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Health, Communities, Disability Services and
Domestic and Family Violence Prevention Committee
via email: careinquiry@parliament.qld.gov.au

To the Chair of the Committee

Thank you for providing AMA Queensland with the opportunity to provide a submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's (HCDSDFVPC) inquiry into aged care, end-of-life and palliative care and voluntary assisted dying.

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system. We are strong advocates for increased funding and access to palliative care, and the greater uptake of end of life care planning.

This submission from AMA Queensland addresses the issue of Aged Care.

Q1. To Q5. – no response from AMA Queensland

Q6. Are adequate numbers of home care packages available in areas at the levels required?

AMA Queensland believes home care funding packages are an important part of the system, but there are too many people waiting for the packages. For instance, In Australia there are currently 90,000 approved home-care packages and another 127,000[1] on the home-care packages waiting list. If the Commonwealth government approved the additional places, AMA Queensland questions the ability of providers to fulfil these places in a timely manner. So, at the moment there is a systems mismatch and a systems funding issue which may lead to a systems failure if this is not corrected in the immediate future.

Q7. Are there sufficient staff in the aged care sector to meet current and future workloads?

AMA Queensland wishes to raise two key issues related to the workforce in the aged care sector. The first is the reduction in both access and number of registered nurses in residential aged care facilities (RACF) and the second is access to multidisciplinary care teams.

AMA Queensland is concerned with reduction in access and number of trained nurses reducing as a proportion of total staff involved in the facilities as this may lead to a lesser standard of care being provided to older Australians in these facilities. The latest data on the number of registered nurses in RACF had gone down from 21% in 2003 to 14.9% now[2].
This decrease, which also confirmed by Leading Aged Services Australia (LASA)[3] during the Aged Care Royal Commission, corresponded with an increase in the number of personal care workers who have significantly less training an background than trained nurses.

Registered nurses should be involved in all stages of care for patients including clinical handover, ensuring prescriptions are actioned, managing emergency situations and in the provision of palliative care.

Clinical handover - Nurses are crucial when it comes to clinical handover between the General Practitioner, nurses and other staff in the facility. This exchange of information is critical and vital to the continuity of care of the patient. Without an appropriate trained nurse, tests may not be

[1] Aged Care Royal Commission, National Aged Care Alliance 12 February 2019
[2] Aged Care Royal Commission, Australian College of Nursing quoting data from Flinders University 13 February 2019
[3] Aged Care Royal Commission, Leading Aged Services Australia 19 February 2019

followed up or not carried out at all and clinical handover may not occur as this forms the foundation of good clinical care.

When a General Practitioner prescribes medication - Having access to a nurse is also important when a General Practitioner prescribes medication for patients in residential aged care facilities. The General Practitioner needs the facility to action the script as soon as possible, so in the situation that a nurse is not present, then the pharmacist should pick up the script at the next available opportunity or the General Practitioner would fax it off to the pharmacist for action. Without a nurse present there is the possibility of a delay in the script being acted upon.

Managing an emergency event -The importance of having trained nurses is also important, in the event of an emergency event, where an ambulance may have to be called. In the event a nursing supervisor is not available, and a personal care attendant is required to call an ambulance, then the patient would typically be transferred to an emergency department.

Provision of palliative care - AMA Queensland believes the opportunity to access palliative care should be no less in a residential aged care facility as it should be to any other older Australian. AMA Queensland would suggest the lack of an appropriately trained nurses, particularly in overnights shifts, is also limiting access to appropriate palliative care. This issue is addressed in more detail later in the submission.

The AMA strongly supports minimal acceptable staff ratios to be introduced in line with the care needs of residents and ensuring on-site 24 hour registered nurse availability. The acceptable staff ratio in residential aged care facilities will depend on the level or number of patients with complex conditions in the facility at the time.

AMA Queensland notes that both the Commonwealth Department of Health and Aged and Community Care Australia[4] recently provided evidence to Aged Care Royal Commission disagreeing with the proposal to introduce staff quotas as they believe quotas may not give providers the flexibility they need to address changes in the levels of patients with complex conditions, which does not remain stable.

AMA Queensland wants to see a best practice and the best evidenced approach to this issue. For instance, AMA Queensland would strongly advocate for residential aged care facilities to offer access to a Geriatrician as this would help facilitate use of technology based consults such as Telehealth which would result in a three-way consultation between the General Practitioner, patient and geriatrician. Having a Geriatrician would be able to help with diagnostics and coordination of the multi-disciplinary team. Technology based consults can occur in a General Practice, rather than the residential aged care facility, if the General Practitioner has a good understanding of the patient's history and connection with the patient

In terms of access to multidisciplinary care teams, AMA Queensland believes timely access to appropriately trained staff in multidisciplinary teams is becoming increasingly difficult, particularly registered nurses and allied health who are essential when it involves the care of patients with chronic disease conditions. General Practitioners routinely coordinate multidisciplinary teams involving appropriately trained nurses, allied health staff (such as physiotherapists, nutritionists, audiologists or occupational therapists) and other health professionals, in order to deliver the most comprehensive care for their patients.

Registered nurses, in particular, form one of the most important roles as part of the multi- disciplinary care team as they have the training, expertise and coordination skills needed to ensure the care required to be delivered is implemented. For instance, if the care involves development of a care plan, the charge nurse or nurse involved in the care of the patient must be consulted at all stages of the care including providing feedback to the General Practitioner. Allied health staff are also important, but at the moment, should the care require a physiotherapist or podiatrist visiting the facility this has to be organised independently of the facility and access to psychologists, which are not covered under the Medicare agreement can only occur if a private fee is paid by the patient.

[4] Aged Care Royal Commission, Aged and Community Care Australia 19 February 2019

Q8. Is the mix of staff appropriate for different settings within the aged care sector?

AMA Queensland believes the mix of staff in different settings should correspond with the care needs of residents but this is not what currently happens in the majority of settings with access to registered nurses, allied health and psychologists becoming increasingly difficult. Of particular concern is the rapid increase in the number of personal care workers whose training (Certificate 3 or 4) is insufficient to care for older people in RACS, many of which have complex conditions.

Q9. Do aged care staff receive training that is appropriate and adequate to prepare them for the work?

See response Q8.

Q10. No response from AMA Queensland.

Q11. Are suitable health care services being provided within residential aged care settings and/or aged care providers?

AMA Queensland wishes to identify a number of issues which are limiting the quality of care being provided within RACF. The first is the lack of access and number of appropriately trained nurses, allied health (such as physiotherapists, nutritionists, audiologists or occupational therapists) psychologists and geriatricians but this has been covered in our response to Q7 (above).

The second issue, which is limiting the involvement of General Practitioners in RACF, is the current remuneration arrangements under the Medical Benefits Scheme (MBS). Item numbers under the MBS describe an episode of care, have a number of components and often a minimum time period as well as a descriptor to other item numbers which may be relevant.

In the normal course of events, when someone comes to see a General Practitioner an item number will be charged. If its bulk-billed, then a payment will be charged to Medicare or if there's a shared payment facility then a payment will be made by the patient and Medicare will pay the balance. Standard consults are level B $37.60 or for consults which require more complex consultation level C.

However, in a residential aged care facility the payment depends on the number of patients seen in the facility at the one time. So if one patient is seen the rebate is $85.00 then if two patients are seen, the rebate which can be accessed is $37.60 so the two rebates are combined and divided by two. The third patient accessed the rebate is $37.60 combine the three rebates together and divide by three and so on up to six.

By the time the General Practitioner see's the seventh patient the rebate will be $40.95. The AMA suggests this level of compensation for a General Practitioner to see a patient in a residential care facility is inadequate, particularly as the recompense bears no resemblance to the cost of providing that care. A recent survey of members of the AMA[i] indicated that anywhere between a 50 to 100 percent increase in the Medicare rebate was appropriate to compensate for the care.

Aged and Community Care Australia[5] recently admitted that aged care providers can't guarantee that a General Practitioner will actually visit a patient in an aged care residential facility, and because facilities don't generally employ General Practitioners on staff, then it is becoming increasingly rare that a resident can go and visit a General Practitioner in that setting.

The third factor limiting the quality of care which General Practitioner are able to provide is access to the patients aged care records. One of the most important issues for General Practitioner is the level of access to the patients aged care records, and this becomes particularly difficult when the residential aged care facilities clinical records are not compatible with the General Practitioners own data systems.

[5] Aged Care Royal Commission, Aged and Community Care Australia 19 February 2019

[i] AMA 2017 Survey on Aged Care

Access to this information is one of the most important issues associated with providing continuity of care, which relates to the General Practitioner having a clinical history and connection with the patient. This is less of an issue when the patient being seen in a facility has been part of the General Practitioners practice, as often knowing what concerns him or her and the values that go into their care are an important part of the trust and relationship between General Practitioner and patient.

It is more of an issue when a General Practitioner sees a patient for the first time in a residential aged care facility. The patient may already be stressed, have anxiety and the worry of being in a facility and then have to discuss their health with a General Practitioner who they may not know. General Practitioners being able to access a patient's records prior to this first appointment and the General Practitioner having a thorough understanding of their health conditions may help alleviate this worry.

Q12. - No response from AMA Queensland.

Q13. How can the delivery of aged care services in Queensland be improved?

AMA Queensland believes there a number of actions which would help improve the delivery of services in RACF.

Action 1 — For RACF to introduce minimal acceptable staff ratios in line with the care needs of residents including registered nurses, allied health, psychologists and personal care staff. The acceptable staff ratio in residential aged care facilities will depend on the level or number of patients with complex conditions in the facility at the time.

Action 2 — For all RACF to implement on-site 24 hour registered nurse availability.

Action 3 — For all RACF encourage access to multi-disciplinary teams when the care needs of residents requires this to happen.

Action 4 — For the Commonwealth Government to ensure the remuneration for General Practitioners under the Medical Benefits Scheme (MBS) matches the cost of providing the care, by supporting an increase in the remuneration for episodes of care in RACF by General Practitioners.

Action 5 — For the Commonwealth Government to review item numbers under the MBS to support increased use of telehealth by RACF. Technology based consults improve consultation between the patient, nursing staff and General Practitioner, facilitate prescriptions being filled and assessments made, and improve hospital avoidance.

Action 6 — For the Commonwealth Government to review item numbers under the MBS for non-face time consults such as addressing issues over the phone or utilising a practice nurse to review the patient.

Action 7 — For RACF to improve the level of access to the patients aged care records by General Practitioners.

Action 8 — For RACF to limit the use of physical and chemical restraints. The AMA Queensland believes physical and chemical restraints should be used as a last resort. Sadly, however, they are sometimes used in situations when the patient is at risk of harming themselves, staff or other residents. This includes behaviours such as aggressive yelling, throwing food and other items at staff and/or other residents or spitting and hitting others. For the attending General Practitioner, it is important to understand whether there is a clinical reason the patient is behaving in this manner, such as an infection or deteriorating mental health. At all times the General Practitioners focus is on continuity of care, having a patient-centred approach and the ensuring the staff are attuned to the wishes of the patient.

Action 9 When a patient from an RACF attends an emergency department - For the General Practitioner to receive a copy of the medical report from the emergency department of hospitals at the time the patient is discharged from hospital back to the RACF to ensure continuity of care of the patient.

Action 10 Increased cooperation is needed between residential aged care settings and/or aged care providers and service providers which deliver medical care, allied health care (e.g. physiotherapists, nutritionists, audiologists or occupational therapists), psychologists and geriatricians. This includes increased cooperation between RACF and the health system to ensure greater continuity of care for older Australians.

Q14. - No response from AMA Queensland.

Q15. How will the model of aged care develop with evolving technology and medical practices?

The model of aged care in Australia already has major limitations due to serious workforce issues, systemic and structural issues which need to be addressed as a matter of urgency, particularly with an ageing population which means increased demand in future years.

The response from AMA Queensland in Q13 (above) indicates a set of actions which are needed now to ensure a high standard of comprehensive care in RACF but some of these, which could be addressed now by the Commonwealth government, would strongly influence the standard of care *and* meet the needs of operators of RACF and service providers including General Practitioners). Firstly, RACF should introduce minimal acceptable staff ratios in line with the care needs of residents including registered nurses, allied health, psychologists and personal care staff including coordinated access to multi-disciplinary teams when the care needs of residents require this to happen

Secondly, for the Commonwealth Government to review item numbers under the MBS to support increased use of telehealth by RACF. Our members indicate that when telehealth is used, the difference in patient care is substantial; scripts can be dispensed to patients, assessments made and timely hospital referral actioned. A video-based app allows for collaborative consultation with patient and nursing staff and non-urgent procedures such as scans can be organised. Projects such as RADAR or GEDI are invaluable in hospital avoidance for RACF residents and helps to reduce burden on General Practitioners. Telehealth improves care to residents where they can be managed in their own environments as well as supporting RACF staff and may lead to the creation of new guidelines for management of patients in a non-hospital setting.

Thirdly, for the Commonwealth Government to work with RACF to develop a streamlined electronic documentation system which enables service providers (including General Practitioners) to access patient's records.

Finally, for the Commonwealth Government to ensure the remuneration for General Practitioner under the Medical Benefits Scheme (MBS) matches the cost of providing the care, by supporting an increase in the remuneration for episodes of care in RACF by General Practitioners. As this submission has already indicated, aged care providers cannot guarantee that a General Practitioner will actually visit a patient in RACF now! so unless this issue is addressed the number of General Practitioners visiting these facilities will continue to decline.

Q16. What are the key priorities for the future?

AMA Queensland recommends more attention be placed on the interface between palliative care and aged care.

Today many patients receiving palliative care, who are too ill to live in their own homes, reside in residential aged care facilities (RACFs). Feedback from AMA Queensland's General Practitioner members indicates the medical care offered to patients who move into RACFs is fractured and difficult to access.

When a patient moves into an RACF they lose a large part of their independence, including the opportunity to visit their own GP. GPs report that they find it extremely difficult to treat their patients in RACFs due to limited organisational support at some RACFs and poor financial incentives. Many GPs are forced to relinquish giving care to these patients. Other GPs provide extra, unpaid, work to patients and their families by writing prescriptions out of hours and providing bereavement support.

This is not a sustainable model of care. GPs need to be supported to provide care to patients in RACFs. The Queensland Government should lobby the Commonwealth Government for increased Medicare payments for GPs and other allied health groups to provide palliative treatment to patients in RACFs. Increased medical treatment in RACFs is an efficient way of treating patients and will relieve pressure on acute treatment beds in hospitals.

Yours sincerely

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