Bill. If the proposed Bill is passed, the ANMF foresees the potential for significant regulatory complications for nurses and personal care workers in aged care. The proposed system would make aged care staff more highly regulated than most health practitioners while taking on an enormous and disproportionate degree of personal financial risk in circumstances where there is no clear, due process for decision-making.

Recommendation 77 of the Royal Commission and explanatory memoranda referred to 'personal care workers' which appears to be a definition that does not include nurses. However, the ANMF raises a significant concern with regard to the draft Bill's definition of 'aged care worker' (Schedule 3, cl 2 and 5) which includes nurses. While keeping this definition broad, the Bill also delegates the ability for the 'rules' to potentially exclude nurses from the Code of conduct (see: Schedule 3, cl11, s74AE), however the details of this remain unclear and there are no guarantees that such an exclusion would occur.

The ANMF submits that in the current draft of the Bill has no regard or understanding of the arrangements that are already in place for the regulation of nurses through Australia's existing National Registration and Accreditation Scheme (NRAS). Nor is there any acknowledgment of the varying state-based Codes of Conduct for unregistered health workers, including assistants in nursing, and personal care workers (however titled) and any state-based legislation that applies to complaints made about workers in those jurisdictions. Given that the current state-based processes incorporate unregistered health workers in sectors other than aged care (and so would not be replaced in any way by this Bill), the ANMF submits that the proposed model in this Bill would effectively create duplicate processes and powers.

The implementation of the Bill as it is drafted may have different implications across varying jurisdictions, however due to the timeframe for this consultation, we are not able to comment on every state and territory's context. As an example of the issues this Bill will create in jurisdictions, in the New South Wales context, the Health Care Complaints Commission has the power to assess, investigate and make a finding and orders (e.g., prohibition order, public statement) in relation to complaints about (unregistered) health care workers. A prohibition order is effectively the same as a banning order. The Health Care Complaints Commission also has the power to assess, investigate, and prosecute complaints against registered health practitioners in consultation with the applicable health professional council (e.g., the Nursing and Midwifery Council of NSW). The draft Bill lacks regard for these processes that occur within NRAS and associated co-regulatory models. The ANMF therefore considers that the Bill creates an additional (and additionally punitive) process that the worker would be subjected to in response to a complaint.

Under the proposed duplicate regulatory system, there does not appear to be any mechanism for the transfer of information between regulators where both are undertaking an investigation into the same complaint. The current draft Bill would appear to create the possibility where two regulators could be tasked with considering the same complaint with these processes yielding either conflicting outcomes or, alternatively, where one regulator's decision could potentially prejudice another's decision.

The ANMF also has serious concerns about the proposed powers in Schedule 3, cl 23 (74FA). These powers do not provide any of the appropriate protection from incrimination that should be in place in order for

information to be freely given by the worker. If in circumstances where workers are compelled to provide information, appropriate protections should be in place so that any information given by the worker can be provided freely without fear that such information could be used against them in civil or criminal proceedings or a coronial inquest.

For example, if a worker who has been charged with a criminal offence is exercising their right to silence and they are compelled to answer questions; such a direction is a clear infringement on this right. In order for information to be able to be provided freely, an opportunity should be given for a worker to make an objection and have the benefit of a legislated protection on how and where such information can be used. As an example, the powers under s34A and 37A of the *Health Care Complaints Act 1993* (NSW) outline how such protections can be granted.

Duplication of the screening for nurses

The ANMF submits that the screening of nurses in the manner proposed by the Bill is a wholly unnecessary layer of regulation for registered and enrolled nurses. Nurses should not be subject to pre-employment screening that is designed to act as a replacement for existing police check obligations. Under NRAS, nurses are not only subject to national and international police checks upon registration, they have ongoing disclosure requirements in accordance with s130 of the National Law as well as annual declarations required for *any* change to their criminal history under s109(1)(b) of the National Law.

The ANMF acknowledges that the current state-based models for unregistered health workers vary and do not include any screening functions in the way that the NRAS does. It is the position of the ANMF that the appropriate response to the lack of screening for unregistered health care workers is to create a mechanism for those workers to be regulated under NRAS. Such a model would ensure screening of all workers providing care to older people, not just those employed by an 'approved provider'.

Workers' screening link to the approved provider

The ANMF raises potential concern regarding whether the proposed database would be accessible to the general public. If so, then the ANMF highlights the concern that explicitly disclosing workplace(s) of individuals to the public (per section 74AG(5)(h) of the Bill) is unnecessary and may place those workers at risk in certain circumstances. In contrast, if a worker is registered through the NRAS, their workplace does not form part of the information kept on the public register, because this information is not considered necessary for the health and safety of the public.

Further, regarding the information contained in the database, the ANMF highlights that the parameters of personal information of individuals proposed to be contained in the database are not explicitly stated as they are in the National Law. Also there appears to be no mechanism to apply for an exemption for particular information to be contained. Addressing this issue will be important for protecting any workers who have concerns for their safety arising from the publishing of personal information.

Workers failing to comply with the Code of Conduct resulting in a civil penalty

As stated above, unregistered health care workers, including personal care workers in aged care are already subject to a requirement to comply with a Code of Conduct for unregistered health practitioners in many jurisdictions. e.g. Schedule 3 of the *Public Health Regulation 2012.*

The ANMF submits that the introduction of a new Code of Conduct will mean that any nurse or unregistered health worker in aged care would be subject to three different Codes of Conduct. The second being either the Code of Conduct for nurses/Code of Conduct for unregistered health practitioners and the third being the Code of Conduct of their employer. The layering and duplication will no doubt create confusion which may lead to compliance issues.

The ANMF highlights that the process/scheme outlined in the Bill only refers to outcomes for contraventions of the proposed Code of Conduct, but does not have any reference to the process to be undertaken in determining the contravention, nor a proposed Code of Conduct to provide feedback on.

The ANMF submits that a large proportion of unregulated staff in aged care do not have English as their primary language. Although it is important at implementation to ensure that any Code is distributed in a sufficient variety of community languages, the ANMF highlights the concern that for people who have English as an additional language, there may be barriers to being afforded procedural fairness in this process. This is particularly worrying in light of the sizeable penalties that such workers may be subjected to.

The proposed penalty for a contravention of the Code of conduct is 250 penalty units which at present amounts to $55,500. The ANMF is extremely concerned that such significantly high penalties could be issued in circumstances where there is no clarity about how evidence will be considered and/or tested in relation to an alleged breach, no reference to the processes for establishing whether a breach has occurred, and in circumstances where the vast majority of individuals working in aged care are on such low wages. A full-time aged care worker with a Certificate III, being paid the Award wage will take home a base wage of approximately $47,000 per annum.

Further, the ANMF is alarmed that the Bill sets out the same penalty for a contravention by a worker as it does for a contravention by an approved provider (Part 8AA, 74AB and 74AC). In circumstances where aged care workers have little power over their working conditions, it would appear unreasonable for them to be liable to the same penalty as an approved provider for any breach.

It is important that any pecuniary penalty operates as a sufficient deterrent. For aged care workers, such severe penalties may serve as a deterrent from engaging in work in the sector at all, however for an approved provider the same penalty may only result in a slight reduction in profits.

By comparison, the civil penalty for a breach of the Health Practitioner Regulation National Law by a body corporate is twice that for an individual (e.g., s113 provides for fines of $60,000 for individuals and $120,000 for a body corporate for a breach of the restriction on protected titles). The penalties for a breach of banning orders in the bill are similarly concerning to the ANMF; $222,000 whether it be an individual, an approved provider, or a governing member (e.g., Board member).

Banning orders

The ANMF submits significant concerns that in its current form, the Bill includes no reference to any assessment or investigation processes that may lead to the making of a banning order. Our concerns are about the broad discretion that would be given to the Commissioner in making a banning order. Instead of setting out the matters which may empower the Commissioner to make an order, the Bill sets out that the Commissioner must not make an order unless certain circumstances exist (Schedule 3, cl 25, 74Gb (2)). One of these circumstances is that the Commissioner reasonably believes that the person is not suitable to be involved in the provision of aged care and in ss6, there is no limit to the matters that the Commissioner may consider. The ANMF is concerned that based on this available information, there would appear to be no requirement to establish a breach of the proposed Code of Conduct before empowering the Commissioner to make a banning order.

Further, there does seem to be any need for a nexus between the conduct alleged and the provision of aged care. The Bill includes little to no guidance or information about how a banning order (however made) would impact upon someone's registration or whether being subject to a banning order could be sufficient grounds for a state-based prohibition order (in the case of unregistered health workers).

Although the Bill does contain provisions for applications for banning orders to be reviewed/varied/removed, the Bill does not appear to provide any appeal mechanism which is fundamental in ensuring procedural fairness is maintained where decisions that so significantly affect the lives and livelihood of workers are made.

EXTENDING THE SERIOUS INCIDENT RESPONSE SCHEME TO HOME CARE

Schedule 4 of the Bill responds to Royal Commission Recommendation 100.The Bill would extend the Serious Incident Response Scheme to home care and flexible care delivered in a home- or community-care setting from 1 July 2022. These amendments are designed to give effect to Royal commission Recommendation 100. The new requirements seek to build provider capacity to identify risk, respond to incidents, and drive learning and improvements that will reduce the number of preventable incidents in the future. Under the scheme, providers of in-home aged-care services would be required to identify, record, manage and resolve all incidents that occur. By extending the definition of 'reportable incident', this Bill is designed to ensure the most serious incidents occurring in home- and community-care settings are reported to the Aged Care Quality and Safety Commission. Protections against retribution or vilification for individuals reporting such incidents will also extend to reportable incidents in these settings.

Due to the tight timeframe for this consultation, the ANMF urges the Government to consider our position outlined in our submission to that consultation.[2]

[2] Australian Nursing and Midwifery Federation. Submission to the Serious Incident Response Scheme (SIRS) for in-home aged care services [Online]. Melbourne. ANMF. 2021. Available: https://anmf.org.au/documents/submissions/ANMF_submission_to_Serious_Incident_Response_Scheme_for_inhome_aged_care_services_13August2021.pdf (Accessed 1 Nov 2021).

ENHANCED INFORMATION SHARING

Schedule 6 of the Bill concerns alignment of the regulation of providers across aged care, disability support and veterans' care to facilitate increased information-sharing about providers and workers operating across the care and support sector who are not complying with their obligations, are failing to provide quality care or whose conduct might be putting senior Australians at risk by the Aged Care Quality and Safety Commission, Department of Health and Department of Veterans' Affairs with specified Commonwealth bodies.

The ANMF notes that greater information sharing between these sectors is consistent with our position and highlights that the main goal of any amendments and reforms to information sharing within and across sectors must be to improve the sector for staff and consumers.

INCREASED FINANCIAL AND PRUDENTIAL OVERSIGHT

Schedule 7 of the Bill concerns the implementation of a new financial and prudential monitoring, compliance, and intervention framework for the aged care sector to build the sector's financial resilience and improve its accountability to identify at-risk providers earlier and help ensure providers meet their obligations to refund deposits to residents. Schedule 7 of the Bill will:

a) Enable the secretary or commissioner to request information or documents from a provider or borrower relating to the use of a loan made with a refundable deposit or accommodation bond.
b) Make it an offence for a borrower to not provide the information or documents.
c) Extend the period of liability between misuse of refundable deposits and insolvency for both providers and key personnel from two years to five years.

Schedule 7 of the Bill responds in part to Royal Commission Recommendation 134. The proposed changes appear consistent with the ANMF's position and our recommendations to the Royal Commission, however in-depth analysis would be required to ascertain the degree to which they improve the sector for consumers and staff. As heard by the Royal Commission, aged care providers are known to use complex corporate structures and approaches with the result that their business and financial practices can be opaque and virtually impossible to adequately scrutinise. One consideration that is not explicitly clear in the amendments is whether the movement/loan of resident deposits within a provider's complex corporate structure is adequately transparent.

The ANMF also notes that the Bill provides limited/no details that appear to improve the need for providers to utilise funding on care. In evidence provided to the Commission, the ANMF has emphasised the critical need for much greater transparency and accountability across the aged care sector with regard to how funding of the sector is directed and how the sector is held accountable across a range of measures, including acquittal of funding and in broad terms accountability through regulation within the sector. The ANMF has further submitted that both the Government and providers must be required to be transparent and accountable in relation to direct care funding. Aged care providers are not currently transparent regarding the staffing and skills mix of their facilities, or on how much they spend on other resources related to direct care provision, e.g., continence aids, medical equipment and supplies, and even

nutrition. Yet, the public has a right to know that taxpayer provided subsidies to the sector are being directed to quality care provision.

Information as to how much each provider, and each site they operate, is funded and how they deploy that funding is essential information required to assess the performance of the provider and specific site. This is most important with respect to funding allocated for staffing levels and skills mix. Too often we have seen Government initiatives intended to improve funding for wages in the sector allocated without any discernible benefit to workers in aged care, nor any accountability for how those allocated funds have been expended.

The ANMF submits that to address this the Government must also be required to be more transparent as to the allocation of funds, identifying where the funds are directed, in particular funds allocated to provide direct care services. Providers at both the provider and site level must then be required to report how allocated funds have been acquitted. Transparency in funding will serve as an important measure for the public, consumers of residential aged care services, their families, the workforce and their representatives to have confidence in how tax-payer funded money is spent in the sector. Transparency must be accompanied with accountability in funding. Not only should the level of funding allocated be visible, once allocated its expenditure must be reported and appropriately acquitted. A failure to acquit funds for the allocated purpose should carry consequences for future funding allocations.

The ANMF submits that the current aged care funding arrangements are no longer fit for purpose, do not reflect the actual costs of care using an efficient price/cost approach, and particularly, lack transparency and accountability on the part of aged care providers for funding expenditure. Given the increasing concerns regarding some providers' financial viability, particularly as this now seems to be used to justify staffing reductions, greater transparency of information is essential so that situations of genuine need can be differentiated from opportunistic behaviour during this critical time.

The ANMF recommends that the aged care sector must have legislated transparency and accountability measures, which should include the following at a minimum:

(i) Any allocation of additional funds to aged care providers must come with a clear mandate of accountability and transparency and that all funding provided for the purposes of direct care is the subject of accountability and acquittal arrangements such as if funds specified and allocated for care are not applied they are surrendered. To assist this funding must be linked to quality of care outcomes and determined through an evidence based methodology.
(ii) Funding for wage costs must be demonstrated to have been used for that purpose and a failure to account for the use of tax-payer funds must have consequences. For example, any funds allocated to direct care not spent should be returned to government or deducted from the next round of funding. In addition, funding available for wages and conditions must be made clear to the bargaining parties during enterprise bargaining.
(iii) An independent assessment body, which assesses and fixes funding by reference to independently assessed resident need, should be established.
(iv) As a system steward, the Commonwealth must have explicit accountabilities around public reporting of data, funding, and aged care outcomes.

INDEPENDENT HEALTH AND AGED CARE PRICING AUTHORITY

Schedule 8 of the bill expands the functions of a renamed Independent Health and Aged Care Pricing Authority to also include the provision of advice on healthcare and aged-care pricing and costing, and to perform functions conferred on it by the Aged Care Act. This will transfer functions performed by the Aged Care Pricing Commissioner to the new pricing authority. Schedule 8 of the Bill responds fully or in part to Recommendations 6, 11, 115 and 139 of the Royal Commission.

This creation and transfer of functionality to an independent pricing authority is consistent with our recommendations and underpins a transparent, fair, and fit-for purpose funding instrument (i.e. the AN-ACC). By ensuing sufficient funding, this will support provision of safe, dignified care – but the funding needs to be right and accountably used by the provider for care which does not appear to be specified in the Bill. Importantly too, the Independent Health and Aged care Pricing Authority should ensure that all their work leading to establishing pricing is transparent and publicly available.

RESTRICTIVE PRACTICES – AMENDMENT (HOUSE OF REPRESENTATIVES)

A new 'Schedule 9' section has been added to the Bill as an amendment. This section addresses issues regarding the use and minimisation of avoidable restrictive practices in aged care. It must also be acknowledged that restraint is sometimes necessary and effective. Inappropriate use of chemical and physical restraint is an indicator, however, that appropriate behaviour management, pain management or other forms of care have not been adequately provided. The root cause of this in many cases is lack of sufficient staffing levels and skills mix in many nursing homes.

Fundamental to ensuring that restrictive practices are avoided and minimised wherever possible is ensuring that there are enough of the right kinds of staff to provide safe, effective, dignified care. Despite the high proportion of people with dementia living in residential care there are no mandated minimum staffing levels, skills mix or models for aged care to ensure elderly people receive the care they need. In under-resourced nursing homes whether in terms of staffing numbers or staffing at appropriate skills mix and training levels, behaviours of concern are sometimes inappropriately managed with physical and chemical restraint. Inappropriate restraint practices are unacceptable on many levels.

People with dementia should be treated and cared for with respect for their human rights and be provided care that allows and encourages optimal engagement in life and wellness. Use of practices that are not clinically justified due to work pressure arising from lack of staffing and lack of suitably skilled staff to deliver quality care is an issue of great concern. This problem may arise particularly where people with dementia behave violently, which may be physical, verbal or sexual violence, towards staff, visitors or other residents. The risk of self-harm or injury may also be inappropriately managed by physical or chemical restraint. The issue of balancing the need for safety for all residents, visitors and staff and ensuring people with dementia are not excessively or inappropriately restrained is ongoing and difficult. The problem can result in unreasonable pressure on doctors to prescribe medication outside of clinical best practice. Staff may resort to the use of restraint as the only measure available to prevent injury to themselves and others. Families are faced with the distress of seeing loved ones either restrained or exposing themselves or others to harm. This problem highlights that inadequate staffing and skills mix is a significant barrier to ensuring that chemical and physical restraint is only used as a last resort and as part of agreed care plan.

REGISTERED NURSES 24/7

A new 'Schedule 9' section has been added to the Bill as an amendment. This section addresses the provision of at least one RN on duty in nursing home 24/7 to provide care to care recipients and supervise the provision of care to care recipients.

The ANMF strongly recommends that the Government implement a phased introduction of 24/7 RNs in nursing homes as a matter of urgency. Care provided by registered nurses is especially important in nursing homes due to an increasing number and proportion of residents with complex care needs, polypharmacy, dementia, mental health care needs, chronic and acute conditions, functional disabilities, and frailty.[3,4,5,6,7,8,9] Please refer to the attached Appendix 1 regarding further evidence and information regarding the importance of 24/7 RN presence in nursing homes as well as the ANMF's recommended phased implementation plan that provides a feasible and effective approach to ensuring suitable staffing levels and skills mixes in nursing homes including RN presence 24/7

[3] Australian Institute of Health and Welfare (AIHW). People's care needs in aged care [Online]. Canberra: Australian Government. 2021. Available: https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care (Accessed 27 July 2021).
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Australian Nursing & Midwifery Federation

"Appendix 1"

POLICY BRIEF: 24-HOUR REGISTERED NURSE PRESENCE IN NURSING HOMES

4 November 2021

Background

Care provided by registered nurses (RNs) is especially important in nursing homes due to an increasing number and proportion of residents with complex care needs, polypharmacy, dementia, mental health care needs, chronic and acute conditions, functional disabilities, and frailty.[1,2,3,4,5,6,7]

The Royal Commission into Aged Care Quality and Safety (the Commission) heard that by 2050, the provision of best-practice nursing home care will require almost 48,000 new RNs with 3,600 in the next two years alone.[8] While a widespread lack, and even decline, of sufficient numbers of RNs predates 2020,[9,10] nowhere has the need for more RNs in aged care been so clearly illustrated than in the context of the COVID-19 pandemic.[11] Even when one RN is present, this is often not enough to provide safe, high-quality care for the large number of residents in their care.[12]

Without an RN onsite at all times, many vulnerable residents are in danger because less qualified staff who are not adequately supervised by RNs cannot safely and effectively provide the necessary care.[13,14] Without legislated 24/7 RN presence in nursing homes, care is delayed, rushed, or missed altogether especially overnight when staffing levels and skills mix is often lowest.[15] This means that residents' health can deteriorate and result in avoidable deaths, illness, injury, and distressing trips to hospital emergency departments for issues that could have been addressed in place had there been an RN available.[16,17]

Without an available RN onsite, there are many tasks and activities that cannot be safely or legally carried out by other staff including but not limited to medication administration and management, clinical and wellbeing assessment, and care planning and management.[18] Often residents, staff, family members, and visiting health professionals cannot find an RN because either there are no RNs in the nursing home at the time, or there are too few of them to be quickly found when needed.[19,20,21] The Australian Federal Government must act now to ensure genuine and timely reform.

What was the Royal Commission's recommendation and Government's response?

The Commission found that many of Australia's nursing homes are significantly understaffed with no obligation to ensure that even one RN is present onsite for every shift regardless of the number of residents or size of the facility.[22]

At **Recommendation 86.3** *'Minimum staff time standard for residential care'* the Royal Commission recommended that:

> *"…[F]rom 1 July 2022, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility for the morning and afternoon shifts (16 hours per day*."

Then at **86.5**, the Commission recommended that:

> "*In addition, from 1 July 2024, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility at all times*."[23]

The Federal Government had claimed that they have accepted Recommendation 86, however has not committed to legislating RN presence in nursing homes in the manner recommended by the Commission. In the Department of Health's response to the Commission's recommendations, the Government states:[24,25]

> *"With the introduction of the Australian National Aged Care Classification (AN-ACC) funding model on 1 October 2022, additional funding will be provided to support services to meet the Royal Commission's recommended minimum 200 minute care time standard, and having a registered nurse onsite for 16 hours per day. The minimum care time standard will become mandatory from 1 October 2023."*

Further, the Government has not responded to the Commission's recommendation that by 1 July 2024, at least one RN should be on site at all times.

What is the ANMF's policy position and recommendation?

The ANMF recommends that there must be immediate legislative change to mandate that at least one RN be present on site in a nursing home 24/7. The ANMF recommends that Australia's direct care workforce in nursing homes should be made up of 30 percent RNs, 20 percent ENs, and 50 percent PCWs.[26,27] This position is in line with the position of the International Council of Nurses (ICN),[28,29] and supported by peak professional bodies including the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP), and the Australian and New Zealand Society for Geriatric Medicine (ANZSGM).[30,31,32]

The ANMF's staffing and skills mix implementation plan provides the best approach for Australian nursing homes to be able to provide safe, quality care to aged care residents now and in the future. Adopting the ANMF's implementation plan will not only ensure that Australian nursing home residents receive safe, quality care more quickly it will also guarantee better working conditions and therefore improved attraction and retention of nursing home staff.

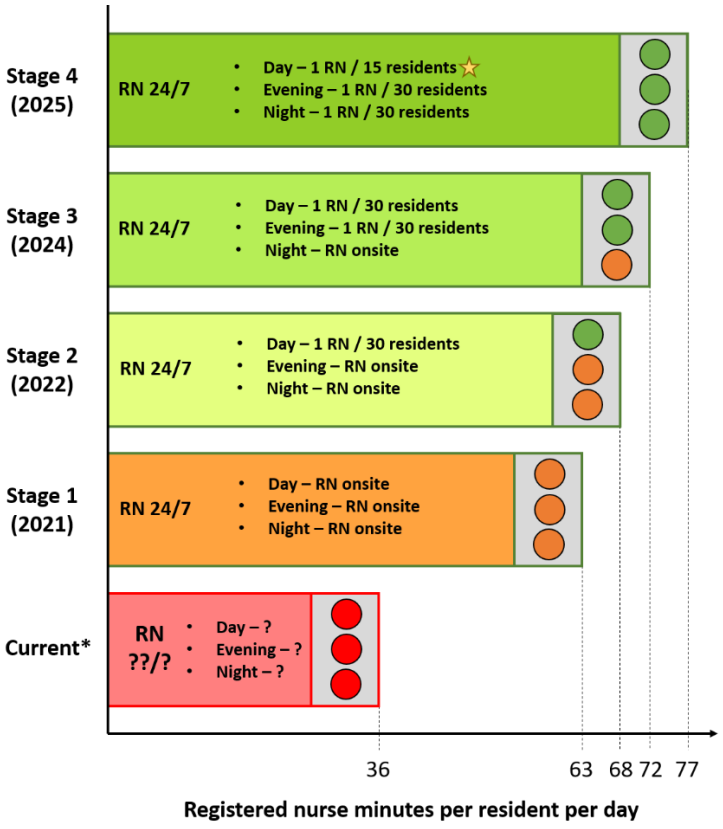

Figure 1: The ANMF's proposed plan for staffing levels and skills mix including 24-hour RN presence in Australian nursing homes will achieve safe, high-quality, dignified care for residents.

The staffing levels and skills mixes above are calculated across the facility, not by individual units or wings. This gives nursing homes the flexibility needed to respond to varying care needs of the residents. Toward the end of the implementation period, reassessment should occur to ensure that any future adjustments to minimum standards for nursing home staffing levels and skills mix will continue to provide safe, quality care for residents.

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