Submission by the Australian Nursing and Midwifery Federation

New Aged Care Act Rules Consultation – Release 1 – Service list

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Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and 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 more than 326,000 nurses, midwives and care-workers across the country.

2. 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.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides 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.

4. 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.

5. The ANMF thanks the Department of Health and Aged Care for the opportunity to provide feedback on the New Aged Care Act Rules Service list (the Rules).

6. This submission sets out our key concerns with respect to the delivery of care and the need to ensure that the Rules enable nurse-led care across the full spectrum of care delivery. The ANMF is concerned that artificial distinctions between nursing, clinical and personal care will fragment the delivery of care, leading to a focus on tasks and how they are funded, rather than providing holistic care for the individual.

7. The submission also identifies some specific issues and proposes additional wording or areas

that should be clarified to ensure the Rules operate effectively and promote safe and quality care.

Key concerns regarding the delivery of care

Clinical Governance

8. Clinical governance frameworks are a key element to providing oversight for safe care at home and in residential aged care environments. This is consistent with best practice and is a clear requirement of the Aged Care Quality Standards.[1] The effective use of clinical information can mitigate risk of harm to an older person when changing settings, health providers and when there is a change to their health or deterioration. Timely access to up-to-date clinical information informs clinical decision making and allows health professionals to understand an older person's clinical history at the point of care and allows providers to plan for appropriate clinical care on entry or return to their service. ANMF members tell us this is often done poorly by aged care providers in home care despite the existence of the Serious Incident Reporting Scheme (SIRS) which identifies the incidents including neglect, inappropriate use of restrictive practices, and others that must be reported. Compliance with the Quality Standards is still much lower in-home services than in residential care. Only 65% of home services were fully compliant with the relevant Quality Standards in Q4.[2] We see the effect of poor clinical governance in lower compliance with Quality Standard 3 (Personal care and clinical care). In home services, compliance with Quality Standard 3 fell 9 percentage points in Q4 from the previous quarter, to 81%. Of concern, the compliance rate among home services providers is now lower than it was at the beginning of the previous financial year.

9. Both nurses and care workers have told us that they often do not have effective escalation processes within their employer's governance structure or appropriate professional support structures with senior nursing positions in the organisation to raise and escalate issues around nursing practice. This can be that there is no one to escalate an issue to, or that the person they are required to escalate to is a manager with no clinical qualifications or

experience. For example, the Queensland Nurses and Midwives' Union has received reports of non-clinical managers working on call attempting to direct clinical and nursing care. It is highly concerning that registered providers are permitted to operate without effective and appropriate clinical governance frameworks and that the Aged Care Quality and Safety Commission is not currently regulating this more assiduously. It will be vital for the Rules to ensure that nursing models of care in aged care (residential, respite, and in-home) are supported as an effective approach for helping to embed enhanced clinical governance expertise in the aged care sector. Here, the Rules should address the issue that generally, only nurses (and other registered medical and allied health professionals for example regarding specifically prescribed medications) should be able to direct nurses. In the Rules, a clear requirement for clinical governance frameworks should be stipulated. This should be detailed in the Rules on page 10 (Division 2, 34 – Care management), in Division 8 (Residential care service types), and under Division 2 (44 – Restorative care management).

Nursing Care

10. Aged care is perhaps the only sector in the broader healthcare field where clinical and personal care are not currently considered intrinsically linked as part of a care continuum. Nurses have a vital role in providing continual oversight and coordination of care for older people in residential aged care and in-home care. To help ensure that nursing is not unreasonably viewed and treated as a 'specialist service', the Rules must ensure that nurses are able to be involved in all aspects of care – from intake assessment to care management, direct and indirect supervision of care delivery, and direct clinical and non-clinical care. The Rules make a distinction between 'Nursing care' (Division 2, 41) and 'Personal care' (Division 2, 43) and 'Residential clinical care' (Division 8, 60) and 'Residential non-clinical care'. Here, it will be critical that the pricing of services under both be developed with recognition that both nurses and care workers will be involved in delivering personal and non-clinical care and that registered and enrolled nurses will have key roles in clinical supervision. For example, while the Rules do not explicitly state that nurses would *not* be involved in providing 'assistance with self-care and activities of daily living', if the base efficient price ($ per hour) is calculated

without recognising that nurses can and do provide such services, there will be little to no incentive to ensure that nurses are involved in delivering personal care. Ensuring that staffing and skills mix levels are sufficient and that nurses are engaged in the gamut of personal and clinical services is vital,[3] as care delivered by nurses and ensuring nurses 'at the bedside' has well established links to better care experiences and outcomes.[4,5,6]

11. It is also important that services provided by nurses are costed within relevant personal care and non-clinical care items as nurses are responsible for providing holistic, person-centred care and should not be excluded from this. Nursing has long since moved away from lists of skills and competencies and adopted contemporary 'standards of practice' and a focus on holistic, person-centred care that encompass the breadth and depth of nursing practice which involves everything from personal care to complex clinical care. Whenever care is provided for an older person, such as assisting with hygiene, or mobilisation, a nurse is also using their clinical expertise and experience to observe and assess the individual for potential health and wellbeing issues or conditions.[7] By ensuring that services provided by nurses and nursing models of care are recognised in the pricing of personal care and non-clinical services, safer, more effective, and appropriate care will be better supported by the Rules. Aligned with this also, is that the term 'assistant in nursing' be retained to embed nursing models of care in aged care providing that assistants in nursing must work under the supervision and delegation of registered nurses and work to their defined scope of practice. Similarly, personal care workers, who may have a range of job titles (including under the Aged Care Award as being classified as 'aged care employees- direct care') also work under the supervision and delegation of registered nurses. This approach will also assist with the wider aim of reinforcing the pipeline of people who choose to work towards becoming enrolled nurses or registered nurses and ensure that clinical care is nurse-led.

12. Related to the issue described above, is the potential risk that the Rules perpetuate an outmoded conception 'task focussed care' instead of holistic 'person-centred care'. Here, while it is clearly important that there be a defined and well-specified list of services provided in the context of aged care, task focussed care that is aimed at the prioritisation of efficiency

is known to be detrimental to the delivery of high-quality, dignified person-centred care.[8] Further, task-based care is known to be linked to nurses feeling unable to meet professional values and standards which in turn can contribute to moral distress and workplace dissatisfaction. By ensuring that the base price of services is great enough to safeguard the delivery of services by nurses as well as care workers and that the amount of time allocated to each service is sufficient to ensure services are not rushed holistic, person-centred care can be better supported and engendered by the Rules. This will also be achieved by ensuring that nursing models of care are recognised and supported within the service list.

Care Management

13. Section 34 outlines the requirements of care management for home support care, however it does not specify who is able to complete care or otherwise known as case management. In-home aged care of older people should receive care management from clinically qualified staff (ideally registered nurses) who have received additional training and/or have vast experience in care management methodologies and geriatric assessments and planning. Care management should incorporate expertise from the multidisciplinary team (including registered nurses, enrolled nurses, medical officers and allied health), utilising the caseload work method, to plan, deliver, or make referrals for all care required to a caseload of older persons living in their homes. It will be essential that the pricing of services under care management incorporates costings for the multidisciplinary team.

Care Minutes

14. While it is understood that this Service List component of the Rules does not explicitly relate to the issue of mandated direct care minutes provided to older people in aged care, it is important to recognise that service list items will clearly have direct influence on the delivery of care and that the allocation of care responsibility to staff will be impacted. Here, it is critical that care recipients receive a sufficient amount of care from a suitably qualified and skilled workforce including registered nurses, enrolled nurses, assistants in nursing, and personal care workers and that sufficient direct care time as well as personal care time is allocated to support

the best possible experiences and health outcomes. This will necessarily include ensuring that nurses (registered and enrolled nurses) are not excluded from providing personal care services supported by assistants in nursing and personal care workers, that the pricing of services is determined with recognition that a variety of staff will be involved in delivery of care, and that providers must be required to abide by strict conditions around transparency and accountability of the use of funds to support a suitably sized workforce with an appropriate skills mix to deliver care in both residential and in-home aged care settings.

Nurse practitioners

15. Nurse practitioners provide safe, high-quality care and are a widely underutilised group of advanced healthcare professionals in Australian aged care.[9] To address the omission of a nurse practitioner funding item and to recognise and support nurse practitioner roles in the sector, an additional item (5) 'Nurse practitioner clinical care – Clinical care provided by a Nurse Practitioner, including on the clinical care matters' should be specified in Subsection (4) Division 2, 41 – Nursing Care.

Specific Issues

Clinical care matters

16. On page 15 (Division 2, 41 – Nursing Care), Clinical care matters stipulates "the assessment, treatment and monitoring of medically diagnosed conditions". Here, clarification is required to specify that conditions might not necessarily have been medically diagnosed for nursing care to be provided. This is because an older person might not have been medically diagnosed with a condition prior to nursing care being necessary (e.g., a nurse might notice signs that an older person might have experienced a stroke when assisting them to get out of bed or with eating breakfast and perform an assessment without a prior medical diagnosis and inform other relevant members of the care team such as a nurse practitioner or general practitioner so that full and appropriate care is implemented). Further, conditions that are not medically diagnosed but often require active management from registered and enrolled nurses also include presentations such as chronic constipation, malnutrition, short-term

delirium, and pain management. While nurses work in collaboration with multidisciplinary teams, nurses develop care plans in relation to nursing care independently of other health practitioners. The current wording must be extended and should also capture diagnosis, assessment, treatment, and monitoring undertaken by nurse practitioners. By removing the term 'medically' from the Rules at Division 2, 41 – Nursing Care (4)(a) this issue could be addressed.

17. All assistants in nursing or personal care workers must always work under the direction and supervision of a registered nurse and only provide aspects of nursing care at the delegation of the registered nurse. Under this section, also, the Column 2 description for Item 3 'Nursing assistant clinical care' should be reworded to read 'Clinical care provided by a nursing assistant or personal care worker *under the supervision and delegation of a registered nurse,* including the clinical care matters specified in subsection (4)*(a) and (c-g).* As outlined above, assistants in nursing or personal care workers working under the supervision and delegation of registered nurses to their defined scope of practice will also assist in embedding nursing models of care in aged care, address workforce shortages by supporting articulation between assistant in nursing or personal care worker, enrolled nurse, and registered nurse qualifications and roles.

Emergency assistance

18. On page 30, 'Emergency assistance' is listed as a service type for residential everyday living (Division 8): "where at all times, having at least one suitably skilled employee of the registered provider onsite able to take action in an emergency" is stipulated. It is currently unspecified what 'suitably skilled employee' means, however, as registered health professionals, registered nurses are well-placed to act in this role. While every nursing home is required by law to have at least one registered nurse on site and on duty 24/7, for many facilities (particularly those with multi-story layouts, multiple buildings, or larger homes with many beds), one registered nurse would not be sufficient to be able to act in an emergency. Here, the type of employee(s) this service should be delivered by must be clearly defined and the requirement must be increased to ensure that enough qualified staff are onsite and able to

act. Here, the Rules could also be clarified in terms of including clear requirements around Workplace Health and Safety Representatives who are needed to respond to workplace health and safety issues that involve clients, staff, and site visitors.

Quality and quantity of meals and refreshments

19. The wording on page 32 (Division 8, Residential everyday living) regarding meals and refreshments (9,a) is vague and subjective in terms of specifying what is meant by 'quality' and 'quantity'. Based both on the extensive evidence of aged care providers serving nutritionally deficient, poor-quality foods and unplanned weight loss among older people in aged care (as recognised by the Royal Commission and Government), as well as the vast array of individual differences and preferences around food and eating, these terms should be more clearly specified to provide stakeholders with a clear benchmark in terms of what level of quality and quantity must be achieved.

20. The way that different dietary requirements and preferences are detailed in the rules is problematic. It is unclear what the rationale is for separating individuals' medical, cultural, or religious needs in terms of food from what is described as an 'individual's social preferences on food sources'. The current language could be interpreted as creating an artificial hierarchy or distinction between peoples' choices to avoid certain food sources. For example, while some cultures and faiths encourage a vegetarian or vegan diet, for many people the decision to eat vegan or vegetarian food sources might better be described as an 'individual's social preference'. Here, it is important that the Rules do not create confusion and potential issues due to some people's dietary preferences and requirements being considered more important or valid than others, as currently it would appear that a person's decision to avoid genetically modified food would be considered unreasonable while a person's decision to adhere to a vegan diet would be considered incorporated within the wording of the rules and therefore reasonable.

Definitions – Diverse cultural activities

21. The definition of 'Diverse cultural activities' includes point (c) 'individuals who are lesbian,

gay, bisexual, trans/transgender or intersex or other sexual orientations, gender diverse or bodily diverse'. Whilst members of this diverse group are often classified as a 'cultural' group, framing the legislation this way for funding purposes risks diminishing the funding of specific services that meet the needs of this often vulnerable and under-served community. This risk could be partially mitigated by changing the language used in the Rules and instead articulating this category as 'Diverse cultural and community activities'.

Therapeutic services for independent living

22. Under Division 2, 46 – Therapeutic services for independent living, part (3)(e) should ensure that pricing and wording reflects when a health practitioner is indirectly supervising the delivery of care to ensure that suitable clinical governance and oversight is properly supported and provided for through sufficient funding. This point is also related to concerns raised above in relation to ensuring that effective clinical governance frameworks are upheld by the Rules and that nurses are supported by the rules and sufficient funding to not be excluded from 'non-clinical' services.

Residential accommodation

23. Item 2 under Section 57 (Division 8) should specify that this funding category is for non-clinical documentation relating to residents. This is important as it would help to ensure that clinical documentation is adequately captured in funding and to disincentivise the use of nursing time being utilised on non-clinical administrative documentation relating to residents. Here, the description of Item 2 should read: 'Administration relating to the general operation of the residential care home, including accommodation agreements, service agreements and other *non-clinical* documentation relating to residents.'

Advance care planning

24. Item 1(c) (Division 8 Section 59 – Residential non-clinical care) refers to administration related to advance care plans as being a non-clinical care service. Advance care planning is also included under Division 8 Section 60 Item 4(s). Here, clarification is requested regarding the distinction between 'administration' related to advanced care planning and advance care

planning as non-clinical/clinical services.

Medication management

25. Item 3 (Division 8 Section 60 – Medication management) Medication management must be amended so it does not provide for the administration of medications by workers who are not registered nurses or enrolled nurses. The wording currently implies that these activities are only undertaken under the delegation and clinical supervision of a registered nurse or other appropriate health professional. The administration of prescribed medication in certain circumstances by persons other than a nurse in New South Wales is illegal. We believe it is not the intent of this legislation that it should sanction any activity that is illegal in other contexts. However, Item 3 – Medication management part (b) should be re-worded to state: 'administration of, and monitoring the effects of, medication (via all routes (including injections)), including supervision and physical assistance with taking both prescription and over-the-counter medication by a registered nurse and enrolled nurses under the supervision and delegation of a registered nurse or other appropriate health professional'.

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