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AMA submission to the Standing Committee on Community Affairs: Inquiry into the future of Australia's aged care sector workforce

The AMA has advocated for some time to secure medical and nursing care for older Australians. This is even more necessary now given that 15 per cent of the population are over 65 years of age and this proportion continues to grow[1]. In addition, the health care needs of residents of aged care facilities are complex with 83 per cent of people in permanent residential aged care at 30 June 2014 in high care[2]. The complexity of multisystem medical disorders that afflict older people warrant the regular attention of medical practitioners and quality nursing care which must be taken into account when planning for the aged care workforce. General Practitioners, as the coordinators of care prevent more expensive downstream costs. Conditions, particularly chronic conditions which are more prevalent in older Australians, are less likely to result in the patient requiring hospital care if treated early by a practitioner[3,4].

The aged care sector must evolve to be able to care for older Australians while preserving a person's access to quality medical care. For older Australians, whether living in residential aged care facilities or in the community, access to ongoing medical care and supervision is fundamental to ensuring they receive the best quality of care as they grow older. The same applies to people who are living independently but who are not able to attend the doctor's surgery.

However, medical practitioners are not traditionally counted as part of the aged care workforce.

Medical Practitioners as a part of the aged care workforce

In the same way that medical practitioners are an integral part of the hospital workforce, medical practitioners and other health practitioners comprising the general practitioner-led team are an integral part of the aged care workforce, particularly in residential aged care. They are central to the provision of quality care for older people.

[1] Department of Health 2015. *2014-15 Report on the Operation of the Aged Care Act 1997*, p 6
[2] Australian Institute of Health and Welfare 2014. *Residential aged care and home care 2013-14*, National Aged Care Data Clearinghouse, data table: Care Needs, Figure 2
[3] Australian Institute of Health and Welfare. Australia's Health 2014. Canberra: AIHW, 2014. (AIHW Cat. no. AUS 178; Australia's Health Series No. 14.)
[4] NHPA (2015) Healthy Communities: GP care for patients with chronic conditions in 2009-2013

Providing medical care in the aged care sector is challenging for a number of reasons, which illustrate that the medical workforce is not considered integral to the residential aged care workforce.

1. Poor access to properly equipped clinical treating rooms. Treatment usually has to be provided in a shared room where there is a lack of privacy for the patient and no equipment for the treating doctor, limiting the medical treatment that can be provided in that setting.
2. An absence of information technology infrastructure to facilitate access to electronic patient records and medication management. This includes software appropriate to the needs of general practitioners and improved electronic interface between pharmacy services and aged care facilities records, and/or support for remote access to the practitioner's medical records. A larger investment in information technology could see better communication between the care team, faster access to hospital discharge summaries, fewer medication errors and better access to Advance Care Directives. The My Aged Care Gateway should be interoperable with clinical software. The My Aged Care Gateway referral form needs to be integrated into general practice clinical software so that the form can be auto-populated, attached to the patient record, and securely sent.
3. A strong financial disincentive for the medical practitioners to leave their surgery, with all its attendant costs, to provide services in aged care facilities.
4. Limited MBS support for telehealth services often means that the doctor needs to present at the facility or not be paid.
5. A growing tendency to build facilities in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by medical practitioners away from their surgeries.
6. A lack of access to registered nurses with whom to co-ordinate care. Nursing services are currently provided in a variety of ways, and a lack of adequate nursing services impacts negatively on the timeliness and quality of care for residents.
7. A number of AMA members identified a practical impediment to working in aged care facilities being the consistent lack of formal arrangements for doctors to be provided with after-hours access to the facility (including the provision of codes).
8. An increasing use by aged care facilities of agency staff who are not familiar with residents which compromises continuity of care.

Appropriate support for medical services, including limited forms of pharmacology and pathology, in aged care facilities will improve residents' access to medical care, and can reduce unnecessary pressure for, and counter-productive utilisation of, acute services. Investment in medical services in aged care facilities will lead to a more efficient health system.

Respite Care

Another example of how the medical professions contribution to aged care can be better incorporated is the area of respite care. Demand for respite services is likely to increase as the trend towards community care increases and the carer base diminishes. The need for respite care usually occurs when the carer has become unwell and/or is temporarily unable to provide care. In these situations it is often very difficult to access respite care.

Approval for respite care depends on a formal Aged Care Assessment Team (ACAT) assessment. Difficulty in accessing an ACAT assessment means it can take months before approval for respite care is given. In the meantime, sometimes the only option is to admit the patient to hospital in order to give the carer some relief. This causes great distress for patients

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.

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 need of urgent respite care in much the same way a doctor determines that a hospital admission is necessary.

Advance Care Plans and End of Life Care

Where possible, the patient should be cared for in the environment of their choice, including the residential aged care facility. Supporting end of life care and advanced care plans will provide residents with good quality patient-centered care that is a collaboration between the patient and the health care team. This care should be facilitated and coordinated by their medical practitioner.

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

Alternate Models for Providing Care

The Government should consider the merits of different models of providing medical care services within aged care facilities. Various examples exist of medical practitioners being employed either in a full time or part time capacity at an aged care facility, but, to date, this is only at the initiative of certain facilities. Alternate models should expand the opportunities for medical practitioners working in an aged care facility and support practitioners to provide ongoing medical care. This has the potential to reduce unnecessary transfers to more expensive forms of care such as hospitals. Such a model would provide residents with ongoing access to medical care in their environment of choice.

Nursing

As mentioned above, sufficient numbers of registered nurses should be on site to manage patient care between doctors' visits.

There has been a shift in the composition of the aged care workforce across Australia in recent years, and whilst the increase in personal care attendants is welcome, the decline in the proportion of registered nurses and enrolled nurses needs to be reversed to ensure residents are provided with timely and appropriate clinical care[5].

[5] Debra King, Kostas Mavromaras et al, Commonwealth Department of Health and Ageing, *The Aged Care Workforce, 2012 – Final Report*, Flinders University, p 22.

Table 1: Full-time equivalent direct care nurses and personal care attendants in the residential aged care workforce: 2003, 2007 and 2012 (estimated Full Time Equivalent)*[6].

Occupation	2003[#]	2007	2012
Nurse Practitioner	n/a	n/a	190 (0.2)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)
Allied Health Assistants and Professional	5,776 (7.6)	5,204 (6.6)	5,026 (5.3)
Total number of employees (FTE) (%)	76,006 (100)	78,849 (100)	94,823 (100)

** data in this table was extracted from The Aged Care Workforce, 2012 – Final Report: Table 3.3*

The absence of specific nurse to patient ratios in the accreditation standards has allowed the shift in the proportions. This has placed additional pressure on nursing and medical practitioners and has most likely led to increased transfers to hospitals.

The AMA strongly believes that there must be specific accreditation standards around access to medical services, in a similar fashion to the existing standard on access to clinical care and specialised nursing care. To this end, the AMA supports calls by the Australian Nursing and Midwifery Federation for the provision of a minimum number of registered and enrolled nursing staff, to meet the assessed care needs of all residents.

Spot checks and review processes

Spot checks by accreditation teams without warning are very disruptive to the aged care facility, and are potentially dangerous for residents as staff, particularly nurses, are taken away from their main duties during the check. AMA members have reported that these checks are totally demoralising for all staff. Whilst we acknowledge that there needs to be a review process, the processes should be designed to improve care and quality, and should not be stressful for staff.

The impact of the current system of spot checks and review processes upon the provision of care and staff moral should be reviewed.

Teaching in residential aged care facilities

Aged care facilities are a fertile ground for teaching. The provision of appropriate and accredited medical training places in these facilities would add to the overall breadth and depth of medical training and improve the quality of care of residents.

[6] Debra King, Kostas Mavromaras et al, Commonwealth Department of Health and Ageing, *The Aged Care Workforce, 2012 – Final Report*, Flinders University, Table: 3.3.

The comparatively smaller and more stable population, compared to the patient population of large teaching hospitals, offers medical students and trainees a different experience. They are exposed to patients over a much longer period of time.

Offering appropriate and accredited medical training places in aged care facilities would educate the next generation of doctors about caring for the aged as part of routine medical practice. These places need to be supported by appropriate incentives.

Conclusion

The aged care sector needs to evolve in order to be structured to provide the medical care needed by Australia's ageing population. Aged care providers should have arrangements in place to ensure that residents' needs for medical care are identified and that they receive ongoing access to medical care appropriate to their needs and that they age in place. This will include, but is not limited to:

- ensuring adequate numbers of appropriately skilled nurses are employed;
- having management practices in place to ensure residents who require medical attention from a doctor are identified quickly, and that doctors are contacted;
- providing doctors with access to properly equipped clinical treatment rooms that afford patient privacy; and
- providing doctors with access to information technology infrastructure, and patient records.