QACAG
Quality Aged Care Action Group Incorporated

QACAG SUBMISSION

Design and early implementation of residential aged care reforms

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About QACAG

Quality Aged Care Action Group Incorporated (QACAG) is a grassroots 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 NSW in 2005, became incorporated in 2007 and now has individual and organisational members from across Australia. 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.; 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 consultation, to provide input to the *design and early implementation of residential aged care reforms*.

Margaret Zanghi
President
QACAG Inc.

QACAG has a diverse membership and has consulted its membership in the following ways to ensure every member has been provided the opportunity to engage in a suitable format regarding this consultation:

- E-mail communication
- Extraordinary online meeting
- Telephone conversations

From your correspondence we understand the audit will examine:

- Whether the Department of Health and Aged Care provided robust policy advice on residential aged care workforce reforms.
- Whether the Department of Health and Aged Care effectively introduced the new workforce requirements; and
- Whether the regulatory system is prepared for the new requirements.

We do not believe the Department has provided **robust policy advice on workforce reforms** for the following reasons:

Lack of consumer and worker voice

Consumers, including families and carers experiences of the aged care system, and those employed in the aged care workforce are the most accurate measure of quality and whether workforce arrangements are adequate. However, consumer and worker voice has been silent throughout the past 10 or more years in aged care reforms. Without these perspectives, reforms are built on bureaucratic systems which are often audit-based and lack experience focus.

There has been a narrowly utilised draw pool on which to gain consumer perspectives. Preferred consumer advocacy organisations have included one which has a history of being a shareholder in a platform care agency, having lobbied strongly for its value using its political contacts. Potential conflicts of interest appear to be ignored, further reducing true consumer voice.

Failure to embed broad consumer representation has hindered quality improvements. The same organisations who represented consumer voice before and during the widespread neglect uncovered through the Royal Commission into Aged Care Quality and Safety (Royal Commission) remain the first choice of the Department and are embedded in many advisory committees, existing and newly proposed.

Whilst impossible to facilitate inclusion of every consumer representative, transparency measures must be strengthened when selecting advisory bodies, and we suggest including organisations that do not rely on government funding. We hope through this review, a recommendation will be made to examine the effectiveness and value of existing consumer representation relative to the timeline and findings of the Royal Commission.

There has also been over-reliance by the Department on provider representation as a source of policy guidance at local level. An example would be in NSW where the state regulatory branch of the Department meets with stakeholders quarterly after a three-year hiatus attributed to the pandemic. We were made aware at a recent meeting the Department has a regular one to one meeting with the state representative of the peak body ACCPA, yet we do not. We also understand they do not have similar meetings with workforce representatives.

When attending meetings with the Department our experience is one of information giving rather than receiving, with overly complicated online voting and Q&A systems which hinders participation since many of our members are retired and not used to communicating in this way, or using these programs. This biases consultation opportunities.

A similar experience has been had relative to engagement by the Aged Care Quality and Safety Commission (ACQSC). Consumers and workforce representatives, rather than being consulted have been met with a barrage of information giving sessions labelled as consultation opportunities. Or not engaged at all. Not having the full 360-

degree perspective is a fatal flaw which has neither been identified nor rectified leading to ill-informed policy decisions regarding workforce.

Capability

In formulating policy, the Department would take advice from the ACQSC. However, we believe there is lack of connectedness of the regulator with consumer experience for a variety of reasons.

It has been clearly demonstrated there are widespread capability issues both structurally and operationally with the ACQSC. We believe this has contributed greatly to the lack of accurate and constructive advice about what improvements are needed to drive workforce improvements. People receiving services, and those caring for them formally or informally, have not been central to policy reforms. We have heard much about embedding a human rights approach to aged care, but the system for regulating care is inherently flawed in existing and new proposals.

Basing policy on proportionate regulation through risk-reporting creates a system reliant on failure, rather than prevention. For older people, particularly those requiring residential care, a failure could prove life-limiting. What we have seen of the proposals for a new system of regulation this has not been addressed. We have made a submission outlining ways in which we see a human rights approach working, including embedding consumer and worker voice and the need to implement an additional workforce standard which is measurable and enforceable.

The Royal Commission, and again through the Tune review (yet unreported) provided a window of opportunity to develop a world-class system for regulating the aged care sector. Unfortunately, the messaging so far suggests we can expect tinkering around the edges of a failing system rather than true structural reform.

In relation to whether the Department **effectively introduced the new workforce requirements**, we have been pleased with the approach of the Federal Government in implementing and funding registered nurses 247, care minutes and transparency measures. We consider there is potential within reforms to create real change, but

reforms need to go much further than current proposals. We will expand in our response to the targeted questions you provided.

The impact of direct care minutes on resident experience

We are fortunate our membership includes those currently receiving services and in the current nursing and care workforce, enabling us to draw on their experience of what is happening in real time. We have been informed the measures implemented by the Department have not been effectively communicated to those working directly with residents. This means worker voice and the ability to be advocates is inhibited, since they are not able to understand with any degree of accuracy how direct care minutes should and are being implemented and interpreted at a local level.

For example, one nursing home had informed workers to work certain hours, but the hours recorded on the rota were longer. Similarly, it was reported there are names on a rota of workers who are absent from providing direct care. There is inherent risk of direct care minutes being manipulated, even with payroll data collection. Workers are ideally placed to be able to provide intelligence to the Department but lack education on what is right and wrong.

Empowerment of workers is key to ensuring workforce requirements produce the best resident outcomes. If they are enabled to understand the care minutes, they can provide true advocacy.

Similarly, the ACQSC can only go on information providers give. They need qualitative as well as quantitative information. All visits must be unannounced so a true picture of the effectiveness of workforce measures can be established. Our membership participated in a past pilot of ‘experts by experience’ whereby a consumer perspective could be gained on site visits, but this project although having much potential, was never further developed by the Department.

We also consider there is a lack of transparency in ensuring sufficient workforce at a provider level. Each nursing home would benefit from a Director of Nursing who is professionally accountable to ensure a suitably qualified health professional is there to drive clinical governance. Only a registered nurse can look at the skills mix against

the care needs of residents and assess if the staffing and skills mix is sufficient. The drive to employ care managers without nursing qualifications has impaired the ability of the worker to ensure workforce requirements are sufficient.

"I haven't noticed any impact of direct care minutes at all, many residents require two CSEs to provide care as their conditions worsen including, for example, using the hoist. The CSEs are running off their feet, as I visit every day and make my expected standards well known, the CSEs generally attend to my buzzer first, that means those residents who have no families there with them, the CSEs would attend their care needs to their best ability when they can (2 CSEs for 20 or 16 residents). I provide all hands-on care while I am there, I can't imagine (my loved one) will receive the same amount of care when I am not there." QACAG member.

"If there was lots of time with each resident it would allow for unrushed showering, drying and dressing. I saw this in the weeks I took Uni students into facilities when I was a facilitator. The students were all extras but able to help the care staff. Hair is dried properly, then combed and styled; feet are dried thoroughly esp. between the toes. Residents are dressed in warm clothes, not left shivering, waiting for a rushed care worker to help. Then of course removing dentures, cleaning them and helping the resident put them back in their mouths. Those with dementia often found this a lengthy, difficult task. Teeth were often put in upside down or sideways. Similarly cleaning hearing aids and helping the residents to put them back in their ears can be very time-consuming." QACAG member.

Whether we are satisfied with the consultation opportunities around RN 247 and care minutes

Our members have subscribed to various stakeholder webinars and consultations. Our findings have been these are slanted towards certain people, with questions which are provider focused given priority and any opposing views unanswered or left as pending. Often opportunities marked as engagement by the Department end up as information giving sessions with limited time to ask questions and no other opportunity given to interact.

We believe a fake front is given to consumer engagement and most of our members feel their concerns haven't been heard or taken on board. The current consultation on regulation is a prime example, with a consultation document that presents as a fait accompli, like being guided towards something that's already happened.

"I feel politicians are totally disinterested yet they are the ones deciding on the minutes required to care for our ambulant and bedridden aged." QACAG member.

Whether we have seen any improvements in care outcomes recently and extra staffing

Our members currently working in aged care or visiting believe there are still staffing shortfalls. Providers are using care minutes as an optimum not an average to be surpassed as need dictates. We are concerned that meeting care minutes will be viewed as best practice when they are essentially just a bare minimum to keep residents safe. It is essential the ACQSC reward those who are providing over and above that minimum.

The current push to meet care minutes has an unintended consequence of onboarding many new staff who are unfamiliar with residents and their routines. Staff being brought in from overseas is a concern because we do not consider enough focus has been given to ensuring workplaces are culturally safe environments, meaning workers may be exposed to racism and exploitation.

Whilst we welcome diversity, it will be important to ensure new workers have appropriate support. We welcome the Federal Government initiative to ensure employers engage with unions and signpost new arrivals. However, this is just one of many measures that will be required. Movement of workers from overseas will lessen worker empowerment and its essential they are provided with protections and a voice.

Our members believe the Department need to change the mindset around aged care. Considering aged care as somehow separate to health care delivered in other contexts such as medical wards, mental health and rehabilitation is ageist policy and

inconsistent with a human rights focus. We believe staffing and skills mix needs to align with other settings in which health care is delivered such as public hospitals.

We believe the establishment of care minutes and registered nurses 247 has been a positive start and we are pleased the Federal Government is pressing ahead with reforms. There remains an ongoing issue regarding the omission of enrolled nurses from direct care minutes and funding. Our members believe their role is crucial to support registered nurses to deliver optimal health care. One single registered nurse cannot possibly meet the totality of health care needs of a resident cohort. Having enrolled nurses ring-fenced in direct care minute funding would enhance quality and resident experience.

Our members experience may suggest there is some manipulation of care minutes occurring as previously mentioned. The following comments also identify areas where the Department may need to focus its attention.

"There is concern about how the direct care minutes are going to be measured when there are generic Cert III and IV care workers who do work which cannot be strictly considered "direct care". For example, the Household Model does not use an easily identified direct care role, the worker is expected to do cooking, cleaning, laundry, so what proportion of that shift can be used to contribute to the direct care minutes? An assistant in nursing (AIN) job description focuses solely on direct care under a registered nurse so it's easy to determine that a seven-hour shift for an AIN can contribute to direct care minutes." QACAG member.

"The extra staffing that I noticed was to look after the visiting appointments and follow up the entrance requirements for visitors and staff, such as RATs, supply masks and face shields etc. since COVID. They are there from 9:30am to 3:30pm, weekend shorter hours. One afternoon RAO (Recreational Activity Office) and one RAO for the dementia wing during the morning, whereas no RAO for afternoon/evening and no RAO for the dementia wing. I haven't seen any extra staff for the provision of direct care." QACAG member.

Finally, in relation to **whether the regulatory system is prepared for the new requirements**, we would reiterate our earlier point, that the current and newly proposed system for regulation is inherently flawed. It neither provides tangible and measurable workforce expectations, nor embeds a system whereby workforce adequacy can be tested using a human-rights based approach.

We consider this can only be resolved through implementation of a separate workforce standard which is both measurable and enforceable, and through a regulatory system which starts with the person and whether their plan of care is being met, and is not reliant on reporting measures such as falls, complaints and weight loss.

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