LEADING AGE SERVICES AUSTRALIA

The voice of aged care

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

Submission to the Inquiry

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Leading Age Services Australia (LASA)

Leading Age Services Australia (LASA) is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. Our vision is to enable a high performing, respected and sustainable age services industry delivering affordable, accessible, quality care and services for older Australians. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

Thank you for the opportunity to comment on this Senate Inquiry. Should you have any questions regarding this submission, please don't hesitate to contact Sean Rooney, CEO Leading Age Services Australia on e: ceo@lasa.asn.au or ph: 02 62301676.

General observations

Leading Age Services Australia (LASA) thanks you for the opportunity to provide a submission to the Senate Inquiry: *Effectiveness of the aged care quality assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced.* The age services industry is shocked by the failures in governance and care provision at the Makk and McLeay wards at South Australia's Oakden Older Persons Mental Health Service. However, LASA notes that Oakden is not a residential care facility as stated by the reviewers on page 31 of the South Australian Government's Oakden Review. Thus, LASA is not in a position to comment specifically on the failures which occurred there. Rather, LASA offers the following submission to contribute the aged care sector perspective on the industry's quality assessment and accreditation processes and systems.

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

Effectiveness of the Aged Care Quality Assessment and Accreditation Framework for protecting residents from abuse and poor practices

LASA believes that Australia's aged care industry is a high performing and professional sector, supported by a workforce that is passionate about providing quality care for older Australians. LASA welcomes the opportunity this inquiry provides to scrutinise the regulatory and accreditation processes in aged care and to reassure older Australians and their families that the care and services they receive meet stringent national quality and safety standards. If this Inquiry and the Department of Health's (the Department) independent Review of National Aged Care Quality Regulatory Processes reveal any system failures, then industry will use this intelligence to inform continuous improvements in quality and safety.

On the international canvass, the Australian aged care system is recognised as being of good quality. Australia's aged care system is highly regulated when compared internationally. For example, accreditation of Residential Aged Care Facilities (RACFs) is not universal internationally. The OECD reports that only two thirds of OECD member countries use a system of accreditation as foundation for ensuring their RACFs' quality performance[1].

Nationally, performance reports against quality indicators published by the Australian Government and its agencies indicate a general improvement in RACF's quality over recent years. For example, as a proportion of the total number of providers, the rate of sanctions and non-compliance notices for RACFs decreased between 2011-12 and 2015-16[2]. The Australian Aged Care Quality Agency (AACQA) sets a *timetable for improvement* (TFI) for agencies that fail to meet one or more of the 44 Accreditation Standards. The AACQA reports that the number of RACFs placed on TFIs dropped significantly from 134 in 2013-14 to 70 in 2015-16, a 48% decrease[3]. The incidence rate of reportable assaults in residential aged care has remained relatively stable at around 1%[4]. This rate of assaults is

[1] OECD 2013, Policy Brief: *A good life in old age. Monitoring and improving quality in long term care.*
[2] Reports on the Operation of the Aged Care Act, 2011-12 to 2015-16.
[3] Australian Aged Care Quality Agency 2017, Annual Report 2015-16
[4] Reports on the Operation of the Aged Care Act, 2011-12 to 2015-16.

considerably lower than that experienced by the general community at 2.4%[5]. However, LASA believes that any assault occurring in a RACF is highly regrettable and would welcome a further reduction of the already low rate.

LASA is of the view that the industry's quality system is not broken. However, LASA believes that the existing system should focus more strongly on continuous quality improvement. Such a focus should include learning from identified system failures and the continual nurturing of a care environment that values quality of care.

At the level of individual RACFs, a key factor as to how people experience life in a RACF is the quality of their and their family's relationship with the care providers. An important component of managing quality in a RACF is paying attention to and nurturing of the quality of these relationships.

Effectiveness of the Aged Care Quality Assessment and Accreditation Framework for ensuring proper clinical and medical care standards are maintained and practised.

The AACQA's *Results and processes guide* (the Guide) operationalises the Accreditation Standards under the *Aged Care Act 1997* into Results (outcomes) and Processes. Standard 2:Health and personal care includes 15 Expected outcomes that prescribe the quality of clinical and medical care to be delivered to residents[6]. Each Expected outcome describes the processes required to achieve the quality for the Expected outcome and the Results expected for residents. LASA considers Standard 2 to comprehensively evaluate the safety and quality of the health and personal care delivered in a RACF. However, for an effective assessment of care quality, Standard 2 and the associated Expected outcomes require expert application by assessors with the appropriate clinical background to do so. Members have informed LASA that they consider AACQA assessors without a background in clinical care to be ill equipped for the task of assessing RACF's quality of care. Members consider that ideally all AACQA assessors should have a background in clinical care.

Under TOR e) LASA discusses some of the Expected outcomes relating to Standard 2 in more detail.

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

the adequacy and effectiveness of complaints handling processes at a state and federal level,

LASA is of the view that any complaints process is only as good as the response to a complaint the process elicits. However ineffective the complaints mechanism may have been at Oakden, this experience is not borne out nationally. LASA knows that most complaints are resolved locally by the RACF. Issues with quality of the magnitude to elicit a complaint external to a RACF are rare events. In 2015-16 the rate of complaints received by the Aged Care Complaints Commissioner (1,746) for all RACF residents (199,449) is 0.9 per cent. Even these complaints tend to be resolved quickly. The

[5] Australian Bureau of Statistics 2017, National Crime Victimization Survey 2015-16

[6] Standard 2 includes following clinical Expected outcomes: *Medication management, Clinical care, Specialised nursing care needs, Other health and related services, Pain management, Palliative care, Nutrition and hydration, Skin care, Continence management, Behavioural management, Mobility, dexterity and rehabilitation, Oral and dental care, Sensory loss* and *Sleep*.

Aged Care Complaints Commissioner's National Quarterly Bulletin published in July this year reports that 89 per cent of complaints to the Commissioner are resolved within 30 days.

including consumer awareness and appropriate use of the available complaints mechanisms;

LASA welcomes any measures undertaken by the Aged Care Complaints Commissioner or the Department to improve consumer awareness about available complaint mechanisms. Further, LASA supports an appropriate level of public transparency about quality issues in RACFs. LASA encourages its Members to seek continuous improvement in engaging residents and their families regarding feedback and complaints. This includes ensuring there is a shared understanding of complaints systems and processes, as well as the expectations and responsibilities of all involved. However, LASA believes that appropriate and transparent complaints mechanisms must include a RACF's right of reply to a complaint. Further, LASA would like public reporting about complaints to identify the number of complaints that can be classed as vexatious if they are clearly unreasonable and/or are repeated to burden the RACF. Reporting should also clearly explain to the public that complaints rarely lead to investigations by the Aged Care Complaints Commissioner[7].

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

To the industry as a whole it is of utmost concern that the AACQA addresses any serious failings in quality performance by an RACF in a timely manner. The aged care sector is working tirelessly to deliver high quality care but one 'bad apple' can taint the reputation of the entire industry.

LASA believes that introducing a stronger outcome focus into the section of the Guide dealing with complaints may strengthen monitoring of this component of quality performance. The AACQA's Guide considers comments and complaints under Standard 1 *Management systems, staffing and organizational development*. Four Results out of five under Expected outcome 1.4. deal with stakeholders' awareness about complaints processes being in place and how to access these. One Result *Management demonstrates it monitors the effectiveness of the complaints mechanism* addresses whether an effective response to the complaint occurred only indirectly. Thus, the Guide's focus is on complaints processes rather than whether the complaint was resolved and to what degree. LASA suggests that the AACQA may review Expected outcome 1.4 with view to giving it a stronger outcome focus.

[7] Aged Care Complaints Commissioner, National Quarterly Bulletin published 25 July 2017.

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

As mentioned earlier, LASA does not wish to comment specifically on clinical care and governance matters at Oakden.

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

Adequacy of injury prevention, monitoring

RACFs balance residents' legislated right to engage in activities involving an element of risk with the RACFs obligation to provide a safe, secure and homelike environment…'[8] This said, the AACQA's Guide which directs RACFs' accreditation process strongly focusses on harm prevention through assessment, auditing and quality improvement activities. For example, Expected outcome 2.5 *Specialised nursing care needs* asks assessors whether clinical care incidents were documented and appropriately addressed (for example, skin tears, falls, infections). Further the Guide asks whether such incidents were used to identify opportunities for quality improvement in relation to health and personal care. Expected outcome 2.7 *Medication management* requires regular evaluation and review of the medication management system. Expected outcome 2.14 *Mobility, dexterity and rehabilitation* requires assessors to investigate whether the RACF conducts falls risk assessments (taking into consideration, for example, history of falls, medication, confusion, anxiety, sensory impairment, continence, feet and footwear, the environment, etc) and falls prevention programs. Thus, LASA is of the view that the requirements placed on providers of residential aged care are sufficient to manage and mitigate the risk of preventable injuries.

and reporting mechanisms the need for mandatory reporting and data collection for serious injury

The *Aged Care Act 1997* through the *Quality of Care Principles 2014* and the Guide obliges providers to implement and maintain **internal reporting** mechanisms about serious injury. These internal reporting mechanisms are subject to review by AACQA assessors. For example, the Guide requires assessors to ascertain whether mobility and dexterity incidents such as slips and falls are documented and appropriately addressed[9]. The section immediately above in this submission provides further examples of requirements for internal reporting of injuries or other adverse events.

Providers of residential aged care are further subject to compulsory **external reporting** requirements under federal and state legislation. The Department requires notification of reportable assaults or suspicion or allegation of reportable assaults to be made to the local police and to the Department within 24 hours. Unlawful sexual contact is considered a reportable assault. The absence of a resident with the RACF being unaware for the reason of this absence must be reported to local police ('within a reasonable timeframe') and to the Department within 24 hours of report having been made to police.

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[8] Australian Government; *Aged Care Act 1997,* Schedule 1 User Rights Principles*, Charter of care recipients' rights and responsibilities – residential care.*

[9] AACQA *Results and processes guide*, Expected outcome 2.14 *Mobility, dexterity and rehabilitation*, p.59

State based WorkSafe legislation may also require facility managers to report to WorkSafe injuries to residents. State based Work Health and Safety legislation outlines the responsibilities of businesses to provide a safe environment to employees, contractors and members of the public. Legislation also prescribes when a serious work related injury or illness, which could include an injury or illness sustained by a resident during a fall, requires reporting to the appropriate state regulator. The nature of the incident, the environment and any other contributing factors influence whether an incident, and any injuries or illnesses sustained, are considered reportable by legislation. There may be variation from state to state in what constitutes a notifiable incident under WorkSafe legislation.

State legislation determines which deaths require reporting to the Coroner. However, *Coroners Acts* usually require deaths to be reported that occur within 24 hours of:

- having received hospital treatment;
- a surgical procedure; or
- anaesthetic; or
- occurs in a place other than a hospital but within 24 hours of the person having been discharged from hospital after being an inpatient; or
- the person having sought emergency treatment at a hospital.

LASA considers the regulatory frameworks legislating the prevention, monitoring and reporting of serious injury and related mortality to provide sufficient information to governments.

and mortality incidents.

Mortality is a common event for residents in RACFs. Four out of five residents die in their aged care facility because people tend to be admitted to aged care facilities towards the end of their lifespan. In 2015 alone 60,000 residents died in an RACF[10]. For this reason LASA does not support special reporting on the mortality rate in RACFs. However, LASA does support that the Australian, State and Territory Governments undertake steps to ensure data is collected that enables governments to monitor how well end-of-life care services are meeting the needs of older Australians in in all care settings. The data set proposed by the Productivity Commission and supported by LASA includes information about the care setting in which the death occurred[11].

Deaths in RACFs due to serious injury are not very frequent. Recent Australian research shows that only 15.2 per cent of RACF residents' deaths between 2001 and 2012 were due to external factors. In most cases these deaths occurred after falls (81.5per cent). However, the research quoted does not investigate the causes for the falls[12]. LASA would welcome if more research funding was made available to investigate causes of falls in RACFs.

In conclusion, RACF providers have significant mandatory reporting obligations about their quality of care under state and federal legislation. LASA considers the current level of mandatory reporting of injuries and deaths to be sufficient to protect RACF residents' health and safety and thus does not

[10] Productivity Commission 2017, *Introducing Competition and Informed User Choice into Human Services:* Draft Report, Canberra.
[11] LASA submission to Productivity Commission 2017, *Introducing Competition and Informed User Choice into Human Services,* dated 14 July 2017.
[12] Ibrahim J, Bugeja L, Willoughby M, Bevan M et al, 2017 *Premature deaths of nursing home residents: an epidemiological analysis.* Medical Journal of Australia, 206 (10), 442-447.

support an expansion of mandatory reporting, without evidence to support how this would result in improvements in quality and safety.

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

LASA adopts the Australian Institute of Health and Welfare's definition of adverse events: ' as incidents in which harm resulted to a person receiving health care. They include infections, falls resulting in injuries, and problems with medication and medical devices. Some of these adverse events may be preventable[13].'

Residents and their families

The Australian Government's *Charter of Care Recipients' Rights and Responsibilities – Residential Care* does not place responsibility on residents to report adverse events they themselves may experience or observe happening to other residents. LASA supports this stance by the Australian Government because we believe that such reporting requirements would place an unfair burden on residents.

Further, LASA does not consider it appropriate to place responsibility or accountability on resident's families to report adverse incidents. In LASA's view such responsibility and accountability properly rests with the provider who is responsible for the safe environment of the RACF. Residents and their families are informed about available complaints processes and have these available to them if they wish to report an incident.

Agency and permanent staff

Care staff, regardless whether agency or permanent, have reporting obligations commensurate with their training and seniority under policies and procedures put in place by their employing facility. Many of these reporting mechanisms are an accreditation requirement by the AACQA.

Additionally, registered care professionals are usually subject to reporting requirements under their specific professional regulation. These requirements apply regardless whether the registered care professional works as agency or permanent staff[14].

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[13] Australian Institute of Health and Welfare, Hospital performance: Adverse events treated in hospitals <http://www.aihw.gov.au/haag11-12/adverse-events/>

[14] For example, the Nursing and Midwifery Board of Australia's Code of Professional Conduct for Nurses in Australia (Code of Conduct) and Code of Ethics for Nurses in Australia (Code of Ethics) places reporting obligations on registered and enrolled nurses. The Code of Conduct required registered and enrolled nurses to report to appropriate authorities any unlawful conduct they observe. Breaching the Code of Conduct may constitute either professional misconduct or unprofessional conduct. The Code of Ethics for Nurses in Australia includes a responsibility to question and report to relevant authorities what a registered or enrolled nurse considers, on reasonable grounds, to be unethical behaviour and treatment.'

Aged care providers

In LASA's view the regulatory frameworks and associated accreditation mechanisms sufficiently protect residents from adverse events. Both, regulatory frameworks and accreditation requirements include reporting mechanisms for those adverse events serious enough to justify notification of relevant authorities. They also identify actions to be taken to remediate conditions leading to an adverse incident. LASA does not consider that any expansion of existing requirements to report and act on adverse incidents would positively contribute to reducing residents' risk of experiencing such an event[15]. In addition, RACFs apply their own standards, systems and processes within their facilities in accordance with the AACQA's Guide. Operators of RACFs also have mechanisms to garner feedback from residents and their families regarding quality of care, their perceived safety of the accommodation as well as services and the support residents experience. These mechanisms are regulated and monitored by the AACQA.

State and federal governments

LASA considers the legislative demarcation between state and federal government responsibilities to be clear in general. As far as LASA wishes to comment on events specific to Oakden, LASA believes that the events in Oakden need to be considered in their specific context. Oakden is a state run mental health facility for older people, funded by dual funding streams. In LASA's view, this context may indeed have resulted in unclear accountabilities with Oakden falling 'through the cracks', so to speak. Notwithstanding this, LASA further notes that such complex Federal/State Government arrangements have been successfully implemented elsewhere in Australia.

TOR g) any related matters.

Concluding comments

The 2013 Berwick NHS Review following the mid-Staffordshire tragedy in the UK stated: "culture will trump rules, standards and control strategies every single time, and achieving a safer NHS will depend far more on major cultural change than on a new regulatory regime (p.11)"[16]. LASA does not believe that an expansion of, or other changes to, existing regulatory and monitoring instruments are necessary. Rather, in addition to monitoring regulatory compliance overseeing bodies should consider encouraging other, non-regulatory approaches to ensuring quality. Regulatory bodies charged with ensuring residents' quality of life and quality of care should strongly encourage providers to establish and nurture a culture of continuous improvement in care and services. The foundation to such a culture are positive and respectful relationships between providers, caregivers and residents and their families.

[15] Aged care providers straddle federal legislation (e.g. Aged Care Act 1997, Australian Aged Care Quality Act 2013) and state-based legislation (e.g. Drugs and Poisons Acts, legislation prescribing water quality, fire safety and WorkSafe legislation). Both the AACQA and the Department of Health have a role in monitoring aged care services' compliance with prescribed national standards. Further, the Aged Care Complaints Commissioner and state agencies also monitor compliance.

[16] Berwick 2013, Review into Patient Safety: A promise to learn – a commitment to act: improving the safety of patients in England.