



Submission to

The Senate Community Affairs References Committee

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

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submission

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The primary function of nurses is to provide early surveillance and to detect problems that could lead to death and other complications. If there aren't enough nurses at the bedside with visual contact with patients, nurses don't have a chance of making those decisions.

Linda Aiken, Professor of Nursing, Pennsylvania State University

Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Senate Community Affairs References Committee (the Committee) for providing the opportunity to make a submission to the 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 (the inquiry).

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 56,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

The QNMU, its federal peak body, the Australian Nursing and Midwifery Federation (ANMF) and other peak nursing bodies have been lobbying for many years to address the widespread systemic failures that have come to characterise aged care.

Most recently we made submissions to the Review of National Aged Care Quality Regulatory Processes, the Australian Law Reform Commission (ALRC) Inquiry into Elder Abuse, the Aged Care Legislated Review and the Senate Inquiry into the Aged Care Workforce. These are just a few of a plethora of reviews and inquiries into aged care, yet despite the many, consistent recommendations around the need for a properly skilled workforce, tragedies such as those at Oakden continue to occur.

We are encouraged by the ALRC's numerous references to the submissions of the professional nursing bodies in its report on elder abuse (ALRC, 2017) and again we ask

this committee to listen and respond to the nurses who are at the frontline of aged care.

Summary of Recommendations

The QNMU recommends:

- 1) The regulation of aged care be amended to include provisions mandating nursing ratios that allow RNs to comply with their statutory duties. Using the evidence-based research conducted by Flinders University and University of South Australia, that ratio of Residents to RNs must be **a maximum of 20 Residents to each RN**;
- 2) As a safety net, there must be amendments to aged care regulation to include provisions mandating **a minimum of one RN on each aged care residential worksite at all times** to enable RNs and ENs comply with their professional standards;
- 3) The regulation of aged care be amended to include provisions mandating the number of nursing and care staff rostered on shift must be able to provide nursing and personal care hours per resident per day at **a minimum of 4.30 hours**, on average;
- 4) The regulation of aged care be amended to include provisions mandating **a skill mix of 30% RN, 20% EN and 50% AIN** so quality care can be provided by all categories of staff and missed care (abuse by neglect) will be minimised, if not eliminated;
- 5) The regulation of aged care be amended to include provisions mandating that **aged care regulation must be read in conjunction with the *Health Practitioner Regulation National Law Act 2009* (National Law)**;
- 6) The Accreditation Standards be amended to include **explicit provisions mandating that relevant nursing professional standards, best listed in an Appendix to the Standards, are audited by accreditation assessors** with respect to compliance by the provider;
- 7) The Quality Agency does not give residential aged care facilities notice of an 'unannounced' visit.
- 8) All notifications related to individual registered health professionals should be made directly to one agency, and dealt with by that agency;
- 9) The enactment of a regulatory framework where unregulated healthcare workers (however titled), who assist registered and enrolled nurses in the provision of care, have clearly defined education standards and skill competencies which encapsulate relevant nursing professional standards and accountability in the provision of healthcare and particularly nursing;

- 10) The patient safety framework for the acute hospital sector be used as a model for a residential aged care safety framework. Essential components of such a framework would be:
- An aged care equivalent of the Australian Commission on Safety and Quality in Health Care as an independent standards making body for aged care to avoid capture by aged care providers and influence by government;
 - Robust accreditation processes based on a comprehensive set of aged care national standards;
 - A mandatory, comprehensive and transparent clinical indicator/patient safety reporting regime for aged care based on national standards;
- 11) Comprehensive governance mechanisms (currently lacking) must be implemented in aged care focused on the safety of residents and quality of care. These governance mechanisms include:
- An aged care equivalent of the Australian Commission on Safety and Quality in Health Care as an independent standards making body to avoid capture by aged care providers and influence by government;
 - Robust accreditation processes based on a comprehensive set of aged care national standards;
 - A mandatory, comprehensive and transparent clinical indicator/resident safety reporting regime for aged care based on national standards;
 - Transparent financial reporting by providers to identify where public money is spent, particularly in relation to resident safety issues, e.g. staffing and skill mix and training;
 - Adding residential aged care to state based clinical safety processes to form a coregulatory model of responsibility that leverages the well established practices of the acute sector.

Term of Reference

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.

Staffing

In any form of health care, including residential aged care, compliance with clinical and medical care standards is crucial to the achievement of positive outcomes of care and the minimisation of adverse outcomes. As such, clinical and professional healthcare standards are the cornerstones of contemporary nursing practice.

Prior to admission to a residential aged care facility (RACF), all aged care residents have been assessed as having a significant self-care deficit that will require nursing and/or personal care, with 24-hour supervision. Under the current regulation of health practitioners, governed by the *Health Practitioner Regulation National Law Act* (the National Law) enacted in every state and territory, the only entity authorised to provide these types of care autonomously is the RN.

Here, for the benefit of the Committee, we draw a distinction between the role of the aged care provider and the role of the RN practising in aged care.

The primary role of the aged care provider is to ensure the resident is provided with the appropriate accommodation and services they require. This includes not only the physical surroundings and material resources, but also *sufficient*¹ human resources to meet the resident's needs. The exclusive role of the RN, as a component of those human resources, is to ensure each resident's health and personal care needs are assessed, their care is planned, interventions are implemented as per the plan, and the outcomes of care are evaluated, with changes made as required.

Unfortunately, in reality, there are not enough RNs and ENs working in aged care to carry out these activities for which they are personally accountable. As a result, aged care providers employ unregulated healthcare workers, commonly known as assistants in nursing or personal care workers to assist the RN.

¹ *Quality of Care Principles 2014* (Cth), Schedule 2, Part 1, Standard 1.6.

However, many employers believe they engage these support workers to provide nursing and personal care. This belief is erroneous, simply because the only person authorised at law to provide autonomous nursing and personal care is the RN.

With the relatively low and continually declining numbers of RNs working in aged care (King et al., 2013), the RN must delegate the bulk of nursing activities to AINs (however titled and will include e.g. personal care workers). The NMBA's codes and guidelines provide for the delegation of nursing to competent AINs by the RN, however there is a large number of criteria to be considered before and after the RN delegates that episode of care.

An AIN or personal carer is not able to provide personal care autonomously because only the RN is authorised under the National Law to determine the resident's nursing needs and therefore (by exclusion) their personal care needs. Thus, these workers require direction from the RN to assist the resident.

This process of client assessment, clinical decision-making and appropriate delegation by the RN is essential so the AIN or personal care worker does not provide care they are not qualified to perform. In short:

- Only RNs can be employed to autonomously provide nursing care;
- ENs are employed to assist the RN by providing nursing care within their scope of practice, as delegated and supervised by the RN;
- AINs, also known as personal carer workers, assist the RN by providing *routine client-specific activities requiring a narrow range of skill and knowledge* (NMBA, 2013, p. 18) that they have been assessed by the RN as competent to perform, that have been delegated to them, supervised by, and evaluated by, the accountable RN.

Whilst many AINs are trained to Certificate level, the quality of that training is not subject to scrutiny by the Australian Nursing and Midwifery Accreditation Council (ANMAC) or the NMBA and the scope of the training varies from individual to individual, dependent upon their work experiences. There is also a large cohort of AINs who do not have any specific training or qualification for providing delegated nursing, i.e. aged care.

AINs are a valued member of the nursing team, however the current inadequacies in regulation and inconsistencies in training put both AINs and residents at risk. The staffing and skill mix methodology we recommend in this submission acknowledges the important and continuing role of AINs and proposes they make up 50% of the workforce, with RNs and ENs making up the remaining 50%.

The variability of AIN training and qualifications creates a number of difficulties for RNs “on the floor”. One of the NMBA-mandated requirements for delegation is the assessment of competence of the individual AIN to perform the episode of care safely and confidently. This assessment requires from the RN instruction, demonstration, observation, assessment and (initially) direct supervision of the AIN.

It is a mandated requirement that the RN must evaluate the outcome of the delegated episode of care (NMBA, 2013, p. 17). This means the RN must personally assess the resident to ensure the care was provided correctly and had the intended outcome.

The assessment of AINs and the evaluation of the outcomes of delegated care are difficult and often impossible for many RNs in aged care due to the sheer numbers of residents they are accountable for.

In one negotiation on behalf of an individual member, QNMU officials discovered the RN member was accountable for the care of *136 high care residents during her shift*, with the assistance of six AINs. This circumstance is repeated in many RACFs where a single RN can be accountable for the care of up to 150 residents (Australian Nursing and Midwifery Federation, 2016, p. 21).

It would be a nonsense to suggest that any RN was able to comply with her/his statutory duty to evaluate the outcome of every delegated episode of care to 136 residents. Such situations are verifiable evidence of why a statutory scheme that ensures there are sufficient RNs on duty at any given time must be implemented as a matter of urgency to allow RNs to comply with their minimum standards for practice and provide *true* quality care.

When discussing staffing levels in the context of the RNs’ requirement to comply with the nursing professional practice framework established by the NMBA pursuant to statutory instruments, QNMU officials are commonly told by employers - “we’ve passed accreditation”. This appears to be the answer to so many of the failings we consistently see in aged care.

With regard to the minimum hours of care required for quality care, recent research (Willis et al., 2016) on the provision of residential aged care has shown that each resident requires, on average, 4.30 hours of nursing and/or personal care in every 24-hour period. This is the evidence-based minimum requirement to ensure quality residential and restorative care.

Drawing on the real life example given above, those 136 residents would require a total of 585 minimum care hours per 24 hours, or an average of 195 hours per shift

over three shifts. 195 hours of care in any given eight-hour shift would require 24 care staff. The facility described above employed only seven on the given shift, yet it met the quality criteria contained within the Accreditation Standards. This facility is indicative of many facilities run by the for-profit and not-for-profit providers in the aged care sector.

In 2016, the ANMF (2016) conducted a national aged care survey. We have listed just four of the comments received from consumers or their relatives, but there are many more:

“My mother is left to wet herself as no staff come to toilet her, she becomes dehydrated due to water or trolley not left near her, bell not near her to call staff. No skin care so my mother has bedsores now. All due to no experienced [carers], and no nurse as [there’s] one nurse to 100 patients.

“Not enough staff on esp. overnight. My mother fell in her room when getting up to toilet and was lying on floor a long time with fractured femur. Only 2 or 3 staff on for 50 residents. Not enough! “

“Residents often were not showered, looking constantly uncared for. Teeth not cleaned, basic care not attended. On a few occasions they just left my Nan in her room rather than getting her for meals as they forgot as they were too rushed.”

“My mother who is paralysed left side and suffers memory loss due to a stroke is often left in bed all day, often not showered, rarely has teeth cleaned and was left unsupervised twice resulting in ambulance to hospital and further brain injury and surgery. More staff would allow adequate care.”

The absence of mandated RN staffing ratios in the Accreditation Standards for aged care forces RNs into a situation where they are prevented from complying with their statutory duties. The current *Quality of Care Principles 2014* (Cth) are grossly inadequate to provide quality aged care to a nursing professional standard which is the right of every aged care recipient to receive and the statutory duty of every nurse to provide.

The QNMU emphasises that to encourage or direct an RN to engage in unprofessional conduct by forcing them into a position where they are unable to comply with their statutory duty or a professional standard, e.g. the standards for quality nursing care, or the principles for delegation and supervision of nursing care, is an offence under s.136 of the National Law and carries substantial penalties.

Recommendations

The QNMU recommends -

- 1) The regulation of aged care be amended to include provisions mandating nursing ratios that allow RNs to comply with their statutory duties. Using the evidence-based research conducted by Flinders University and University of South Australia, that ratio of Residents to RNs must be **a maximum of 20 Residents to each RN**;
- 2) As a safety net, there must be amendments to aged care regulation to include provisions mandating **a minimum of one RN on each aged care residential worksite at all times** to enable RNs and ENs comply with their professional standards;
- 3) The regulation of aged care be amended to include provisions mandating the number of nursing and care staff rostered on shift must be able to provide nursing and personal care hours per resident per day at **a minimum of 4.30 hours**, on average.

Skill Mix

Recent research (Willis et al., 2016) has also provided an evidence base for the establishment of mandated skill mix requirements within aged care. This research has found there should be a **minimum skill mix of 30% RN, 20% EN and 50% AIN**.

In the example given above, where the facility caring for 136 residents would require 195 care hours in an eight hour shift from 24 staff, the skill mix required to provide quality care in keeping with the National Law would be seven RNs, five ENs and 12 AINs. The facility in fact had only one RN and six AINs on shift.

Given the deplorable level of staffing and the poor skill mix generally engaged by aged care providers, there is little wonder that the research project exposed horrendous levels of missed care, which of course is a form of neglect and thus, a form of elder abuse.

Recommendation

The QNMU recommends -

- 4) The regulation of aged care be amended to include provisions mandating a skill mix of 30% RN, 20% EN and 50% AIN so quality care can be provided by all categories of staff and missed care (abuse by neglect) will be minimised, if not eliminated.

Nursing practice

The National Law establishes the Nursing and Midwifery Board of Australia (NMBA). The NMBA makes Codes and Guidelines for the nursing profession, pursuant to the National Law. These Codes and Guidelines create the nursing professional practice framework, which includes the mandated obligation to provide nursing in accordance with professional nursing standards.

The *National Framework for the Development of Decision-making tools for Nursing and Midwifery Practice* (NMBA, 2013) requires the RN to undertake a risk management process in assessing whether an activity can be delegated to an AIN or carer. This process requires the RN to consider seven criteria.

The *Aged Care Act 1997* (Cth) and the *Quality of Care Principles 2014* (Cth) fail to acknowledge this fact. These statutory instruments create the framework authorising the obligations of providers of funded aged care, however they do not adequately articulate how the nursing and care staff must provide care to the residents. This articulation is found only in the Codes and Guidelines of the NMBA and in the Council of Australian Governments (COAG) *National Code of Conduct for Unregistered Healthcare Workers*.

The Accreditation Standards set out in Schedule 2 of the *Quality of Care Principles 2014* (Cth) state that providers must have ‘*systems in place*’ to ensure compliance with professional standards and guidelines. However there is ample evidence that, whilst providers may have systems in place, these systems are failing because many nursing professional standards are not being complied with in aged care.

Given nursing professional standards are not being complied with, we assert the Australian Aged Care Quality Agency (AACQA) is not appropriately assessing the actual compliance (as opposed to desktop compliance) with nursing professional standards and guidelines with regard to direct nursing care.

This evidence includes, but is not limited to:

- Unregulated healthcare workers administering medication to residents who do not have competence to self administer;
- Single RNs on shift being accountable for the care of up to 200 residents, where they do not have the capacity to evaluate the outcomes of all delegated care;
- ENs practising nursing without appropriate supervision from RNs;
- AINs providing delegated care without RN supervision or that care being evaluated by the RN.

The NMBA (2016a) *Codes and Guidelines for the nursing and midwifery professions* set out the relevant professional standards together with the Commonwealth Department of Health's *'Guiding Principles for medication management in residential aged care facilities'* (the Guiding Principles) support this evidence.

In our experience, the AACQA audits do not explicitly acknowledge that quality aged care is heavily influenced by the nurses' capacity to provide quality nursing, which in turn is dictated by the number of nurses 'on the floor'. The AACQA is aware of this but chooses not to assess it, despite having the remit to evaluate professional standards and guidelines.

Further, the QNMU can point to AACQA audit reports where facilities have met as few as 33 of the expected 44 outcomes, yet still received accreditation, despite failures in nutrition, hydration, clinical care and medication management.

The Committee should also be aware that when the AACQA carries out 'unannounced' assessment audits, the facility receives three working days' notice. According to our members, a 'flurry of activity' occurs just prior to an AACQA visit, hence we believe 'unannounced' visits should be truly unannounced.

Recommendations

The QNMU recommends -

- 5) The regulation of aged care be amended to include provisions mandating that **aged care regulation must be read in conjunction with the *Health Practitioner Regulation National Law Act 2009* (National Law)**;
- 6) The Accreditation Standards be amended to include **explicit provisions mandating that relevant nursing professional standards, best listed in an Appendix to the Standards, are audited by accreditation assessors** with respect to compliance by the provider;
- 7) The Quality Agency does not give RACFs notice of an 'unannounced' visit.

Medication

Guiding Principle 14 of the Commonwealth Department of Health's *Guiding principles for medication management in residential aged care* refer to a the *Nursing guidelines: management of medicines in aged care* (ANMF, 2013), a document developed by the former Royal College of Nursing Australia and the Australian Nursing and Midwifery Federation.

The guidelines (ANMF, 2013) are the 'minimum standard for safe management of medicines in aged care' and therefore create a professional standard for nurses, given that the NMBA's *Code of Professional Conduct for Nurses in Australia* (2008) stipulates that standards developed by professional nursing organisations are standards for the profession.

However, the evidence indicates many if not most residential aged care facilities (RACF) fail to comply with this nursing professional standard or guideline, where such compliance is implied under the Accreditation Standards. It therefore follows the AACQA is failing to assess the actual direct-care compliance with this 'professional standard or guideline'.

This professional nursing standard states that AINs and carers may be delegated to assist with a resident's medication only where that resident has been assessed as competent to self administer their medicines.

RN Evaluation of Nursing

The NMBA's Codes and Guidelines (2016a) stipulate that the unregulated healthcare worker cannot provide nursing unless delegated to do so by the RN. Once delegated, by words or conduct, the RN must then evaluate the outcome of that delegated care. It is unrealistic to suggest the RN could conduct an evaluation of the care provided for any more than 20 residents on their shift.

However it is routine in RACFs to find RNs accountable for the nursing care of up to 200 residents on their shift. They cannot undertake the essential evaluation because there are not enough RNs employed.

The AACQA's inaction in taking steps to correct this makes it complicit in encouraging RNs to practice unprofessionally.

EN Practice

The NMBA's Codes and Guidelines mandate that the EN may practice nursing only under the supervision of a named and accessible RN. However many RACFs have an EN as the only regulated nurse on shift, with a remote RN providing indirect supervision.

This creates problems for both the EN and the RN. The EN Standards for Practice do not permit the EN to make changes to care or to document the care plan. They are permitted only to provide planned care as documented by the RN. Any potential

changes to care an EN might identify can only be authorised by the RN after the EN collaborates with them on their clinical findings.

However, this of course creates a time gap when the supervising RN is remote to the facility. It also fails to meet the RN Standards for Practice because the RN is required to make an assessment of the resident prior to changing planned care and then document that care. Any RN making that assessment from a remote site without sighting the resident is potentially engaging in unprofessional conduct.

Further, the RN must have assessed the competence of the EN to provide delegated nursing care in each context of care as well as the care needs of the individual resident. Providers rely on indirect supervision to justify this, but fail to identify the components of that form of supervision, which has a number of criteria for the EN and RN to consider.

A providers' exploitation of indirect supervision is taken to the extreme when we see ENs in a facility in Gladstone in Queensland being supervised by an RN in Nambour, some 400km away.

All of the above real-life examples pose significant risk to the safe and quality care of residents, yet they are widespread within the sector in Queensland. When we challenged the AACQA to demonstrate if they audit such standards, they assured us in writing that they do, however the evidence above indicates they are clearly failing in this aspect of the assessment.

The QNMU emphasises that to encourage or direct an RN to engage in unprofessional conduct, by forcing them into a position where they are unable to comply with their statutory duty or a professional standard, e.g. the standards for quality nursing care, or the principles for delegation and supervision of nursing care, is an offence under s.136 of the National Law and carries substantial penalties.

Term of Reference

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.

Complaints Handling in Queensland

The QNMU supports an effective and efficient health complaints system that provides for protection of the community, and fairness to health practitioners. Since 1 July

2014, the Office of the Health Ombudsman (OHO) has received all complaints about Queensland health practitioners and undertaken responsibility for certain complaints handling functions that were previously carried out by the Australian Health Practitioners Regulation Agency (AHPRA) and the former Health Quality and Complaints Commission (HQCC).

The OHO is responsible for managing serious complaints relating to the health, conduct and performance of health practitioners, and determines which complaints go to AHPRA and the national boards after assessing their severity. The OHO must also report on the performance of AHPRA and the national boards in Queensland.

The OHO can deal with complaints about any public or private organisation or entity providing a health service including those aligned with both registered and unregistered practitioners.

Health service organisations are broadly defined as “an entity, other than an individual, who provides a health service”, and examples include:

- a corporation providing a health service at a private health facility under the *Private Health Facilities Act 1999*;
- a Hospital and Health Service established under the *Hospital and Health Boards Act 2011*, section 17;
- an ambulance service;
- a medical, dental, pharmaceutical or physiotherapy practice (Office of the Health Ombudsman, 2016).

The QNMU notes the OHO was initially established to strengthen the health complaints management system in Queensland following various inquiries² and media

² See Davies, G. (2005) *Queensland Public Hospitals Commission of Inquiry Report*, retrieved from <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2005/5105T5305.pdf> (the Davies Inquiry)

Forster, P. (2005) *Queensland Health Systems Review*, Final Report retrieved from <http://www.parliament.qld.gov.au/documents/tableoffice/tabledpapers/2005/5105t4447.pdf> (the Forster Review)

Chesterman, R. (2012) *Assessment Report into Allegations made by Ms Jo-Anne Barber in a Statement dated 21 April 2012 and a Submission delivered 8 May 2012*, Report to the Legislative Assembly of Queensland, no. 87 retrieved from <http://www.parliament.qld.gov.au/documents/tableoffice/tabledpapers/2012/5412t549.pdf> (the Chesterman Inquiry)

Forrester, K., Davies, E. & Houston, J. (2013) *Final Report Chesterman Report Recommendation 2 Review Panel* retrieved from <http://statements.qld.gov.au/Content/MediaAttachments/2013/pdf/16-4forrester.pdf> (the Forrester Review)

reports highlighting fundamental deficiencies in the way the system (primarily the Medical Board of Queensland) protected the public. This included:

- unjustified delays in dealing with serious allegations against health practitioners;
- inadequate responses to these allegations;
- Inadequate communication and explanation of decisions to the public and health practitioners;
- lack of clarity around the roles of the existing health complaints management entities; and
- inadequate transparency and accountability.

The QNMU acknowledges there have been difficulties with timeliness of action and decisions from AHPRA and the NMBA with which QNMU members are involved. However, we remain concerned about the following areas of the OHO's operations:

Duplication and Uncertainty of Roles Performed by Agencies

One of the criticisms levelled against the complaints system prior to establishing the OHO was the uncertainty in the roles performed by the various regulatory agencies. We believe there has been limited progress in clearly delineating responsibilities between these bodies. In fact, the problem has arguably worsened, with the OHO and AHPRA often dealing with the one matter.

We have experience of matters being sent from one agency to the other and back again seemingly without regard to timeliness and the adverse impact this can have on the individual involved. An example of this is self-disclosure of a criminal charge by a registered practitioner, which, pursuant to s 130 of the National Law, must be made to the relevant national board. AHPRA then refers this disclosure to the OHO. In the vast majority of cases, the OHO will then refer this matter back to AHPRA and the NMBA to deal with.

In some cases a complaint may be 'split' where the OHO decides to keep one aspect of the matter, and refer another aspect of the matter to AHPRA. An example of this may be a criminal charge relating to drug use by a practitioner. The OHO may decide to retain the conduct aspect of the matter, whilst referring the personal health aspect of the matter to AHPRA and the NMBA to manage.

In general, the conduct and health aspects of a matter are related and dependent on each other. Treating these sorts of complaints separately as a conduct matter and a distinct health matter is artificial, in our view, and fails to take a holistic perspective of the situation.

At present it can be difficult to anticipate which matters the OHO will retain, and which it will choose to refer to AHPRA. We are not aware of any published guidelines providing detailed information regarding matters the OHO retains and those it chooses to refer.

Once a matter is referred to AHPRA, which occurs in the majority of cases involving registered practitioners, AHPRA and the NMBA start their consideration of the matter from the beginning. There is no efficiency at all gained for AHPRA and the NMBA in the OHO considering the matter beforehand. In our view:

- there is a clear duplication of resources in making assessments and conducting investigations by both AHPRA and OHO;
- 'double handling' of matters by the OHO and AHPRA is fundamentally inefficient and creates unnecessary delays;
- there seems to be insufficient clarity regarding which matters will be dealt with by the OHO and which will be referred to AHPRA; and
- splitting of matters between agencies is inefficient, causes unnecessary delay, and potentially inconsistent results.

The inadequacies in the current triaging function of OHO, the consequent delays and the fact that AHPRA ultimately deals with the majority of matters affecting our members support our recommendation that all notifications related to individual registered health professionals should be made directly to one agency, and dealt with by that agency. To maintain national consistency and the national registration and accreditation scheme set up by the National Law, that agency should be AHPRA. Separate systems of regulation for registered practitioners amongst the states are inefficient and risk the great improvements and advances brought about by a national system of registration introduced with the commencement of AHPRA and the national boards in 2010.

Recommendation

The QNMU recommends -

- 8) All notifications related to individual registered health professionals should be made directly to one agency, and dealt with by that agency.

Greater Regulation of Unregistered Health Practitioners

For many years the QNMU and the ANMF have been campaigning for the regulation of AINs (howsoever titled). We have consistently argued anyone undertaking nursing

work whether it is in the home or an RACF should be designated as a nurse and operate within a regulated framework. Indeed we recommend AHPRA undertakes the regulation of all unregistered healthcare workers.

Those who assist RNs and ENs in the provision of nursing should be registered with the NMBA according to clearly defined NMBA-approved education standards and skill competencies which encapsulate relevant nursing professional standards and accountability. Through a registration regime, AINs would require a minimum level of formal education and accountability in their practice. Competency standards for AINs, when developed, should be based on those currently governing the regulated nursing workforce.

The QNMU notes the OHO provides greater accountability and professional oversight of all persons providing healthcare services to the community. Whilst greater accountability and oversight of unregulated healthcare workers is a positive step in protecting the public from harm, and is supported by the QNMU, it is difficult to envisage how the OHO measures the standards of care provided by unregulated healthcare workers such as AINs when there are no universally accepted and regulated standards to apply as a reference point in an investigation or adjudication of a specific complaint. It is also unfair to expect unregulated healthcare workers to be called to account when professional standards and relevant competencies that apply specifically to this type of healthcare worker do not exist.

The QNU contends the NMBA as the regulating body for RNs, ENs and RMs should also regulate AINs. Through a registration regime, AINs would require a minimum level of formal education and accountability in their practice. Competency standards for AINs, when developed, should be based on those currently governing the regulated nursing workforce.

Recommendation

The QNMU recommends -

- 9) The enactment of a regulatory framework where unregulated healthcare workers (however titled), who assist registered and enrolled nurses in the provision of care, have clearly defined education standards and skill competencies which encapsulate relevant nursing professional standards and accountability in the provision of healthcare and particularly nursing.

Term of Reference

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.

The QNMU has been concerned about the lack of compliance with professional and clinical standards in aged care for many years. We have written to the former Aged Care Standards and Accreditation Agency, the AACQA, the former Minister Sussan Ley, former Assistant Minister Mitch Fifield and current Minister Ken Wyatt.

The responses received from those entities demonstrate a fundamental misunderstanding of the relationship between aged care and clinical standards. When we wrote to the former Aged Care Standards and Accreditation Agency regarding their apparent failure to assess compliance with professional standards at several aged care facilities, their response was that they do assess such compliance. The evidence from members at these facilities suggests otherwise.

When we wrote to the AACQA regarding implementation of recommendations of the Tasmanian Coronial inquest into the death of Stanley Whiley³, they responded that their role was to audit compliance with standards, not to make the standards.

We did not receive a response to our correspondence to Minister Ley about professional standards in aged care. Neither did we receive a reply from Assistant Minister Mitch Fifield to our correspondence on the same topic.

When we wrote to Minister Ken Wyatt about professional standards in aged care, his response was -

“The Quality Agency does not have any statutory authority to determine if an aged care service complies or fails to comply with all the requirements that fall within the purview of state or territory governments, or national professional standards.”

³ Magistrate’s Court of Tasmania Coronial Division, 2013 TASCD 144.

If this is the Minister's belief, then it is not surprising the AACQA is not assessing professional standards and guidelines, even though that function is prescribed within the Accreditation Standards contained in the *Quality of Care Principles 2014* (Cth).

Mr Wyatt also stated -

"If the relevant regulatory authority has found a service in breach, this will be taken into account in the Quality Agency's assessment of the service against the appropriate Standards."

The Minister's response here indicates a fundamental misunderstanding of the role of the NMBA which is to ensure that individual practitioners are practising competently, in accordance with the Codes and Guidelines for nursing practice. The NMBA does not have a role in assessing service provision or the standards of care provided by a corporate service provider.

Unfortunately, some politicians fail to grasp the NMBA's prescribed role under the National Law is to assess the *individual* practitioner's competence to practice safely. Only the *Aged Care Act 1997* (Cth) and its subordinate legislation can create a framework for practitioners to provide aged care in a manner that satisfies the NMBA's Codes and Guidelines for the profession.

Term of Reference

D. The adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden.

The QNMU is unable to make comment on the specific issues relevant to the Oakden facility in South Australia.

However, we are fully aware many aged care providers in Queensland are implementing policies and procedures that create an unsafe environment for medication management of residential aged care clients. This occurs because many employers fail to recognise or implement the professional nursing standard in medication management mentioned in our response to part A of this submission.

AINs and carers have no training or education in pharmacology, yet many are directed by their employers to administer medicines to our most vulnerable elderly citizens. This is despite the fact that 40% of new hires in aged care are migrant workers

(Department of Health, 2016, p. 10) and English language competency standards only exist for RNs and ENs. If AINs were licenced as we have recommended above, they would also be subject to language competency and education standards for practice. The QNMU promulgates the professional standard for medication management in aged care to our members, however many employers refer to our information as 'union rubbish'. Some employers cajole RNs to accept unsafe practices as 'legal' and are apparently unaware of the relevant professional nursing standard contained within the Department's Guiding Principles which strictly limit the delegation of carers to assist with medication. As a result, many RNs working in aged care unwittingly put themselves at risk of engaging in unprofessional conduct.

We have assisted RN members to collectively advise their management they must comply with the professional standard relevant to medication in aged care. This has resulted in management accepting the RN's professional responsibilities. However, we have then found those RN members have lost some of their regular shifts and have been financially disadvantaged for promoting professional practice in aged care.

Such occurrences represent a slight on both the regulation of aged care and industrial rights.

Term of Reference

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.

In the acute sector, harm is now a well recognised phenomenon with approximately 10% of patients receiving a hospital acquired diagnosis (Duckett, 2016). It is not unreasonable to assume that the residential aged care environment has similar levels of harm.

Within residential aged care, clinical care is a significant component of overall care. In 2015, the percentage of aged care residents with high care needs across all Aged Care Funding Instrument (ACFI) domains (activities of daily living, behaviours and complex care needs) was approaching 30 percent. That residents of aged care facilities have complex needs is supported by the evidence from a sample population that on average they:

- have 3.4 – 4.5 separate diagnoses;
- have 6 comorbidities and
- take 8.1 medications (Willis, et al., 2016).

The latest Aged Care Complaints Commissioner's Report (2017) acknowledges the highly clinical nature of residential aged care and the need for robust safety surveillance, reporting and remediation processes.

The report (Aged Care Complaints Commissioner, 2017) identified the top complaint areas as:

- medications management;
- falls prevention and management;
- personal and oral hygiene;
- communication and continence management.

While a range of comprehensive and robust accreditation standards exist for the acute sector via the Australian Commission on Safety and Quality in Health Care (ACSQHC) in relation to such events as falls, pressure injuries, medication safety, clinical deterioration and infection management, there is no corresponding set of standards for the aged care sector. The draft document *Single Aged Care Quality Framework* (Department of Health, 2017) has been circulated for comment, but it is not as comprehensive as the acute sector standards.

In the acute sector, all health jurisdictions have comprehensive surveillance, monitoring and investigative processes in place to identify and respond to episodes of harm. These processes are now well developed and recognise patient safety is an organisational imperative.

Unfortunately, resident safety in the aged care sector does not have the same profile. While there is mandatory reporting of suspicions or allegations of reportable assaults, an Aged Care Complaints Commissioner for complaints relating to quality of care and an Aged Care Quality Agency (AACQA) with an accreditation role, this safety framework is poorly developed in comparison to the acute sector.

Providers maintain internal incident reporting systems but there is no attempt at sector wide reporting other than a fledgling Residential Aged Care Quality Indicators program for pressure injuries, restraint and unplanned weight loss. Recent research (Ibrahim, 2017) on premature deaths of aged care facility residents demonstrates the need for a more comprehensive focus on resident safety. Ibrahim et al. (2017) found an increasing incidence of an external cause of deaths in residential aged care for the period 2001 – 2012, particularly those related to falls.

The robust incident investigation processes such as root cause analyses used for events that result in permanent harm or death, that are a feature of the acute sector are also absent from the residential aged care sector, with the effect that systemic issues impacting on resident safety are not systematically reviewed and responded to.

Recommendation

The QNU recommends -

10) The patient safety framework for the acute hospital sector be used as a model for a residential aged care safety framework. Essential components of such a framework would be:

- An aged care equivalent of the Australian Commission on Safety and Quality in Health Care as an independent standards making body for aged care to avoid capture by aged care providers and influence by government
- Robust accreditation processes based on a comprehensive set of aged care national standards;
- A mandatory, comprehensive and transparent clinical indicator/patient safety reporting regime for aged care based on national standards.

Term of Reference

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.

The provision of residential aged care is largely a public good provided by the private sector ranging from charities, not-for-profit organisations and for-profit providers. State governments provide some residential aged care.

The funding and regulation of aged care falls primarily under federal jurisdiction via the *Aged Care Act 1997*. While it is likely that state government do have capacity to legislate/regulate the provision of aged care services within their jurisdictions, there has been a general reluctance for state governments to do so. While we have no philosophical objection to federal control of aged care, an essential element of this responsibility is the implementation of regulatory mechanisms (e.g. complaints handling, incident reporting and follow-up, standards and governance).

The primary issue however, is that any current division of responsibility is the consequence of a failure of the federal government to implement robust standards and enforcement mechanisms regarding the safety of aged care residents as part of the overall governance of aged care. This is a consequence of a number of factors including:

- inadequate surveillance by the AACQA as demonstrated by the most recent accreditation issues at the Oakden Aged Care Facility;
- a disproportionate provider influence in the aged care agenda at the expense of other key groups such as the ANMF and other employee and community representative groups;
- a lack of comprehensive standards; and
- a paucity of transparency requirements for providers to demonstrate how they spend the significant public contribution to aged care funding they receive, particularly in relation to those factors known to directly influence resident safety, e.g. staffing and skill mix levels.

Recommendation

The QNMU recommends -

- 11) Comprehensive governance mechanisms (currently lacking) must be implemented in aged care focusing on the safety of residents and quality of care. These governance mechanisms include:
- An aged care equivalent of the Australian Commission on Safety and Quality in Health Care as an independent standards making body to avoid capture by aged care providers and influence by government;
 - Robust accreditation processes based on a comprehensive set of aged care national standards;
 - A mandatory, comprehensive and transparent clinical indicator/resident safety reporting regime for aged care based on national standards;
 - Transparent financial reporting by providers to identify where public money is spent, particularly in relation to resident safety issues, e.g. staffing and skill mix and training;
 - Adding residential aged care to state based clinical safety processes to form a coregulatory model of responsibility that leverages the well established practices of the acute sector.

Conclusion

The QNMU has consistently advocated on behalf of older Australians for improvements in all aspects of aged care. We would be pleased to discuss our submission further with the committee should members decide to hold public interviews or hearings.

References

- Aged Care Complaints Commissioner (2017) *National Quarterly Bulletin, March Quarter 2016 – March 2017 Quarter*, retrieved from <https://www.agedcarecomplaints.gov.au/wp-content/uploads/2017/07/National-Quarterly-Bulletin-March-quarter-2016-March-Quarter-2017.pdf>
- Australian Law Reform Commission (2017) *Elder Abuse – A National Legal Response* Final Report 131, Sydney.
- Australian Nursing and Midwifery Federation (2013) *Nursing Guidelines: Management of Medicines in Aged Care*, Melbourne.
- Australian Nursing and Midwifery Federation (2016) *National Aged Care Survey Final Report*, unpublished.
- Chesterman, R. (2012) *Assessment Report into Allegations made by Ms Jo-Anne Barber in a Statement dated 21 April 2012 and a Submission delivered 8 May 2012*, Report to the Legislative Assembly of Queensland, no. 87 retrieved from <http://www.parliament.qld.gov.au/documents/tableoffice/taledpapers/2012/5412t549.pdf>
- Davies, G. (2005) *Queensland Public Hospitals Commission of Inquiry Report*, retrieved from <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2005/5105T5305.pdf>
- Department of Health (2016) *National Aged Care Workforce Census and Survey – The Aged Care Workforce* retrieved from <https://agedcare.health.gov.au/news-and-resources/publications/2016-national-aged-care-workforce-census-and-survey-the-aged-care-workforce-2016>
- Department of Health (2017) *Single Aged Care Quality Framework. Draft Aged Care Quality Standards Consultation Paper*, retrieved from <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/single-quality-framework-draft->

[standards/supporting_documents/Single%20Aged%20Care%20Quality%20Framework%20%20Draft%20Quality%20Standards%20Consultation%20Paper.pdf](#)

Department of Health and Ageing (2012) *Guiding Principle for Medication*

Management in Residential Aged Care retrieved from

[http://www.health.gov.au/internet/main/publishing.nsf/Content/3B17BD9642D56802CA257BF0001AFDA5/\\$File/Guiding%20principles%20for%20medication%20management%20in%20residential%20aged%20care%20facilities.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/3B17BD9642D56802CA257BF0001AFDA5/$File/Guiding%20principles%20for%20medication%20management%20in%20residential%20aged%20care%20facilities.pdf)

Forrester, K., Davies, E. & Houston, J. (2013) *Final Report Chesterman Report*

Recommendation 2 Review Panel retrieved from

<http://statements.qld.gov.au/Content/MediaAttachments/2013/pdf/16-4forrester.pdf>

Forster, P. (2005) *Queensland Health Systems Review*, Final Report retrieved from

<http://www.parliament.qld.gov.au/documents/tableoffice/tabledpapers/2005/5105t4447.pdf>

Ibrahim, J., Bugeja, L., Willoughby, M., Bevan, M., Kipsaina, C., Young, C., Pham, T & Ranson, D. (2017) *Premature deaths of nursing home residents: an epidemiological analysis*, *Medical Journal of Australia*, 206 (10), pp. 442-447.

King, D., Movromaras, K., Wie, Z., He, B., Healy, J., Macaitis, K., Moskos, M. & Smith, L.

(2013) *The Aged Care Workforce, 2012 – Final Report* retrieved from

https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/11_2014/rdp004-nacwcas-report.pdf

Magistrate's Court of Tasmania Coronial Division, 2013 TASCD 144.

Nursing and Midwifery Board Australia (2008) *Code of Professional Conduct for Nurses in Australia* retrieved from

<http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjvru-bsqXVAhWHJ5QKHc49Cz8QFggI&url=http%3A%2F%2Fwww.nursingmidwiferyboard.gov.au%2Fdocuments%2Fdefault.aspx%3Frecord%3DWD10%252F1353%26dbid%3DAP%26chksum%3DAc7KxRPDt289C5Bx%252Ff4q3Q%253D%253D&usg=AFQjCNF8F4L8vBEpHna0npODjOPPsDxbgg>

Nursing and Midwifery Board Australia (2013) *A national framework for the*

development of decision-making tools for nursing and midwifery practice

retrieved from <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx>

Nursing and Midwifery Board Australia (2016a) *Codes and Guidelines* retrieved from

<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements.aspx>

Willis, E., Price, K., Bonner, R., Henderson, J., Gibson, T., Hurley, J., Blackman, I., Toffoli,

L. & Currie, T. (2016) *Meeting residents' care needs: A study of the requirement*

for nursing and personal care staff, Australian Nursing and Midwifery Federation.