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AMA submission to the Royal Commission into Aged Care Quality and Safety

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Contents

Background

Australia's health and aged care systems are currently not keeping pace with the needs of its older people. Australia's population is ageing. In 2017, 15 per cent of Australia's population (3.8 million) was aged 65 years and over. By 2057, the proportion of older people is expected to rise to 22 per cent (8.8 million)[1].

While Australians are living longer, it is not uncommon for older people to have multiple chronic conditions that are inherently complex. This will only increase over time due to an increase in chronic disease in Australia's population[2], and a lack of support from governments for primary care and health prevention in earlier years of life.

AMA members feel a responsibility to advocate on behalf of their patients and are deeply concerned about the quality of care their patients are receiving under the current aged care system. AMA members are registered medical practitioners (doctors), many of whom care for older people in various settings. This includes in their consulting rooms, in the hospital, at the older person's home, and in residential aged care settings. AMA membership also includes medical students.

There are several factors that contribute to poor quality care in aged care settings. However, many quality issues could be rectified by improving the capacity and capability of the aged care workforce to meet the needs of older people. Aged care staff and the external aged care workforce are the people delivering the care and therefore are the biggest influencers of the quality of care. This needs to be recognised and reflected by both the government and the aged care sector.

The aged care workforce

Doctors

Despite the older population's increasing need for medical attention, doctors are not well supported to provide their services to older people in aged care settings. This lack of support comes from both the health and aged care systems. AMA members report that a focus on continuity of care (receiving care from a usual doctor) in aged care settings is generally not recognised, despite the evidence that continuity of care is linked with improved health outcomes[3].

[1] Australian Institute of Health and Welfare (2018) *Older Australia at a glance*
[2] Australian Institute of Health and Welfare (2018) *Australia's health 2018. Chapter 3.3: Chronic conditions*
[3] Barker, I Steventon, A, and Deeny, S (2017) *Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data* BMJ. 356:j84

While Medicare Benefits Schedule (MBS) data shows that the number of services per resident is increasing[4], the 2017 AMA Aged Care Survey indicates that doctors, mostly general practitioners (GPs), intend to decrease their visits to aged care in the future. The 2017 AMA Aged Care Survey identified that one in three respondents (doctors) intend to either visit current patients but not new patients, decrease the number of visits, or stop visiting residential aged care facilities (RACFs) entirely over the next two years[5]. Respondents who had decreased their visits over the past five years provided a number of reasons as to why[6], with inadequate MBS rebates and an increase in unpaid work major influencers. Decreases may also be partially due to an ageing medical workforce[7].

Additionally, AMA members report it is common that past MBS trends are observed and studied to assess medical access in RACFs, while forward trends are largely ignored. In the future, residents will require more complex medical care provided more often, however past MBS trends do not adequately recognise this. The AMA believes that this warrants further investigation into the demographics and movements of doctors in the aged care sector.

Recommendation 1: Retaining and increasing the number of doctors interested in working in the aged care space should be the focus of any future reforms in aged care if appropriate clinical care is to be provided. Investing in primary care particularly for patients in aged care settings will save on public hospital expenditures.

Recommendation 2: Further investigation and research is needed into the demographics and movements of GPs in the aged care sector due to the decreasing trend in GP aged care visits and an ageing medical workforce. The research needs to take into consideration the forward-looking trends of expenditures related to Australia's ageing population and the projected need for the medical workforce.

Funding doctor services

RACF and home attendances by a doctor for older people are paid through the MBS. A doctor may choose to 'bulk-bill' an older person which means they pay nothing. Alternatively, the doctor may charge a private fee, where the older person incurs an out-of-pocket cost (the difference between the private fee and the MBS benefit). The MBS benefit goes to the older person in this scenario.

Nationally, almost 100 per cent of GP non-referred attendances to older people in RACFs are bulk-billed[8]. This means that older people are receiving GP services for no out-of-pocket cost (i.e. for free), and GPs are accepting the MBS rebate. There is a consensus that this MBS payment does

[4] Medicare Benefits Schedule Review Taskforce (2018) *Report from the General Practice and Primary Care Clinical Committee: Phase 2* Page 103
[5] Australian Medical Association (2017) *2017 AMA Aged Care Survey Report* Page 30
[6] Australian Medical Association (2017) *2017 AMA Aged Care Survey Report* Page 35
[7] Australian Medical Association (2017) *2017 AMA Aged Care Survey Report* Pages 8, 30, 32
[8] Based on advice from the Department of Health

not adequately compensate for the time spent carrying out the service, and all activities that relate to the service (i.e. non-contact time).

For example, before 1 March 2019, the MBS rebate for item 35 for the first patient was $85.00. This comprises the ordinary Level B fee ($37.60) plus an additional fee of $47.40. However, the additional fee decreased per patient when the number of patients seen in one visit increased. For example, if five level B Consultations are carried out in the one visit, the total MBS rebate for each of the five patients is the ordinary Level B fee ($37.60) plus an additional fee of $9.48 (being $47.40 divided by five).

The AMA believes that the derived fee for a GP attendance at a RACF did not adequately consider the additional time and complexity involved in comparison to a GP attendance in the GP's own consulting rooms.

There have been recent changes to the funding structure. As of March 2019, GPs can claim a flag-fall item number (90001 attracts a rebate of $55) for the initial attendance at one RACF[9]. In addition, the item number for the service may also be claimed by the GP if they bulk-bill. For example, item number 90035 attracts an MBS rebate of $37.60 (equivalent to a Level B service in the GPs consulting rooms).

Based on the results of the 2017 AMA Aged Care Survey, MBS rebates needed to increase by at least 50 per cent to adequately compensate for the additional time and complexity involved in comparison to a GP attendance in their own consulting rooms. The $98 million increase announced at MYEFO 2018 falls a long way short of this 50 per cent mark. Further, the new structure leaves GPs who visit a large number of patients in one RACF visit financially worse off than before. The AMA believes the new structure is still not adequate to compensate for the time spent carrying out the service or for non-contact time. The AMA has received complaints from some members that reinforce the AMA's position.

Doctors have had to fight to retain the Practice Incentive Program (PIP) Aged Care Access Incentive (ACAI). While a relatively small incentive, AMA members perceive it as recognition from the government that visiting RACFs is important work. Many AMA members reported that if the PIP ACAI was discontinued, they would have to stop visiting RACFs. Fortunately, further funding for the PIP ACAI was announced in the 2019-20 Budget. AMA members also contend that ACAI has never been indexed and that it should be in order to cover the practice costs.

GPs provide a substantial amount of non-remunerated, non-contact time when looking after their older patients (see Table 1). This includes phone calls from RACF staff concerning the patient, and from relatives. GPs may provide medical advice during this phone call. The requirement of existing telehealth MBS items 2125, 2138, 2179, and 2220 that a specialist or consultant physician must be included in the telehealth consultation does not facilitate timely access to GP services on some occasions. The AMA has been advocating for some time to introduce a MBS telehealth

[9] Department of Health (2019) *Medicare Benefits Schedule Book: Operating from 1 March 2019* Page 10

item for phone calls between the GP, RACF staff and relatives. This may reduce some barriers to accessing medical services after-hours.

The Government should consider introducing telehealth for RACFs for after-hours consultations as a pilot. Outcomes of such a pilot program will help inform government policy and provide an evidence base for informed decision making. The after-hours definition applied in this case should be as defined by the MBS[10].

The AMA is also concerned with the proposed changes to the MBS under the review currently conducted by the Department of Health. Under the newly proposed MBS system, geriatricians and other doctors who provide care for patients with multiple conditions and co-morbidities, such as patients in aged care, could be disproportionately disadvantaged with the proposed removal of consultant geriatric complex plan items and replacement by the introduction of time tiered attendance items. Geriatric assessments are often very different from other standard doctor consultations and caring for patients with cognitive decline often requires significant input from family members and carers, as well as consultations with stakeholders such as aged care providers, allied health, and pharmacists which would likely be hampered by the time-tiered consultations.

Finally, for a number of years the aged care and health care sectors have been moving towards the full implementation of patient-centred care concept. The Australian Commission on Safety and Quality in Health Care defines patient-centred care as "health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers."[11] This concept in aged care is promoted and supported by the Single Charter of Aged Care Rights[12], new Aged Care Quality Standards, Australian Charter of Healthcare Rights and other national and state policies and initiatives. Doctors form an integral part of patient-centred care in aged care.

For patient-centred care to be fully implemented, it requires doctors, primarily GPs, to work in partnership with older people, their carers and families, aged care staff, medical staff in RACFs, service coordination, after-hour calls from RACF staff and consultations with nurses. Currently most of these activities are non-billable by GPs, although doctors are required to and engage in these activities on a regular basis.

[10] Department of Health (2019) *Medicare Benefits Schedule Item 5020*
[11] Australian Commission on Safety and Quality of Health Care (2011) *Patient Centred Care: Improving Quality and Safety through Partnerships with Patients and Consumers*
[12] Department of Health (2019) *Single Charter of Aged Care Rights*

Example of a typical doctor visit to a RACF

The following example outlines a typical RACF visit by AMA President, Dr Tony Bartone, as outlined in his Witness Statement. The following is provided as an example to indicate the additional unremunerated time doctors must take for RACFs visits. The AMA notes that this example is likely to vary depending on the doctor and their arrangements with the RACF, the arrangements within the RACF and the patient complexity and distance from the GP practice.

For the first patient, a visit made by Dr Bartone to a RACF may involve:

Action	**Time (minutes)**
Travel time	20
Finding a car park	5
Finding a staff member (preferably a registered nurse) and discussing the patient's needs and history	5
Finding the patient	5
Level B attendance (although can be longer noting older patients are on average, more complex)	14
Filling out prescriptions and paperwork	5
Finding the registered nurse (if available) to provide a clinically reliable handover	5
Travel time back to the practice	20
Talking to relatives and RACF staff over the phone or at the RACF	5
Entering patient records into clinical practice software	5
TOTAL	**89**

Table 1: Example of time involved for GP attendances at RACFs (first patient)

Excluding travel time, the time for second and subsequent patients is still substantially higher (44 minutes) compared with the average time of a Level B consultation at the GP's own practice (14 minutes[13]). The time spent finding a registered nurse, patient, or staff member may double if the second and subsequent patients are in a different ward or different part of the RACF.

Action	**Time (minutes)**
Finding a staff member (preferably a registered nurse) and discussing the patient's needs and history	5
Finding the patient	5
Level B attendance (although can be longer noting older patients are on average, more complex)	14
Filling out prescriptions and paperwork	5
Finding the registered nurse (if available) to provide a clinically reliable handover	5
Talking to relatives and RACF staff over the phone or at the RACF	5
Entering patient records into clinical practice software	5
TOTAL	**44**

Table 2: Example of time involved for GP attendances at RACFs (subsequent patient)

Inadequate funding for RACF doctor services is just one example of how the aged care and health systems are not supporting the needs of older people. While more people are staying at home for longer, the needs of older people living in RACFs will become more complex.

The Royal Commission should also investigate the absence of routine roles for geriatricians and psychogeriatricians and how this should be addressed to better support GPs. Doctors must be adequately supported to provide medical services to older people. With the growing number of dementia patients entering aged care, the need for proper dementia management and adequate prescribing of medication will grow. GPs will continue to need support in this time-consuming complex area of clinical care. GPs also require specialist support in palliative and end of life care in RACF settings, where complexity of treatment is amplified by the growing number of chronic conditions in patients.

Recommendation 3: Medicare rebates need to increase in excess of 50 per cent to begin to adequately compensate for the additional time and complexity involved in comparison to a GP attendance in their own consulting rooms.

Recommendation 4: Introduce an MBS telehealth item for phone calls between the GP, RACF staff and relatives. This may reduce some barriers to accessing medical services after hours. The Government should consider introducing telehealth for RACFs for afterhours consultations

[13] University of Sydney (2016) *General Practice activity in Australia 2015-16* Page 39

as a pilot. Outcomes of such a pilot program will help inform government policy and provide an evidence base for informed decision making.

Recommendation 5: The Royal Commission should investigate the absence of routine roles for geriatricians and psychogeriatricians and how this should be addressed to better support GPs.

If a sustainable future aged care model which provides best consumer outcomes is to be achieved, the AMA urges the Royal Commission to explore different models of GP care. The AMA supports continuity of care and believes that patients benefit the most from a lifelong relationship with their usual GP. However, the AMA recognises that this may not always be possible as some patients move outside of the usual GP's area of practice. Research into improved funding and workforce models regarding medical care for older people should be supported, however, the following must be guaranteed:

i. Models must be financially viable for all RACFs or service providers and medical practitioners.
ii. Patient choice of GP is maintained. If patients choose to keep their usual GP, they are still supported by their RACF or service provider to arrange consultations with their usual GP.
iii. There must be protections in place to ensure RACFs or service providers cannot influence the GP's duty of care to their patients for financial or commercial gain.
iv. A practice should still be able to choose a care model that allows them to maximise the ability of GPs to visit patients.

Finally, improved models of care should not be a substitute for improving inadequate MBS rebates. Funding models need to recognise the important leadership role GP-led teams can play in providing advice on how to improve overall health outcomes beyond direct clinical needs. For example, GP-led teams can advise on policy procedures, clinical governance, and an appropriately resourced care environment.

Recommendation 6: Further research is needed into improved funding and workforce models for medical care of older people.

Support from aged care providers

The lack of incentive to visit RACFs is not solely a result of the lack of suitable funding. The support doctors receive from aged care providers vary across RACFs. The AMA believes that RACFs should be required to meet a 'medical access' Aged Care Quality Standard to facilitate access to medical services, that includes the following:

- Providing clinically equipped and available doctor treatment rooms that enables patient privacy and an appropriate working environment. This is highlighted by the recent Royal Commission testimonies where one witness spoke about examinations being conducted in common areas such as dining rooms[14].

[14] Aged Care Royal Commission, (2019) *Transcript of Proceedings* 6.5.19R1 Page 1163

- Provided all privacy measures are met, providing practitioners with the ability to access patient files through a contemporary eHealth system that is interoperable with clinical software, My Aged Care, My Health Record, and RACF software to increase communication and efficiency.
- Providing access to the RACF, through the use of swipe cards, access codes, and car parking facilities.
- Providing access to a registered nurse (RN) to carry out a reliable clinical handover.
- Facilitating access to mobile x-ray and ultrasound services, as well as medication reviews.
- Ensuring that older people have timely access to allied health professionals[15].

The above measures should reduce the non-contact time that comes with visits to RACFs (thus attracting doctors to this work) and improve access to high quality, safe medical care for older people living in RACFs. The AMA recognises that for aged care providers to achieve some of these measures, there must be investment from government (for example, interoperability between My Aged Care, My Health Record, clinical and aged care software systems).

AMA members report that the lack of access to clinical software in RACFs results in serious losses of clinical data and gaps in the information exchange between doctors, RACF staff and other medical practitioners who may visit the patient (e.g. after-hours locums). An additional gap is the inability of most clinical software to allow restricted "read-only" remote access to selected data, resulting in doctors' inability to write notes in their software and share them with the RACF's nursing staff.

Recommendation 7: Aged care providers need to provide basic equipment and facilities to support doctors to carry out their services in aged care settings. This includes access to a consulting room, a computer and appropriate clinical software.

Education and training of doctors in the care of older people

Education and training for doctors in caring for older people should be increased and this must begin at medical school. Only a small proportion of younger doctors that responded to the 2017 AMA Aged Care Survey visit RACFs[16].

RACFs are a fertile ground for teaching. 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.

The provision of appropriate and accredited medical training places in RACFs would add to the overall breadth and depth of medical training and improve the quality of care of RACF residents.

[15] Australian Medical Association (2018) *Resourcing aged care*
[16] Australian Medical Association (2017) *2017 AMA Aged Care Survey Report* Page 8

Offering appropriate and accredited medical training places in RACFs would educate the next generation of doctors about caring for older people as part of routine medical practice. To achieve this, these places need to be supported by appropriate incentives.

The AMA worked with the Department of Health's General Practice Education and Training (GPET) program to develop a pilot program in 2012 through the Prevocational General Practice Placements Program (PGPPP) for aged care placements. However, the pilot never progressed due to the abolition of GPET and the cessation of the PGPPP in 2014. The AMA raised this pilot in 2019 with the (then) Minister for Senior Australians and Aged Care, Hon Ken Wyatt AM.

Recommendation 8: Education and training for Doctors in Training and medical students on caring for older people should be increased.

Nurses

As discussed, the ageing population will come with an increased need for clinical care. Registered Nurses (RNs) are the only aged care provider employees that can provide frontline, timely clinical care within their scope of practice. Doctors rely on RNs to carry out their clinical directions when they leave the RACF or the patient's home. Doctors need to communicate with RNs because RNs have clinical backgrounds and can assist to determine the best clinical care for older people. Older people who require aged care need RNs to safely administer medicines and help prevent medical issues such as bed sores and fractures.

AMA members report that aged care providers tend to use agency nurses, which can fragment care. Like a doctor, a nurse who has a long-standing relationship with an older person is hugely beneficial to the older person's health. For example, an older person whose behaviour is changing over time will be picked up faster by a staff member who knows them, and is trained to recognise the symptoms, in comparison to one that does not. Availability of nurses to provide care of older patients can ensure earlier detection of other health complications such as UTIs, cellulitis, community acquired pneumonia as well as deteriorating heart function and other conditions. Greater availability of nurses in aged care can subsequently lead to a reduction in preventable hospital admissions.

AMA members report that aged care providers tend to minimise rostering of RNs after hours or overnight. Sometimes there is no RN on site at all, just a remote "on call" service providing telephone advice to carers. This is particularly concerning when a patient does not receive their palliative care medication because there is no RN to administer it. One AMA member provides an example:

> *RACF that had no Registered Nurse on site overnight/after hours. The onsite overnight/afterhours staff did not have the authority/training to give PRN oral narcotics nor any injectables, and, in the event such medications were required (eg terminally ill patient), the on-call nurse needed to be phoned.*
>
> *PRN medication [was] charted but [tended] to be under-utilised (including simple analgesics, laxatives and salbutamol).*

> *[An] increasing number of facilities [are] using medication trained personal care attendants rather than RNs for medication administration.*

In contrasting examples, the AMA is informed of situations where staff are giving the most potent pain medication to residents first. AMA members report examples where patients are prescribed paracetamol as well as PRN paracetamol with codeine. In such cases the staff will commonly apply the latter as this will settle patients' behavior more quickly. Such examples could be avoided with continuous availability of RNs onsite, who would be able to make a judgment on the appropriate medication at the time.

The AMA is very concerned about the decrease in the proportion of RNs in RACFs (see also *staffing ratio in RACFs* section). One member highlights these issues:

> *High turnover of agency RN's and carers – lack of consistency in carers meant that staff were not up to date with patients' current medical condition.*
>
> *High proportion of staff from non-English speaking backgrounds and very junior RN's (new graduates) with little medical knowledge or clinical experience from the hospital or other places (where they are more supported).*
>
> *[In a 12 month period, there was] a turnover of 2-3 clinical managers (with non-clinical staff stepping in while waiting for the new manager).*
>
> *Lack of staff on the ground.*

The AMA believes that increasing the availability of RNs in aged care services will significantly improve quality and safety for the care of older people. Low wages for RNs in the aged care sector represent a major disincentive to attract qualified nurses to work in RACFs. 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 $100 less per week than nurses who work in acute care settings[17].

Finally, AMA members express concerns over the deskilling of nurses in aged care. As one member put it:

> *The deskilling of nurses is obvious and progressive. That is, their skill and knowledge with regard to dressings, vaccinations, clinical care protocols and antibiotics is obvious. RN's are not allowed to vaccinate patients, are professionally deskilled and have very little personal time for patients.*

Recommendation 9: Registered nurses should be available on site, 24 hours a day in RACFs to ensure older peoples' medical needs are adequately met, including the appropriate administration of medicines.

[17] Senate Community Affairs References Committee's (2017) *Future of Australia's aged care sector workforce inquiry* para 3.46

Personal care attendants

Personal care attendants (PCAs) spend proportionally more time caring for older people than any other staff type[18]. This makes them a crucial component to the aged care workforce and a crucial component in influencing safety and quality issues.

However, PCAs are not equipped to provide basic health care. The *Aged Care Workforce Strategy Taskforce* identified significant health-specific training gaps such as basic care skills (nutrition and hydration), oral health, mental health, dementia, palliative care and end-of-life care, and medication management[19]. There is no requirement for aged care providers to ensure that their PCA employees receive training or professional development for the above, or any, care skills[20].

Other professions that have the responsibility to care for people have mandatory minimum qualifications and are regulated. RNs, doctors and other health professionals are regulated under the Australian Health Practitioner Regulation Agency[21], and the AMA believes that this should be no different for PCAs. The AMA calls for a mandatory minimum qualification for PCAs. This qualification should include the basic health care skills listed above, and:

- Strategies to prevent deterioration in health, such as exercise programs, adequate nutrition 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
- Mental health skills
- Strategies to address other common health issues that older people face
- Basic life support.

In addition to the above, AMA members have been raising the issue of English language proficiency of some aged care staff. One in every four people aged over 80 will be from CALD backgrounds by 2026[22]. Bilingual and bicultural staff hold the potential for improving cross-cultural understandings, language skills, and community engagement[23]. This was demonstrated by a case study presented before the Royal Commission of an older man with an Egyptian background who was living with dementia[24].

[18] Department of Health (2018) *A matter of care: Australia's aged care workforce strategy* Aged Care Workforce Strategy Taskforce Page 28
[19] Department of Health (2018) *A matter of care: Australia's aged care workforce strategy* Aged Care Workforce Strategy Taskforce Page 26
[20] Department of Health (2018) *A matter of care: Australia's aged care workforce strategy* Aged Care Workforce Strategy Taskforce Page 40
[21] Australian Health Practitioner Regulation Agency (2017) *Who we are*
[22] Australian Institute of Health and Welfare (2001) *Projections of Older Immigrants, People from culturally and linguistically diverse backgrounds, 1996–2026*, Australia, Department of Health and Aged Care May 2001 Page xviii
[23] Federation of Ethnic Communities Councils FECCA (2018) *Submission – Aged Care Workforce Strategy* Page 5
[24] Royal Commission into Aged Care Quality and Safety (2019) *Transcript of Proceedings* 6.5.19R1 Page 1151

Workers from CALD backgrounds should be supported by employers in aged care to further develop and improve their English language skills. This includes Australian cultural practices and language idioms, as it is often assumed that migrant staff understand these[25]. Supporting migrant workers in developing their English language skills can provide multiple benefits to aged care consumers (improved communication, improved satisfaction with services, etc), providers of aged care (developing a skilled workforce, greater retention of staff, greater staff and consumer satisfaction) and CALD aged care workers themselves (increased options for career progression, further education and professional development).

The AMA looks forward to the findings of the Aged Services Industry References Committee[26] to further identify the range of skills PCAs should have.

The new Aged Care Quality Standards require providers to employ a workforce that is "skilled and qualified to provide safe, respectful and quality care services". They also require that staff are able to "describe the training, support, professional development and supervision for them to be able to carry out their role" [27]. However, the Standards do not specify the type of training that staff are required to undertake. In addition, government has not provided any specific funding dedicated for this purpose. In practice this may mean that providers will choose not to invest in training, but still impose professional development and training requirements on their staff. Often PCAs are expected to carry out training in their working hours, however they lack time to do so[28,29]. Alternatively, they may be expected to attend training in their own time and/or at their own cost. Risks associated with this approach include opting for shorter, less costly courses that do not provide sufficient training, higher turnover of staff, de-incentivisation of workforce, and lack of opportunities for career progression for staff that are personally motivated to work in the aged care sector.

Recommendation 10: There should be a mandatory minimum qualification for personal care attendants that includes basic health care.

Recommendation 11: Government should provide additional funding for specialised training of the aged care workforce, primarily personal care attendants. This should include a professional development leave option for those wanting to further develop their skills.

Allied health professionals

There is a range of important allied health services that older people currently do not have adequate access to. Doctors regularly refer their older patients to allied health professionals, and they are an important asset to many older people's health care needs. In particular, dental services are required to prevent and treat the severe impact that gum disease and tooth decay

[25] Federation of Ethnic Communities Councils FECCA (2018) *Submission – Aged Care Workforce Strategy*
[26] Australian Industry and Skills Committee (2018) *Aged Services Industry Reference Committee*
[27] Aged Care Quality and Safety Commission (2019) *Aged Care Quality Standards, Standard 7: Human Resources*
[28] Aged Care Royal Commission (2019) *Transcript of Proceedings* 15.5.19 Pages 1685-86
[29] Rayner, J-A et al (2019) *Research priorities in residential aged care services: A statewide survey* Australasian J Ageing; 00: 1– 8

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). The Royal Commission should consult with the allied health professions to ensure older people can access their services.

Inadequate access to psychologists is of concern to AMA members. This is described in the *Mental Health* section of this submission.

Informal carers

There are estimates that if informal carers were replaced by formal carers, it would cost over $40 billion per year (at 2010 prices)[30]. This highlights that informal carers are critical in caring for older people. Pressure on informal carers will only increase as Australia's population ages. Currently, approval for respite care depends on a formal Aged Care Assessment Team (ACAT) or Regional Assessment Service (RAS) assessment. There can be significant difficulty in accessing ACAT/RAS assessments[31], meaning it can take months before approval for respite care is given. In the meantime, AMA members report that sometimes the only option is to admit the older person to hospital in order to give the carer some relief. This can cause great distress for older people and their carers and may increase the risk of delivering respite care that is inappropriate both in timing and in the nature of the care given. Admitting the older person to hospital is also expensive and burdens public hospital bed availability for acute care presentations.

A streamlined process is required to improve access to respite care for older people who have not yet been assessed by an ACAT/RAS or who have not yet entered the aged care system. GPs who work in aged care know their patients' 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 that a doctor determines that a hospital admission is necessary. This recommendation is in line with the views of some consumer advocate groups such as Dementia Australia who argue that, for people living with dementia, more weight should be given to health professionals' referrals[32]. 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[33,34]. However, research suggests Day Respite Centres are under-utilised by carers because they believe it will result in negative outcomes for the consumer[35,36]. The AMA suggests further

[30] Productivity Commission Inquiry Report Vol 1, No. 53 (2011) *Caring for Older Australians* Page 18
[31] Department of Health (2017) *Legislated Review of Aged Care 2017* Page 139
[32] Dementia Australia (2019) *Submission to the Streamlined Assessment for Aged Care*
[33] 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, Page 245
[34] 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, Page 24
[35] 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, Page 245
[36] 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, Page 24

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/RAS assessment, and could be streamlined through the patient's GP.

Recommendation 12: Implement a streamlined process to improve access to respite care for people who have not yet been assessed by an ACAT/RAS or who have not yet entered the aged care system.

Staffing ratios in residential aged care facilities

The AMA believes that the main issue influencing the safety and quality of care in aged care is the capacity, capability, and connectedness of the aged care workforce. It is extremely difficult to provide safe and quality care without enough staff to carry out the work. There is substantial evidence that links staffing numbers to the quality of care received[37,38,39].

Despite the evidence, aged care providers are not sufficiently obligated to provide the appropriate mix and number of staff to meet older people's needs. Standard 7: Human Resources of the new Aged Care Quality Standards states:

> *The sufficiency of the workforce – Organisations providing care and services are expected to have enough skilled and qualified staff to meet consumers' needs. Organisations are responsible for using Australian Government funding to make sure they have the staff numbers and mix of skills needed to provide consumers with quality care[40].*

However, the Standard does not provide any parameters for what constitutes 'enough skilled and qualified staff', or how providers will be evaluated against this Standard.

The lack of focus on maintaining staffing levels has resulted in an increase in the proportion of inadequately trained PCA's, and a decrease in the proportion of registered and enrolled nurses (see Figure 3). This is despite the increasingly complex and severe medical conditions of older people living in RACFs, which will continue to increase over time due to the focus on keeping older people at home for as long as possible. The proportion of nurses should reflect the increasing proportion of older people with complex and severe medical conditions. The AMA believes a lack of focus on RNs that deliver clinical care is evidenced by the frequency that the Clinical Care and Medication Management Standards are not met[41]. In addition to an inadequate number of RNs, inadequate numbers of PCAs are also compromising quality of care. Availability of, and an appropriate mix of, staff should ensure that medical complexity is better managed on

[37] Henderson et al (2016) *Missed care in residential aged care in Australia: An exploratory study* Collegian
[38] Dellefield, M et al (2015) *The relationship between registered nurses and nursing home quality: an integrative review (2008-2014)* Nursing Economics. 33:2, Pages 95-108
[39] Castle, N and Engberg, J (2005) *Staff turnover and quality of care in nursing homes* Medical Care. 43:6
[40] Aged Care Quality and Safety Commission (2018) *Standard 7. Human resources*
[41] Australian Aged Care Quality Agency (2018) *Annual Report 2017-18* Page 26

site, will reduce unnecessary hospital transfers and ultimately ensure provision of person-centred care, as required by the Aged Care Quality Standards.

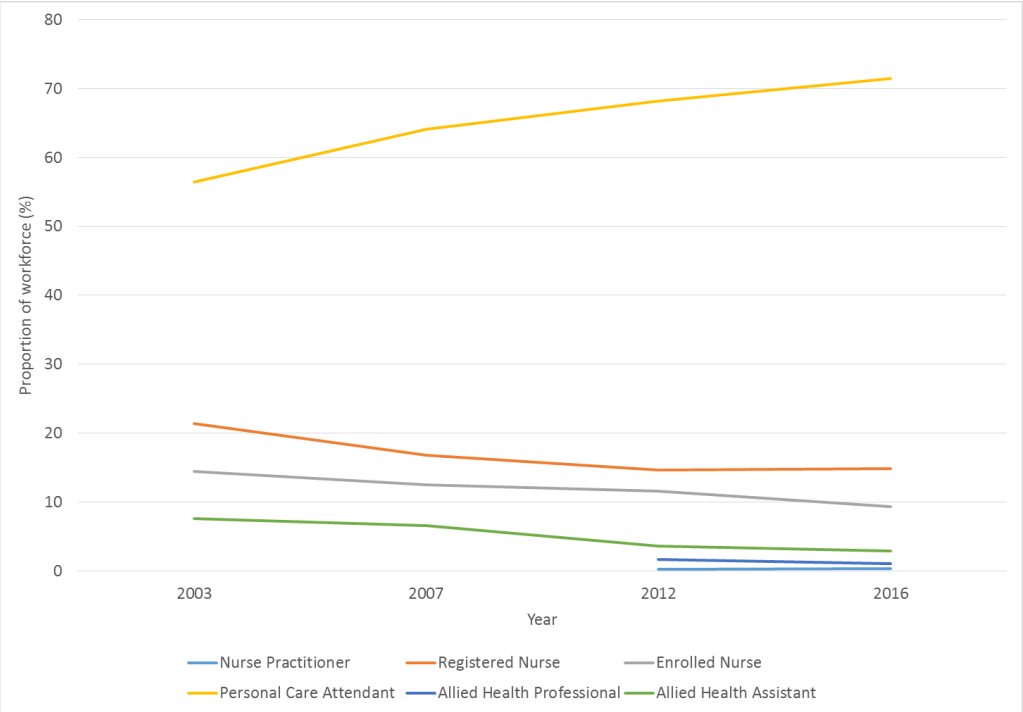

Figure 3: Graph of the proportion of Full Time Equivalent employee types in the residential aged care workforce generated by the AMA, using data source: Mavromaras et al (2016) The aged care workforce. Department of Health

The AMA has consistently called for a legislated minimum acceptable staff ratio for each RACF that is in line with the care needs of older people living in that RACF, and ensures appropriate, on-site, 24-hour RN availability. Ensuring a 'minimum' acceptable ratio provides a safety net for older people living in RACFs while still allowing for innovative models of care. Aligning the ratio with the needs of older people in each RACF recognises that the overall level of care need can change between RACFs. For example, a RACF with older people who have low levels of clinical care need would require less hours of care by a RN compared with a RACF with older people with high levels of clinical care need. Clinical care for older people does not always occur in-hours, and so it is important that RNs are available 24/7 to ensure medical attention is received in a timely manner.

There needs to be independent research and modelling into the most effective minimum staffing ratio, in consultation with all stakeholders. Currently, there is limited research into staffing ratios for RACFs in Australia. The AMA envisages an algorithm which allows an aged care provider to simply enter their residents' level of care need details in order to produce a rostering system that provides the appropriate number of staff and skills mix.

AMA notes that the Queensland Government recently introduced mandated staff ratios in 16 Government run RACFs, with a minimum requirement of 3.65 hours of direct contact time

between nurses and individual residents[42,43]. The AMA does not have full information on what formula/algorithm was used to determine the minimum hours and staffing ratios, but is in principle supportive of the Queensland Government's decision. The AMA acknowledges that adequate staffing ratios alone might not ensure quality in all aspects, but inadequate staffing certainly prevents it. The AMA believes that its advocacy for a minimum, adaptable, staff ratio has been misrepresented. The AMA does not support what has been termed a 'crude' or 'blunt' staff ratio and believes that these terms are not constructive to the issue at hand. The government and the aged care sector must recognise the significant influence staffing numbers and skills mix have on the quality and safety of aged care.

In addition to calling for a minimum staffing ratio, the AMA supported the principles behind the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018* in its submission[44] to the Bill's parliamentary inquiry.

Recommendation 13: Minimum mandatory staff-resident ratios should be researched and then introduced in RACFs that reflect the level of care need of older people and ensure 24 hour on site registered nurse availability.

Recommendation 14: The Aged Care Safety and Quality Commission should investigate staff turnover when assessing and auditing aged care providers.

Government workforce

Assessment workforce

AMA members report that non-medical ACAT/RAS assessment workers often have no health knowledge and that the skills mix in assessment teams vary widely. Some assessment teams are integrated with regional geriatric teams while some are separate. Geriatricians should be included in assessment teams and should form strong collaborative relationships with the older person's usual GP. In addition to the assessment team, the triage workforce should be trained with health knowledge so the appropriate assessment team can be identified.

Ultimately, members of the multidisciplinary team chosen for each assessment should align with the older person's medical and social history. It is imperative that the assessment team collaborate with the older person's usual GP. One AMA member had this to say about the current assessment processes, both ACAT and RAS:

> *Then came a change to local ACAT teams. It always seemed odd to me that a stranger would travel to the home by car and spend an hour with the patient and often family members to determine the information the GP already had at their fingertips. How did they manage patients with poor insight, confusion or complex*

[42] Queensland Government, The Queensland Cabinet and Ministerial Directory *Media Statement July 2019*
[43] ABC News, *Federal inquiry into Earle Haven announced as Premier moves to set nurse numbers in state care*
[44] Australian Medical Association (2018) *AMA submission to the Standing Committee on Health, Aged Care and Sport – Inquiry into the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018*

conditions? There were now delays as ACAT nurses dealt with the demand that GPs had previously managed. In general, we were able to work with the local ACAT nurses particularly when there was an urgent case, or to pre-empt difficult situations and provide them with background information. ACAT teams also developed relationships with local aged care facilities and were aware of where vacancies for respite or permanent care were. This was a very useful service for GPs and their patients, who would otherwise ring around many RACFs looking for suitable accommodation.

More recently aged care assessment has been centralised via My Aged Care and the Regional Assessment Service. There is no attempt to gather the information that GPs hold. Complete strangers now attend for the assessments, and there is a new category of workforce with lesser qualifications to do some of the assessments.

Recommendation 15: The effectiveness of the aged care assessment process should be improved by including the patient's usual doctor in the assessment arrangements.

My Aged Care workforce

The My Aged Care workforce must have a thorough knowledge of the aged care system and how the health system interacts with it. Distinguishing between these two systems can be confusing for older people and their carers. The My Aged Care workforce must be able to recognise when medical attention through the health system is required as opposed to through the more limited medical services under the aged care system.

Fragmentation between the health and aged care systems

The health and aged care systems are the responsibility of a range of jurisdictions. For example, hospitals and hospital services are state-funded, while aged care is funded by the Commonwealth. There is a lack of coordination when an older person needs to move between the two. This has created gaps in care and increases the complexity of the care for workers and the older person. It is not adequately recognised that the two systems interact with, and can influence, each other. Aged care services have an important role in preventing older people from being admitted to hospital. If an aged care service closes and other services cannot accommodate the additional demand, a hospital must meet the demand. Similarly, if a large RACF opens in an area, this increases demand for GP services (funded by Medicare). The health system is already running above capacity, and demand for GP services will only increase over time to service the ageing population. One AMA member provides an example of this:

One particular issue I find frustrating…is the establishment of Aged Care Facilities without ANY consideration of GPs attending. There seems to be a total lack of consultation and an assumption that the local GPs will just attend after the facility is built. We have recently had [a large RACF open]. We had NO contact with management prior to the opening of the facility and we get continued requests to take on new patients here who arrive from out of our catchment and have no

> *connection to our practice. We are already busy and have our own aged care patients in this and other facilities in the town. It appears that the attendance of medical staff (both in hours and out of hours) was not considered in the planning at all. The medical "staffing" of these facilities MUST be part of the planning process and be a long term process also. My feeling is that because the facilities don't have any financial commitment to attending GPs, they don't feel the need to address this issue as they do staff that are under their employment.*

In addition, AMA members report that there is a growing trend for RACFs to be built on the urban fringe of towns and cities with very little infrastructure surrounding them, including no or few pharmacies and medical practices. This creates a barrier to patients accessing pharmacy and medical services and further increases travel time for GPs to visit their patients in RACFs.

From the aged care setting to the hospital

Hospitals are not ideal settings for older people. There is a high risk of infection[45] and delirium, and they can be disorientating and stressful. Hospital transfers or out-patient hospital services can be disruptive and costly to aged care providers. For example, it takes time for RACF staff to accompany a resident to hospital to carry out an imaging service (although family members, friends and carers are often relied upon). Hospital transfers are costly to the government as well, because most patients will be in the public health system. In 2017-18, 22 per cent of Emergency Departments (EDs) presentations in Australia were from people aged 65 and over, despite this cohort making up only 15 per cent of the population at the time[46].

Despite hospitals being unsuitable environments for older people, there is a tendency for RACFs to transfer older people to hospital even if primary care services are more appropriate to resolve the issue[47]. In one Adelaide study, GP input occurred in only 30 per cent of RACF resident-to-hospital transfers[48]. Older people are being transferred to EDs for Potentially Avoidable GP Presentations (PAGP) such as some injuries, skin disorders, and urinary tract infections (UTIs)[49].

AMA members report there may be multiple factors that influence unnecessary hospital transfers. They might include:

- RACF staff do not have the appropriate medical knowledge to determine whether the older person requires primary or tertiary care.
- A RN is not available to determine the appropriate action.
- It is the RACF's policy to transfer older people to hospital no matter the health issue.

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[45] Australian Commission on Safety and Quality in Health Care (2018) *Healthcare- associated infections*
[46] Australian Institute of Health and Welfare (2018) *Emergency department care 2017-18 – Australian hospital statistics* Page 7
[47] Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?* Emergency Medicine Australasia. 27:5, Pages 412-418
[48] Leong, L and Crawford, G (2018) *Residential aged care residents and components of end of life care in an Australian hospital* BMC Palliative Care. 17:84
[49] Mazza, D. et al (2018) *Emergency department utilisation by older people in metropolitan Melbourne, 2008-12: findings for the Reducing Older Patient's Avoidable Presentations for Emergency Care Treatment (REDIRECT) study* Australian Health Review. 42:181-188

- It is sometimes difficult for the RACF to access a GP in the required timeframe.

Additionally, different states may have different regulation and guidelines as to what conditions need to be treated in hospitals. One AMA member provided an example:

> *In WA we have a Health Department standard that says every person in RACF who has a fall and has (or may have) hit their head and is on blood thinning agents (interpreted to include aspirin) must be sent to ED for assessment and a CT scan, regardless of clinical status. I know one RACF resident who was sent to ED 6 times in 6 weeks, against the wishes of care staff. The person is at advanced stages of dementia and hospital transfers only add further to their stress.*

Conversely, according to AMA members who practice in Queensland, there is no requirement to send falls patients to hospital, but are rather prioritised for GP's review at the next weekly visit.

From the hospital to the aged care setting

In June 2018, the reported average occupancy rate for residential aged care was 90.3 per cent[50] and some future funding for residential aged care places was transferred to home care packages because there were additional funds that were not required to meet perceived demand[51]. This data is not consistent with reports from our members which suggest that there are not enough residential aged care places to meet the needs of older people being discharged from hospitals. Further, 2016-17 hospital data shows that 11.4 per 1000 patient days are taken up by older patients waiting for an aged care place[52]. This discrepancy between reports at the coal-face and the government's perceived demand suggests that the systems used to determine supply of aged care places may require revisiting – or at least communication with the profession who feel an issue remains. There is limited public data available to determine supply and demand issues for aged care places[53], and the AMA supports further work in this space. Part of the issue may be where places are available, versus where the emerging population of need is. It may also be that there are not enough providers to take up the government funding. The AMA notes the Department of Health's impact analysis of alternative arrangements for allocating residential aged care places[54].

Communication

There needs to be better communication between the aged care provider, hospitals, and the older person's GP. Better communication results in better health outcomes for the older person

[50] Productivity Commission (2019) *Report on government services: Chapter 14: Aged care services* Page 14.6
[51] Grove, A (2018) *Aged Care Budget Review 2018-19 Index* Parliament of Australia
[52] Productivity Commission (2019) *Report on Government Services 2019* Chapter 14 Page 14.17
[53] Jukic, M and Temple, B (2018) *Recommended long term care settings following aged care assessments in Australia* PLoS ONE. 13:11: e0204342, Page 5
[54] Department of Health (2019) *Impact analysis of alternative arrangements for allocating residential aged care places*

and is more efficient for the multiple parties involved. AMA members highlight that on occasion they have not been contacted when their patient was transferred to hospital. Aged Care Quality Standard 3 – Personal Care and Clinical Care (July 2019) highlights that information should be communicated to all parties who share a responsibility for care[55]. This was not specified in the previous Accreditation Standards[56]. The AMA notes that the Aged Care Quality and Safety Commission developed clinical governance guidance documents for aged care providers. The AMA worked with the Commission to provide input into these guidance documents.

The AMA refers the Royal Commission to the AMA's position statement on *General Practice/Hospitals Transfer of Care Arrangements – 2018*[57]. This document outlines the necessary communication that is required for transfer of care arrangements between GPs and hospitals. These principles can also be applied to aged care settings.

The AMA has also developed *10 minimum standards for communication between health services and general practitioners and other treating doctors*[58]. Although these standards are principally concerned with health services, GPs and other medical professionals, the communication approach could also be used by residential aged care providers and be applied as an example of good practice.

Recommendation 16: Communication between doctors, hospitals and aged care providers must be improved through minimum standards and guidelines.

Demand for home care

Older people prefer to stay in their own home as they age[59]. This has a range of benefits. They are able to stay independent and in their own community, and it is significantly cheaper for themselves, their families, and the government, compared with RACF care.

However, the government has not invested enough into home care and this is resulting in serious safety issues. There are over 129,000 older people waiting for their approved home care package level[60]. The average waiting time for a level four home care package in 2017/18 was 22 months[61]. This means that older people and their families need to make interim arrangements, such as taking time off work to care for the older person or moving to a RACF or hospital. 16,000 people who requested packages in 2017-18 died waiting for a home care package[62].

[55] Aged Care Quality and Safety Commission (2019) *Guidance and resources: for providers to support the Aged Care Quality Standards* Page 41
[56] Australian Government (2014) *Quality of Care Principles 2014, Schedule 2- Accreditation Standards*
[57] Australian Medical Association (2018) *General Practice/Hospitals Transfer of Care Arrangements – 2018*
[58] Australian Medical Association (2017) *10 minimum standards for communication between health services and general practitioners and other treating doctors*
[59] Productivity Commission (2015) *Housing decisions of older Australians* Page 2
[60] Department of Health (2018) *Home care packages program – data report 3rd quarter 2018-19* Page 12
[61] Royal Commission into Aged Care Quality and Safety (2019) *Transcript of proceedings – 18 March 2019* Page 669
[62] Royal Commission into Aged Care Quality and Safety (2019) *Transcript of Proceedings–22 March 2019* Page 1098

AMA members shared their personal experiences and those of their family members waiting for home care packages:

> *My father died before his package was implemented, my wife's uncle is now in hospital (and likely to go to a RACF) largely because an HCP could not be implemented. My mother-in-law is living alone, frail and deteriorating having been waiting almost 2 years for a high-level HCP. I am waiting for the call about a fall and a hip fracture. This is all known, predictable and preventable. I can find three examples in my family alone of the effect that the waiting times have had on people assessed for* [HCPs].

Recommendation 17: Government must make more home care packages available to older people to address their care needs and to prevent the need for more complex care in RACFs and hospitals.

Aged care regulation

Aged care regulation to date has not adequately protected older people from quality and safety issues.

Aged Care Standards

As highlighted in Dr Bartone's witness statement[63], the AMA believes that any industry that is responsible for the care of another human being should be held to the highest standards. This includes the aged care system. While the new Aged Care Quality Standards (the Standards) that came into effect 1 July 2019 consist of important principles of respect, dignity, and engagement with older people, they are high level, subjective and potentially vague.

The AMA is concerned that the Standards will simply alter the administrative duties of aged care providers but not improve the actual care the older person receives. The additional administration requirements are perceived by AMA members as 'tick box' exercises that detract from the time aged care staff have to actually care for the older person.

In addition to regulating against bad quality care, the AMA believes the aged care culture and environment needs to change to incentivise good quality care. The AMA believes the Aged Care Quality Standards by themselves will achieve little without this.

The AMA also understands that the Standards are drafted on the basis that the older people will be more involved in the accreditation process. This assumes that older people have the health literacy to understand what good clinical care entails. For example, the average older person may not be able to determine best practice medication management or antimicrobial stewardship.

[63] Anthony Bartone (2019) *Amended Statement of Dr Antony Bartone: 18 February 2019*

In the three-year period ending in June 2018, the Clinical Care Standard (pre-1 July 2019) was the second most common outcome not met by aged care providers. The Medication Management Standard was the fourth most common outcome not met, followed by Behavioural Management as the fifth most common. Skin care was also a frequently unmet Standard (Figure 4).

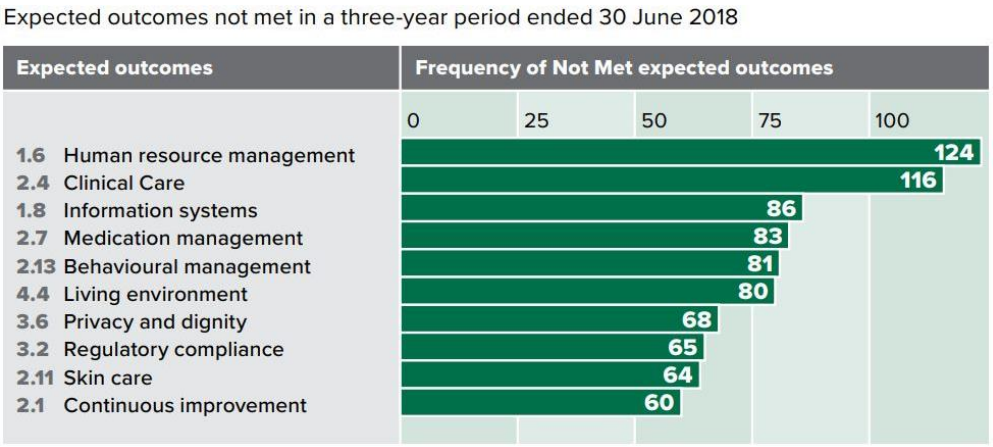

Figure 4: Standards frequently not met by residential aged care providers. Source: Australian Aged Care Quality Agency (2018) Annual Report 2017-18. Page 26

The most common complaints made about RACFs include medication management, fall prevention and management, and personnel/number ratio[64].

While the AMA hopes the new Standards will improve quality of care and consumer outcomes, some aspects do not meet older people's clinical care needs. Specifically, the previous Accreditation Standards for clinical care required that residential aged care providers refer older Australians to appropriate health specialists[65]. It also required that older Australians' nursing care needs be met by appropriately qualified nursing staff[66]. *Standard 3: Clinical Care* of the new Standards do not mention health specialists or nursing staff. They require "timely and appropriate referrals to individuals, other organisations and providers of other care and services"[67]. This is too broad and does not sufficiently address the need for nursing staff to be available in clinical care or for RACFs to work with health practitioners to optimise the level of care provided in the aged care setting. The AMA's position is that GPs can, and do, provide a substantial level of care in RACFs and increased GP engagement can improve outcomes for older people. Similarly, nurses form an integral part of any aged care workforce, especially where clinical care is delivered. More detail is available in the *staff-resident ratio* section.

A medical access Standard

The AMA has been advocating for a Medical Access Aged Care Quality Standard (see *support from aged care providers* section). The AMA believes aged care provider support to facilitate access to

[64] Aged Care Complaints Commissioner (2019) *Residential care sector performance – January to March 2019* Pages 9-10
[65] Aged Care Quality and Safety Commission *Accreditation Standards for Aged Care*
[66] Aged Care Quality and Safety Commission *Accreditation Standards for Aged Care*
[67] Department of Health and Ageing (2019) *Aged Care Quality Standards*

doctor services should be standardised. This would in turn ensure there are adequate minimum protocols, equipment, and facilities to incentivise medical practitioners to visit RACFs, and guide aged care providers to ensure older people receive the appropriate medical treatment they need.

The AMA understands that accessing medical care and health care professionals may be more difficult in residential aged care than it is for consumers accessing home care options. Older people who receive home care either through the Commonwealth Home Support Program (CHSP) or HCPs have different options for obtaining medical care and accessing health professionals, such as transportation services. In RACFs currently there are limits. As evidenced by one of the witnesses before the Royal Commission[68], older people often must rely on family members, friends and carers to provide transportation to access the health care professionals they need.

Recommendation 18: More specific Aged Care Quality Standards, including a Medical Access Standard should be developed for RACFs that helps to facilitate access to doctor services and high-quality clinical care.

National Quality Indicator Program

The National Quality Indicator Program was introduced as a voluntary program in 2016. Prior to 1 July 2019, participation in the Program was only 10 per cent[69]. As of 1 July 2019, all Commonwealth subsidised residential aged care homes were required to collect and provide clinical quality indicator data to the Department of Health. Commonwealth subsidised residential aged care services must collect and report on three clinical quality indicators: unplanned weight loss, use of physical restraints and pressure injuries.

AMA welcomes the mandated reporting on quality indicators by residential aged care providers. Key clinical data set reporting should be compulsory for all RACFs to improve performance monitoring and research[70]. Quality implementation programs both overseas and in Australia have resulted in significant quality improvements[71].

However, the AMA believes that there should be broader coordination between the Quality Indicator performance measurements and the Aged Care Quality Standards audits and accreditation. As it stands now, "quality indicator data will be consolidated and published on the Australian Institute of Health and Welfare GEN Aged Care data website… Providers of aged care will be able to compare their results with a national data set gained from the consistent approach to measuring quality outcomes"[72]. It is not clear whether data collected will also be used to monitor the compliance of aged care providers with the Aged Care Quality Standards. This should occur. The previous measurement of performance against the Accreditation Standards (replaced

[68] Aged Care Royal Commission (2019) *Transcript of Proceedings* 6.5.19R1 Page 1163
[69] Joseph Ibrahim (2019) *Royal Commission into Aged Care Quality and Safety: the key clinical issues* Australian Medical Journal 210 (10)
[70] Joseph Ibrahim (2019) *Royal Commission into Aged Care Quality and Safety: the key clinical issues* Australian Medical Journal 210 (10)
[71] Department of Health 2019 *About the National Aged Care Quality Indicator Program*
[72] Department of Health (2019) *About the National Aged Care Quality Indicator Program*

by the Aged Care Quality Standards) includes elements of clinical care and whether the provider complies with clinical care requirements. However, accreditation reports do not refer to Quality Indicator performance, or whether the provider collects the Quality Indicator data and, if so, how that data is used by the provider to improve or maintain their levels of performance. Quality Indicator data should be made an integral part of the accreditation/audit reports conducted by the Aged Care Quality and Safety Commission.

However, AMA members caution that publishing Quality Indicator data may drive perverse outcomes for older people. RACFs may reject patients with dementia or advanced disease that makes them at high risk of skin breakdown or weight loss out of fear that published data may reflect badly on the RACF. There must be safeguards to prevent this from occurring.

Recommendation 19: Quality Indicator data should be made an integral part of the accreditation/audit reports conducted by the Aged Care Quality and Safety Commission.

Aged care funding

AMA members are not directly exposed to aged care provider funding measures, as doctor services are funded by Medicare. However, AMA members do report that aged care staff have raised concerns about aged care funding. Concerns around funding for HCPs, and Medicare rebates, are described in other sections of this submission.

The AMA wrote a submission to the Department of Health on the *proposal for a new residential aged care funding model*[73]. The AMA acknowledged that this significant reform will need to be improved over time as unknown risks emerge. For this reason, the AMA regards the Australian National Aged Care Classification (AN-ACC) model as a positive first step to improving the funding of the aged care sector in order to improve the quality of care older people receive. The AMA cautioned that Cost per National Weighted Activity Unit (NWAU) prices must be adequate, sufficiently indexed, and adjusted for staff wages growth so quality care is not compromised by a lack of funding. The AMA urged the Department to consider the existing issues under the hospital NWAU system under the AN-ACC model context.

Quality of care in aged care settings

Palliative Care

The primary goal of palliative care is to optimise an individual's quality of life. Palliative care is person and family-centred care focussed on supporting those with a life-limiting or terminal illness to live their life as fully and comfortably as possible[74]. In addition, palliative care aims to assist the person's carers through practical and emotional support.

[73] Australian Medical Association (2019) *AMA submission to the Department of Health – Proposal for a new residential aged care funding model*

[74] Palliative Care Australia (2019) *What is palliative care?*

Comprehensive palliative care services that reflect an older person's needs and wishes must be readily available for any person and in any setting when required, especially in community settings and RACFs. This will enable older people to remain in their own home if they wish and reduce unnecessary hospital transfers and admissions.

However, currently palliative care services are significantly lacking, especially in outer regional and rural areas. Aged care providers are not well trained to support palliative and end of life care, or to support the development, implementation, and review of formally recorded advance care plans.

Doctors play a key role in planning around and provision of palliative care services. They are often the main conduit for people to start thinking about advance care planning and making their wishes formally recorded. Doctors must be supported by aged care providers, and the government, to provide services to older people living in RACFs.

In 2017-18, more than 80 per cent of exits from permanent residential aged care were due to death[75]. Palliative and end of life care must be built into every aged care model, by defining the skills and staff requirements and recognising that palliative and end of life care is a basic RACF service. The funding model must be flexible enough to account for increased needs at the end of life and be responsive enough to allow for reassessment when required.

Recommendation 20: Palliative care must be built into any aged care model, by defining the skills and staff requirements and recognising that palliative management is a basic RACF service. The funding model must be flexible enough to account for increased needs at the end of life and be responsive enough to allow for reassessment when required.

Advance care plans

Advance care planning is a process of stating health care preferences, including goals of care and preferred health outcomes, to help guide those who make decisions on an older person's behalf should the older person lose decision-making capacity in the future.

Advance care planning benefits not only the older person but plays an important role in supporting family members and other substitute decision-makers to act in accordance with the older person's wishes. The plans also support the healthcare and aged care teams by informing the development of a clinical care plan, where doctors can set out specific treatment directions based on a person's healthcare preferences and goals of care.

One AMA member noted:

> *Over the years I became aware how important it was for the patient in aged care to have an advocate acting for them. This is often a family member. This is a much safer situation. People in aged care are vulnerable and there needs to be someone*

[75] Australian Institute of Health and Welfare (2018) *GEN aged care data: People leaving aged care*

> *who is their advocate for that person's wellbeing, or someone appointed to be their advocate. It's just a much safer way to go.*

As part of advance care planning, older people should be encouraged to appoint a substitute decision maker (SDM) who will be authorised to make health care decisions on their behalf should they lose decision-making capacity in the future. It is essential, however, to recognise that decision-making capacity may fluctuate over time. Older people should be encouraged to participate in treatment decisions consistent with their level of capacity at the time a decision needs to be made. Some will have sufficient capacity to make a supported decision - where the individual makes the decision themselves with the assistance of a support person - while others with insufficient capacity will require a substitute decision from their authorised SDM.

Advance care planning is a process that may or may not involve multiple conversations with the older person and should lead to the development of an Advance Care Directive (ACD). An ACD is defined as "a legal document that allows a person to make their future healthcare preferences known if they were to lose their capacity to make decisions. It will only operate when a person no longer has decision-making capacity"[76]. For older people with declining cognitive abilities having an ACD in place as early as possible is advised.

In spite of the potential benefits that advance care planning can bring, there is little awareness from RACF staff on the importance of developing, carrying out or respecting ACDs. One AMA member provides an example:

> *Patient with Advance Care Directive (ACD) "not for hospital transfer", was transferred to hospital via ambulance when patient had an episode of altered consciousness. Patient was transferred back to the facility via ambulance a few hours later with no new management. Facility staff explained that Agency staff were not aware of the patient's ACD.*

Another AMA member shared their experience:

> *I have seen examples where RACFs provide their residents with Advance Care Directive templates with clauses that make the older person's wishes ultimately meaningless. For example, not to be transferred to hospital "except when you need care that can't be provided at the RACF". This means transfer can be arranged at RACF discretion regardless of resident or family wishes.*

Advance care planning should form an integral part of person-centred care in aged care. With the introduction of the Aged Care Quality Standards and clinical governance frameworks in RACFs, implementing and respecting ACDs should form an integral part of any clinical governance in aged care. A clinical care plan developed by the 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

[76] Palliative Care Australia (2017) *Advance care planning*.

or RACF. When the patient has an existing ACD, this should inform the development of the clinical care plan.

The AMA recognises that ACDs can be complex legal documents and that aged care providers might find it too cumbersome to engage in the advance care planning process. One example of good practice is currently being rolled out in Queensland. Queensland Health developed a shorter simplified document titled "Statement of Choices". Form A is for people who can make their own health care decisions. Form B is for people who cannot make their own health care decisions or who require support with decision-making[77]. These Statements of Choice are being uploaded to the My Health Record.

AMA members support mandating the requirement that all RACFs residents should have a current up to date ACD. AMA members also contend that there should be an MBS item/fee available for GPs to complete ACDs with their patients living in RACFs or their SDMs.

Therefore, AMA suggests that further work is needed to raise awareness among aged care providers on: the importance of advance care planning; the role of aged care providers in ensuring the development and implementation of advance care plans; the need for aged care staff to be aware of the existence of ACDs; the inclusion of ACDs in the older person's My Health Record; and the role of ACDs in clinical care.

Recommendation 21: AMA members support mandating the requirement that all RACFs residents should have a current up to date ACD. AMA members also contend that there should be an MBS item/fee available for GPs to complete ACDs with their patients living in RACFs or their SDMs.

Recommendation 22: Further work is needed to raise awareness among aged care service providers on advance care planning, the role of aged care providers in ensuring the development and implementation of advance care plans, directives and communication around hospital transfers and the person's usual GP, the need for caring staff to be aware of existence of ACDs, My Health Record and advance care planning, as well as the role of ACDs in clinical care.

Mental Health

Currently, the rates of anxiety and depression of people over the age of 65 are not known, but is estimated to be between 10 and 15 per cent [78]. In 2018, 49 per cent of RACF permanent residents had depression[79]. Factors that can increase a person's risk of developing depression include deterioration in physical health, loss of independence and relationships, social isolation and loneliness and change in living arrangements (such as moving to a care setting and admission to hospital). As one AMA member put it:

[77] Queensland Health (2019) *My Care My Choices Advanced Care Planning*
[78] Australian Institute of Health and Welfare (2015) *Australia's welfare 2015 – 6.4 Mental health of older Australians* Page 2
[79] Australian Institute for Health and Welfare (2018) Reports and Data, *Health and Welfare Services: Aged Care*

> *RACFs are unattractive for patients: they often [feel] they are locked away in gaol, away from their home and independence. Places can be sad with uninterested, too busy staff. More community focused, regular outings, and access to gardens, and more activities, with interested staff would help.*

AMA members report that boredom can be a common cause of mental health distress for older people living in RACFs. Boredom can result in frustration and anger[80]. Aggravated by changed living circumstances, unmet need can lead to further negative outcomes for older people. Older people may become bored, sad, stressed, cranky, anxious, depressed, agitated, angry and violent[81]. Hopelessness and isolation are more common in older people, particularly those living in RACFs, and can lead to suicidal thoughts[82]. Mental and physical health are linked to each other. For example, chronic physical conditions are a risk factor for poor mental health, and vice versa[83].

It is difficult for older people to access the same level of mental health care as their younger counterparts. Mental health care must be enhanced and supported in community and aged care settings to prevent hospital admissions and re-admissions.

Under the *Better Access to Mental Health Care* initiative, patients can claim MBS rebates for mental health services provided by, or through, a GP[84]. They include GP Mental Health Treatment Plans, 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"[85]. Older people living in RACFs are generally not eligible for this initiative and therefore do not receive MBS rebates for some *Better Access to Mental Health Care* items[86,87]. Older people deserve to have the same access to mental health services as other Australians.

The AMA welcomes the Government initiative announced in 2018-19 budget to invest in mental health services for people living in RACFs[88]. However, AMA believes that this initiative would bring greater benefits to older people if GPs were involved along with psychiatrists, psycho-geriatricians, and allied health professionals. Depression in older people, particularly when coupled with dementia, can be difficult to treat and therefore requires a high level of expertise and monitoring[89]. AMA believes that additional funding should go towards expansion of the *Better Access to Mental Health Initiative* and to ensure equitable access to mental health services.

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[80] Dementia Australia (2007) *Quality Dementia Care: Practice in Residential Aged Care Facilities* Page 24
[81] Lee-Fay Low (2018) The Conversation. *How our residential aged care system doesn't care about older people's emotional needs*
[82] American Psychological Association *Ageing and Depression*
[83] Canadian Mental Health Association *Connection Between Mental and Physical Health*
[84] Department of Health (2017) *Better access to mental health care: fact sheet for patients*
[85] Department of Health (2019) *Medicare Benefits Schedule From 1 August 2019* Page 107
[86] Department of Health (2019) Medicare Benefits Schedule – *Note AN.0.56*
[87] Department of Health (2019) Medicare Benefits Schedule – *Note MN 6.2*
[88] Department of Health (2018) *Better Ageing – mental health support for older Australians*
[89] Curran, E and Loi, S (2013) *Depression and dementia* Med J Aust. doi: 10.5694/mja12.10567

Recommendation 23: Expand the Better Access to Mental Health Initiative to ensure older people living in RACFs receive the same access to mental health services as the rest of the population.

Dementia

Dementia is a leading cause of death among Australian women and remains the second leading cause of death across all Australians[90]. Dementia is diagnosed in just over half of permanent residential aged care residents[91]. Furthermore, according to the AIHW report from 2014, people admitted to hospital from residential care (either respite or permanent) were six times more likely than other older people admitted to have dementia recorded as a diagnosis[92]. Additionally, in the 2016-17 reporting period, 71 per cent of dementia hospitalisations were diagnosed to be of 'highest clinical complexity', in contrast to only 16 per cent of hospitalisations where patients did not have a dementia diagnosis[93].

With the numbers of dementia patients expected to increase in the coming years, dementia care should be part of the mainstream care provided in RACFs. Appropriate training in dementia management and reducing responsive behaviours for all aged care staff will therefore be crucial. This may contribute to the reduction of chemical and physical restraint use in aged care. Another important aspect of dementia care will be appropriate environmental design suited to the needs of dementia patients.

One AMA member noted:

> *I grew weary of being involved in handling patients with dementia and aggressive patients. This can be quite spontaneous at times. It was difficult with nursing staff from overseas who are coming from different cultures and who found it hard to deal with aggressive Australians living with dementia. I think that [this gap] needs to be developed with education as it can be demanding and make doctors back away.*

International research supports observations by AMA members. A known successful intervention for minimising the use of antipsychotics in RACFs was the UK Focussed Intervention Training and Support (FITS) program. This program included comprehensive education of aged care staff about psychosocial approaches to care for people with dementia[94]. In this study, an in depth 10-day education course in person-centred care was delivered to care-home staff designated as Dementia Care Coaches (DCCs) responsible for implementing interventions. Intervention results

[90] AIHW (2018) Deaths in Australia report *Leading Causes of Death*
[91] AIHW (2019) GEN Aged Care Data: *People's care needs in aged care, web report*
[92] AIHW (2014) Australia's health series no. 14 Page 2
[93] AIHW (2019) *Hospital care for people with dementia 2016–17*. Cat. no. AGE 94
[94] Brooker D, Latham I, Evans S, et al.(2016) *FITS into practice: translating research into practice in reducing the use of anti-psychotic medication for people with dementia living in care homes* Ageing Mental Health 2016; 20: 709-718

demonstrated increased staff knowledge and confidence, improved attitudes to dementia, with a 31% reduction in prescription and use of antipsychotic medication.

AMA members wish to draw the Commission's attention to an initiative by the Australian Federal Government introduced in 2004. Aged Care GP Panels[95] allowed GPs to work with RACFs to create strategies to improve quality and increase access to primary medical care for RACF residents. Part of this program entailed training in psychosocial behavioural management interventions and recognition of nurses' upskilling in that field. AMA members contend that this initiative demonstrated reduced use of chemical and physical restraints but was abolished just as measurable outcomes were starting to become visible[96].

Recommendation 24: ***Improve dementia management and behavioural training for nursing and personal care staff attendants to reduce prescription of antipsychotic medication.***

Medication management

Medication management is an integral part of clinical care provided to patients. Medication management entails: selection, order and supply of medication; how use of medicines is recorded and reviewed; how medicines are stored and disposed of safely; and how the use of medicines is monitored and evaluated. Medication management in aged care should be implemented by health practitioners, in both residential and home care settings. The AMA upholds that doctors must maintain clinical independence in order to make the best treatment recommendations for patients, based on current evidence. It is vital that the medical profession remains independent to make their own clinical judgments regarding treatment recommendations.

The AMA is concerned by the increasing number of reports received from our members where medication management in RACFs is not being implemented by nursing staff but rather transferred to personal care attendants (PCAs). An AMA member reported:

> *Increasing number of facilities using medication trained PCAs rather than RNs for medication administration.*

PCAs are not equipped to provide clinical health care. As noted previously, the Aged Care Workforce Strategy Taskforce identified significant health-specific training gaps including medication management. Further, PCAs are not regulated by any regulatory body.

Another problem is the lack of available qualified nursing staff to appropriately administer medication and monitor older people. An AMA member remarked:

> *Elderly patients in various homes suffer from the short comings of the funding model lack of staff, not enough Div 1 nurses to provide proper care for patients who have hospital level medical problems but only carers to look after them. As an example, an 80 plus year old type 1 diabetic with a cva* [cerebrovascular accident]

[95] Department of Health (2007) *Aged Care GP Panels Initiative*
[96] Department of Health (2006) Aged Care GP Panels Initiative *2006 Aged Care Homes Survey*

> *on peg feeds who either hypos or hypers every 3 or 4 days and winds up in hospital because one div one nurse is expected to care for 60 plus sick elderly patients.* [The patient] *requires individual attention many times a day and night and how does the nurse choose between him and the other 59 patients.*

This example further demonstrates the need for staff to resident ratios in RACFs.

Currently, prescription of antipsychotics is a common treatment for behavioural and psychological symptoms of dementia. A multi-pronged interdisciplinary study demonstrated that 39 per cent of RACF residents prescribed antipsychotics and benzodiazepines successfully had these medications ceased or doses reduced[97]. Medication reviews are important safety mechanisms to reduce the use of unnecessary medications. They are available to older people living in RACFs (Residential Medication Management Reviews, RMMRs) and to patients in their home (Home Medicines Reviews, HMRs). However, there are restrictions via MBS and pharmacist funding (through the Sixth Community Pharmacy Agreement (6CPA)) that create barriers to access. The RMMR/HMR MBS rebates are only payable to GPs once in a 12 month period, unless there is a significant change in the older person's medication, or medical condition[98]. Under the 6CPA, a pharmacist can only conduct one RMMR service every two years per person (unless the GP has decided there is a significant change in their medication, or medical condition)[99]. Moreover, pharmacists can only be remunerated for up to 20 HMRs per month[100]. The clinical indicators listed as reasons to conduct more than one RMMR/HMR are too restrictive and act more as reactive than preventative measures, which means they are not as effective as they could be.

The Department of Health's MBS Review into GP rebates has proposed a reduced rebate for medication reviews. The AMA does not support a reduction into any medication management review items for GPs. These items support proactive care, better medication management, and reduce potentially avoidable hospitalisations by reducing the risk of an adverse drug event.

The AMA believes that medication reviews should occur annually, and then on an as-needed basis to ensure medications are appropriate for older people. Pharmacists who work with doctors have an important role in: assisting with medication adherence; improving medication management; and providing education about medication safety.

Recommendation 25: Doctors must be able to maintain clinical independence in order to make the best treatment recommendations for patients, based on current evidence, preserving their own clinical judgments regarding treatment recommendations.

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[97] Westbury et al (2018) *RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities* Medical Journal of Australia MJA 20B (9)
[98] Department of Health (2018) *MBS Online: Medicare Benefits Schedule – Note AN.0.52*
[99] Pharmacy Programs Administrator (2018*) Residential Medication Management Review and Quality Use of Medicines – Program FAQ*
[100] Pharmacy Programs Administrator (2018) *Home Medicines Review – Claiming and payments*

Recommendation 26: Medication reviews should occur annually, and when there is a significant change in an older person's medication and/or medical condition.

Recommendation 27: A National strategy on polypharmacy should be developed, along with evidence-based guidelines for prescribing to the elderly. Having a strategy and guidelines may reduce adverse events, hospitalisation and PBS costs.

Nutrition

Strategies to prevent deterioration in health, such as exercise programs and adequate nutritious meals and hydration are important to overall wellbeing of older people. Poor nutrition can lead to a number of health issues, including a decrease in immunity and physical and mental health[101].

Energy needs decline as people age and, for some individuals, this is accompanied by a decreased appetite. A transition in living circumstances and income may also contribute to a decline in eating habits. However, there is an increased protein requirement in older people. Poor nutrition can contribute to many health conditions and the worsening of pre-existing conditions. Inappropriate nutrition can also adversely impact the effectiveness of certain medications. In order to maximise functional capacity in older people, ensuring appropriate nutrition is vital[102].

Food is also an important cultural aspect of a person's life and can be a means of retaining one's cultural identity. Access to traditional food and food preparation can be particularly important for older people and people living with dementia. Traditional food can increase dementia patients' appetite, sense of wellbeing, and joy[103].

Despite the importance of palatable, good quality, diverse and nutritionally balanced food in the wider community, approximately one in two residents are malnourished[104]. While this may be partially due to underlying medical conditions, there are concerns that food delivered by aged care providers are not meeting older people's nutritional requirements. One study revealed that RACFs spend on average $6.08 per resident per day on raw food ingredients[105]. Further, Australian studies have found insufficient serves of dairy, vegetables, grain foods, micronutrients, and high consumption of saturated fat, sodium and sugar by older people in RACFs [106,107]. This indicates there is a lack of focus on good quality food.

[101] World Health Organization (2019) Health Topics, *Nutrition*
[102] Australian Medical Association (2018) *Nutrition*
[103] Hanssen, I. and Kuven, B. M. (2016), *Moments of joy and delight: the meaning of traditional food in dementia care* J Clin Nurs, 25: 866-874. doi:10.1111/jocn.13163
[104] Hugo, C et al (2018) *What does it cost to feed aged care residents in Australia?* Nutrition and Dietetics 75: 6-10
[105] Hugo, C et al (2018) *What does it cost to feed aged care residents in Australia?* Nutrition and Dietetics 75: 6-10
[106] Woods, J et al (20019) *Malnutrition on the menu: nutritional status of institutionalised elderly Australians in low-level care* The Journal of Nutrition, Health and Ageing 13:8
[107] Iuliano, S et al (2013) *Meeting the nutritional needs of elderly residents in aged care: are we doing enough?* The Journal of Nutrition, Health and Ageing 17:6

AMA members consider that unplanned weight gain and obesity as a result of high fat, high energy food with limited amounts of protein deserves equal recognition to unplanned weight loss in the Standards.

To ensure people living in RACFs receive appropriate nutrition, the AMA supports the development and implementation of national nutrition standards for these facilities. However, varied and palatable food must also be considered in the Standard.

Recommendation 28: Develop and implement national nutrition standards for aged care facilities, ensuring menus are varied and food is appealing and palatable.

Falls prevention

The estimated age-standardised rate of fall injury cases occurring in RACFs for people aged 65 and over in 2014–15 was 10,090 cases per 100,000 population This is five times the rate of falls in the home involving people aged 65 and over (1,814 cases per 100,000 population)[108]. Significantly higher rates per year of fall-related injuries were experienced in RACFs compared to falls in a person's home. Both locations saw rates increase over the study period. The analysis suggests that higher rates of fall-related injuries in RACFs could be due to higher levels of frailty in this population relative to the people of the same age who remain at home. However, the findings also indicate the need for interventions to be implemented in the aged care setting to tackle this growing problem.

AMA members who attend RACFs report that continuous cuts to staffing numbers lead to increases in falls among residents, and that interventions where staff numbers have been increased lead to reductions in falls. Anecdotally, the AMA has received reports of RACFs where increased falls are registered at specific times of day, when staffing numbers are lower.

The AMA maintains that no matter the location, there should be an appropriate level of well-trained staff to deliver quality personal and health care services to cater for older peoples' physical, functional and psychosocial needs. Also, aged care settings need to be designed and adapted to the needs of their elderly residents. Adequate exercise programs, and access to physiotherapists, should be implemented to maintain older people's functional ability. As previously mentioned, annual RMMRs should be carried out to reduce the risk of falls as a side effect of medication.

Abuse and neglect

Elder abuse includes psychological or emotional abuse, financial abuse, physical abuse, neglect and sexual abuse.

[108] AIHW: Pointer S (2018) *Trends in hospitalised injury due to falls in older people* 2002–03 to 2014–15. Injury research and statistics series no. 111. Cat. no. INJCAT 191

It is estimated that about four to six per cent of older Australians (generally considered 65 and over) experience elder abuse. As Australia's population ages, this form of family and domestic violence is likely to increase[109].

The medical profession has a key role to play in early detection, intervention and provision of specialised treatment to those who suffer the consequences of family and domestic violence, whether it be physical, sexual or emotional. Continuing education of the profession is essential to emphasise the extent of family and domestic violence and the medical and psychiatric consequences for the victims. Doctors also have a role in community-wide efforts to advocate and strengthen resources for victims and perpetrators, and to encourage preventive education programs through the media and community organisations.

Abuse and neglect also happen in aged care settings and it is therefore crucial that all preventative measures and protocols are put in place. The role of aged care service providers in abuse and neglect of older people can be two-fold. On one end, providers of CHSP and HCP services can be the first line of defence in identifying and responding to elder abuse in the home care setting. On the other end, they can be perpetrators of abuse and neglect of older people accessing their services, or they do little or nothing to prevent abuse by family members from happening. AMA members report situations where older people are victims of financial abuse perpetrated by family members and have not been protected by aged care service providers despite being alerted to the issue.

The AMA supports the recommendations by the *Elder Abuse – A National Legal Response*[110] proposed in 2017.

AMA members have also highlighted that neglect of older people has occurred due to insufficient staff:

> *Pain management cannot be done properly with insufficient staff. I also feel the rules around narcotics are pitched at preventing abuse by staff but instead cause the abuse of patients who can't get adequate analgesia. Palliative care patients often bear the brunt of this.*

Finally, we have seen from the Oakden case study presented before the Royal Commission[111], that abuse and neglect of older persons in RACFs can be systemic and implemented at the management level. The role of whistle-blowers in such cases then becomes crucial. It is important that relevant safeguards are put in place for the protection of whistle-blowers as well as regulation for urgent mandatory investigations where concerns have been raised. Whistle-blowers can often be employees of RACFs who have little or no awareness of protections available to them, who may be of lower socio-economic background, and prevented from speaking because of fear of losing their job. Noting the workforce can be from a range of different cultural backgrounds, with potentially low English language proficiency, and often limited by the type of

[109] Seniors Rights Victoria (2016) *Online Elder Abuse Toolkit*
[110] Australian Law Reform Commission (2017) *Elder Abuse – A National Legal Response Final Report*
[111] Royal Commission into Aged Care Quality and Safety (2019) *Transcript of Proceedings* 11.2.19R2

visa that allows them to work in Australia, the fear of speaking up can be significant. Putting in place relevant legislated safeguards for them may help lead to earlier identification of concerns and ultimately to the improvement of services provided to older people in aged care.

Recommendation 29: Continuing education on elder abuse and neglect of the profession, including doctors, nursing aged care staff and personal care staff is essential to evaluate and mitigate medical and psychiatric consequences for the victims.

Recommendation 30: Introduce relevant safeguards for whistle-blowers in aged care, along with regulation for urgent mandatory investigations into their revelations.

Choice in services

Most older people prefer to live in their own homes as they age. This allows them to remain independent within their functional capacity and make decisions that affect their life. This should be their choice wherever feasible, and support provided.

Older people, including those living in RACFs, want a greater say in their care. They perceive their decision-making, choice and control relating to the physical and social environments as important factors in their lives[112].

Older people should have the choice of their preferred doctor. A usual GP not only knows the needs of their patient best but can also serve as an advocate for their needs and improvement of their care.

The market-based processes involved in accessing aged care support and managing services makes it difficult for vulnerable older people to receive the care they want. Any market system is predicated on having an informed consumer capable of understanding the choices available.

Having choice and control and empowered decision making means that older people are able to access all the information they need on aged care service providers. This primarily relates to the quality of care they can provide (staff availability, staff turnover, availability of doctors in RACFs, training of staff, service fees, specialist services, etc). Currently, most of this information is difficult to obtain from providers. Government must collect and publish data on the quality of aged care.

The current aged care system is still too complicated to allow for full utilisation of available choices, particularly for special needs groups. Once the older person has registered with My Aged Care and received an assessment, the wait times are too long to provide them with immediate access to care they need. This is not conducive to enabling choice and control. After that, they have to know where to go for information. The majority of older people are not internet savvy, so making information available online is not conducive to their needs. Of older people using the

[112] E. Kalaitzidis, A. Harrington (2018) *Resident decision-making in the context of residential aged care* Collegian 25 (2018) 509–515

internet, only 15 per cent accessed online government services, health and medical information[113]. Additionally, doctors often find it difficult to assist their older patients with access to aged care services. As commented by an AMA member:

> *There is now no centralised information regarding RACFs with vacancies. The delays often result in deteriorating patients defaulting into hospital. Another complication is that if a patient has a stay in hospital and then wants to have a trial at home, then there is a policy that assessment must occur at home. (I had a case last year where this happened. The trial at home quickly failed and because there was no assessment in place the patient again defaulted back to hospital. Even though we had identified an available Aged Care place, there were further delays waiting for the assessment.).*

One of the key areas of choice is to have a consistent carer, and to determine when services are delivered. The same is applicable to residential aged care. Having long term staff, particularly nursing staff, who know the residents and engage with them on a regular basis can help identify deterioration early on and support implementation of relevant measures to stop and prevent further deterioration.

Recommendation 31: Older people should maintain the choice of their preferred medical practitioner in residential care.

Recommendation 32: Simplify the aged care navigation process and ensure access to more information on aged care provider performance against the Aged Care Quality Standards.

The use of restrictive practices

The AMA is concerned about the inappropriate use of chemical and physical restraints in aged care settings. The AMA has previously advised the Department of Health and parliamentary inquiries that AMA members have heard reports of aged care staff requesting chemical restraints so older people are easier to handle[114,115]. However, the extent to which restraints are used in aged care settings is currently not well-documented[116].

The AMA's position[117] on the use of restrictive practices is that they should always be used as a last resort – where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. The older person's doctor, along with the aged care provider, the older person's family and SDM should be involved in the decision to use a restraint. However,

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[113] Australian Communications and Media Authority (2016) *Digital Lives of Older Australians* Research Snapshots. ACMA

[114] Australian Medical Association (2018) *AMA submission to the aged care workforce strategy taskforce – the aged care workforce strategy*

[115] Australian Medical Association (2018) AMA submission – *Inquiry into the quality of care in residential aged care facilities in Australia*

[116] Royal Commission into Aged Care Quality and Safety (2019) *Restrictive practices in residential aged care in Australia* Page 11

[117] Australian Medical Association (2015) *Restraint in the care of people in residential aged care facilities*

it is ultimately the responsibility of the doctor to restrain the older person. The decision should always be made on a case-by-case basis and needs to find a balance between the need to ensure the older person's safety, and those around them, while respecting their right to dignity and self-determination, including via previously expressed or known values or wishes (if they have lost decision-making capacity).

The Royal Commission has heard several examples of antipsychotics being used as a chemical restraint and used inappropriately. The AMA agrees that inappropriate use is concerning. However, it is important to note that the intended purpose of an antipsychotic is to reduce the distressing symptoms and the specific treatment of medical conditions such as delirium, anxiety, depression, psychosis, and behavioural and psychological symptoms of dementia. The aim of antipsychotics is not always to restrain.

One member provides their experience:

> *I have read a lot about how bad it is that GPs prescribe antipsychotic medications. I would just like to comment that there is a place for them and misunderstanding among the public of their role.*
>
> *What one tends to read suggests that the sole reason for prescribing antipsychotics is to sedate elderly nursing home residents to prevent them being a nuisance. This is not true. In some cases, elderly patients with dementia have distressing psychotic symptoms such as paranoid delusions and hallucinations similar to schizophrenics. Antipsychotic medication can remove these distressing symptoms and make the patient feel a lot calmer and more comfortable and be better able to relate to family and others.*
>
> *The mainstay of treatment of behavioural disturbances in dementia will always be behavioural management. However, apart from the above comments, often in nursing homes there is not a sufficiently high ratio of nursing staff to patients, for the agitated, psychotic and often aggressive (to staff and other residents) patients to have one on one care 24/7, which is what it would need to manage their behaviour without any chemical means.*
>
> *GPs should not be demonised for occasionally using medications such as risperidone in nursing home patients with challenging behaviours. Yes, we do look for underlying reversible causes such as UTIs, RTIs, untreated pain, urinary retention etc and we do review the use of antipsychotics and cease them as soon as possible, but it is not always bad practice to prescribe them, nor is it practical to refuse to do so.*

The AMA has been working with the Department of Health on methods to minimise the use of restraints in RACFs. The AMA is supportive of the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2014*. However, more work needs to be done. This submission has already outlined some of the actions required to minimise the inappropriate use of restraints, notwithstanding the following

- Train aged care staff to understand the ethical, medical, and legal issues and responsibilities when using restraints, and to contact the older person's usual doctor to determine whether there are underlying causes of their distress.
- Ensure the aged care environment is welcoming, both physically and socially. Sometimes this may mean just some simple changes to the living environment such as introducing coloured toilet seats in bathrooms, which are more conducive to dementia patients' continence control[118].
- Encourage the older person, their family or SDM to develop an advanced care plan.
- Review medication regularly.
- As part of a mandatory minimum staff ratio, ensure there are adequate numbers of registered nurses available on site, 24/7 to monitor the older person and to manage their medication safely.

The AMA looks forward to continuing to work with government to further minimise the inappropriate use of restraints.

The use of technology in aged care

My Aged Care

My Aged Care fails to recognise the caring role of the older person's usual GP. AMA members have reported that My Aged Care is difficult to use and delays access to much needed care. My Aged Care staff have been inefficient and have not sufficiently consulted with the older person's referring doctor. One AMA member noted:

> [The] *web-based referral process doesn't work well enough for doctors and consumers, as it has no links to clinical software. It is almost impossible at the moment to make a good referral via this process and even when we do attach clinical documents, they are routinely not forwarded to the assessment or treating team. This is despite now taking at least twice as long as previously to make a referral. The old system of referral to a local ACAT team or other care service where everyone knew each other and communicated was far superior and quicker.*

The AMA supports the Health Professional Referrals Project to integrate the My Aged Care referral form into GP clinical software. At the time of writing, the AMA has not been informed of when this project will be implemented. Moreover, the project in its current form does not incorporate a feedback loop to update GPs on their patient's progress through the assessment stages, or when they begin receiving the services. All doctors can follow up on their patient's assessment progress by calling My Aged Care, but this is inefficient.

Doctors need to know whether their older patient is receiving the services they have been referred to in a timely manner. Some older people, such as those with cognitive impairments, require a doctor or other person to request services on their behalf because they cannot do it

[118] Dementia Australia (2013) *Overcoming Perception Difficulties*

themselves. Without a feedback loop to the doctor or other referrer, there is a risk that the older person will not be receiving the services they need. With a feedback loop, doctors can act if a delay puts the older person's health at risk. The AMA calls for feedback loop capability within clinical software programs, in addition to the referral form being integrated within clinical software programs. This will reduce the administrative burden placed on GP practices and reduce the risk of harm if older people are not receiving the services they have been referred to. Currently, for example, the dashboard that displays the position in the queue of a patient that has been assessed for a home care package is not available to GPs. An AMA member commented:

> *The current system causes arguments between agencies about responsibilities and process. It took endless paperwork and over 6 weeks to arrange someone to rub cream onto a patient's back with skin condition, whereas previously … treatment would have started within 48 hours. The system is in effect denying care – care delayed is care denied.*

The system should ensure that for an older person that requires a high level of care, their management is optimised before a decision is made on the level of care they require. The current system does not connect management of their condition and assessing their care needs, even though these two are inextricably linked.

The Department of Health is currently reviewing the aged care assessment process and the AMA provided a submission[119] to the inquiry into streamlined consumer assessment for aged care.

Older people are experiencing long waiting times for ACAT and RAS assessments. This may create significant risk to their health and increase avoidable cost hospital transfers. Respondents to the AMA 2017 Aged Care Survey reported that the highest average wait times for an initial ACAT assessment for their patients was one to three months[120]. There are also reports of older people waiting up to 12 months for an ACAT assessment[121]. This is in addition to the waiting times that older people experience obtaining an HCP and a residential aged care place. The current aged care assessment process is not efficient, nor responsive to the needs of older people.

The AMA's position on the assessment workforce is available under the *aged care workforce* section of this submission.

Recommendation 33: Greater transparency for GPs and patients to be able view the progress of aged care assessments. This will provide GPs with confidence that their patients are being provided with the necessary care in a reasonable timeframe, as well as enable GPs to take action if this is not occurring.

[119] Australian Medical Association (2019) *AMA submission to the Department of Health – Streamlined Consumer Assessment for Aged Care*
[120] Australian Medical Association (2017) *2017 AMA Aged Care Survey* Page 24
[121] Department of Health (2017) *Legislated Review of Aged Care 2017* Page 139

My Health Record

My Aged Care and aged care software systems should be interoperable with My Health Record (MHR). As noted elsewhere in this submission, older people living in RACFs have a higher likelihood of frequent hospital admissions, complications during an admission and adverse outcomes from contra-medications. They may also not have a long-term therapeutic relationship with a single GP or geriatrician to co-ordinate their care as a result of moving from their community to be closer to relatives. This elevates the importance MHR adoption in RACFs.

While MHR is not designed to replace traditional communication channels between multiple clinicians and healthcare providers involved in the care of a patient, if it is used by the majority of healthcare providers across all sectors of the health system, MHR will be a vital repository of each event in a patient's clinical history. Access to MHR from the RACF will mean all healthcare providers who treat an older person within the RACF have access to their clinical history.

Achieving interoperability between MHR and My Aged Care is also important to reduce fragmentation between the health and aged care systems.

Great care will be required to ensure the older person's privacy and security is protected in an interoperable MHR/My Aged Care environment. Further, an aged care provider's access to an older person's MHR does not replace the involvement of their usual GP, geriatrician or other doctor. The consumer-controlled nature of MHR may mean some records are incomplete. This underscores the necessity of maintaining the involvement of the older person's usual GP to ensure a holistic overview of the older person's needs is obtained. Aged care IT systems need to be modern and the aged care workforce needs to improve their IT literacy for MHR interoperability to be successful.

Assistive and digital technologies

Digital health and assistive technologies have the potential to significantly improve the aged care system through increased efficiency and coordination of care providers, and increased independence and health of older people[122].

Unfortunately, the current aged care system does not sufficiently support the application of assistive technologies in aged care. For example, CHSP allows for a small discretionary $500 per financial year under the 'Goods, Equipment and Assistive Technology' service type. It includes "communication aids, support and mobility aids, self-care aids, medical care aids, reading aids, car modification and other goods and equipment". This is a relatively small sum for someone whose needs are expected to grow as they get older. The National Aged Care Alliance (NACA) reports that the Department of Health has advised providers that HCPs are not designed to be used as an assistive technology program[123].

[122] National Aged Care Alliance (2018). *POSITION PAPER: Assistive Technology for Older Australians* Page 8
[123] National Aged Care Alliance (2018). *POSITION PAPER: Assistive Technology for Older Australians* Pages 8-9

NDIS on the other hand allows for much greater possibilities in use of assistive technologies for those accessing support services through that scheme and Government should consider replicating the same or similar system in the aged care sector.

Digital technologies

Use of digital technologies in aged care in the future should be planned now. Future generations of aged care users are expected to be more digitally savvy and should be provided with options to continue to use their skills after they start accessing aged care services. For example, home assistant systems may hold huge potential for use in aged care in the future, as well as wearable technology such as smart watches and activity tracking.

Consequently, the aged care sector should keep up with the developments in the digital space, which it seems is not the case at the moment. AMA members report on the constant need for improvement. The AMA hears of difficulties associated with different RACFs using different software packages, most of which will not be compatible with clinical software programs.

Similarly, underutilisation of digital technologies can cause problems with dispensing medication. An AMA member reported:

> *Different drug charts at different facilities. Some charts, especially computerised are not available for me to see. Challenging to know whether correct medication, especially non-packed medication, has been given and difficulty seeing when PRN medication might have been used.*

MHR could lead to some improvements in this space, but a further standardisation of IT systems used across aged care is still needed. AMA contends that all providers of health services to persons in RACFs should use a single medical record for that person, including allied health practitioners.

Recommendation 34: More investment in innovation, digital technologies and telehealth in aged care.

Recommendation 35: Use of digital technologies in aged care in the future should be planned now by the Government and in coordination with relevant stakeholders.

Aged care in regional, rural, and remote Australia

Older people are more likely to live outside of major cities compared to the general Australian population[124]. Research also shows that older people in regional, rural and remote areas have lower incomes and education levels, poorer housing, and poorer health outcomes. This further amplifies their need for aged care support. In addition, many areas have higher proportions of Aboriginal and Torres Strait Islander (ATSI) people among their populations. Due to poorer health

[124] AIHW (2018) *Older Australians at a Glance report – Diverse groups of Australians – Regional and remote communities*

status and premature ageing, ATSI Australians may need access to aged care services at younger ages, and cultural safety is vital.

It costs more to provide health care and aged care in regional, rural and remote Australia. People living in regional, rural and remote Australia often struggle to access health and aged care services that are available to urban Australians. For example, people living in regional and remote areas were less likely to visit a GP (than people in major cities) and have higher rates of potentially avoidable hospital admissions[125]. These inequalities mean that they have lower life expectancy, worse outcomes on leading indicators of health, and poorer access to care compared with people in major cities. This is in spite of the fact that rural communities are served by highly skilled doctors who often work long hours and are totally dedicated to the needs of their community.

Providers of aged care services in rural and remote areas comprise not-for-profit (76.6 per cent) and government services (23.4 per cent)[126]. They face extra challenges particularly in delivering residential care, with higher cost pressures and lower profitability. Challenges include the ability to attract and retain staff, high travel and freight costs, poor internet coverage, and limited catchment populations meaning smaller scale operations. Thirty-eight per cent of Remote RACFs and 75 per cent of Very remote RACFs have fewer than 20 aged care places[127].

Government needs to develop comprehensive plans to better support the provision of health and aged care in regional, rural, and remote Australia, and to commit to significant funding increases to bridge the gap between city and country. It should focus on measures that will make a long-term difference, and commit to policies that:

- rebuild health infrastructure – particularly public hospitals;
- support the recruitment and retention of the medical and aged care workforce;
- provide more opportunities to train medical students and doctors in rural areas;
- provide incentives for aged care staff, particularly nursing staff, to live and work in rural and remote areas;
- support rural medical and aged care practices to ensure they are able to meet the complex health needs of people in rural and remote communities; and
- support multipurpose services that provide combined medical and aged care, including support in the process of accreditation and re-accreditation.

It is essential that government policy and resources are tailored and targeted to cater to the unique nature of rural health care and the diverse needs of rural and remote communities to ensure they receive timely, comprehensive, and quality health care.

AMA members argue that there should be at least one multi-purpose health service in every rural town that has a rural hospital facility. Such an arrangement would prevent older people from being transferred to other towns and communities. These transfers result in less frequency of

[125] Australian Institute of Health and Welfare (2017) *Rural and remote health – access to health services*
[126] Australian Institute of Health and Welfare (2018) *Explore services in aged care*
[127] Australian Institute of Health and Welfare (2018) *Older Australia at a glance*

visits by family members and friends due to distance and cost, which can lead to withdrawal, depressive symptoms and behavioural disturbances in older people.

Recommendation 36: Government needs to develop comprehensive plans to better support the provision of health and aged care in regional, rural, and remote Australia, and to commit to significant funding increases to bridge the gap between city and country.

Recommendation 37: Multi-purpose model of services for rural and remote communities should be further supported by the Government, particularly with the implementation of new Aged Care Quality Standards and accreditation under those standards for multi-purpose providers.

Young people living in residential aged care facilities

In 2017-18, 8,304 young people (under the aged of 65) used permanent residential aged care[128]. The AMA believes that RACFs are not appropriate environments for younger people.

One AMA member voiced concerns over younger people living in RACFs:

> *An aged care facility is no place for a disabled young person to be. Being intellectually normal but stuck in a place where everyone else is very old and mostly living with dementia is demeaning and humiliating and has led to profound depression and a loss of interest in living. Surely we can do better than this for people with disability!! There appears to be no interest or will power from government to deal with this issue. Perhaps if every health minister had to spend a week in a nursing home every year they might get motivated to address the issue.*

An indicative case study of an intersection of medical care, aged care and disability is the diagnosis of younger onset dementia (YOD) in people who are under the age of 65. It is estimated that there are more than 25,000 Australians living with YOD[129]. Due to progressive nature of the condition, many of them will eventually live in RACFs.

On one hand, disability services do not have a good understanding of dementia or the specialist services required to support people with YOD, as dementia is often not their core business. On the other, RACFs will often reject people living with YOD due to lack of capacity to manage their behaviour. Many people living with YOD are often physically healthy and live active lifestyles without experiencing the co-morbidities linked with later onset dementia. They require access to individually tailored, person-centred services that are more age-appropriate for them. Many RACFs are not able to provide this type of service and people living with YOD often spend much time being transferred from hospitals to home to respite care, before a suitable RACF can be identified[130].

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[128] Australian Institute of Health and Welfare (2019) *Pathways of younger people entering permanent residential aged care* Page 1
[129] Dementia Australia. *Support Pathways for People with Younger Onset Dementia* Page 5
[130] Alzheimer's Australia (2011). *Report for the Department of Health and Ageing* Consumer Engagement in the Aged Care Reform Process

People living with YOD often fall through gaps between the My Aged Care and NDIS systems. They can receive relevant supports and services under the NDIS, up to the point of entry into aged care. In order to access aged care services, they need to register with My Aged Care and go through an ACAT assessment. However, currently the system is not equipped to manage this intersection, and there are situations where people are being transferred back and forth between the two systems[131]. Even when referrals for ACAT are coming from their GPs, people living with YOD spend months waiting for an assessment. In the meantime, due to the progressive nature of the disease and their deteriorating condition they can end up in the hospital system.

An example of the negative outcomes of this intersection was recently shared by Dementia Australia in their submission to the Streamlined Consumer Assessment for Aged Care consultation:

> *For people living with YOD, their GPs are their key link to medical services, and as their needs increase and their conditions deteriorate, GPs are their link in the transitioning from disability services (NDIS) to aged care. However, Dementia Australia is aware that people living with YOD referred to My Aged Care through GPs fail to be connected or unable to receive ACAT assessments as described previously. For instance, Dementia Australia is currently aware of a fifty-nine year old client with dementia who has been waiting for six months from the original GP referral to an ACAT assessment. In the assessment process, the ACAT team leader requested a number of additional documents to be submitted, including a letter from the NDIS, even though the NDIS does not issue letters of referral. In the process of waiting for the finalisation of an ACAT assessment, the client lost 8 kg in weight which resulted in a hospital admission following a serious fall due to his increasing frailty.*[132]

The AMA supports the Commonwealth's announcement of a national action plan to decrease the number of young people in RACFs[133]. Better coordination between NDIS and aged care systems is required to enable seamless transition between different services for people living with disability. Coordination with primary care in the process is crucial as well as other service sectors, including allied health.

Recommendation 38: Options other than residential aged care facilities should be explored and implemented by the Government for younger people with disabilities who are currently serviced by residential aged care facilities.

Recommendation 39: Better coordination between disability and aged care systems is required to enable seamless transition between different services for people living with disability.

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[131] Dementia Australia (2019) Submission to the Department of Health consultation *Streamlined Consumer Assessment for Aged Care* Page 7
[132] Dementia Australia (2019) Submission to the Department of Health consultation *Streamlined Consumer Assessment for Aged Care* Page 7
[133] Australian Government (2019) *Younger people in residential aged care – action plan*

Coordination with primary care in the process is crucial as well as other service sectors including allied health.

Aged care for special needs groups

It is the AMA's position that special needs groups should be given particular attention when designing, implementing and funding aged care services. Older people from CALD and ATSI backgrounds require culturally appropriate aged care providers and services that recognise and respond to their ethno-specific needs. Aged care policies, programs and services should be inclusive of, and appropriate to, the ethnospecific, religious/spiritual and cultural needs of people from CALD and ATSI backgrounds.

For people from CALD and ATSI backgrounds, understanding and catering to cultural considerations such as food, language and customs are particularly important in delivering care services. As discussed previously, food is an important cultural aspect of a person's life and can be a means of retaining one's cultural identity. RACFs should provide culturally appropriate food to their residents. Also, AMA understands that individual RACFs will have their own rules regarding allowing visitors to bring food to people they are visiting. AMA members inform of situations where ethno-specific food has to be smuggled in for the residents of RACFs. It is the AMA's view that if RACFs are unable to provide culturally appropriate food, they should at least enable food to be provided to residents by relatives and community members, provided that relevant food safety regulation is met.

Language is another aspect of one's identity. Interpreter and translation services must be available for people from CALD and ATSI backgrounds to ensure they are informed and able to navigate all aspects of the aged care system.

ATSI people living in regional, rural and remote Australia experience particular challenges in accessing culturally and linguistically appropriate aged care services and supports. Ongoing investment into programs such as the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) is essential in supporting the growth and development of aged care services for Indigenous Australians.

Finally, government should continue to recognise the need to provide specific LGBTQI aged care services and resources. Ongoing investments in specific workforce training, sector collaborations, and 'diversity within diversity' policies are needed to ensure LBGTQI aged care services meet the unique needs of older people and carers.

Recommendation 40: The AMA calls for more research into health and aged care needs of special needs groups, including but not limited to CALD, ATSI and LGBTQI. These groups have particular needs around culturally appropriate and culturally safe services, which should be further documented and enable equity in accessing services and service provision.

The need for research on the care of older people

The AMA wants to see more research into the care of older people. Research will ensure an evidence base to inform policy makers on the future developments and the way forward for reforms in the aged care space. Improvements in care will result from properly designed, analysed and reported biological, clinical and public health research.

As a matter of urgency, resources and support should be made available by governments to ensure the funding of research programs that focus on age related issues, with focus on:

- The care of older people with co- and multi- morbidities.
- Prevention of, management of, and cure for, dementia, as it is a leading cause of death in Australia.
- The prevalence and management of elder abuse in Australia.

This research should be multidisciplinary because of the complex inter-relationships between genetic, psycho-social, environmental and economic factors causing dysfunction from disease, disuse, and the effects of biological ageing.

To enable research, the AMA calls for appropriate data collection. The introduction of MHR will provide significant opportunities for future research of needs of older people, particularly when it becomes interoperable with My Aged Care. Again, privacy and security measures must be in place for this to occur.

Finally, scientific evaluation of the impact of government policies to the wellbeing of older people will be crucial. The new Aged Care Quality Standards are focused on consumer outcomes and hence should make it easier to monitor and evaluate whether they lead to actual improvement of outcomes for people accessing aged care services. The data for this evaluation should be readily available through the regular accreditations and audits conducted by assessors. Proper evaluation of the impact of the new Standards could lead to their adjustment and revision in the future, improvement in the assessment/accreditation processes and identification of additional policies are required for improvement of outcomes for consumers.

Recommendation 41: More research into care of older people in the future, including appropriate aged care and health care data collection to inform future policy and regulation.

Recommendation 42: Conduct a scientific evaluation of the impact of government policies on the wellbeing of older Australians. This will lead to proper policy adjustments and revisions as needed.

Conclusion and recommendations

The AMA reiterates that the extensive safety and quality issues for older people within the aged and health care systems are complex and interlinked with each other. The AMA has consulted extensively with its members regarding their experiences with the aged care system and have lodged several submissions to inquiries and reviews[134]. While the AMA has raised multiple safety and quality issues in this submission, AMA members consistently, and overwhelmingly, raise inadequate staff numbers and staff training as the most urgent issue. The AMA has explained in this submission how a minimum mandatory staff to resident ratio can act as a safety net to prevent most safety and quality issues.

The AMA sees the work of the Royal Commission into Aged Care Quality and Safety as an opportunity to not just improve the current situation in aged care in Australia, but also as an opportunity to create an environment that promotes good care for the most vulnerable members of our society. If the momentum is not utilised now, the AMA is concerned that older Australians, and Australians in general, will be the losers and that a great opportunity for real reform will have been lost.

The AMA makes the following recommendations to the Royal Commission and looks forward to further working with the Royal Commission and the Australian Government to further improve the aged and health care systems.

Aged care workforce

Recommendation 1: Retaining and increasing the number of doctors interested in working in the aged care space should be the focus of any future reforms in aged care if appropriate clinical care is to be provided. Investing in primary care particularly for patients in aged care settings will save on public hospital expenditures.

Recommendation 2: Further investigation and research is needed into the demographics and movements of GPs in the aged care sector due to the decreasing trend in GP aged care visits and an ageing medical workforce. The research needs to take into consideration the forward-looking trends of expenditures related to Australia's ageing population and the projected need for the medical workforce.

Recommendation 3: Medicare rebates need to increase in excess of 50 per cent to begin to adequately compensate for the additional time and complexity involved in comparison to a GP attendance in their own consulting rooms.

Recommendation 4: Introduce an MBS telehealth item for phone calls between the GP, RACF staff and relatives. This may reduce some barriers to accessing medical services after hours. The Government should consider introducing telehealth for RACFs for afterhours consultations as a

[134] Australian Medical Association (2019) *Aged Care – Submissions*

pilot. Outcomes of such a pilot program will help inform government policy and provide an evidence base for informed decision making.

Recommendation 5: The Royal Commission should investigate the absence of routine roles for geriatricians and psychogeriatricians and how this should be addressed to better support GPs.

Recommendation 6: Further research is needed into improved funding and workforce models for medical care of older people.

Recommendation 7: Aged care providers need to provide basic equipment and facilities to support doctors to carry out their services in aged care settings. This includes access to a consulting room, a computer and appropriate clinical software.

Recommendation 8: Education and training for Doctors in Training and medical students on caring for older people should be increased.

Recommendation 9: Registered nurses should be available on site, 24 hours a day in RACFs to ensure older peoples' medical needs are adequately met, including the appropriate administration of medicines.

Recommendation 10: There should be a mandatory minimum qualification for personal care attendants that includes basic health care.

Recommendation 11: Government should provide additional funding for specialised training of the aged care workforce, primarily personal care attendants. This should include a professional development leave option for those wanting to further develop their skills.

Recommendation 12: Implement a streamlined process to improve access to respite care for people who have not yet been assessed by an ACAT/RAS or who have not yet entered the aged care system.

Recommendation 13: Minimum mandatory staff-resident ratios should be researched and then introduced in RACFs that reflect the level of care need of older people and ensure 24 hour on site registered nurse availability.

Recommendation 14: The Aged Care Safety and Quality Commission should investigate staff turnover when assessing and auditing aged care providers.

Recommendation 15: The effectiveness of the aged care assessment process should be improved by including the patient's usual doctor in the assessment arrangements.

<u>Fragmentation between health and aged care systems</u>

Recommendation 16: Communication between doctors, hospitals and aged care providers must be improved through minimum standards and guidelines.

Recommendation 17: Government must make more home care packages available to older people to address their care needs and to prevent the need for more complex care in RACFs and hospitals.

Aged care regulation

Recommendation 18: More specific Aged Care Quality Standards, including a Medical Access Standard should be developed for RACFs that helps to facilitate access to doctor services and high-quality clinical care.

Recommendation 19: Quality Indicator data should be made an integral part of the accreditation/audit reports conducted by the Aged Care Quality and Safety Commission.

Quality of care in aged care settings

Recommendation 20: Palliative care must be built into any aged care model, by defining the skills and staff requirements and recognising that palliative management is a basic RACF service. The funding model must be flexible enough to account for increased needs at the end of life and be responsive enough to allow for reassessment when required.

Recommendation 21: AMA members support mandating the requirement that all RACFs residents should have a current up to date ACD. AMA members also contend that there should be an MBS item/fee available for GPs to complete ACDs with their patients living in RACFs or their SDMs.

Recommendation 22: Further work is needed to raise awareness among aged care service providers on advance care planning, the role of aged care providers in ensuring the development and implementation of advance care plans, directives and communication around hospital transfers and the person's usual GP, the need for caring staff to be aware of existence of ACDs, My Health Record and advance care planning, as well as the role of ACDs in clinical care.

Recommendation 23: Expand the Better Access to Mental Health Initiative to ensure older people living in RACFs receive the same access to mental health services as the rest of the population.

Recommendation 24: Improve dementia management and behavioural training for nursing and personal care staff attendants to reduce prescription of antipsychotic medication.

Recommendation 25: Doctors must be able to maintain clinical independence in order to make the best treatment recommendations for patients, based on current evidence, preserving their own clinical judgments regarding treatment recommendations.

Recommendation 26: Medication reviews should occur annually, and when there is a significant change in an older person's medication and/or medical condition.

Recommendation 27: A National strategy on polypharmacy should be developed, along with evidence-based guidelines for prescribing to the elderly. Having a strategy and guidelines may reduce adverse events, hospitalisation and PBS costs.

Recommendation 28: Develop and implement national nutrition standards for aged care facilities, ensuring menus are varied and food is appealing and palatable.

Recommendation 29: Continuing education on elder abuse and neglect of the profession, including doctors, nursing aged care staff and personal care staff is essential to evaluate and mitigate medical and psychiatric consequences for the victims.

Recommendation 30: Introduce relevant safeguards for whistle-blowers in aged care, along with regulation for urgent mandatory investigations into their revelations.

Recommendation 31: Older people should maintain the choice of their preferred medical practitioner in residential care.

Recommendation 32: Simplify the aged care navigation process and ensure access to more information on aged care provider performance against the Aged Care Quality Standards.

The use of technology in aged care

Recommendation 33: Greater transparency for GPs and patients to be able view the progress of aged care assessments. This will provide GPs with confidence that their patients are being provided with the necessary care in a reasonable timeframe, as well as enable GPs to take action if this is not occurring.

Recommendation 34: More investment in innovation, digital technologies and telehealth in aged care.

Recommendation 35: Use of digital technologies in aged care in the future should be planned now by the Government and in coordination with relevant stakeholders.

Aged care in regional, rural, and remote Australia

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The need for research on the care of older people

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Recommendation 42: Conduct a scientific evaluation of the impact of government policies on the wellbeing of older Australians. This will lead to proper policy adjustments and revisions as needed.

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