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AMA submission to the Aged Care Workforce Strategy Taskforce – the aged care workforce strategy

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1. Why does an aged care workforce strategy matter?

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 dementia[1]. This proportion will continue to grow over time, with projections reaching up to 1,100,890 people with dementia by 2056[2], which is estimated to cost Australia $36.85 billion by the same year[3]. A recent study identified that residents of RACFs with dementia had direct health and residential care costs of $88 000 per year[4]. Currently, the aged care system as a whole, and its workforce, does not have the capacity or capability to adequately deal with this growing, ageing population. The Productivity Commission has estimated that the number of nurses and personal care attendants in the aged care workforce must quadruple by 2050 to meet demand for aged care services[5]. This will put enormous pressure on a system already facing recruitment and retention issues. The aged care system needs a strategy to ensure the workforce is appropriate to meet the demands of older people in the future.

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

- 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 older people.

[1] Australian Institute of Health and Welfare (2012) *Dementia in Australia*, p15.
[2] 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]
[3] https://reports.dementia.org.au/costofdementia
[4] 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
[5] Productivity Commission (2011) *Inquiry report – Caring for older Australians*. Pp XLV

- Aged care needs funding for the significant recruitment and retention of, and support for, nursing staff and carers, specifically trained in dealing with the issues that older people face.

2. What practical difference do you hope a strategy will make?

Defining the role of aged care

There is a disparity between the views of aged care providers, medical professionals, and the public, on the roles of aged care services. The Senate and Community Affairs References Committee's interim report on *The effectiveness of aged care quality assessment and accreditation framework*[6] highlighted that some aged care providers believe they should not be held accountable for clinical services, while the Aged Care Quality Agency has a clinical care Standard that is commonly not met by aged care providers[7]. Most of the reports on the appalling incidents that have recently occurred in the aged care sector more broadly (for example, the Oakden Older Persons Mental Health Service[8]) have been a result of a lack of quality clinical care provided by the aged care service provider. The AMA believes that to dismiss clinical care as a responsibility of aged care settings is not responding to older people's greatest, most urgent needs, leading to further stories of the neglect of older people. The Taskforce needs to clearly define the responsibilities of each aged care service to avoid confusion within the workforce and ensure older people receive timely, appropriate care.

Clinical care provided by aged care services is limited to a nurse and through prevention strategies such as (but not limited to) supplying nutritious meals, adequate hydration, hygiene, and exercise programs. For this reason, medical practitioners are a crucial part of the aged care workforce. Aged care providers can still ensure that more complex clinical care needs of their patients are met by ensuring that their consumers have access to timely, appropriate medical care.

Medical practitioners are currently not well supported to provide their services to older people outside of their own practice. The perception that aged care providers are not responsible for medical services, and that aged care providers are not incentivised through the Accreditation Standards to facilitate access to medical practitioners, produces an additional barrier for older people to access medical services in aged care settings.

The AMA urges the Taskforce to develop clearly defined roles within the aged care sector, with an aim to improve the health and wellbeing of older people through facilitating access to timely medical care and other health preventative strategies.

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[6] The Senate Community Affairs References Committee (2018) *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 practised* interim report. p54-56

[7] Australian Aged Care Quality Agency (2017) *Annual Report 2016-2017,* p13

[8] http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/About+us/Reviews+and+consultation/Review+of+the+Oakden+Older+Persons+Mental+Health+Service/

3. How do you think a strategy can contribute to meeting future needs in aged care?

Care of an older person involves a diverse range of professions. All providers of aged care services need to collaborate together to ensure the optimal level of care for the older person. The strategy will be able to provide an ultimate goal for the whole aged care workforce, which should include access to the older person in order for each workforce profession to be able to provide quality care for that older person.

For example, RACFs can facilitate medical practitioner access to patients by ensuring the following:

- The medical practitioner can easily contact a Registered Nurse about a patient's care, and this nurse is qualified to put into effect any prescribed instructions and treatments 24hrs a day.
- Clinically-equipped available doctor treatment rooms that enables patient privacy and an appropriate working environment.
- The ability to access patient files through a contemporary eHealth system that allows interoperability between a medical practitioner's clinical software, My Aged Care, My Health Record, and RACF software to increase communication and efficiency (provided all privacy measures are met).
- Easy physical access to the actual facility, through the use of swipe cards, access codes, and car parking facilities.

The Taskforce should work with the Department of Health to develop Accreditation Standards that incentivise aged care service providers to facilitate patient access to other members of the care team, including medical practitioner-led teams and allied health professionals.

4. Tell us what you see as the changes on the horizon that aged care needs to be ready for, and how you think the workforce strategy can contribute to meeting these future needs (in the context of an ageing population calling on aged care services in a variety of settings)?

<u>A focus on prevention</u>

There needs to be a focus on prevention to ensure older people remain healthy for as long as possible to remain in their own home, but also to reduce demand and pressure on the aged care workforce. Medical practitioners, in particular GPs, regularly incorporate prevention methods as part of providing holistic health and medical care. This includes immunisation, screening for diseases, providing education and counselling to their patient, and also referring the patient to a specialist or allied health professional if required. It is therefore imperative that older people have access to a GP and other services provided by health professionals.

Prevention of adverse health issues does not need to stop once a person reaches old age. For example, while there is currently no cure for dementia, aged care service providers can prevent or reduce the amount of distress dementia patients can experience. This can be achieved through

aged care workforce education and training on methods to appropriately handle the symptoms of dementia. This includes:

- improve methods of communication and social interaction with dementia patients[9],
- reduce the overuse of physical and chemical restraints,
- identify signs of undiagnosed pain and when medical attention from a GP or specialist is required,
- improve overall health by supplying nutritious meals, hydration, and implementing adequate exercise programs[10],
- create a physical environment that is fit for purpose (for example, dementia patients require safe walking areas, or alcoves for small groups to have private conversations[11])
- address mental health issues in a timely manner, and
- increase support and awareness of the needs of Culturally and Linguistically Diverse (CALD) individuals.

The above strategies are also beneficial to the health of older people without dementia.

In 2013, the Australian Institute of Health and Welfare (AIHW) found that 52 per cent of permanent aged care residents had symptoms of depression[12]. Under the *Better Access to Mental Health Care* initiative, patients can claim Medicare rebates for mental health services provided by or through a GP[13]. They include GP Mental Health Treatment Plan, where GPs undertake early intervention, assessment and management of patients with 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 Medicare Benefits Schedule (MBS) rebates for these services[14]. 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 the 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, dietetics, podiatry, and speech pathology need to be considered. Older people would benefit from allied health professionals that are more specifically trained in conditions that older people experience (e.g. dementia).

[9] https://www.dementia.org.au/files/20090200_Nat_QDC_QDC1PracResAgedCareFacAll.pdf
[10] https://www.dementia.org.au/files/20090200_Nat_QDC_QDC1PracResAgedCareFacAll.pdf
[11] https://www2.health.vic.gov.au/ageing-and-aged-care/dementia-friendly-environments/desigining-for-dementia
[12] https://www.aihw.gov.au/getmedia/c2ff6c58-e05e-49ed-afd7-43bd21eef4e2/AW15-6-4-Mental-health-of-older-Australians.pdf.aspx
[13] http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat
[14] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.56&qt=noteID&criteria=AN%2E0%2E56

Supporting access to medical care

The current policy settings do not support GPs visiting RACFs, working after hours, or being available to answer telephone concerns about their patients. 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 2880 residents of RACFs presented to the ED, one third of presentations could have been avoided by incorporating primary care services. 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 Victoria[15]. 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 mortality[16].

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.

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 have said it is in part 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-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 consultation[17]. Results from the *AMA Member 2017 Aged Care Survey*[18] 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 spent as a result of the lack of nursing staff on hand, efficient communication pathways, lack of access to patient records in the RACF and other time-intensive, 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] 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]
[18] To be published.

Acknowledging and remunerating this non-contact time becomes more essential as the Practice Incentive Program (PIP) Aged Care Access Incentive (ACAI) is due to cease in April 2019[19], making it more costly for GPs to visit RACFs, potentially creating yet 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. However, our members are concerned that once GPs abandon visiting RACFs if the PIP ACAI is removed, they would not return to RACFs if the decision is subsequently reversed. This policy may cause irreversible loss of GP availability to service the age care sector.

An MBS item for phone consultations with a nurse or carer from a RACF should be considered to incentivise GPs 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.

The Taskforce 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 maintain their professional relationship 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 and 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.

5. Tell us what is working well in the aged care workforce (across the industry, at provider or service level or through place-based initiatives) and where future opportunities lie.

What is working well

Medical practitioners provide dedicated medical care to older people. The *AMA Member 2017 Aged Care Survey* showed that nearly two-thirds (62 per cent) of responding GPs who visit RACFs make themselves available to their patients after-hours. Reasons for this include to provide continuity of care and to avoid hospital admissions. Medical practitioners who had increased their visits to RACFs 'agreed' that the influences behind this was that they enjoy the work (45.28 per

[19] https://www.humanservices.gov.au/organisations/about-us/budget/budget-2017-18/health/quality-improvements-general-practice-implementation-practice-incentives-program

cent), and have a sense of obligation (54.29 per cent) to their patient to provide continuity of care.

There are a number of passionate, hardworking aged care workers that deserve recognition for their commitment to the care of older people. Many respondents from the *AMA Member 2017 Aged Care Survey* reported that aged care staff do their best with what limited resources, training, funding, and staff capacity they have.

Innovation in aged care

Embracing Information and Communication Technology (ICT) potentially has huge benefits for the aged care sector. It can increase communication between healthcare (and other service) providers, reduce administrative burden, and assist to improve the health and independence of older people. For example, telehealth consultations allow health professionals to extend availability to provide advice to the patient's nurse or carer. Further, there are health monitoring machines that allow a patient to measure their own blood pressure or blood glucose levels[20], where data is transferred to a practice and reviewed by a nurse or GP each day, increasing the likelihood of their health professional identifying and responding to a health issue quickly.

Aged care providers require improved ICT systems that are interoperable with the My Health Record, in particular its Medication Overview feature. This would ensure medical health professionals have the tools in place to access all relevant medical information with all relevant stakeholders to improve prescribing and to reduce the risk of adverse reactions and interactions between medications.

The My Health Record, provided all ICT security requirements are met, should be interoperable 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 ICT 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 efficiency, 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.

However, the aged care sector will need assistance to adapt to more modern ICT practices. To encourage innovation and technology in the aged care sector, the Taskforce should work with the Government to provide useful guidelines and frameworks that assist aged care providers in embracing ICT. The Government could also provide incentives for aged care providers, like the

[20] http://www.racgp.org.au/digital-business-kit/remote-monitoring-devices/

Practice Incentive Program for medical practices[21], to improve and update their ICT systems. Education and training grants would also be useful to ensure staff are ICT-literate.

6. What do you think are the key factors the Taskforce needs to consider to attract and retain staff?

Ensuring an appropriate and rewarding working environment

Although working with older people is generally a rewarding experience, it comes with multiple challenges. For example, older people can be highly reliant on an aged care worker, and many have behavioural conditions that make day-to-day tasks difficult, and sometimes dangerous for the carer to carry out if the older person's mental health is not appropriately managed. Carers are known to have high rates of moderate stress and depression[22]. The health and wellbeing of aged care staff must be considered for the wellbeing of the workers, and so this stressful environment does not deter people from wanting to work in the aged care sector, or force existing workers to leave.

The Taskforce also must consider strategies to ensure there is an adequate amount of appropriately trained staff to ensure a better working environment for all aged care workers. This includes the availability of medical practitioners, registered nurses, and allied health professionals trained to be able to respond to issues that older people face that personal care attendants cannot resolve. The level of appropriately trained staff is expanded upon in more detail under question ten, while ensuring the attendance of medical practitioners in aged care settings is detailed under question four. All aged care workers should be appropriately trained in the fields outlined in section seven.

Aged care workers are well known to have low wages compared to other sectors, which contributes further to deterring people from working in this sector. For example, the Senate Community Affairs References Committee's *Future of Australia's aged care sector workforce* inquiry was provided with evidence that nurses working in aged care are paid significantly less ($100 per week) compared to nurses who work in acute care settings[23].

As mentioned under question five, aged care workers also require efficient, streamlined administration processes and ICT systems to ensure there is more time to address older peoples' more direct care needs, and to reduce the amount of stress in the aged care working environment.

[21] https://www.humanservices.gov.au/health-professionals/services/medicare/practice-incentives-program
[22] Cummins et al (2007) *The wellbeing of Australians – Carer health and wellbeing*. Australian Centre on Quality of Life, p5-6
[23] Senate Community Affairs References Committee's *Future of Australia's aged care sector workforce* inquiry. p52.

Support for respite care

There are estimates that if informal carers were replaced by formal carers, it would cost over $40 billion per year (at 2010 prices)[24]. This highlights that informal carers are critical in caring for older people. Pressure on informal carers will only increase with an increase Australia's older population. Currently, approval for respite care depends on a formal Aged Care Assessment Team (ACAT) assessment. There is significant difficulty in accessing an ACAT assessment, meaning it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the older person to hospital in order to give the carer some relief. This causes great distress for older people and their carers and increases the risk of delivering respite care that is inappropriate both in timing and in the nature of the care given. Admitting the older person is also expensive and burdens the public hospital bed availability for acute care presentations.

A streamlined process is required to improve access to respite care for people who have not yet been assessed by an ACAT or who have not yet entered the aged care system. GPs who work in aged care know their patient's circumstances and requirements. In these circumstances, access to respite care could be streamlined by allowing GPs to approve respite care for older people in much the same way a doctor determines that a hospital admission is necessary.

Caring for an older person can be stressful and it is important that the carer is also taking care of themselves. The use of Day Respite Centres can improve wellbeing and socialisation through group activities, and provides a break for the carer[25,26]. However, research suggests Day Respite Centres are under-utilised by carers because they believe it will result in negative outcomes for the consumer[27,28]. The AMA suggests further investment into the availability of Day Respite Centres, and campaigning to promote the benefits of Day Respite Centres from both a carer and consumer perspective. Again, this short-term respite care should not require an ACAT assessment, and could be streamlined through the consumers' GP.

There should be a public campaign to support and recruit more volunteers to further reduce the pressure on informal carers.

[24] Productivity Commission (2011) *Caring for Older Australians*. p 18.
[25] Stirling, C.M et al. (2014), *Why carers use adult day respite: a mixed method case study*, BMC health services research, vol. 14, no. 1, p. 245.
[26] Phillipson, L. & Jones, S.C. (2012), *Use of day centers for respite by help-seeking caregivers of individuals with dementia*, Journal of gerontological nursing, vol. 38, no. 4, p. 24.
[27] Stirling, C.M et al. (2014), *Why carers use adult day respite: a mixed method case study*, BMC health services research, vol. 14, no. 1, p. 245.
[28] Phillipson, L. & Jones, S.C. (2012), *Use of day centers for respite by help-seeking caregivers of individuals with dementia*, Journal of gerontological nursing, vol. 38, no. 4, p. 24.

7. What areas of knowledge, skills and capability need to be strengthened within the aged care workforce?

The following fields should be included in aged care staff education and training to improve quality of care for older people:

- Strategies for addressing common health issues that older people face
- Strategies to prevent deterioration in health, such as exercise programs, diversional therapy, and providing adequate nutritious meals and hydration
- Strategies to reduce distress in dementia patients
- Intervention and management of elder abuse
- Engaging with Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) older people
- Palliative Care skills, including recognising and respecting Advanced Care Directives
- Mental health skills.

The AMA agrees with the recommendation outlined in the report on the *Senate Inquiry into the future of Australia's aged care workforce*[29] that there should be support mechanisms in place to assist RACFs and aged care services to access quality training to ensure staff are aware of their responsibilities, and learn about ways to improve the quality of care they provide.

Aged care workers need to be appropriately skilled and trained in aged care. Only half (51 per cent) of community care workers in 2016 had a Certificate III in Home and Community Care[30]. The Taskforce should consider a minimum qualification for people to work in aged care, and review the quality of available training programs, such as the Certificate III, to ensure the aged care workforce has the capability to provide the services that are expected of them.

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 mis-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'[31]. 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

[29] Community Affairs References Committee (2017) *Future of Australia's aged care workforce.*
[30] Mavromaras et al (2016) *The aged care workforce, 2016.* Department of Health. p79
[31] Australian Aged Care Quality Agency (2017) *Annual Report 2016-2017,* p13

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.

8. What do you think is needed to improve and better equip the workforce to meet individual needs and expectations?

Please see questions six and seven.

9. What is needed for leadership, mindset and accountability to innovate and extend new ways of working tailored to the needs of older people who use aged care services, their families, carers and communities?

Aged care's division of responsibilities

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 Governments. However, there is a lack of coordination and information-sharing between the different levels of jurisdiction[32]. Aged care is the 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.

It has been raised with the AMA that 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 2017[33].

The incidents at Oakden Older Mental Health Service[34] 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***

[32] Carnell, K and Paterson, R (2017) *Review of National Aged Care Quality Regulatory Processes*, p77
[33] Carnell, K and Paterson, R (2017) *Review of National Aged Care Quality Regulatory Processes*, p85
[34] Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report.* Adelaide, South Australia: SA Health, Department for Health and Ageing.

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.[35]

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.

The AMA proposes that there should be a role under the Commission that works with the aged care sector to ensure there is an adequate supply of appropriate, well-trained staff to meet the demand of holistic care to a multicultural, ageing population, and also to ensure the aged care workforce has clear roles and responsibilities (as detailed in section two).

10. What should aged care providers consider with workforce planning?

<u>Access to staff</u>

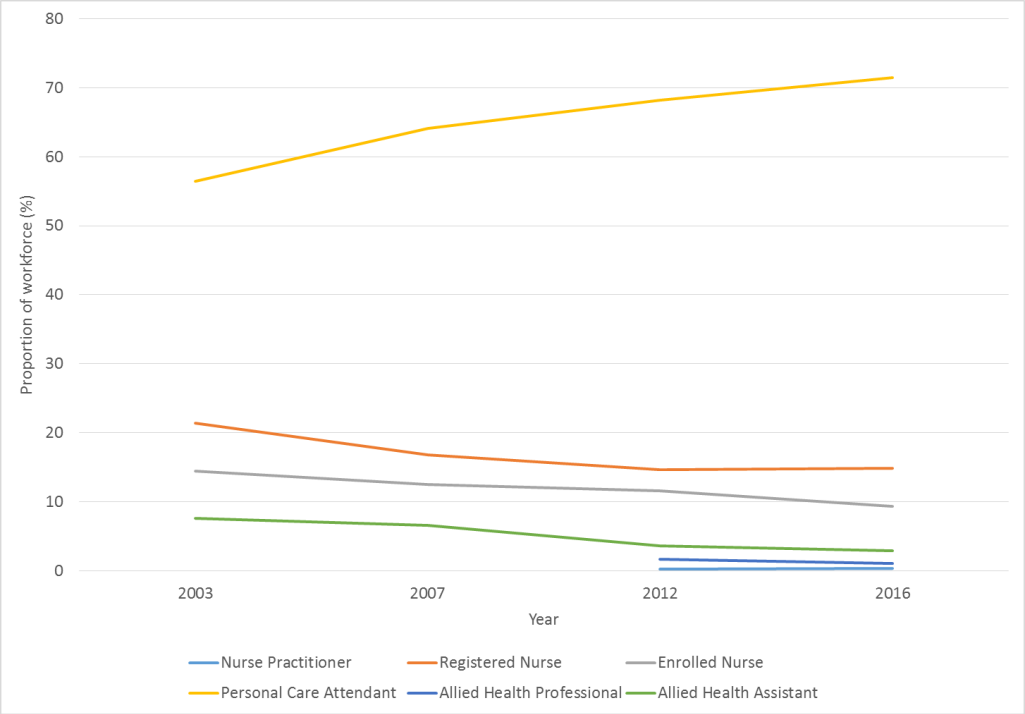

Figure 1: The proportion of Full Time Equivalent employee types in the residential aged care workforce. Data source: Mavromaras et al (2016) The aged care workforce, 2016. Department of Health

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

There has been a decreasing trend in the proportion of registered and enrolled nurses in the residential 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, or to put prescribed clinical instructions into effect. 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.)[36]. 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 Taskforce's strategy 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. Nurses that are qualified and available to put into effect prescribed and necessary clinical treatment at any hour is essential to ensure residents are provided with timely and appropriate clinical care. The increasing trend against this requirement has placed additional pressure on nurses and medical practitioners and has surely led to increased hospital transfers as a result. For example, situations where there is not staff qualified to provide palliative medications to a patient overnight. The Accreditation Standards should require that RACFs demonstrate staffing with a ratio of suitably trained registered nurses to patients to ensure people living in RACFs with complex needs are receiving appropriate care at all hours. 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.

Catering for a diverse ageing population

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 overseas[37]. Projections for 2021 suggest that the older population will comprise 30 per cent of people born in a country other than Australia[38]. This presents a major challenge in the form of incorporating different cultures into Aged Care, and communicate with individuals who may have low levels of English literacy.

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.

In the case of ATSI 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.

[36] Henderson et al (2016) *Missed care in residential aged care in Australia: An exploratory study*, Collegian.
[37] 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]
[38] Department of Social Services (2015) *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*

11. In undertaking its work, the Taskforce has been asked to have regard to recent submissions to and reports of relevant inquiries on aged care workforce matters, and government responses. If you want the Taskforce to draw on a submission you have made, or evidence or materials you want to draw to our attention, please provide the details in the text box below.

Many of the points raised in this submission are reflected under different contexts in the following AMA submissions, available here:

- *Standing Committee on Health, Aged Care and Sport Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*[39],
- *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 practised*[40];
- *Review of the Commonwealth Government's regulatory activities applying to quality of care in aged care residential facilities*[41];
- *Future reform – an integrated care at home program to support older Australians*[42];
- *Aged Care Legislated Review*[43]; and
- *Senate Community Affairs References Committee on the Future of Australia's aged care workforce*[44].

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 older peoples' 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 or remunerated to do so due to the range of issues described above. This has resulted in an unnecessary barrier to quality medical services for RACF residents.

The aged care workforce needs clear leadership and accountability, which an Aged Care Commission could provide. Many aged care governance (and workforce) issues described above

[39] https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/AgedCareFacilities/Terms_of_Reference
[40] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality/Submissions
[41] https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes
[42] https://consultations.health.gov.au/aged-care-policy-and-regulation/discussion-paper-future-care-at-home-reform/
[43] https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2017/legislated_review_of_aged_care_2017.pdf
[44] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report

have already been addressed in recommendations to the Government as a result of the multiple aged care reviews[45,46,47]. 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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[45] Future of Australia's aged care sector workforce [https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Report]
[46] Aged Care Legislated Review [https://agedcare.health.gov.au/legislated-review-of-aged-care-2017-report]
[47] Review of National Aged Care Quality Regulatory Processes [https://agedcare.health.gov.au/quality/review-of-national-aged-care-quality-regulatory-processes-report]