Advancing nurse leadership

Australian College of Nursing

Standing Committee on Health, Aged Care and Sport
PO Box 6021
Parliament House
CANBERRA
Canberra ACT 2600

Email: Heatlh.Reps@aph.gov.au

Dear Committee Secretariat

Re: ACN submission to the *Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*

The Australian College of Nursing (ACN) is pleased to provide a submission to the *Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia.* ACN consulted its member base consisting of Nurse Practitioners, registered nurses and enrolled nurses for their input to the inquiry's terms of reference.

ACN is the pre-eminent and national leader of the nursing profession. We are committed to our intent of advancing nurse leadership to enhance health care and strongly believe that all nurses, regardless of their job title or level of seniority, are leaders.

ACN looks forward to seeing the outcomes of this inquiry in due course. Please do not hesitate to contact Carolyn Stapleton, Policy Manger, if you require further information.

Yours sincerely

Adjunct Professor Kylie Ward
Chief Executive Officer
RN, MMgt, Dip App Sci (Nursing), Acute Care Cert, FACN, Wharton Fellow, MAICD

31 January 2018

Australian College of Nursing

Australian College of Nursing (ACN) submission to the Standing Committee on *Health, Aged Care and Sport Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*

ACN submission to the Standing Committee on Health, Aged Care and Sport Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia

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

1. The incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistle blowers;

2. The effectiveness of the Australian Aged Care Quality Agency, the Aged Care Complaints Commission, and the Charter of Care Recipients' Rights and Responsibilities in ensuring adequate consumer protection in residential aged care; and

3. The adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.

General comments

The Australian College of Nursing (ACN) welcomes the opportunity to provide a submission to the Australian Parliament's Standing Committee on Health, Aged Care and Sport Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia. ACN is of the view that the mistreatment of residents in residential aged care facilities (RACFs) is a serious concern and has previously made two submissions to the Australian Law Reform Commission (ALRC) inquiry into elder abuse in 2016 and 2017. ACN believes mistreatment is a term synonymous with elder abuse. ACN encourages the Committee to take note of the recommendations made in *Elder Abuse – A National Legal Response (ALRC Report 131)*.

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 mistreatment of residents in RACFs. Without nurses fulfilling vital roles in 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.[1]

The nursing workforce is highly educated, flexible, fiscally accountable and responsive to resident. Nurses are rated as the most highly regarded and trusted of all professions.[2]

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 be a scientifically based profession that identifies and meets unmet needs in healthcare.

Nurses spend more time with residents than any other health professional. This allows nurses to gain a greater understanding of the residents' needs, an understanding that other health professionals struggle to attain due to the confines of their role. As a result, they get to know the residents more closely and they notice when changes occur, for example: new injuries, changes in appetite or behaviour. Nurses understand the resident situation within the family and social construct. Nurses talk to the residents'

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

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 is problematic, as they have a limited and varied degree of training and preparation.

Law reform in NSW removed the requirement for a registered nurse (RN) to be on site 24/7 in aged care facilities.[3] This is of great concern as enrolled nurses (ENs) and AINs (however titled) must work under RN direction and supervision and they do not possess the education, knowledge and skills to substitute for a RN.[4] 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.[5]

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 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.[6]

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 more stringent safety.

Nurse sensitive indicators

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.[7] Nursing-Sensitive Indicators are those indicators that capture care, or its outcomes, most affected by nursing care.[8] 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,

---

[3] 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>
[4] Australian College of Nursing 2016, above n 13.
[5] Australian College of Nursing 2016, above n 16.
[6] Australian College of Nursing 2016, above n 6.
7 Isis Montalvo, 'The National Database of Nursing Quality Indicators™ (NDNQI®)' (2007) 12 (3) *OJIN: The Online Journal of Issues in Nursing*.
8 Montalvo 2007, above n 20.

pressure injury prevalence, preventable infection rates and nursing skill mix would draw Australia more in line with the international standards such as the National Database of Nursing Quality Indicators® (NDNQI®).

The business case for quality

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.[9] Enhanced nursing levels have already been found to reduce unnecessary hospitalisations in RACF residents with dementia.[10]

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.[11] 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.[12]

Another study showed 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.[13]

Recommendations

Recommendation: The Australian Government should consider 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.

9 Nancy Dunton et al, 'Nurse staffing and patient falls on acute care hospital units' (2004) 52, *Nurse Outlook* 53.
10 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.
11 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>.
12 Lillian Jeter Workshops, Facts on Elder Abuse – Australia (February 2011) <http://www.ohchr.org/Documents/Issues/OlderPersons/Submissions/ElderAbusePreventionAssociation.pdf>.
13 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>.

ToR 1. The incidence of all mistreatment of residents in residential aged care facilities and associated reporting and response mechanisms, including the treatment of whistle blowers.

The incidence of all mistreatment of residents in residential aged care facilities

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.

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 mistreatment do occur in RACFs. Many members asserted that until there are mandated staffing levels and skill-mix requirements within residential aged care, resident protections would be inadequate.

It would be beneficial for the Standing Committee on Health, Aged Care and Sport to define mistreatment for the purposes of this inquiry as it can occur in different ways such as through physical, verbal or other means. Defining mistreatment should incorporate physical, mental and language issues such as elderspeak where adjustments are made by people speaking to older adults that can assume the speaker has greater control, power, wisdom and knowledge than the older adult listening. Elderspeak, when used inappropriately and frequently can lead to an increase in resistive behaviours by residents.

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 mistreatment in Australia. Research does however highlight that available data indicates that two to five percent of older Australians aged over 65 experiences some form of mistreatment.[14] Other research providing evidence of types of mistreatment in the community setting indicates an average prevalence rate in Western Australia (WA) of 4.6% (ranging between 3.1% and 6.0%) based on hospital derived figures.[15] 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.[16]

According to the literature, in Australia, mistreatment perpetrated in the community is a largely hidden concern.[17] 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.[18] Furthermore, women are twice as likely as men to experience abuse.[19] While research reports up to 80% of perpetrators of elder abuse are family members with the largest majority being the victim's children,[20] evidence relating to the

[14] 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.
[15] 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; Kurrie, S & Naughtin, G 2008, 'An overview of elder abuse and neglect in Australia', Journal of Elder Abuse and Neglect, vol.20, no. 2, pp. 108-125
[16] 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
[17] 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.
[18] 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.
[19] 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.
[20] 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.

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.[21]

Current anecdotal feedback from ACN members who are RNs and ENs experienced in aged care, supports the literature reporting a broad range of mistreatment is perpetrated in formal and informal aged care settings with neglect, financial and physical abuse, including the use of excessive force and physical restraints, being the most common forms.

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.[22] 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.

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

Reporting and response mechanisms associated with mistreatment of residents

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 more stringent application of policy requirements and clear accountabilities should improve responses to mistreatment in aged care settings.

[21] Alzheimer's Australia, 2014, 'The use of restraints and pschotropic medications in people with dementia'. A report for Alzheimer's Australia Paper 38 March 2014.
[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.

- 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 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.[23] 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 which visits the RACF against which the claims have been made to further 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.

[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; 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.

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.

Awareness by staff, residents, family and carers of reporting and response mechanisms

ACN members reported that some residents' families are not always clear about how to go about making a complaint and they are also of the opinion that their relative will be negatively affected through a reduced standard of care if they make a complaint on their behalf.

ACN members also said there are no clear nationally consistent guidelines for residents and families of reporting and response mechanisms regarding mistreatment because relevant policies are determined by individual providers.

ACN is aware of inconsistencies regarding what should be identified as a form of mistreatment. Member feedback explains that most staff are aware of the mandatory requirement to report sexual abuse, but not aware of the same requirement to report any type of assault.

AINs (however titled), working as un-registered staff are not monitored by registers or Boards and are able to move from one employer to another if they have been found to have mistreated a resident. ACN members voiced their concern that due to the difficulty in attracting workers to RACFs references of AINs (however titled) are not always adequately checked.

The treatment of whistle blowers

Aged care providers have whistle blower policies designed to protect employees who make a complaint. However, complainants may be subjected to marginalisation and poor treatment from management and other staff. Member feedback noted that it is very important for any RACF Manager to know how to treat any complaints without placing the 'whistle blower' in a compromising position. This entails investigating all issues and respecting employees' confidentiality.

The role of staff employed in residential aged care facilities to ensure the mistreatment of residents is reported and responded to appropriately

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 departure from accepted professional standards."[24]

[24] 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>.

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.' Furthermore, ACN supports the regulation of AINs through participation in the National Registration and Accreditation Scheme, and the establishment of a practice framework which articulates a minimum level of education, a defined scope of practice, and national codes, standards and guidelines.[25]

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 which 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, educated about the processes and valued for their contribution.

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.

[25] 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>.

ToR 2: The effectiveness of the Australian Aged Care Quality Agency, the Aged Care Complaints Commission, and the Charter of Care Recipients' Rights and Responsibilities in ensuring adequate consumer protection in residential aged care

The effectiveness of the Australian Aged Care Quality Agency in ensuring adequate consumer protection in residential aged care

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

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

Compliance with the Agency requirements does not equate to improved resident outcomes. Rather, compliance requires key staff to be dedicated to documentation and audits to provide evidence of care rather than actually delivering the care. Examples include the over-reliance on the outdated system of care plans to meet the requirements of the Agency. Considerable RN time is spent on care plans that are not read other than by the Agency. If this system must continue, then the Federal Government must provide funding for providers to have staff working in these roles. Such funding does not presently exist. Similarly, ACFI requires laborious care plans to evidence the level of care a resident needs. The staff hours required to generate such detailed assessments are not recouped in the funding, nor does it improve the quality of care provided to the resident. Such care plans and audit documents have little tangible advantage to the staff who are providing direct care to the residents.

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.

The effectiveness of the Aged Care Complaints Commission in ensuring adequate consumer protection in residential aged care

ACN believes there is scope to improve the effectiveness of the Aged Care Complaints Commission as the majority of member responses received by ACN illustrated 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 and their families or carers. Member input to ACN suggested real time monitoring take place in RACFs to identify mistreatment as it comes to light.

The effectiveness of the Charter of Care Recipients' Rights and Responsibilities in ensuring adequate consumer protection in residential aged care

ACN members overwhelmingly viewed the Charter of Care Recipients' Rights and Responsibilities (the Charter) to be ineffective in ensuring adequate resident protection in residential aged care. It was pointed out to ACN that the Charter is not available in many community languages making it very difficult for people of culturally and linguistically diverse backgrounds to read it. Feedback provided by ACN members revealed that the Charter is displayed on a wall within the RACF but not discussed frequently and its recommendations not adopted into practice. Staff and residents would benefit from more frequent reminding of the Charter's points.

ToR 3. The adequacy of consumer protection arrangements for aged care residents who do not have family, friends or other representatives to help them exercise choice and their rights in care.

Resident Advocacy

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 therefore welcomes the protection that Recommendation 14-7 in *Elder Abuse – A National Legal Response (ALRC Report 131)* provides surrounding the disclosure of elder abuse.

Recommendation 14-7

Adult safeguarding laws should provide that any

person who, in good faith, reports abuse to an adult safeguarding agency should not, as

a consequence of their report, be:

(a) liable, civilly, criminally or under an administrative process;

(b) found to have departed from standards of professional conduct;

(c) dismissed or threatened in the course of their employment; or

(d) discriminated against with respect to employment or membership in a profession or trade union.

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 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.

It was pointed out to ACN 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.

Consideration should be given to expanding the role of the Public Guardian (PG) as delays may occur as the PG will not approve RACF placements and many residents are left in hospital beds for more than six months.

It would be helpful if the PG decision-making capacity did not end the moment a resident passes away. When this occurs, providers are left with the deceased's body and possessions and no decision maker for funeral arrangements, or disposal of belongings and personal items.