



Australian College of Nursing

AUSTRALIAN COLLEGE OF NURSING (ACN) SUBMISSION TO THE
SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY INTO THE EFFECTIVENESS OF THE AGED CARE QUALITY
ASSESSMENT AND ACCREDITATION FRAMEWORK FOR
PROTECTING RESIDENTS FROM ABUSE AND POOR PRACTICES,
AND ENSURING PROPER CLINICAL AND MEDICAL CARE
STANDARDS ARE MAINTAINED AND PRACTISED

ACN submission to the Senate Community Affairs References Committee Inquiry into the effectiveness of the aged care quality assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

This submission responds to the following inquiry terms of reference (ToR):

- (a) the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;
- (b) the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;
- (c) concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;
- (d) the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;
- (e) the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;
- (f) the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and
- (g) any related matters.

General comments

The Australian College of Nursing (ACN) welcomes the opportunity to provide a submission to this inquiry. ACN is of the view that the mistreatment of residents is a serious concern and has previously made two submissions with similar viewpoints to the Australian Law Reform Commission (ALRC) inquiry into elder abuse in 2016 and 2017. ACN encourages the Committee to take note of the recommendations made in *Elder Abuse – A National Legal Response (ALRC Report 131)*.¹

Nurses, with their training, wide-reaching presence and public trust are one of the most appropriate health professionals to assess and, with the appropriate support, are the best placed to respond to potential problems regarding the mistreatment of residents. Without nurses fulfilling vital roles in residential aged care facilities (RACFs,) the risk of mistreatment is increased. Each resident contact is an opportunity to make an impact by responding to needs, listening to concerns, and updating residents and their families and/or carers.²

¹ Australian Law Reform Commission 2017, *Elder Abuse – A National Legal Response (ALRC Report 131)*, <<https://www.alrc.gov.au/publications/elder-abuse-report>>.

² Health Education England, *Making Every Contact Count* (2017) National Health Service <<http://www.makingeverycontactcount.com/>>.

The nursing workforce is highly educated, flexible, fiscally accountable and responsive to residents. Nurses are rated as the most highly regarded and trusted of all professions.³

However, increasingly nurses are being replaced in aged care, and a focus on 'fiscal' measures is seeing increased use of unregulated workers. Nursing has considerable value in aged care, having built on its foundations of caring to now being a scientifically based profession that identifies and meets unmet needs in healthcare.

Nurses spend more time with patients than any other health professional. This allows nurses to gain a greater understanding of people's needs, including those of residents in RACFs. As a result, they get to know the residents more closely and they notice when changes occur, for example: deteriorating medical condition(s), new injuries, changes in appetite or behaviour. Nurses understand the resident situation within the family and social construct. Nurses talk to the residents' carers, and due to their status as the most trusted professional, residents are more likely to confide in them.

The direct care with residents at the bedside provides valuable opportunities where an appropriately trained health professional can assess and identify potential problems and respond accordingly. However, increasingly business models are being deployed where nurses are being utilised only for 'legislative requirements', with Assistants in Nursing (AINs) (however titled) fulfilling most of the traditional care elements. This can be problematic, as they have a limited and varied degree of training and preparation. There is an abundance of evidence demonstrating that extensive substitution of nurses with AINs, and the subsequent reduction in skill mix (proportion of qualified RNs) can have deleterious effects for individuals⁴.

Law reform in NSW removed the requirement for a registered nurse (RN) to be on site 24/7 in aged care facilities.⁵ This is of great concern as enrolled nurses (ENs) and AINs (however titled), must work under the direction and supervision of a RN. ENs and AINs do not possess the education, knowledge and skills to substitute for a RN.⁶ At a time of increasing aged care service demand, retaining the number of nurses should be a key priority and ACN's position is that regulation of RACFs should at a minimum mandate a requirement that a RN be on-site and available at all times to promote safety and well-being for residents.⁷

Due to the growing prevalence of co-morbidities associated with physical and cognitive decline, polypharmacy, and greater professional accountability, increasingly the residential aged care population requires more complex care that can only be provided under the direct supervision of RNs. The RN scope of practice enables the high-level clinical assessment, clinical decision making, nursing surveillance and intervention, service coordination, and clinical and managerial leadership required to meet desired outcomes and to ensure the provision of safe and high quality care. RNs provide frontline leadership in the delivery of nursing care and in the coordination, delegation and

³ Roy Morgan Research, *Roy Morgan Image of Professions Survey 2016: Nurses still easily most highly regarded – followed by Doctors, Pharmacists & Engineers* < <http://www.roymorgan.com/findings/6797-image-of-professions-2016-201605110031>>.

⁴ Dellefield, ME, Castle, NG, McGilton, KS & Spilsbury, K 2015, 'The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008-2014)', *Nursing economic\$,* 33 (2). 116. 95 - 108.

⁵ Australian College of Nursing, *ACN concerned about removal of legal requirement for registered nurses (RNs) in nursing homes* (3 May 2016) <<https://www.acn.edu.au/australian-college-nursing-concerned-plans-remove-legal-requirement-registered-nurse-rn-be-site-and>>

⁶ Australian College of Nursing, *Assistants in Nursing (however titled) Position Statement* (March 2016) <https://www.acn.edu.au/sites/default/files/advocacy/submissions/ps_assistants_in_nursing_c5.pdf>.

⁷ Australian College of Nursing, *Assistants in Nursing (however titled) Position Statement* (March 2016) <https://www.acn.edu.au/sites/default/files/advocacy/submissions/ps_assistants_in_nursing_c5.pdf>.

supervision of care provided by ENs and AINs (however titled). The continuous presence of RNs is essential to ensure timely access to effective nursing assessment and comprehensive nursing care, and to the evaluation of that care.⁸

ACN maintains that AINs (however titled) need to be registered at the national level through participation in the National Registration and Accreditation Scheme and supports the establishment of a practice framework, which, articulates a minimum level of education, a defined scope of practice, and national codes, standards and guidelines. This would ensure robust governance, a greater accountability for the work AINs do, lead to better resident outcomes and ensure safety that is more stringent.

Within residential aged care, safeguards against mistreatment are directly linked to quality of care. Evaluating the quality of nursing practice began when nursing's role in health care quality was identified and resident outcomes started to be measured.⁹ Nursing-Sensitive Indicators are those indicators that capture care, and its outcomes, most affected by nursing care.¹⁰ Currently, the National Aged Care Quality Indicator Program is voluntary, and only includes three indicators: physical restraint, unplanned weight loss, and pressure injuries. ACN suggests that consideration should be given that this program be mandatory. Additional indicators such as restraint prevalence, falls, nursing hours per resident day, pressure injury prevalence, preventable infection rates and nursing skills and skillmix of the workplace would draw Australia more in line with the international standards such as the National Database of Nursing Quality Indicators® (NDNQI®).

The pursuit of quality in healthcare is financially beneficial. Research has shown that reduced nurse staffing has endangered some aspects of resident safety. One study showed higher fall rates were associated with fewer nursing hours per resident day and a lower percentage of RNs.¹¹ Enhanced nursing levels have already been found to reduce unnecessary hospitalisations in RACF residents with dementia.¹²

The Elder Abuse Prevention Unit (EAPU) reported the additional cost to Queensland's hospital system due to elder abuse admissions for the 2007/08 financial year could be between \$9.9 million dollars and \$30.7 million.¹³ This figure range is solely for Queensland and includes only the hospital admission costs. By 2025, it is estimated that nationally elder abuse will be costing the health system over \$350 million dollars per year.¹⁴

⁸ Australian College of Nursing, *Assistants in Nursing (however titled) Position Statement* (March 2016) <https://www.acn.edu.au/sites/default/files/advocacy/submissions/ps_assistants_in_nursing_c5.pdf>.

⁹ Isis Montalvo, 'The National Database of Nursing Quality Indicators™ (NDNQI®)' (2007) 12 (3) *OJIN: The Online Journal of Issues in Nursing*.

¹⁰ Montalvo 2007, above n 20.

¹¹ Nancy Dunton et al, 'Nurse staffing and patient falls on acute care hospital units' (2004) 52, *Nurse Outlook* 53.

¹² Mary Carter and Frank Porell, 'Vulnerable populations at risk of potentially avoidable hospitalizations: The case of nursing home residents with Alzheimer's disease' (2005) 20 (6) *American Journal of Alzheimer's Disease and Other Dementias* 349.

¹³ Les Jackson, Elder Abuse Prevention Unit, *The cost of elder abuse in Queensland: who pays and how much*, The Elder Abuse Prevention Unit a program of Lifeline Community Care Qld (June 2009) <

http://www.eapu.com.au/uploads/research_resources/Who_Pays_Financial_Abuse_QLD_SEP_2009-EAPU.pdf>.

¹⁴ Lillian Jeter Workshops, *Facts on Elder Abuse – Australia* (February 2011)

<<http://www.ohchr.org/Documents/Issues/OlderPersons/Submissions/ElderAbusePreventionAssociation.pdf>>.

A study has also shown that Nurse Practitioners with expert gerontology clinical skills and knowledge, and who work in collaboration with the primary health team (primarily the General Practitioners), can significantly reduce hospital admissions and emergency department presentations.¹⁵

Recommendations

Recommendation: The Australian Government should mandate that a RN be onsite and available at all times in RACFs.

Recommendation: Ensure mandatory training is provided to aged care workers about mistreatment prevention, detection, response and mandatory reporting. This training should take into account the multicultural nature of Australian society.

Recommendation: Regulate the AIN (however titled) workforce through participation in the National Registration and Accreditation Scheme and establish a practice framework, which articulates a minimum level of education, a defined scope of practice, and national codes, standards and guidelines. An adequately regulated workforce enables quality care and safe environments

Recommendation: A Clinical Services Capability framework should be embedded in every organisation and should underpin the standards and accreditation system, especially in the domains of personal care and clinical care with stated minimum requirements for all staff. This approach should be underpinned by defining scope of practice for the workforce. There must be accountability at all levels.

ToR (a) the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

The framework needs to ensure quality of life for residents. Sanctions should remain where serious risk of harm or abuse have been identified. In such situations, the number of visits by the Quality Agency to facilities should be increased and unannounced if complaints have been received.

In terms of assessment, audits appear to be more about ensuring the correct information is provided (paper-based) and does not ensure the Accreditation Standards are complied with (i.e. the reality of what is occurring within a facility). Consequently, ACN believes qualitative data may also need to be collected in addition to self-assessment and site audit (as it is currently). This could be in the form of feedback/interviews from staff, residents, and family members/carers.

ACN believes all residents in RACFs expect and deserve care that is clinically appropriate, professional, compassionate and timely in order to ensure their needs are met. Nurses are required

¹⁵ Kathy Peri et al, *Evaluation of the Nurse Practitioner in Aged Care*, University of Auckland, (April 2013) <http://www.midcentraldhb.govt.nz/Publications/AllPublications/Documents/NP_aged%20Care_15NM.pdf>.

to abide by the *Code of conduct for nurses*¹⁶ and the *ICN Code of Ethics for Nurses*¹⁷ developed by the Nursing and Midwifery Board of Australia and the International Council of Nurses respectively in the delivery of appropriate care for residents.

Clinical care and clinical governance

Clinical governance: the integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centred care underpinned by continuous improvement. The aged care quality assessment and accreditation framework lacks adequate systems for monitoring the effectiveness of clinical and medical care. Quality outcomes for residents will not be realised through a compliance focused accreditation approach. Expectations around standards of care need to be clear and specific so that: care recipients and providers understand these expectations; performance can be objectively measured and reported, and not open to broad interpretation by either providers or assessors and support high standard consistent care that should be delivered to the consumer. This includes defining safety and quality and adverse events as they relate to aged care. Compliance with minimum standards is an important part of the approach however this needs to be complemented by a broader framework that promotes continuous improvement through evidence informed best practice.

Wherever clinical services are delivered, clinical governance is vital to ensuring clinical care is safe, effective, appropriate and person-centred and able to be delivered within the service setting where it is most appropriate and safe to do so.

While clinical governance frameworks are well established within the healthcare system, there is no agreed clinical governance framework for aged care providers in Australia from ACN's understanding. This is concerning as older people are inherently predisposed to clinical risk due to multi-morbidity and frailty, especially those living in residential aged care facilities. A good clinical governance framework would usually have seven pillars and have at a minimum five key domains, for example:

Pillars:

- clinical effectiveness
- audit
- risk management
- education and training
- information management
- openness and clinical research

Domains:

- leadership and culture
- consumer partnerships
- workforce
- clinical practice

¹⁶ Nursing and Midwifery Board of Australia 2018, *Professional standards*, < <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>>.

¹⁷ International Council of Nurses 2012, *The ICN Code of Ethics for Nurses*, < https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20Eng.pdf>.

- risk management

Such a framework supports services to focus on consumers and system improvement that reaches beyond compliance with minimum standards. This approach needs to be supported by an investment in research to build a body of evidence that can later inform standards and expectations of service providers. These systems need to be embedded across the organisations with accountability at every level.

Clinical risk is defined as 'where action or inaction on the part of the organisation results in potential or actual adverse health impact'. Key risks include: abuse, infections, constipation, medication management, delirium, oral and dental hygiene, diabetes management, pain, depression, palliative care, falls, skin integrity, functional decline, sleep management, hydration and nutrition, swallowing disorders, incontinence and unmet needs behaviours. Capacity to identify and respond to these risks require adequate clinical resourcing to ensure care is effective and appropriate.

Standards for the provision of clinical care are inextricably linked to expectations about what is to be provided and by whom. For instance, standards and expectations for the identification of risks would be expected to vary fundamentally between clinicians' care and personal carers. A Clinical Services Capability framework should underpin the standards and accreditation system, especially in the domains of personal care and clinical care with stated minimum requirements for registered staff. This approach should be underpinned by defining scope of practice for the workforce.

ACN consulted its members for their views on the terms of reference for this inquiry and there was an overwhelming view that different forms of abuse do occur in RACFs. Many members asserted that until there are appropriate staffing levels, and appropriate skills and skill-mix requirements within residential aged care, resident protections would be inadequate.

While there are some data sources providing evidence of mistreatment committed in aged care settings, including mandatory reporting data held by the Australian Department of Health (DoH) as well as data available from various state and territory guardianship bodies, there is a lack of reliable consolidated national data providing evidence of the prevalence of abuse in Australia. Current available data indicates that two to five percent of older Australians aged over 65 experience some form of mistreatment.¹⁸ In New South Wales, it is estimated that 1 in 20 people aged 65 and over have experienced some form of mistreatment, accounting to approximately 50,000 people.¹⁹

According to the literature, in Australia, abuse perpetrated in the community is a largely hidden concern.²⁰ It is reported that the forms of abuse experienced include psychological, physical, sexual and financial abuse with financial and psychological abuse being the most prevalent.²¹ Furthermore,

¹⁸ Lacey, W 2014, 'Neglect to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' Sydney Law Review, vol. 36, no. 1, pp. 99-130.

¹⁹ Clare, M, Black Blundell, B, Clare, J 2011, Examination into the extent of elder abuse in Western Australia. A qualitative and quantitative investigation of existing data. University of Western Australia

²⁰ Cairns J & Vreugdenhil A 2013, 'Working at the frontline in cases of elder abuse: It keeps me awake at night', *Australasian Journal on Ageing*, vol. 33, no. 2, pp. 59-62; Lacey, W 2014, 'Neglect to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' Sydney Law Review, vol. 36, no. 1, pp. 99-130; Weirs, D, Chittick, M. (2006) *Case Study, Elder abuse – a hidden form of familial violence*. ACCNS Journal for Community Nurses, April 2006, vol 11, no 1.

²¹ Clare, M, Black Blundell, B, Clare, J 2011, Examination into the extent of elder abuse in Western Australia. A qualitative and quantitative investigation of existing data. University of Western Australia; Lacey, W 2014, 'Neglect to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' Sydney Law Review, vol. 36, no. 1, pp. 99-130.

women are twice as likely as men to experience abuse.²² While research reports up to 80% of perpetrators of elder abuse are family members with the largest majority being the victim's children,²³ evidence relating to the use of excessive force or physical restraint in the delivery of care is an important consideration in the context of health and aged care. Alzheimer's Australia reports a high prevalence of physical restraint ranging from 12% to 49% in acute and residential aged care settings.²⁴

Current anecdotal feedback from ACN members, who are RNs and ENs with experience in aged care, supports the literature, which reports on a broad range of abuse perpetrated in formal and informal aged care settings. The most common forms of abuse reported include neglect, financial and physical abuse, including the use of excessive force and physical restraints.

Social isolation and a lack of visibility of older people in the community hinder the detection and reporting of mistreatment and therefore the sourcing and accumulation of evidence, particularly in the home setting.²⁵ Vulnerabilities associated with older age, such as declining physical and cognitive capacity, also compound the risks and impacts of elder abuse. Members stressed, however, that mistreatment being perpetrated in the community by known relations may not be due to a person's older age but can be a continuation of family violence and other abuse that has occurred throughout the person's life.

ACN members reflected that residents also assault one another and this occurs more frequently than the mostly unintentional mistreatment of residents by staff. Actual mistreatment of residents by staff is low and it mainly occurs during times of work stress and mismanagement of resident conditions leading to them being aggressive and uncooperative with efforts to assist them. ACN members felt that individual staff members do not routinely mistreat residents - most are kind, hard-working and dedicated people who have a deep regard for residents' well-being. It is important to note that there is a critical difference between deliberate mistreatment and neglect. There is also a very significant and important difference between neglect and being able to provide the level of care expected and demanded by residents and families.

ToR (b) the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;

Available complaints mechanisms include the Australian Aged Care Quality Agency (the Agency) and the Aged Care Complaints Commission. ACN members overwhelmingly viewed the Agency to be ineffective in ensuring adequate resident protection in residential aged care. Reasons given by ACN members to justify their position include:

- Inadequate care in RACFs can be hidden from the view of the Agency, even with unannounced visits.

²² Lacey, W 2014, 'Neglect to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' Sydney Law Review, vol. 36, no. 1, pp. 99-130.

²³ Lacey, W 2014, 'Neglect to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' Sydney Law Review, vol. 36, no. 1, pp. 99-130.

²⁴ Alzheimer's Australia, 2014, 'The use of restraints and psychotropic medications in people with dementia'. A report for Alzheimer's Australia Paper 38 March 2014.

²⁵ Lacey, W 2014, 'Neglect to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' Sydney Law Review, vol. 36, no. 1, pp. 99-130.

- The Agency could be improved with a stronger emphasis on being objective and being guided by a robust process to ensure consistency.
- The Aged Care Quality Standards need to be measurable so that performance can be evaluated to see what is effective and where improvements can be made.

The Agency needs to have the resources allocated to it that ensures sufficient time is given to review RACFs and an RN should be part of the review team. Furthermore, a member of the Complaints Commissioner's team should also be part of the review team.

ACN believes there is scope to improve the effectiveness of the Aged Care Complaints Commission as the majority of ACN member responses illustrate that the Commission is not sufficiently effective in ensuring adequate resident protection in residential aged care. Members revealed that the Aged Care Complaints Commission is not well known to residents/consumers and their families or carers.

ToR (c) concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements

ACN members provided some anecdotal accounts to support assertions that lapses in standards of care are common. Communication of accurate medical information about aged care residents on admission to and discharge from hospital is often poor particularly around medication orders.

ACN acknowledges that protocols have been developed since 2009 around transfers of aged care residents to hospital, which came out of a study funded by the Australian Commission on Safety and Quality in Health Care through the Divisions of General Practice.

Some of these issues could be overcome by residents/consumers having an up to date eHealth record.

Australia has seen a rise in the number of migrants. In 2013, 32 per cent of the Australian population (5.8 million people) were born overseas.²⁶ Projections for 2021 suggest that the older population will comprise 30 per cent of people born in a country other than Australia.²⁷ This presents a major challenge to incorporate different cultures into aged care, and communicate with individuals who may have initially low levels of English literacy.

In the case of Aboriginal and Torres-Strait Islander populations, it is important to ensure RACFs are culturally aware and informed, similar to the cultural understanding seen in Aboriginal Community-controlled Health Services. This will ensure a smooth transition between the health system and the aged care provider.

Our members have recently highlighted the communication difficulties both with Culturally and Linguistically Diverse (CALD) staff and residents of RACFs, and more awareness of the services and training available to staff is required if CALD residents are to receive equitable aged care.

²⁶ Australian Bureau of Statistics (2013) *Characteristics of Recent Migrants* [online <http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/6250.0/> accessed 26/11/2018]]

²⁷ Department of Social Services (2015) *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*

ToR (d) the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;

ACN is not in a position to comment on the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden specifically, although we would like to comment on polypharmacy.

Polypharmacy (the use of multiple five or more medicines) can cause cognitive impairment, delirium, frailty, increase the chance of falls and mortality to name a few. This in turn increases the number of visits to the Emergency Department.²⁸

Polypharmacy is an issue that occurs nation-wide, with reports of 20-30 per cent of hospital admissions over the age of 65 being medication-related, and studies suggesting that up to 63 per cent of RACF residents take nine or more medications regularly.²⁹

The Standard '2.7 – Medication management' should include specific guidelines around medication reviews that align with the *National Strategy for Quality Use of Medicines*.³⁰

RACFs require improved IT systems that are interoperable with the My Health Record, namely its Medication Management feature, to ensure aged care staff have the tools in place to effectively communicate with all relevant stakeholders to prevent the risk of adverse reactions to using multiple medications. All Aged Care Service providers need significant uptake of contemporary and interoperable IT systems to achieve quality information management systems.

ToR (e) the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents

Nurses must comply with the Australian Health Practitioners Regulation Agency (AHPRA) Guidelines for mandatory notifications that stipulate the requirements for registered health practitioners to make mandatory notifications under national law to prevent the public from being placed at risk. The guidelines for notifiable conduct are appropriately broad encompassing any conduct by a regulated health practitioner "placing the public at risk of harm because of practice that constitutes a significant departure³¹ from accepted professional standards."³¹

ACN welcomes Recommendation 4-8 in *Elder Abuse – A National Legal Response (ALRC Report 131)* that 'Unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers.'³² Furthermore, ACN supports the regulation of AINs through participation in the National Registration and Accreditation Scheme, and the

²⁸ National Prescribing Service 2018, <<http://www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines/for-health-professionals/polypharmac>>.

²⁹ Sluggett et al (2017) *Medication management policy, practice and research in Australian residential aged care: current and future directions*. Pharmacological Research. 116: p27-35.

³⁰ Commonwealth of Australia (2002) *The national strategy for quality use of medicines*. [https://www.health.gov.au/internet/main/publishing.nsf/Content/8ECD6705203E01BFCA257BF0001F5172/\\$File/natstrateng.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/8ECD6705203E01BFCA257BF0001F5172/$File/natstrateng.pdf)

³¹ Australian Health Practitioner Regulation Agency, *Guidelines for mandatory notifications* (March 2014) <<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Guidelines-for-mandatory-notifications.aspx>>.

³² Australian Law Reform Commission 2017, *Elder Abuse – A National Legal Response (ALRC Report 131)*, <<https://www.alrc.gov.au/publications/elder-abuse-report>>.

establishment of a practice framework that articulates a minimum level of education, a defined scope of practice, and national codes, standards and guidelines.³³

In practice, staff are supposed to report incidents to their immediate work supervisor and depending on the seriousness of the incident; this can be escalated to management for further attention. ACN received member feedback that pointed out that the problem is that work-stress caused by management decisions is not always identified as a cause of the incident and staff do not feel able to report managers for poor decision-making regarding staff resourcing and workload. It was suggested to ACN that a way of overcoming this disconnection is to introduce a system of clinical governance that holds managers to account and personally responsible for their resourcing and staffing decisions leading to clinical errors and adverse incidents such as falls, weight loss and pressure injuries.

ACN believes annual staff training, education during initial orientation, support and encouragement from management to report mistreatment even when unsure if the incident constitutes abuse are important steps for aged care providers to make. Having a clear organisational mission, vision and values together with policies and procedures encourages robust reporting mechanisms.

ACN believes nurses have the appropriate training and education to understand different forms of mistreatment and how to respond appropriately. All staff need to be encouraged and supported to report mistreatment, educated about the processes and valued for their contribution.

ToR (f) the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents

Nurses are first and foremost resident advocates, and as such, advocacy sits at the core of what it means to be a nurse and what the nursing profession is. Like all advocates nurses act in the best interest of the residents: they do not profit at their expense; they do not betray their confidence; and at all times the resident comes first.

For nurses, advocacy is about ensuring residents are cared for when they cannot care for themselves, and speaking for them when they cannot speak for themselves.

ACN believes that aged care residents who do not have family, friends or other representatives do not have the same level of access to adequate protection arrangements to help them exercise choice and their rights in care compared to those with family, friends or other representatives. Without family, friends or other representatives, residents are reliant on staff in RACFs to act in their best interest. Member feedback to ACN pointed out that these residents may ask visitors/relatives of other residents for assistance with questions relating to billing and accounting who do not always have the answers and who are not able to act on someone else's behalf.

Residents at greatest risk of mistreatment without family, friends or other representatives to care for them are those with a severe degree of Dementia and Behavioural and Psychological Symptoms of Dementia (BPSD). These residents usually have no coherent speech and inadequate cognition to

³³ Australian College of Nursing, *Assistants in Nursing (however titled) Position Statement* (March 2016) <https://www.acn.edu.au/sites/default/files/advocacy/submissions/ps_assistants_in_nursing_c5.pdf>.

be able to report any instances of mistreatment. They are reliant on the culture and ethics of their professional carers for their welfare.

Member input to ACN showed support for the mandatory introduction of a clinical governance system that holds managers and board members accountable and personally responsible for the care outcomes experienced by residents.

Members' feedback indicated that for residents who do not have direct family, friends or other representatives, in NSW for example, NSW Guardianship and Tribunal is often the next advocate for the resident. However, these agencies are not always able to assist residents or facilities in a timely manner. Issues can also arise when concerns around mental health and capacity to consent are raised. As with the entire aged care system, the burden of documentation delays can at times prevent care being provided in a timely fashion to a very vulnerable person.

ToR (g) any related matters

ACN members made the following recommendations regarding the reporting of assault in aged care settings that may improve responses to mistreatment:

- As well as the current reporting of suspected assault, regulation should stipulate reporting evidence of suspected assault on admission or following hospital transfer to support ongoing surveillance.
- Workers must be comprehensively trained and supported to apply organisational policies relating to the reporting of assault and must be accountable for their actions including failure to report as required. Improved training, education and communication, coupled with a more stringent application of policy requirements and clear accountabilities, should improve responses to mistreatment in aged care settings.
- There is member feedback suggesting while reporting mechanisms are sound, it is staff education and training that is lacking. It is argued that some staff, particularly AINs (however titled), lack the skills, including English language skills, to effectively manage and respond to the incidence of assault. ACN believes that there must be mandated training provided to aged care workers about mistreatment prevention, detection and response. This training should take into account the multicultural nature of Australian society.
- Training and education should place emphasis on risk assessment and sensitive investigation of any suspected or actual assault. Aged care staff should be encouraged to report any suspicious behaviour and receive adequate support for doing so, with a clear direction of how the issue will be managed and/or elevated.

ACN members reported a culture of underreporting in some formal care settings as well as their concerns relating to significant underreporting in informal care settings. Ineffective mechanisms for addressing financial abuse were also raised. Members stressed concerns that current systems are too slow to address indicators of financial abuse as too often funds are already depleted by abusers by the time actions are taken.

Limited community awareness of mistreatment and the lack of training for health professionals and care and community workers also constrain the identification and reporting of mistreatment.³⁴

³⁴ Lacey, W 2014, 'Neglect to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' Sydney Law Review, vol. 36, no. 1, pp. 99-130; Joubert L & Posenelli S. (2009) *Responding to a "window of opportunity" the detection and management of aged abuse in an acute and subacute health care setting*. Social Work in Health Care, 48: 702-704; Sandmoe, A, Kirkevold, M, & Ballantyne, A. (2011) *Challenges in handling elder abuse in community care: An exploration study among nurses and care coordinators*. Journal of Clinical Nursing, 20:3351-3363.

Current feedback from ACN members supports these observations and further highlights that the reluctance by older people to report mistreatment is due to a fear of unwanted repercussions. Furthermore, a lack of knowledge of the available support services contributes to underreporting.

There is member feedback detailing that most incidents of mistreatment result in self-reporting. Resident well-being is of paramount concern for most staff and they will report staff who demonstrate unacceptable behaviour or actual mistreatment of residents. Reporting is compulsory for assaults.

State and Territory laws legislate reporting and response mechanisms regarding mistreatment. The Aged Care Complaints Commission reports abuse to the Australian Aged Care Quality Agency that visits the RACF against which the claims have been made to investigate the complaint. Member feedback pointed out that response mechanisms vary across different RACFs without consistent policies.

Other member feedback pointed out that some staff over-report incidents due to fearing the consequences of not reporting. The resulting effect is that significant incidents may be overlooked due to effectively being outnumbered by minor incidents, which may arise due to resident behaviours related to dementia and delirium, or other mental health disturbances. This can affect staff morale, confidence and relationships with families.

Mental health:

In 2013, the Australian Institute of Health and Welfare (AIHW)* found that 52 per cent of permanent aged care residents had symptoms of depression.³⁵ Further, 73 per cent of residents with symptoms of depression had higher care needs compared to residents without symptoms of depression (53 per cent).³⁶ Whilst on average the prevalence of mental illness lowers as an individual ages, there is only a slight decrease in the prevalence of high or very high psychological distress.³⁷ This data identifies mental health as a major issue affecting the quality of life for residents of aged care facilities.

Under the *Better Access to Mental Health Care* initiative, patients can claim Medicare rebates for mental health services provided by or through a GP.³⁸ They include GP Mental Health Treatment items where GPs undertake early intervention, assessment and management of patients with mental disorders, and include referral pathways from GPs for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items are not available to residents of aged care facilities.

Aged care residents do not have access to the full range of MBS items for mental health treatment including access to psychological services under the *Better Access* initiative. It was considered their mental health care needs were covered under existing government funding for aged care, through the Aged Care Funding Instrument (ACFI) assessment (under the Behaviour Supplement, which assesses needs based on characteristics such as cognitive skills, behaviour and depression). There needs to be an increase in awareness for including mental health as a factor when completing an ACFI assessment, and for incorporating mental health treatments into residents' aged care plan,

³⁵ Australian Institute of Health and Welfare 2013, <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544771>>.

³⁶ Australian Institute of Health and Welfare 2013, <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544771>>.

³⁷ Australian Institute of Health and Welfare 2013, <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129552306>>.

³⁸ Department of Health 2017, <<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat>>.

including adequate access to multidisciplinary mental health teams that include psychiatrists, psychologists and social workers.

Palliative care:

The World Health Assembly (WHA) has endorsed palliative care as a human right under article 12 of the ICESCR, specifically stating that: *'access to palliative care and to essential medicines... including opioid analgesics ... contributes to the realization of the right to the enjoyment of the highest attainable standard of health and well-being'*.³⁹

ACN would like it noted that palliative care within the new Aged Care Quality Standards has been omitted. While the Standards do make reference to 'end of life planning' within Standard 2 and 'the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved' under Standard 3, these do not encompass the entirety of palliative care.

It is the frailty and co-morbidities frequently found in aged care that make palliative care including end-of-life support so critical. There is concern that without an underpinning framework with which to hold providers more accountable, there will continue to be unacceptable inconsistency in palliative care delivery and make it harder for residents/consumers, and their families, carers and representatives, to understand what they can expect from their service provider.

Accreditation is limited by a focus on minimum standards. In 2011, the Productivity Commission report *Caring for Older Australians* noted the absence of accepted definitions for quality in aged care. The current system continues to suffer from inadequate definitions, poor transparency, variability between assessors, inadequate measures of quality and the inability to promote a culture of improvement.

The accreditation process has supported improvements in residential aged care services over the past two decades. However, with its focus on compliance by individual providers with a minimum accreditation standard, it does not provide a framework for continuous quality improvement. Accreditation does not support system wide capacity building and does little to improve performance beyond minimum benchmarks.

ACN supports clear and measurable standards that are specifically applicable to residential aged care. Specific and measurable standards would make it possible to hold residential aged care providers accountable for the quality of care they provide. Residential aged care services should be explicitly expected to hold responsibility for providing ongoing safe care that meets the needs of the whole person. This contrasts with the care for older people living in the community who retain responsibility for determining whether they can live in their own home and what services they prioritise. Clinical care and clinical governance underpin good residential care.

Data Collection

Data collection, linking existing data sets, analysis and dissemination of information would improve the effectiveness of the current framework. The monitoring of resident outcomes and a culture of continuous improvement need to be underpinned by robust systems for collecting and analysing data both locally and at a whole of system level.

³⁹ World Health Assembly, *Strengthening of Palliative Care as a Component of Comprehensive Care Throughout the Life Course*, WHA Res 67.19, 67th sess, 9th plen mtg, Agenda Item 15.5, A67/VR/9 (24 May 2014).

Further work must be prioritised to support the availability of consistently comparable data for improvement. There will need to be a cultural shift to support better use of data. Building a culture of openness and learning from past mistakes and poor performance will lead to systems improvement. It is essential that clinical performance data be used as a positive tool, for quality improvement not for judgment or sanctions. Consumers should also have access to comparative data and information about complaints, responses, incidents, accreditation reports and inputs such as staffing levels.