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## AMA submission to the Australian Aged Care Quality Agency – Draft Guidance Aged Care Quality Standards

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### Background

The AMA thanks the Australian Aged Care Quality Agency (AACQA) for the opportunity to provide feedback on the draft guidelines for the new Aged Care Quality Standards (the Standards). It is, however, disappointing that stakeholders have such a short timeframe to give feedback. This is an important document that affects the lives of every older person receiving aged care services, their families and carers, and the organisations and external professionals that provide the services. The AMA would support providing ongoing feedback to the AACQA on the Standards.

The AMA understands that medical practitioners will not be assessed by the new Standards, however, medical practitioners can provide insight into clinical principles and methods that should be included. Medical practitioners also have a responsibility to advocate for their patient's care needs. We also observe that some Standards involve 'other' members of the workforce, which includes medical practitioners. The AMA understands there are multiple Standards that require consultation with other service providers involved in the care of consumers. We support this change, as AMA members state that there was little to no consultation with them during the previous Accreditation Standards assessments.

The AMA regards this guidance document as aspirational. There are important principles within the document regarding consumer choice and engagement in their care, and respect and dignity for all older people, with an emphasis on meeting their cultural needs and beliefs. However, the AMA is concerned about how these aspirational principles are going to be implemented. This document does not give any advice on how these guidelines will be achieved. For example, Standard 3.7 requires timely referral to other providers when necessary<sup>1</sup>, but does not say how this will occur. To meet these guidelines, providers could call in a deputising service every night and unnecessarily transfer numerous patients to an emergency department (ED). Care is best provided by the consumer's usual GP, as they are aware of the consumer's medical and personal situation. Transferring residents to EDs are expensive and can be disorientating and stressful to the consumer. In a study of 408 residents of Residential Aged Care Facilities (RACFs) presenting at two Melbourne EDs, one third of presentations of residents who were returned to their RACF

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<sup>1</sup> Page 73

could have been avoided by incorporating primary care services<sup>2</sup>. The Standards are not specific enough to ensure care is provided in the most appropriate way. Aged care staff should work with the consumer's usual GP to discuss after hours medical care.

The AMA understands that the new Standards will demonstrate a consumer-focus rather than a provider-focus. Sometimes, however, consumer feedback on the quality of a service may not necessarily align with the clinical quality that a service should demonstrate. Many of the Standards remain flexible and will be assessed subjectively in order to promote innovation and quality improvement, and to be applied to a range of aged care providers<sup>3</sup>. The AMA does not believe this is the right approach to the Standards that involves clinical care. For example, a consumer may not have the health literacy to understand the requirements for good antimicrobial stewardship or medication management. Good clinical care is rarely subjective.

### Minimum staffing ratios

Most importantly, the Standards do not specify minimum staffing ratios. This is critical to consumer safety and quality of care. This section applies to Standard 7, however the AMA believes this should be a priority for the Standards to implement.

The AMA agrees that there should be an appropriate mix of staff that have the capability and capacity to carry out their roles in an aged care service. However, the previous Accreditation Standards failed in measuring what the appropriate mix is. The AMA is concerned that the definition of a sufficient workforce is not specific enough to protect consumer's health care needs. The existing definition in the guidelines is that:

“Organisations providing aged care services are required to have adequate numbers of appropriately skilled staff to meet consumers' needs. It is the responsibility of individual services to use Australian Government funding to make sure they have the staffing mix and numbers they require for their consumers to receive high-quality care.”<sup>4</sup>

There is a disparity between the views of aged care providers, medical professionals, and the public, on the roles of aged care services. The Senate and Community Affairs References Committee's interim report on *The effectiveness of aged care quality assessment and accreditation framework*<sup>5</sup> highlighted that some aged care providers believe they should not be held accountable for clinical services, while the AACQA's existing clinical care Standard is commonly not met by aged care providers<sup>6</sup>. Most of the reports on the appalling incidents that

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<sup>2</sup> Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?*. Emergency Medicine Australasia. 27:5, p412-418

<sup>3</sup> *Each organisation should interpret the guidance considering its own service delivery model. Outcomes, and the manner in which they are demonstrated, will be unique to individual services' responses to their consumers' needs.* Page 2

<sup>4</sup> Page 127

<sup>5</sup> The Senate Community Affairs References Committee (2018) *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised* interim report. p54-56

<sup>6</sup> Australian Aged Care Quality Agency (2017) *Annual Report 2016-2017*, p13

have recently occurred in the aged care sector more broadly (for example, the Oakden Older Persons Mental Health Service<sup>7</sup>) have been a result of a lack of quality clinical care provided by the aged care service provider. The AMA believes that to dismiss clinical care as a responsibility of aged care settings is not responding to older people’s greatest, most urgent needs, leading to further stories of the neglect of older people. The Standards need to clearly define the responsibilities of organisations to avoid confusion within the workforce and ensure older people receive timely, appropriate care.

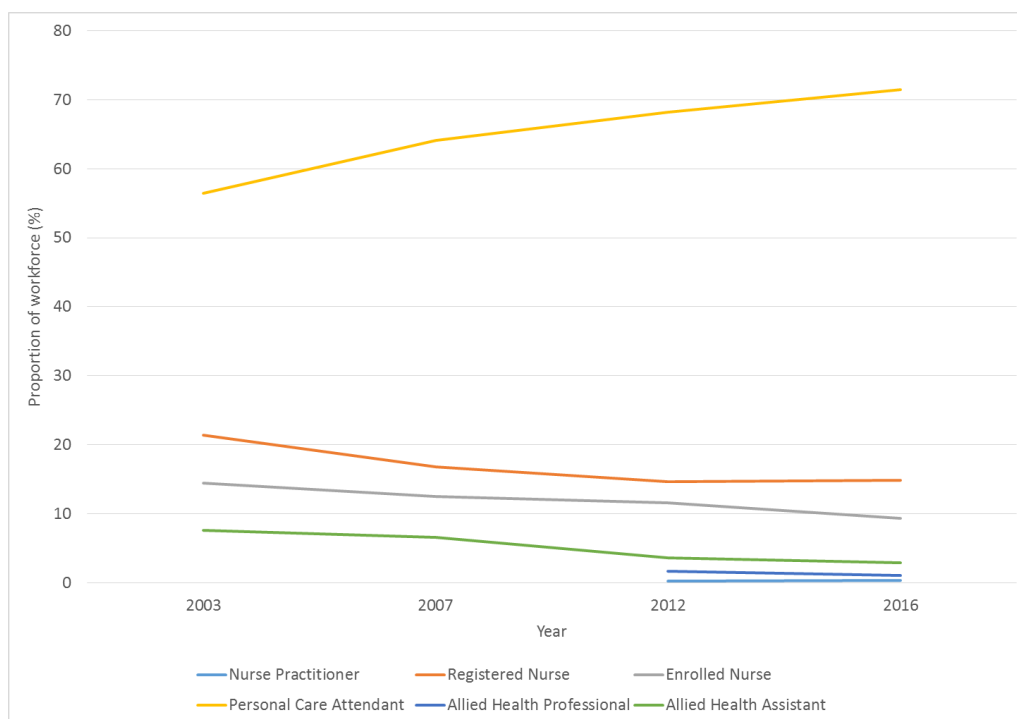


Figure 1: The proportion of Full Time Equivalent employee types in the aged care workforce. Data source: Mavromaras et al (2016) *The aged care workforce, 2016*. Department of Health

Clinical Care Standard 3 will not be adequately met by any aged care organisation without well-trained, appropriate quantities of clinical staff. There has been a decreasing trend in the proportion of registered and enrolled nurses in the aged care workforce (Figure 1). Our members have reported cases where nurses are being replaced by junior personal care attendants, and some RACFs do not have any nurses staffed after hours. This presents significant communication difficulties and risks to health, as our members have advised that there is on occasion no nurse or appropriate staff member available to discuss their patient’s requirements. Further, a recent survey identified low staffing levels in RACFs as the main cause of missed care (e.g. not responding to bed calls within five minutes, checking vital signs etc.)<sup>8</sup>.

The Standards must ensure that RACFs do not have a restricted quality of care due to a workforce shortage. The decline in the proportion of registered and enrolled nurses needs to be reversed to ensure residents are provided with timely and appropriate clinical care. This has placed additional

<sup>7</sup><http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/About+us/Reviews+and+consultation/Review+of+the+Oakden+Older+Persons+Mental+Health+Service/>

<sup>8</sup> Henderson et al (2016) *Missed care in residential aged care in Australia: An exploratory study*, Collegian

pressure on nurses and medical practitioners and has likely led to increased transfers to the ED. The Standards should demonstrate a ratio, or minimum, of suitably trained nurses to patients at any one time to ensure people living in RACFs with complex needs are receiving appropriate care.

### Document layout

The formatting of the document lists 'evidence' and 'strategies' for meeting the Standards, which are helpful as examples. However we believe this may cause confusion for the sector, as there is nothing in concrete that tells them exactly what is required. The National Safety and Quality Health Service Standards (NSQHS)<sup>9</sup> clearly sets out what actions should be taken to meet each criteria. This is the format the AACQA should consider for the guidance document.

For example, the NSQHS 'Comprehensive Care Standard' states (noting that discharge planning is not applicable to aged care settings): "5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:

- a) Addresses the significance and complexity of the patient's health issues and risks of harm
- b) Identifies agreed goals and actions for the patient's treatment and care
- c) Identifies the support a patient wants involved in communications and decision-making about their care
- d) Commences discharge planning at the beginning of the episode of care
- e) Includes a plan for referral to follow-up services, if appropriate and available
- f) Is consistent with best practice and evidence."<sup>10</sup>

In contrast, the guidance document refers to care planning sporadically throughout the document and never specifically lists what should be included in a care plan. Care plans are essential to ensuring that everyone in the care team, whether internal or external of the organisation, is aware of a person's care requirements.

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

### Choice

The AMA supports the emphasis on consumer dignity and choice. Of particular importance is that consumers are able to choose their medical practitioner, which is evident under this Standard. The AMA believes that continuity of care with a patients' usual GP provides the most benefits, however we acknowledge that this is not always practical (for example, if a consumer moves away from their usual GP). There are emerging models of providing medical care, particularly in RACFs, where a GP or other medical practitioner is employed by the organisation. AMA members are concerned that organisations may cut off the consumer's usual GP if an in-house GP were employed. While an increase in access to a GP is warmly welcomed, consumer choice in their GP must be maintained. If the consumer chooses to keep their usual GP, they must be supported by

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<sup>9</sup> <https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

<sup>10</sup> <https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>, page 42

the organisation to arrange consultations with their usual GP. This should be included as a 'supporting strategy', and it should be emphasised that this includes the internal and external workforces involved in a consumer's care. It is acknowledged that Standard 4.4 states that "Consumers choices about who they want to meet their care needs are respected and followed and these are documented".<sup>11</sup> It is important that the consumer or their representative is consulted on this Standard to ensure the documented information matches their experience.

### Dignity

An AMA Aged Care Survey, carried out in 2017, reported that 36 per cent of RACFs 'never' had medical practitioner treatment/visiting rooms, while 22 per cent 'rarely' had them. Our members report that occasionally they have to perform consultations in a RACF tea room or other public area. This does not provide the consumer with the dignity and respect they deserve. It also does not provide the medical practitioner with an appropriate, or safe, work space. Consumers deserve to be treated in an appropriate environment that maintains their privacy and dignity. There should be a requirement within the Standards that demonstrates RACFs have an external workforce space (or the availability of the consumer's private room) to ensure appropriate, safe, and private, care is provided.

### **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?**

Standard 2.3 indicates that "Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes."<sup>12</sup> Organisations also need to be able to demonstrate that a consumer's advanced care plan was met and if not, why not. Advanced care plans must not be regarded as a 'tick box' approach, where once a plan or directive is written, that is the end of it. Rather, it is a wider process of ongoing reflection, discussion, and communication of health care preferences that may result in oral/written directives.

It is also important to recognise in the Standards that advanced care plans should be reviewed as the consumer's conditions, and possibly treatment preferences, change. Preferences and conditions may also change in different settings (such as if a consumer moves from their home into a RACF). These changes must be reflected in the consumer's plan (or advanced care directive) and the relevant internal and external workforce should be made aware of these changes.

As with the legislative requirement that aged care organisations must offer influenza vaccinations to their workforce and promote the benefits of vaccination<sup>13</sup>, aged care organisations should also be required to support the process of advanced care planning and also promote the benefits of having one to consumers. Consumers should be strongly encouraged by the organisation to develop an advanced care plan. The need for palliative or end of life care can sometimes occur quickly, without warning. Everyone involved needs to be prepared to carry out the consumer's wishes.

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<sup>11</sup> Page 92

<sup>12</sup> Page 26

<sup>13</sup> Aged Care Legislation Amendment (Influenza Vaccination in Residential Care) Principles 2018

Staying in the hospital can increase the risk of infection<sup>14</sup> and delirium<sup>15</sup>, and can be disorientating and stressful for the patient. Older people can also experience fear from the thought of being transferred to a hospital, and may refuse to go<sup>16</sup>. It is important that advanced care plans ask, record the answer to, “under what circumstances if any do you wish to be sent to hospital?”.

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

Providers of clinical care that are external to the organisation need to be appropriately supported by the organisation. This includes that:

- The medical practitioner can easily contact a registered nurse about a patient’s care, and this nurse is qualified to put into effect any prescribed instructions and treatments 24hrs a day.
- Clinically-equipped available medical practitioner treatment rooms (or availability of the consumer’s private room) that enables patient privacy and an appropriate working environment.
- The ability to access patient files through a contemporary eHealth system that allows interoperability between a medical practitioner’s clinical software, My Aged Care, My Health Record, and RACF software to increase communication and efficiency (provided all privacy measures are met).
- Easy physical access to the actual facility, through the use of swipe cards, access codes, and car parking facilities.

The Standards should ensure aged care organisations facilitate consumer access to other members of the care team, including medical practitioner-led teams and allied health professionals.

Other Standards that should be introduced include:

- Every consumer should have a documented GP. This Standard should also include how to access the GP (or their nominated substitute such as a locum service) after hours.
- Staff will work with a consumer’s GP to support best care.
- Staff will communicate with GPs to best support care.

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<sup>14</sup> Avci, M. et al. (2012) *Hospital acquired infections (HAI) in the elderly: comparison with the younger patients*, Archives of gerontology and geriatrics, vol. 54, no. 1, pp. 247

<sup>15</sup> Caplan, G et al (2015) *Appropriate care for older people with cognitive impairment in hospital*. The Medical Journal of Australia. 2015:23-15

<sup>16</sup> Kjelle, E and Lysdalh, KB (2017) *Mobile radiography services in nursing homes: a systematic review of residents’ and societal outcomes*. 17:231

### Supporting people living with dementia

The 'C. supporting people with dementia' guidelines<sup>17</sup> appropriately refers to evidence-based clinical care as a basis for caring for consumers with dementia. There are, however, additional ways to improve the symptoms of dementia that are not mentioned:

- improve methods of communication and social interaction with consumers with dementia<sup>18</sup>,
- identify signs of undiagnosed pain and when medical attention from a GP or specialist is required,
- improve overall health by supplying nutritious meals, hydration, and implementing adequate exercise programs<sup>19</sup>,
- create a physical environment that is fit for purpose (for example, consumers with dementia require safe walking areas, or alcoves for small groups to have private conversations<sup>20</sup>), and
- address mental health issues in a timely manner.

The above strategies are also beneficial to the health of consumers without dementia. There should be a requirement that the workforce is trained in ways to interact with dementia patients.

### Minimising restrictive practice

The AMA believes this is an extremely important Standard. Some of our members are concerned that aged care staff are requesting sedation of consumers so they are easier to handle. Restraints such as sedation should only be prescribed where any potential risk or harm caused by the restraint itself is less than the risk of the consumer not being restrained. They should always be considered a last resort. Providing care should ensure the safety, wellbeing and dignity of the consumer and ensure a medical practitioner assesses the consumer for any underlying behavioural conditions.

It is extremely important that the workforce understands and keeps track of the use of restraints in their organisation, and the decision to use restraints should not occur in isolation. It involves a process of request, assessment, team involvement and consent within an ethical and legal framework. However, the medical practitioner providing the patient's care is ultimately responsible for the decision to restrain a patient. Any decision and plan of care to restrain must be documented and signed by the medical practitioner in the patient's record.

This also applies to the Standard 3.8, where "staff are supported to promote appropriate prescribing of antibiotics". It is essential that the appropriateness of prescribing antibiotics is at the discretion of the medical practitioner. It should instead read that "staff are supported to understand about appropriate prescribing of antibiotics". Medication management can be

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<sup>17</sup> Page 52-53

<sup>18</sup> [https://www.dementia.org.au/files/20090200\\_Nat\\_QDC\\_QDC1PracResAgedCareFacAll.pdf](https://www.dementia.org.au/files/20090200_Nat_QDC_QDC1PracResAgedCareFacAll.pdf)

<sup>19</sup> [https://www.dementia.org.au/files/20090200\\_Nat\\_QDC\\_QDC1PracResAgedCareFacAll.pdf](https://www.dementia.org.au/files/20090200_Nat_QDC_QDC1PracResAgedCareFacAll.pdf)

<sup>20</sup> <https://www2.health.vic.gov.au/ageing-and-aged-care/dementia-friendly-environments/designing-for-dementia>



challenging if multiple medical practitioners are responsible for the one consumer. Access to consumer records is therefore critical for medical practitioners to provide quality medical care.

This Standard does not mention workforce training in the use of restrictive practices. This must be a fundamental element of workforce training. Definitions of what a physical or chemical restraint is, is required in these guidelines and in staff training. Staff education and training should include<sup>21</sup>:

- The ethical, medical, and legal issues associated with the use of restraint.
- Provision of written guidelines for the application of environmental, pharmacological and physical restraint(s).
- The potential for harm arising from the use or non-use of restraints.
- Optimal prevention, minimisation, assessment and management of aggressive and/or challenging behaviour.
- Timely access to medical assessment and treatment of illnesses associated with, and potentially causing aggressive and/or challenging behaviour.
- Regular audit and clinical review of the use of restraint in the facility including individual case review, critical incidents and near miss monitoring, aggressive and/or challenging behaviours and the subsequent use of restraint(s).
- Flexible work practices.

### Medication management

As described in the guidelines<sup>22</sup>, medication management is critical to avoid adverse health events and avoidable hospital admissions. The guidelines should identify a strategy to ensure that staff communicate to visiting medical practitioners, the consumer's current medication list, and any health concerns. This should be demonstrated through the medical practitioner's ability to access consumer files that identifies their health conditions. These strategies apply not only to medication management, but all clinical standards, in particular, Standard 3.6 should, under 'policies and practices', include 'observation that the relevant treating medical practitioner has access to consumer health records'<sup>23</sup>.

There needs to be training for aged care staff and awareness of protocol relating to adverse reactions to medicines. Residential Medication Management Reviews (RMMRs) are available to permanent residents of government-funded RACFs<sup>24</sup> and are an important review and safety tool. However, RMMRs are becoming sparse. Although GPs are able to carry out one RMMR in a 12-month period<sup>25</sup>, some members have reported they are only occurring every two years, and that many patients are prescribed medication for behavioural issues when unnecessary in order to make them easier to handle. RMMRs should occur annually and on an as-needed clinical basis to ensure medications are not harming the patient and to avoid any time restrictions on reviews, which could ultimately cost the government more in medical costs to treat adverse outcomes, in

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<sup>21</sup> Australian Medical Association (2015) *Restraint in the care of people in Residential Aged Care Facilities*. [https://ama.com.au/position-statement/restraint-care-people-residential-aged-care-facilities-2015]

<sup>22</sup> Page 57

<sup>23</sup> Page 71

<sup>24</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/rmmr-factsheet>

<sup>25</sup> <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=AN.0.52>



the long run. Pharmacists working with medical practitioners and patients can help ensure medication adherence, improve medication management, and provide education about medication safety.

Aged care organisations require improved IT systems that are interoperable with the My Health Record, namely its Medication Management feature, to ensure there is clear, complete communication with all relevant care providers to prevent the risk of adverse reactions to using multiple medications, with GPs remaining as the primary curator of the patients' My Health Record. Aged care services need significant uptake of contemporary and interoperable IT systems to achieve quality information management systems (see 'gaps in the guidance material' feedback). IT systems could set reminders for annual RMMRs that would prompt aged care staff to consult with the consumer's medical practitioner.

**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?**

#### Requirement 4.5

Good quality, palatable food is important to ensure dignity and quality of life for consumers.

Approximately 1 in 2 residents in Australian RACFs are malnourished<sup>26</sup>. While this is commonly due to underlying medical conditions, a recent study revealed RACFs spend an average of \$6.08 per resident per day on raw food and ingredients<sup>27</sup>. This indicates a lack of focus on food quality. While this Standard correctly indicates the importance of having access to a variety of foods for the consumer that is enjoyable and meets their cultural (or other) needs, there needs to be more emphasis on supplying nutritious meals.

The Standard indicates that organisations should "Consult regularly with dietitians around the appropriateness of the food prepared and delivered to consumers." However, what is 'appropriate' is not covered here. Instead it would be clearer to state "Consult regularly with dietitians that the food prepared and delivered to consumers is nutritionally balanced".

It is also unclear how quality and variety will be measured. For example, the Standards must ensure that a simple name change from 'shepherd's pie' to 'potato pie' on a menu does not qualify for variety.

In summary, this Standard should ensure that food is palatable, good quality, diverse, and nutritionally balanced.

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<sup>26</sup> Hugo, C et al (2018) *What does it cost to feed aged care residents in Australia?* Nutrition and Dietetics. 75: 6-10

<sup>27</sup> Hugo, C et al (2018) *What does it cost to feed aged care residents in Australia?* Nutrition and Dietetics. 75: 6-10

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

See ‘Supporting people living with dementia’ feedback.

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

Standard 6 is largely based around feedback and complaints that come from the consumer. However, sometimes the consumer is unable to communicate this complaint or feedback. AMA members have reported that their complaints or feedback to an aged care organisation sometimes goes unrecognised, if the consumer is unable to communicate this themselves. There should be processes in place that allow other carers, external to the organisation, to be able to provide feedback or make a complaint when they believe the consumer is being disadvantaged in some way, and for it to be taken seriously. This is broadly covered in Standard 6.1<sup>28</sup>, but could be strengthened further. The AMA suggests engaging with external carers to assess whether their complaints have been adequately resolved as evidence of the Standard.

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

‘Workforce and others experience’ under Standard 7.1 states “the workforce describe that they have sufficient number and mix of staff deployed to plan and deliver care consistent with Standards one [and eight]”. Standard 3 should also be mentioned here, and its absence suggests that there is a lack of focus on clinical care.

Standard 7.3 asks ‘What processes are used to monitor that visiting professionals have the appropriate qualifications, experience, professional standing, competencies and other relevant professional attributes?’<sup>29</sup> and requires ‘Policies that describe the credentialing processes for health practitioner such as a register of workforce qualifications and areas of credentialed practice.’<sup>30</sup> It is important for consumer protection that aged care organisations confirm that visiting professionals are who they say they are. However, AMA members have reported that some aged care organisations are requesting credentialing of medical practitioners such as ‘Working with Children’ checks. Medical practitioners are regulated under the Medical Board of Australia<sup>31</sup>, which ensures they have the appropriate credentials and meet particular Standards to carry out their work. It is unnecessary for aged care organisations to ask for specific credentials of medical practitioners such as the above. The Standard should be more specific in what the required credentials are.

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<sup>28</sup> Page 113

<sup>29</sup> Page 136

<sup>30</sup> Page 137

<sup>31</sup> <http://www.medicalboard.gov.au/>

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

Clinical governance policies should be developed with medical practitioners and nurses that:

- Develop assessment and communication protocols for common conditions (such as falls, medication errors, as described in Standard 3).
- Develop and document criteria, mechanisms for escalation for communication by aged care staff to health professionals.
- Address how care by GPs (or other medical practitioners) is best supported.
- Develop and document referral criteria, mechanisms and communication to health professionals.
- Develop protections to ensure that the organisation cannot influence a medical practitioner's duty of care to their patients for financial or commercial gain.

**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?**

Education and training

While there is an indication that there should be education and training programs specified in requirement 7.3<sup>32</sup>, there is a gap in specifying what organisational staff should be trained in to ensure they have the competence to carry out their work. The AACQA should work with the government to develop a mandatory qualification for aged care staff. From a health care point of view, the following fields should be included:

- Strategies for addressing common health issues that older people face.
- Strategies to prevent deterioration in health, such as exercise programs, diversional therapy, and providing adequate nutritious meals and hydration.
- Strategies to reduce distress in dementia patients.
- Intervention and management of elder abuse.
- Appropriate use of restraints (as described above).
- Engaging with Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) older people.
- Palliative Care skills, including recognising and respecting Advanced Care Directives.
- Mental health skills.

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<sup>32</sup> Page 135

## Information and Communication Technology

Embracing Information and Communication Technology (ICT) potentially has huge benefits for the aged care sector. It can increase communication between healthcare (and other service) providers, reduce administrative burden, and assist to improve the health and independence of older people. However, the aged care sector is not typically ICT-literate and this creates a barrier to a more efficient aged care system. To encourage innovation and technology in the aged care sector, the Government needs to provide useful Standards, guidelines and frameworks that assist aged care providers in embracing ICT.

The aged care sector is currently not capable of fully embracing technology. The Aged Care Technology Benchmark Survey conducted by the Aged Care Industry Information Technology Council (ACIITC) found that Australia's aged care providers' management systems and provisions of care have low levels of technology readiness<sup>33</sup>. A study on community aged care services reported that falls and medication incidents had the highest prevalence in community aged care settings<sup>34</sup>. This kind of data is rare in the aged care sector as reporting incidents are usually not easily done, with reasons such as a lack of time, training and education and feedback to staff who reported the incident. For aged care providers to embrace technology in their day-to-day work, they need education and training to improve their ICT literacy.

ICT is the future of aged care. With the introduction of My Health Record, My Aged Care, and the increasing use of clinical and aged care software, the Standards need to ensure that the aged care system is ready for this, and that the systems can be interoperable.

## Considerations under Palliative Care

Palliative care and its principles need to be embedded within organisations, understood and practised by all staff. A palliative approach in aged care settings recognises that healthcare should not be based on diagnosis alone. The aim of a palliative approach is to maximise quality of life through appropriate needs-based care. This approach provides a positive methodology for reducing an individual's symptoms and distress.

There are some statements within the document regarding hospital avoidance by avoiding falls and good nutrition, but no plan on hospital avoidance by making decisions to not treat certain conditions, especially when consumers are approaching the end of their life and such treatments may not be in the patient's interests or wishes. The AMA suggests developing different guidelines for patients for palliative and end of life care (in consultation with a GP and a geriatrician).

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<sup>33</sup> Aged Care Industry Information Technology Council (ACIITC) (2017) *A Technology Roadmap for the Australian Aged Care Sector*. p 21.

<sup>34</sup> Tariq, A. et al (2015), *A Descriptive Analysis of Incidents Reported by Community Aged Care Workers*, Western Journal of Nursing Research, vol. 37, no. 7, pp. 859-876.

An AMA member recalls a recent issue with meeting guidelines in a palliative care situation:

“I was recently called to [a patient] who had end stage dementia and was extremely paranoid and did not want to eat. To meet the nutrition guidelines [the aged care staff] wanted me to sedate her and then force feed her. Fortunately, the geriatrician disallowed this and shortly after we began good quality palliative care in the aged care facility. However, the aged care facility was not funded to provide enough staff to provide palliative care, but as usual staff stayed back late to provide this care.”

There must be a recognition that frail older people do deteriorate eventually and also at some point palliation is more appropriate than trying to maintain life at all costs.

#### Aged care in rural settings

Delivering aged care in rural and remote settings presents a unique set of challenges compared to aged care in metropolitan areas. The AMA believes that the document does not address this fact. The document discusses how there should be integration between various health services. It does not take into account that there may not be access to these services.

#### Respect for aged care workers

There are a number of passionate, hardworking aged care workers that deserve recognition for their commitment to the care of older people. AMA members report that aged care staff do their best with what limited resources, training, funding, and staff capacity they have.

AMA members report that the accreditation process can be extremely stressful to the workforce. Aged care workers are well known to have low wages compared to other sectors. For example, nurses working in aged care are paid significantly less (\$100 per week) compared to nurses who work in acute care settings<sup>35</sup>. This, coupled with the perception that they may lose their jobs if they fail Accreditation, leads to a culture where everything has to be documented and checked off. Thus the actual stated goals of this document are not achieved as staff rush to meet guidelines rather than provide individual and holistic care. There are concerns that if workers do not meet certain administrative guidelines on an already very busy day the facility, will lose services. Aged care staff must be respected by the rest of the health system and regulators, but must also be respected financially and provided good working conditions to ensure the best quality care is received by consumers.

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<sup>35</sup> Senate Community Affairs References Committee's *Future of Australia's aged care sector workforce* inquiry. p52.

## **Conclusion**

This guidance document sets out good principles for aged care services. The next step is to provide guidance on how the Standards will be implemented, and to provide the funding for adequately trained staff to be able to meet the Standards while still providing quality care to their consumers. The current document does not include clear measures for the Standards, and aged care organisations may find challenging to understand what is required of them.

This guidance document covers the majority of care and concerns for consumers, however the AMA is concerned that this will require a huge administrative burden that will take up the little time that the aged care workforce has to care for consumers. Like the previous Accreditation Standards, the AACQA must ensure that this process does not become a barrier to receiving quality care.

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