QACAG SUBMISSION

Consultation on strengthened quality standards for aged care and associated framework

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About QACAG

Quality Aged Care Action Group Incorporated (QACAG) is a grassroots community activist 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 2005 and became incorporated in 2007.
Membership 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.; Kings Cross Community Centre; Senior Rights Service; Multicultural Communities Council of the Illawarra; Public Services Association; Carers Circle; Aged Care Reform Now; NSW Nurses and Midwives' Association and the Retired Teachers' Association.

QACAG members welcome the opportunity, through this submission, to provide input to *the strengthened quality standards for aged care and associated framework*. To ensure the consumer voice is carried in this submission we held a caucus for members, held individual conversations, invited handwritten and electronically submitted feedback and sought feedback from our organisational membership which includes consumer and workforce representatives. The feedback received is incorporated throughout.

Margaret Zanghi

Margaret Zanghi
President
QACAG Inc.

Recommendations

1. Standards should only be written in terms that are measurable providing clear benchmarks from which to regulate compliance.

2. Standards must be enhanced to include a section on safe medication practices, including providing guidance on the role of unlicensed care workers.

3. In recognition of the Royal Commission findings around staffing, an additional standard focusing solely on workforce must be set. This should include:

    - the setting of numbers and skills mix of workers, including registered nurses, enrolled nurses, allied health/lifestyle and care workers.
    - Ways in which nurses can be supported to maintain their professional obligations.
    - Separate systems and pathway outside of complaints and whistleblowing for workers to raise concerns about non-compliance with care minutes and RN 24/7 responsibilities.

4. The regulator, and regulatory system must be capable and well resourced.

Standards should be measurable and provide clear compliance benchmarks

Standards must be aspirational but not at the expense of them being measurable. They need to be easily measured and enforceable. Currently they lack sufficient detail to enable benchmarks to be set, creating difficulty for providers, consumers, workers, and regulators to clearly determine what compliance looks like.

The language through all standards and associated documents is difficult for consumers to interpret. It would be useful for a simplified easy-read version to be developed of all resources so older people and their families are clear about what standards they should expect, and what system there is to ensure compliance.

Standards must be enhanced to include a section on safe medication practices, including providing guidance on the role of unlicensed care workers.

With every version of the standards, detail around the requirements for safe medication practices have been erased, yet we know medication safety is a top concern for our members and the public more broadly as evidenced through Aged Care Quality and Safety Commission (ACQSC) reports.

Whilst commonwealth best practice documents[1] imply medication management is a nursing role, they do not go so far as to say that only registered nurses or enrolled nurses acting under the supervision and delegation of a registered nurse are the most appropriate person to administer medications.

There is much confusion amongst workers about what is *assisting with self-administration* of medicines which QACAG believes can be adequately performed by care workers with education and training, and *administration* of medicines which should only be undertaken by nurses. This could be overcome by providing these definitions within the guidance materials, so everyone is clear on their roles and expectations. Medication safety is a top area of

[1] https://www.health.gov.au/resources/publications/guiding-principles-for-medication-management-in-residential-aged-care-facilities

consumer complaint and additional safeguards should be articulated through the standards and guidance materials.

In recognition of the Royal Commission findings around staffing, an additional standard focusing solely on workforce must be set.

The proposed standards rightly focus on what older people should expect as a minimum care requirement, and place expectations on workers to achieve this. However, placing responsibilities on workers without providing optimum conditions of employment for them, will only lead to non-compliance.

This should include as a minimum:

- the setting of numbers and skills mix of workers, including registered nurses and enrolled nurses, lifestyle, and allied health workers through direct care minutes.
- Ways in which nurses can be supported to maintain their professional obligations.
- Separate systems and pathway outside of complaints and whistleblowing for workers to raise concerns about non-compliance with care minutes and RN 24/7 responsibilities.
- Measures to ensure the psychological and physical safety of workers.
- Induction, training, and supervision of workers, including off-site education and training where required.

Having a separate standard for workers will shine a spotlight on their needs and enable workforce requirements to be articulated in the regulatory framework and monitored through risk assessment and site audits. A standard for workforce has been provided for in a UK context, suggesting it is possible to provide for both in aged care standards and associated legislation[2].

[2] https://www.cqc.org.uk/guidance-providers/regulations/regulation-18-staffing

The regulator, and regulatory system must be capable and well resourced.

QACAG members consider a large proportion of care delivered in nursing homes, is clinical care. It is vitally important auditors, and those assessing reports from providers as part of risk assessment, have the right clinical background knowledge to interpret the information and how it translates to quality of care.

Case tracking methodology should be a key feature of the regulatory framework, with both random and planned selection of older people to track. Care plans, risk assessments and associated documents such as medication charts should be mapped against the persons actual needs, determined through consultation with them and/or direct observation, and discussion with workers, family/visitors and management. This will require highly skilled and experienced registered nurses and allied health professionals to interpret information and make informed judgements.

The experience of those conducting site audits and interpreting risk is important. Fundamentally, no system will be effective if the ACQSC lacks capability. It is important the ACQSC receives sufficient funding to enable them to employ and retain experienced registered nurses and allied health professionals to be able to determine whether clinical care needs are being met.

Additionally, those employed to determine compliance should have no conflict of interest. We are aware through media reports, of external auditors who have had links to the aged care industry through other consultancy work, being used by the ACQSC. The public expectation is that regulation of aged care is transparent and robust.

Whilst we broadly support a risk-based approach to regulation, risk analysis is only as good as its data inputs. There is over-reliance on provider self-reporting and not enough on feedback from workers, consumers, and families. A QACAG member working at a nursing home for over 20 years has never been consulted by auditors despite being the most familiar with day-to-day operations. Governance systems to receive regular feedback from all parties should be embedded in the standards, with independent reports going to the ACQSC quarterly, in the same way providers report on Serious Incidents (SIRS) and Quality Indicators (QI's).

It is important to have the benefit of independent visitors, like the Official Visitor Program[3]. Whilst QACAG members acknowledge this requires careful consideration, we are also cognisant of the fact there is little time on site audits to conduct meaningful conversations with people using the service and their families. Having someone available, with dedicated time to speak with people would enhance the quality of feedback received.

Risk-based systems must not detract from a regular program of site visits to determine compliance, which should be unannounced. Both the staff and resident cohorts can experience high turnover, it is possible that an older person receiving aged care in a nursing home may never have a quality assessment of their service during their tenure. This could result in substandard care being the norm for the entirety of their aged care journey. This is unacceptable. Only through observation of the day-to-day operation, and direct discussion with visitors, older people and staff who care for them, can true experiences be determined.

Our members report that site audits continue to be announced, and this allows a false picture of day-to-day operations to be presented. Our members would support all site audits being unannounced initially, with further planned visits to catch up on paperwork to minimise disruption. A larger percentage must occur out of hours.

[3] https://inspectorcustodial.nsw.gov.au/official-visitor-program.html