New South Wales Nurses and Midwives' Association

Response to

Consultation: Draft Guidance Aged Care Quality Standards

May 2018

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes: registered nurses; enrolled nurses and midwives at all levels including management and education, and assistants in nursing/care workers (however titled, who are unregulated).

The NSWNMA has approximately 64,500 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

We currently have over 10,500 members who work in aged care. We consult with them in matters that are specific to their practice. We wish to acknowledge the contributions made by our members in preparing our comments.

We welcome the opportunity to provide a response to this consultation.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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Introduction

This consultation is one of a number of inquiries and consultations[1] [2] [3] [4]. All have closely examined the factors that define quality in residential aged care facilities (RACF) and those which contribute to failures. Many have been triggered by the appalling conditions endured by those receiving services at the Oakden facility in SA[5]. It is without doubt that these were prolonged not only by systemic failures at provider level, but also failures attributed to poor regulation of the sector.

In addition there has been ongoing media interest in exposing an emerging epidemic of neglect in aged care. This is further substantiated by concerns raised by our members that unsafe staffing levels mean they are unable to provide effective, evidence based care and a safe place for people to live[6]. It is a fundamental right of older Australians to live in a safe environment. Sadly, this has not been the case and is a shameful reflection of the value we place on both our older citizens and those who care for them.

The correlation between safe staffing and good quality care has been a common thread identified in previous consultations. The provision of safe staffing ratios and skills mix in aged care are intrinsically linked to safety and protection against abusive practices. Attempts to enhance quality standards will be futile unless legislative reforms also dictate measurable ratios and skills mix in RACFs.

For these reasons it is essential that any guidance intended to assess quality in residential aged care is fit for purpose and able to protect people from abusive

[1] Inquiry can be found at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality
[2] Report available at: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/10_2017/review_report_final_23_october_2017.pdf
[3] Report available at: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2017/legislated_review_of_aged_care_2017.pdf
[4] Report available at: https://www.alrc.gov.au/publications/elder-abuse-report
[5] Groves A, Thomson D, McKellar D and Procter N. (2017) *The Oakden Report*. Adelaide, South Australia: SA Health, Department for Health and Ageing.
[6] NSW Nurses and Midwives Association (2016) *Who will keep me safe? Elder Abuse in Residential Aged Care.* Available at: http://www.nswnma.asn.au/wp-content/uploads/2016/02/Elder-Abuse-in-Residential-Aged-Care-FINAL.pdf
NSW Nurses and Midwives Association (2016) *Solutions from the frontline: Practical approaches to reduce the risk of abuse in aged and disability services.* .Available at:https://issuu.com/thelampnswnma/docs/solutions_from_the_frontline
NSW Nurses and Midwives Association (2017) *The state of medication in NSW residential aged care.* Available at: https://issuu.com/thelampnswnma/docs/medication_in_nsw_ras_final_lr

practices, whether as a direct result of institutional practices, or as a consequence of the way an organisation is operated and managed.

We are concerned that whilst extensive in their current form, these draft standards have weakened what was already an inadequate assessment framework. There is little prescriptive direction as to what quality outcomes look like and what assessors should observe. Terminology is vague and unhelpful and there is heavy reliance on provider reported self-assessment.

There are significant omissions in the assessment of staffing adequacy, medications management and maintaining a safe environment. Our concerns are heightened by the fact that these are already amongst the highest areas of non-compliance. This appears to be 'business as usual' for our members who remain as vulnerable within the system as those they care for.

We support the increased focus on consumer experience. However, shifting a focus on outcomes can only be effective if they are measurable and legislative action can be taken should a perceived breach occur. Legislation that relies on terms such as 'sufficient' and 'adequate' is open to consumer challenge and there is little evidence to substantiate its past effectiveness in ensuring safe, quality care.

The use of the word 'requirement' throughout the draft standards is misleading as it implies that all are enforceable. Indeed, unless the legislation is strengthened many remain good practice guidelines and should be termed as such, to ensure the public are aware of their intent.

We remain concerned that to date, there has been no indication of intent to review the legislation underpinning the proposed quality standards. This is a monumental oversight in ensuring adequate protections for our most vulnerable in society.

Brett Holmes
General Secretary

List of Recommendations

1. The Aged Care Quality Standards and the *Aged Care Act 1997* including associated legislative instruments should be strengthened to set clear and directive benchmarks to be tested by the AACQA (and successive Commission).

2. Enhanced measures to test quality should be introduced in favour of self-reported compliance. Including, but not restricted to: Demonstration of safe staffing based on an evidence based staffing model; monitoring of key quality indicators such as incidence of pressure sores; preventable hospital admissions; Infection rates; prescribing trends and untoward incident reports.

3. Under Requirement 1 evidence should be sought regarding the information made available (in an appropriate format) to prospective consumers. Also that in reviewing this evidence it is explicit as to those services the RACF can and cannot provide, for whatever reason.

4. Requirement 1.3 an additional test of evidence should be stated. That the staffing model in operation at the RACF demonstrates that it enables the workforce to support residents to effectively maintain consumer choice and control.

5. Requirement 1 an additional test of evidence should be stated, that the staffing model in operation at the RACF enables the workforce to uphold residents dignity.

6. Requirement 2 p27 the wording should be amended to state that the staffing model in operation at the RACF enables the assessment and planning of care to be undertaken by a registered nurse, in consultation with the consumer and wider team of health and allied professionals.

7. Requirement 2 p32. An additional example of evidence should include confirmation of how the assessment and subsequent plan of care is used to inform the model of care. For example, in the mapping of acuity and needs to the scheduling of appropriate qualification and numbers of staff to meet those needs.

8. Use of vague terminology as a test of compliance should be removed throughout the draft standards since they provide no purposeful direction for providers or auditors and as such, provide no protection for care recipients and the workforce.

9. Requirement 2.7. Examples of evidence should include a check that the staffing model is adaptable to the fluctuating needs of consumers following care reviews. A test of this would be to observe scheduling of staff on staffing rosters, clinical care outcomes and consumer feedback.

10. A more suitable system to link providers and workers to a wider range of the latest key resources and legislation should be sought.

11. It is recommended that mental health and bariatric care are added to the list of prevalent risks under requirement 3A.

12. The wording against the final supporting strategy under requirement 3B should be changed to read: *Enable access to relevant numbers of nursing, allied health and medical services so the consumer is supported to maintain optimum health and wellbeing.*

13. A further example of evidence should be added to requirement 3B. Evidence that there is a system in place to ensure the personal and clinical care needs of consumers informs the required number and skills mix of staff to ensure safe, effective care.

14. Requirement 3D should include a test of sufficiency applied to staffing given the volume of research to support that increased staff supervision is instrumental in reducing falls, particularly in those with dementia.

15. Requirements 3E and 4.5 should include a test of sufficiency should be applied to staffing to ensure there are sufficient numbers of staff available to assist people to maintain adequate nutrition and hydration.

16. We believe that it is not the role of aged care providers to develop and implement a system for defining and verifying the scope of clinical practice for administering medicines, and advise this is removed from requirement 3G.

17. An additional test of how the planning of staffing and skills mix allows for safe medication practices, should be included in requirement 3G.

18. The reflective strategies listed under requirement 3H should include assessment of how staffing models ensure the right staff are present to assess, administer and monitor the effectiveness of pain relief.

19. The supporting strategies listed under requirement 3I should include examination of how workforce planning allows for safe implementation of preventative strategies to reduce the risk of pressure injuries and wounds.

20. It is recommended that requirement 3J includes the presence of a risk assessment which is regularly reviewed, and which clearly identifies the number and skills mix of workers required to minimize the risk of restrictive practices.

21. Examples of evidence required under requirement 3.4 should also include how workforce planning allows a palliative approach to care to be implemented, to ensure that the right number and skills mix of workers are available at times required by consumers.

22. An additional point should be added under supporting strategies for requirement 3.5. That the staffing model allows for timely recognition and response to unexpected changes in consumers condition.

23. An additional example of evidence should be added under requirement 3.7 to examine the workforce strategies implemented to enhance hospital avoidance measures.

24. Requirement 3.8 should be broadened to include more detail about and evidence of transmission based precautions.

25. Requirement 6.2 should explicitly state that processes must allow for workers to raise issues in good faith, without fear of reprisal both internally and externally.

26. An evidence-based staffing model should be legislated. Quality standards under requirement 7 should test whether this sufficiently determines a safe ratio of staffing numbers and skills mix for the consumer group accommodated at any given time.

27. Key resources under requirement 7 should include the Australian Nursing and Midwifery Federation (2016) Staffing and Skills Mix Project.

28. Inclusion of an assessment of the English language skills of workers as a quality measure under requirement 7.3.

29. A safer way to assess compliance under requirement 8f would be to explicitly cite work health and safety legislation.

30. Draft standards should be made more explicit to ensure the safety of residents and the workforce with particular regard to work health and safety issues.

About the Aged Care Standards

We are concerned about the following comment:

"It is recognised that many organisations will choose to go beyond these core Standards and provide an even higher quality of care and services" p1

Given widespread concern regarding the ineffectiveness of the underpinning legislation in terms of defining adequacy and sufficiency, standards intended to test these definitions should at least aspire to set a high quality benchmark. Assuming many providers will achieve higher standards is characteristic of self-regulation and suggests that the Aged Care Quality Agency (AACQA and successive commission) will seek the lowest denominator of quality as a test of sufficiency. This is a system that is already failing and it is concerning that this fundamental issue has not been recognised.

Having a robust legislative framework to underpin standards would seem to be the most protective response in this circumstance. *We recommend that the Standards and the Aged Care Act 1997 including associated legislative instruments are strengthened to set clear and directive benchmarks to be tested by the AACQA.*

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Points 1 to 4 criteria for assessing performance against standards suggests that organisations are able to identify and address areas of risk that are prevalent in the sector and suggest that self-reporting will feature heavily in the test of safety in the delivery of care. Whilst there are some providers who are able to operate effectively to provide good outcomes for their residents, our members tell us there are many that cannot.

We have already highlighted the ineffective nature of existing legislation, standards and processes in weeding out those providers who are unable to self-regulate. Market forces will do little to change this situation due to finite allocation of aged care places. *We recommend that enhanced measures to test quality are introduced in*

favour of self-reported compliance. Including, but not restricted to: Demonstration of safe staffing based on an evidence based staffing model; monitoring of key quality indicators such as incidence of pressure sores; preventable hospital admissions; Infection rates; prescribing trends and untoward incident reports.

> ***"It has been noted that there is an increase in the amount of pressure areas on residents in our facility. Registered nurses are asking why. Staff explain that they would love to be able to turn people more but if you are working with shortages of staffing this is not possible."***
>
> ***Assistant in Nursing, RACF***

Standard 1: Consumer dignity and choice

In some cases, access to a range of organisations and to particular care and services may be limited by location and environment p10

We would suggest that care recipients need to know in advance of securing a residential aged care place where a RACF may not be able to provide a full service. Although partly covered in s1.4 it is recommended that *evidence is sought regarding the information made available (in an appropriate format) to prospective consumers. Also that in reviewing this evidence it is explicit as to those services the RACF can and cannot provide, for whatever reason.*

The workforce can provide specific and meaningful examples of how the organisation has supported consumers to exercise choice and control even where that choice posed risks to them p20

Whilst we acknowledge the intent behind this statement. We would argue that this places unreasonable demands on the workforce, since our members tell us they are unable to uphold the choices of residents for reasons beyond their control. Good care takes time *and* resources. However, this is often compromised due to unsafe staffing ratios and skills mix. A factor which is outside the individual control of

workers in most circumstances. We believe this example needs to be supported by an additional test of evidence, that *the staffing model in operation at the RACF enables the workforce to support residents to effectively maintain choice and control*.

In addition, although pleasing to note the increased focus on training. This will be largely ineffective if workforce are not present in sufficient numbers and with the right mix of skills to provide safe, dignified care. We therefore also suggest an additional test of evidence, that *the staffing model in operation at the RACF enables the workforce to uphold residents' dignity*.

Standard 2: Ongoing assessment and planning with consumers

P27 point three identifies that assessment and planning of the residents care should be undertaken by an *appropriately skilled and qualified workforce*. We argue that this terminology is too vague and therefore open to individual auditor interpretation. We believe that registered nurses, in consultation with the consumer and wider team of health and allied professionals are best placed to assess and plan care. This is a fundamental element of their graduate education, and a key requirement of their professional code of practice.

These draft standards are intended not only to inform current practice, but also to withstand the test of time. It is unlikely that any RACF will be devoid of at least one resident requiring complex healthcare management. Therefore we recommend the wording is amended to: *The staffing model in operation at the RACF enables the assessment and planning of care to be undertaken by a registered nurse, in consultation with the consumer and wider team of health and allied professionals.*

Requirement 2.2 p32. An assessment and plan of care is ineffective if they are not used to determine the required ratios of staff to residents. Also if they are not used to determine the skills required from within the workforce to meet care needs. Good examples of this are in the assessment and planning of a behaviour management program. This will often require additional numbers of staff to provide supervision

and diversional therapy. Also, the presence of identified complex wound management in a care plan should prompt the availability of a registered nurse within the skills mix. These are fundamental elements of assessment and care planning that appear to be overlooked in the evidence required to assess compliance against these draft standards. *An additional example of evidence should include confirmation of how the assessment and subsequent plan of care is used to inform the model of care. For example, in the mapping of acuity and needs to the scheduling of appropriate qualification and numbers of staff to meet those needs.*

Requirement 2.7 p42. Under Consumer experience it states: *Evidence of a range of methodologies being used to seek and understand, the consumer experience against this standard*. This sentence does not provide any context for auditors to assess compliance and is open to individual interpretation. If striving for a meaningful and purposeful audit of compliance it is recommended that *use of vague terminology as a test of compliance is removed throughout the draft standards*.

Requirement 2.7 p43. Although it is important to ascertain that the workforce understand their role in the review of care. Examples of evidence should also include a check that the staffing model is adaptable to the fluctuating needs of consumers following care reviews. A test of this would be to observe scheduling of staff on staffing rosters, clinical care outcomes and consumer feedback. We believe this is a further example of the unhelpful nature of these draft standards in directing auditors to relevant evidence to test compliance.

Standard 3: Personal care and clinical care

P45. The list of key resources and relevant legislation is not comprehensive and focuses on dementia care and palliative care only. Although two of the largest reasons for admission to RACFs, there are many other medical conditions experienced by consumers. The listed documents are also time-limited. If the intent is to ensure evidence-based practice and clinical benchmarking then *a more suitable*

system to link providers and workers to the latest key resources and legislation should be sought. This also applies to other sections of the draft standards.

P47. The list provided of high impact or high prevalence risks omits a couple of important risks that our members tell us are on the increase in aged care and are currently not well managed. These relate to the significant increase in residents with mental health issues and bariatric residents. The poor management of these issues has a serious impact on the health and safety of consumers and care workers. *It is recommended that mental health and bariatric care are added to the list of prevalent risks under requirement 3A.*

P49 Supporting strategies. The list states: *Enable access to relevant allied health and medical services so the consumer is supported to maintain optimum health and wellbeing*. It is fundamental to health and wellbeing, particularly given the list of key risks on p47, that nursing staff are also accessible to consumers. It is also vital that these are provided in sufficient numbers to ensure they are able to deliver the services required. *It is recommended that the wording is changed to read: Enable access to relevant numbers of nursing, allied health and medical services so the consumer is supported to maintain optimum health and wellbeing.*

"If you haven't got staff on the floor people can't be attended to as often as they should be. That's when you end up with broken down ulcers and they take longer to heal."

Assistant in Nursing, RACF

P49 Examples of evidence. This does not include assessment of how the care needs of consumers is matched to the provision of staffing. *A further example of evidence should be added to standard 3B. Evidence that there is a system in place to ensure the personal and clinical care needs of consumers informs the required number and skills mix of staff to ensure safe, effective care.*

P54 D Minimising the risk of falls and harm from falls.

Fall occur for many reasons. However, good practice guidelines suggest that identification of risk factors and provision of education to staff alone are ineffective in falls prevention and must be accompanied by a strategy to ensure adequate supervision of consumers[7]. Given the volume of research to support that increased staff supervision is instrumental in reducing falls, particularly in those with dementia, *it is fundamental that a test of sufficiency is applied to staffing in this standard*.

> ***"One afternoon, there were only two personal care workers in the Dementia unit. The two carers were attending to another resident in their bedroom. A physically aggressive resident caused another resident to fall and break her hip."***
>
> ***Registered Nurse, RACF***

P55 E Optimising nutrition and hydration

A test of sufficiency should be applied to staffing to ensure there are sufficient numbers of staff available to assist people to maintain adequate nutrition and hydration.

> ***"You have to be patient to give people sips of fluid, and because this takes time a lot isn't done. It comes down to staffing, especially when we have a heat wave and people get dehydrated."***
>
> ***Assistant in Nursing, rural RACF***

[7] Australian Commission on Safety and Quality in Healthcare (2006) Preventing falls and harm from falls in older people: Best practice guidelines for Australian residential aged care facilities. Available at: https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-RACF.pdf

P57 G Medication safety and minimising medication misadventure

Under supporting strategies it states: *Develop and implement a system for: defining and verifying the scope of clinical practice for administering medicines*. Medication mismanagement is a top area of complaint received by the Aged Care Complaints Commission, top area of non-compliance reported by the AACQA and top concern for our aged care members. One of the major contributory factors would appear to be a lack of clarification about roles and responsibilities in regard to the safe management of medicines in RACFs which is, in part, due to the ability of providers to self-determine the level of skill and qualification required.

We would argue that the scope of clinical practice for administering medicines can only be determined through developing commonwealth and state legislation that is clear and provides sufficient direction to ensure the safe management of medicines. In addition, we believe it is the role of the Nursing and Midwifery Board of Australia to determine the scope of clinical practice. We argue that aged care providers, many of whom do not have a medical or clinical background are not well placed to determine scope of clinical practice and *recommend that this statement is removed*.

"When I was administering lunchtime medications in the Dementia Secure Unit, I received a phone call from the hostel located in another building, that there was a resident choking in the middle of the dining room. The residents there were having their lunch. I had to leave my residents to undertake first aid as she was unable to breathe as there was no registered nurses rostered in the hostel. In addition, lunchtime medications were delayed in the Unit where I was rostered to work that day."

Registered Nurse, RACF

In addition, registered nurses working in RACFs are often caring for upwards of 100 residents and supervising unlicensed care workers. In some RACFs this is without the clinical support of a Director of Nursing. This not only leaves those workers vulnerable, but the people they administer medications to. *An additional test of how planning of staffing and skills mix allows for safe medication practices, should be included.*

P58 H Supporting consumers to live without pain

We welcome this standard as the issue of pain management in RACFs is a top area of concern for our aged care members. One of the main mitigating factors for failure to ensure adequate pain relief is lack of availability of the appropriate level of worker to administer pain relief. Often the presence of a registered nurse is required to legally administer medications.

Pain is not a condition restricted to office hours, it can occur at any time during the day or night on any given day. Therefore the current trend toward reducing the availability of registered nurses outside office hours in RACFs is counter-productive to achieving this draft standard. For this reason, a fundamental test of this would be to assess how staffing models ensure the right staff are present to assess, administer and monitor the effectiveness of pain relief and *it is recommended this is added to the reflective strategies against 3H.*

P60 I Skin care – Preventing and managing pressure injuries and wounds.

Having sufficient number and skills mix of workers to prevent pressure injuries and manage wounds is fundamental to achieving this draft standard[8]. *The supporting strategies listed under 3I should therefore include examination of how workforce planning allows for safe implementation of preventative strategies to reduce the risk of pressure injuries and wounds.*

3J Minimising restrictive practice

We have concerns about the way this section is drafted. Work Health and Safety (WHS) laws override aged care quality standards and under *s19* of the *WHS Act*, the employer has a duty '*to ensure, so far as is reasonably practicable, the health and safety of workers'*. This involves identifying risk, assessing risk and putting in place measures to eliminate risk as far as reasonably practicable (or to minimise risk). Under security of tenure provisions it is extremely difficult to remove a violent

[8] NSW Health (2014) Pressure Injury Prevention and Management Policy Available at: http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_007.pdf

resident from a RACF, leaving staff and other residents at ongoing risk of serious injury arising from assault.
Sometimes even with the best developed behaviour management plans, medication reviews etc, restrictive practices are the only available option. While this section doesn't prevent the use of such practices. The way it is currently worded curtails its use, and is likely to result in an increase in incidents arising from aggressive behaviours. *It is recommended that standard 3J includes the presence of a risk assessment which is regularly reviewed, and which clearly identifies the number and skills mix of workers required to minimise the risk of restrictive practices.*

3.4 Examples of evidence should also include how workforce planning ensures a palliative approach to care can be implemented. It is essential that the right number and skills mix of workers are available at times required by consumers and not dictated by providers. We have examples from our members of registered nurses being removed from night shift leaving no staff on duty who were qualified to deliver effective pain relief for people at end of life. We believe that a palliative approach cannot be effectively implemented without consideration of workforce planning.

3.5 Whilst we would agree that a supporting strategy should be in place to determine the level of training the workforce receives to be able to respond to unexpected changes in consumers. We believe that this would be largely ineffective if the right staff are not available to respond to such circumstances. We recommend *an additional point is added under supporting strategies for 3.5 that the staffing model allows for timely recognition and response to unexpected changes in consumers condition.*

3.7 The ability of the provider to avoid unnecessary hospitalisation of consumers is missing from this standard. However, it is an essential measure of quality for consumers. There is evidence that transfer of people out of a RACF can have a detrimental effect on their general wellbeing. It may also impact on their end of life wishes. There is also evidence to suggest that registered nurses present within the

skills mix of RACFs can be an effective hospital avoidance strategy[9]. *We recommend that an additional example of evidence is added under 3.7 to examine the hospital avoidance measures that are implemented.* For example, having registered nurses in the skills mix.

3.8 Mainly focuses on antibiotic resistance with little focus on standard and transmission based precautions other than the need to wash hands. For example, it does not mention the five moments of hand hygiene. There is nothing about relevant personal protective equipment such as gloves, goggles, masks, aprons and the need for biological spills kits. *We recommend standard 3.8 is broadened to include transmission based precautions in more depth.*

Standard 4: Services and supports for daily living

4.5 An additional test of compliance should include a check of whether the staffing model provides enough staff to assist people to eat their meals in a way that ensures adequate hydration and nutrition, but also which upholds their dignity (see recommendation 16).

Standard 6: Feedback and complaints

6.2 There should be more explicit consideration of whistleblowing in this section. The ability of workers to raise issues in good faith is one of a range of protections that should be in place. *It is recommended that this standard explicitly explores the measures taken to ensure workers are supported to raise issues in good faith, without fear of reprisal both internally and externally.*

[9] Dwyer, R. et al (2015) Unplanned Transfer to Emergency Departments for Frail Elderly Residents of Aged Care Facilities: A review of Patient and Organisational Factors. Available at: http://www.seed.monash.org.au/sites/default/files/Dwyer_2015_JAMDA.pdf

Standard 7: Human resources

Unless legislative measures are put into place that require an evidence-based staffing model to determine ratios of staff and skills mix any attempts to improve what is already weak regulation of the sector will not bring about measurable improvements. It is disappointing that these draft standards continue to use terms such as sufficiency and adequacy when determining compliance against workforce issues. As we have argued, the provision of appropriate number and skills mix of workers is fundamental to these draft standards. It is clear that leaving decisions about staffing open to provider discretion does not always achieve the best outcomes for consumers.

"When a resident was reported missing, questions were asked. We explained that staff were caught up giving out evening meals etc. as there was no extra staff at these times. Residents with dementia are wandering constantly and need one to one attention from staff, but we are unable to provide this as other residents require attention too."

Assistant in Nursing, RACF

"Audits should focus on the staffing shortfalls and the resident to staff ratio - more so for the high care residents (in facilities). Management should also be made responsible for the continuation of staffing shortfalls and issues. There should be a governing body where assistants in nursing, registered nurses etc. can report the ongoing and unresolved staffing shortfalls. If management of the aged care facilities continue to ignore these issues or refuse to put measures in place to resolve these then a governing body should be able to intervene somehow. These shortfalls are directly linked with poor resident care and subsequently elder abuse. How are we expected to do our jobs successfully and efficiently with the highest standard of care when all the facility is focused on is cost cutting?"

Assistant in Nursing, RACF

> ***"A resident wandered off from our non-secure facility and has never been located. We were short staffed on the day. This has been extremely stressful and sad for our community as a whole."***
>
> ***Registered Nurse, RACF***

The law requires clear and demonstrable evidence when determining a legislative breach. Terms such as sufficiency and adequacy are open to interpretation and as such, can easily be challenged by providers. The ability of regulators to take enforcement action against the human resources standard would be wholly determined by failure to comply with other sections of the legislation. For example, medications management where there is clearer demarcation between compliance and non-compliance.

We argue that having legislation in place that requires an evidence-based staffing model to determine numbers of staff and skills mix to be provided at any given time would provide a firmer basis for enforcement. *We recommend that an evidence-based staffing model is legislated and that quality standards ensure they test whether this sufficiently determines a safe level of staffing numbers and skills mix for the consumer group accommodated at any given time.*

It is concerning that revised outcomes fail to define a staffing model that will enable assessors to determine optimum staffing skills mix and ratios. It is our view that this is fundamental to ensuring high quality care as demonstrated in the findings of the Oakden Report; which recommends mandated minimum staffing and skills mix to ensure safe and appropriate care[10]. Australian Nursing and Midwifery Federation research conducted in 2016 found that current staff hours are not adequate to even meet basic care needs[11]. Failure to ensure effective regulation of this area, and

[10] ibid
[11] ANMF (2016) National Aged Care Staffing and Skills Mix Project Report 2016. Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

establish minimum standards to report against will no doubt lead to a continuation of the poor practices such as those displayed at the Oakden facility.

Key resources under standard 7 should include the Australian Nursing and Midwifery Federation (2016) Staffing and Skills Mix Project.

> ***"Last year our facility didn't pass accreditation and most of the failure was unmet needs and the dementia unit. If you take someone to the toilet the rest are left unattended. The registered nurse could be across the road at the dementia unit so there's no eyes left on the remaining residents. It's no surprise we are failing our residents but without any law to back up assessors they can't do anything."***
>
> ***Assistant in Nursing, remote RACF***

7.3 Whilst having a diverse group of workers enhances consumer experience our members regularly report that the written and verbal English skills of some workers, particularly those recruited from overseas is problematic for consumers. *It would be helpful to include assessment of the English language skills of workers as a quality measure.*

A recent independent report by Professor Joseph Ibrahim[12] highlighted a catalogue of preventable deaths arising in RACFs. This should serve as a timely warning of the need to invest more heavily in the aged care workforce; to increase access to skilled registered nurses and provide greater levels of training for all levels of workers. In reality, what data tells us is that staff have less access to training, and that the numbers of registered nurses are decreasing, in favour of unregulated care workers[13].

[12] Ibrahim, J. (2017) Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services. Monash University: Southbank

[13] https://agedcare.health.gov.au/news-and-resources/publications/2016-national-aged-care-workforce-census-and-survey-the-aged-care-workforce-2016

Whilst it is pleasing that unannounced only site visits are planned following the recommendations of the Review of National Aged Care Quality Regulatory Processes [14]. To date, there has been no consultation or indication of any changes to aged care legislation. Unless there are clear links between outcomes to be measured and well-defined legislation, auditors will have little power to take swift remedial action where concerns are identified.

Standard 8: Organisational Governance

8f The section within existing standards that covers occupational health and safety *'Management actively working to provide a safe working environment that meets regulatory requirements'* is now covered with a general statement within 8f "*ensuring compliance with legislative requirements and relevant standards'*. It is recommended that a *safer way to assess compliance would be to explicitly cite work health and safety legislation in this.*

Work Health and Safety – general comment

In addition to these comments we have concerns regarding the weakening of the standards by removal of prescriptive guidance in the area of work health and safety. The following comments relate to sections of the existing standards.

1.7 Inventory and equipment stocks of appropriate goods and equipment for quality service delivery are available has been removed. We regularly visit members at RACFs that have inadequate Personal Protective Equipment (PPE) available for either standard or transmission based infection control. Our members regularly inform us about limitations being placed on use of incontinence pads or items like sick bags being locked away and only the registered nurse having a key (this is a particular problem at night when they may be only one registered nurse in the entire facility).

[14] ibid

2.13 Behaviour management which required that *care recipients with challenging behaviours are managed effectively*. There are new sections on supporting people living with dementia and on minimising restrictive practice, but these focus on the rights of the resident and not on ensuring that aggressive behaviour is managed for the safety of others including staff and other residents. Not all aggression in aged care is attributed to dementia. Delirium, drug and alcohol misuse, mental health, intellectual disability, resistance to care and lifetime predisposition to violence towards family members and others are all possible causal factors. This is not acknowledged in the draft standards and is a serious oversight with the potential for life threatening consequences both for residents and workers.

The examples of evidence provided are listed as:

- Consumer experience
- Workforce and other experience
- Education
- Policies and practices monitoring, reporting and performance improvement

None of the examples under each of these headings include examples that involve inspecting the presence of equipment and stocks of essential products and sundries. For example, 3.8 – minimising infection, does not prompt auditors to observe adequate stocks of PPE to allow for transmission based precautions to be put in place in the event of an outbreak. We have visited a range of facilities with comprehensive written policies and procedures that are clearly not being implemented. We are concerned that the "evidence" being looked at may not reflect what is actually occurring at the workplace.

Additionally, the standards do not adequately address the key issues that we observe. Particularly when conducting workplace health and safety visits to RACFs. These include:

1. Behaviour management/violence;
2. Poor systems re infection control (generally never enough PPE, and not located where it should be)

3. Poor manual handling – equipment not maintained properly, or not fit for purpose, (e.g. a shower chair with a safe working limit of 130kgs being used with three people well over that weight – one was over 170kgs). Plus insufficient staff rostered for two, three and four assist residents.
4. Poor admissions processes which see residents admitted when the RACF does not have the capacity to care for them (e.g. bariatric residents when they only have standard sized rooms/doorways and lack the appropriate equipment and staffing levels to provide safe care).

These real day to day issues have the potential to be overlooked using these draft standards and we would strongly recommend they are *made more explicit to ensure the safety of residents and the workforce.*