Martin Foley MP

Minister for Housing, Disability and Ageing
Minister for Mental Health
Minister for Equality
Minister for Creative Industries

GPO Box 4057
Melbourne Victoria 3001
Telephone: +61 3 9096 7500
www.dhhs.vic.gov.au
DX: 210081

e4585029

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100 Parliament House
Canberra ACT 2600

community.affairs.sen@aph.gov.au

Dear Secretary

Re: The Senate Community Affairs Reference Committee Inquiry into the *Effectiveness of Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practice, and ensuring proper clinical and medical care standards are maintained and practiced.*

Victoria welcomes the opportunity to contribute to this Senate Inquiry into the Effectiveness of Aged Care Quality Assessment and accreditation framework (the framework). The Victorian Government has a strong interest in the quality of residential aged care for older Victorians.

Aged care is an important sector of our economy and of critical importance to the many people, who require residential care, their families, friends and carers. There are one hundred and eighty one Victorian Public Sector Residential Aged Care Services which, in 2015, provided 5,796 (11.3%) of the aged care places in Victoria.

Victoria is particularly concerned that the framework is overly reliant on an accreditation process that works to minimum standards rather than encourage continuous quality improvement. The framework would be more effective if the Commonwealth government:

- provided a definition of quality, safety and wellbeing which could be promulgated, measured and drive improvement;
- promoted a system-wide approach to quality improvement informed by evidence, sound measurement and consumer feedback;
- provided clear and measurable standards that are specifically applicable to residential aged care. Standards are required for clinical care and for personal care as they are distinct activities with different requirements.
- recognised an effective workforce as a key input for safe, quality care. In the absence of benchmarks against impact and outcome indicators, minimum nurse to resident ratios and a minimum staffing framework are required to ensure that appropriate care can be provided to residents in a timely way.

VICTORIA State Government

- provided clearer and more effective requirements for core competencies in end of life care. Aged care providers need to invest in supporting their staff to build and maintain capacity in the provision of end of life care to residents. Poor practice potentially results in residents receiving treatment they don't want, inappropriate transfers to hospitals and residents not dying in their place of choice.

- strengthened requirements for clinical care and clinical governance which underpin good residential care and to improve aged care provider accountability and consumer confidence.

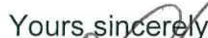
While compliance with minimum standards is an important part of the approach, this needs to be complemented by a suite of evidence based consensus measures to strengthen monitoring and accountability, provide care benchmarks and inform and drive improvement activity.

Further, the Australian Law Reform Commission Report on Elder Abuse made recommendations for improvements to injury prevention, monitoring and reporting mechanisms and data collection for serious injury and mortality incidents in aged care. These recommendations should also be considered by the Committee.

Thank you for the opportunity to contribute to this Senate Inquiry. Our submission is attached. Our comments are consistent with our response to the Commonwealth's review of quality standards earlier this year.

I look forward to reading your report and would be happy to provide further information if required.

Yours sincerely



Martin Foley MP

2 / 8 / 2017

cc Hon Ken Wyatt AM, MP
Minister for Aged Care

VICTORIA State Government

Victorian Submission

To the Senate Community Affairs Reference Committee Inquiry into the ***Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practice, and ensuring proper clinical and medical care standards are maintained and practiced.***

Introduction

Victoria welcomes the opportunity to contribute to this Senate Inquiry into the Effectiveness of the Aged Care Quality Assessment and accreditation framework. The Victorian Government has a strong interest in the quality of residential aged care for older Victorians.

This Senate Inquiry follows a series of reviews which have made considered recommendations, many of which have not been implemented. The Senate Community Affairs Reference Committee is well placed to influence the improvement of the aged care quality framework for the benefit of users and we look forward to the Committee's report.

State health services operate over eleven per cent (11.3%) of the residential aged care places in Victoria, the majority of which are located in rural and regional areas. Coordination between residential aged care facilities and other health sectors including acute health services is critical to the productivity and efficiency of health system operations as well as to the quality of care provided. Older people (65 and over) account for over 40% of all acute inpatient admissions (VAED 2016-17).

The aged care quality framework should be more effective than it is. This is evidenced by the number of past and current inquiries into the aged care system due to systemic failures in standards of care. This inquiry coincides with Minister Wyatt's Review of National Aged Care Quality Regulatory Processes and the Department of Health's consultation on the options for a single aged care quality framework and quality standards.

Key messages from Victoria:

Accreditation is limited by a focus on minimum standards

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

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

The Commonwealth is considering a set of streamlined standards that are applicable to both home care services and residential aged care services. Victoria supports clear and measurable standards that are specifically applicable to residential aged care. Specific and measurable standards would

make it possible to hold residential aged care providers accountable for the quality of care they provide.

Residential aged care services should be explicitly expected to hold responsibility for providing ongoing safe care that meets the needs of the whole person. This contrasts with the care for older people living in the community who retain responsibility for determining whether they can live in their own home and what services they prioritise.

A comprehensive quality framework is required to achieve better outcomes for clients

To achieve better outcomes for consumers, there needs to be a move beyond the current reliance on assessment of compliance by individual providers to an approach that monitors the performance of the aged care sector as a whole and supports the sector to improve quality continuously.

Accreditation should only be one part of a comprehensive framework that supports improved clinical governance, and better use of data which sets clear expectations of providers and systems to monitor performance and improvement at a system or sector level. Comparative analysis of data can provide an understanding of why people experience poor safety and quality of care and what can be done to improve residential aged care services.

Victoria has progressed a range of safety and quality initiatives to support the delivery of high quality care in public sector residential aged care services. We believe the current aged care quality framework would benefit from:

- The development and application of a statement of expectations for residential aged care service providers making explicit what they are obliged to provide. The statement should incorporate a 'sector clinical capability framework' to specify the skills, capacities and infrastructure that should be available to residents.
- Definitions for health, quality, safety and wellbeing for aged care that can be promulgated, measured and drive improvement.
- A systems-wide approach to quality improvement informed by evidence.

Care should be person-centred and responsive to people's needs.

The aged care quality assessment and accreditation framework would be more effective with an improvement rather than a punitive focus.

Clinical care and clinical governance underpin good residential care

Clinical governance is key to ensuring clinical care is safe, effective, appropriate and person-centred and able to be delivered within the service setting where it is most appropriate and safe to do so. Organisational clinical governance requires strengthening to improve aged care providers accountability and consumer confidence.

An appropriate clinical governance framework for aged care providers in Australia should be developed and agreed, drawing on the well-established frameworks elsewhere in health care. Such a framework will support services to focus on consumers and system improvement that reaches beyond compliance with minimum standards.

This approach will need to be supported by an investment in research to build a body of evidence that can later inform standards and expectations of service providers.

Clinical effectiveness is a core component of an effective quality framework for residential aged care. The clinical needs of people living in residential aged care are increasing. Clinical care and personal care are distinct activities with different skill and training requirements. Clearly defining expectations and care standards will facilitate assessment of workforce requirements.

Service coordination between the residential aged care system and acute health services is critical to the productivity and efficiency of operations as well as to the quality of care provided. The communication of accurate medical and medication information is essential to providing quality care to all patients as they transfer between sectors in the health care system. Standards are required for information accompanying patient transfers.

Data collection, linking existing data sets, analysis and dissemination of information would improve the effectiveness of the current framework

The monitoring of resident outcomes and a culture of continuous improvement need to be underpinned by robust systems for collecting and analyzing data both locally and at a whole of system level. With the aim of improving consumer choice, the Commonwealth has rolled out a suite of quality indicators. This national programme was informed by over a decade of Victorian work in this area. Further work should be prioritised to support the availability of consistently comparable for improvement.

There will need to be a cultural shift to support better use of data. Building a culture of openness and learning from past mistakes and poor performance will lead to systems improvement. It is essential that clinical performance data is used as a positive tool, not for judgment or sanctions.

Consumers should also have access to comparative data and information about complaints, responses, incidents accreditation reports and inputs such as staffing levels.

While complaints handling processes are improving they have remained reactive and reliant on informed consumers with the capacity and courage to complain. Complaints would lead to quality improvements if the information was analysed across the system to identify issues of concern.

Investment is required in system-wide data collection for monitoring adverse events to inform, develop and continuously improve residential aged care services. The recent Australian Law Reform Commission Report on Elder Abuse made several recommendations for improvements to the injury prevention, monitoring and reporting mechanisms and in relation to data collection for serious injury and mortality incidents in aged care.

An adequately regulated workforce enables quality care and safe environments

A workforce with the appropriate staff numbers and skill mix underpins the delivery of safe, quality care. In the absence of benchmarks against which to measure achievement of desired outcomes, minimum nurse to resident ratios and a staffing framework for all care staff are required to ensure that skilled care can be provided to residents in a timely way.

Aged care providers and system managers need to support staff to build and maintain their capacity. This is especially important in the provision of end of life care to residents which requires skills in the early recognition of resident deterioration, recognition of the dying resident and escalation of care to meet their needs, including referral to specialist services as required.

The specific terms of reference of the Senate inquiry are addressed below.

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

Protection from abuse and poor practice

The quality assessment and accreditation framework is not a comprehensive and integrated system designed to protect residents from abuse and poor practices.

Evidence of this failure to protect is clearly documented in the May 2017 Australian Law Reform Commission (ALRC) Report, Elder Abuse – A National Legal response. A total of 14 out of the ALRC's 43 recommendations are about improving aged care, in both residential settings and the home.

Consideration should be given to the Commission's aged care recommendations focused on:

- A system to better define, oversee, identify, monitor, report and respond to serious incidents (Recommendations 4-1,2,3,5,6):
- Independent evaluation of optimal staffing models and levels, codes of conduct for direct care and enhanced employment screening for workers in aged care (Recommendations 4-7, 8, 9);
- Legislative regulation of the use of restrictive practices in aged care, including chemical restraints as well as additional safeguards in relation to their use. (Recommendations 4-10, 11)

Residential Aged Care Facilities (RACs) are subject to mandatory reporting to the police, then the department, only of *suspected* assault (unlawful sexual contact, unreasonable use of force or a physical assault) and missing residents.

The Australian Law Reform Commission expressed concern that restrictive practices were sometimes used to manage residents when there was insufficient staff or that abuse or neglect could result from inappropriate or insufficient levels of staff. The aged care sector needs to be better equipped to screen, identify and intervene to protect residents' rights. Elder abuse impacts widely on the children, partners, friends and care staff who advocate for and support older people.

There are currently no departmental guidelines that ensure a consistent response to critical, serious or reportable incidents. Clear evidence-based definitions of the broad range of adverse events, grouping categories and levels of severity, would standardise reporting and enable ongoing monitoring of adverse events at both individual service and system level. For example, currently there is no information about the number and severity of incidents of elder abuse, including sexual assault and neglect, in Australia.

A comprehensive national approach to the reporting and analysis of adverse events would support further improvements across the sector particularly in the area of prevention. Implementation by the Commonwealth of the ALRC's recommendations to improve the reporting and monitoring of serious incidents, such as sexual or physical abuse, and for the process to be overseen by an independent body would make a key contribution to development of a broader monitoring system.

Clinical care and clinical governance

Clinical governance: the integrated systems, processes, leadership and culture that are at the core of providing safe, effective, accountable and person-centred care underpinned by continuous improvement.

The aged care quality assessment and accreditation framework lacks adequate systems for monitoring the effectiveness of *clinical and medical care*.

Quality outcomes for residents will not be realised through a compliance focused accreditation approach. Expectations around standards of care need to be clear and specific so that: care recipients and providers understand these expectations; performance can be objectively measured and reported, and not open to broad interpretation by either providers or assessors and support more consistent care. This includes defining safety and quality and adverse events as they relate to aged care.

Compliance with minimum standards is an important part of the approach however this needs to be complemented by a broader framework that promotes continuous improvement through evidence informed best practice.

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

While clinical governance frameworks are well established within healthcare, there is no agreed clinical governance framework for aged care providers in Australia. Yet older people are inherently predisposed to clinical risk due to multi-morbidity and frailty, especially those living in residential aged care services.

The Victorian clinical governance framework has five key domains:

- leadership and culture
- consumer partnerships
- workforce
- risk management
- clinical practice.

Such a framework supports services to focus on consumers and system improvement that reaches beyond compliance with minimum standards.

This approach will need to be supported by an investment in research to build a body of evidence that can later inform standards and expectations of service providers.

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

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

End of life care

It is important that older people are supported to receive high quality end-of-life care in the setting of their choice, including residential aged care. The majority of residents will die while in residential care making the end of life care an essential element of their experience

In 2015-16, the total number of deaths of permanent Victorian aged care residents was 14,781 and this accounted for 83.4% of all discharges/separations from residential aged care. Nationally there were 56,084 separations from aged care facilities as a result of death.

The Inquiry into end of life choices, Final Report (2016) by the Legal and Social Issues Committee of the Legislative Council Parliament of Victoria identified deficiencies in the end of life care provided to aged care residents. The inquiry made a range of recommendations aimed at reducing variability of care, avoiding unnecessary emergency department presentations and building the capacity of the workforce to provide palliative care to residents.

Victoria recommends that the standards include an expectation that a residential aged care service:

- Has an advance care planning policy (and has adapted other relevant policies to include advance care planning) that articulates the role of staff in advance care planning, and includes systems for storing and retrieving advance care plans and processes for regularly reviewing a resident's advance care plan.
- Ensures that if a resident has appointed a substitute decision maker that this is recorded in the resident's medical record.
- Supports residents and their representatives to develop an advance care plan, in conjunction with the resident's GP, which outlines the level of treatment and health outcomes that the resident would want and assists future decision making about health and personal care.

Core competencies in end of life care should be a requirement in the aged care quality framework. The Victorian Department of Health and Human Services has developed a standardised care process to support residential aged care services implement evidence based end of life care and reduce care variation.

Aged care providers need to invest in supporting their staff to build and maintain capacity in the provision of end of life care to residents, including skills in the early recognition of resident deterioration, recognition of the dying resident and escalation of care to meet the needs of the dying resident including referral to specialist services as required. The standards should support residents to receive care that is person-centred and responsive to their needs. This approach should result in very few, if any older people being transferred out to an acute hospital at end of life.

Principles for Palliative and End-of-Life Care in Residential Aged Care have been developed collaboratively by Palliative Care Australia, Alzheimer's Australia, COTA Australia, Aged & Community Services Australia, Leading Age Services Australia, Catholic Health Australia and the Aged Care Guild to present a united commitment in recognising the diverse needs of residential aged care consumers, families, carers, aged care staff and service providers in providing palliative and end-of-life care. The principles articulate that staff need to be appropriately trained and skilled to deliver end of life care.

It is imperative that the wishes of the resident and their substitute decision maker are known and that these goals are captured in a way that can usefully inform decisions regarding the care of the resident at the end of life. The potential consequences of poor advanced care planning practices include residents potentially receiving care/treatment that they would not want, inappropriate transfers to hospital and residents not dying in their place of choice. In a recent survey of Victorian health service clinicians, palliative care (along with post-falls management) was listed as the third most common reason for a resident to be referred for hospital outreach support.

Protocols should ensure that the goals of care remain current as the health status of the resident changes and that general practitioners are active participants in the development of goals of care for the resident.

Medical care

In 2011 the Productivity Commission reported that the quality assessment and accreditation framework was not effectively ensuring that medical care standards were maintained and practiced. This was confirmed by a recent evaluation (March 2017) of Residential In Reach services in the eastern Melbourne metropolitan area undertaken by the Australian Institute for Primary Care and Ageing, La Trobe University. This evaluation concluded that access to timely and appropriate medical care in residential aged care facilities is problematic, especially when residents are deteriorating and/or dying.

In practice, residents of aged care facilities have varying access to GPs; in some facilities their access is the same as if they were in the community, in others GPs may be credentialed by the organisation and be readily available, and a few large facilities may directly employ a GP to cater for residents. However access to medical services is frequently poor and aged care residences can struggle to find GPs to attend residents.

Under the current system a direct client - doctor relationship may exist over which providers have little control. Transparency or accountability for standards of practice is not ensured. Expectations for credentialing and defining scope of practice for medical and other health practitioners and transparency around costs could be strengthened by the Commonwealth.

The accreditation framework should outline expectations of aged care providers with respect to systems required to support primary care provision to aged care residents consistent with the RACGP's *A best practice guide for collaborative care between GPs and RACFs.*

Barriers to the medical care of aged care residents could be addressed through improved processes for engaging with each resident's GP. For example, streamlining GP access to a resident's clinical file at residential facilities, ensuring that a staff member with clinical knowledge of the resident is

available to actively participate in the GPs' assessment of the resident, and having equipment available to support the clinical care of residents.

Improving processes to support greater GP engagement in resident care would also facilitate greater utilisation of MBS items that support a more holistic approach to resident care but are currently under-utilised, e.g. medication management reviews, comprehensive medical assessment, case conferencing and care planning. A recent review of GP services for aged care residents found that these MBS items represented only a very small proportion of GP services provided to residents (Hillen et.al 2016).

Data collection and performance monitoring

Effective systems of data governance should underpin the reporting of performance outcomes across all aspects of service and care delivery. These need to be robust in order to drive confidence and support appropriate and transparent decision making within each organisation as well as for external reporting.

The Productivity Commission report Caring for Older Australians (2011) recommended that an Australian Aged Care Commission should develop a Quality and Outcomes Data Set for use by care recipients and bring together evidence on best practice care, with the information openly accessible via the Gateway.

The OECD report, *A good life in old age* (2013) identified three key domains that appear to be both central and generally accepted as being critical factors underpinning residential aged care quality. These include:

- effectiveness and care safety,
- patient-centeredness
- responsiveness and care coordination.

Building on this work further research is required to develop a national suite of consensus, evidenced based performance measures to strengthen monitoring and accountability for safe, high quality, person centred care to residents. Victoria is currently undertaking such work as we look to improve monitoring and accountability for high quality care in Victorian public sector residential aged care services.

More broadly, linkage to hospital data is a high priority to support sector capacity building through better understanding of, for example, the number of people who are discharged from aged care to hospital, who subsequently died during that hospital visit. There are considerable sector-wide learnings that could be promulgated through this joined up approach to data use.

Workforce

An effective workforce is a key input for safe, quality care and requires at least a minimum prescription to ensure the objectives of the standards can be measured, community expectations can be met and inappropriate care substitution and hospital admissions are prevented.

In 2011 the Productivity Commission's report noted that providers seeking to minimise costs have an incentive to employ a high proportion of lower qualified care workers.

The diminishing proportion of clinically qualified staff in residential aged care is a cause for significant concern, especially when considered against the increasing average dependency and chronic health needs of residents. The National Aged Care Workforce Census and Survey report 2016 recorded the fourth consecutive drop in the proportion of registered and enrolled nurses in the residential aged care workforce since the census was first conducted in 2003.

The statistics reported in the workforce census are stark. Total nurse numbers (FTE) have dropped lower with each census while aged care places have increased. For the total 13 year period there has been a 10.5% decrease in the number of FTE Registered nurses (RNs), equal to a 35% decrease in RNs per aged care place.

This equates to one registered nurse for every 13.4 aged care places – not per shift, but to provide 24/7 coverage for residents. Decreasing RN staffing is further exacerbated by diminishing enrolled nurse numbers which have dropped again since the 2011 census and are now 16% below the 2003 number. Total nurse numbers have dropped from 35.8% of the workforce (27,210) to 24.2% of the workforce (23,690) over the 13 year period and nurses per aged care place by 34%.

In Victoria, the residential in-reach program has been introduced to prevent avoidable admissions to hospital by aged care residents. However, these services are frequently called upon to deliver basic care such as routine urinary catheterisations and wound management that should be well within the capability and responsibility of aged care providers.

The skills and capacities expected of the aged care sector workforce need to be defined to ensure adequate standards of nursing and personal care. Scarce and expensive to operate acute hospital beds should not be substituted for proper in-house aged care. Further when providers consistently transfer care accountability to others it reinforces deskilling of existing staff.

Workforce expectations for residential care should also ensure suitable conditions are provided to attract and retain consulting clinicians, including GPs, including stipulating appropriate facilities for them to work in and clinical staff that they can communicate with effectively about the needs of residents.

As noted, close consideration should be given to Victorian Law Reform Commission's recommendations (4-7, 8, 9) for an independent evaluation of research on optimal staffing models and levels in aged care and for the results to be used to inform accreditation processes.

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

Older people in residential aged care are vulnerable. At 30 June 2015, 89,000 people in permanent aged care (52% of total residents) had a diagnosis of dementia (AIHW Care Needs in Residential Aged Care Supplementary Table 2014-15) . About one-quarter (27%) of these residents were rated as needing a high level of care across all three care domains (activities of daily living, behaviour and complex health care).

The Aged Care Complaints Commissioner has publicly acknowledged that many family members are worried about making complaints about staff and facilities because they depend on the services they are complaining about. This suggests that more needs to be done to improve confidence in the system.

Quality care will be advantaged by empowering older people to feel they can speak out, providing advocacy and ensuring *consumer directed care* delivers the type of choices older people want. In July 2017 the Commonwealth introduced a clearer approach to who can speak on a client's behalf and in which circumstances and a new process that can be used to appoint a representative.

While complaints handling processes are improving they have remained reactive and reliant on informed consumers with the capacity and courage to complain. Since the Aged Care Complaints Commissioner took responsibility for all complaints about Australian Government funded aged care services on 1 January 2016 the number of complaints has risen (by 20 percent in 2016) but the number of complaints received annually (4,500) is small given the estimated 1.3 million people receiving care. Complaints are mostly about standards of care and financial disputes.

The sector will also benefit if data from complaints is used systematically to inform assessment processes and to feedback to providers to enable them to benchmark and compare performance.

There is no system-wide sector learning from information about complaints, actions and outcomes. However, learning from past mistakes and poor performance can lead to systems improvement. Consumers as well as providers should have access to comparative data and information about, complaints and consideration should be given to how meaningful data can be provided without leading to unintended consequences.

The Aged Care Complaints Commissioner cannot identify providers or release confidential information but has publically called for providers to detail the number and types of complaints they receive and how they were resolved, both on their websites and at actual facilities.

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

Victoria has no systematic information about inadequacies in standards of care that become apparent on the transfer of patients. However anecdotal accounts support assertions that lapses in standards of care are common.

The evaluation of *Residential In Reach*[1] services referred to in our response to Term of Reference (a) found many instances where the In Reach Service 'may be a substitute for the care and services that RACFs, care staff and GPs should provide. (This evaluation) highlighted numerous instances where the intention of the National Aged Care Accreditation Standards may not be met by RACFs, and where these services, as well as some GPs and RNs working in this sector are not fulfilling their roles and responsibilities in the provision of quality health care to aged care residents'.

The evaluation further stated that 'the number and quality of registered nurses (RNs) working in the residential aged care sector is declining. RNs working in this sector are older than others working in other health care sectors, and many do not have the up-to-date clinical skills to assess, plan and manage the care required by residents. Many policies and procedures implemented by individual RACFs reduce the ability of RNs to work within the scope of their practice, effectively deskilling them. Enrolled nurses (ENs) working in this sector do not have the scope of practice and assessment skills to manage the complex nursing care required by residents. Increasingly the residential aged care sector is staffed by personal care workers (PCWs), who provide most of the direct care to residents but who are an unregulated workforce with no national competency standards and extremely varied levels of education and training.'

While the evaluation was limited to one region, the findings are consistent with the views of many working in the field. An evaluation of the In Reach service in a second region now underway is encountering similar issues.

Communication of information about aged care residents on admission to and discharge from hospital is often poor and this is has been noted in various studies. The Evaluation of *Residential in Reach* services found poor communication and handover processes were common when residents were discharged from hospital. The evaluation report noted that issues of poor communication and a lack of information transfer between acute care and aged care settings, particularly of medication orders, had been widely reported in the Australian and international literature with poor outcomes for residents noted.

A systematic review of initiatives (La Manta , M.A. et al., 2010) designed to improve the transition between acute care and aged care settings, in particular communication, found that a standardised patient transfer/discharge form could assist with the communication of advance care plans/end of life directives and medication lists and that pharmacist-led review of medication lists may help identify omitted or indicated medications on transfer.

---

[1] Residential in-reach services for people in residential aged care services provide short-term care coordination and specialist assessment. More specifically, these services provide assessment and management of acute medical conditions that would otherwise result in a resident unnecessarily going to hospital.

The communication of accurate medical information is fundamental to providing quality care to all patients as they transfer within the health care system. Standards for transfer of information with the patient are being set within and on discharge from acute care settings both in Australia and internationally. Similar standards could be adopted for the transfer of aged care residents.

Protocols for the transfer of aged care residents to hospital were developed in 2009 through a study funded by the Australian Commission on Safety and Quality in Health Care with the Northeast Division of General Practice, Victoria as the lead agency. A Transfer-to-Hospital Envelope containing documents, resident information, checklists and crucial clinical and handover information (the yellow envelope) accompanies the resident on transfer. The process has since been adopted by some residential facilities in Victoria and more recently promoted by Queensland health services.

The aged care quality assessment and accreditation framework could better support safe and continuing care between home, acute and aged services by setting information standards for resident/patient transfers.

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

As noted above under Term of Reference (a), there are currently no departmental guidelines that ensure a consistent response to critical, serious or reportable incidents. Clear evidence-based definitions of the broad range of adverse events, grouping categories and levels of severity, would standardise reporting and enable ongoing monitoring of adverse events at both individual service and system level.

A comprehensive national approach to the reporting and analysis of a broad set of adverse events would support further improvements across the sector particularly in the area of prevention. Implementation by the Commonwealth of the ALRC's recommendations to improve the reporting and monitoring of serious incidents, such as sexual or physical abuse, and for the process to be overseen by an independent body would make a key contribution to development of a broader monitoring system.

The Commonwealth does have a mandatory reporting requirement regarding assault and abuse of residents, stipulated in the *Aged Care Act 1997*. Alleged or suspected assaults are reported. The police investigation takes priority as well as action to keep residents safe.

However, the information reported is not collated in a way that would contribute to quality improvement. It is unknown whether the Department of Health follows up or routinely substantiates these reports. While data is forwarded to the Quality Agency on a monthly basis for consideration in their visits to aged care facilities, there is no apparent systematic analysis or use of the data. Reports of suspected assault by care recipients as well as by staff are received and not distinguished in the current data base.

Whilst not all adverse events will result in harm, many adverse events do cause harm with some unfortunately resulting in the death of residents. Research published in the Medical Journal of Australia in May 2017[2] found that 15.2% of over 20,000 deaths of nursing home residents between 2000 and 2013 resulted from external causes (that is, an injury, violence or other external event).

The study collated information from all the investigations into deaths of individual residents by the Coroners Court over the past decade. The most frequent mechanisms of death were falls (2,679 cases, 81.5%), choking (261 cases, 7.9%) and suicide (146 cases, 4.4%).

The incidents leading to death usually occurred in the nursing home (95.8%), but the death itself usually occurred elsewhere (67.1%). This was typically at an acute care hospital where residents had been transferred.

There is insufficient information about the circumstances of serious adverse events in aged care to review the operations of a particular residential aged care service or the residential aged care system as a whole. Greater access to this information will build sector capacity in avoiding preventable adverse events or resident harm.

---

[2] Premature deaths of nursing home residents: an epidemiological analysis
Joseph E Ibrahim, Lyndal Bugeja, Melissa Willoughby, Marde Bevan, Chebiwot Kipsaina, Carmel Young, Tony Pham and David L Ranson
Med J Aust 2017; 206 (10): 442-447

Prevention needs to be a priority. It requires collaborative efforts and partnerships between aged and health care professionals, forensic death investigators, coroners, governments and the aged care sector working together in developing evidence-based strategies in consultation with residents and their families.

The Australian Law Reform Commission Report on Elder Abuse has also made recommendations (Rec 4-1,2,3) for improvements to injury prevention, monitoring and reporting mechanisms and data collection for serious injury and mortality incidents which should be considered. In particular a shared understanding of the definition of a 'serious incident' is critical.

Adverse events do occur and the Victorian government has sought to learn from them. *Targeting zero **Supporting** the Victorian hospital system to eliminate avoidable harm and strengthen quality of care,* Chaired by Dr Stephen Duckett, of the Grattan Institute, reported on a Review of the Hospital Safety and Quality Assurance in Victoria,

The Review concluded the quality processes in place were not capable of detecting significant deficiencies in clinical governance and over-relied on local governance and accreditation processes. There was not the capacity to undertake routine surveillance of serious clinical events (other than sentinel events), or to appropriately respond to incident reports. It was recommended that safety frameworks use routine data to monitor performance to identify opportunities for learning and improvement, rather than singling out individuals for blame.

These findings of this report are relevant to aged care services. The report is available at www2.health.vic.gov.au/hospitals-and-health-services/quality-safetyservice/hospital-safety-and-quality-review.

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

The Commonwealth is responsible for the funding and regulation of residential aged care and should accept primary responsibility for requirements for reporting on and acting on adverse incidents.

The Aged Care Complaints Commissioner handles the concerns of residents and their families. There is a need for a better system that links between adverse incidents, complaints and the quality monitoring system.. This should be addressed.

Responses to individual incidents of a critical nature and collation and analysis of adverse incident data generally can and should proceed without detracting from the separate responsibilities of police or other agencies in investigating and acting on reports of assaults or other criminal behaviour. Similarly, the roles of State Coroners in investigating deaths need not affect parallel reporting on data relating to the death of residents.

Victoria suggests that the Commonwealth introduce a consistent minimum data set for adverse events and critical incidents for the aged care sector, underpinned by clear definitions. This would enable an approach which:

- takes a risk-based reporting system that focuses effort and resources on incidents that have the biggest impact on clients
- provides an oversight mechanisms including to inform the use of audits and benchmarks, to ensure accountability by services
- facilitates alignment between incident management, agency management and regulatory functions