Australian Government
Australian Aged Care Quality Agency

Introduction

Thank you for taking the opportunity to read and consider the draft guidance material that has been developed to support providers of aged care services to meet the new aged care quality standards. We welcome your feedback.

Once completed please save and send this completed form by email to qualityagencypolicy@aacqa.gov.au

Should you require additional support to complete this form, please contact the Australian Aged Care Quality Agency via email qualityagencypolicy@aacqa.gov.au or via phone on 1800 288 025.

1. What is your email address? *(This information will not be published)*

Email:

2. Are you answering on behalf of an organisation? If so, please provide your organisation's name

◉ Yes, on behalf of an organisation	○ No, not on behalf of an organisation

Organisation name: Queensland Nurses and Midwives' Union

3. Do you give consent for your submission to be published in whole or part?

◉ Yes, I give consent	○ No, I don't give consent

4. Where do you live, or, where does your organisation operate? Please select all that apply

☐ NSW	☐ VIC	☑ QLD	☐ WA	☐ SA	☐ TAS	☐ ACT	☐ NT

5. Do you have any specific suggestions in relation to the draft guidance for Standard 1: Consumer dignity and choice? If so, what are they?

See accompanying submission

6. Do you have any specific suggestions in relation to draft guidance for Standard 2: Ongoing assessment and planning with consumers? If so, what are they?

See accompanying submission

7. Do you have any specific suggestions in relation to draft guidance for Standard 3: Personal care and clinical care? If so, what are they?

See accompanying submission

8. Do you have any specific suggestions in relation to draft guidance for Standard 4: Services and supports for daily living? If so, what are they?

See accompanying submission

9. Do you have any specific suggestions in relation to draft guidance for Standard 5: Organisation's service environment? If so, what are they?

See accompanying submission

10. Do you have any specific suggestions in relation to draft guidance for Standard 6: Feedback and complaints? If so, what are they?

See accompanying submission

11. Do you have any specific suggestions in relation to draft guidance for Standard 7: Human resources? If so, what are they?

See accompanying submission

12. Do you have any specific suggestions in relation to draft guidance for Standard 8: Organisational governance? If so, what are they?

See accompanying submission

13. On a scale of 1 to 10 (1 being not clear at all and 10 being very clear) how clear is the guidance material overall?

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What would make it clearer?

See accompanying submission

14. Are there any gaps in the guidance material? If yes, what else should be included in the guidance material, to help aged care service providers to meet the draft new Aged Care Quality Standards?

See accompanying submission

15. Do you have any other feedback on the guidance material?

See accompanying submission

Once completed please save and send this completed form by email to qualityagencypolicy@aacqa.gov.au

If you wish to contribute more information than the feedback boxes will allow, please attach a Word document or write to us in the body of your email.

Should you require additional support to complete this form, please contact the Australian Aged Care Quality Agency via email qualityagencypolicy@aacqa.gov.au or via phone on 1800 288 025.

Thank you for participating in the survey.

Queensland Nurses & Midwives' Union

Submission to

The Australian Aged Care Quality Agency

Consultation re Draft Guidance Document for the Aged Care Quality Standards

June 2018

106 Victoria St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
(07) 3840 1444
(07) 3844 9387
qnmu@qnmu.org.au
www.qnmu.org.au

submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks The Australian Aged Care Quality Agency (AACQA) for the opportunity to provide feedback regarding the draft Aged Care Standards Guidance Material as part of a public consultation process.

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 57,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

The QNMU actively represents members working in the aged care sector at an industrial and professional level, and also draws on the considerable experience the organisation has gained as a stakeholder in safety and quality improvement in the health sector. The QNMU believes that its aged care membership base makes the organisation a stakeholder in any debate regarding the quality and safety of aged care services. As a member led organisation which advocates for nurses and unregulated careworkers in aged care, member feedback consistently identifies a range of endemic and systemic issues which impact on the safety and quality of care provided and which effect both those receiving and providing care. These issues include staffing and skill-mix, working conditions, governance (including clinical governance), nursing and other healthcare standards and regulation, funding and training, all of which should be underpinned by robust standards and regulation.

The QNMU asks that the recommendations of this submission be read in conjunction with the detailed submission by the Federal Branch of the Australian Nursing and Midwifery Federation (ANMF). The alignment of the aged care standards and supporting resources with the National Safety and Quality Health Service (NSQHS) Standards proposed by this submission and the specific feedback provided by the ANMF offer the opportunity for the Aged Care Quality Agency to develop aged care standards that emphasise the importance of person centred health and nursing care in the aged care sector.

Summary of Recommendations

The following summary of recommendations is provided for the detailed recommendations contained in the body of the decision.

1. It is recommended that the draft Aged Care Quality Standards document be reformatted to align with the format of the NSQHS Standards document.

2. It is recommended that the draft Aged Care Standards Guidance Material be rewritten to align with the format of the NSQHS Standards Guide.
3. That the draft aged care Standard 3 – Personal care and clinical care, be reviewed and rewritten to align with the NSQHS Comprehensive Care Standard both in format and content.
4. That the draft Aged Care Standards Guidance Material in relation to Standard 3 – Personal care and clinical care be reviewed to align with the NSQHS standards guide both in format and content.
5. That the draft standard and guidance relating to personal and clinical care incorporate minimum standards around the capacity of aged care facilities to provide primary care as part of hospital avoidance strategies.
6. That the elements of the NSQHS Communicating for Safety Standard be incorporated into Standard 3 – Personal care and clinical care, with particular reference to clinical handover processes.
7. That consideration be given to creating a specific Aged Care Medication Standard. Failing this, that the draft aged care standards guidance document be reviewed with reference to the NSQHS Medication Safety Standard and the ANMF professional standard relating to management of medicines in aged care.
8. It is recommended that the findings of the research - Meeting residents' care needs: A study of the requirement for nursing and personal care staff (Willis et al., 2016), form the basis of an evidence based standard for staffing and skill mix in residential aged care facilities.
9. The QNMU recommends that the NSQHS Clinical Governance Standard be incorporated into Standard 8 – Organisational Governance to emphasise to aged care providers that they are primarily health service providers.

Background

While the aged care sector constitutes both residential and community based services, this submission will focus primarily on the draft Aged Care Quality Standards and draft Guidance Material in the context of residential aged care service provision. While issues such as assessment wait times, queuing for care packages and funding are priority issues in community based aged care, the QNMU believes that a constellation of endemic, system level, issues are severely impacting the capacity of the sector to provide safe, high quality, residential aged care. These issues include:

- chronic and widespread understaffing
- inappropriate staff and skill mix
- lack of a corresponding culture of safety and quality to that which is now well embedded in the acute care sector
- lack of reporting and transparency around the processes and outcomes of care

- a model of care that relies heavily, and increasingly, on a large workforce component of unregulated care workers at a time when the morbidity, acuity and frailty of those receiving residential aged care services is steadily increasing
- a failure of governance, regulation, and particularly enforcement, that has led to the current crisis in aged care.

As identified by Phillips et al., (2017) the proportion of those aged care residents requiring high levels of care has dramatically increased from 13% in 2009 to 61% in 2016, with aged care facilities increasingly acting as hospices for frail older Australians with complex care needs. As succinctly described by the Royal Australian College of General Practitioners (RACGP, 2006):

> *Older people in residential aged care are the sickest and frailest subsection of an age group that manifests the highest rates of disability in the Australian population. The prevalence of chronic conditions among residents in high care is estimated to be 80% sensory loss, 60% dementia, 40-80% chronic pain, 50% urinary incontinence, 45% sleep disorder, and 30-40% depression. Annually 30% of residents have one or more falls and 7% fracture a hip.*

Older Australians, particularly those receiving residential aged care services, are characterised by significant care needs, multiple diagnoses, comorbidities and polypharmacy. It has been estimated that on average they have 3.4 to 4.5 separate diagnoses, 6 comorbidities, and are taking 8.1 medications (Willis et al., 2016). Research also points to a rising trend of avoidable and premature death in Australian aged care facilities (Ibrahim et al., 2017).

Recent care issues identified at the Oakden facility in South Australia, as well as a number of inquiries and reports over the last decade, have pointed to a disparity in terms of safety and quality of care between the hospital and aged care sectors. This should not be the case. The effectiveness of existing aged care standards and associated accreditation processes have been called into question by inquiries such as the ongoing Senate Community Affairs References Committee inquiry into the effectiveness of the aged care quality assessment and accreditation framework.

As stated by the Australian Commission on Safety and Quality in Health Care (ACSQHC), the "… primary aim of the NSQHS Standards is to protect the public from harm and improve the quality of health care. They describe the level of care that should be provided by health service organisations and the systems that are needed to deliver such care." (ACSQHC, 2018). We emphasize here that, under any plausible definition of the term, a residential aged care provider is a health service provider.

The QNMU believes that the primary aim of the NSQHS Standards should also be the primary aim of all aged care standards as well. While the aged care standards must promote choice and independence, this must not be done at the cost of the care that facilitates this very

thing. The QNMU supports the view of Phillips et al., (2017) who make the case that the social model of aged care which has developed following the introduction of the Aged Care Act (1997) has shifted the focus from the significant clinical aspects of residential aged care, replaced a nursing workforce with unregulated and lesser skilled carers, and adversely affected the care that older Australians receive. The QNMU believes that any aged care standards must firmly refocus attention on these care requirements, provide clear minimum standards to a diverse range of aged care providers, and an expectation of best practice and continuous improvement. Significant sanctions, which make the price of non-compliance prohibitive, must also be in place to drive change.

A draft set of aged care quality standards have been developed to replace the existing standards as part of a consultation process for a single aged care qualify framework undertaken by the Australian Government Department of Health, in 2017. While these draft standards are an improvement on the existing standards, the QNMU submits that these standards do not go far enough to enable safe and quality care in aged care.

While residential aged care facilities (RACFs) are not hospitals, they are places where considerable and extensive clinical care is required for a population that has significant frailty, chronic disease, co-morbidity, complex care needs and can be equated to the care required in any medical ward in a hospital.

If a patient in a hospital medical ward had contact with a registered nurse for only a few minutes in the course of an eight-hour shift, there would be public and government uproar. Yet this is the standard we currently see for an aged care recipient's similar care needs.

The QNMU believes that wherever possible, the same standards (particularly relating to clinical care and governance, including clinical governance) should apply across the acute and residential aged care sectors. This view is reinforced by the Senate Community Affairs References Committee in the interim recommendation that "… in the current aged care oversight reforms being undertaken, all dementia-related and other mental health services being delivered in an aged care context must be correctly classified as health services and must therefore be regulated by the appropriate health quality standards and accreditation processes" (The Senate Community Affairs References Committee, 2018). The QNMU believes that this coverage should extend to all those receiving residential aged care given the significant amount of care of a clinical nature that they receive. The comments in this submission will reflect this view.

While not a point by point critique, this submission will address the following standards specifically:

3. Personal care and clinical care

7. Human resources

8. Organisational governance.

General comments

Since its inception in 2006 and following on from the work of the Australian Council on Safety and Quality in Health Care, the ACSQHC has provided the leadership and coordination for safety and quality in the health sector. An essential part of this leadership has been the development of a suite of robust care standards, and other supporting resources, to underpin and drive patient safety and quality improvement in the acute sector. These standards form the basis for accreditation activities with the second edition of the NSQHSS being implemented, and demonstrates a mature governance system for safety and quality in health services.

The implementation of an Aged Care Quality and Safety Commission from 2019 is welcomed by the QNMU as an opportunity to implement sector governance structures that have been lacking, and it is the expectation of the QNMU that the role and activities of this new Aged Care Quality and Safety Commission will be modelled on the success of the ACSQHC.

As the new Aged Care Quality and Safety Commission is established it is hoped that there will be alignment of standards and other resources between the two commissions.

Standards format

The draft aged care quality standards is a sparse document compared to the NSQHS Standards (Second edition). Given the significant issues identified in the aged care sector and the diversity of providers from single stand-alone facilities to large for-profit providers with vertically integrated operations, the QNMU believes that a more directive, comprehensive and thorough format for the draft aged care standards is necessary.

Currently, each aged care standard is relatively brief and consists of a Consumer Outcome, Organisational Statement and Requirements section. In comparison, each NSQHS Standard, consists of the following:

- a statement of the intention of the standard
- explanatory notes
- criteria, items relating to the criteria and actions.

Such a format allows the standards document to be a useful resource for understanding the purpose of the standard, the elements comprising the standard and the actions required by the organisation to meet the standard. While this does not obviate the need for a more thorough guidance document, it does make the standards a useful guide and ready-reckoner.

Recommendation

It is recommended that the Draft Aged Care Quality Standards document be reformatted to align with the format of the NSQHS Standards by:

- adding explanatory notes for each standard

- rewording and refocusing the requirements items of the standard to criteria with actions required.

Aged Care Standards Guidance Material

Again, the QNMU believes that a more robust and directive approach to the guidance document, similar to the NSQHS Standards Guide for Hospitals is essential to clearly articulating the requirements of aged care providers in meeting safety and quality minimum standards but more importantly, demonstrating continuing safety and quality improvement. The NSQHS Standards Guide for Hospitals clearly articulates the intent of the standard/criteria, key tasks that must be done to meet the standard and strategies for improvement relevant to the standard. Terms such as "Supporting Strategies" and "Reflective Questions", while very managerial and excellent examples of Bureaucratese, have no place in a standards based regime and must be replaced with more direct (and directive) terms such as "Key Tasks" and "Strategies for Improvement".

Recommendation

It is recommended that the draft Aged Care Standards Guidance Material be rewritten to align with the format of the NSQHS Standards Guide.

Feedback in relation to specific standards

The following feedback is provided regarding the standards 3, 7 and 8. This feedback is primarily about the intent and thrust of the standards rather than a critique of specific content.

Standard 3 – Personal care and clinical care

As already stated in this submission, the QNMU believes that much of the care delivered in aged care facilities is clinical (specifically nursing) in nature. This care spans the spectrum from personal care to complex clinical care and is well described by the International Council of Nursing definition (2018):

> *Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.*

While this care relates to a predominance of chronic, rather than acute issues, nonetheless the high acuity and frailty of aged care residents and their associated clinical care needs are significant and ongoing. Any attempt at differentiation between personal care and nursing care is contrived and artificial and only serves to deemphasise the clinical aspects of age care

to the detriment of older Australians. Comprehensive standards that clearly identify clinical care minimum standards are required.

In line with the Recommendation 2 of the ongoing Senate Community Affairs References Committee, the QNMU believes that that draft Standard 3 – Personal care and clinical care should be rewritten to align with the NSQHS Comprehensive Care Standard and the standards guidance material adjusted as well.

Primary care

A particular area that the QNMU believes should be addressed in Standard 3 – Personal care and clinical care relates to the capacity of aged care facilities to provide appropriate primary care services and facilities on site. According to the Queensland Health Minister, over 25,000 aged care residents were transported to emergency departments in the period in FY2016-17, a 17% increase (Bita, 2018). An increase of 25% in emergency department transfers from aged care facilities has been reported in Victoria (Bachelard, 2017). According to the Australian Medical Association (2018), one third of presentations by residents to emergency departments who subsequently returned to their RACF could have been avoided by incorporating primary care services at the facility level. Such facilities include both the physical infrastructure and the skilled staff needed, e.g. registered nurses and general practitioners. The QNMU believes that the capacity of RACF's to provide effective primary care, and to practice hospital avoidance, has been significantly impacted though systemic deskilling of the aged care workforce and a model of care that deemphasises the clinical aspects of residential aged care.

Communication

The QNMU believes that effective communication regarding care issues is a key safety mechanism in aged care. A search of the draft aged care standards guidance material only found one occurrence of the phrase "clinical handover". Feedback from members in the aged care sector indicates that clinical handover is a major issue where rostering practices by providers leave little time for this essential practice to take place. The draft aged care standards and guidance material must ensure that providers demonstrate that adequate time is available for shift-to-shift handovers to take place.

Medication Safety

A concerning trend for the QNMU is the increasingly common practice by aged care providers of moving to an unregulated carer model of medication administration which puts the safety of older Australians at risk.

Older Australians, particularly those receiving residential aged care services are characterised by significant care needs, multiple diagnoses, comorbidities and polypharmacy. It has been estimated that on average they have 3.4 to 4.5 separate diagnoses, 6 comorbidities, and are taking 8.1 medications (Willis et al., 2016). Research undertaken by Macquarie University

indicates that 85% of aged care residents were prescribed 5 or more medications, 45% were on 10 or more medications and 4% were on 20 or more medications (Westbrook, 2017).

Medication management is also one of the top five complaint areas reported to the Aged Care Complaints Commissioner (2017). This, and the vulnerable nature of those in RACF's and their significant medication use, highlights that medication management is a critical clinical process in aged care, just as it is in the acute sector, with the following characteristics and issues.

- Nurses are the primary managers of medication therapy in RACF's but generally don't have the onsite resources, such as medical practitioner availability, pharmacists and on-site pharmacies, taken for granted in the hospital sector meaning that this critical support is not available.
- The declining staff and skill-mix in aged care has meant that aged care providers are increasingly using unregulated care workers, often with little training, in medication related roles.
- There is not a specific medication safety standard for aged care, with medication safety and minimising medication misadventure only part of the Personal care and clinical care standard guidance material.
- The use of prepacked medications is common practice in aged care, however there is evidence to suggest that the error rate for this approach is higher than administration from original packaging, and can have greater than a 10% error rate (Hussainy, et al., 2012).
- Approximately 75% of residents in aged care facilities require total help with medication administration (New South Wales Nurses and Midwives Association, 2017).
- While a national residential aged care medication chart has been developed, uptake has been limited, unlike the standardised medication chart used in the acute sector (Jackson et al., 2017).

If medication related errors and adverse events remain a high risk in the acute sector despite the availability of highly trained staff, comprehensive standards and wide-ranging medication safety processes, it is hard to believe that transferring medication administration tasks to AIN's and Personal Care Workers (PCW's) will maintain safety in aged care. Feedback from member AIN's and PCW's indicates that they are often given little choice in undertaking this role, are concerned for their job security if they refuse, and worry about the safety of undertaking this role, often with little training.

The significant theoretical and competency based training in pharmacology undertaken by undergraduates in nursing reflects the minimum standard of knowledge and practice deemed necessary by the Nursing and Midwifery Board of Australia to undertake this role. To believe that this role can be undertaken by unregulated aged care workers with, often, only a few

hours of training, is of significant concern to the QNMU. That the AACQA allows this situation to occur is also concerning.

The QNMU does believe that unregulated aged care workers do have a role in assisting those competent aged care residents who ask for help to take their prescribed medications as identified in the ANMF professional standard document *Nursing Guidelines: Management of Medicines in Aged Care (2013).*

Recommendations

The following is recommended:

1. That the draft aged care Standard 3 – Personal care and clinical care, be reviewed and rewritten to align with the HSQHS Comprehensive Care Standard both in format and content.
2. That the draft Aged Care Standards Guidance Material in relation to Standard 3 – Personal care and clinical care be reviewed to align with the HSQHS standards guide both in format and content.
3. That the draft standard incorporate minimum standards around the capacity of aged care facilities to provide primary care as part of hospital avoidance strategies.
4. That the elements of the NSQHS Communicating for Safety Standard be incorporated into Standard 3 – Personal care and clinical care, with particular reference to clinical handover processes.
5. That consideration be given to creating a specific Aged Care Medication Standard. Failing this, that the draft aged care standards guidance document be reviewed with reference to the NSQHS Medication Safety Standard and ANMF professional standard relating to management of medicines in aged care to ensure that the same best practice processes that are routine in the acute sector are translated into the aged care sector.

Standard 7 – Human resources

A significant issue for the QNMU, other state nursing and midwifery unions and the Australian Nursing and Midwifery Federation (ANMF) is the chronic understaffing and deskilling of the aged care direct care workforce. Research indicates that on average, those receiving residential aged care services require 4.3 hours of care per day and a skill mix of 30% RN's, 20% EN's and 50% AIN's/PCW's (Willis et al., 2016). However, this same research indicates that residents receive only 2.86 hours of care per day, a significant deficit. Evidence gathered by the QNMU supports this finding with analysis of some RACF rosters indicating that residents can receive less than 2 hours of care per day.

These staffing and skill mix deficits directly reduce the safety of residents and the quality of the care they receive, resulting in increased falls, pressure injuries, nutritional deficits and missed care.

While Standard 7 identifies that the "… workforce is planned and the number and mix of staff deployed enables the delivery and management of safe and quality care and services", there is no benchmark or minimum standard in the guidance material to suggest what this should be.

As identified by Phillips (2017), the reduced focus on the clinical aspects of residential aged care have led to significant reductions in the number of RN's and EN's in aged care and the transition to a unregulated carer model where staff have a limited capacity to provide the clinical care required. The long term decline in licensed nurse numbers in aged care, who lead the assessing, planning, delivery and monitoring of care, particularly complex care, has had a negative impact on the safety and quality of care, leading to the current situation where failures of care are reported almost daily in the media.

Recommendation

It is recommended that the findings of the research - Meeting residents' care needs: A study of the requirement for nursing and personal care staff (Willis et al., 2016), form the basis of an evidence based standard for staffing and skill mix in residential aged care facilities. The QNMU would be concerned if the draft aged care standards did not adopt, and were not based on, an evidence/research based approach to aged care standards and strongly urges the Australian Aged Care Quality Agency to incorporate specific minimum staffing and skill mix levels to address the chronic and unsafe understaffing currently endemic in the sector.

Standard 8 – Organisational governance

The publication of seminal patient safety reports such as *To Err is Human* (2000) and *Crossing the Quality Chasm* (2001), have driven significant change in the acute health sector in terms of patient safety and quality. In Queensland the two commissions of inquiry into care at the Bundaberg Hospital in 2005 were a catalyst for significant change. Unfortunately, it is the view of the QNMU that the lessons learned, and processes implemented in the acute sector have not flowed through to the aged care sector, particularly residential aged care where significant clinical care also takes place, and which is arguably the primary service of the organisation.

A major concern of the QNMU is the unsatisfactory level of governance of the aged care sector at the governmental, regulatory, organisational and facility level, with this failure of governance underpinning the many issues now evident in the sector. The recent Tax Justice Network report *Tax Avoidance by For-Profit Aged Care Companies: Profit Shifting on Public Funds (2018)* provides a compelling argument that for-profit aged care providers are benefiting from significant public funding with little evidence that this funding is translating into high quality, safe aged care (Tax Justice Network, 2018). On the basis of this alone, the QNMU believes that rigorous and unambiguous standards relating to governance expectations are essential. Phrases such as "Supporting Strategies" and "Reflective

Questions" have no place in any guidance material around organisational and clinical governance.

Again, it is the view of the QNMU that the governance practices (and particularly clinical governance) accepted as the norm in the acute sector must also be translated in the aged care sector. Residential aged care facilities are places where substantial levels of health services are provided to a vulnerable, high acuity population and any arguments that the aged care sector is somehow different must be regarded as spurious. The QNMU hopes that the new Aged Care Quality and Safety Commission will seek to apply the safety and quality lessons learned from the hospital sector to the aged care sector as a matter of urgency.

Recommendation

The QNMU recommends that the NSQHS Clinical Governance Standard be incorporated into Standard 8 – Organisational Governance to emphasise to aged care providers that they are primarily health service providers.

Conclusion

While the draft aged care standards and guidance material are a step in the right direction, the QNMU believes that further work is required to produce a set of care standards and supporting resources that ensure that those older Australians in residential aged care receive the same standard of clinical care irrespective of their location and circumstances, i.e. be it receiving care in the RACF where they live or during an acute event that requires their hospitalisation. The QNMU believes that demonstrably this is not the current situation.

The diversity of aged care providers and the fact that aged care is largely provided by the private sector in Australia means that there should be significant rigor around the standards of care for this sector. There is no justification for a variation in standards between the acute sector and aged care sector in relation to clinical care.

This submission has made a number of recommendations regarding the current draft aged care standards and guidance material. It is hoped that the Aged Care Quality Agency and its successor the Aged Care Quality and Safety Commission will ensure that older Australians receive consistent, high quality care irrespective of setting.

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