CONSULTATION RESPONSE

Allied Health Professions Australia

Senate Community Affairs References Committee

Inquiry into the Effectiveness of the Aged Care Quality Assessment and accreditation framework

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Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback to the Senate Standing Committee on Community Affairs Inquiry into the 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.

AHPA is the national peak body representing Australia's allied health professions. We have 20 individual member associations, and a further six organisational friends who represent allied health professions or professions closely aligned with the allied health sector. The AHPA membership represents some 93,000 allied health professionals working across a wide range of settings and sectors. Our friend organisations represent a further 5,400 professionals.

A significant proportion of those allied health professionals provide essential care to older people living in residential aged care settings as well as in the community. AHPA and its member associations are committed to ensuring that all Australians, regardless of their background, socioeconomic status or age, can access safe, evidence-based services to support wellness, reablement and maintenance of functionality so that they can live life as fully as possible.

This submission has been developed in consultation with AHPA's allied health association members.

Introduction

It is clear that the current Australian aged care system is failing older consumers, particularly those living in residential aged care. A range of current and previous inquiries have revealed significant issues, not only in individual aged care facilities such as Oakden in South Australia, but within the broader structures and systems that make up the aged care sector. Those issues are contributing to poorer outcomes for older people and their families.

While this submission will focus on the Inquiry's limited terms of reference, we note our strong contention that the quality issues that impacted Oakden residents and that have driven this review are directly impacted by the funding structures that supported the facility in its operations. We argue that those funding issues were a major contributor to the issues within Oakden, including the inability to attract high quality staff and to fill allied health positions. We further argue that those same issues are a major factor in quality issues in other facilities. Without appropriate mechanisms to identify and fund the necessary quality and volume of staff required, no regulations will be able to guarantee quality services. Furthermore we argue that quality issues cannot be separated from the funding that underpins any service.

This is particularly the case when it comes to access to allied health services. Allied health services are important providers of care and support for older people, particularly where the health needs of the older person encompass greater complexity such as where older people are experiencing dementia and mental ill health. In this case, the involvement of appropriate allied health services can be an essential means of supporting the older person and other staff to manage complex behaviours and to meet the various needs that person has. From our perspective, it is clear that quality services depend on the right funding system and AHPA is strongly advocating for better funding for residential aged care facilities to support them to employ appropriate staff.

We note that the Interim Report provides a number of references to the lack of access to allied health services. AHPA contends that this reflects a broader trend where older people continue to lack sufficient access to important allied health services that support improved health and wellbeing. The World Health Organisation Active Ageing Policy Framework (2002) states that choice and control, autonomy and independence are fundamental to healthy ageing.[i] While various Australian governments have supported this goal, in practice, the types of allied health and other services necessary to achieve healthy ageing are limited.

The key factor contributing to poor access to quality care are the limitations in the Aged Care Funding Instrument (ACFI) with regards to assessing and supporting the full range of a person's needs. A number of recent reviews, including the Review of the Aged Care Funding Instrument (released publicly October 2017) and the University of Wollongong report into new models for the ACFI (released publicly April 2017), have noted the lack of support for allied health services and the impact this has on the health and wellbeing of aged care residents. However, these recommendations have not yet translated into reforms. We note that this inquiry remains focused exclusively on quality assessment and accreditation and does not appear to be considering the important intersection with funding.

Mental health remains a major issue for older Australians living in residential aged care services. The National Ageing Research Institute suggests more than 50 percent of those living in aged care facilities have anxiety and/or depression and just under 50 percent enter residential with a pre-existing depressive condition. And while the Federal Government announced $82.5 million dollars in funding to address access among older people, there is still little or no information about how this program will run or who will have access to services.

Responses to the terms of inquiry

The AHPA response addresses only the first term of reference. We encourage the Committee to contact us for additional clarification on any points raised in this response.

A. The 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;

Allied Health Professions Australia (AHPA) strongly argues for the importance of ensuring that a robust and effective Aged Care Quality Assessment and accreditation framework underpins the delivery of services for older people in Australia. This framework must provide the necessary safety mechanisms to ensures residents of Australian residential aged care services are protected from abuses but must also ensure that older people have access to high quality clinical and medical care. It is our contention that changes are urgently required as the current assessment and accreditation framework is failing to assess important aspects related to the quality of care consumers receive. We further contend that current practice as it is understood and practiced by the Quality Agency, is not aligned to current evidence and best practice. We echo the Victorian Government submission, referred to on page 52 of the Interim Report, which noted that while the accreditation process has supported improvements in RACFs over the past two decades, the focus on compliance to minimum accreditation standards by individual providers does not support sector-wide capacity building or encourage improvements beyond the minimum benchmarks.

One of the biggest concerns the allied health sector has in regards to the quality of any aged care assessment is the lack of focus on the relative independence, wellbeing, physical activity and maintenance of mobility and function for aged care residents. We note that there is little focus on choice and control for aged care residents both in the structure of the Aged Care Funding Instrument and in the quality assessment and accreditation framework used to determine if facilities are delivering appropriate care. This leads to significant variation in the services and supports that residents can access and in the quality of those. We argue that it also indirectly leads to outcomes such as experienced by residents at Oakden where patients were overmedicated and had little support to maintain any quality of life or dignity.

Access to allied health care is an integral element of quality care

AHPA argues that the role of allied health in quality care is essential, particularly where patients have more complex needs. In situations where residents are likely to have the most complex needs, staffing must consist of the most experienced, highly qualified staff to ensure that patients are appropriately supported. One of our most significant concerns about the findings of the inquiry is that despite the concerns of the CVS team about allied health staffing, Quality Agency audits were undertaken several times during the same period and no adverse findings made suggesting that this is not an area the assessment process considers.

The interim report states in section 2.53:
The Community Visitor Scheme (CVS) annual report for 2016–17 presented a worsening situation for allied health in the facility. At the time of the annual report, the only allied health professional working at Oakden was a part-time dietitian. An extract from a visitor report stated that there was no occupational therapist, physiotherapist, psychologist, speech pathologist, or social worker employed by Oakden and that while these services were available on call from another centre, staff had 'been told to call on these only in exceptional circumstances…and only two referrals [had] been made in…18 months (one forensic)'.

Given the essential role of some allied health professions in supporting residents with complex needs, this is of significant concern and must be addressed in any recommendations for reform of quality and accreditation frameworks. AHPA argues that as part of potential reforms, work should be undertaken to identify best practice models of care for different types of facilities and different patient cohorts, particularly those supporting the most complex residents, that identify the necessary roles and staffing needed to support the needs of those residents. This should ensure ongoing quality care and a culture of continual improvement within any residential aged care facility. Such a staffing mixture will involve a combination of allied health staff, registered and enrolled nurses, and other aged care support staff. Once identified, and with appropriate flexibility to address the different patient cohorts in different facilities, this staffing mixture should be part of the audit process.

The Oakden report demonstrates that allied health staff are frequently seen as expendable with positions left unfilled or not backfilled for leave and with staff not qualified to do so filling the role. Management of allied health staffing levels varies. There are no quotas and allied health service provision is dependent on the policy or mindset of the facility. Some facilities engage consultant allied health either ad hoc or for programs. Some employ allied health, but they are frequently in sole positions and can lack professional support and supervision. Anecdotal evidence indicates a preference for inexperienced, and therefore cheaper, employees.

The quality assessment process will need to use staffing profiles as part of reporting, ensuring that these models of best practice care are adhered to and key roles not left vacant. We do note that this must be supported by ensuring that residential aged care facilities have access to the necessary funding to maintain staffing through a revised ACFI. We note that *A Matter of Care,* the Report of the National Aged Care Workforce Taskforce (2018), that allied health professionals "will play an increasingly bigger and critical role in delivering holistic care services that support positive ageing and reablement and improve the quality of life of consumers"[ii] and recommended a widespread

review of the workforce across the industry aimed at ensuring that all older people, and particularly those in residential care, have access to holistic, multi-disciplinary care.

A range of recent submissions to aged care inquiries show that there are differing views on whether staffing should be considered in the audit process. Submissions to the Federal Parliament's Inquiry into the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018* show some resistance to reporting on staffing and submissions to this inquiry have also varied in their views on the importance and role of reporting on staffing.

AHPA and our members very much support the need to consider staffing carefully as part of any quality assessment. We note that there is some support for this approach, such as the submission made by BUPA arguing that allied health service provision should be considered in the Quality Agency assessment process. We note however that this should not only encompass staffing numbers or ensuring that particular roles are filled, such as the allied health roles at Oakden. It will be important to ensure that a revised assessment seeks to quantify and assess the various roles and the scope of those not only for standard services that apply for all residents but also those that may be individually focused as is often the case with allied health services. The process will further need to account for the varying employment structures that support allied health services, particularly the common nature of contracted services.

AHPA argues that the high dependence at Oakden on over-medication is a symptom of understaffing and insufficient support by appropriately qualified health professionals. AHPA member feedback suggests that over-medication occurs too frequently and most typically in situations where staff are overworked and where there is high staff turnover rates and dependence on the use of agency staff.

The management of resident behaviour is often managed exclusively by visiting GPs and nursing staff within the facility with limited opportunities for multidisciplinary input to support non-pharmacological intervention. This is partly due to the frequency with which allied health services are outsourced and not a fixed part of facility staffing and partly due to funding structures. The use of medication to manage challenging behaviours is a significantly more cost effective strategy for residential aged care facilities as the cost of medication and GP's services is borne by Medicare while the use of allied health staff as part of non-pharmacological management of behaviours would need to be funded by the facility. Given the lack of support for those interventions through the ACFI, it is unlikely that a facility could or would provide those services.

Despite these structural barriers, AHPA strongly argues that evidence clearly shows that non-pharmacological interventions are better for the consumer and that they should thus be considered as part of quality audits. We note that a key recommendation of the South Australian Chief Psychiatrist's Oakden Review (at page 66) was a much greater role for allied health in whatever facility replaces Oakden.

In addition to including assessment against models of care/staffing profiles, AHPA further submits that the assessment process should seek not only to engage consumers and families, a recommendation we support, but also to engage key allied health roles in audit discussions, even where these are not full-time employees of the facility. We argue that this element of the audit

process is essential, given the specific expertise allied health professionals have in areas such as behavioural support, mental health, modification of environments and reablement and the insight they are likely to have into how well a facility is achieving these goals.

Ensuring we do not over-regulate

We note that Aged and Community Services Australia (ACSA) argued that individual clinical care was not an area that the Quality Agency should be assessing at all, and submitted that concerns about the standard of care provided by doctors and other health practitioners should be considered by the appropriate health practitioner body. While ACSA applied this argument more broadly to argue against including reporting on staffing, AHPA agrees that the specifics of how an individual practitioner provides clinical care may be best referred to an appropriate health practitioner body and that it would be inappropriate to add new regulatory processes for health practitioners, given the current standards, codes of conduct and regulatory frameworks that already ensure they are accountable for their clinical care. Our view is that the aged care system and its regulator do not have responsibility for assessing the standards of clinical care but they do have a responsibility for assessing and ensuring an environment in which safe appropriate care is enabled.

AHPA is highly concerned about recent trends to add additional layers of regulation and accreditation to health professionals already covered by a robust quality framework and wish to pre-empt any consideration of such in this case. The impact of new regulation can be significant and detrimental to the workforce, particularly where there are audit costs associated with compliance and where health professionals work across multiple schemes as is the case for many allied health professionals.

A recent example is the National Disability Insurance Scheme (NDIS) Quality and Safeguarding Framework for disability which adds additional regulation to any practitioner providing services to a cohort of people with disability based solely on the source of funding they receive, not on measures such as vulnerability or risk.

While AHPA recognises the need to manage unregulated elements of the disability (and other) workforces that support potentially vulnerable consumers, these should seek to avoid duplication and any changes made with careful consideration of other regulatory mechanisms.

An example of the arbitrary nature of current regulation is the following:
An older person with a disability receiving NDIS-funded and managed supports can only receive supports from allied health professionals registered under the Quality and Safeguarding Framework. However, when that person turns 65, they are no longer eligible for the NDIS and must transition to aged care. Any services provided by allied health practitioners to that person no longer require registration under the Quality and Safeguarding Framework. While the person, their needs, and their potential vulnerability have not changed, the funding system has changed.

We note that if a review of quality assessment and accreditation identifies gaps in the regulation of allied health professionals, AHPA supports addressing these through modification of the existing regulatory framework.

All allied health professionals are university qualified at the level of AQF7 or above. The competency frameworks for training have been developed rigorously over many years and ensure that practitioners are appropriately trained in the 'health' paradigm with differing emphasis on aspects of care depending on the specialty. Upon graduation they are considered entry level competent to work in a wide range of practice areas. Initially and throughout their careers they could be employed in hospitals of all kinds, community health, disability services, mental health services, justice health, social services, Aboriginal and Torres Strait Islander health services, sports medicine, refugee health and aged care. Applying additional layers of regulation to individuals does not increase safety or quality for allied health practitioners already well regulated either by AHPRA or under robust self-regulation for others.

In this context we note that the following statement in the interim report is incorrect:

> *3.59 The Australian Health Practitioner Regulation Agency (AHPRA) regulates 14 health professions, including all staff responsible for clinical assessment and medical care within an aged care context. They include doctors, registered and enrolled nurses,as well as physiotherapists, occupational therapists and certain other allied health staff. The Complaints Commissioner does not have jurisdiction in relation to the actions of individual registered health practitioners, and refers such complaints to AHPRA for investigation.*

A number of professions involved in providing clinical assessment and medical care are outside the National Registration and Accreditation Scheme (NRAS) and thus not regulated by AHPRA. These include the self-regulated professions of social work, speech pathology, audiology and dietetics. While these professions are not regulated by AHPRA, we note that where typical practice is followed and practitioners from self-regulating professions are required to hold membership with their professional body, the professional body provides a similar function to AHPRA.

Final comments

AHPA is concerned that the Inquiry has been driven by an unrealistic faith in professional regulation to ensure that quality care is delivered. The current aged care system was established at a time when the overall frailty and clinical acuity of Australia's older population was far lower than now and where rates of dementia and complex care needs were significantly lower. The paradigm has shifted but the standards and funding instrument have failed to keep pace.

We note that while AHPRA and individual professional bodies determine the core competency standards for a profession, set out codes of conduct and require evidence of continuing professional development, they do not monitor practice, are agnostic to where individuals are employed and do nothing about individual practice until something goes wrong and a formal complaint is made. It is not in their remit to undertake quality auditing.

Such regulatory powers were well in place when the Oakden situation was evolving but nothing was done because no complaint was made until after the event. It is a classic case of parking the ambulance at the bottom of the cliff rather than fixing the safety barriers which are the guidelines, models of care and culture which support those working within the system.

There are facilities which utilise allied health well and support residents to access appropriate care when needed but this should be the norm, not the exception. Clinical care is clinical care regardless of where it is delivered, and the same standards should apply for the treatment of a particular condition or patient group. Even where lifestyle interventions are provided such as exercises or diversional therapy this should be undertaken according to appropriate standards and staffing.

AHPA argues that in addition to looking at ways to strengthen regulatory systems, audit processes and the interaction between different systems there should be more consistency in the outcomes measures that are applied across health, aged care and disability noting the arbitrary nature of assigning different measures to the different sectors despite the close relationship between them and the likelihood that a single patient/consumer could be supported within all three sectors across a short period of time.

As a final note, we wish to highlight that the following quote from the report is not accurate:
Aged care is the only institution where the person who goes in dies—that is almost guaranteed—so there are no repercussions for society about how they've been treated. If you have a bad education system, a bad prison system or a bad hospital system, there are repercussions for society when those people leave those institutions. That's not the case in aged care.

A range of palliative care services and hospices deliver high quality care and excellent outcomes for consumers in the final stages of their lives.

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[i] World Health Organization. (2002). Active ageing: a policy framework. Geneva: World Health Organization

[ii] The full report can be accessed here: https://agedcare.health.gov.au/aged-care-workforce-taskforce-strategy-report