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Aged Care Quality Standards Review

AMA submission to the Department of Health and Aged Care consultation

Online submission

The AMA welcomes the review of Aged Care Quality Standards undertaken by the Department of Health and Aged Care. The AMA's feedback will address the need for improved clinical care in aged care and how proposed **Standard 5: Clinical care** can ensure that appropriate clinical care is provided, and aged care providers are adequately evaluated against this standard. The AMA believes that appropriate clinical governance in all care settings should ensure that older people receive adequate medical care throughout their entire healthcare journey.

The revised clinical care standard must make clear how:

- clinical governance and accountability is achieved, including through establishment of relevant advisory committees, that must include medical input
- the standard integrates advance care planning and palliative care
- consumer understanding of what clinical care entails can be improved
- clear lines of responsibility for clinical care are established and evaluated.

Clinical care in aged care

In our submission to the Royal Commission into Aged Care Quality and Safety (Royal Commission), the AMA warned that the new Aged Care Quality Standards were high level and vague. While the important principles of respect, dignity, and engagement with older people were noted, these Standards altered the administrative duties of aged care providers but did not improve the actual care provision for the older person.

The additional administrative requirements might be considered analogous to 'tick-box' exercises, without improving clinical care, and also detract from the time aged care staff provide care. In our submissions to the Royal Commission, the AMA recommended more specific Aged Care Quality Standards, including a Medical Access Standard, be developed for RACFs that would facilitate access to medical services and high-quality clinical care. The AMA has advocated for a Medical Access Standard for approximately 20 years.

It is essential that the amended quality standards avoid making the same mistake.

For the standards to be applied properly, accreditation and compliance audits should focus more on quality of clinical care, rather than tick-box documentation of compliance. The accreditation process must prioritise quality of clinical care as Key Performance Indicator, over completed paperwork. The AMA believes that increased number of auditors who have experience in clinical care will be necessary, if any real change in clinical care delivery with the new standards is to be achieved.

Because the Consultation Paper acknowledges that the revised standards will maintain the consumer 'expectation statement' structure, the AMA believes that genuine effort must be made to improve the community understanding of what constitutes appropriate clinical care for older people and their carers. For example, the consumers/carers should understand the difference in roles between nursing staff and personal care staff. One important difference would be that the medication management in aged care should always and only be done by nursing staff, primarily registered nurses. One of the most consistent complaints received about residential care has been medication management.[1] This is often because this important area of clinical care has been outsourced to personal care staff, who are not qualified in provision of clinical care or medication management.

With the new nursing ratios coming into effect from 2023, it will be important that the awareness of the residents and carers is improved to understand the respective roles of clinical and non-clinical staff. Only then will the consumers/carers effectively be able to rate the care provided and identify any improvements that are needed.

The AMA was supportive of the Aged Care Royal Commission's recommendation that proposed that the Aged Care Quality Standards are amended to require "*best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention, and infection control, and providing sufficient detail on what these requirements involve and how they are achieved*".[2] However, the recommendations failed to include a standard for aged care providers to facilitate access to medical practitioner services. This would ensure there are adequate minimum protocols, equipment, and facilities to incentivise medical practitioners to visit aged care homes, and guide aged care providers to ensure older people receive the appropriate medical treatment they need when they need it.

Clinical governance in aged care

The Consultation Paper states that "*the focus of any performance assessment against the Quality Standards would be on ensuring that the provider has appropriate governance, systems and processes in place and testing that these are working in practice to deliver safe and quality care for older people*".[3]

While the AMA supports this intention, we would welcome further clarification on what is meant by 'appropriate governance, systems and processes' for clinical care. For example, the AMA considers Medication Advisory Committees (MACs) an important element of ensuring medication

[1] https://www.agedcarequality.gov.au/sector-performance
[2] https://www.ama.com.au/sites/default/files/2020-11/ACRC_Public_response_to_Counsel_Assisting_final_submissions%20_AMA_FINAL.pdf
[3] https://www.health.gov.au/sites/default/files/documents/2022/10/consultation-paper---detailed-aged-care-quality-standards-review.pdf

safety in aged care. However, we cannot see under the current proposal there would be a requirement put on residential aged care providers to establish MACs.

Furthermore, the AMA believes that clinical care inside an aged care home cannot be separated from the overall healthcare for an older person. Therefore, policies and procedures must be in place that support effective communication with visiting medical practitioners (GPs and other medical specialists, e.g., geriatricians and psychiatrists) and allied health professionals, including standing orders for individual consumers, and protocols for contact after hours and in emergency situations. These must be enshrined in the Standards.

In addition, protocols for sharing an older person's clinical information during care transitions must be in place. Much of this will be made easier with the roll-out of My Health Record in aged care homes, but nevertheless aged care provider performance on this important area must be evaluated as well.

Written protocols should be standardised, with clear lines of clinical responsibility with respect to "who", "what" and "when" in relation to provision of healthcare in aged care homes, in particular between the homes and visiting GPs. The revised clinical care standard must ensure that the clinical and administrative responsibility for enactment of such protocols rests with the aged care facility. From the aged care home perspective, the protocols would outline who is responsible assessing, escalating, notifying an issue to the GP and when. From the GP perspective, the protocols would outline when the GP is prepared to be available to respond with a visit or by phone/telehealth, for what (e.g., level of urgency of situation) and, if they are not available, who then is clinically responsible and should be called (e.g., after hours service). Similar protocols will need to be established by aged care facilities with other visiting medical specialists, such as geriatricians and psychiatrists, and allied health professionals.

A key component of clinical governance is establishing a framework that answers the key questions of responsibility for certain clinical actions or decisions.

Ultimately, in the AMA view, clinical governance structures in aged care must include medical input.

Advance care planning and clinical care in aged care

The AMA believes that advance care planning and advance care directives (ACDs) form an integral part of clinical care in aged care and call on this review to enshrine it in the Aged Care Quality Standards.

It is the AMA's position that it should be mandatory for people accessing residential aged care services to have and ACD in place.[4] Even the act of choosing to not have an ACD should be recorded, as this will mean that that discussion has been initiated with the older person. Having an ACD is beneficial to a person's care when they are unable to make their own decisions.

In our submission to the Royal Commission, the AMA called for advance care planning to form an integral part of person-centred care in aged care. Implementing and respecting ACDs should form a fundamental part of any clinical governance in aged care. A clinical care plan developed by the

4 https://www.ama.com.au/sites/default/files/documents/Medical_care_for_older_people_Position_Statement_2020_FINAL_0.pdf

doctor in charge of the patient's care normally sets out specific treatment directions at the end of life, such as decisions regarding resuscitation and the provision of palliative care, which should be followed by health professionals in a medical facility or an aged care home. When the patient has an existing ACD, this should inform the development of the clinical care plan.

The AMA would like to see the revised standards outline the role of aged care providers in initiating the discussion around ACDs and engaging with older person's usual GP around ACDs when developing their care plans.

Palliative care

The AMA Palliative Care in the Aged Care Setting Position Statement[5] calls for palliative care to be provided in all aged care settings, including residential aged care, home care and respite care and, as much as possible, enable people to be cared for and die at the place of their choice.

Everyone involved in palliative care in the aged care setting should be adequately trained for the provision of that care, including GPs, nursing staff, allied health professionals and personal care attendants. Adequate funding to provide quality palliative care must be built into any aged care funding model by defining the skills and staff requirements and recognising that palliative management is a basic aged care service.

The AMA welcomes the intent of the reviewed standards to provide care at the end of life, but the standards must ensure that this is achieved by requiring appropriate staff training. For example, Registered Nurses working in aged care must have palliative care specialised training, particularly in setting up syringe drivers. The AMA understands that there are many instances where aged care home residents who are receiving palliative care are being transferred to hospitals because the aged care RNs are not trained in providing palliative care.

Additional palliative training for all aged care staff must include:

- Recognising signs of deterioration in older people and increasing palliative care needs that require further specialist assessment, including by Specialist Palliative Care services
- How to talk to the patient and their family members about the diagnosis and the need for palliative care
- Managing conflicts and stressful situations with people who are receiving palliative care, their family members and carers
- Bereavement care
- Resilience mechanisms for coping with death and dying of patients
- Providing social and spiritual support for dying older people
- Cultural, religious and spiritual aspects of palliative care.[6]

5 https://www.ama.com.au/sites/default/files/documents/Position_Statement_Palliative_Approach_in_Aged_Care_Setting_FINAL_0.pdf

6 https://www.ama.com.au/sites/default/files/documents/Position_Statement_Palliative_Approach_in_Aged_Care_Setting_FINAL_0.pdf

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