THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to the Australian Law Reform Commission

Response to Elder Abuse Discussion Paper

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The primary function of nurses is to provide early surveillance and to detect problems that could lead to death and other complications. If there aren't enough nurses at the bedside with visual contact with patients, nurses don't have a chance of making those decisions.
Linda Aiken, Professor of Nursing, Pennsylvania State University

Introduction

The Queensland Nurses' Union (QNU) thanks the Australian Law Reform Commission (ALRC) for providing the opportunity to respond to the Discussion Paper on Elder Abuse (the discussion paper).

The QNU represents all categories of workers that make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care. The QNU also retains specialist lawyers to assist its members in their dealings with the Nursing and Midwifery Board of Australia (NMBA) and Australian Health Practitioner Regulation Agency (AHPRA).

Our more than 54,000 financial 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 QNU and our membership continues to grow.

The QNU has previously made a submission to the Inquiry into Elder Abuse. Here we respond to some of the matters highlighted in the discussion paper.

Changes to the Aged Care Workforce

The QNU has several thousand members working in aged care. The anecdotal evidence they have provided in member meetings indicates that the models of care in residential aged care have changed significantly over recent years.

QNU officials often meet with representatives of approved providers to discuss workload matters or employment conditions. In many of those meetings, facility managers have stated that their models of care have changed because of the difficulty in attracting registered nurses (RNs) to the aged care workforce. However, those models appear more tailored towards meeting business needs rather than residents' needs.

The changes to models of care that have been forced upon providers due to their unwillingness or inability to attract registered nurses have resulted in the registered nurses who remain being restricted to completing non-direct care duties, such as reviewing care plans and completing Aged Care Funding Instrument (ACFI) documentation, while the unregulated workers and

enrolled nurses (ENs) take on greater responsibility for resident care, often with inadequate assessment or supervision.

These changes to the composition of the aged care workforce and their increasing workloads provide the potential for incidents of elder abuse to occur and to go unreported. Therefore the general theme of our submission centres on the concept of 'unintentional neglect'. We point out that the issues we have identified here and in our previous submission are systemic and must not be attributed to individual staff already working to maximum capacity in a notoriously under-resourced sector.

Recommendations

The QNU recommends:

1. The regulation of aged care be amended to include provisions mandating nursing ratios that allow RNs to comply with their statutory duties. Using the evidence-based research conducted by Flinders University and University of South Australia, that ratio of Residents to RNs must be a maximum of 20 Residents to each RN;

2. The regulation of aged care be amended to include provisions mandating that aged care regulation must be read in conjunction with the National Law;

3. As a safety net, there must be amendments to aged care regulation to include provisions mandating a minimum of one RN on each aged care residential worksite at all times to enable RNs and ENs comply with their professional standards;

4. The regulation of aged care be amended to include provisions mandating the number of nursing and care staff rostered on shift must be able to provide nursing and personal care hours per resident per day at a minimum of 4.30 hours, on average;

5. The regulation of aged care be amended to include provisions mandating a skill mix of 30% RN, 20% EN and 50% AIN so quality care can be provided by all categories of staff and missed care (abuse by neglect) will be minimised, if not eliminated;

6. The Accreditation Standards be amended to include explicit provisions mandating that relevant nursing professional standards, best listed in an Appendix to the Standards, are audited by accreditation assessors with respect to compliance by the provider;

7. The Quality Agency does not give residential aged care facilities notice of an 'unannounced' visit.

Quality Aged Care (Quality Nursing)

It is understandable the ALRC would look to the law concerning aged care to determine the adequacy of provisions to ensure quality care is provided to those receiving residential aged care.

However, in our view, the language used in aged care regulation to drive quality care is vague and subjective and therefore open to wide and inconsistent interpretation[1]. Further, it is often overlooked that there are two systems of regulation governing the standards and quality for delivering aged care.

The primary (and often sole) focus of the federal government and approved providers is the regulation of aged care through the *Aged Care Act 1997* (Cth) and its subordinate legislation. This focus is often intense, given it can determine whether an aged care facility will remain approved by the commonwealth or financially viable.

The second system of regulation that impacts on the delivery of quality aged care is that which governs those health practitioners who provide professional health and/or aged care for the recipients of commonwealth-funded aged care services. This regulatory system has a direct impact on the quality of the care provided, but correspondence we have received from accreditation agencies, the Department of Health (Cth) and the Assistant Minister for Health indicates this is not given appropriate consideration when the quality of aged care is assessed.

This second regulatory system is the *Health Practitioner Regulation National Law Act 2009* ('the National Law'), as enacted in every state and territory of Australia. The National Law provides for the protection of the public, including aged care recipients, by regulating the competence, practice and conduct of all RNs and ENs working in Australia.

The relevance of nursing to aged care is highly significant and is emphasised by national health professional peak bodies. For example, the Australian College of Nursing (ACN) holds the view that '*care delivered in residential aged care facilities must be led by RNs*'[2]. The Royal Australian College of General Practitioners' (RACGP) guide for residential aged care states '*registered nurses supervise PCAs and liaise with GPs and other service providers to facilitate health care for residents*'[3]. The Australian Medical Association (AMA) has stated '*the decline in the proportion of registered nurses and enrolled nurses needs to be reversed to ensure residents are provided with timely and appropriate clinical care*'[4].

[1] *Aged Care Act 1997* (Cth), s.54-1(b).
[2] ACN Position statement: The role of registered nurses in residential aged care facilities, July 2016.
[3] RACGP, Medical care of older persons in residential aged care facilities, 4th Edition.
[4] AMA, Future of Australia's aged care sector workforce, Senate Inquiry, Submission 210.

Hence, we highlight the evidential view held by the leading national health professional bodies is that aged care cannot occur unless nursing is provided by RNs and ENs.

The quality of nursing is regulated by the codes and guidelines developed by the Nursing and Midwifery Board of Australia ('the NMBA') pursuant to the National Law[5]. These codes and guidelines are descriptors of the required conduct, ethics and practice of all nurses and is admissible into evidence in tribunals or courts of relevant jurisdiction as constituting appropriate nursing practice or conduct[6].

Here are just a few relevant excerpts from those codes and guidelines[7]:

Code of Professional Conduct for Nurses in Australia

This Code of Professional Conduct for Nurses sets the minimum standards for practice a professional person is expected to uphold both within and outside of professional domains in order to ensure the 'good standing' of the nursing profession.

A breach of the Code may constitute either professional misconduct or unprofessional conduct. While mandatory language such as 'must', 'shall' and 'will' is not used throughout this Code, it is important for nurses to understand that there is a presumption the conduct discussed is mandatory and therefore not discretionary for nurses practising nursing.

Professional Standards include… this Code of Professional Conduct for Nurses in Australia… (and) standards developed by professional nursing organisations.

Code of Ethics for Nurses in Australia

Nurses who value quality nursing care ensure the professional roles they undertake are in accordance with the agreed practice standards of the profession.

Decision Making Framework[8]

Registered nurses are accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care.

This type of decision, depending on assessment of dynamic contextual factors, must be made by the accountable registered nurse at the time. Such decisions cannot be made in advance. An organisation can prepare certain groups of workers to be capable of performing the activity

[5] *Health Practitioner Regulation National Law Act 2009* (Qld), s.39
[6] *Health Practitioner Regulation National Law Act 2009* (Qld), s.41
[7] http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements.aspx, accessed 10 Jan 2017.
[8] NMBA: A national framework for the development of decision-making tools for nursing and midwifery practice.

when the registered nurse determines that it is appropriate for a specific health consumer in a specific context.

Nurses providing and supervising aged care must comply with the codes and guidelines in their nursing practice. However, our experience in assisting members is that aged care providers generally make it very difficult for them to comply with the standards of nursing practice that ensure quality nursing.

This difficulty lies in three main areas – staffing, skill mix and compliance with practice standards. In our view, this is because the regulation of aged care is not considered in conjunction with the regulation of nursing.

Staffing

With the relatively low and continually declining numbers of RNs working in aged care[9], the bulk of nursing activities must be delegated to and performed by assistants in nursing ('AINs') (however titled and will include e.g. personal care workers). The NMBA's codes and guidelines provide for the delegation of nursing to competent AINs by the RN, however there are a large number of criteria to be considered before and after the RN delegates that episode of care.

Whilst many AINs are trained to Certificate level, the quality of that training is not subject to NMBA scrutiny and the scope of the training varies from individual to individual, dependent upon the work experiences that have developed their skill sets. There is also a large cohort of AINs who do not have any specific training or qualification for providing delegated nursing , i.e. aged care.

AINs are a valued member of the nursing team, however the current inadequacies in regulation and inconsistencies in training put both AINs and residents at risk. The staffing and skill mix methodology we recommend in this submission acknowledges the important and continuing role of AINs and proposes they make up 50% of the workforce, with RNs and ENs making up the remaining 50%.

The variability of AIN training and qualifications creates a number of difficulties for RNs "on the floor". One of the NMBA-mandated requirements for delegation is the assessment of competence of the individual AIN to perform the episode of care safely and confidently. This assessment requires from the RN instruction, demonstration, observation, assessment and (initially) direct supervision of the AIN.

[9] The Aged Care Workforce, 2012 – Final Report, p.22.

Another of the mandated requirements for delegation is that the RN must evaluate the outcome of the delegated episode of care[10]. This means the RN must personally assess the resident to ensure the care was provided correctly and had the intended outcome.

The assessment of AINs and the evaluation of the outcomes of delegated care are difficult and often impossible for many RNs in aged care due to the sheer numbers of residents they are accountable for.

In one negotiation on behalf of an individual member, QNU officials discovered the RN member was accountable for the care of 136 high care residents during her shift, with the assistance of six AINs. This circumstance is repeated in many residential aged care facilities, where a single RN can be accountable for the care of up to 150 residents[11].

It would be a nonsense to suggest that any RN was able to comply with her/his statutory duty to evaluate the outcome of every delegated episode of care to 136 residents. Such situations are verifiable evidence of why a statutory scheme that ensures there are sufficient RNs on duty at any given time must be implemented as a matter of urgency to allow RNs to comply with their minimum standards for practice that will provide *true* quality care.

When discussing staffing levels in the context of the RNs' requirement to comply with the nursing professional practice framework established by the NMBA pursuant to statutory instruments, QNU officials are commonly told by employers - "we've passed accreditation".

With regard to the minimum hours of care required for quality care, recent studies[12] on the provision of residential aged care have shown that each resident requires, on average, 4.30 hours of nursing and/or personal care in every 24-hour period. This is the evidence-based minimum requirement to ensure quality residential and restorative care.

Drawing on the real life example given above, those 136 residents would require a total of 585 minimum care hours per 24 hours, or an average of 195 hours per shift over three shifts. 195 hours of care in any given eight-hour shift would require 24 care staff. The facility described above employed only seven on the given shift, yet it met the quality criteria contained within the Accreditation Standards.

This facility is indicative of many facilities run by the for-profit and not-for-profit providers in the aged care sector.

[10] NMBA: A national framework for the development of decision-making tools for nursing and midwifery practice, p.17.
[11] ANMF National Aged Care Survey Final Report, July 2016, p.21.
[12] ANMF, National Aged Care Staffing and Skills Mix Report 2016, Flinders University & University of South Australia.

In 2016, the Australian Nursing and Midwifery Federation (ANMF) conducted a national aged care survey. Four of the comments received from consumers or their relatives are detailed here:

"My mother is left to wet herself as no staff come to toilet her, she becomes dehydrated due to water or trolley not left near her, bell not near her to call staff. No skin care so my mother has bedsores now. All due to no experienced [carers], and no nurse as [there's] one nurse to 100 patients.

"Not enough staff on esp. overnight. My mother fell in her room when getting up to toilet and was lying on floor a long time with fractured femur. Only 2 or 3 staff on for 50 residents. Not enough!

"Residents often were not showered, looking constantly uncared for. Teeth not cleaned, basic care not attended. On a few occasions they just left my Nan in her room rather than getting her for meals as they forgot as they were too rushed.

"My mother who is paralysed left side and suffers memory loss due to a stroke is often left in bed all day, often not showered, rarely has teeth cleaned and was left unsupervised twice resulting in ambulance to hospital and further brain injury and surgery. More staff would allow adequate care.

We submit that the absence of mandated RN staffing ratios in the Accreditation Standards for aged care forces RNs into a situation where they are prevented from complying with their statutory duties. We also submit that the current *Quality of Care Principles 2014* (Cth) are grossly inadequate to provide quality aged care, to a nursing professional standard, which is the right of every aged care recipient to receive and the statutory duty of every nurse to provide.

The QNU emphasises that to encourage or direct an RN to engage in unprofessional conduct, by forcing them into a position where they are unable to comply with their statutory duty or a professional standard, e.g. the standards for quality nursing care, or the principles for delegation and supervision of nursing care, is an offence under s.136 of the National Law and carries substantial penalties.

The QNU recommends:

1. aged care regulation be amended to include provisions mandating nursing ratios that allow RNs to comply with their statutory duties. Using the evidence-based research conducted by Flinders University and University of South Australia, that ratio of Residents to RNs must be a maximum of 20 Residents to each RN;

2. as a safety net, there must be amendments to aged care regulation to include provisions mandating a minimum of one RN on each aged care residential worksite at all times to enable RNs and ENs comply with their professional standards;

3. the regulation of aged care be amended to include provisions mandating that aged care regulation must be read in conjunction with the National Law;

4. the regulation of aged care be amended to include provisions mandating the number of nursing and care staff rostered on shift must be able to provide nursing and personal care hours per resident per day at a minimum of 4.30 hours, on average.

Off site supervision and delegation

In residential aged care facilities, it is not uncommon to find facilities that do not have a RN on shift 24 hours a day. Many facilities are staffed by ENs as the most senior nurse on shift during afternoon and night shifts.

This is another example of aged care nurses being placed in a situation where they are unable to comply with their statutory duty because an EN may practice nursing only under the supervision of a named and accessible RN[13] and an EN cannot delegate nursing care to AINs[14].

The NMBA states that the supervision of ENs can be direct or indirect. Indirect supervision is defined as where the RN works in the same facility or organisation as the EN but does not constantly observe their practice[15].

Generally, aged care providers take a very wide view of indirect supervision and persuade nurses that the supervising RN can be off site, in some instances over 100 kilometres away from the facility the EN is working in, but still "within the organisation".

The following comment from an aged care worker is representative of the widespread abuse of the NMBA's definition of supervision:

There were 53 residents, including an 8 bed special care unit, and 85% of these required high care (according to their ACFI scores). Overnight, there were only 2 PCAs rostered, and an RN on call. These staff were expected to wake residents at 0500 to commence the personal hygiene tasks.

[13] NMBA Enrolled Nurse Standards for Practice.
[14] NMBA: A national framework for the development of decision-making tools for nursing and midwifery practice.
[15] NMBA: A national framework for the development of decision-making tools for nursing and midwifery practice.

Again it is a nonsense to suggest that an off-site RN can assess the competence of ENs and AINs and evaluate all or any of the episodes of care provided to aged care residents by on-site ENs and AINs.

As a result we see hundreds of aged care providers across Australia develop roster systems and models of care that include off-site RN supervision. Such systems are not challenged by auditors of accreditation criteria, despite the fact that RNs and ENs are cajoled into non-compliance with their legal duties emanating from the National Law.

We submit there is a chasm between the Accreditation Standards and the nursing professional practice framework, that the regulation of aged care does not contemplate the provisions of the National Law, nor is it read in conjunction with the National Law.

The QNU recommends:

5. The Accreditation Standards be amended to include explicit provisions mandating that relevant nursing professional standards, best listed in an Appendix to the Standards, are audited by accreditation assessors with respect to compliance by the provider.

Skill Mix

The recent research referred to above[16] has also provided an evidence base for the establishment of mandated skill mix requirements within aged care. This research states that there should be a minimum skill mix of 30% RN, 20% EN and 50% AIN.

In the example given above, where the facility caring for 136 residents would require 195 care hours in an eight hour shift from 24 staff, the skill mix required to provide quality care in keeping with the National Law would be seven RNs, five ENs and 12 AINs. The facility in fact had only one RN and six AINs on shift.

Given the deplorable level of staffing and the poor skill mix generally engaged by aged care providers, we submit that it is little wonder that the research project exposed horrendous levels of missed care, which of course is a form of neglect and thus, a form of elder abuse.

The QNU recommends:

6. The regulation of aged care be amended to include provisions mandating a skill mix of 30% RN, 20% EN and 50% AIN so quality care can be provided by all categories of staff and missed care (abuse by neglect) will be minimised, if not eliminated.

[16] National Aged Care Staffing and Skills Mix Report 2016, Flinders University & University of South Australia.

Aged Care Regulation

The *Aged Care Act 2014* (Cth) ('the Act') requires residential facilities to maintain "*an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met*"[17]. The *Quality of Care Principles 2014* (Cth) ('the Principles') provide for the Accreditation Standards and states that the residential facility must ensure that "*there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives*".[18]

That is as far as Australian law goes in its provisions for the staffing of residential aged care facilities, using subjective terms such as 'appropriate' and 'sufficient' for the care of our most vulnerable Australians.

The provisions also fail to refer to the standards required of nurses when it comes to the provision of quality nursing, i.e. that the RN ensures that the staffing and skill mix supports their capacity to make sound nursing decisions and provide quality care.[19]

We submit that these subjective terms in the Act and the Principles ***must*** be removed in favour of defined nurse to resident/patient ratios, or at the very least read in conjunction with the National Law and its subordinate codes and guidelines for nursing practice, in order to determine exactly what is 'appropriate' and 'sufficient' for quality aged care.

We also submit that the recent research referred to above is the only evidence base in existence to determine an appropriate methodology for staffing and skill mix in aged care. This evidence base should be the starting point for ensuring missed care does not occur and nurses can comply with their mandatory obligations, through well-defined staffing and skills mix.

Schedule 2 of the Principles also states that providers of aged care must "*ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about health and personal care*".

We strongly urge the ALRC to consider the demonstrated inadequacies of the current state of staffing and skill mix in aged care as evidence that most approved providers fail to accommodate the legislation and regulatory framework governing nursing practice.

[17] *Aged Care Act 1997* (Cth), s.54-1(b)
[18] Quality of Care Principles 2014 (Cth), Schedule 2, clause 1.6
[19] NMBA: A national framework for the development of decision-making tools for nursing and midwifery practice.

Practice Standards

QNU members working in aged care can provide a swathe of evidence suggesting most facilities fail to ensure compliance with nursing professional standards and guidelines. The best example of this evidence is in provider practices regarding medication management.

By far the majority of aged care facilities use AINs to administer medicines to most if not all residents. However the professional standard on this matter[20], endorsed by the Department of Health (Cth)[21] and the Australian Coalition of National Nursing and Midwifery Organisations[22], is that AINs or carers may assist only those residents who are competent to self-administer their medicines. This professional standard is rarely complied with in practice in contemporary residential aged care.

The use of AINs in administering medication commenced as a means of accommodating insufficient numbers of RNs and ENs to administer medicines. Recruitment and retention of aged care nurses has been an ongoing concern, a situation exacerbated by significantly lower rates of pay for RNs.[23]

It has become clear that current medication management which can put aged care residents at risk and is therefore a form of abuse, is establishing itself as an embedded practice. This is despite the fact that Queensland Health abandoned the development of guidelines for AIN involvement in medication assistance (in low care facilities only) in 2008 due to unanimous concerns for resident safety.

We submit that the majority of residential aged care facilities fail to comply with professional nursing legislation, regulatory requirements, professional standards and guidelines relevant to health and personal care.

The QNU is ready and able to assist with the development of a list of relevant Standards.

Lack of Accountability

The various correspondence QNU has had with the regulators of aged care and even the Minister has denoted, in our view, a clear lack of accountability for aged care standards and a lack of understanding of the practical implications of the National Law.

[20] Nursing Guidelines for the Management of Medicines in Aged Care at http://anmf.org.au/pages/nursing-guidelines-for-the-management-of-medicines-in-aged-care

[21] Guiding Principle for Medication Management in Residential Aged Care, Guiding Principle 14, Resources

[22] http://connmo.org.au/

[23] Aged care RNs receive around $200 per week less than their counterparts in the public sector. ANMF Nurses'Paycheck, 2016.

On 25 March 2013, we wrote to the Aged Care Standards and Accreditation Agency seeking reasons why accreditation reports on facility audits fail to indicate whether a residential facility complies with relevant professional standards and guidelines for nursing care.

The Agency responded on 13 May 2013, stating that the audit team assesses how the facility itself undertakes the task of compliance. The Agency did not offer any evidence that nursing standards are considered in an audit.

On 29 May 2015, we wrote to the Australian Aged Care Quality Agency regarding the recommendations of the Tasmanian State Coroner following the inquest into the death of residential aged care recipient Stanley Valentine Whiley. The State Coroner made various recommendations to the Agency regarding the knowledge and experience of RNs in charge of facilities and the appropriateness of engaging AINs in medication management.

On 29 July 2015, the Agency responded by letter stating, et al "*it is not within our remit to make standards or to mandate particular matters or methods to be practised by care homes in order to meet the Standards*".

On 18 August 2015, we wrote to then Assistant Minister for Aged Care, Senator the Hon Mitch Fifield about professional standards in relation to medication management in aged care. We did not receive a reply from Senator Fifield.

On 21 January 2016, we wrote to the then Minister for Aged Care, the Hon Sussan Ley MP reiterating our concerns regarding professional standards in relation to medication management in aged care. On 9 March 2016, we received a letter from the Hon Ken Wyatt AM MP, Assistant Minister for Health and Aged Care, replying to our letters to Senator Fifield and Minister Ley.

The Assistant Minister stated "*The Quality Agency does not have any statutory authority to determine if an aged care service complies or fails to comply with all of the requirements that fall within the purview of state and territory governments, or national professional standards*".

If that is the case, then we submit the current Accreditation Standards mandating compliance with professional standards and guidelines are, in practice, ineffective.

The Assistant Minister further assumes it is up to the relevant regulatory authority (the NMBA) to find a service in breach (of professional standards). This assumption indicates a clear lack of understanding of the provisions of the National Law and the role of the NMBA – to keep the public safe by ensuring that ***individual*** practitioners are competent to practice quality nursing care.

ALRC Discussion Paper Claims

In Chapter 11 of the discussion paper, the Department of Health (Cth) claims there is a strong focus on the quality and accountability of aged care services. In our view, quality aged care relies on health care professionals meeting regulatory standards.

This is further supported by the fact that the Government Ministers responsible for ensuring quality aged care defer the issue of the clinical practice of nurses working in aged care to the NMBA to regulate, rather than addressing the matter and its impact on quality aged care. This clearly misunderstands the role of the NMBA in regulating the practice of individuals, not services.

ANMF surveys and University research have provided QNU with an evidence base that missed care is rife in aged care services. Missed care should be of great concern to the ALRC as probative evidence of elder abuse in aged care.

Whilst the Department of Health (Cth) has the power to take action, the QNU is not aware of any instance in recent years where an aged care provider has had their approval status as a service provider suspended or revoked.

With regard to the Quality Agency, their audits ignore the fact that quality aged care is heavily influenced by the nurses' capacity to provide quality nursing , which in turn is dictated by the number of nurses 'on the floor'. The Quality Agency is aware of this but chooses not to assess it, despite having the remit to evaluate professional standards and guidelines.

Further to our claim, the QNU can point to Quality Agency audit reports where facilities have met as few as 33 of the expected 44 outcomes, yet still received accreditation, despite failures in nutrition, hydration, clinical care and medication management.

The ALRC should also be aware that when the Quality Agency carries out 'unannounced' assessment audits, the facility receives three working days' notice. According to our members, a 'flurry of activity' occurs just prior to a Quality Agency visit, hence we believe 'unannounced' visits should be truly unannounced.

The QNU recommends:

7. The Quality Agency does not give residential aged care facilities notice of an 'unannounced' visit.