RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

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The Royal Australasian College of Medical Administrators (RACMA)

The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college accredited by the Australian Medical Council (AMC) dedicated to the education, training and professional development of medical practitioners in senior leadership, management and administrative roles, in clinical and non-clinical settings, throughout the world.

The College's constantly evolving Fellowship and professional development program responds to, and pre-empts, the ever-changing landscape of medical administration both in Australasia and beyond. RACMA's involvement in education, policy formulation and decision-making enables it to help contribute to the Australian and New Zealand Health systems.

RACMA is pleased to provide the Royal Commission with this paper, in which we address the quality of Aged Care services provided to Australians and how best to deliver Aged Care services.

Sincerely

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EXECUTIVE SUMMARY

This submission for the Australian Royal Commission into Aged Care, specifically addresses the quality of Aged Care Services being delivered, the extent to which they meet the needs of those accessing them, the presence of system failures and the issues that surround Aged Care facilities. As a medical college, our recommendations have the intent to ensure that we have a system which delivers high quality and safe Aged Care services. The main theme of this paper rests within the clinical care issues surrounding common clinical conditions for older people, infrastructure, workforce planning and governance issues of Aged Care facilities.

RACMA areas of concern are:

- Choosing Aged Care facilities
- Corporate and Clinical Governance
- Transparency
- Risk Register
- Complaints Structure
- Workforce Planning
- Nursing and Medical Care
- Regulation and Licensing of Aged Care workers
- Cuisine and Diet
- Oral Health
- Using Technology to improve Quality of Care
- Transition from Hospital care to Aged Care facilities
- Rural and Remote Health
- Education
- End of Life Decisions
- Elder Abuse

1.0. INTRODUCTION

All Australians deserve to age well with dignity, whether they are at home or in residential Aged Care. As Australia's population is ageing, there is more pressure on our growing Aged Care sector than ever before, and the demands will only continue to grow. The challenges are becoming greater for an Aged Care system that is already complex and demonstrating key weaknesses. The sector is difficult to navigate, services are limited, and consumer choice and quality is variable. Issues include the governance infrastructure of Aged Care facilities, including a lack of clinical governance oversight, workforce shortages and planning, and gaps in Aged Care worker skills. These issues are particularly exacerbated in rural and remote Australia.

The Aged Care Act 1997 introduced a new model of care which encouraged older Australians to stay at home. However, our ageing population and the focus on helping older people to stay at home for as long as possible, means that, by the time people now enter an Aged Care facility, they are older and sicker than ever before. The proportion of older people requiring high care for complex needs, which includes assistance with all activities of daily living such as eating and bathing, has quadrupled from 13% in 2009 to 61% in 2016[1], and around half of the people living within an Aged Care facility have dementia, depression, or mental health and behavioural conditions.

In this feedback response, RACMA highlights a number of areas of concern (refer to section 2) which we believe impact Aged Care Services. Whilst RACMA supports the recently released Aged Care Standards (May 2019), particularly the updated quality standards, the College is of the view that Standard 8 requires much more rigour. The College believes that section 3(e) "where clinical care is provided – a clinical governance framework etc" does not sufficiently address the issues of clinical care in Aged Care facilities.

In the following section (2.0) RACMA outlines the areas of concern.

2.0. AREAS OF CONCERN

2.1. Choosing Aged Care Facilities

The transition of older people into an Aged Care facility is a very difficult, emotional and complex decision for prospective residents and their family members. The period, when this decision making occurs, can range from a decision following an unexpected hospital admission, to a "planned' decision where residential care is assessed as being required as the older person is no longer able to live at home, even with assistance.

In some situations, the choice of residential care may be unduly influenced by the highly-appointed presentation and aesthetic of the facility, rather than the quality of the health care/services provided. Attractive capital assets and lavish facility appointments (such as chandeliers, pianos, marbled entrances, shops and cafes) may mask poor service and levels of care that an Aged Care facility can provide. Prospective residents may assume that high quality capital assets are equated with high quality Aged Care services, when such an association may be unwarranted.

RACMA believes that prospective residents and family members must be assisted in this process by the provision of accurate and transparent information about all issues that should be taken into account in this decision-making process. There should be a focus on the provision of quality care and service performance.

[1] https://www.gen-agedcaredata.gov.au/Resources/Factsheets-and-infographics/Care-needs-factsheet.pdf?ext= (cited 19 June).

2.2. Corporate and Clinical Governance

Good practice within any regulated Australian corporation or business activity requires the adoption of a corporate governance framework for meeting both strategic and economic outcomes. Corporate Governance should outline the system by which companies are directed and controlled. In particular, it should define the relationship between shareholders, management, the Board of Directors and stakeholders. All Aged Care provider organisations should have a corporate governance framework that is easily accessible by consumers, staff and the general public.

However, in the Aged Care sector there is also the core function of providing clinical services. Many residents of Aged Care facilities suffer from a range of health issues, including chronic illnesses with various co-morbidities, intermittent acute illnesses, and/or physical and cognitive decline. RACMA advocates that it is essential for Aged Care services to also have a Clinical Governance framework, for which the Board of Directors is likewise responsible and held accountable.

The term "Clinical Governance" emerged in 1999 in the United Kingdom. At that time, maintaining and improving the quality of care was understood, by the National Health Service (NHS) Trust boards, to be the responsibility of the relevant clinical professions and that the boards had no statutory duty to ensure a particular level of quality care. Following the 1995 Bristol 'heart scandal', during which an anaesthetist exposed the high mortality rate for paediatric cardiac surgery at the Bristol Royal Infirmary, the NHS Trust Boards assumed a legal responsibility for the quality of care equal in measure to their other statutory duties such as proper financial management of the organisation. RACMA suggests that there are parallels with today's Aged Care sector.

As stated above, the College believes that further strengthening is required of the recently revised Aged Care Standards, especially in relation to clinical matters and clinical governance. Clinical governance has been defined as the set of relationships and responsibilities established by a governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. The clinical governance system outlines how responsibilities and accountabilities for the quality of care are shared, including the minimisation of risks through continuous improvement initiatives and the fostering of an environment of excellence in care for consumers. A key objective of clinical governance is to ensure that the community can be confident that systems are in place to deliver safe and high-quality care[2]. The College believes that clinical governance applies to Aged Care facilities.

The National Model Clinical Governance Framework (NSQHS Standards)[3] demonstrates the key features of a model Clinical Governance framework. The requirement that there be a clinical governance framework, where clinical care is being provided, may not be an easy undertaking for many Aged Care facilities. Many facilities may not have the expertise to develop and implement a clinical governance framework. Maintaining and continuously improving the reliability, safety and quality of clinical care requires focus on governance, leadership, culture, patient safety systems, clinical performance and the care environment in order to deliver high quality care. An important consideration is the need to define the required standards of care, assign responsibilities and accountabilities for meeting those standards and fostering a culture of a constant dynamic of improvement. To accomplish this in the Aged Care sector, it will be necessary to define a common set of safety and quality performance indicators, which will need to be monitored across Aged Care providers. Key Performance Indicators (KPIs) might include measures, such as pressure and injury care, consumer engagement tools and complaints management systems, which would need to be monitored and assessed as part of the accreditation of a facility.

[2] https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf.
[3] https://www.safetyandquality.gov.au/topic/national-model-clinical-governance-framework (viewed May 2019).

2.3. Transparency

There should be open sharing of data on comparative practice and performance of Aged Care facilities. Data relating to service performance and provision should be easily and clearly available to the community, including prospective residents and their families to enable more informed decision making when choosing an Aged Care facility.

2.4. Clinical Risk Register

A clinical risk register should be created and adopted to enable a uniform and consistent record of clinical incidents across all Aged Care providers. This would include having an appropriate severity rating, to guide the type and timing of further investigations, in much the same way that hospitals do. There should be a clinical risk register, where all the incidents adversely affecting the safety and quality of care delivered to the residents can be reported.

2.5. Complaints Structure

Further strengthening of the revised Aged Care Standards is also required in standard six, where RACMA recommends that having a formal structure and process for receiving and resolving complaints, is an essential feature of good clinical governance frameworks. Responsiveness, transparency and accountability are crucial components of complaints management. Processes for Aged Care facilities to uphold these responsibilities (i.e. complaints made by residents) currently seem to be variable and, in many cases, lack process. RACMA believes that a complaints management system and process, including having an identified person to whom complaints can be directed, is a must for Aged Care facilities. This complaints officer would collaborate with the safety and quality team, to review all the adverse incidents. This proactive management of adverse incidents will foster a communication process (with residents and family members) and reduce grievances.

2.6. Workforce Planning

Over past decades, the title attached to the entities where older people receive care, usually towards the end of their lives, has changed from ‘nursing homes’ to ‘Aged Care Providers’. However, many facilities are still basing workforce management on the minimalist ‘nursing home’ model. As the proportion of the aged population increases, together with the increase in chronic illness with various co-morbidities or more acute illnesses, there is a mismatch between a predominantly nursing care model and the needs of the residents of the Aged Care entities which is no longer appropriate.

Even where there are claims that 24-hour nursing care is available, the staffing levels are often inappropriately low for the care needs of the residents. In addition to low numbers, qualification levels and seniority of trained staff may also be inadequate and concerning. A high turnover of staff in Aged Care facilities may also be an issue, as this adversely impacts the ongoing quality of care received by residents. Other negative impacts of Aged Care facilities having inappropriately trained staff and inadequate staffing numbers include:

- The failure to assist those requiring assistance at meal times;
- The lack of general mobility assistance for those requiring it;
- Lack of timely attention to a resident’s personal hygiene and care;
- Lack of diversional therapy activities, e.g. music and exercise; and
- Increased anxiety and despair among residents.

2.7. Nursing and Medical Care

A new nursing skill mix model is required in Aged Care to address the level of unmet health care need. At a minimum, the Act, should be amended to stipulate appropriate staffing requirements for the delivery of direct clinical care, including a prescribed ratio of resident to registered nurse numbers at all times.

This should not be left up to the Aged Care provider to determine what is "reasonable". As part of the skill mix, a higher ratio of registered nurses and enrolled nurses supported by a team of care workers is required to ensure adequate resident care and safety. RACMA recommends that there needs to be a requirement for an on-site Registered Nurse on a 24/7 basis, especially in rural/remote Aged Care facilities.

The availability of physicians in geriatric medicine and medical practitioners with additional skills and commitment to care of the elderly in Aged Care facilities would do much to improve care. It is also likely that the addition of this tier of health professional would reduce the need for unnecessary emergency department presentations, which are often distressing for the resident and their family, as well as being costly to the system.

The bulk of medical care provided to residents in Aged Care facilities is delivered by General Practitioners (GPs), with varying degrees of time availability and experience. RACMA recommends that better funding support is provided for primary health care in Aged Care services, including adjustments to the Medicare Benefits Schedule (MBS). Nursing staff have commented to RACMA Fellows, that they do not have the time to accompany a visiting GP when they see a resident. There is a need to re-evaluate the type and level of clinical support available to those in residential Aged Care and their families. Too few Aged Care residents have access to help from a geriatrician, and there is a need to strengthen the expertise in Primary Care in caring for the frail aged, such as through specific additional training, including in clinical governance. Medical oversight could also be facilitated through networking with geriatric (or relevant) services in public hospitals or through the employment of a clinician, in some capacity, in order to ensure adequate medical cover onsite during working hours and on-call services during out of hours. The day services could resemble the GP model of service on-site.

RACMA recommends that medical governance is better facilitated by one of the attending medical practitioners, adopting a Medical Director role. RACMA provides specialist training programs which specifically enable clinicians to acquire the skills necessary for such roles. Both RACMA Fellows (FRACMA) and Associate Fellows (AFRACMA) would be qualified to undertake a Medical Director role within an Aged Care setting. A RACMA Fellow is recognised as a "specialist" medical practitioner, having the competencies which align to the CanMEDS roles[4]. These include, communicator, collaborator, health advocate, manager, scholar and professional. A RACMA Associate Fellow, although not recognised as a "specialist" medical practitioner, has completed a rigorous educational training program, which allows them to practise as medical leaders and managers.

We recommend to the Royal Commission that RACMA would be able to develop training programs to "upskill" medical clinicians (including GPs and geriatricians), to take on roles as Medical Directors in Aged Care facilities with responsibility for the oversight of clinical governance.

There should also be greater access to other health professionals such as dieticians, physiotherapists, podiatrists, diabetic educators, social workers, pharmacists, and psychologists,

[4] CanMEDS is an educational framework that describes the abilities physicians require to effectively meet the health care needs of the people they serve. (http://canmeds.royalcollege.ca/en/framework).

who play an important role in care. Additionally, families have minimal access to psychological and social support, and bereavement follow-up.

2.8. Regulation, Licensing and Education of Aged Care Workers

With the exception of clinical staff, such as doctors, nurses and physiotherapists, the majority of Aged Care staff are not registered or licensed. Workers, in any Aged Care setting regardless of cost, should undergo formal licensing requirements. There should be a serious attempt to redress the current pay differential which occurs between the Aged Care and other comparable sectors including the disability and acute healthcare sectors.

A system of regulation and/or registration is crucial for workforce planning. There should be a framework which monitors staffing competence and currency of skills, much the same way as many vocations are regulated where there is risk to human life. Regulatory and licensing intervention should be considered to ensure that “high risk” staff are prevented from moving from one facility to another.

An analysis should be performed to determine what regulations are required and what types of formal qualifications are essential to provide the necessary competencies for Aged Care staff. Every attempt must be made to mitigate risks affecting Aged Care. Consideration must be given to identify training needs of Aged Care workers and skill shortage gaps.

RACMA highly recommends that medical colleges and other health professional bodies be involved in the education and support of clinical staff, providing training tailored to caring for the frail aged, end of life and palliative care issues as well as strengthening clinical governance in the Aged Care sector.

2.9. Cuisine and Diet

There is much anecdotal evidence and media coverage within the sector, which suggests that the standard of food in Aged Care facilities is inadequate for the population that is being served, despite their often-well-appointed dining rooms. Reports suggest that many Aged Care providers spend as little as $6 per day on total food cost per resident. This is supported by a research study published in the Journal of the Dieticians Association of Australia on average food expenditure and trends in Australia residential Aged Care facilities (RACFs)[5].

The study suggests that the current spend on food in Aged Care facilities has decreased over recent years, reflecting an increasing reliance on supplements, and is significantly less than the current community food spend, correctional services and that spent in Aged Care facilities internationally.

This concern extends into the nutritional value of the food being served. “Toasties” and sandwiches are a common evening dinner meal in some facilities, which is clearly inadequate. Menus must reflect nutritional values and should be appropriate for those with poor dentition or issues with swallowing. Consideration should also be given to cultural diversity, with offerings of cuisines and menu options, better suited to Australia’s multicultural population.

2.10. Oral Health

Oral health concerns care of teeth, gums, lips, tongue and inside the cheeks. There is much evidence that chronic oral infections are associated with a range of diseases and conditions, such as heart and lung diseases and stroke.

[5] Hugo, C., Isenring, E., Sinclair, D., & Agarwal, E. (2018). What does it cost to feed Aged Care residents in Australia? Nutrition & dietetics, 75, 6-10. doi: 10.1111/1747-0080.12368.

Aged Care service providers may see dental health as a low priority and a high cost option for older people, in the face of competing demands. There seems to be a lack of clarity about whose role it is to provide oral care to residents. It has been reported that tooth brushing may be neglected for some residents with swallowing disorders and for those who are resistant or aggressive (including people with dementia). As a result, some residents go without oral care "for weeks". There is an ambivalence about the delivery of oral care by non-dental professionals and a lack of training in general dental health education. Studies have also indicated that dental professionals may lack the training and support to undertake geriatric dentistry.[6] Additionally, it may be expensive and logistically difficult to take some residents to external private dental practitioners.

RACMA suggests that a practical solution would be to adopt a mobile dentist model as occurs in Western Australia. Visiting mobile dentists using the latest in portable dental equipment technology, offer Aged Care facilities, high quality dental treatment for the frail aged and those unable to visit a dentist.

2.11. Using Technology to Improve the Quality of Care

Digital health and assistive technologies have the potential to significantly improve the Aged Care system through increased efficiency and coordination of care and increased independence and health of older people. It is important that older people and their carers are adequately supported to use digital health, Telehealth/Telemedicine and assistive technologies. However, further research into incorporating technology in the Aged Care sector needs to be considered. RACMA recommends the following to be considered:

- Aged Care facilities implement a central monitoring system that enables carers to attend to deteriorating residents without delay;
- the delivery of medications should be automated. This will save time for the carers and allow them to focus on improving the quality of care delivered to residents and ensure safety;
- electronic clinical risk registers could be introduced to make the risk management more efficient and effective;
- Recommend that Aged Care facilities and acute hospitals establish roles, responsibilities and policies with the 'My Health Record" system. This ensures that Aged Care patient medical records and information are kept up to date and accessible between acute hospitals and Aged Care facilities.
- simulation education should be promoted to train new staff and improve the staff skills;
- Implementation of Telehealth services[7], with external providers such as GPs, Medical specialists and Geriatric services in acute hospitals. This would reduce travelling for medical appointments and transfers to emergency departments thus reducing hospital admissions.

2.12. Transition from Hospital to an Aged Care Facility

The dependency of those in care (the "frail aged") is increasing, as is the complexity of their medical problems. The pressure for rapid discharge from hospital, to 'reduce length of stay', places an increased pressure on the residential Aged Care sector. Many Aged Care facilities are not sufficiently resourced and funded to provide this additional support. There are large gaps in care that exist for older Australians and their caregivers during critical transitions which lead to adverse events, such as, unmet needs, low satisfaction with care, and high re-hospitalization rates.

[6] Slack-Smith L, Durey A and Scrine C. Successful aging and oral health: incorporating dental professionals into Aged Care facilities, July 2016.
[7] https://www1.health.gov.au/internet/main/publishing.nsf/Content/e-health-telehealth. Viewed August 2019.

Consideration needs to be given to how the discharge process and transition of care is administered and what formalities should be in place to regularise the interaction between hospital and Aged Care facilities. There needs to be more formality in the transition process. An explicit handover process between the two care providers needs to be established which governs the clinical needs of a patient discharged from hospital to ensure that the relevant resources, particularly staffing, are in place at the Aged Care facility. Workforce management strategies must be sufficiently flexible to accommodate these case by case requirements.

2.13. Rural and Remote Health

In Rural and Remote areas, a range of demographic, geographic, climatic, cultural and socio-economic factors contribute to the complexity of providing high quality health and other Aged Care services. Particular attention must be given to addressing the needs of Aboriginal and Torres Strait Islander people and other vulnerable groups.

Rural and remote primary health care is a key component of Aged Care and must be seen as a priority for investment. Government must work with rural and remote GPs to identify best practice models of Aged Care and tailor them for local contexts. This would involve the development and implementation of care protocols that are in the best interests of rural and remote Aged Care patients.

It is clear that regional and remote Aged Care service providers often struggle to find appropriately trained workers and that they also face difficulties in accessing affordable and suitable training opportunities for their staff, given the additional costs involved with travel, accommodation, temporary replacement staff, or in attracting trainers to more remote places to deliver training on-site. There must be far more recognition and support to rural and remote doctors and their teams in the area of Aged Care and initiatives are warranted that dramatically improve Aged Care services. RACMA has provided a case study on the Northern Territory to highlight the issues faced by rural and remote areas (Refer to Appendix 5.2 for a case study on the Northern Territory).

2.14. Community Education

There is a large amount of ignorance surrounding the process of ageing; both what can reasonably be expected to occur and what might not be considered to be a “normal” part of the ageing process. Vulnerabilities increase with age, including physical, emotional, cognitive and financial vulnerabilities. Consideration should be given to a large-scale community educational campaign that highlights some of these issues.

2.15. Consent

There are situations when informed consent is required, such as in the making of wills and the assignment of enduring guardianship and power of attorney. Informed Consent is required in many situations, including consenting to various forms of treatment, as well as, in certain circumstances, consenting to care, such as residential Aged Care.

For the elderly, informed consent means that the person understands their condition, what is being proposed, such as treatment, and freely gives their consent. Without the information that relates to their medical condition and treatment, a person can't make a fully informed choice and give valid consent for their medical treatment.

The prevalence of significant dementia in residential care mandates that a proper cognitive assessment is undertaken to determine whether the individual is able to give consent. In making such assessments the caregiver’s history of cognitive decline is of paramount importance in assessing consent.

Thus, for the elderly transferring to residential care, it is important to fully document their cognition, physical function, social support, needs and background. Put simply as an "aide-memoire", which means "who is this person?", "What can they do?" and "Have they forgotten a relative or two?". The mental state of older persons in residential care is formally documented by brief cognitive screening tools.

2.16. Elder Abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse and sexual abuse, and often a combination of these. Too often incidences of elder abuse go unreported because they are carried out by carers or trusted individuals such as family members. "The Australian government has released a national plan to address elder abuse[8], titled "A National Plan to respond to the Abuse of Older Australians"[9]. This includes a new national elder abuse free call number, which will allow older Australians in every state and territory to confidentially discuss cases of elder abuse, and receive referrals and information, so they can be protected. In addition, a series of national trials of front line services were also rolled out.

Many older people become victims of financial fraud, both by people known to them, such as family members, and by people previously unknown to them, including those assigned to care for them by various agencies. The likelihood of elder financial abuse may be increased if organisations and officials who deal with older people, such as banks, lawyers, guardianship tribunals, Aged Care providers and real estate agents, do not recognise the need to assess consent (see section 2.15) in a very different way to the way that this may occur with a younger population. The impacts of ageing vary considerably, making an assessment of cognitive competence a very complex issue. A cursory assessment that the person "seemed to understand" is insufficient. RACMA believes that this assessment should be particularised for older people in much the same way driving for older people has been. (Refer to Appendix 5.1, for further recommendations about the ways to reduce or prevent elderly financial abuse).

Further, the College urges the Commission to review the recommendations of the 2017 Australian Law Reform Commission report[10], titled the "Family Law for the Future-An inquiry into the Family Law System", on this issue and in particular, the recommendations about the need for changes to inheritance laws in order to give weight to greater scrutiny of changes made to the wills of older people in the immediate period prior to their death where major changes are made and new, often "stranger", beneficiaries are introduced. (Further recommendations about ways to reduce elder financial abuse are outlined in Appendix 5.1).

2.17. End of Life Decisions

"End of life" is a phenomenon experienced by every living being and preparation for this time is important. While it can happen at all stages of life, our older population should be encouraged to make plans for this period when they still have the cognitive and physical ability to do so. This might include preparations of wills, nomination for power of attorney, enduring guardianship and end of life decision planning. Limitation of choices increases as most people age or fall victim to declining cognitive function. It might be appropriate for the Royal Commission to suggest further accessibility and funding for palliative care.

[8] https://aifs.gov.au/cfca/2019/03/21/national-plan-respond-abuse-older-australians-2019-2023. (viewed August 2019).
[9] https://www.ag.gov.au/ElderAbuse. (viewed August 2019).
[10] https://www.alrc.gov.au/publication/family-law-report/. (viewed August 2019).

3.0. CONCLUSION

With this submission, RACMA has tried to highlight the issues that impact on the provision of robust and holistic quality care for the elderly. RACMA would like to thank the Royal Commission for the opportunity to be involved and we look forward to the Commission's final report.
In the following section (4.0.) we provide a summary of recommendations for the Royal Commission to consider in its report of what should be done to make Aged Care services better in Australia.

4.0. RACMA RECOMMENDATIONS

Choosing Residential Care

1. Reviews from service users be published and available to prospective users, such as the assessment reports for Aged Care facilities listed on the Aged Care Quality and Safety Commission website.[11]
2. Clear and transparent information about client contributions, service costs, service provision, staffing levels, specialised services be available.

Corporate and Clinical Governance

3. There is a need for both corporate and clinical governance frameworks with the Boards of Directors, legally accountable for the effectiveness of the frameworks.
4. Quality systems are implemented which monitor and report on the safety and quality of resident care and informs changes in practice to improve safety and quality.
5. Metrics are implemented for resident experiences and outcomes through routine data collection.
6. Key performance indicators for clinical care and safety are developed and implemented.
7. Aged Care facilities implement clinical risk registers, which record incidents adversely affecting the safety and quality of care delivered to the residents.

Managing Complaints

8. A complaints management system and process is deployed at Aged Care facilities. Staff managing the complaints management system need to collaborate with the facility's safety and quality team to review adverse incidents.
9. There is proactive communication with residents and family members.
10. A person to whom complaints can be directed to is a must for Aged Care facilities.

Workforce Planning, Nursing and Medical Care

11. There is a need for greater medical involvement and oversight of care.
12. There needs to be greater involvement of Nurse practioners who work in Aged Care. They are invaluable and should be used more than they are now, as they could manage patients acutely, and assist to prevent hospital admissions. Nurse practitioners can work with Aged Care providers and the hospital to ensure the most appropriate management of the patient is carried out, whether homes, Aged Care facilities or subacute or acute wards.
13. The need for 24/7 on-site Registered Nurse in Aged Care facilities.
14. There is a need for a re-evaluation of the type and level of clinical support available to those in residential age care.

[11] https://www.agedcarequality.gov.au/reports. (viewed August 2019).

15. A comparative analysis needs to be conducted into the differential pay and condition rates between the Aged Care and other comparable sectors.
16. Staff shortages in Aged Care facilities are addressed.
17. An agreed industry-wide career structure across the full range of Aged Care occupations is developed.
18. A new nursing skill mix model with a higher ratio of registered nurses and enrolled nurses to patient resident numbers, supported by a team of care workers is implemented.
19. There is better funding support for Aged Care services in primary health care, including through Medicare Benefits Schedule (MBS) support.
20. Greater medical governance is better facilitated by one of the attending medical practitioners or specific trained geriatricians, adopting a “medical direction” role.

Regulation, Licensing and Education of Aged Care Workers

21. Workers in any Aged Care setting, regardless of cost, should undergo formal registration and licensing.
22. There should be a process which monitors staffing competence and currency of skills, much the same way as many vocations are regulated where there is risk to human life.
23. An analysis be performed to determine what regulations are required and review the types of formal qualifications required to provide the necessary competencies for Aged Care staff.
24. Medical colleges to be involved in the education and support of clinical staff, providing training which is geriatrically focussed.
25. RACMA would be able to develop training programs to “upskill” medical clinicians (including GPs and geriatricians), to take on roles as Medical Directors in Aged Care facilities with responsibility for the oversight of clinical governance.

Community Education

26. There is a need to increase the education in the general community about changes that might be considered normal as one ages, including vulnerabilities, and end-of-life choices and decision making.

Cuisine and Diet

27. Aged Care facility menus must provide well-balanced nutritional diets, which focus on the provision of the essential food groups, suitable for older people. This includes menus that are eclectic, attuned to the cultural diversity of Australia’s multicultural population.

Oral Health

28. Oral care within Aged Care facilities must be improved. Define and clarify whose role it is to provide oral care to Aged Care facility residents.
29. Contextualised Aged Care Oral care training and education be provided for Aged Care staff and dentists.
30. A Mobile Aged Care dentist model be implemented.

Using Technology to Improve the Quality of Care

31. There is increased automated medication delivery, to reduce medication errors.
32. There is an implementation of Electronic risk registers.
33. There is an increase in simulation education.
34. That acute hospital and Aged Care facilities define the roles and responsibilities for the implementation and access to My Health records.

Transition from Hospitals to Aged Care Facilities

35. There is a requirement for formalised discharge planning process from hospital to residential care.

Rural and Remote Issues

36. Providing adequate funding and resources, and ensuring development and implementation time frames are appropriate, are critical to achieving positive health and wellbeing outcomes in rural and remote areas.
37. Addressing the needs Aboriginal and Torres Strait Islander people and other vulnerable groups.
38. There is the provision of culturally appropriate aged health care, activities and support in rural and remote Aged Care facilities.
39. The government must work with rural and remote GPs to identify best practice models of Aged Care and tailor them for local contexts.
40. Address the increasing need for mental health care for aged people by recognising the central role rural doctors play in mental health care for the aged, including in rural Aged Care facilities.
41. More recognition of and support for rural and remote doctors and their teams in the area of Aged Care.

End of Life Planning

42. A program be implemented which encourages people to consider and plan for end of life.
43. The Royal Commission should make recommendations to investigate further accessibility and funding for palliative care.

5.0. APPENDIX

5.1. Elder Financial Abuse[12]

RACMA raises specific attention to clauses: 8.24, 8.25, 8.26 and 8.27. The following is suggested in limiting the occurrence of elder financial abuse:

i. Stricter requirements on recipients of government funding, and on the accreditation of these providers including requiring that Aged Care providers ensure that their "no personal gains for staff" polices are not only in place but are effective in preventing staff from influencing their vulnerable aged clients for their personal gain. Such a policy might include early intervention when complaints are made, effective action such as moving carers to other positions, and ultimately substantial sanctions such as loss of employment, though this may be little deterrent where a large inheritance from a client is involved.

   The aim should be to prevent substantial gifting by clients to carers and should go further than having a policy in place, which is demonstrably totally ineffective where a staff member has ill intent and a large financial benefit is involved. Prevention strategies must be multi-faceted, including relevant policies but must also include other strategies, such as staff rotation (say every 2-3 years) and independent assessment of the carer /client relationship.

   In one case, a carer providing cleaning and social support for a house bound client was left in place for over 15 years, and even after family concerns were raised about the frequent will changes that the client was making and the perception of family members and neighbours about undue influence that the carer seemed to exercise over the decisions made by the client, especially financial. Case workers not only gave misleading information to the family about the effectiveness of their "no gifts" policy but also failed to intervene when concerns were raised. A case worker advised a family member that they were powerless to intervene unless they had 'proof", even when they, too, shared concerns about the behaviour of the carer.

ii. Stricter requirements for all Aged Care staff to regularly and formally report to their employer any gifts or benefits received by them, or anyone related to or associated with them, must be strengthened.

iii. Regulations should be introduced that make Aged Care providers vicariously liable for policy breaches by their staff. Agencies funded by the Government have a duty of care to clients, which must extend, at a minimum, to ensuring that their "no personal benefits for staff" policies are effective in deterring staff from receiving gifts or inheritances from their clients, and where that policy is breached the organisation must bear some of the responsibility for the actions of their staff.

iv. While most agencies have policies, which they say are strictly enforced, there is evidence that they are aware that gifting from clients to carers, even if voluntary, is an issue within the Aged Care sector, both in home care and residential. Carers, especially those who attend the elderly in their home, are in regular and close contact with their elderly clients, many of whom are lonely, often housebound and vulnerable. In that sense carers are in a position of power, which, at times, could be used to influence the elderly person for whom they are providing care.

[12] <https://www.alrc.gov.au/publications/law%E2%80%99s-response-0, (viewed July 2019).

v. Increasingly society is now viewing with greater scrutiny other relationships where there is a power asymmetry and the ability to influence another for self-gain. Further, where the power inequality arises from employment situations, the employing authority is expected to have enforceable policies in place to avoid exploitation of the vulnerable and to take rapid action where questions arise.

vi. Requirements that providers publish relevant policies and have clearly enunciated fair and transparent procedures for investigating and assessing complaints and providing feedback to the complainant.

vii. Requirements that Aged Care providers record and report to the funding, or accrediting, bodies:
- All gifts declared by staff
- All complaints made regarding gifting and the actions taken.

viii. This recording and reporting will ensure that action is taken and will also enable the funders and accreditors to identify the extent and the nature of this type of abuse, and any particular 'trouble spots' so that appropriate regulatory steps can be considered.

ix. A regulation to prevent any staff member who receives substantial financial benefits from a client (including as a beneficiary of a will) evading sanctions of a "no personal gains for staff" policy by simply leaving their employment voluntarily. It is understood that some employees have resigned in order to receive a large bequest, thus "avoiding" the policy.

x. Legislation to prevent non-family member carers, provided through Aged Care providers and government programs, from being major beneficiaries of the wills of the clients to whom they were assigned to provide care. Legislation could require specific examination, during the probate process, of wills that benefit a non-family carer provided through a government program and could specifically preclude such a carer or their family members, from being a beneficiary of the will of a client.

xi. The Australian Law Reform Commission report of June 2017,[13] titled; the "Family Law for the Future-An inquiry into the Family Law System".

xii. Discusses a number of steps that can be taken against elder abuse, including pressure to change their wills. The Victorian Law Reform Commission has also considered making bequests to unrelated 'strangers' subject to increased scrutiny.

xiii. Additional legal protections, including the registration, licencing and regulation of all Aged Care workers should be considered. Aged Care carers should also be licenced and regulated, in the same way that other health and Aged Care workers. This would assure clients and their families that there was some regulatory body they could turn to, and which would ensure that "rogue carers" cannot evade sanctions by moving from one employer to another.

5.2. Rural and Remote

A Case Study – Aged Care in the Northern Territory

According to the last census, the NT is the smallest jurisdiction in Australia at 228,833 people. People aged 65yrs or older makeup 7.2% of the NT population. (Reference: Northern Territory Department of Health, Annual Report 2015-2016). 25.5% of the NT population are Aboriginal.

[13] https://www.alrc.gov.au/publication/family-law-report/. (viewed August 2019)

80% of elderly Aboriginal Territorians live in remote areas. (Reference: SCRGSP, Report on Government Services 2016). NT has the lowest rate of Government Expenditure per person at $3582.62 compared with $4571.61 on average nationally. (Reference: Productivity Commission, Chapter 14; Aged Care Services, Report on Government Services 2019).

Out-of-Hospital Programs

Out-of-hospital programs for the elderly in all parts of Australia are organised into three main service streams; Community based care, Residential Aged Care and Flexible care. (Reference: Department of Health, Ageing and Aged Care, Aged Care funding, Canberra, Australian Government 2016). Aged Care services in the NT have higher ratios of community-based to residential care.

Community-Based Care

Community Home Support Program (CHSP) was implemented in 2015 by bringing 4 programs together one of which was formally known as the Community Home and Community Care (HACC). CHSP is targeted as entry level home support by providing domestic assistance, transport, social activities, meals etc. HACC program in the NT operated differently compared with other jurisdictions. Food and meal services were provided at well over twice the national rate and other HACC services such as nursing care and allied health care were below national average or not delivered at all. (Reference: SGRGSP Steering Group of the Review of Government Service Provision; Report on Government Services 2015).

Home care packages are delivered as consumer directed packages of care and there are four levels. Level 1, being for clients needing basic care, to Level 4 for clients needing high care. In the NT, there were nearly twice as many Level 1-2 HCPs per target population compared with nationally. Aboriginal elderly people were the recipients of 57.2% of Level 1-2 HCPs and 22.6 of Level 3-4 HCPs. (Reference: SGRGSP; Report on Government services2016). Once a person is accepted needing community care, they are placed on a nationally managed queue. Currently waiting time for Level 4 HCP is over 12 months. This results in some clients entering the residential Aged Care facility prematurely.

Residential-Based Care

There are fewer residential Aged Care places in the NT per target population than nationally. For elderly Aboriginal people in the NT the RACF placement rates were comparable to the national rates. For non-Aboriginal elderly, the NT RACF rates were 26.1 per 1000 compared with 62.6per 1000 nationally. (Reference: SCRGSP: Report on Government Services 2016). 65.9% of the NT RACF residents were classed as concessional in 2013-14, compared with 33.3 nationally. (Reference: SCRGSP, Report on Government Services,2016). In other words, NT has a higher rate of poverty alongside poorer levels of health.

Flexible Care

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) funds organisation to provide flexible, culturally appropriate Aged Care to Aboriginal people in the communities, chiefly in rural and remote areas. There are 14 providers across NT. (SCRGSP: Report on Government Services 2016).