New South Wales Nurses and Midwives' Association

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

Supplementary Submission
November 2018

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes Assistants in Nursing (who are unregulated), Enrolled Nurses, Registered Nurses and Midwives at all levels including management and education.

The NSWNMA has approximately 66,000 members including over 10,300 members employed in aged care, and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

We welcome the opportunity to provide a supplementary submission to this Inquiry.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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Term of Reference to be reported on

1. 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

Introduction

Previous submissions have been made in relation to this term of reference. We would support the evidence provided therein. This is set out in **section one** of this submission. Supplementary information is contained within **section two**.

In making this supplementary submission we would reiterate that there has been prolonged failure by the Government to give consistent weight to the findings of the various aged care inquires that have been undertaken within the past five years. Many of which have examined the role of the Australian Aged Care Quality Agency (AACQA).

We have consistently argued for aged care policy to be focused on the experiences, needs and desires of the older person themselves. The Aged Care Quality and Safety Commission will need to ensure that there are accurate measures in place to quantify what is needed to provide safe, effective quality care to people living in residential aged care facilities (RACFs).

Failures by the current AACQA must be attributed to a lack of focus around the individual and high regard for provider self-reporting on policy and systems. Putting people at the centre of aged care regulation would allow for matters such as clinical benchmarking, staffing models and outcomes monitoring to be front and centre of the activities conducted by the Aged Care Quality and Safety Commission going forward.

Recommendations

1. An evidence-based methodology for calculating staffing and skills mix ratios must be legislated. This must determine optimum numbers and skills mix of staff relative to the acuity of residents, their needs and direct and indirect duties to be performed.

2. Legislated benchmarks against clinical, well-being and safety indicators that span public, not for profit and private aged care sector should be introduced and used to assess compliance. Aged care providers must be required to report on performance against these benchmarks.

3. Legislation must ensure that the Aged Care Quality and Safety Commission is an independent and transparent entity in the interests of public protection.

4. Any advisory body established within the Aged Care Quality and Safety Commission must ensure balanced representation amongst its membership. Membership must include independent experts, clinicians, employee representatives and a diverse range of consumer representative bodies.

5. Any advisory body members providing direction to the Aged Care Quality and Safety Commission must be selected in a fair and transparent way.

Section one – previous submission

Taken from NSWNMA submission July 2017

The NSWNMA regularly attends Agency Liaison Meetings with the state branch of the AACQA where local and national data sets are provided. Data suggests there is a continual lack of compliance in regard to: staffing; medications management; clinical care and behaviour management. It is our view that this can be explained through a combination of the following:

- Failure of consecutive Governments to address the fundamental issue of safe staffing in residential aged care and lack of impetus to establish minimum safe staffing ratios for aged care in all states; and

- Inadequate systems for determining adequacy of safe staffing, including lack of commonwealth safe staffing methodology; and

- Inadequate regulatory processes determined by risk management that allows for the same outcomes to be reported against at each site visit, leaving large gaps between reports on other outcomes (or absence of reporting); and

- Inadequate system for assessing against each outcome upon re-accreditation of facilities and over-reliance on paper based audit and self-reporting; and

- Lack of a case-tracking system for assessing care outcomes against individual care needs.

The accreditation framework is inherently flawed with regulator performance targets more focused on reducing regulatory burden on providers[1]. Also, 'Better Practice Awards' offered as incentives for providers to display innovative care, which portray this as aspirational rather than a basic regulatory requirement[2]. Both of which do little to evoke consumer confidence and promote neutrality.

[1] https://www.aacqa.gov.au/about-us/quality-agency-regulator-performance-1
[2] https://www.aacqa.gov.au/providers/promoting-quality/better-practice-awards/copy_of_2016-better-practice-award-winners

The re-accreditation system relies heavily on self-reporting against care outcomes and is a largely paper-based audit. Yet accreditation may result in a licence to operate for up to five years[3]. Interim site audits conducted more regularly are likely to be more detailed, longer and use more assessors. However, they are often targeted based on intelligence about the service. This means that a set of outcomes may not be assessed against, other than through an audit based system for over three years.

Since accreditation audits lack depth it is unsurprising that the latest annual report by the AACQA shows that in 2015-16, more than 97% of all residential aged care facilities that went through a full audit met all expected outcomes of the Accreditation Standards, with only 13 review audits identifying concerns that the Accreditation Standards may not be met[4]. Figures from the England aged care regulator, show that 347 services were either de-registered or had their registration cancelled within the same period, took 1,090 enforcement actions and at the year-end were also in the process of taking another 777 actions[5]. Accounting for the differences in breadth of coverage; these figures still suggest under-reporting of non-compliance by the AACQA.

Changes proposed to the regulatory framework through the Single Aged Care Quality Framework to be introduced in 2018[6] support less, not more regulation of the sector. Regulation will rely more on risk assessment and indications are that there will be less definition within outcomes meaning that there will be greater chance of individual assessor discretion.

It is also concerning that revised outcomes fail to define a staffing model that will enable assessors to determine optimum staffing skills mix and ratios. It is our view that this is fundamental to ensuring high quality care as demonstrated in the findings of the Oakden Report; which recommends mandated staff training and states

[3] South Australia 'Innovation Hub' Initiative
[4] https://www.aacqa.gov.au/about-us/annual-reports/annual-report-2015-2016/AACQ%20Annual%20Report%202016%20ACCESSIBLE%20WEB.pdf
[5] Care Quality Commission Annual Report 2015-16. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541546/CQC-15-16_ARA_acc.pdf
[6] https://www.aacqa.gov.au/providers/news-and-resources/single-aged-care-quality-framework/single-aged-care-quality-framework

minimum staffing and skills mix to ensure safe and appropriate care[7]. Australian Nursing and Midwifery Federation research conducted in 2016 found that current staff hours are not adequate to even meet basic care needs[8]. Failure to ensure effective regulation of this area, and establish minimum standards to report against will no doubt lead to a continuation of the poor practices such as those displayed at the Oakden facility.

To date, there has been no consultation or indication of any changes to aged care legislation. Unless there are clear links between outcomes to be measured and legislation, assessors will have little power to take swift remedial action where concerns are identified.

Government reform has removed the distinction between low and high care RACFs allowing people to 'age in place'. High care can now be provided in former low care provision and most people being admitted have high care needs in some form[9]. However, legislation does not stipulate minimum staffing requirements and many RACFs do not have registered nurses on-site at all times. Many are staffed either entirely by unlicensed care workers, employ registered nurses during office hours or have on-call arrangements which often leave people waiting to receive vital medications until suitably skilled staff can attend.

Legislation and guidelines determining best practice in relation to medication management have failed to keep pace. Guidelines designed for unlicensed care workers assisting people to self-administer medications are now irrelevant in RACFs where high care is mainly provided. This is a serious oversight that must be addressed as a matter of urgency.

As a recurring area of non-compliance reported by the AACQA it is without doubt that medication practices, such as were evident at the Oakden facility, have been inadequately addressed by existing regulatory and complaints processes.

[7] Government of South Australia (2017) The Oakden Report. Available at: http://apo.org.au/node/76130
[8] ANMF (2016) National Aged Care Staffing and Skills Mix Project Report 2016. Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf
[9] Australian Institute of Health and Welfare (2017) *Residential aged care and Home Care 2014–15 supplementary data*. Available at: http://www.aihw.gov.au/aged-care/residential-and-home-care-2014-15/data/

Taken from NSWNMA supplementary submission November 2017

We surveyed over 700 of our aged care members on medication practices in NSW RACFs. This resulted from widespread concern within our aged care membership, over unsafe medication practices. Findings showed that the presence of registered nurses on site, and improvements in the ratio of registered nurses to assistants in nursing (AINs/PCWs) has the potential to reduce life-threatening medication errors. Facilities that provided registered nurses on site at all times were more likely to be able to provide prompt pain relief and make informed clinical judgments about the appropriateness of medication administration[10].

[10] NSWNMA (2017) The state of medication in NSW residential aged care. Available at: https://issuu.com/thelampnswnma/docs/medication_in_nsw_ras_final_lr

Section two – supplementary submission November 2018

There have been significant changes to the regulation of the sector since our previous submissions, with the formation of the Aged Care Quality and Safety Commission and appointment of an Aged Care Quality and Safety Commissioner. Procedurally, unannounced audits have been commenced and compliance action has increased as a result of high media coverage of significant failures in the care and treatment of aged care recipients.

However, there continues to be a push for self-regulation of the sector and voluntary codes of practice[11], and a failure to address the fundamental issue of causal factors as to why the sector has failed so badly to protect our vulnerable elderly. Medical, clinical and allied health organisations have argued that staffing and skills mix is intrinsically linked to higher quality of care. The only push back against mandating staffing ratios has been from within the sector itself. Our members are continually discouraged by the failure to acknowledge the concerns and recommendations of frontline staff.

We would question the rationale for voluntary codes of practice. It seems counter-productive to push self-regulation of the sector when the sector has failed to prevent situations such as Oakden in SA, and given the level of sanctions currently imposed. At the time of writing, in NSW alone there are currently 10 RACFs with sanctions and 22 with current notices of non-compliance[12]. Clearly this is evidence of an industry that does not yet have capability to effectively self-regulate.

We would re-affirm the recommendations of our previous submissions in noting that without legislation that prescribes ratios of safe staffing and skills mix, assessors will lack the necessary tools to take enforcement in this area. There is clear evidence that staffing and skills mix are directly correlated with enhanced quality of care[13]. Unless a methodology for calculating safe staffing and skills mix is legislated, the

[11] Aged Care Workforce Taskforce Report: A Matter of Care, Released September 2018
[12] https://www.myagedcare.gov.au/quality-and-complaints/notices-non-compliance
[13] http://www.nswnma.asn.au/wp-content/uploads/2018/05/Ratios-save-lives-WEB.pdf

AACQA will have little capacity to take enforcement action in this regard, and have no methodology at hand to determine 'adequacy and sufficiency'.

There is no legislation that formerly requires aged care providers to report on clinical, wellbeing and other associated outcomes. Additionally there are currently no clinical benchmarks that span public, not for profit and private aged care sector. This was a recommendation of the Senate Committee on Health, Aged Care and Sport following the Inquiry into the Quality of Residential Aged Care Facilities in Australia. The Inquiry recommended mandating and extending the National Quality Indicators program to increase transparency within the sector[14]. Intelligence gathered through such programs must be integrated within data collection processes undertaken by the Aged Care Quality and Safety Commission and used to inform judgements about compliance.

Our members also have concerns regarding transparency within the newly established Aged Care Quality and Safety Commission. In making our submission to the Aged Care Quality and Safety Commission Bill 2018 and related Bill, and Aged Care Quality and Safety Commission (Consequential Amendments and Transitional Provisions) Bill 2018 we noted:

"The process by which this Bill was derived, and consultative processes once established offer little assurance that this Commission will provide a new direction for aged care. It is lacking in both transparency and consumer engagement and suggestive of a 'business as usual' approach.

The continued heavy bias of aged care industry peaks and line of direct communication to the proposed Commissioner will neither benefit, nor enhance transparency." p2[15]

14 https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024167/toc_pdf/ReportontheInquiryintotheQualityofCareinResidentialAgedCareFacilitiesinAustralia.pdf;fileType=application/pdf

15 NSWNMA submission 2018. Available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQSCommission/Submissions

In making this comment we refer to specific consultation undertaken in preparation for the establishment of the new Commission. Advice was sought from 'targeted sector meetings.' It is disappointing that the Government sought to individually consult with the sector, rather than a broad range of consumer advocacy organisations and workforce representatives. In addition, the Aged Care Sector Committee Quality Subgroup will continue to be a resource for policy direction and advice. At the time of the consultation into structuring of the new Commission, this subgroup did not have a single member representing the workforce. Consumer representation was tokenistic and lacking in breadth.

Transparency must be a key feature of the Aged Care Quality and Safety Commission going forward if consumer confidence, safety and meaningful regulation is to be achieved.