QUALITY AGED CARE ACTION GROUP INC

QACAG Submission

12 November 2020

About QACAG

Quality Aged Care Action Group Incorporated (QACAG) is a community group in NSW that aims to improve the quality of life for people in residential and community aged care settings. QACAG is made up of people from many interests and backgrounds brought together by common concerns about the quality of care for people receiving aged care services.

QACAG Inc. was established in 2005 and became incorporated in 2007. Membership includes: older people, some of whom are receiving aged care in NSW nursing homes or the community; relatives and friends of care recipients; carers; people with aged care experience including current and retired nurses; aged care workers and community members concerned with improving aged care. Membership also includes representatives from: Older Women's Network; Combined Pensioners & Superannuants Association of NSW Inc.; Kings Cross Community Centre; Senior Rights Service; NSW Nurses and Midwives' Association and the Retired Teachers' Association.

QACAG members welcome the opportunity, through this submission, to provide additional input into the impact of COVID-19 on aged care services to the Royal Commission into Aged Quality and Safety.

Margaret Zanghi
President
QACAG Inc.

The Quality Aged Care Action Group (QACAG) is pleased to offer this final submission to the Royal Commission into Aged Care Quality and Safety. Given the breadth and depth of the 124 recommendations, it is disappointing that so little time was given for responses. At least double the timeframe for feedback would be required to ensure proper and thorough community consultation.

Due to time constraints this submission is limited to the issues of advocacy, staffing, governance and quality in aged care which are the central foci of our membership.

Advocacy

Consumers appear to have been overlooked in these recommendations. In August 2019, Senior Counsel Assisting Peter Gray stated "the voices of providers are predominant in the Australian system and appear to be highly influential in policy debates with ministers, departments, agencies and officials, but the voices of consumers, families and consumer advocates are relatively weak."[1] **Aged Care Royal Commission (ACRC) Recommendation 113** stands alone in setting out provisions for consumer consultation. However, the recommendations are limited to consumer experience upon receiving care. Although these measures are welcome, it is disappointing to see that the key issues of consumer empowerment have been overlooked. Consumers are the ever-present participants in, and observers of care delivery and they provide a true insight into care services. There must be structures put in place which involve and empower the consumer and this means giving them a role as stakeholders in decision making processes at all levels. If we don't have this, much of the work of the commission will have been in vain.

QACAG Recommendation: that consumer representation be mandatory on boards of directors of provider companies.

QACAG Recommendation: that consumer representation be mandatory on State and Federal Government committees and enquiries related to aged care.

[1] https://www.southernhighlandnews.com.au/story/6320935/tardy-govt-urged-to-overhaul-aged-care/

ACRC Recommendation 10 supports an increase in “care finders”. The aged care system can be difficult to navigate. While QACAG supports the recommendation in principle, there is not enough information provided to allay our members concerns. Registered Nurses are best placed to fulfil such a role. However due to the vulnerabilities of persons and their loved ones receiving care, the role of “care finders” must be independent of providers or any incentives such as a “finders-fee” paid by providers. While the recommendation mentions that workers are suitably qualified, it fails to specify what those qualifications are. QACAG members find this concerning.

QACAG Recommendation: that care finders are registered nurses who are independent of providers and receive no finders’ fee commissions.

The Culturally and Linguistically Diverse (CALD) community is especially vulnerable. **ACRC Recommendation 19** addresses some of the issues however is more reactive than proactive. More work is required with the CALD community directly to examine cultural shortfalls and ways to manage this.

QACAG Recommendation: that the CALD community is thoroughly and comprehensively engaged on an ongoing basis to identify shortfalls in provision of care.

ACRC Recommendation 62 calls for a new primary care model to improve access, again there is a clinical gap with no mention of Registered Nurses. Nurses provide an essential interface between consumers and providers of care.

QACAG Recommendation: that registered nurses are included in improved access to primary health care.

ACRC Recommendation 72, Improving the transition between residential aged care and hospital care: QACAG has long advocated for improvements to the transition between residential care and hospital care. Appropriate staffing and skills mix would prevent hospitalisations in the first place, address the issue of cost shifting and would improve the interface between residential care facilities and hospitals. An

increase in appropriate numbers of Registered Nurses in aged care facilities is essential for this to occur.

ACRC Recommendation 1, A new Act: QACAG members agree that a new Act is needed. It is concerning that in this recommendation there is no mention of provider responsibilities including minimum staffing requirements and skill mix. The current Act lacks any specific requirements on providers and QACAG is concerned that if a new Act does not provide clearer expectations and requirements of providers, effective change definitely will not occur.

QACAG Recommendation: that the new Act provides clear expectations on staffing and skills mix including mandated methodology to determine ratios and skills mix relative to resident need.

ACRC Recommendation 24, Urgent review of the Aged Care Quality Standards: The current quality standards are non-prescriptive and cannot be used to measure the facilities' performance especially on care management. QACAG agrees that the revised quality standards must include a number of health outcome indicators including specific information which can be measured to show whether care services are meeting the needs of vulnerable residents. Oral care, falls, burns, wound management, pressure injury prevention, urinary tract infections, unexplained skin abrasions/injuries and bruises together need to be meticulously documented and reported on. The health outcome indicators must be entered into a Register (legislated in the new Aged Care Act) and reported to the new Aged Care Safety and Quality department, similar to reportable infectious diseases which are reported to the Ministry of Health. Furthermore, using these health outcome indicators to calculate the percentages of residents who obtain negative health outcome could be listed as percentages on the My Aged Care website. The general public can then easily decide which facility is providing quality care.

QACAG members are aware of long waiting times for complaints to the Aged Care Quality and Safety Commission. Without both adequate and appropriate staffing, timely investigation and enforcement of quality standards cannot occur.

QACAG Recommendation: that the Aged Care Quality Standards are measurable.

QACAG Recommendation: that the Aged Care Quality and Safety Commission is adequately resourced to respond to complaints and enforce the Aged Care Quality Standards in a timely manner.

Staffing and skills mix

ACRC Recommendation 47, Minimum staff time standard for residential care: QACAG supports the Australian Nursing and Midwifery Federation's (ANMF) *National Aged Care Staffing and Skills Mix Project Report 2016 Meeting residents' care needs: A study of the requirement for nursing and personal care staff*[2]. This report includes research the ANMF undertook with Flinders University and the University of South Australia. From this work the ANMF have developed a tool for RACFs to use that incorporates the time taken for both direct and indirect nursing, personal care tasks and assessment of residents to reflect the level of care required by residents. This tool identifies the minimum level of staffing required to meet the needs and acuity of residents. A recommendation of four hours and eighteen minutes of care per day, with a skills mix requirement of Registered Nurse (RN) 30%, Enrolled Nurses (EN) 20% and Personal Care Worker (PCW) 50% is the evidence based minimum care requirement and skills mix to ensure safe residential and restorative care. Our members strongly advocate that providers should be required to use this tool and skill mix recommendation to determine safe levels of skill mix and staff ratios.

Recommendation 47 falls short of the rigorous evidenced based model described above. Without adequate numbers of suitably qualified staff, quality standards are unable to be met. QACAG members often cite their experience of loved ones not receiving assistance with activities of daily living such as feeding due to staffing inadequacies. Members often spend long hours in facilities to ensure their family

[2]Australian Nursing and Midwifery Federation (2016) *National Aged Care Staffing and Skills Mix Project Report 2016 Meeting residents' care needs: A study of the requirement for nursing and personal care staff*. Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

members needs are met and it is not unusual that they have assisted other residents when no one else was available. Members fear if they are not present their loved one will not be fed and will miss out on other basic needs. The existing lack of safe staffing levels in aged care leads to chronic episodes of missed care across the sector with staff being unavailable to assist those under their care with activities of daily living.

When staff are available to assist, our members have provided examples where time pressures often lead to inappropriate delivery of care. One account was from a member who arrived to a facility to find their husband being showered with the bedroom door, window and bathroom door open. When asked why, the response was that the member of staff attending to his care felt *"hot and stuffy"*.

QACAG Recommendation: that the ANMF minimum care requirement of four hours and eighteen minutes of care per day and skill mix ratio of RN 30%, EN 20% and PCW 50% be mandated.

GOVERNANCE

Regarding **recommendations 52, 53 & 54** QACAG has previously stated it has long been our experience that the quality of care delivered to residents is determined by the governing body of the providers. At the workforce level, facility directors and staff are not decision makers in terms of funding and they merely carry out their duties within the confines set by the company's board of directors.

The boards of directors of provider companies has historically been primarily compromised of people from a business background. The recent COVID-19 outbreaks in some nursing homes has highlighted that the composition of boards, including the non-inclusion of medical and health professionals and consumer representation, is a significant issue.

Recommendations 52,53 & 54 go some way toward addressing concerns, however, as QACAG has long advocated for improved clinical governance (including both consumers and nurses on boards), references to "care governance" should be replaced with "clinical governance". QACAG is concerned that the omission of the

term “clinical” will mean nurses and other clinical professionals will continue to be excluded from Boards of Directors and governance practices more broadly.

It is the lack of clinical governance that contributed to the issues in the sector which called for a Royal Commission.

QACAG Recommendation: that the recommendations from the Royal Commission change references of “care governance” to “clinical governance”.

Good governance depends upon a balanced approach to board membership. The business-driven approach to aged care can be summarised by the experience of one QACAG member, who, at the time was director of nursing. When visited by a board member was told that the priority of the company was to the shareholders. This was incompatible with their code of ethics leading to their resignation and seeking alternative employment.[3] [4]. Governance must include board members and managers with clinical backgrounds to ensure quality health care outcomes for recipients of aged care services.

QACAG has made a number of recommendations throughout this document to the Royal Commission into Aged Care Quality and Safety. It is hoped the insights of our members assist.

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[3] Nursing and Midwifery Board (2018). *Code of Conduct for Nurses.* NMBA. Accessed 9 July 2020: https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx
[4] Nursing and Midwifery Board (2018). *Registered Nurses Standards for Practice.* NMBA. Accessed 9 July 2020: https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx