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AMA submission – Inquiry into the quality of care in Residential Aged Care Facilities in Australia

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Background

The previous two years have seen extensive consultation with aged care stakeholders on the quality of Residential Aged Care Facilities (RACFs), and the aged care system as a whole. This includes:

- *Senate Community Affairs References Committee on the Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised¹;*
- *Review of the Commonwealth Government’s regulatory activities applying to quality of care in aged care residential facilities²;*
- *Future reform – an integrated care at home program to support older Australians³;*
- *Aged Care Legislated Review⁴; and*
- *Senate Community Affairs References Committee on the Future of Australia’s aged care workforce⁵.*

AMA submissions to the above consultations are available [here](#)⁶.

As a result of these consultations, the government now has a huge range of submissions from the sector and the public, and reports and recommendations on methods to improve the aged care system. The AMA urges the government to urgently act on these recommendations in order to produce the foundations of a high quality, reformed, aged care system that best meets the current and future needs of Australians.

¹https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality/Submissions

²<https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes>

³<https://consultations.health.gov.au/aged-care-policy-and-regulation/discussion-paper-future-care-at-home-reform/>

⁴https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2017/legislated_review_of_aged_care_2017.pdf

⁵https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report

⁶<https://ama.com.au/advocacy/aged-care/submissions>

Australia has an ageing population that is experiencing chronic, complex medical conditions that require more medical attention than ever before. For example, 53 per cent of residents in RACFs have dementia⁷. This proportion will continue to grow over time, with projections reaching up to 1,100,890 people with dementia by 2056⁸, which is estimated to cost Australia \$36.85 billion by the same year⁹. A recent study identified that residents of RACFs with dementia had direct health and residential care costs of \$88 000 per year¹⁰. Currently, the aged care system as a whole, and its workforce, does not have the capacity, capability or systems integration to adequately deal with this growing, ageing population.

In order to improve the quality of the aged care system, the following is required:

- The aged care system needs an overarching, independent, Aged Care Commission that provides a clear, well-communicated, governance hierarchy that brings leadership and accountability to the aged care system.
- Medical practitioners need to be recognised and supported as a crucial part of the aged care workforce to improve medical access, care and outcomes for residents of aged care facilities.
- Access to appropriate Medicare-funded allied and mental health services in RACFs that is currently available to the rest of the population.
- Aged care needs funding for the significant recruitment and retention of nursing staff and carers, specifically trained in dealing with the issues that older people face.
- The aged care sector needs to be supported to adopt modern eHealth systems which enable more effective and efficient patient management.
 - A contemporary eHealth system will need a number of features, outlined in greater detail below, but including medication management to reduce the risk of polypharmacy.
- There needs to be clear, specific, and confidential complaints referral pathways in each RACF so information on complaints processes are easily accessible to residents, family and staff.

Many of these issues need to be reflected in specific Accreditation Standards that have a strong focus on health. In particular, an ‘access to medical care’ standard should be introduced.

Aged care’s division of governance

In order for the aged care system to evolve we must also consider that, like the broader health system, aged care impacts upon state, territory, and Federal Government. However, there is a lack of coordination and information-sharing between the levels of jurisdiction¹¹. Aged care is the

⁷ Australian Institute of Health and Welfare (2012) *Dementia in Australia*, p15.

⁸ Alzheimer’s Australia (Now Dementia Australia) (2017) *Economic cost of dementia in Australia*. p6
[<https://www.dementia.org.au/files/NATIONAL/documents/The-economic-cost-of-dementia-in-Australia-2016-to-2056.pdf>]

⁹ <https://reports.dementia.org.au/costofdementia>

¹⁰ Gnanamanickam, E et al (2018) Direct health and residential care costs of people living with dementia in Australian residential aged care. *International Journal of Geriatric Psychiatry*. 10.1002/gps.4842

¹¹ Carnell, K and Paterson, R (2017) *Review of National Aged Care Quality Regulatory Processes*, p77

purview of the Commonwealth but when a health complication arises, residents are often transferred to a hospital, which is the responsibility of the State or Territory Government. This means that the States and Territories often bear a financial cost resulting from issues that arise in a Commonwealth-run aged care environment.

The Aged Care Complaints Commissioner and the Aged Care Quality Agency (ACQA) do not take advantage of the information they receive as a result of their sometimes overlapping functions to identify issues with the system. Only 15 per cent of complaints received by the Complaints Commissioner were communicated to ACQA between July 2016 and June 2017¹².

The incidences at Oakden Older Mental Health Service¹³ is a typical example of how this lack of coordination and information-sharing can result in the inexcusable continuous neglect of older people:

*Serious complaints about medication mismanagement and unexplained bruising on a resident at Oakden were raised with the Principal Community Visitor in June 2016 and then with Northern Adelaide Local Health Network (NALHN). This led the CEO of NALHN to request South Australia's Chief Psychiatrist to undertake an extensive review of clinical care within the Oakden facility in December 2016 and appoint a senior nurse manager on 9 January 2017 to oversee delivery of clinical care. **Inexplicably, the Commonwealth aged care quality regulators were not advised of these issues and instead found out about them through a media report on 18 January 2017.***¹⁴

There is no overarching regulatory body for the whole aged care sector. This be confusing for aged care providers and consumers, as well as create inefficiencies and a lack of communication between the existing regulatory bodies. As part of significant reform, the Department of Health should re-introduce an Aged Care Commission. The aged care sector (both government and non-government funded) needs an overarching body that provides a clear, well-communicated, governance hierarchy implemented so aged care service providers are aware of their responsibilities, and who is responsible for regulation and quality improvement.

Better access to medical practitioners will improve quality of care

The current policy settings do not support GPs visiting RACFs, working after hours, or being available to answer telephone concerns about their patients. This fails to acknowledge the benefits of continuity of care. Our members report that continuity of care goes generally unacknowledged in many RACFs and a resident's care management plan is not well known. This creates an environment where the default step for RACF staff may be to refer the patient to a hospital emergency department (ED). In a study of 408 residents of RACFs presented at two Melbourne EDs, one third of presentations of residents who were returned to their RACF could

¹² Carnell, K and Paterson, R (2017) *Review of National Aged Care Quality Regulatory Processes*, p85

¹³ Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report*. Adelaide, South Australia: SA Health, Department for Health and Ageing.

¹⁴ Carnell, K and Paterson, R (2017) *Review of National Aged Care Quality Regulatory Processes*, p85

have been avoided by incorporating primary care services¹⁵. Reasons for decisions to transfer residents to an ED include limited skilled staff, delays in GP consultations, and a lack of suitable equipment. A single transfer from a RACF to the ED has been estimated to cost above \$1800 in Victoria¹⁶, such transfers cost government a significant amount of money for health issues that could be resolved by a GP, and also causes considerable distress to the patient and puts them at an increased risk of mortality¹⁷.

Medical practitioners also need to be supported within the broader health care system to provide high quality care in RACFs. For example, by local hospitals providing secondary referral, timely specialist opinion, specialist services and rapid referral pathways to advice and services.

There should be funding for the development of guidelines for the medical management of RACF residents and other older Australians. Our members report that usually medical practitioners are supplied with guidelines and standards that are based on younger patients and may not be relevant to the health conditions of older Australians. Developing clear guidelines would assist all care providers (both medical practitioners and aged care staff) in providing quality care, but would also reduce the risk of transferring patients to a high cost environment for little return (i.e. transfers to a hospital without long-term medical management).

Older people are often burdened with complex and multiple medical disorders that requires the regular attention of medical practitioners, quality nursing care and allied health care professionals. Although there is currently no publicly available complete data that shows how many Australian GPs visit RACFs, the AMA believes it is approximately only 21 per cent. AMA members (including GPs and specialists) who have decreased their visits to RACFs do so because it is not financially viable to visit RACFs, especially due to the unpaid non-contact time that comes with caring for a RACF patient. This non-contact time arises from the increased time required in activities such as liaising with family and carers, and finding, organising and coordinating care with RACF staff, other medical professionals and services and allied health care staff. This non-Medical Benefits Schedule (MBS) remunerated time is reported to be an average of 14 minutes per patient – approximately the same amount of time as the mean length of a GP consultation¹⁸. Results from the *AMA Member 2017 Aged Care Survey*¹⁹ showed that 38 per cent of participants believe that a MBS fee increase of 50 per cent would appropriately compensate for the non-contact time spent on a patient, while 31 per cent believe a 100 per cent increase would be appropriate. Such a move would still not address the extra time that results from the lack of nursing staff on hand, efficient communication pathways, lack of access to patient records in the age care facility and other time-intensive, but non-clinical activities that deters medical practitioners from visiting RACFs.

¹⁵ Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?*. *Emergency Medicine Australasia*. 27:5, p412-418

¹⁶ Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?*. *Emergency Medicine Australasia*. 27:5, p412-418

¹⁷ Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?*. *Emergency Medicine Australasia*. 27:5, p412-418

¹⁸ University of Sydney (2016) *General Practice activity in Australia 2015-16*, p39.

[https://ses.library.usyd.edu.au/bitstream/2123/15514/5/9781743325148_ONLINE.pdf]

¹⁹ To be published March 2018

Acknowledging and remunerating this non-contact time becomes more essential as the Practice Incentive Program (PIP) Aged Care Access Incentive (ACAI) ceases in April 2018²⁰, making it more costly for GPs to visit RACFs, and providing another barrier to access to quality care. The government will need to monitor how this will impact the number of GPs visiting RACFs, and reverse the decision if the data reveals an unintended consequence of a reduction in medical access for residents of RACFs.

An MBS item for phone consultations with a nurse or carer from a RACF should be considered to incentivise doctors to be on call after hours and provide timely care to patients and support to nurses and carers. This could in turn increase the number of GPs who make themselves available out of normal business hours and reduce costs in comparison to reimbursing a GP physically-attended consultation. In addition, the care of patients' regular GP would improve appropriate care, avoid unnecessary referrals to the ED and the associated triage issues. GP phone access to a geriatrician or related specialist for guidance on managing difficult problems may also improve quality of care, as sometimes a patients' specialist appointment can be in several months' time.

In the *AMA Member 2017 Aged Care Survey*, 49 per cent of participants reported that it was 'very difficult' for their patients living in RACFs to access mobile X-ray and ultrasound services. Appropriate support for medical services, including mobile X-ray and ultrasound, and pharmacology and pathology, in RACFs, will improve residents' access to medical care, and reduce unnecessary pressure for, and counter-productive utilisation of, acute services and transfer to the ED. Investment in medical services in RACFs will lead to a more efficient health system that is more person-centred.

The government should consider the merits of different models of providing medical care services within RACFs. Currently, many residents have minimal choice in deciding who their GP will be once they enter a RACF. Patients should be able to decide whether they stay with their existing GP, or transition to the in-house GP if available. Alternate models should expand the opportunities for medical practitioners working in a RACF and support practitioners to provide ongoing an comprehensive medical care. This has the potential to reduce unnecessary transfers to more expensive forms of care such as hospitals, and also reduce the risk of medical neglect going unnoticed for long periods of time. However, GPs who choose to provide medical care from within RACFs must remain independent in both providing medical advice to patients, and when raising concerns about the quality of care residents receive.

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

The complaints handling process

Although an effective complaints procedure is important, the quality of aged care should not deteriorate to such a level that there is a significant amount of complaints. This can be achieved through improving the quality of aged care system, as stated in other sections of this submission.

²⁰ <https://www.humanservices.gov.au/organisations/about-us/budget/budget-2017-18/health/quality-improvements-general-practice-implementation-practice-incentives-program>

The Government has recently introduced an independent Aged Care Complaints Commissioner to replace the former Aged Care Complaints Scheme. There has been an 11 per cent increase in the number of complaints from the first six months of 2015 to the first of 2016, however this could be due to increased awareness of the new Commissioner or an improved complaints process²¹. While the new complaints process is in its early days, our members have reported that generally the process has improved since its implementation.

However, the Commissioner fails to address complaints regarding issues that need to be resolved under new policy settings. For example, one AMA member complained to the Commissioner that staff cuts in a RACF was compromising residents' safety and quality of care, as falls and other injuries occurred more often with limited staff. However, no further action was taken as there is no legislation that a RACF should have mandated resident to staff ratios. There should be further reporting and communication with the Department so complaints like this are acknowledged as an issue with the wider aged care system, and actioned appropriately.

While the Government's complaints process is seeing improvements, there also needs to be a focus on the RACF's internal complaints process. Accreditation Standard '1.4 – comments and complaints' implies that the RACF needs to have mechanisms in place that "each care recipient (or his or her representative) and other interested parties have access to internal and external complaints mechanisms²²." Further, one AMA member reported that they feel their complaints are not taken seriously if the patient is unable to directly articulate the issue. There needs to be clear, specific complaints referral pathways in each RACF so information on complaints is easily accessible to both residents and staff. These complaints must be taken seriously.

*The Oakden report*²³ outlined that there was a lack of leadership and responsibility that led to its multiple problems. There was a lack of awareness and structure of clinical governance within the facility and who was ultimately in charge and accountable for issues. Even when issues were raised, staff were bullied and harassed into silence. Our members report that this often occurs in RACFs – where staff are not aware of who is ultimately responsible for quality of care processes. There needs to be increased communication between governments and RACFs to ensure they have an authority figure to report on any aspects of running an aged care facility. The Government also needs to ensure that the privacy and confidentiality of both aged care staff and consumers are protected when making a complaint.

²¹ Aged Care Complaints Commissioner (2016) *Annual Report 1 July 2015-30 June 2016*.

²²<https://www.aacqa.gov.au/providers/residential-aged-care/resources/brocah0011accreditationstandardsfactsheetenglishv14.1.pdf>

²³Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report*. Adelaide, South Australia: SA Health, Department for Health and Ageing. p75.

The Australian Aged Care Quality Agency

To receive funding from the Federal Government, a RACF must pass Accreditation Standards which are assessed by the Australian Aged Care Quality Agency (AACQA)²⁴. We recognise that these standards will vary with the introduction of the single set of aged care quality standards²⁵, however there are several required improvements that should be included in the new standards. The current Accreditation Standards:

“...do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its care recipients. It is not expected that all residential care services should respond to a standard in the same way.”²⁶

For some standards, a flexible approach is adequate, as different services have different capabilities and capacities. However, this may lead to inconsistencies between each assessor, or the assessment process not picking up on vital signs of incompetence – something that should not occur.

Standards that relate to medical care should not be subject to interpretation to ensure quality care is received and so RACFs are aware of their specific responsibilities. Residents should have access to, and their medical needs met by, qualified medical practitioners. The standards ‘2.4 – access to clinical care’ and is not adequate to ensure quality health care.

To rectify this, the standards should incorporate an ‘access to medical care’ standard. Rather than vague standards that say RACFs should ensure compliance with all relevant legislation, a medical care standard should reflect aspects of the *National Safety and Quality Health Service Standards*²⁷. People living in RACFs should have access to the same quality health services as other Australians. The AMA has been advised that currently, RACFs (with the exception of facilities that provide acute services) do not have to comply with these standards.

Under a medical care standard, there are other aspects that should be considered to achieve quality care, as described below.

²⁴ <http://www.aacqa.gov.au/consumers/for-providers>

²⁵ <https://agedcare.health.gov.au/quality/single-set-of-aged-care-quality-standards>

²⁶ <https://www.legislation.gov.au/Details/F2014L00830>

²⁷ Australian Commission on Safety and Quality in Health Care (2012) *National Safety and Quality Health Service Standards*.

Access to staff

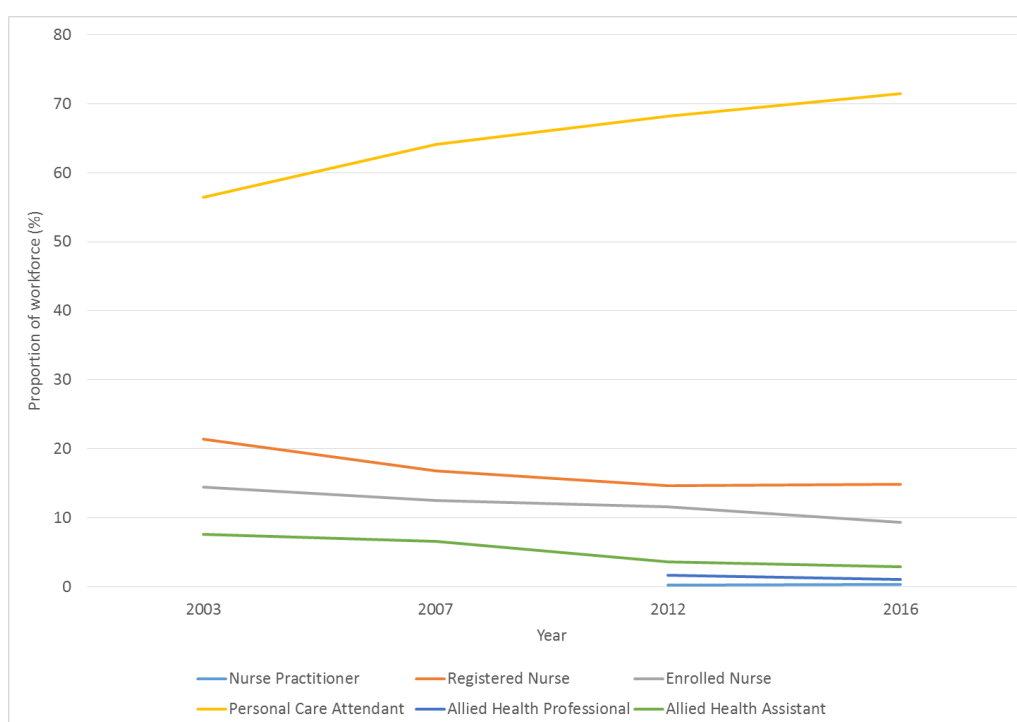


Figure 1: The proportion of Full Time Equivalent employee types in the aged care workforce. Data source: Mavromaras et al (2016) *The aged care workforce, 2016*. Department of Health

There has been a decreasing trend in the proportion of registered and enrolled nurses in the aged care workforce (Figure 1). Our members have reported cases where nurses are being replaced by junior personal care attendants, and some RACFs do not have any nurses staffed after hours. This presents significant communication difficulties, as our members have advised that there is on occasion no nurse or appropriate staff member available to discuss their patient’s requirements. Further, a recent survey identified low staffing levels in RACFs as the main cause of missed care (e.g. not responding to bed calls within five minutes, checking vital signs etc.)²⁸. Our members have also reported a high turnover of staff and the use of agency staff in RACFs, which may also negatively impact the RACFs’ quality of care as they do not know the resident, and have little responsibility beyond their limited shifts.

The Government must ensure that RACFs do not have a restricted quality of care due to a workforce shortage. The decline in the proportion of registered and enrolled nurses needs to be reversed to ensure residents are provided with timely and appropriate clinical care. This has placed additional pressure on nurses and medical practitioners and has likely led to increased transfers to the Emergency Department (ED). The Accreditation Standards should demonstrate a ratio of suitably trained nurses to patients at any one time to ensure people living in RACFs with complex needs are receiving appropriate care. This is critical to the quality of the aged care system, but will need a joined up approach noting the significant workforce issues at play.

²⁸ Henderson et al (2016) *Missed care in residential aged care in Australia: An exploratory study*, Collegian.

Access to the patient

RACF patient records are not easily accessible to visiting medical practitioners and are commonly incomplete. Currently, the standard '1.8 – Information systems'²⁹ ambiguously outlines that there should be effective information management systems in place, which is evidently not helpful to RACFs, as it is the most frequent unmet standard³⁰. There needs to be a specific standard on the management of medical records that aligns with the Royal Australian College of General Practitioners' standards on patient health records³¹.

Medical records should be based through an efficient and accurate electronic system that is accessible to all staff and visiting medical practitioners to avoid the 'doubling up' of records and the possibility of missing information. A study³² published in 2016 highlighted that only 37.4 per cent of RACFs used an electronic health record (EHR) system, with the remaining 62.6 per cent relying on paper-based records. They found that compliance with the Accreditation Standards in EHR users was of a significantly higher proportion than those who relied on paper-based records. Although IT systems are a useful tool to assist with improving quality of care and clinical communication, the quality is dependent on staff being trained to use them appropriately, and then actually using them.

Standard 1.8 currently only applies to RACF staff access. Medical practitioners should also have full time ready access to these information management systems, including clinical files on a contemporary clinical software system. This includes software that is user-friendly and appropriate to the needs of medical practitioners, improved electronic interface between pharmacy services and RACF records, and/or support for remote access to the practitioner's medical records. The My Health Record, provided all IT security requirements are met, should sync with aged care software systems and My Aged Care. This will achieve better communication between the care team, faster access to hospital discharge summaries, fewer medication errors, and better access to Advance Care Directives.

A modern, quality eHealth system should also enable the transfer of information across health care systems (e.g. electronic referrals, letters or discharge summaries, and advanced care plans), investigation management (e.g. the ordering, tracking, receipt and action of pathology and imaging tests and results), and medication management. This will increase efficiencies, decrease duplication and waste, improve coordination, accountability and safety of care and reduce the risk of polypharmacy, and in turn reduce the likelihood of cognitive impairment, delirium, frailty, falls, and mortality in RACFs.

²⁹ <https://www.aacqa.gov.au/providers/residential-aged-care/resources/brocah0011accreditationstandardsfactsheetenglishv14.1.pdf>

³⁰ Australian Aged Care Quality Agency (2017) *Annual Report 2016-2017*, p13

³¹ <http://www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/patient-health-records/>

³² Jiang et al (2016) *The impact of electronic health records on risk management of information systems in Australian residential aged care homes*. J Med Syst. 40:204.

Access to the facility and suitable room

There is a growing tendency to build facilities in the outer growth corridors or ‘urban fringe’ of metropolitan areas which further adds to the time spent by medical practitioners away from their surgeries. This also forces people to move further away from their community and reduces the likelihood of retaining their usual GP, which in turn breaks continuity of care.

A car parking space and 24-hour access through the main entry should be available to medical practitioners to ensure they have access to their patients quickly and whenever it is required. This suggestion requires no additional cost to the facility and could be easily implemented.

The standard ‘1.7 – inventory and equipment’, should include use of an onsite, suitably accessible, equipped and private medical treatment room that meets RACGP standards. This includes easy access, appropriate requirements for hygiene and sharps disposal, access to eHealth records and privacy. Treatment on occasion has to be provided in a shared room where there is a lack of privacy for the patient and no equipment for the treating doctor, limiting the medical treatment that can be provided in that setting. A survey by Catholic Health Australia also found that GPs were more likely to visit RACFs that had GP visiting rooms³³. Currently, this standard states that there should be appropriate goods and equipment available for quality service delivery³⁴, however this is not occurring for the goods and equipment medical professionals require to provide a quality service.

Standards, training and quality improvement

The importance of standards, training and quality cannot be underestimated, and each need to be considered separately, and how they interact as a whole.

The aged care sector is heavily regulated and is currently going through significant reform³⁵, so it is difficult for the sector to keep track of all relevant legislation, policies and guidelines. The Accreditation Standards however give vague indications to RACFs on how to achieve adequate care. Regulations and standards in the aged care sector needs to be flexible in areas that will improve innovation and quality in the sector, but not where medical care is involved. We hope to see standards refined through the development of a single set of aged care quality standards.

Currently, the AACQA runs workshops to assist RACFs in understanding their accreditation requirements – costing (post July 2017) \$572 per participant, or \$5280 for an AACQA representative to run the workshop in-house³⁶. Training should be more financially accessible as many RACFs do not have the resources or capacity to attend costly workshops. The AMA agrees with the recommendation outlined in the report on the *Senate Inquiry into the future of Australia’s aged care workforce*³⁷ that there should be support mechanisms in place to assist

³³ Catholic Health Australia (2010) *Survey of Access to General Practice Services in Residential Aged Care*

³⁴ <https://www.aacqa.gov.au/assessors/PocketguideSeptember2014updatedforweb.pdf>

³⁵ <https://agedcare.health.gov.au/aged-care-reform>

³⁶ <https://www.aacqa.gov.au/providers/education/courses-and-workshops/understanding-accreditation>

³⁷ Community Affairs References Committee (2017) *Future of Australia’s aged care workforce*.

RACFs and aged care services to access quality training such as this to ensure staff are aware of their responsibilities, and learn about ways to improve the quality of care they provide.

It has been reported to the AMA that many aged care staff do not have to appropriate training to properly handle the major issues facing the elderly, such as behavioural conditions, dementia, falls prevention, pressure sore prevention, and pain management. We have been informed that this can lead to an increase in medication use. The '2.4 clinical care' Accreditation Standard was the second highest outcome not met by RACFs in 2016-17, followed by '2.7 – medication management'³⁸. This shows that aged care staff find it difficult to understand, or are unable to carry out, what is expected of them in terms of clinical care.

Some of our members are concerned that aged care staff are requesting sedation of residents so they are easier to handle. Restraints such as sedation should only be prescribed where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. They should always be considered a last resort. Providing care should ensure the safety, wellbeing and dignity of the patient and ensure a medical practitioner assesses the patient for any underlying behavioural conditions. Aged care staff should be properly trained on the ethical, medical and legal issues that can arise from using a restraint, and also educated on ways to improve the aged care environment through ensuring a friendly physical space, and through social and staffing structures.

Culturally and Linguistically Diverse (CALD) individuals

Australia has seen a rise in the number of migrants. In 2013, 32 per cent of the Australian population (5.8 million people) were born overseas³⁹. Projections for 2021 suggest that the older population will comprise 30 per cent of people born in a country other than Australia⁴⁰. This presents a major challenge to incorporate different cultures into Aged Care, and communicate with individuals who may have low levels of English literacy.

In the case of Aboriginal and Torres-Strait Islander populations, it is important to ensure RACFs are culturally aware and informed, similar to the cultural understanding seen in the Aboriginal Community-controlled Health Service. This will ensure smooth transition between the health system and the aged care provider.

Our members have recently highlighted the communication difficulties both with CALD staff and residents of RACFs, and more awareness of the services and training available to staff is required if CALD residents are to receive equitable aged care.

³⁸ Australian Aged Care Quality Agency (2017) *Annual Report 2016-2017*, p13

³⁹ Australian Bureau of Statistics (2013) *Characteristics of Recent Migrants* [online <http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/6250.0/> accessed 23/11/2016]

⁴⁰ Department of Social Services (2015) *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*

Accreditation visits and compliance

Spot checks (i.e. unannounced site visits) are important tools for quality improvement and aim to be an educative experience for RACFs. With the recent announcement that announced site visits will no longer occur⁴¹, it is important that spot checks do not take nurses and staff away from any essential duties of care in the RACF.

Our members have also observed that the review process has a great focus on paperwork compliance addressed in Standard 1 rather than the major indicators of quality care in Standards 2 and 3. While management systems within the RACF are important, members have observed that RACF staff are worried about failing accreditation over a minor documentation compliance issue and instead focus on this rather than providing care to patients. The process should ensure that quality of care is considered a more essential indicator of quality than the existence of paperwork.

Medical practitioners reported in the *AMA 2017 Aged Care Survey* that they are not involved in the accreditation process and are not asked to participate in reviewing care in the RACF when it is due for re-accreditation. Medical practitioners as providers of medical care for older people may have a unique opportunity to identify issues with the quality of an aged care home or signs of elder abuse. Medical practitioners are also the second highest profession Australians trust⁴², and could be consulted for feedback on a RACFs performance. Visiting doctors should also be engaged on the ongoing evolution of the accreditation framework, noting the insights they may bring.

Polypharmacy in RACFs

Polypharmacy (the use of multiple (five or more) medicines) can cause cognitive impairment, delirium, frailty, increase the chance of falls, and mortality to name a few. This in turn increases the number of visits to the ED⁴³. Polypharmacy is an issue that occurs nation-wide, with reports of 20-30 per cent of hospital admissions over the age of 65 being medication-related, and studies suggesting that up to 63 per cent of RACF residents take nine or more medications regularly⁴⁴. Medicine-related hospital admissions have been estimated to cost \$1.2 billion a year⁴⁵

The standard '2.7 – Medication management' should include specific guidelines around medication reviews that align with the *National Strategy for Quality Use of Medicines*⁴⁶. There also needs to be training for aged care staff and awareness of protocol relating to adverse

⁴¹ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-wyatt107.htm>

⁴² <https://www.roymorgan.com/findings/7244-roy-morgan-image-of-professions-may-2017-201706051543>

⁴³ <http://www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines/for-health-professionals/polypharmacy>

⁴⁴ Sluggett et al (2017) *Medication management policy, practice and research in Australian residential aged care: current and future directions*. Pharmacological Research. 116: p27-35.

⁴⁵ Roughead, E (2016) *The extent of medication errors and adverse drug reactions throughout the patient journey in acute care in Australia*. International Journal of Evidence-Based Healthcare, pp113-122.

⁴⁶ Commonwealth of Australia (2002) *The national strategy for quality use of medicines*.

[https://www.health.gov.au/internet/main/publishing.nsf/Content/8ECD6705203E01BFCA257BF0001F5172/\\$File/natstrateng.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/8ECD6705203E01BFCA257BF0001F5172/$File/natstrateng.pdf)

reactions to medicines. Governments need to contribute funding to regular medication reviews – currently the National Aged Care Quality Indicator Programme does not include a medication quality indicator⁴⁷. This funding would result in significant savings for both the patient, the RACF, and hospitals – as a reduction in polypharmacy has been found to significantly reduce the costs of care⁴⁸. For example, the number of medications a patient takes predicts the risk of an Adverse Drug Event (ADE), and, when they occur, ADE's contribute to over 10 per cent of a patient's health care costs⁴⁹.

Residential Medication Management Reviews (RMMRs) are available to permanent residents of government-funded RACFs⁵⁰ and are an important review and safety tool. However, RMMRs are becoming sparse. Although GPs are able to carry out one RMMR in a 12-month period⁵¹, some members have reported they are only occurring every two years, and that many patients are prescribed medication for behavioural issues when unnecessary in order to make them easier to handle. RMMRs should occur annually and on an as-needed clinical basis to ensure medications are not harming the patient and to avoid any time restrictions costing the government more in medical costs in the long run. Pharmacists working with doctors and patients can help ensure medication adherence, improve medication management, and provide education about medication safety.

Aged care facilities require improved IT systems that are interoperable with the My Health Record, namely its Medication Management feature, to ensure there is clear, complete communication with all relevant care providers to prevent the risk of adverse reactions to using multiple medications, with GPs remaining as the primary curator of the patients' My Health Record. This adds to our previous argument that aged care services need significant uptake of contemporary and interoperable IT systems to achieve quality information management systems.

Mental health, allied health and oral health in RACFs

In 2013, the Australian Institute of Health and Welfare (AIHW) found that 52 per cent of permanent aged care residents had symptoms of depression. Further, 73 per cent of residents with symptoms of depression had higher care needs compared to residents without symptoms of depression (53 per cent)⁵². This data identifies mental health as a major issue affecting the quality of life for residents of aged care facilities.

Under the *Better Access to Mental Health Care* initiative, patients can claim Medicare rebates for mental health services provided by or through a GP⁵³. They include GP Mental Health Treatment Plan, where GPs undertake early intervention, assessment and management of patients with

⁴⁷ Sluggett et al (2017) *Medication management policy, practice and research in Australian residential aged care: current and future directions*. Pharmacological Research. 116: p27-35.

⁴⁸ Kojima et al (2012) *Reducing Cost by Reducing Polypharmacy: the polypharmacy outcomes project*. Journal of the American Medical Directors. 13:9 p818

⁴⁹ Scott et al (2014) *First do no harm: a real need to deprescribe in older patients*. The Medical Journal of Australia. 201:7 p390

⁵⁰ <http://www.health.gov.au/internet/main/publishing.nsf/Content/rmmr-factsheet>

⁵¹ <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=AN.0.52>

⁵² <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544771>

⁵³ <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat>

mental disorders, and include referral pathways from GPs for treatment by psychiatrists, clinical psychologists and other allied mental health workers. Residents of aged care facilities are not eligible for this Initiative and therefore do not receive MBS rebates for these services⁵⁴. Residents of RACFs deserve to have the same access to mental health services as other Australians.

There is also a range of other important allied health services that aged care residents currently do not have adequate access to. In particular, dental services noting that significant and sometimes severe impact that gum disease and tooth decay can have on pain, sleep, nutrition and mental health. Equally, access to services such as physiotherapy, dietician, podiatry, and speech pathology need to be considered.

Palliative Care

Our community needs to be educated about the reality of death and dying. Similarly, health care professionals need to be upskilled and supported to provide quality, collaborative, palliative care. There should be training in palliative care and grief and bereavement counselling available to all health practitioners, to support both patients and their family members.

Acute medical care in Australia prioritises treating disease and preserving life. This acute model of care does not necessarily respect the needs of patients living with life limiting illnesses and can impose additional unnecessary pain and distress without necessarily delivering desirable outcomes. A palliative approach in aged care settings recognises that healthcare should not be based on diagnosis alone. The aim of a palliative approach is to maximise quality of life through appropriate needs-based care. This approach provides a positive methodology for reducing an individual's symptoms and distress.

The majority of Australians want to die in their own home⁵⁵. On many occasions, home is an aged-care facility (i.e. not the hospital). Where possible, the patient should be cared for in the environment of their choice, including the RACF. Currently, there is a lack of resources to respect this choice. Supporting end of life care and advanced care plans will provide residents with good quality patient-centred care that is a collaboration between the patient and the health care team. This care should be facilitated and coordinated by their medical practitioner. RACFs need supporting policies in place that allows the generation of clear advanced care plans appropriate for the RACF setting, that are taken seriously and reviewed regularly.

There is emerging data to suggest that community-based care for the last three months of an individual's life is significantly cheaper than if they were to die in hospital (\$6,000 compared to an average hospital admission cost of \$19,000 per patient)⁵⁶. These substantial savings, coupled with the ability to respect a person's choice in their place of death, argues that more should be invested in providing good quality palliative care in the home.

⁵⁴ <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.56&qt=noteID&criteria=AN%2E0%2E56>

⁵⁵ Foreman et al (2006) *Factors predictive of preferred place of death in the general population of South Australia*, *Palliative Medicine*, vol. 20, no. 4, pp. 447-453.

⁵⁶ Swerissen, H and Duckett, S (2014) *Dying Well*, Grattan Institute, Melbourne

By remaining in the RACF, residents are able to receive care in a familiar setting, reducing confusion and the anxiety that results from transfers to hospitals. Appropriate integration of the GP in the facility will improve outcomes for residents through better clinical management, improved continuity of care and reduced readmissions. Hospital in the home-type services provided by a Local Health Directorate can also support treatment in a RACF rather than transfer the patient to a hospital.

Conclusion

Many of the issues outlined above can be rectified by improving the capability, capacity and connectedness of the aged care workforce. Currently, this workforce is not adequately trained to be able to care for older Australians, as their care needs are growing in both complexity and volume. In addition, although medical practitioners are well-equipped to provide quality medical care to residents living in RACFs, they are not adequately supported to do so due to the range of issues described above. This has resulted in an enormous barrier to quality medical services for RACF residents.

The aged care workforce needs clear leadership and accountability, which an Aged Care Commissioner could provide. Many aged care governance (and workforce) issues described above have already been addressed in recommendations to the Government as a result of the multiple aged care reviews^{57,58,59}. Now is the time to act on these recommendations to prevent more unacceptable examples of neglect and bad quality care in RACFs, and to give people living in RACFs the quality of life that they deserve.

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⁵⁷ Future of Australia's aged care sector workforce
[https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report]

⁵⁸ Aged Care Legislated Review [<https://agedcare.health.gov.au/legislated-review-of-aged-care-2017-report>]

⁵⁹ Review of National Aged Care Quality Regulatory Processes [<https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes-report>]