

Royal Commission into Aged Care Quality and Safety

Workforce submissions

4 December 2019

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Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.¹

The ALA office is located on the land of the Gadigal of the Eora Nation.

¹ *Australians Lawyers Alliance* (Website). Accessed on 19 July 2019 <www.lawyersalliance.com.au>.

Introduction

1. The ALA welcomes the opportunity to provide a submission focusing on workforce issues to the Royal Commission into Aged Care Quality and Safety (the Royal Commission).
2. The ALA provided a public submission to the Royal Commission on 6 September 2019. This submission will focus on the workforce issues that were addressed in our earlier submission.
3. The ALA submits that an underlying cause of the systemic problems in aged care is that the drafting and operation of the *Aged Care Act 1997* (Cth) (the Act) is weighted in favour of providers and large 'for-profit' healthcare groups. While the Act meant that the aged care sector became more heavily regulated, it also promoted privatised services and competition that led to the privatisation of the aged care sector. The ALA is concerned that these privatisation policies have resulted in an imbalance of power between provider and care recipient.

History of Aged Care Act 1997

4. The Act was introduced by the Howard government in 1997 and is the overarching legislation that outlines the obligations and responsibilities of aged care providers in order to receive funding from the Australian Government.² In effect, it is legislation written for aged care providers by aged care providers.³
5. The ALA submits that the Australian Government's reforms of 1997 have negatively contributed to the current situation in aged care. In 1997, control of oversight and regulation was taken away from the states and replaced by a federal accreditation and complaints system, which also became responsible for data collection and reporting about care.⁴

² Parliament of Australia, *Aged Care Bill Second Reading* (26 March 1997). Accessed on 19 July 2019 <<https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22chamber/hansardr/1997-03-26/0105%22>>.

³ Aged Care Crisis, *Review: National Aged Care Quality Regulatory Processes and Framework* (Report, 7 June 2017) 11. Accessed on 19 July 2019 <https://www.pc.gov.au/data/assets/pdf_file/0020/219620/subdr525-human-services-reform-attachment2.pdf>.

⁴ Countries such as Australia, the UK and the United States with centrally controlled models of regulation have repeatedly and consistently failed some of their most vulnerable citizens, despite having different systems of regulation for aged care: Aged Care Crisis, *Effectiveness of the Aged Care Quality Assessment and accreditation*

6. The ALA submits that the Act, which at the time represented the most significant reform of aged care services in over a decade, changed the context of care from smaller community-based and charity-run nursing homes and hostels to larger, often corporatised, residential aged care providers, which promote the interests of the aged care industry. An aged care 'consumer' now engages with multinational healthcare groups. The ALA notes that reliance on humanitarian motivation has been replaced by reliance on competition. According to Braithwaite, a reliance on a 'consumer choice' model to improve the quality of care in residential aged care facilities (RACFs) is naïve since the notion of depending on the rationality of the market does not work well to improve the quality of care.⁵ The ALA submits that residents are generally (but not always) too frail and vulnerable to 'vote with their feet', and in circumstances where available choices may be limited.⁶
7. The ALA submits that government policy to support the aged care sector requires an effective regulatory system, which encourages the participation of public and not-for-profit community-based providers. The ALA submits that substantive and structural reform is required to improve the culture, and the processes for the delivery of, aged care services in Australia. This is only possible if the existing overarching aged care legislation is redrafted.

Recommendation 1

That the Australian Government review and redraft the *Aged Care Act 1997* to incorporate clear safeguards that promote and protect the interests of aged care residents.

Residential aged care facilities

8. The ALA submits that the characteristics and services provided by RACFs vary widely and that there may also be corresponding variance in the capacity of individual RACFs to follow best

framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised (Submission to Senate Inquiry, August 2017) 42. Accessed on 19 July 2019 <https://www.agedcarecrisis.com/images/pdf/sub41_ACC.pdf>.

⁵ *Ibid*, 36.

⁶ John Braithwaite, Toni Makki and Valerie Braithwaite, *Regulating Aged Care : Ritualism and the New Pyramid* (Edward Elgar Publishing Limited, 2007) 263. Accessed on 19 July 2019 <<http://johnbraithwaite.com/wp-content/uploads/2016/06/Regulating-Aged-Care-Ritualis.pdf>>.

practice in the provision of specialised care, particularly in relation to end-of-life and dementia care.⁷ A RACF provides residential care to a resident or ‘care recipient’ on a permanent or respite basis. Different facilities may specialise in the provision of a range of services — and have a variable composition of residents with various clinical and social needs. The ALA notes that the Act defines the meaning of residential aged care, but does not define the place in which this care is offered, other than as a ‘residential facility’.⁸

9. A RACF may provide accommodation and geriatric health-care services and other types of support to frail and aged residents, including assistance with day-to-day living, as well as to a range of people with a very wide spectrum of care needs, including:
 - homes for ambulant aged people with mild to moderate dementia, chronic anxiety or a stable physical disability who are unable to live independently
 - medical and nursing facilities for people with multiple comorbidities
 - specialist dementia care units managing the full range of challenging behaviours
 - long-term accommodation for younger people with brain damage from trauma or younger onset neurodegenerative disease
 - hospices for end-of-life care
 - long-stay care for older people with chronic mental illness, and
 - rehabilitation/recuperation units for people who have been discharged from hospital but who have not yet recovered sufficiently to go home.
10. The ALA submits that there is a need for a greater range of options in residential aged care, including support for the development of specialised, smaller, purpose-built facilities that can

⁷ Coulton, Charles and Catherine Boekel, ‘Research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice’, *Department of Health* (31 March 2017). Accessed on 19 July 2019
<[https://www.health.gov.au/internet/main/publishing.nsf/Content/EF57056BDB047E2FCA257BF000206168/\\$File/Palliative-care-and-end-of-life-care-within-gp-research.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/EF57056BDB047E2FCA257BF000206168/$File/Palliative-care-and-end-of-life-care-within-gp-research.pdf)>.

⁸ *Aged Care Act 1997* (Cth) s41.3 (1).

be properly staffed for each type of service.⁹ The ALA recognises that a RACF may be forced to provide at least seven different types of services.

11. RACFs may have differing care objectives; for example, dementia care. The ALA recognises that a significant number of residents of RACFs have dementia.¹⁰ The ALA is concerned that some residents are cared for in environments totally unsuited to this health issue, and by staff with limited specialised training.¹¹
12. The ALA submits that an appropriate skill mix of trained, specialised staff is required to assist with the provision of each type of service provided by a facility. The ALA notes that a smaller purpose-built facility may provide, for example, specialised end-of-life services for people affected by dementia, and requires a skill-mix of experienced and trained workers for that specific type of service.
13. The ALA submits that variability in service delivery by RACFs also leads to variability in knowledge of best practice in dementia and end-of-life care and that to improve the quality of care, RACFs must engage with the latest evidence-based clinical practice and models of care and have access to a specialised and skilled workforce.¹²
14. Aged care services are delivered by providers that are either large for-profit companies or not-for-profit, faith-based or government-operated organisations. In particular, the ALA submits that there is a need for government to encourage community-based, small group options such as the Abbeyfield model of supported housing.¹³

⁹Ward, Dr John, Senior Staff Specialist Geriatrician, Conjoint Assoc. Professor, University of Newcastle, Submission to the Aged Care Royal Commission on Quality and Safety in Aged Care (November 2018) 2.

¹⁰ Aged Care Guide, *Information: Dementia*. Accessed on 19 July 2019 <<https://www.agedcareguide.com.au/information/dementia>>.

¹¹ Coulton and Boekel, above n 7.

¹² End of Life Directions for Aged Care (ELDAC), *Residential Aged Care Toolkit*. Accessed on 19 July 2019 <<https://www.eldac.com.au/tabid/4901/Default.aspx>>.

¹³ Abbeyfield website, Providing housing, residential care and supporting the needs of older people. Accessed on 19 July 2019 <<https://www.abbeyfield.com/>>; Abbeyfield Australia website, *The Abbeyfield model*. Accessed on 19 July 2019 <<http://www.abbeyfield.org.au/>>.

Recommendation 2

That the Australian Government encourage community-based small group options such as the Abbeyfield model of supported housing.

Recommendation 3

That the Australian Government support RACFs to engage with evidence-based clinical practice and models of care and utilise a specialised and skilled workforce.

RACFs require a skilled workforce: complex chronic health conditions, dementia and palliative care

15. The ALA submits that the aged care workforce provides care for people with long-term, sub-acute, and complex chronic health conditions. The ALA submits that RACFs require skilled palliative care nurses. The average life expectancy of an aged care resident is two and a half years; 30% of residents die each year; and 80% of exits from permanent residential care is due to death.¹⁴ The ALA is concerned that some residents suffer from complicated medical problems, but are being cared for in RACFs that lack skilled nurses, including registered nurse (RN) expertise. The ALA notes that most people in residential care will be there until the end of their lives and many RACFs lack both a suitable environment and trained staff to facilitate a good death.¹⁵ The ALA submits that it is vital that RACFs engage with evidence-based, end-of-life organisational and clinical support and resources.¹⁶ The ALA is concerned that the Act is silent on this issue.

¹⁴ Australian Government, Australian Institute of Health and Welfare, *Aged Care Data: Factsheet 2015-16: People leaving aged care*. Accessed on 19 July 2019 <https://www.gen-agedcaredata.gov.au/Resources/Factsheets-and-infographics/Exits_factsheet.pdf?ext=; Australian Government, Australian Institute of Health and Welfare, *People leaving aged care*. Accessed on 19 July 2019 <<https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care>>.

¹⁵ Palliative Care Australia, *Palliative Care in Aged Care*, Accessed on 19 July 2019 <<https://palliativecare.org.au/palliative-care-in-aged-care>>.

¹⁶ End of Life Directions for Aged Care (ELDAC), *Organisational Support: Residential Aged Care Toolkit*. Accessed on 19 July 2019 <https://www.eldac.com.au/Portals/12/Documents/Factsheet/RAC-HC/Residential%20Aged%20Care_Organisational%20Factsheet_Web.pdf>.

16. More than half of residents in RACFs have dementia.¹⁷ The ALA submits that each RACF with 60 residents or more should have a trained dementia nurse, skilled to assess and manage challenging behaviours associated with dementia.¹⁸
17. The ALA submits that as RACFs find it difficult to attract GPs, each RACF with 100 residents or more must have a nurse practitioner to manage standard medical issues such as urinary tract infections, respiratory infections, cellulitis, leg ulcers, diabetes, hypertension, etc.¹⁹ The ALA recognises that this would allow visiting GPs to concentrate on the more complicated medical issues that arise.²⁰

Recommendation 4

That the Australian Government legislate that RACFs engage with evidence-based end-of-life organisational and clinical support and resources.

Recommendation 5

That the Australian Government legislate that RACFs require additional nursing staff, such as Nurse Practitioners, to manage standard medical issues as well as other specialised staff to manage the needs of dementia patients and palliative care patients.

Staffing requirements under the Act

18. Staffing requirements are not mentioned in the Act. The Act fails to mandate a minimum safe staffing standard or skill mix of workers required to meet the care needs of residents. The Act states that providers are to 'maintain an adequate number of appropriately skilled staff to

¹⁷ Health Direct, *Dementia Statistics*. Accessed on 19 July 2019 <<https://www.healthdirect.gov.au/dementia-statistics>>.

¹⁸ Ward, Dr John, Senior Staff Specialist Geriatrician, Conjoint Assoc. Professor, University of Newcastle, *Submission to the Aged Care Royal Commission on Quality and Safety in Aged Care* (November 2018) 3.

¹⁹ Australian Nursing and Midwifery Federation, *Nurse Practitioners: The answer for aged care*. Accessed on 19 July 2019 <<https://anmf.org.au/pages/professional-november-2016>>.

²⁰ Above n 17, 3.

ensure that the care needs of care recipients are met'.²¹ The Act does not specify what constitutes 'appropriately skilled and qualified staff' for the purpose of providing care. The ALA notes that as the Act does not specify a minimum staffing mix, a provider cannot be in breach of this obligation by providing a substandard level of experienced and skilled workers. The ALA submits that there is a compelling need for greater transparency and public accountability of staffing ratios in RACFs. The Aged Care Quality and Safety Commission (the Commission) does not have direct oversight of staffing – its functions are more indirect and relate to accreditation.

19. On 20 August 2018, Rebekha Sharkie MP introduced a Private Member's Bill, the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018* (the Bill), which required quarterly disclosure by RACFs of staffing ratios by category, namely: numbers of RNs, enrolled nurses (ENs), nurses with a certificate IV or equivalent qualification, personal care attendants, allied health staff and other staff members. Submissions to the Inquiry into the Bill demonstrated providers' opposition to the Bill. The Bill lapsed at dissolution on 11 April 2019.²²
20. International research suggests that higher RN staffing levels, higher total staffing levels and a high skills mix (ratio of RNs to other nursing staff) is associated with better quality care.²³ The ALA submits that improved care in the aged care sector could be achieved by mandating an appropriate number and mix of skilled and experienced staff; a nursing skill mix requiring the compulsory physical presence of a RN at all times in all RACFs.

Recommendation 6

That legislation is required to mandate an evidence-based approach that sets minimum staff-to-resident ratios; a nursing skill mix and staff training requirements; and the compulsory physical presence of a Registered Nurse at all times in all RACFs.

²¹ *Aged Care Act 1997* s 54.1 (1)(b); s 41.3 (1) (i).

²² Parliament of Australia, Parliamentary Business, Bills Legislation. Accessed on 19 July 2019 <https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bld=r6157>.

²³ Spilsbury, Karen, Catherine Hewitt, Lisa Stirk and Clive Bowman, 'The Relationship Between Nurse Staffing And Quality Of Care In Nursing Homes: A Systematic Review' (2011) 48(6) *International Journal of Nursing Studies*.

Conclusion

21. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into this stage of the Royal Commission into Aged Care Quality and Safety which focuses on workforce issues.
22. The ALA makes the following recommendations:
 1. **The Australian Government review and redraft the *Aged Care Act 1997* to incorporate clear safeguards that promote and protect the interests of aged care residents.**
 2. **The Australian Government encourage community-based small group options such as the Abbeyfield model of supported housing.**
 3. **The Australian Government support RACFs to engage with evidence-based clinical practice and models of care and utilise a specialised and skilled workforce.**
 4. **The Australian Government legislate that RACFs engage with evidence-based end-of-life organisational and clinical support and resources.**
 5. **The Australian Government legislate that RACFs require additional nursing staff, such as Nurse Practitioners, to manage standard medical issues as well as other specialised staff to manage the needs of dementia patients and palliative care patients.**
 6. **Legislation is required to mandate an evidence-based approach that sets minimum staff-to-resident ratios; a nursing skill mix and staff training requirements; and the compulsory physical presence of a RNs at all times in all RACFs.**

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