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The industrial and professional organisation for Nurses, Midwives and Assistants in Nursing in Australia

Submission to the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia

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Introduction

The Australian Nursing and Midwifery Federation (ANMF) welcomes the opportunity to provide a submission to the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia.

The ANMF is Australia's largest professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of 268,000 nurses, midwives and carers (assistant in nursing, personal care worker) across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance. Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

Our members work across all settings in which aged care is delivered, including approximately 40,000 members who are currently employed directly in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors (acute, residential, community and in-home care), depending on their health needs. Being at the fore-front of aged care, and caring for elderly people over the twenty-four hour period in acute care and residential facilities, our members are in a prime position to make clear recommendations to improve the care provided to people being cared for in residential facilities.

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

Incidence of all mistreatment of residents

The issue of elder abuse and mistreatment is of great concern to registered nurses, enrolled nurses and assistants in nursing. Our members working in aged care observe first-hand the compromising effect this has on the person's ability to enjoy optimal health and well-being.

The ANMF has been working to improve the care being provided in residential aged care facilities, for many years. Our members have been relentless in expressing their concerns for the people they care for in aged care facilities, and these concerns continue to be ignored by government and providers. As a result, the mistreatment of people being cared for in some of these environments continues. The ANMF has listened to our members and their concerns. Along with our continued lobbying and campaigning, we have built an evidence base to substantiate our members concerns and to find evidence based solutions to these complex issues.

ANMF National phone in day and on-line survey

In 2016, the ANMF conducted a national survey involving both a phone-in day and an on-line survey. We received feedback from 1,724 aged care nurses and care workers and 699 community members, mostly relatives of people in aged care.[i] The survey explored how the Australian Government funding cuts are, or will continue to impact the delivery of care in residential care facilities across Australia. The results supplied concerning information on the inadequacy of staffing levels and staffing skill mix to provide necessary care to elderly people. In short, participants were describing elder abuse and mistreatment, essentially through insufficient staffing or material resources to meet care required.

The following extract from the Executive Summary of our survey report points to our argument of elder abuse and mistreatment by neglect:

The overwhelming theme to emerge from both the aged care worker and community group responses to the ANMF's aged care survey was the participants' belief that the elderly deserve much better care than they are currently receiving. This belief related to care in every aspect: personal care, physical care, medical care, psychological care, and emotional and social care.

The picture of residential aged care painted by the stories and comments of participants is one approaching despair. Participants state that resources in facilities, both human and otherwise, are becoming so scarce that on many occasions it is just not possible for residents to be cared for safely or, as reported by many participants, even humanely.

Their accounts describe a situation of widespread substandard care which offers little or no dignity to the elderly at the end of their lives. A situation which shows no recognition or regard for the contribution the elderly have made to Australian society and which, they believe, represents a profound lack of respect for Australia's elderly. They believe the elderly are not treated as individuals, not treated as real people or, on occasion, not even as human beings.

The findings describe a systemic failure to ensure safe and adequate care to all aged care residents and suggest governments and providers are denying the elderly the dignity they deserve whilst living in residential aged care.

> *On my last shift before quitting I was the registered nurse in charge for 120 residents, a pill load, a schedule 8 round across three buildings and not enough staff to manage the secure unit. At the same time I had two very serious falls and one inexperienced new graduate RN [Registered nurse] ...*
> *I left after being routinely stuck with dangerous staffing levels shift after shift. It was downright reckless and shameful as I knew residents were at risk due to poor staffing. The residents stay in faeces longer than is acceptable, had delayed assessments and sat on toilets waiting for help inhumane lengths of time night after night. I couldn't be part of that anymore. I lost sleep over it and felt my soul was being destroyed by being part of such an industry.*[1] Registered Nurse

The survey's participants, and ANMF members more broadly, questioned the kind of society that Australia has become to condone such disrespectful treatment of our elderly. They were firmly of the view that such a society is not a moral and compassionate one.

However, this is what they would like to see, a moral and compassionate approach to care for our elderly, which would ensure them safe, dignified and respectful care at the end of their lives.

The survey's participants believe that this will require:

- *Adequate Government funding that is directed to care for residents;*
- *Appropriate mechanisms to ensure that funding is directed to ensuring safe staffing levels;*
- *Mechanisms that ensure genuine accountability and transparency from aged care providers;*
- *A mandated requirement for minimum training and regulation of all staff, including a sufficient supply of registered nurses and nursing staff specialised in the delivery of aged care; and,*
- *A commitment from governments, providers and the community to improving care for the elderly.*

NSWNMA survey

The New South Wales Nursing and Midwifery Association (NSWNMA), the ANMF NSW Branch, invited their members to complete a survey in 2016 regarding elder abuse. The majority of respondents were staff working in residential aged care facilities. The survey results highlighted areas of good practice but also showed that staff skill mix with high numbers of low skilled staff and low numbers of registered nurses, was a common factor in situations where resident to resident abuse occurred, and, that inadequate staff numbers overall was a precursor to elder abuse.[ii] In highlighting elderly resident to resident abuse in residential aged care facilities (most often persons with dementia), the report referred to members who considered inadequate staffing (both in terms of numbers and qualification level) meant residents couldn't be appropriately supervised and monitored. In addition, staff were often not qualified to de-escalate aggressive situations.[iii]

> *There is a need for much higher level of staff in aged care…. This is a speciality area that requires highly trained staff.* Registered nurse

> *Staff are often unable to answer calls for care promptly due to insufficient staff especially on evening shifts.* Enrolled nurse

ANMF submission to the Senate Inquiry - The future of Australian's aged care sector workforce

This document was developed in March 2016 in response to the Senate Inquiry - *The future of Australia's aged care sector workforce.*[iv] The document addresses the following areas of aged care relevant to this legislated review:

- current composition of the aged care workforce;
- future workforce requirements;
- attracting and retaining aged care workers;
- education for aged care workers; and,
- aged care funding.

This 2016 submission provides evidence of the current aged care workforce, outlining the significant shortfalls and the future workforce needs. The submission discusses the regulatory impacts that currently face registered nurses and enrolled nurses in the sector and the need for further national regulation for personal care workers. It provides member comments throughout the submission outlining their concerns.

> *I work in aged care, there's only one Registered Nurse on evening shifts to 140+ residents. No Registered Nurse at night. It is very stressful.* ANMF member.

> *I am not comfortable with compromising resident care or being placed in a position where I have to prioritise importance of care. If I went through the falls records and the residents aggressive and physically abusive incidents towards staff and other residents you will be able to determine that the residents are very high care, and therefore requiring extra staff overnight. You will also notice that the number of incidents both falls and aggression and physical aggression are incredibly high. I am concerned about resident safety, should we have to evacuate the home in the advent of a fire or other emergency.* ANMF member

ANMF National Aged Care Staffing and Skills Mix Project : *(Meeting residents' care needs: A study of the requirement for nursing and personal care staff)*

The ANMF commissioned the National Aged Care Staffing and Skills Mix Project Report, which was released in 2016. This project is the first of its kind in Australia and demonstrates the urgent need for implementation of a staffing and skills mix methodology that considers both staffing levels (the right number) and skills mix (the right qualification) for residential aged care.

Over eighteen months, the National Aged Care Staffing and Skills Mix Project, was undertaken in conjunction with the ANMF's South Australian Branch, the Flinders University Research Team and the University of South Australia, in response to the urgent need to establish evidence based staffing levels and skills mix in the aged care sector.

This comprehensive project developed an evidence based complexity profile, tested the elements of care associated with the resident profiles, determined what care interventions were being missed and confirmed the need for, and structure of, a staffing model for residential aged care.

The National Aged Care Staffing and Skills Mix Project, through extensive validation of the staffing methodology, evidenced how the current level of staffing is inadequate to provide for the needs of Australians living in residential aged care facilities.

> *I work in a 100 bed facility, in charge the same situation all afternoons, we have 1,2,3,4 enrolled nurses that I need to oversee; I have my own floor to look after as well and medications to do. And so I've got to do all the DDA's [dangerous drugs of addiction]. They have prescribed that we have to have two people to do insulins. So I'm over 5 floors as well as looking after my own floor as well as staffing, taking outside phone calls, etc., etc., its becoming very untenable actually and quite dangerous I feel.* Registered Nurse

> *The falls because they are in a rush- in a hurry because – the tasks that's why that happens.* Personal Care Worker

Missed care tasks are a common unacceptable situation in aged care facilities. The ANMF project demonstrated that, on average, all tasks were reported missed at least some of the time, with many tasks being missed more frequently. The research found that the nurses and personal care workers cited the main reason care is missed is because there is a lack of nursing and care staff [v].

> *I feel there is not enough staff to attend to residents' need, therefore there is an increase in UTI's [urinary tract infections], wounds, falls and limited emotional support. I would like there to be a realistic staffing ratio to manage residents' needs and, most importantly, their emotional support to ensure their transition into aged care [is] more amenable.*

The study outlined how nurses and personal care workers identified that the increasing resident acuity exacerbated poor care.

> *The acuity of residents is increasing. You can see a shorter length of stay to prove this. They have chronic and complex disease and their families also need lots of support. There is no funding for this in our good facility… our older people deserve better.*

On average residents receive 2.84 hours of care/day from nurses, care workers and therapy staff, that results in over 21 hours in a 24 hour period where residents currently do not receive care. The missed care survey component found that 8.2% of respondents indicated staffing was always adequate and that the highest staff to resident ratio was in government owned facilities compared to not-for-profit and private for-profit.

> *I work for a private company- a money- making machine. Upper management and financial stakeholders want high profits not high care, and the government lets them do it.*

This research has shown that mistreatment is occurring in aged care facilities and provides the evidence based solution to rectify the situation. The National Aged Care Staffing and Skills Mix Project report key solutions are that:

- evidence based staffing and skills mix methodology must be adopted nationwide for residential aged care facilities.
- residential aged care facilities must incorporate the time taken for both direct and indirect nursing, and personal care tasks and assessment of residents; it also needs to reflect the level of care required by residents.
- residents require an average 4 hours and 18 minutes of care per day - compared to 2.84 hours which is currently being provided.

- a skills mix of Registered Nurses (RN) 30%, Enrolled Nurses (EN) 20% and Personal Care Worker (PCA) 50% is the minimum skills mix to ensure safe residential care.

National workforce survey

The ANMF launched a national survey in August 2017 and over 744 aged care nurses and carers have responded to date.[vi] The survey asks aged care nurses and care staff to identify cuts to care hours at the aged care facilities where they work and how this is impacting vulnerable residents. More than 92% of respondents said they are being asked to care for the same number of aged care facilities residents with less staff or less rostered care hours.

Participants were asked to identify the changes that are happening in their aged care facility. Over 60% stated that there were roster changes to reduce staff hours and 52.49% of respondents said there is also a reduction in the number of care staff. A common theme in the survey outlined that members believe there is inadequate staffing and, even though there is increasing resident acuity, there are still staff reductions. A total of 84% of respondents said they were worried about the residents at their facility.

*A very recent example of mistreatment was provided by an ANMF member, she explained the distressing case of a 58 year old woman *Tanya (for confidentially reasons the residents real name was not used) who has early onset dementia and has been living in a nursing home in Queensland for the past 6 months. This nursing home is four hours from her family as it is the only place available. Unfortunately, Tanya had a fall over the Christmas/ New Year break and with a recent history of a fractured pelvis, she should have been assessed and managed closely. It took 10 days for this poor woman to be diagnosed with a fractured femur. The pain and suffering that Tanya experienced would have been excruciating. Once diagnosed Tanya was transferred to the regional hospital approximately three hours away and required immediate surgery. This heart breaking case provides much information about the state of some nursing homes.* Registered Nurse

Inadequate staffing - levels not reflecting the increasing demands of changing levels of dementia and or mobility or care of residents as they age. Less staff rostered over weekends than weekdays, but no change in number of residents or workload.

Compromised care due to staffing levels

The ratio of resident to carer is unreasonable 37 residents between 3 staff

Residents requiring a higher level of care, but same level of staff

Participants in the survey were asked if they believed the ratio of registered nurses to other care staff in their facility is adequate. Over 70% believed that there is not an adequate ratio. Similarly, 89% of respondents believed that the ratio of assistance in nursing/carers/personal care workers is inadequate.

Registered Nurses, Enrolled Nurses, Personal Care Workers and Regulation

Registered nurses and enrolled nurses are nationally regulated which requires compliance with professional standards. There is compelling evidence that professional standards and registration are compromised by the inadequate staffing profiles that continue to be enforced in many aged care facilities by numerous provider organisations. Those same inadequate staffing profiles commonly result in missed care; mistreatment and ultimately resident harm.

Registered nurses are educationally prepared to assess and instigate or delegate appropriate care, and to monitor for, and identify, where mistreatment might be occurring. However, current staffing conditions, in terms of staffing numbers and levels of qualified staff, are undermining their role as clinical leaders within aged care.

The ANMF contends low staff to care recipient ratios, and the gradual reduction of registered nurses in aged care, has led to an increased incidence of mistreatment due to neglect.

Our members tell us that the registered nurse: resident ratio is inappropriate. In each piece of evidence the ANMF collects, members tell us that registered nurses are caring for anywhere between 60 to over 100 residents, and in some organisations they are required to complete this care by being 'on call', with no registered nurse on site.

The ANMF missed care survey showed *the mean number of residents managed by all respondents was 38.05, with registered nurses reporting higher ratios of one registered nurse to 59.25 residents, enrolled nurses of 1 to 31.39 and personal care workers 1 to 24.19.* [vii]

One RN to 50 residents is compromising resident care. It is unsafe.

I can be the only registered nurse on duty for 80 residents

One nurse for 110 beds registered nurse has to supervise

A common question asked of the ANMF is why registered nurses are leaving aged care. The answer is clear, and has been provided in the foregoing commentary. On average, registered nurses working in an aged care facility are responsible and accountable for 38 residents as a minimum, but as high as 59 residents, according to the research. Our members have suggested that it can be a lot higher. With the increasing acuity level of residents, it is very difficult for registered nurses to provide quality care that is not categorised as mistreatment, when providing nursing care in these settings. Registered nurses are also responsible and accountable for overseeing

care that is delegated to enrolled nurses and personal care workers. The care provided by registered nurses, including their responsibilities in delegating, is regulated by the Nursing and Midwifery Board of Australia (NMBA).

The NMBA's remit is to protect the public through the legislative power of the *National Health Practitioner Regulation National Law Act 2009* (National Law). To that end, the NMBA has mandated the Professional Practice Framework (PPF),[viii] which governs the practice of registered nurses and enrolled nurses under their national regulation and provides a consistent risk mitigation mechanism for those who work in aged care. This includes minimum education requirements to gain and maintain registration. Registered nurses and enrolled nurses must work within these frameworks, including the code of ethics, conduct and the decision making framework.

The decision making framework[ix] clearly articulates the criteria under which a registered nurse is able to delegate a nursing activity to another nurse or a non-nurse. The NMBA's definition of a non-nurse is any person who is not registered to practise as a registered nurse or enrolled nurse. The decision making framework states that registered nurses are accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care.[x] The explanatory statements in the decision making framework state that:

Decisions about nursing practice are made, in partnership with the client whenever possible, to ensure that the right person (nurse or non-nurse) is in the right place to provide the right service for the client at the right time.

Decisions are based on, justified and supported by considerations of whether:

- *there is a legislative or professional requirement for the activity to be performed by a particular category of health professional or health care worker*
- *the registered nurse has completed a comprehensive health assessment of the client's needs*
- *there is an organisational requirement for an authority/certification/credential to perform the activity*

- *the level of education, knowledge, experience, skill and assessed competence of the person who will perform an activity that has been delegated to them by a registered nurse from a nursing plan of care has been ascertained by a registered nurse*
- *the person is competent, confident of their ability to perform the activity safely, or is ready to accept the delegation, and understands their level of accountability for performing the activity*
- *the appropriate level of clinically-focussed supervision can be provided by a registered nurse for a person performing an activity delegated to them by a registered nurse*
- *the organisation in which the nurse works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the person performing the activity, and to support the decision-maker in providing support and clinically-focussed supervision.*[xi]

The decision making framework then outlines the following*: If all of these factors are positive, then the registered nurse can delegate the activity and ensure that the appropriate level of supervision is provided. If any of these factors is negative, the activity should not be delegated. In the absence of another competent non-nurse, or if necessary additional support (education, competence assessment, supervision etc.) cannot be provided, the activity should either be performed by a nurse or referred to another service provider.*[xii]

Registered nurses have to work within these regulatory requirements to maintain their registration and for the protection of the public. A registered nurse working in the current aged care environment of an aged care facility, is faced with this complex regulatory issue every shift.

The *Aged Care Financial Performance Survey* published by Stewart Brown (2015) states that, on average, at best, registered nurses are spending 7 minutes and 19

seconds per shift with a resident in a residential facility.[xiii] A comprehensive health assessment on its own takes more than 7 minutes and 19 seconds to complete. Therefore, the current working environment puts significant pressure on registered nurses to fulfil the regulatory requirements.

Medicines administration is also a good example to demonstrate the issue of delegation in aged care. Medicines administration, even when using a blister pack or similar dose administration aid, is considered a high risk activity. For a registered nurse to delegate this activity, she or he needs to have completed a comprehensive health assessment of the person receiving the care; to have ensured the nurse or non-nurse has the appropriate level of education, knowledge, experience, skill and is assessed as competent and confident to complete the care; and, then be in a position to be able to provide the appropriate level of supervision to the nurse or non-nurse completing the care.

While the drugs and poisons legislation in each state and territory is different across jurisdictions, all clearly state that a registered nurse, or an enrolled nurse (without a notation) can administer medicines. Enrolled nurses who complete a Diploma of Nursing are educated to the level required by the NMBA to administer medicines, and have been assessed as competent on completion of their course.

As the decision making framework outlines, if any requirements to delegate were negative then the enrolled nurse could not be delegated the care. Delegation to administer medicines to a non-nurse or a personal care worker within aged care, is complex. The drugs and poisons legislation is unclear in some states and territories, and in fact in some, is silent relating to personal care workers and medicines. This silence does not infer that personal care workers can administer medicines. Assessment of a personal care workers level of education, knowledge, experience skill and competence is difficult. A registered nurse needs to understand the education completed by each personal care worker. As there is no nationally consistent minimum education requirement, this is not simple.

Further to this, personal care workers are not nationally regulated and do not work to professional standards, which makes the assessment of delegation and determination of the level of supervision required very difficult. The ANMF has developed nursing guidelines titled *Management of Medicines in Aged Care*[xiv] to help support nurses and personal care workers to understand medicines administration in aged care. This document provides best practice guidelines for quality use of medicines. Although the process of delegation and supervision is complex for registered nurses in the aged care setting, registered nurses are required by their employer in many settings across the country to delegate medicines administration to personal care workers, not on the basis of professional judgement, taking into account the resident's needs and staff competence, but due to the staffing ratio not allowing the registered nurse or enrolled nurse to undertake this function themselves. This is further compounded when the registered nurse is 'on call' and not physically on site. The personal care workers are also put in a difficult position in these circumstances.

> *The night duty RN said "well no… I can't do that because I can't assess, I can't remotely assess the resident". How can I say whether she needs an endone?"*[1]

The ANMF receives extensive enquiries from personal care workers who are required by their employer to administer medicines. Personal care workers express concern about their personal liability in the event of making an error. Personal care workers are unclear of the boundaries of care they can provide and are required by some employers to take on high risk care, such as medicines administration, with little, if any, foundation knowledge and poor remuneration for such responsibility.

It is important to note that the NMBA, with its remit of public protection, will not allow an enrolled nurse who has completed a minimum of 12 months preparatory education (minimum of Certificate IV) in nursing, to administer medicines, if they have not also completed the approved regulated medication educational units. This is irrespective of the years of experience of the enrolled nurse and the provider facilitating training or competence assessment. The only way an enrolled nurse can administer medicines is

if they have completed the preparatory education program, currently an 18 month Diploma of Nursing progam, which includes medicines administration requirements.

Considering this, personal care workers across the country are currently administering medicines in the aged care setting, without the safeguards of a minimum education level or professional standards. Registered nurses and enrolled nurses are held to account for their actions within the nursing role and the NMBA state that nurses are accountable to the people in their care, the NMBA, their employers and the public. The NMBA further state that the registered nurse who delegates an activity to another person is accountable, not only for their delegation decision, but also for monitoring the standard of performance of the activity by the other person, and for evaluating the outcomes of the delegation. [xv] Considering the national regulatory framework that holds registered nurses accountable and responsible for their practice in delegating and supervision, it is essential that the staffing and skills mix is appropriate to enable these nurses to practice lawfully, remembering the intent of these requirements is to keep the public safe, thus preventing mistreatment and harm.

As discussed earlier, there is no national registering or licensing system for personal care workers as there is for nurses. Personal care workers are not, therefore, required to work in accordance with a professional practice framework. National regulation of personal care workers would afford a similar risk assessment mechanism. This would assist to prevent mistreatment of residents in aged care facilities, as it would require personal care workers to have a minimum education requirement to work in the sector. It would also require them to maintain regular professional development.

As there is no national system in place for personal care workers, consumers, families or employers cannot check to ensure the care worker is appropriate to be looking after them or their loved one. Currently, if a care worker is found to be unsafe in the care they provide and is dismissed from their employment, they can move onto another employer, with a minimal checking process occurring or, on many occasions, without any process at all. This currently presents a significant and very real risk of harm to the public.

It is essential that the criminal history checks for personal care workers are extended from what is currently in place and that international history checks are completed. We refer to the Australian Health Practitioner Regulation Agency (AHPRA) *Registration standard: Criminal history*[xvi] for regulated health practitioners which includes national and international criminal history: *"…when making a declaration about criminal history, applicants and registered health practitioners must declare their entire criminal history, from Australian and any other country, including any spent convictions."*
Given that around one-third of unregulated health workers who are employed in direct care work within the aged care sector (both residential and community) were born outside Australia[xvii] the ANMF considers the criminal history declaration for this group must also encompass national and international convictions.

The National Code of Conduct introduced as a quasi-regulatory mechanism for health workers outside the National Regulation and Accreditation Scheme, is a 'negative licensing scheme.' Under this system it must be shown that harm has been perpetrated against a person, in this instance by one of the many forms of elder mistreatment, before any action can be taken. The ANMF argues that this retrospective mechanism for managing abuse is inadequate in the protection of Australia's residents. It would be appropriate to include those workers within the existing regulation scheme through expanding the coverage of the National Law.

A national system, consistent with the provisions of the *National Law*, would obviate the need to create a parallel code of conduct. The *National Law* and professional practice frameworks developed in accordance with the provisions of the *National Law*, form the ideal model for personal care workers, who comprise the bulk of the aged care workforce in residential and community settings.

The vulnerability of the people who are cared for in aged care facilities and the inherent potential for harm in delivering their care demand appropriate regulation. A comprehensive regulatory framework to manage this risk for personal care workers, especially those responsible for direct care, must be implemented.

Other research

Television documentaries and media reports have showcased mistreatment in aged care facilities in Australia over the past decade. These too, provide examples of mistreatment and subsequent neglect to basic care needs.[xviii]

Along with the endless media portrayals of mistreatment of residents, there is extensive evidence in the literature confirming existence of this maltreatment.

Sarah Russell recently released her research titled *Living Well in an Aged Care Home,* where 174 relatives and visitors described their experiences with aged care facilities. One of the outcomes from the study found that *some aged care homes employ an inadequate number of appropriately skilled staff.*[xix] Relatives in this study provide examples of unnecessary admissions to hospitals and suggest that these admissions are occurring because of low staffing levels. They also describe the complex conditions residents in aged care facilities have such as, chronic pain, heart conditions and diabetes and suggest that the skill of experienced registered nurses supported by the health care team, are required. [xx] This research shows that the community is aware of the need for evidence based staffing and skills mix and the importance of registered nurses leading the team in aged care facilities.

The work of Professor Joseph Ibrahim, has produced article after article[xxi] [xxii][xxiii][xxiv] highlighting the coronial cases where the outcomes suggest there was mistreatment through suboptimal care being provided through inefficient systemic processes. The latest piece of work produced by Professor Ibrahim provides many recommendations to improve the care of people who are residents in aged care facilities and to prevent mistreatment. Professor Ibrahim states the following:

...Older persons in RACFs [aged care facilities] suffer preventable harm and that the workforces, the community, the law, health and aged care sector are ill-equipped to address the issue. Systemic factors and not individuals are the underlying cause compounded by knowledge gaps to inform evidence-based policy and practice in aged care. The lack of academic discourse and absence of leadership for improving quality of care in RACFs means the status quo is not being challenged.[xxv]

The ANMF maintains registered nurses are prime leaders in aged care facilities and if given the opportunity in a manageable environment, they can champion quality care, challenge status quo and with the team, significantly contribute to stamping out mistreatment of residents. *What is required is a fundamental shift in attitudes and practice, a change in culture of care and governance.*[xxvi] Registered nurses need to be working in aged care facilities on site 24 hours per day and it is essential that an evidenced based staffing and skills mix methodology be adopted nationwide for aged care facilities.

Staffing is the core issue contributing to the mistreatment of people being cared for in aged care facilities. Mistreatment of residents will only be significantly reduced when an evidence based staffing and skills mix formula is legislated and implemented in aged care facilities. Put simply, the elderly cannot receive proper care unless there is an appropriate number and mix of skilled and experienced staff, which includes registered nurses, enrolled nurses and personal care workers. We reiterate our recommendation that a skills mix of Registered Nurses (RN) 30%, Enrolled Nurses (EN) 20% and Personal Care Worker (PCA) 50% is the minimum skills mix to ensure safe residential care.

Our members are clear, and so is the evidence, that aged care facilities staffing levels must be urgently addressed. Without legislated aged care staffing requirements in all Australian jurisdictions to mandate a minimum number and required qualifications of nursing and care staff in the aged care sector, safe and quality care for the elderly cannot be assured.

Recommendations

The ANMF recommends that:

1. The legislation reflects mandated minimum staffing levels and skill mix requirements for registered nurses, enrolled nurses and assistants in

nursing/personal care workers in the residential and community aged care sectors. A skills mix of Registered Nurses 30%, Enrolled Nurses 20% and Personal Care Worker 50% is the minimum skills mix to ensure safe residential care.

2. The legislation mandates the requirement for 24 hour registered nurse cover for all aged care facilities.
3. All assistants in nursing/personal care workers must be registered with the Nursing and Midwifery Board of Australia (NMBA) and subject to nursing regulation by the NMBA.
4. Medicines are only administered in aged care facilities by registered nurses or enrolled nurses

Associated reporting and response mechanisms and treatment of whistle blowers

Our colleagues at the New South Wales Nurses and Midwives' Association (NSWNMA) has made a separate submission to this inquiry and the ANMF supports their submission. The NSWNMA submission makes an essential contribution to the Inquiry, in particular, it states:

> *Previous consultations with our aged care members on the issue of elder abuse and mistreatment of residents were reported in the following reports: 'Who will keep me safe?'; 'Solutions from the frontline' and 'The state of medication in NSW residential aged care'. These catalogue a series of failings within the Aged Care Act 1997 and associated regulations in regard to the reporting of serious incidents and management of care. In particular: failure to make appropriate safeguards where restrictive practices are used; failure to implement effective behaviour management plans; fear of reprisal for workers wishing to raise issues in good faith and exemption from reporting incidents where a person is cognitively impaired. Over 60% feared reprisals if they raised issues of concern. Over 40% said that relatives and residents also considered fear of reprisal and it prevented them from raising concerns.*

This is a telling story of the culture of the aged care sector in Australia. As we have previously mentioned nurses and personal care workers have been expressing their concerns for residents in aged care facilities for many years. This appears to have fallen on deaf ears evidenced by the paucity of response to date from aged care providers and the Australian Government, regarding the improvement of staffing and skills mix.

With regard to residents and relatives making reports about mistreatment, this process needs to be improved. The Aged Care Complaints Commission is making progress in managing these ever increasing numbers of complaints, however, the power imbalance remains a problem with residents reliant on the service being delivered and less inclined to report mistreatment. It is also essential in this discussion to ensure focus remains on proactive mechanisms to providing quality care in the first instance, that will prevent mistreatment.

Compulsory reporting

In regard to the Australian Government's Department of Health and Ageing guideline documents for compulsory reporting for approved providers of residential aged care,[xxvii] the ANMF supports these requirements and suggests they should be expanded. The ANMF position statement on *Compulsory reporting of abuse in aged care settings for nurses and assistants in nursing*,[xxviii] states that compulsory reporting, on its own, will not prevent the abuse or mistreatment of residents. There must be clear policies and protocols developed for the workplace, outlining the process to be followed by a person making a report on any alleged abuse, in order for compulsory reporting to be effective. While it is preferable for nurses and assistants in nursing to report instances of an alleged elder abuse or mistreatment to their employer first, the mechanism should exist for them to be able to report directly to the police or the relevant Australian Government department. In addition, it should be noted there are requirements under the *National Law* for registered nurses and enrolled nurses to make mandatory notifications to the NMBA in relation to the abuse of patients / residents by another registered health practitioner.

Treatment of whistle blowers

The ANMF has an established policy on whistleblowing and we refer the Inquiry to this important piece of work.[xxix] Nurses and personal care workers working in aged care should be able to speak out without fear of reprisal or intimidation in circumstances of suspected or actual misconduct, corrupt or criminal conduct. Aged care facilities should have policies and procedures in place to assist employees, including managers, to deal with making, receiving and responding to reports of mistreatment. Processes need to be in place to ensure responses to employee concerns are managed in a timely manner for the betterment of the resident and that employees are clear on how to escalate a concern.

It is essential that nurses and personal care workers are protected under the law and they do not suffer any form of retaliation, victimisation, discrimination or adverse action as a result of making a report or complaint on mistreatment. One of the common examples members express is that if they raise any concerns, then they may be treated differently for example their shifts are reduced or roster requests are denied. Some members have suggested that if they make a compliant then a performance management process begins soon after, questioning their professional performance.

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

The effectiveness of Australian Aged Care Quality Agency

The ANMF has grave concerns about the disconnect between the current outcomes of the Australian Aged Care Quality Agencies important work and actual care being provided within some parts of the aged care sector.

The 2016-2017 Australian Aged Care Quality Agency Annual report outlines that in residential aged care facilities, they conducted 3,964 visits. Out of this extensive work being conducted only 33 review audits were identified as having 'concerns' that they may not meet the accreditation standards. Out of the 2,677 residential aged care services only 73 services had a timetable for improvement.[xxx] This apparent need for minimal intervention from the Australian Aged Care Quality Agency seems incongruous with the many accounts of poor and unsafe care across the aged care sector, reported by our members and the public.

ANMF members employed in the aged care sector in various Australian states and territories frequently express their ongoing concern about the care standards and their perception of poor quality care that is going unnoticed by the Australian Aged Care Quality Agency in some parts of the aged care sector. Specifically, our members will report that when a residential facility is being audited by the Agency, standards are usually higher than they are when they are not being audited for compliance against the current standards.

Aged care providers are often given advance notice of site visits and these may occur at intervals of more than a year apart. The Australian Aged Care Quality Agency is, therefore, not always in a position to assess how a service is operating between site visits or following accreditation. Given the lack of opportunity to observe the operation of the service on a day to day basis, or through unannounced site visits, the reliability of a risk-based approach may be flawed. The ANMF also notes and supports the recent recommendation from the Carnell and Paterson (2017) review which states:

> *Ongoing accreditation, with unannounced visits, to assure safety and quality of residential aged care.*
>
> *Actions:*
>
> *i. The initial accreditation visit will be announced.*
>
> *ii. Eliminate re-accreditation visits and replace with unannounced visits:*
>
> *a. Conducted over at least two days;*
>
> *b. Assess residential service performance against all standards;*

c. *Risk-based process used to determine frequency and rigour of visits.*[xxxi]

Accreditation Standards

As we have previously highlighted, it is the ANMF members' primary priority to address the myriad of complex workforce issues within the aged care sector, as a matter of urgency, in order to increase staffing numbers and improve skills mix levels.

Nursing is legislated to assess, plan and co-ordinate care in accordance with the *Aged Care Act 1997*. This requires registered nurses to plan nursing care. Approved providers are required under the *Aged Care Act 1997* and its principles to provide adequate numbers of care staff to carry out the assessed care needs, including a tailored plan for individualised person centred care. However, the Act is silent as to the number of nursing or unregulated care staff required as sufficient to deliver assessed care.

This is the critical problem. The fact that the *Aged Care Act 1997* is silent on detailing what is sufficient staffing numbers, has led to the current parlous state of the aged care workforce. Despite the very best efforts of those who work in the sector, there simply is neither enough workers nor workers with the necessary level of skill to provide quality care to meet the needs of all elderly Australians.

This deficiency in the Act has also prevented the Australian Aged Care Quality Agency from having the mechanism to enable them to effectively audit and assess minimum staffing and skills mix. This has in turn exacerbated the workforce and quality care issues within the sector. The current standards are also silent, as well as being ambiguous and open to interpretation.

The Australian Aged Care Quality Agency assesses against the Accreditation Standards, which are not prescriptive in matters of quality relating to staffing. These standards should state: an aged care facility must demonstrate minimum staff numbers using a mandated evidence-based methodology that accounts for the time taken to assess, perform and evaluate direct and indirect nursing and personal care for

residents with the following minimum staffing skills mix: registered nurses (RN) 30%, enrolled nurses (EN) 20% and personal care worker (AIN/PCW) 50%.[xxxii]

The new draft aged care quality standards that are currently under review have improved from the previous standards, however, there are many examples of how the standards can be improved and these are highlighted in the ANMF's response to the *Single Aged Care Quality Framework, draft aged care quality standards consultation paper 2017* (section A).[xxxiii]

The ANMF makes the following recommendations to improve the Quality Agency processes:

- Unannounced site visits with a minimum of two-three per year.
- More opportunity for nurses and assistants in nursing to have frank discussion with the assessors about the care and work practices being provided within the service. It is important this consultation process is clearly outlined in the standards to ensure it is measurable.
- Consideration might be given to enable staff to provide written comments to the assessors confidentially (thus removing any risk of reprisal).
- Interviews with staff should include prompts to ensure organisational systems are functioning as per policies and procedures.
- All coronial cases that are relevant to consumers receiving aged care services should be reviewed and included in future assessments and monitoring.
- Aged Care Funding Instrument (ACFI) summary reports of providers should be provided and reviewed by the Australian Aged Care Quality Agency.
- A review of incident reports relating to high impact or high prevalence risks must be reported upon during all audits.
- Review of the prevalence of and reasons for consumer transfers to hospitals.
- Where early discharge from the acute sector occurs, for example, 1-2 days post hip replacement, auditing needs to include assessing the appropriate staffing and skills mix present to provide the required complex sub-acute care.
- Assessors need to be expert clinicians.

- Residents and carers should have the same ability to provide confidential written comments to the Accreditation Agency.
- The accreditation standards must provide clear and concise information about specific requirements for compliance, be evidence-based, and. ensure the standards are not open to interpretation by the approved provider.
- The accreditation standards must be more aligned to the National Safety and Quality Health Service Standards

The effectiveness of the Aged Care Complaints Commission

The *Aged Care Complaints Commissioner's annual report from 2016-2017* outlines there were *3656 recorded formal complaints about aged care facilities. The most common complaints were about medication administration and management (559), falls prevention and post falls management (382) and personal and oral hygiene (365).*[xxxiv] These statistics are not surprising and are a reflection of the state of the aged care sector for aged care facilities.

The Commission is efficiently implementing their processes and is attempting to be more visible to the community. The work being completed in the area of departure from clinical standards appears to be working well.

Considering the quality framework that is in place for accreditation and complaint management between the Quality Agency and the Department of Health and the Commission, the ANMF notes the importance of the recommendation in the Carnell and Paterson (2017) review that the accreditation, compliance and complaints handling become centralised. This is a reasonable recommendation that would enable a more coordinated response to quality. It would also enable more effective data sharing.

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

The Charter of Care Recipients Rights and Responsibilities is an essential document and is supported by the ANMF. This Charter should be the bases for all care provided to residents in aged care facilities, however, this is not the case. Our submission has outlined in depth how quality care is not being provided to many residents and some residents are not being treated with dignity and respect as outlined in the Charter.

The Charter needs to be more rigorously enforced as residents and their relatives should expect to receive the care outlined. Aged care providers should be held to account if they do not adhere to providing these basic rights to residents in aged care facilities.

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

The ANMF maintains that in order to protect vulnerable elderly people, both those who are capable of decision-making, and those who are not, there needs to be legally sanctioned frameworks around who can make decisions on their behalf. At present there is a variety of approaches across jurisdictions. A national approach to this, such as the formalisation of a medical and/or financial power of attorney, would provide for consistency across the country, beneficial to both health professionals working in aged care and elderly people and their families/carers.

In 2016/17 the Australian Law Reform Commission (ALRC) undertook an extensive study of elder abuse in Australia, with a final report from this study being released in June 2017. [xxxv] The ANMF advises this Inquiry to read the ALRC report in its entirety and pay attention to the comprehensive recommendations arising from the study findings, particularly those relating to protection and safeguarding of older people. The Executive Summary of the report states:

The recommendations in this Report seek to balance two framing principles: dignity and autonomy, on the one hand; and protection and safeguarding, on the other. The

ALRC recognises that autonomy and safeguarding are not mutually inconsistent, as safeguarding responses also act to support and promote the autonomy of older people.[xxxvi]

The ALRC found there are various laws in place for an older person to have an arrangement whereby someone else looks after their financial or personal affairs through enduring powers of attorney (financial) and/or enduring guardianship (personal, lifestyle and medical), as well as advance care directives. However, there is significant difference between the states and territories in the legal formats for these arrangements. The ALRC found that:

There was strong support in submissions for harmonising state and territory laws on enduring documents, including from welfare organisations, community legal centres, financial, banking and accountant professional organisations and peak bodies. The Law Council of Australia explained that '[u]niformity would reduce the current complexity and overlap in the application of the law in relation to powers of attorney and enduring guardianship.[xxxvii]

In acknowledgement that the adequacy of protection arrangements for older people (including those in aged care facilities) is limited, the ALRC report carries recommendations for strengthening the safeguards on rights and preferences of the elderly in our community.[xxxviii]

It is not uncommon that carers and residents believe that they will be treated differently (worse) should they make a complaint about staff or care. This fear also extends to being asked to relocate or leave the facility therefore a mechanism is recommended to check on changes to care provision following outcomes of complaints.

We also acknowledge the difficulty in lodging a complaint for residents in aged care facilities. For example this could include not having access to a phone, or computer and a resident may not have the physical ability to write a letter. If a resident does not have a phone they would need to access the facilities phone which may be situated in the nurses station or another place that does not provide privacy and confidentiality.

Use of visitor advocates, trained to visit and assist those residents without family to lodge a complaint when required, should be considered. This model would be consistent with the community visitor advocate model used for people with mental health issues.

Conclusion

The ANMF welcomes the opportunity to provide the foregoing evidence and advice to the Committee who, as stated by the Committee Chair, 'will be examining Australia's residential aged care system, in particular, the quality of care and services provided to aged care residents.' Our members who work in residential aged care have consistently informed the ANMF of significant concerns in some facilities regarding these matters. These concerns are outlined in our submission.

In raising our concerns we have also provided solutions, which we urge the Committee to carefully consider in your deliberations on recommendations to the Government. The ANMF argues that evidence provided by our members working in aged care, and highlighted in other studies in the sector, clearly points to solutions which, if enacted, will lead to improvements in quality of care for the elderly residents of aged care facilities.

In concluding, the sentiments of ANMF members responding to surveys on aged care eloquently describe the frustrations of nurses working in the sector:

> *Basically the whole situation shows very poor form. Our frail and elderly citizens should be shown respect and supported in their twilight years. They have worked hard and paid taxes, fought for their country (in many cases) and now they are an easy target.*
>
> *I think it is disgusting that people of this country who have contributed so much during their working life can be treated in this way in their old age.*
>
> *Not good enough, our frail aged deserve much better. They deserve respect, dignified care, and mostly, professional care.*
>
> *Having to rush frail, anxious, vulnerable, perhaps demented, persons in order to attend to their most basic requirements instead of maximising their remaining abilities, hearing their concerns and honouring who they are, or - at worst -*

allowing the cover-up of cruelties & neglect, is a disgrace and poor reflection on the society that ignores or fails to address such issues.[xxxix]

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[iii] Ibid. p.11.
[iv] Australian Nursing and Midwifery Federation. 2016. Submission to Senate Inquiry. The furture of Australia's aged care sector workforce.
http://www.anmf.org.au/documents/submissions/ANMF_Aged_Care_Inquiry_2016_Report.pdf
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[vi] Australian Nursing and Midwifery Federation. 2017 Media release: Nurses say aged care staffing levels 'inadequate'. http://anmf.org.au/media-releases/entry/media_170829
[vii] Willis, E., Price, K., Bonner, R., Henderson, J., Gibson, T., Hurley, J., Blackman, I., Toffoli, L and Currie, T. *Meeting residents' care needs: A study of the requirement for nursing and personal care staff.* Melbourne: Australian Nursing and Midwifery Federation, 2016.
[viii]The NMBA Professional Practice Framework (PPF) includes national:
- minimum mandatory standards of education and qualifications
- standards for practice
- scope of practice
- Decision Making Framework
- Code of Ethics, Code of Professional Conduct, and professional boundaries guidelines
- registration (with publicly available register)
- mandatory reporting of misconduct by other health professionals
- notifications of unprofessional practice or health impairments affecting practice
- Registration Standards, including: Recency of Practice; Continuing Professional Development; Criminal History; Professional Indemnity Insurance Arrangements for Nurses; English Language Skills

All elements of the Framework ate available at NMBA website: http://www.nursingmidwiferyboard.gov.au
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[x] Ibid
[xi] Ibid
[xii] Ibid
[xiii] Stewart Brown (2015) Aged Care financial Performance Survey, Residential Care. June 2015 Annual Report.
[xiv] Australian Nursing and Midwifery Federation. 2013 Management of medicines in Aged Care, Nursing Guidelines. Available at: http://anmf.org.au/pages/nursing-guidelines-for-the-management-of-medicines-in-aged-care
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[xvi] Australian Health Practitioner Regulation Agency. Registration standard: Criminal history. Available at: http://www.ahpra.gov.au/Registration/Registration-Standards.aspx
[xvii] King, D., Mavromaras, K., and Wei, Z. et al. 2012. *The Aged Care Workforce.* Canberra: Australian Government Department of Health and Ageing. (particularly sections 3.7 and 5.1.4)
[xviii] Lateline - Margot O'Neill. Aged care workers cite abuse and neglect of nursing home patients. Retrieved from ABC website on 2 August 2016 at: http://www.abc.net.au/news/2013-08-13/aged-care-understaffed-as-nursing-home-patient-numbers-rise/4884056
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