LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

FINAL REPORT
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 PRACTISED. (XENOPHON INQUIRY)

Short overview, April 2019

A strong voice and a helping hand
for all providers of age

Leading Age Services Australia

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 purpose 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. 55% of our Members are not-for-profit, 37% are for-profit providers and 8% of our Members are government providers. 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.

On 3 April 2019 the Senate tabled its final report of 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 practised*.

In this report the Senate Community Affairs References Committee (committee) states that it received compelling evidence about systemic issues that negatively impact the quality of aged care services throughout Australia. The evidence described failures of care in residential aged care facilities (RACFs) including personal and clinical care standards, nutrition, social inclusion, rehabilitation and palliative care.

The committee concluded that: 'notwithstanding the defences put forward by the RACF sector, it is now a universally accepted truth that a poor standard of care is being experienced by too many RACF residents' (p.13).

The committee remains sceptical of RACF sector claims that these are individual outlier events that do not represent the general standard of care. When these events are collated into a single body of evidence, the committee forms a picture of an RACF service sector with an unacceptably high level of 'individual' incidents of poor care.

Key factors contributing to poor clinical care standards are identified as:

- A lack of an appropriate model of care for most RACFs.
- Lack of access to clinical services, often due to funding constraints.
- Insufficient internal governance and external regulation of clinical practice.
- Restrictive practices being used at alarmingly high rates.

The committee's findings on the regulation of clinical care include:

- The change to person-centred care —must be met with a corresponding change to person-centred regulation. Assessments of care standards should not be limited by jurisdictional barriers, but look holistically at the care needs of RACF residents with a 'no wrong door' approach to issues of concern. The committee appears particularly concerned about RACFs' compliance with state and territory laws that regulate the dispensing of medications to individuals with cognitive impairment.

- ***The new Charter of Aged Care Rights may be too brief, may not meet the needs of RACF residents and may leave their rights to be interpreted by the RACF. This is not desirable (p.56).***

- The Department may need to work with providers, advocates and RACF residents to ensure that the rights are imbued with appropriate content and that residents' rights are strengthened.

- ***The element of clinical governance is lacking across the board in RACFs. The committee is troubled that the requirements for clinical governance are watered down in the incoming Single quality framework (p. 71).***

- The committee concurs with the views of the AMA that inadequate staffing prevents quality care.

- ***The committee is highly concerned with the oversight of medications in RACFs (p. 72).***

- External oversight is lacking that ensures medications in RACFs are being managed safely, are prescribed appropriately, and are administered according to relevant laws.
- Oversight of restrictive practice in the aged care context cannot be any less than the oversight in any other care context, such as that used in the health or disability care context.
- Data collection should support ongoing research, clinical best-practice and consumer choice.

- ***There needs to be additional regulation of personal care workers and aged care workers in RACFs. At minimum, people providing direct care should be covered by the National Code of Conduct for health care workers. The committee considers that a central registry may be desirable (p.79).***

Committee's findings on the interaction with the health care sector

- RACF residents are predominantly people with complex health care needs. They often require a great deal of clinical care beyond day-to-day nursing care.
- The Australian Commission on Safety and Quality in Health Care (Health Care Commission) submitted that RACF providers have a non-delegable duty of care to residents to protect them from harm. This duty of care would extend to external medical services provided on-site in RACFs.
- Leading Age Services Australia submitted that under the Aged Care Act 1997 (Cth) the RACF provider is ultimately responsible for the overall care of the care recipient, although RACF providers' responsibility for the quality of care delivered by visiting health professionals 'has not been tested and remains a grey area'.
- The committee considers a broader role for PHNs in creating linkages between RACFs and the broader health sector to ensure that the appropriate care is wrapped around the care recipient.

- ***The committee is concerned about the lack of access to GPs in RACFs and believes this issue needs addressing as a matter of urgency (p.89).***

Committees views on quality and funding

- The quality of clinical and medical care in aged care services is not of a consistent standard that any reasonable person would accept. The committee considers that issues of funding and the overall viability of the aged care sector are inextricably linked to the quality standards of aged care.

Overall committee views

- Residential aged care is a hybrid model of service delivery, awkwardly straddling the divide between being a health facility and support accommodation.
- A lack of clarity exists about where the dividing line is between personal and clinical care, who should be responsible for delivering those types of care, and who should be responsible for the standards of care. Until we solve the fundamental problem of defining what we want from residential aged care facilities (RACFs), no regulatory framework will be able to resolve these issues.
- This lack of definition is also evident within policies, operational guidelines and funding frameworks within the Department of Health itself, which lack clarity and are often contradictory in how aged care is defined.
- This inquiry demonstrated that gaps exist in the current framework for the delivery of clinical services in RACFs and that poor clinical care for older Australians who live in RACFs has too often been the result. The Single Aged Care Quality Framework which promotes person-centred care is a positive step forward. However, much more needs to be done to promote a higher quality of care for people living in RACFs.
- To get person-centred care, the sector needs person-centred regulation.

List of recommendations

Recommendation 1: The committee recommends the Australian Government release its consolidated response to all recommendations in key reports made in the past decade to improve aged care service delivery and regulation, and its interaction with the primary health and acute care sectors.

Recommendation 2: The committee recommends that the Australian Government clarify that residential aged care providers ultimately hold a duty of care to all residents.

Recommendation 3: The committee recommends that the Australian Government implement a clearly articulated principle that the duty of care for the regulation of all care within the aged care residential setting ultimately rests with the Aged Care Quality and Safety Commission.

Recommendation 4: The committee recommends the Australian Government establish a body with responsibility for aged care research.

Recommendation 5: The committee recommends the Australian Government continue work to expand the role of the Aged Care Quality and Safety Commission, in consultation with aged care stakeholders, to drive continuous improvement in levels of quality and safety in aged care.

Recommendation 6: The committee recommends that the Aged Care Quality and Safety Commission work collaboratively with the Department of Health, the Australian Commission on Safety and Quality in Health Care and aged care stakeholders to develop an industry model of care. This model of care should incorporate a model clinical governance framework which clearly defines the scope of personal and clinical care.

Recommendation 7: The committee recommends that the requirements for a model of care and clinical governance framework be more clearly articulated within the Single Aged Care Quality Framework, including clearly defined service outcomes expected from those frameworks.

Recommendation 8: The committee recommends that the Aged Care Quality and Safety Commission work collaboratively with the Department of Health, the Australian Commission on Safety and Quality in Health Care and aged care stakeholders to develop benchmarks for staffing levels and skills mix, which includes the requirement to roster an Registered Nurse on duty at all times, to assist residential aged care providers in staff planning and aged care assessors in regulating safe and appropriate staffing.

Recommendation 9: The committee recommends the Australian Government take action, as a matter of urgency, to ensure the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector is extended to cover the aged care sector.

Recommendation 10: The committee recommends the Australian Government investigate, as a matter of urgency, changes to ensure that the use of antipsychotic medications in residential aged care facilities must be approved by the Chief Clinical Advisor of the Aged Care Quality and Safety Commission.

Recommendation 11: The committee recommends that the Aged Care Quality and Safety Commission develop a regulatory model to oversee medications management in residential aged care facilities.

Recommendation 12: The committee recommends that the Aged Care Quality and Safety Commission work with the Department of Health and aged care stakeholders to improve the palliative care environment in residential aged care facilities.

Recommendation 13: The committee recommends that the Aged Care Quality and Safety Commission work with the Department of Health to develop mechanisms to increase the focus on wellness and re-ablement in residential aged care facilities.

Recommendation 14: The committee recommends the Department of Health work collaboratively with the Aged Care Quality and Safety Commission, the Australian Commission on Safety and Quality in Health Care, Primary Health Networks, residential aged care providers and medical stakeholders to achieve better integration of the aged care environment with the primary health and acute care sectors.

LASA response

Most of the issues identified by the Committee are consistent with challenges that have been widely identified by aged care providers themselves. LASA's concern with this report is that it does not

acknowledge the high quality of care that is usually delivered, and does not distinguish between problems that arise due to poor care delivery rather than constrained resources.

While the committee does acknowledge the issue of funding, its recommended responses are generally premised on the idea that additional rules and guidance from a regulatory authority can solve these challenges. LASA view is that while additional guidance may be useful in some circumstances – including potentially greater clarity around relative responsibilities of providers and visiting health professionals – these are fundamentally complex problems where the solution will depend on circumstances of a particular organisation, service, or client.

The recommendation for 24 hour registered nurses (RNs) is a good example of this. Feedback from LASA members suggests that this would not be an appropriate minimum standard because there are facilities that operate without 24hr RNs that are meeting all quality standards and are receiving good customer experience ratings. Requiring 24 hour registered nurses would require them to fund this by diverting resources from services that are currently valued by their clients.

Additional concerns around the 24hr RN proposal include that it may force facilities to use RNs when this would not lead to the best quality care.

Similarly, if a rostered RN is unavailable it may be better to bring in an EN that knows the needs of residents rather than an agency RN that has never visited the facility.