QUALITY AGED CARE ACTION GROUP INC

QACAG Submission

COVID-19

31 July 2020

About QACAG

Quality Aged Care Action Group Incorporated (QACAG) is a community action 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.

Margaret Zanghi
President
QACAG Inc.

QACAG members welcome the opportunity to provide input into examination that COVID-19 has had in the aged care sector. We are pleased that this Royal Commission is continuing. However, we are concerned that its valuable conclusions and recommendations might become lost within post-pandemic rhetoric and fiscal decision making.

The pandemic has certainly highlighted the vulnerability of aged care residents, and the need to better integrate aged and heath care at state level. The sector is on record as acknowledging it simply is not equipped to provide hospital type healthcare. We agree. However, we do not attribute current failings to the pandemic. Rather it is a symptom of long-standing rationalisation of aged care budgets, ageist policy and a sector more concerned with profit than care. Mandating that boards of directors of RACF must have a balanced mix of business, medical, nursing, allied health and consumer representatives would go a long way toward ensuring more appropriate decision are made within the sector.

It is no secret that people residing in aged care facilities are getting older, and frailer. Indeed, it is government policy to ensure wherever possible, people are able to stay longer in their own homes. However, the government, and aged care sector cannot have it both ways. If residential aged care is intended to cater for the most vulnerable, it must be funded and staffed accordingly, and receive a level of clinical governance consistent with public hospitals.

It is our belief, and to a certain extent evidenced in the higher number of coronavirus infections arising in private, compared to public run aged care in Victoria, that had aged care been subject to the same staffing and clinical care standards and governance as a public hospital, we may be seeing a much improved picture in relation to the current outbreak.

Since its inception QACAG has advocated for government mandated ratios of nurses to residents in Residential Aged Care Facilities (RACF), with a good skill mix of Registered Nurses (RNs), Enrolled Nurses (ENs) and Assistant's in Nursing (AINs, or care workers). We have emphasised the essential clinical skills which RNs

provide and the necessity for good clinical governance. The need for such support to be in place has become glaringly obvious during this pandemic.

During this time the Australian public have been confronted by the many sad facts concerning the management of COVID-19 residents in RACF. We have been made aware of facilities where response to the illness has spiralled out of control and the Aged Care Quality and Safety Commission (ACQSC) response has been slow, resulting in prolonged situations.

We are aware that aged care providers have been awarded several substantial one-off payments by the federal government during the pandemic to cover associated costs. Also that the government is offering free supplies of personal protective equipment (PPE) and surge staffing at no cost where needed. However, we are also aware there are several aged care providers who continue to make staffing cuts, on the basis their occupancy has reduced owing to the pandemic. If the additional pandemic payments have not been used to purchase PPE, or to secure surge staffing we would question where these one-off payments have been spent.

We would seek transparency around the utilisation of pandemic payments. Also justification why some providers are making staffing cuts at a time when experienced staff are at their most valuable. Recommendations

"Tragic though the crisis is in Victorian aged care homes, this may be a turn-around in public awareness about the state of play and the time has come for closer accountability of how the providers use the LARGE sums of money given to them by the taxpayers. Better pay for aged care workers and staff patient ratios. I notice that the figures for infections in Government run homes ,where there is better staff resident ratios, is less than the private ones. That in itself says a lot".
QACAG Member

The members of our group who have professional nursing qualifications and clinical experience have observed that at the first sign of COVID-19 amongst residents, providers should have actively sought out the services of experts in infection control to carry out an audit of their practices and to offer education to the staff. Our

members have expressed their concern that in facilities with poorly qualified staff and lacking the supervision of a clinical manager, symptoms went unnoticed and necessary responses to the residents and to infection control resulted in the tragic consequences that have been documented.

It is on the public record that public health experts, globally, have been warning of the inevitability of a global pandemic for years. Previous outbreaks, including (but not limited to) SARS, should have signalled governments to prepare the responses of government, industry and society more broadly, in readiness for the current pandemic.

Given the high acuity of the resident cohort in RACF there should be recognition that RACFs are clinical environments and there must be a requirement for a clinical expert in every facility. Something that could be achieved if a Director of Nursing position was required.

Media coverage on a Western Sydney RACF demonstrated how the COVID-19 pandemic has revealed limitations of regulation by the ACQSC. The RACF passed ACQSC accreditation standards prior to COVID-19. After the outbreak, the ACQSC identified evidence of lack of infection control policies and issues around responses to concerns raised by residents and their families. Those in our society receiving aged care services are amongst our most vulnerable cohort, requiring a highly trained and skilled workforce. An investigation into the failures of the regulator to identify gaps in infection control knowledge and systems, and the impact this had on resident safety should occur.

We are concerned about the lack of consistent and compassionate advice on visiting arrangements throughout the pandemic. Thanks to organisations such as OPAN there have been some improvements. The lack of trust the public has that aged care providers can deliver quality care only heightens the need for people to access their loved ones.

In addition, the sustained depletion of skilled workers in aged care, and lack of staffing ratios means our members have little confidence our loved ones would

receive the necessary care and treatment unless we, the unpaid and voluntary workforce are there to assist them with meals and personal hygiene.

"I was unable to visit my husband for four days in early March, then I emailed to management, signed a declaration that myself and our personal carers will comply with all infection control procedures and precaution measures… I had been approved by the facility to visit more than two hours. I have to go straight to the room and not go anywhere until I leave and walk straight to the front entrance. The care is much the same, but the staff have to do more, such as put our home-cooked lunch in the fridge on my arrival, reheat our meals at lunch and bring the tray to our room. With adequate clinically trained staff and rigorous infection control practices in place this scenario need not occur in the first place. I have been able to visit my partner daily so far… I comply fully with the restrictions and precautionary measures, including go straight to my husband's room till leaving. I was recently provided with a mask and I supply a mask for our personal carer. The rules can change anytime, it depends on the pandemic!"
QACAG member

Robust systems should have already been in place to ensure that access to family members (particularly next of kin) remained. The current Royal Commission into Aged Care Quality and Safety has highlighted the vulnerability of those in RACF, the systemic inadequacies that exist from aged care providers and, as a result, the need for residents and recipients of aged care to have access to those who are their advocates and their voice.

QACAG is concerned about the Aged Care Assistant (ACA) role proposed by Leading Aged Services Australia (LASA). The training is provided by Altura Learning and takes 10 hours to complete. Issues identified from the Royal Commission into Aged Care Quality and Safety and during the Covid-19 pandemic have identified that more RNs and ENs are required in aged care to identify and respond to clinical issues in a timely manner. QACAG also sees no justifiable reason to add another tier to the aged care workforce beyond what AINs already provide. In addition, there has been no consultation more broadly, regarding this additional workforce group.

Mable has been engaged by the Australian Government for the aged care workforce to source additional workers through Mable's online platform. There are concerns about why a single service has been used to supply staff to the sector and why no transparent tendering process occurred.

QACAG recommends that all RACF and other services providing aged care services in a private home or other community setting have adequate numbers of RNs and an evidence based skill mix including ENs and AINs. Any supply of additional staff to the sector should not be provided from a singular entity (Mable) and the process needs to be transparent.

QACAG also recommends the staffing model presented by the Australian Nursing and Midwifery Federation, along with Flinders University and the University of South Australia. This research provides a model of care that would aid appropriate responses to events such as COVID-19 and provide robust quality care more broadly, as outlined in their report 'National Aged Care Staffing and Skills Mix Project Report 2016'[1]. Those in RACF and receiving aged care services are amongst the most vulnerable in our community. As such, highly trained clinical staff are required to respond promptly and effectively particularly in a COVID-19 world. With effective clinical knowledge, outbreaks of COVID-19 in staff, residents and visitors will be prevented and contained and effective processes will be implemented that allow next of kin and other significant others access to residents in RACF.

[1] 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 http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

Recommendation 1:

Consideration should be given to mandating that boards of directors of RACF must have a balanced mix of business, medical, nursing, allied health and consumer representatives.

Recommendation 2:

RACF must have staffing ratios based on evidence based practice recommendations of clinical staff to residents/clients. The “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” provides a useful template.

Recommendation 3:

RACF must be funded and staffed to receive a level of clinical governance consistent with public hospitals.

Recommendation 4:

RACFs are clinical environments and there must be a requirement for a clinical expert in every facility. A Director of Nursing position should be a requirement.

Recommendation 5:

An investigation into the failures of the regulator (ACQSC) to identify gaps in infection control knowledge and systems, and the impact this had on resident safety.

Recommendation 6:

Robust systems must be implemented to ensure that access to family members (particularly next of kin) remain.

Recommendation 7:

Regarding the ACA role proposed by LASA, QACAG sees no justifiable reason to add another tier to the aged care workforce beyond what AINs already provide. In addition, there has been no consultation more broadly, regarding this additional workforce group. Therefore, rigorous consultation must occur across the aged care sector.

Recommendation 8:

An investigation should occur into why a single service (Mable) was used to supply staff to the sector during the COVID-19 pandemic. Why did no transparent tendering process occur?

Recommendation 9:

QACAG recommends that all RACF and other services providing aged care services in a private home or other community setting have adequate numbers of RNs and an evidence based skill mix including ENs and AINs. Any supply of additional staff to the sector should not be provided from a singular entity (such as Mable) and the process needs to be transparent.

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