OPAN Older Persons Advocacy Network

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Senate Community Affairs References Committee 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

Submission from the Older Persons Advocacy Network
30 November 2018

The Older Persons Advocacy Network appreciates the opportunity to make a submission to this inquiry.

Our understanding is that the continuing work of the inquiry is focusing on the following:

- Terms of Reference (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
- With an emphasis on the regulation of clinical, medical and allied health care in the aged care context

We are available for any further information by contacting OPAN Chief Executive Officer Craig Gear on 0410 695 659 or at craig.gear@opan.com.au.

INTRODUCTION

From 1 July 2017, the Department of Health has funded the Older Persons Advocacy Network (OPAN) to deliver the National Aged Care Advocacy Program (NACAP). OPAN is a network of nine service delivery organisations (one in each state and territory, two in the Northern Territory). Each organisation provides a nationally consistent model of information, advocacy and education focused on the rights of older people to access the aged care system and have high quality interactions with providers. Advocacy services ensure that the rights of aged care consumers are supported, and that they are empowered to make informed decisions about their care.

During 2017/18, OPAN assisted 11,474 older people through provision of information and/or advocacy. Nearly one third of those assisted were classed as 'vulnerable.'[1] In addition, OPAN visited 1,467 residential aged care services to deliver education sessions on resident rights and responsibilities. Two thirds of these sessions were delivered to residents who were classed as 'vulnerable.'[2]

The most common issue raised by residents or their representatives is quality of care; further details on consumer matters raised with OPAN are detailed in Appendix 1. OPAN is well placed to comment on the consumer experience of health care in residential care.

THE EFFECTIVENESS OF THE AGED CARE QUALITY ASSESSMENT AND ACCREDITATION FRAMEWORK

OPAN supports the work done by the Australian Aged Care Quality Agency (the Quality Agency) to unite and upgrade the four existing quality standards that cover aged care and believe that this will go some way towards protecting residents from abuse and poor practices and towards ensuring proper clinical and medical care standards are maintained and practiced.

OPAN notes that Standard 8 (Organisational Governance) of the new Quality Standards introduces the requirement for a Clinical Governance Framework:

> (8e) where clinical care is provided – a clinical governance framework, including but not limited to the following:
> (i) Antimicrobial stewardship;
> (ii) Minimising the use of restraint
> (iii) Open disclosure.

Clinical governance is defined as:

> An integrated component of corporate governance in organisations that provide clinical care. It encompasses the systems used by organisations, from Boards to the frontline clinical and other workforce, to account to consumers and the community for assuming the delivery of safe, effective and consistent, consumer-centred clinical care and for continuously improving the safety and quality of clinical care and services.[3]

Clinical care is defined as:

> Health professionals, such as doctors, nurses and pharmacists provide clinical care. Organisations providing clinical care are expected to make sure it's best practice, meets the consumer's needs, and optimises the consumer's health and well-being.[4]

[1] The use of 'Vulnerable' is taken to mean 'disclosing/having special needs as defined in the *Aged Care Act, 1997*
[2] OPAN Annual Report, November 2018
[3] Australian Aged Care Quality Agency (Aug, 2018) Guidance and Resources for Providers to support the new Aged Care Quality Standards, Glossary
[4] Ibid

OPAN believes that clinical governance is critical, in fact a lack of awareness and structure of clinical governance was a key reason for failure at Oakden as well as lack of accountability for clinical issues.[5]

The challenge within aged care is most of the delivery of care occurs under delegation to under-regulated staff or through a workforce model with indirect supervision. This does not negate the need for good clinical and care governance, but rather heightens the need for clearly understood allocation of clinical responsibilities and an active focus on clinical governance.

Whilst a provider designed Clinical Governance Framework goes some way towards ensuring proper clinical and medical care standards, OPAN believes that there are significant aspects of care not included, such as:

- Minimising the use of restraint (both physical and chemical[6])
- Quality Indicator – pressure injuries
- Quality Indicator – unplanned weight loss
- Psycho-social care.

A comprehensive clinical care framework is provided in Appendix 2.

Additionally, the Clinical Governance Framework has not included mechanisms that measure compliance with professional standards and guidelines where they exist, or accountability arrangements with visiting professionals such that responsibilities are clear and the facility can demand an appropriate standard of care. (This would cover arrangements noted by the Australian Medical Association[7] to facilitate a resident's choice to stay with their existing GP when moving to a Facility rather than transition to the in-house GP (if available), as well as ongoing medical care by specialists such as geriatricians and psycho-geriatricians).

OPAN points out the Australian Committee on Safety and Quality in Health Care (ACSQHC) has developed the Australian Safety and Quality Framework for Health Care, specifying three core principles for safe and high quality care: care is consumer centred, driven by information, and organised for safety. The Framework was endorsed by Health Ministers as the national safety and quality framework for Australia in November 2010.

OPAN proposes that the soon to be formed Aged Care Quality and Safety Commission (ACQSC), under purvey of the Chief Clinical Advisor, develop a national Aged Care Safety and Quality Framework that providers are required to implement, to be assessed through the accreditation system.

REGULATION OF CLINICAL, MEDICAL AND ALLIED HEALTH CARE IN THE AGED CARE CONTEXT

OPAN agrees that older people living in residential care have the right to a standard of health care equal to that experienced by all Australians. Our experience is that there are times when

[5] Groves, A et al (2017) The Oakden Report. Adelaide, South Australia: SA Health, Department for Health and Ageing
[6] See also Inquiry Submissions 20, 24
[7] Inquiry Submission 13

this does not occur due to timely access and availability of medical and clinical professionals as well as the lack of clarity of responsibilities regarding clinical governance.

OPAN notes the Committee's view in the Interim Report for this Inquiry that the lack of a defined model of care, coupled with appropriate clinical governance to deliver that model of care, is a significant contributor to substandard service delivery,[8] and that there is significant conflict within the aged care sector as to the definition of the care being provided, who is responsible for providing appropriate clinical care in RACFs, and which agencies should have quality oversight responsibility of that care.[9] OPAN agrees with the Committee that the current impasse cannot continue and needs to be resolved.[10]

OPAN is aware that a range of regulatory options – Quality Agency, providers, professional associations, APHRA – have been discussed in submissions to the Inquiry. Whilst it is the view of some providers and peak bodies[11] that standards of health care should be oversighted by professional colleges/national boards rather than the Australian Aged Care Quality Agency (the Quality Agency), OPAN does not support this view.

OPAN believes that whilst it is appropriate for national boards to oversight complaints against health professionals, it is only quality assessors who can take a pro-active approach and systematically pick up the signs of a problem whilst it is still a minor issue. We are supported in this view by:

- The Queensland Nurses and Midwives Union[12] who believe it is the responsibility of the Quality Agency to assess compliance with professional standards at aged care facilities, as prescribed within the Accreditation Standards contained in the Quality of Care Principles 2014 (Cth). They point out that **the National Board's prescribed role under the National Law is to assess the individual practitioner's competence** to practice safely in accordance with the Codes and Guidelines for nursing practice and that the Board does not have a role in assessing service provision or the standards of care provided by a service provider. Only the *Aged Care Act 1997* (Cth) and its subordinate legislation can create a framework for practitioners to provide aged care in a manner that satisfies the National Board's Codes and Guidelines for the profession.

- The Nursing and Midwifery Board of Australia, with the Australian Health Practitioner Regulation Agency, who submitted[13] that its code of conduct provides guidance to practitioners on their professional conduct in the practice of their profession. They noted that employers of registered health practitioners must provide a supportive environment for nurses to safely delegate tasks and supervise staff, including provision for safe staffing levels, and where Registered Nurses are supervising Enrolled Nurses, a Registered Nurse is contactable and available to the Enrolled Nurse at all times.

[8] Inquiry Report Paragraph 4.28
[9] Inquiry Report Paragraph 4.29
[10] Inquiry Report Paragraph 4.30
[11] Inquiry Submissions 11, 12
[12] Inquiry Submission 6
[13] Inquiry Submission 44

- The Pharmacy Board of Australia[14] who similarly pointed out that pharmacists must abide by its code of conduct and guidelines, including those relating to the dispensing and supply of medications to patients; the profession's standards and guidelines relevant to their clinical environment and the pharmacy services that they provide, and supports workplaces applying robust approaches to medication assessments and thorough documentation in the interests of patient safety.

It is important that the credentialing and privileging of clinical staff (usually by the Facility Care Manager) be a formal process to facilitate regulation of health professionals within the scope of practice developed by AHPRA and the clinical practice limitations which may be required given the aged care environment. This process is currently unclear and can compromise the quality and standard of care in residential facilities.

WORKFORCE ARRANGEMENTS

OPAN supports the intent of Standard 8 to ensure proper clinical and medical care standards through workforce governance, including the assignment of clear responsibilities and accountabilities (3(a)(iv).

Many submissions, as well as OPAN's own consumer data, note the existence of inadequate workforce arrangements:

- The Royal Australian and New Zealand College of Psychiatrists[15] state that whilst residential aged care providers have responsibilities to provide care and services to meet recipients' needs in accordance with the Accreditation Standards as set out in the Quality of Care Principles 2014, specifically that "recipients' physical and mental health will be promoted and achieved at the optimum level in partnership between each care recipient (or his or her representative) and the health care team,"[16] individual interpretation of this requirement varies and some facilities only have a registered nurse rostered on once a week, meaning it is challenging to implement appropriate care plans to support residents' physical and mental health.

- The Australian Medical Association[17] points out the Oakden Report[18] discussed very low levels of nursing staff, and nurses being replaced by personal care attendants, and that this situation exists in other homes as well, including homes that do not have any nurses staffed after hours.

The Standards require:

[14] ibid
[15] Inquiry Submission 43
[16] Quality of care principles 2014 schedule 2 part 2
[17] Inquiry Submission 13
[18] Groves, A et al (2017) op.cit.

- that staff have qualifications and knowledge to effectively perform their roles - Standard 7 (3c)
- best practice clinical care -Standard 3 (3) (i)
- effective communication where responsibility for care is shared - Standard 3 (3) (e)
- timely and appropriate referrals -Standard 3, (3) (f); Standard 4 (3) (e).

Despite this, the majority of care in nursing homes is undertaken by a large, unstructured workforce of personal carers and nursing assistants who provide direct care with no regulatory safe guards or accountability.[19] "It is still possible to work with extremely vulnerable older people while having no relevant qualification. This should be an outrage."[20]

OPAN believes that, similar to systems for other health professionals, there needs to be a government oversighted Licencing Scheme of Persons Working in Aged Care. Such persons should be called Health Care Support Workers and included in the COAG-proposed National Code of Conduct for Health Care Workers. The Licencing Scheme should be able to accept complaints for referral to the Health Care Complaints Commissioner, and apply sanctions including deregistration.

OPAN believes that all healthcare workers who assisted registered and enrolled nurses in care provision should:

- have defined qualification, generally accepted as the Certificate III in Individual Support[21]
- abide by a code of conduct
- follow practice standards.

It is critical that supervision arrangements for these staff be formal and binding in order to maintain quality and safety of care.

This work could also be undertaken by a Professional Association to cover Health Care Support Workers.

OPAN acknowledges that the costs of training and licensing are often borne by the worker who is usually low paid. Industry must support the workforce to become appropriately qualified through Recognition and training, including specialised training in areas such as dementia and palliative care.

[19] See also Inquiry submissions 20, 29

[20] Emeritus Professor Rhonda Nay "The Good, the bad and the Downright Ugly: Reflections on 10 Years" 2016, 11(4) Residential Aged Care Communique, 6.

[21] The Certificate III in Individual Support was recommended by the National Review of Nursing Education and Career Pathways for the VET Workforce (Our Duty of Care) as the minimum competency level for this work. According to the Australian Government Department of Education and Training website it consists of course work and 120 hours work placement which would typically take 1 to 2 years. Providers offering the course however report that the average duration is actually 8 months.

AUDITING INFORMATION

The Quality Agency 'case source information' [22] can come from:

- Individual complaints
- Information raised with the Agency by the public
- Advocacy organisations
- Compliance assistance outcomes
- The Department
- The Complaints Commissioner
- Public Health Units of State and Territory governments
- Others regulators such as health professional boards
- Coroner findings
- Media reporting

Mechanisms for sharing information include:

- Quality Agency mechanism for data exchange within the Commonwealth's aged care regulatory framework
- Quality Agency memorandum of understanding with the Department and with the Complaints Commissioner.
- Quality Agency receiving referrals from the Department and the Complaints Commissioner, flagging the level of seriousness of the issue being referred.

It appears however that this does not work in practice. Part of the failure of uncovering abuse at Oakden arose from lack of coordination of information, as well as the Quality Agency apparently not receiving complaints from the State or Commonwealth health departments, the Aged Care Complaints Commissioner or other external sources.

The new Standards include a shift towards highlighting consumer experience data as an information source for auditors, anticipating this would counter-balance/verify the facility's narrative. However, OPAN's work as an advocate to ensure residential aged care services are delivering care and quality services consistent with the Charter of Aged Care Rights, is aware of situations where providers, rather than making advocacy an important part of their complaint handling process, actively resist consumer feedback or advocacy involvement. We are supported in this view by COTA who submit[23] that the culture must shift from one of 'fear of retribution' to complaints as 'a normal and welcome part of customer service.'

OPAN is aware that some older people are afraid to complain. The Complaints Commissioner has shared Australian and international research that many people who could complain in fact do not do so. She speaks of the need to continue to actively find ways to ensure highly vulnerable aged care consumers and their families know they can raise a complaint, feel safe to do so, and know that it will make a positive difference.[24]

[22] Inquiry submission 42
[23] Inquiry submission 70
[24] Inquiry Submission 7

As such, residents who fear complaints will result in retribution may not be a reliable source of information. OPAN currently provides data to the Department of Health as its funding body. It may be appropriate to share information further, as in the dot points listed above, to increase the effectiveness of the new risk profiling accreditation tools.

Appendix 1

CONSUMER HEALTH CARE ISSUES RAISED WITH OPAN

The most common issues raised by residents or their representatives is quality of care, specifically:

- Inadequate hydration and nutrition- typically identified by family members who notice significant weight loss.
- Conditions going unnoticed/undiagnosed until they have reached a critical stage and hospital admission is required – Urinary Tract Infections is perhaps the most common example.
- Wound care - particularly in relation to the prevention, identification and management of pressure wounds.
- Oral hygiene- residents often not supported to brush teeth daily. One residential respite client did not have their teeth brushed once during a two week stay. Lack of oral hygiene leads to other health concerns.
- Chemical restraint – often used as a behaviour management strategy before other less restrictive options have been explored.
- Poor medication administering/management – with residents experiencing long waiting times and receiving incorrect doses or medications. Some examples are:
    - Undiagnosed and untreated oral thrush resulting in resident not eating resulting in significant weight loss and not taking medication resulting in hospitalisation.
    - Long wait time for medication for Parkinson's Disease resulting avoidable hospitalisations.
    - Non-response from visual and hearing impaired resident to instruction to take medication results in medication left on bedside table and lack of monitoring of what happens to it.
- Over medication of residents – including anti-psychotic and anti-depressant medications. Residents/representatives who raise questions about their medication can receive patronising responses from clinical staff to their questions, even when medication is no longer required.
- Poor continence management. Rationing of pads can result in Urinary Tract Infections, scalding, and sores as well as a loss of dignity. Continence assessment may not be carried out by a qualified person. It is often family members who detect the need for a clinical response.
- Mental health issues – residents are often not provided with psychological supports such as counselling or therapy for issues including grief and loss, depression, anxiety, trauma, PTSD, domestic violence, and on-going mental health disorders affecting quality of life.
- Pain medication not administered over night as no qualified staff (RNs) and have to wait till morning. Not appropriate for palliative care, chronic pain, falls where severe pain may be treated by phone order.
- Untrained junior staff telling residents to wait 15 minutes to see if their chest pain settles before calling the RN to review them
- Graduate RNs used with no experience or supervision to plan for care of older people with complex needs

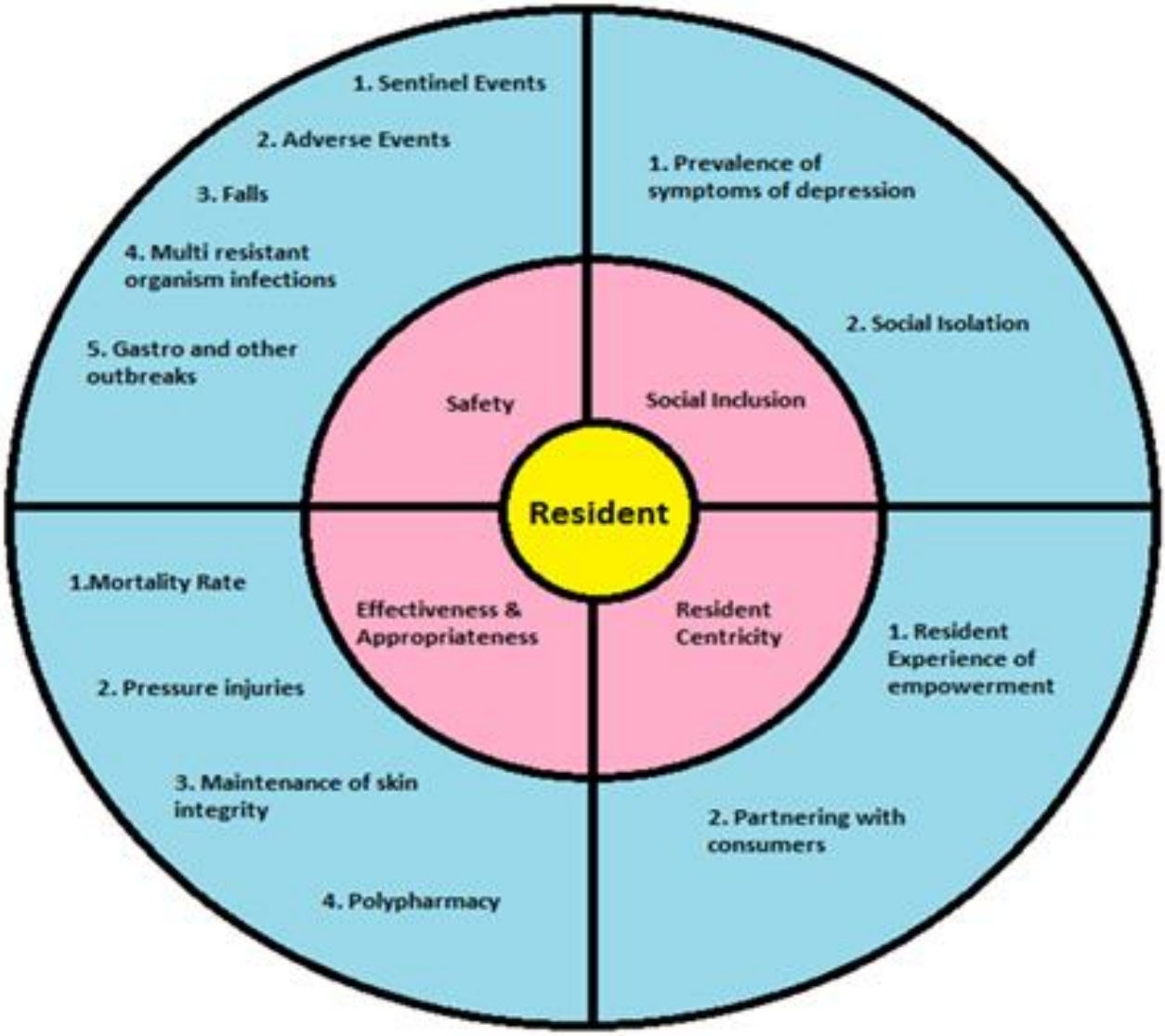
- Insufficient physiotherapy to promote independence and maintain mobility, and to prevent contractures
- Speech pathologists and dieticians not routinely requested to assess for swallowing and nutritional needs; supplements available but not used to address weight loss
- General practitioners are reluctant to visit residents in aged care as cannot find trained staff to provide medical history and record signs and symptoms of change in condition
- Medical appointments cancelled in rural areas due to lack of transport to regional hospitals and centres.

In OPAN's experience, the underlying reasons for clinical care issues are:

- inadequate staffing numbers
- time constraints leading to staff taking short cuts
- inadequately skilled workers unable to monitor, assess, identify and respond to clinical issues on a day to day basis
- lack of accountability and supervision
- poor culture – "she'll be right" attitudes, carelessness, low standards.

Appendix 2

Comprehensive Clinical Care Governance Framework[25]



[25] Personal communication with Richard Olley, Senior Lecturer, Health Services Management, School of Medicine, Griffith University and Assistant Chief Examiner, Australasian College of Health Service Management, 28.11.2018

Appendix 3

OPAN SUPPORT FOR REFORM

OPAN supports the recommendations made in *Australian Law Reform Commission Report 131, Elder Abuse: a National Legal Response*. The ALRC recommended:

- establishing a serious incident response scheme in aged care legislation;
- reforms relating to staffing in aged care;
- regulating the use of restrictive practices in aged care;
- reforms relating to decision making in aged care; and
- national guidelines for the community visitors scheme regarding abuse and neglect of care recipients

OPAN commends the government on action to establish a serious incident response scheme. The following recommendations also require attention by government:

- Recommendation 4–7 The Department of Health (Cth) should commission an independent evaluation of research on optimal staffing models and levels in aged care. The results of this evaluation should be made public and used to assess the adequacy of staffing in residential aged care against legislative standards.
- Recommendation 4–8 Unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.
- Recommendation 4–10 Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:
  (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
  (b) to the extent necessary and proportionate to the risk of harm;
  (c) with the approval of a person authorised by statute to make this decision;
  (d) as prescribed by a person's behaviour support plan; and
  (e) when subject to regular review.
- Recommendation 4–11 The Australian Government should consider further safeguards in relation to the use of restrictive practices in residential aged care, including:
  (a) establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices;
  (b) requiring aged care providers to record and report the use of restrictive practices in residential aged care; and
  (c) consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme.