QACAG
Quality Aged Care Action Group Incorporated

QACAG SUBMISSION

A new model for regulating aged care.

JUNE 2023

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About QACAG

Quality Aged Care Action Group Incorporated (QACAG) is a community group 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 NSW in 2005 and became incorporated in 2007. Membership now consists of people from across Australia and includes older people, some of whom are receiving aged care in 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.; Council of Elders; Kings Cross Community Centre; Senior Rights Service; Multicultural Communities Council of the Illawarra; NSW Nurses and Midwives' Association; Public Service Association, Carers Circle, Aged Care Reform Now and the Retired Teachers' Association.

QACAG members welcome the opportunity, through this submission, to provide input to *A new model for regulating aged care*.

Margaret Zanghi
President
QACAG Inc.

QACAG members broadly welcome the proposals for a new model and are pleased to see a focus on the provision of quality aged care and enhanced measures to embed consumer voice, putting them at the heart of the regulatory model. This is essential to regain confidence and trust when loved ones enter aged care.

Consumer voice is essential to drive the cultural shift required to raise the quality of aged care. To achieve this, the format of consultations must be accessible, easy to navigate and written in inclusive terms. QACAG members have found this consultation has created barriers to participation. We wish to bring this to your attention ahead of any feedback in the hope improvements can be made:

Consultation Paper No.2

The layout, use of broad terminology, lack of consistent page numbering and formatting of questions in blocks with no numbering continuity or individual identifying headings over-complicates the response process. Having no exposure to the proposals in the New Aged Care Act, nor outcome of the capability review of the Aged Care Quality and Safety Commission hinders feedback, since there is no context in which to provide informed responses.

Webinar 9 May 2023

We attended this expecting some questions to be answered but were disappointed our questions remained ‘under review’ and were never open for others to view or answered. There was no other opportunity to engage through that medium.

We appreciate the efforts made by the Department to engage consumers; however, we believe engagement must be meaningful and appropriate. Whilst we know consultation cannot include every community group, it would be useful for grassroots groups such as QACAG to be specifically consulted, particularly given the breadth of our organisational membership, including those from diverse backgrounds.

We offer the following responses to the questions provided; our recommendations are highlighted in each section:

Raising the Quality of Aged Care

1. **What regulatory interventions are needed to raise the quality of aged care?**

Whilst we support the need to build provider capacity. The Royal Commission into Aged Care Quality and Safety (The Commission) highlighted the risk to consumers where regulatory safeguards are not initiated pre-registration. This leaves potential for things to go badly wrong and relies on risk to be identified through non-compliance rather than prevented. **It is vital enhanced provisions are made to ensure the suitability of individuals to run a nursing home, or home care service are determined prior to registration and monitored as changes occur thereafter.**

2. **To raise the quality of aged care, what role should government and non-government stakeholders play? These include:**
   - **the Regulator and the Department**
   - **providers, workers, professional associations, advocacy groups, unions, volunteers, and community groups**
   - **older people and their representatives**

The regulator and department need to be fit for purpose. Those assessing compliance need to possess the necessary expertise to make informed judgements and triangulate complex clinical and other evidence to determine compliance. **Every direct or indirect assessment of compliance must include a registered nurse with significant experience. To achieve this, the regulatory workforce must be attracted through good working conditions and remunerated according to their level of skill.**

The more stakeholders are meaningfully consulted, the better intelligence will be gathered about compliance or non-compliance. **Requirements for formal consultation with workforce representatives, consumers, families and Carers, other statutory agencies and clinical experts should be embedded in legislation as a pre-requisite when assessing compliance.**

3. **Culture change is key to raising the quality of care aged. Who can be the culture change champions, either at the local or the sector level? What support will they need to champion culture change?**

Consumers, and their advocates, workforce and their representatives and clinical and medical experts are all ideally placed to form Culture Change Champion Alliances (CCCA). They are often able to present a 'live' picture of how services are being delivered at a lower level than a centralised regulatory model. We believe this could easily be established within local health districts, but not necessarily run by them.

A good example of organisations being able to provide a live perspective is found in the voluntary association of organisations in the NSW Aged Care Roundtable, consisting 19 consumer, Carer, medical, clinical and workforce representatives who collectively hold a breadth of local level intelligence regarding the current quality of care being delivered to older people. A model like this, which interested organisations can apply for and memorandums of understanding could work well.

It is essential that any organisation championing cultural change has no ties to the sector either as a board member or provider. It would also be preferable for any proposed CCCA to consist both government and non-government funded organisations as a governance and transparency measure.

CCCA's should be considered as part of local intelligence gathering and embedded in legislation.

Supporting quality care

1. **What are your views on the proposed approach to supporting quality care?**

We are pleased to see the inclusion of consumer engagement as part of the strategy and provision of additional information such as star ratings.

Given we do not yet know the proposed regulatory regime, nor the outcome of the Tune review it is difficult to respond to whether a risk-based approach would be suitable. We are concerned about the current capability of the regulator to manage compliance in that some services can go over four years without a site audit. We do not consider this guarantees a good measure of quality.

2. **What challenges can you identify for implementing the proposed approach to engagement and capability building? What could be the solutions?**

Currently QACAG members participate in consumer facing consultations and workshops, however these are mainly focused on the giving rather than receiving of information. Online platforms used to consult vary and sometimes become inaccessible as they are difficult to navigate. Similarly, MyAgedCare as a platform for information sharing such as star ratings is difficult to navigate.

Although marginally better, the Aged Care Quality and Safety Commission website (ACQSC) also does not provide a single source of truth, with consumers having to navigate between this, and MyAgedCare to make informed choices about aged care, or to seek information.

As consumers, and care recipients, it feels like previous governments have tried to make MyAgedCare work, even when it clearly does not. We believe there is real opportunity to re-frame the provision of information about aged care services in a way that is both informative and user-friendly. **A platform similar to the UK regulator https://www.cqc.org.uk/care-services would be preferable. The**

ACQSC website could be easily modified to accommodate the required information.

3. **How else could provider capability be improved in aged care at the individual provider and sector wide levels?**

Whilst we acknowledge things never run 100% all the time and recognise the value of incident management as a quality improvement measure, we reiterate our position that providers need to be assessed for their competence before they begin to deliver quality aged care services.

The registration of the non-nursing workforce is broadly supported but we recommend consultation with workforce representatives ahead of any proposals being embedded. Ahpra would be a natural organisation to undertake this role.

Nurses are already subject the stringent regulations and codes of conduct. We want to attract more nurses into nursing homes and do not support the over-regulation or duplication of codes of conduct for this category of worker, which has the capacity to put nurses off seeking employment in aged care. We recommend they are excluded.

4. **What types of education or engagement do you think would support providers to continuously improve?**

There should be no demarcation between health care delivered in aged care and that delivered in other settings, with an expectation that standards align with those for other services. For example, benchmarks for management of delirium embedded in the clinical care standards set by the Australian Commission for Safety and Quality in Health Care[1] are equally as applicable in nursing homes.

[1] https://www.safetyandquality.gov.au/standards/clinical-care-standards

Setting different standards is ageist and suggests that health care delivered to older people is somehow different, or of lesser value than that delivered to younger people. Greater linkages within primary healthcare networks and local health districts will help raise standards of practice and quality of care delivered. Ad-hoc education and engagement will not be as effective as having continuous connection to other service provision and expertise within the local area.

Alignment of clinical care standards to other healthcare settings, and greater linkages with primary health networks and local health districts should be embedded into the new regulatory requirements to promote continuous improvement.

5. **How could the Regulator, the Department and providers improve the provision of information to older people and their representatives so that they have access to the right information, at the right time, in the right way?**

See response to Q2 in this section.

Becoming a provider

1. **What are your views on the proposed registration categories?**

The categories appear suitable, we are interested to know where platform care agencies would fit in these.

2. **Which registration category should care management and personal care be in and why?**

We believe this should be determined by risk.

3. **How should online platforms that connect older people to aged care services (but are not themselves Approved Providers) be regulated under the proposed new model?**

We are pleased online platforms are being considered. Online platforms should be included even though workers may not be paid for using commonwealth funds. This does not mitigate risk to consumers using this model of service delivery. As these workers may provide direct care or nursing services it is logical people receiving these services should be subject to similar safeguards to those provided through commonwealth funded services.

There is a shortfall in commonwealth funded home care, and existing providers are often unable to deliver flexible aged care. The use of platform providers is likely to grow and thrive in these conditions. **If not considered in this regulatory model, online platforms connecting workers to consumers should be considered relative to the new Aged Care Act.**

Anyone providing direct care could be subject to proportionate regulation, with obligations to ensure qualifications, education, professional registration, work health and safety and other risks are mitigated through the platform agency.

It is unacceptable a platform agency can withdraw responsibility for the care delivered via a disclaimer when there is so much inherent risk to consumers if things go wrong. Platform agencies charge fees to both worker and client but have no responsibility for the quality of services delivered. In no other context would this be deemed acceptable.

The discussion and linkages made in the following could be of value when exploring where this type of care delivery could sit relative to regulation
https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/BriefingBook47p/GigEconomy

4. **What are your views on how the proposed model will allow other business types, such as sole traders and partnerships, to enter the sector?**

The suggested model of proportionate regulation tied to each provider category has merit.

5. **What, if any, alternatives are there to 3-year re-registration periods, and why would they be appropriate?**

The first year of operation is a good indicator of capability and a provisional license could be given for the first year with closer scrutiny by the regulator and other parties such as the CCCA measures considered in an earlier section. We agree with the recommendation that any significant change to the organisation and its personnel should require a variation to registration.

6. **What challenges can you identify for implementing the proposed registration model? What could be the solutions?**

The challenge will be the ability of the ACQSC to administer the program, this will require its workforce to be skilled and remunerated appropriately. We believe stakeholder engagement to be key to moderating risk and recommend a model be proposed such as the CCCA measures.

Responsibilities of a provider

1. **What are your views on the proposed approach to provider obligations?**

The Statement of Rights will need to be embedded in legislation and understood by workforce, consumers and families. Although the workforce has a role to play in upholding rights, as part of the regulatory framework workers need pathways to raise concerns in good faith if they believe rights are not being upheld. **The role of whistleblowing protections is key but need to be enshrined in legislation**

which is not prohibitive should a worker perceive they have been subject to negative action following an allegation made in good faith.

2. **What challenges can you identify for implementing the proposed approach? What could be the solutions?**

There is scope to make required improvements to the quality of care people receive through these proposals. The challenge will be to ensure conditions and obligations are legally measurable. This could be overcome through **application of SMART principles to quality standards, guidance, and legislation so everyone is clear what compliance looks like, the test of compliance and what non-compliance looks like.**

3. **Do you think there are any key areas of risks that are not addressed by the core conditions proposed to apply to all providers?**

See response to Q2 in this section.

4. **Are there any other category-specific obligations that you think should apply?**

Choice and control, privacy and dignity, complaints and workforce-specific requirements should apply across all categories.

5. **What are your views on the proposed application and audit of the Quality Standards to categories 4 to 6?**

We are disappointed the recently released revised Quality Standards offer very little improvement on the last version. QACAG is well connected through the consumer advocacy space and there is consensus that the consumer voice has once again, not been heard. The Quality Standards seen to have been a done deal well ahead of any consultation.

We reiterate our view the Quality Standards are too broad containing ideological statements which are well-intentioned but provide little direction to workers, consumers, providers or regulators and provide weak regulatory benchmarks.

The challenge for any regulator will be whether the care delivered constitutes a breach of the legislation. Generalised statements such as 'act in a way that treats people with dignity and respect and values their diversity' are difficult to quantify. **We recommend a 'litmus test' approach is applied to all these statements using criteria such as:**

- **How can this be measured?**
- **What would be the evidence required (triangulated)?**
- **Is this expectation easy to communicate and be understood by consumers, workers, providers and regulators?**
- **What would non-compliance look like?**
- **Is this legally enforceable?**
- **What would the legislation need to say?**
- **What evidence would be required to test a perceived breech (triangulated)?**

In relation to the clinical care standards we believe these should be consistent with standards that apply to other settings in which health care is delivered.

We disagree that the quality standards as presented on p51 are strengthened from previous versions. We believe they would be very problematic to evidence and enforce and need to be far more prescriptive.

The new Act must embed workforce requirements more explicitly as there is clear evidence through the Royal Commission to support providers only utilise the minimum level of workers required for compliance. This is owing in part, to the lack of required and legislated ratios for numbers and skills mix. This is only partially

addressed through AN-ACC funding changes and Direct Care Minutes. Low staff and skills mix are precursors to poor quality care.

A good example of this is within Direct Care Minutes which currently fund enrolled nurses with minutes for all other workers such as personal carers and assistants in nursing. Since enrolled nurses are regulated and more costly, rather than seeing the benefit they bring to creating a well skilled clinical workforce, they are being removed in favour of cheaper alternatives.

6. What does high quality care mean to you?

- it is proposed that high quality care be defined as the delivery of aged care services to a person in a manner that **prioritises**:
    - delivery of services with compassion and respect for the individuality, life experiences, self-determination and dignity of a person accessing care, and their quality of life
    - providing services that are trauma aware and healing informed and responsive to the person's expressed personal needs, aspirations, and their preferences regarding how services are delivered to them
    - facilitating regular clinical and non-clinical reviews to ensure that the services delivered continue to reflect their individual needs
    - supporting the person to enhance their physical and cognitive capacities and mental health where possible
    - supporting the person to participate in cultural, recreational and social activities, and remain connected and able to contribute to their community.

We provided this definition and asked our members to respond to this question, since many are care recipients and carers. The following feedback was provided:

"We don't need just motherhood statements but follow up with tangible and measurable requirements. Don't just make statements – things need to be quantifiable".

"Homely and safe – somewhere we don't feel guilt putting a loved one into".

"High quality is achieved when people receive professional care including nurses and allied health. Where all care and services are provided to meet individual needs. We know what it's not".

"The above definition that you sent us earlier is beautiful on paper, but with only two CSEs for 16 or 20 residents (afternoon three CSEs for 36 residents), I would question how on earth this definition can be met. Also how do you measure them?"

"Remembering my times in several facilities with students I feel quality care looks like having the staff to ensure residents are dressed in warm clothes and carers have time to take them for a walk in the sun, sit and have coffee with them, smell the flowers and chat".

Holding providers accountable

1. **What are your views on the proposed features of this safeguard that seek to hold providers accountable?**

We support the move towards a rights-based approach and strengthened enforcement powers for the regulator. However, as previously stated, these will be words on paper if the legislation and standards do not provide direction or clear expectations and lack detail sufficient to pass the 'litmus test' of compliance.

The current regulator has not performed well, the same regulator failed to take the necessary measures to prevent the abuse and neglect uncovered through the Royal Commission. It will take a lot of convincing for consumers to have

confidence this entity can manage risk appropriately. It is our experience that we are less engaged with the regulator now than in the past. There is less, not more scope to gather consumer input even with the Royal Commission findings. **We would need assurance, built into legislation, that broadened stakeholder engagement is a key resource for measuring compliance.**

2. **Do you think the proposed new complaints model will help older people to raise concerns about the standard of services and have them addressed? Please include your reasons for this view.**

The proposals in the new model have potential to assist consumers and their representatives to raise concerns and we look forward to seeing the detail of the enhanced whistleblowing protections. **The complaints system needs to be transparent particularly given the proposed move towards a more risk based regulatory regime.**

The system for managing complaints to providers should require providers to complete standard documentation with a copy sent to the regulator and a copy to the complainant. The regulator would not necessarily have to investigate but should triage every complaint. The number and nature of complaints could be logged centrally so it assists intelligence about the service. It also provides a starting point for the regulator to assess compliance on site audits, including the triangulation of evidence.

The four-part complaint model does not include a pathway for workers. **The workforce is often best placed to identify concerns, a similar system must be considered for their concerns.** This will enhance any whistleblowing protections and is good evidence should there be any adverse consequences for the employee relative to their employment.

The penalty measures to deter retaliation are promising but may be difficult to regulate, we would be interested to know how the regulator will monitor and assess against retaliation particularly in relation to workers.

We have heard many examples of working conditions, particularly relative to staffing and skills mix, which place registered nurses and enrolled nurses at risk because they are working in conditions that compromise their ability to comply with their professional obligations. Examples might include being unable to complete necessary paperwork within the shift, or failure to administer medication in a timely manner due to workloads.

In these scenarios workers options are to seek alternative employment which compounds workforce shortages in aged care, or to complain to their employer leaving them exposed in the workplace. In extreme cases they may lose their registration. Nurses should have a system which allows any situation which potentially compromises their ability to work within professional guidelines to be reported and result in immediate remedial action.

There should be a confidential reporting pathway for nurses to report an employer who may be compromising professional standards. This should result in immediate remedial action being taken by their employer and must be an essential element of any quality standards as a measure of compliance. There is no value in requiring RN 247 if the nursing care is compromised.

The current complaints process, whilst allowing concerns to be raised anonymously, often cannot be properly investigated, or by their nature identify the source albeit by default. This will always be a challenge but requires consideration in any complaints process and would be one of the measures we would expect from a new system that protects against reprisal.

Omitting workforce specific standards from proposed quality standards and previous versions has been a significant oversight. This is a good example of why it is important to embed a workforce quality standard.

3. **Do you think the proposed enforcement mechanisms will be sufficient to address poor performance by providers where required?**

See response to Q2. in this section. In addition, enhanced enforcement powers will only be effective if the measures used to test compliance are measurable and systems to report concerns safe. We also refer to our response to Q5 on p11 of this response for detail.

4. **How should restorative justice outcomes be reflected in the new Act?**

Since the new Act will have a human rights focus the outcomes and restorative measures must be tied and proportionate to those rights.

5. **How and when do you think access to financial compensation should be available?**

This is dependent on the matter being investigated. If the matter has resulted in loss of finances, a two to four week time period to be financially compensated must be applied to ensure people are not forced into financial hardship.

6. **What role should the Regulator have in seeking compensation on behalf of older people?**

The regulator should have a role by requiring the provider to act appropriately in all matters, including in the provision of any compensation due.

Transitioning to the new model

1. **What are your views on the proposed transition arrangements?**

We advise caution in implementing these arrangements until the capability issues with the current regulator, and ambiguity of Quality Standards have been resolved.

2. **What challenges can you identify for implementing the proposed transition arrangements? What could be the solutions?**

Knowledge about the new regulatory regime will be key to its success and we suggest a **wide public education strategy is utilised and appropriate to the demographic e.g. include CALD appropriate information and communication**.

3. **What support do you need as a provider to help you with a smooth transition to the new model?**

N/A

4. **What other transitional arrangements need to be considered?**

Education of workforce. We also believe **this strategy should be delayed until the Act and associated guidance materials are finalised, meaningfully consulted upon and communicated.**